STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2025 HOSPITAL BUDGET DECISION AND ORDER

In re: University of Vermont Medical Center Fiscal Year 2025	)))	Docket No. 24-004-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 and optimally allocate and use the significant dollars already devoted to the system. 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, and hospital utilization and patient acuity are increasing. 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 hospital clinical productivity data that revealed 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.

[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.

§ 9371; *see also* 18 V.S.A. § 9375(a)), its obligation to establish budgets with the considerations 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.

The University of Vermont Medical Center (UVMMC) requested a 9.3% increase in NPR over its FY24 approved budget and a 6.8% increase in commercial rate over its FY24 approved commercial rate. On July 19, 2024, after hospital budget submissions were closed, UVMMC submitted a letter purporting to "amend" its commercial rate increase to 7.91%.[22] UVMMC's and University of Vermont Health Network's (UVMHN) senior leadership presented UVMMC's proposed budget to the Board at a public hearing held on August 28, 2024. UVMMC also submitted pre-hearing and post-hearing responses to questions asked by GMCB staff.[23] On

[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] UVMMC Letter to GMCB Re FY25 Budget 071924.pdf (vermont.gov)
[23] *See* Additional FY25 Hospital Budget Information. https://gmcboard.vermont.gov/node/11866

September 11, 2024, following GMCB staff presentations and Board deliberations, and for the reasons set forth below, the Board established UVMMC'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.

FINDINGS

1. The University of Vermont Medical Center is a prospective payment system hospital with its primary location in Burlington, Vermont. UVMMC is Vermont's largest hospital by revenue and the state's only tertiary care hospital and academic medical center.

2. In its FY25 budget submission UVMMC requested 9.3% growth in NPR from its FY24 budgeted NPR, for a total of $2,004,174,791. *See* UVM Submission, Income Statement, 2. This proposed increase exceeds the 3.5% growth benchmark.

3. UVMMC requested commercial negotiated rate growth of 6.8% over its FY24 approved rate. *See* UVMMC Workbook, Rate Decomposition Sheet. This proposed increase exceeds the 3.4% commercial negotiated rate growth benchmark. On July 19, 2024, UVMMC sent a letter purporting to amend its commercial rate request to 7.91%.

4. UVMMC's proposed budget anticipates an operating margin of approximately $69 million, or 2.9%, 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 its requested commercial rate increase. UVMMC assumes that for FY25, reimbursement rates will increase by 2.1% for Medicare, 3.0% for Medicare Advantage, and 6.6% for Medicaid. *See* Rate Decomposition Sheet, *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 118.

6. 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;[24] CMS Newsroom, FY25 Hospital OPPS and ASC Payment System Proposed Rule.[25] 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.* UVMMC's assumption of a 2.1% increase in the Medicare reimbursement rate was not explained or adequately justified.

7. UVMMC's assumption of a 6.6% increase in Medicaid rates was also not adequately explained or justified. *See* Narrative, 22. The Department of Vermont Health Access (DVHA) will not increase Medicaid rates for FY25, but UVMMC could potentially realize some increased rates from neighboring state Medicaid programs.

[24] https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0
[25] 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. UVMMC anticipates a 5.1% increase in NPR due to increased utilization. *See* Rate Decomposition Sheet; *see also* Hospital Budget Review, GMCB Staff Presentation (Sept. 9, 2024), 119. In FY23 UVMMC underbudgeted its utilization by over $121 million, or 7.3%. UVMMC FY23 Actual-to-Budget Narrative (July 31, 2024), 1.

9. Presuming an appropriate expense base and operational efficiency, an analysis of net revenue and public payer reimbursements can estimate the revenue a hospital may seek from commercial payers. Hospitals are required to provide this analysis each year, along with an analysis showing reductions in bad debt or charity care due to an increase in the number of insured lives. *See* FY25 Hospital Budget Guidance & Reporting Requirements, Section VI, Part 11; *see also* 18 V.S.A. § 9456(b)(9). UVMMC submitted the following account of its methodology, which deducts projected public payer rate increases from its commercial negotiated rate request. *See* UVMMC Accompanying Chart to Response to GMCB Follow-Up Questions (Aug. 16, 2024).[26] Although UVMMC's methodology reflects a reduction in net revenue needs pursuant to 18 V.S.A. § 9456(b)(9), the Medicare and Medicaid revenue increases below represent UVMMC's unjustified rate assumptions, described above.

UVMMC	FY2025 Cost Inflation	
	Original Budget	Revised Budget
Total Cost Inflation	$85,434,400	$98,656,926
Less Retail Pharmacy	($7,783,141)	($7,783,141)
Net Cost Inflation for Commercial Rate Calc	**$77,651,258**	**$90,873,784**
Less:		
FY2025 - Medicare Rate Increase	$7,277,283	$7,277,283
FY2025 - Medicare ACO Rate Increase	$0	$0
FY2025 - Medicaid Rate Increase	$8,508	$8,508
FY2025 - Other Payer Changes	$2,016,053	$2,016,053
APM Shared Savings	$5,975,837	$5,975,837
LOS Reduction & Placement Impacts	$14,250,827	$14,250,827
GME/IGT Change	$4,000,000	$7,259,044
UM/UR Change	$2,217,597	$2,217,597
PHSO	$1,089,673	$1,089,673
Legislative Changes - Bad Debt/Charity/Denials	$2,706,261	$2,706,261
Rate Impact on Bad Debt/Charity/Denials Calculation	($8,142,746)	($8,142,746)
Sub-Total	**$31,399,293**	**$34,658,337**
Required Funding from Commercial Rate	**$46,251,965**	**$56,215,447**
Per 1 % Impact of Commercial Rate:		
Budget Year (9 months: Jan-Sept)	$7,104,757	$7,104,757
Commercial Rate Increase in FY2025 Budget	**6.51%**	**7.91%**

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. UVMMC has

[26] https://gmcboard.vermont.gov/node/11866

a recent history of its public payer actual performance varying significantly from its budget assumptions. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 105.

	FY18 Δ		FY19 Δ		FY20 Δ		FY21 Δ		FY22 Δ		FY23 Δ	
Commercial	(7.63)	-1.1%	7.75	1.0%	(107.11)	-13.3%	(100.18)	-11.6%	(51.06)	-5.7%	(18.36)	-1.8%
Medicaid	8.17	6.3%	(8.79)	-6.4%	2.41	1.8%	17.05	13.1%	20.38	12.5%	34.08	20.0%
Medicare	44.55	13.1%	12.41	3.3%	(43.61)	-11.0%	(24.83)	-6.0%	10.61	2.4%	76.40	17.1%
DSH	(0.71)	-5.2%	0.39	3.7%	(0.09)	-0.8%	0.02	0.2%	9.03	80.5%	(11.83)	-51.4%
	44.38	3.67%	11.77	0.92%	(148.40)	-11.01%	(107.94)	-7.62%	(11.04)	-0.73%	80.29	4.84%

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. UVMMC underestimated operating revenues in FY22 and FY23 and is currently projected to have underbudgeted operating revenues again in FY24 by 4.1%. *Id.* at 109. UVMMC underestimated operating expenses by a wide margin in FY22, FY23, and FY24. *Id.* Overall, UVMMC shows a recent pattern of significantly exceeding its budgeted operating revenues and expenses. *Id*.

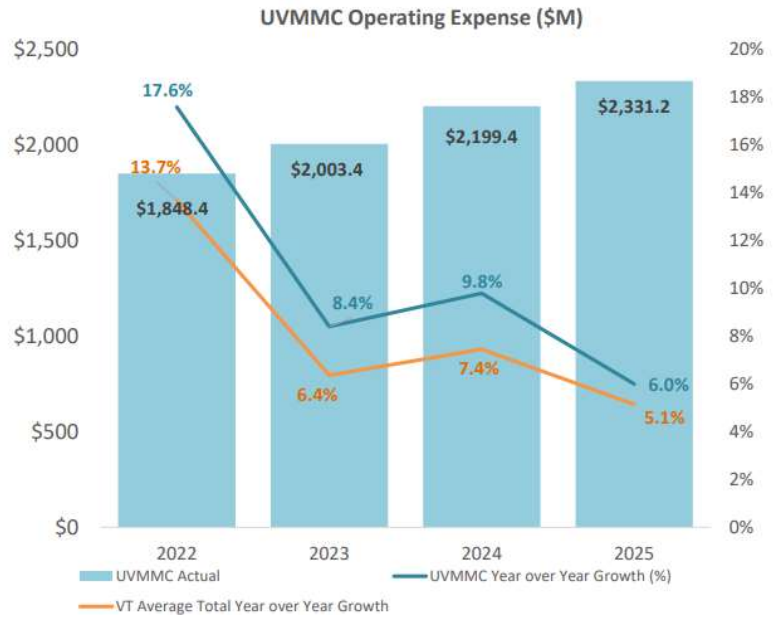
	2022	2023	2024
UVMMC Operating Revenue	$1,825,629,645	$2,067,962,231	$2,267,584,149
UVMMC Operating Expense:	$1,848,355,820	$2,003,412,010	$2,199,398,007
UVMMC Margin:	-$22,726,174	$64,550,221	$68,186,142
UVMMC Operating Revenue: (Actual - Budget)	$103,540,109	$107,047,250	$88,747,089
UVMMC Operating Revenue: % Difference in Actual vs. Budget	6.0%	5.5%	4.1%
UVMMC Operating Expense: (Actual - Budget)	$185,604,141	$81,798,636	$85,103,164
UVMMC Operating Expense: % Difference in Actual vs. Budget	11.2%	4.3%	4.0%
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 UVMMC's actual operating margin was greater than budgeted. *Id*. at 110. In FY24, UVMMC is projecting that its operating margin will be in line with its budget due to operating revenue and expense overages that are roughly equivalent (see above).

UVMMC's total margin is projected to exceed budget by 1.5%. *Id.* This may indicate favorable or conservative budgeting of revenue opportunities.

	FY22 Budget	FY22 Actuals	FY23 Budget	FY23 Actuals	FY24 Budget	FY24 Projected	FY25 Budget
Operating Margin	3.4%	-1.2%	2.0%	3.1%	3.0%	3.0%	2.9%
Total Margin	4.6%	-10.6%	2.8%	5.6%	3.7%	5.2%	3.7%
EBIDA	8.0%	3.4%	6.2%	7.3%	6.9%	6.8%	6.5%

13. The trajectory of a hospital's operating expense growth is one method of examining operating efficiency. UVMMC's operating expenses have consistently grown at a faster rate than the Vermont average. *Id.* at 107.



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, UVMMC has a ratio of 31.0%, which is higher than its comparator hospitals. *Id*. at 124.

15. A hospital's ratio of clinical to non-clinical employees is another method of gauging efficiency. For its FY25 ratio, UVMMC budgets 66% clinical staff and 34% non-clinical staff. Its distribution of newly budgeted FTEs is 57% clinical and 43% non-clinical. *Id.* at 108.

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). UVMMC's 2022 Medicare-payment-to-cost ratio was 72% (down from 94% in 2011), which was the worst among its peers, which had a median payment-to-cost ratio of 103%. *Id.* at 16-17. This indicates that cost inefficiencies exist at UVMMC which, if successfully managed, would decrease expenses and could lead to greater margins and less financial burden on commercially insured patients.

17. Hospitals also monitor clinical productivity. When assessed at the hospital level, as done here, this measure is an indicator of systemic inefficiencies. UVMMC's productivity data, as submitted, shows that 36.6% of its physician FTEs are in specialty areas performing below the 25th percentile of its peers, with 79.2% of physician FTEs in specialty areas performing below the 50th percentile. *See* Workbook Submission, Clinical Productivity; *see also* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 124. Many of UVMMC's preventative health services (including psychiatry, child and adolescent psychiatry, family medicine, adolescent medicine, etc.) perform below the 50th percentile. UVMMC's productivity data segmented by clinical practice area shows 38% of its specialties below the 25th percentile. *Id.* These figures for productivity are significantly below the median. However, UVMMC generally targets the median salary for a position (50th percentile) using national benchmarks, targeting above the national median (65th percentile) for positions that are in high demand. *See* Testimony of Sunil Eappen, Hearing Tr. (Aug. 28, 2024), 213:21-214:4. To the extent that provider salaries are at or above national medians, UVMMC could lower salary expenses to match benchmarked clinical productivity or raise productivity to match benchmarked salaries. Improving clinical productivity would reduce UVMMC's high wait times, but either of the strategies provide the hospital opportunity to improve financial performance and advance Vermont's goals of an affordable, accessible health care system without relying on increases to commercial price.

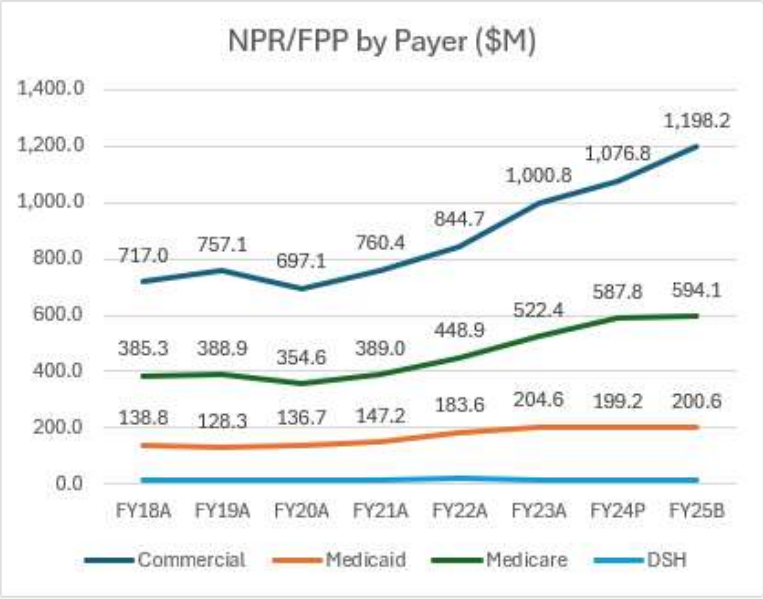
18. A hospital's wait times are also an indicator of system efficiencies. While longer wait times can occur for numerous reasons, longer wait times paired with inadequate clinical productivity suggests the existence of poor operational performance and the potential to increase patient access and realize additional revenue with little additional cost, mitigating the need for higher commercial price. UVMMC reports that 37% of appointments are scheduled within three business days of referral. *See* Workbook Submission, Referral Lags and Visit Lags. UVMMC reports that 33% of new patients are scheduled to be seen within 14 days, 13% of new patients are scheduled to be seen within 15-30 days, 33% of new patients are scheduled to be seen within 31-90 days, and 15% of new patients are scheduled to be seen within 91-180 days. *Id.* These wait times are among the longest reported by Vermont hospitals, a state that experiences longer wait times than its peers. *See* GMCB Staff Analysis, FY25 Hospital Aggregated Wait Times;[27] *see also* Health Services Wait Times Report, AHS, GMCB & DFR (Feb. 16, 2022), 24. Furthermore, UVMMC acknowledged that its reported wait time data is inaccurate and has historically been inaccurate, that some of its departments restrict scheduling such that patients who cannot schedule appointments are not accurately captured in the data (a practice that has never been disclosed with wait time data submitted to the GMCB), and that wait time data submitted by UVMMC underestimates the actual time patients wait to receive care by an

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

amount that the hospital itself does not know. *See* Testimony of Bradley Krompf, Hearing Tr. (Aug. 28, 2024), 263:13-264:9, 264:21-265:6; *see also* Testimony of Sunil Eappen, Hearing Tr. (Aug. 28, 2024), 306:12-17; *see also* UVMMC Post-Hearing Responses to GMCB Questions (Redacted) (Sept. 6, 2024), 38.[28]

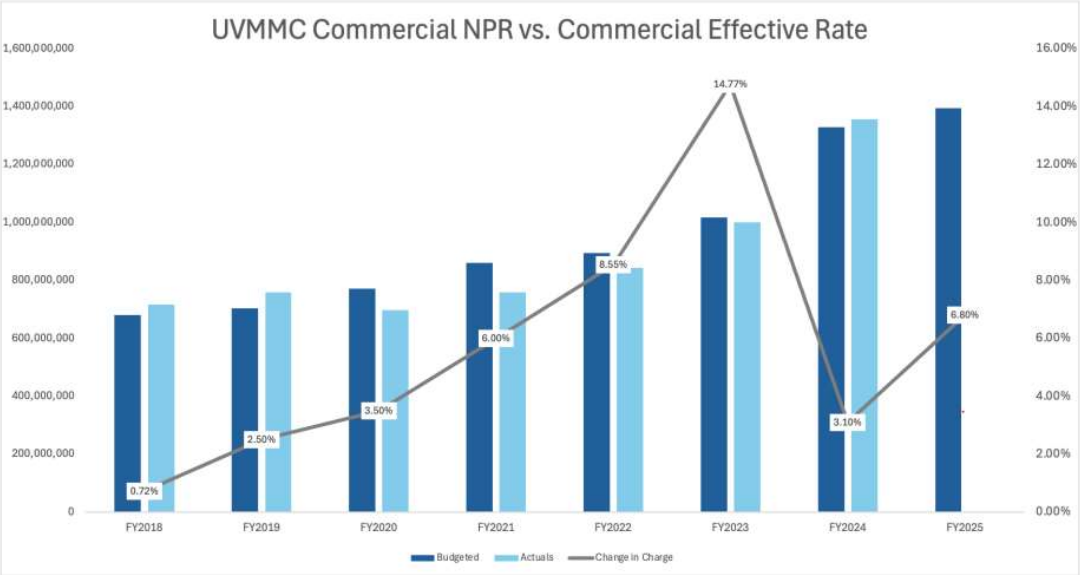
19. A hospital's investment in workforce development is an important aspect of its budget. *See* 18 V.S.A. § 9456(b)(12). Progress in this area can both improve access to services and reduce costs at a time when statewide locum and traveler expenses remain high. UVMMC described several workforce development initiatives, including an LNA to RN pathway and phlebotomy and dialysis technician training programs. UVMMC also noted investments in employee housing, subsidized childcare and tuition reimbursement programs. *See* Narrative, 32-33. Despite these efforts, UVMMC has not demonstrated adequate workforce retention or recruitment as its traveler costs remain unacceptably high. *See* UVMMC Post-Hearing Resp (Sept. 6, 2024), 15 (noting UVMMC's FY23 traveler costs were above the 75th percentile of other academic medical centers nationally).

20. Except for FY18, commercial revenue has been the highest contributor to UVMMC's overall NPR. While public payer revenues have seen relatively small changes, commercial revenues have substantially increased from $717.0 million in FY18 to a budgeted $1.1982 billion in FY25, a 67% increase. *See* Hospital Revenue Trends by Payer, GMCB Staff Analysis, 29.[29]



21. UVMMC has previously been approved for commercial charge increases as shown below. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 106. These increases, including the 8.55% increase in FY22 and the 14.77% increase in FY23, have contributed to the commercial NPR increases shown both above and below, and correlate with UVMMC's significant expense growth described herein. *Id.*

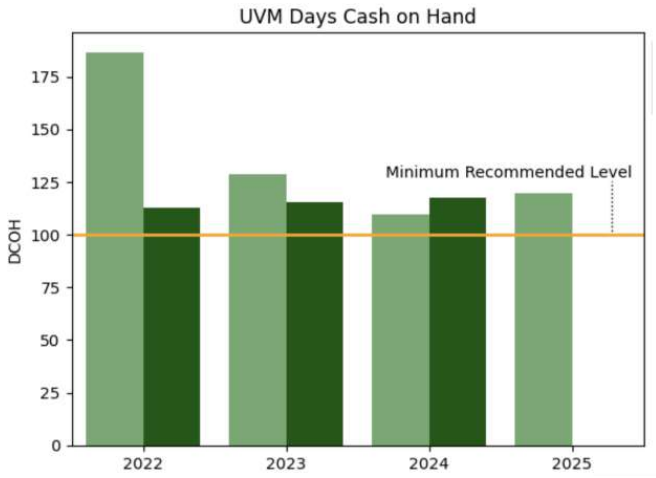
[28] UVMMC Redacted Response to Post-Hearing RFIs re FY25 Budget.pdf (vermont.gov)
[29] https://gmcboard.vermont.gov/hospital-budget-review/FY25-Professional-Staff-Analyses



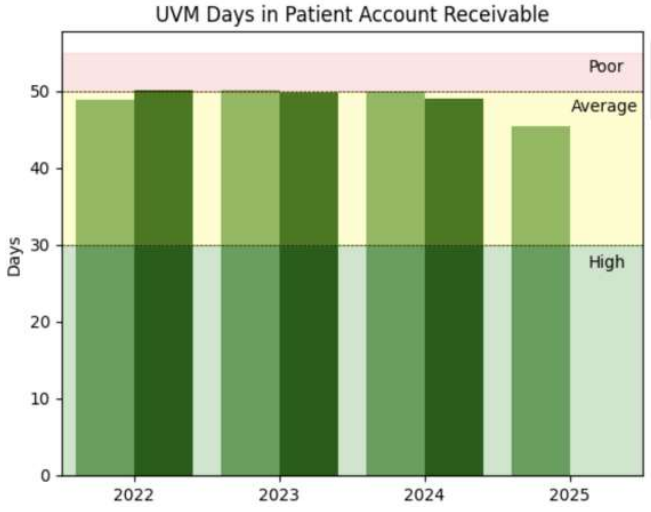
22. RAND standardized pricing provides a national comparison of hospital commercial prices. To determine standardized price, RAND first calculates a relative price by comparing a hospital's commercial prices to Medicare payments. RAND calculates the standardized price by adjusting for case mix and other relative weights. For standardized price, higher deciles indicate commercial prices above national median, while lower deciles indicate commercial prices lower than 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. UVMMC's commercial standardized prices are very high compared to national medians, as shown below. *See* Hospital Budget Review, Staff Presentation (Sept. 9, 2024), 116. UVMMC's outpatient service prices are in the highest decile nationally (10th decile), its inpatient service and facility prices are in the 9th decile, and its outpatient facility prices are in the 8th decile. *Id.* UVMMC's relative prices are also high, with outpatient in the 10th decile, inpatient the 6th decile, inpatient and outpatient in the 9th, and professional, inpatient facility, and outpatient facility each in the 10th deciles. *Id.*

Core Service Line	Relative Price	Relative Price Decile	Standardized Price	Standardized Price Decile
Outpatient	427%	10	$556.73	10
Inpatient	243%	6	$31,753	9
Inpatient & Outpatient	317%	9		
Professional (Inpatient & Outpatient)	257%	10		
Inpatient Facility	246%	10	$28,811	9
Outpatient Facility	508%	10	$434.89	8

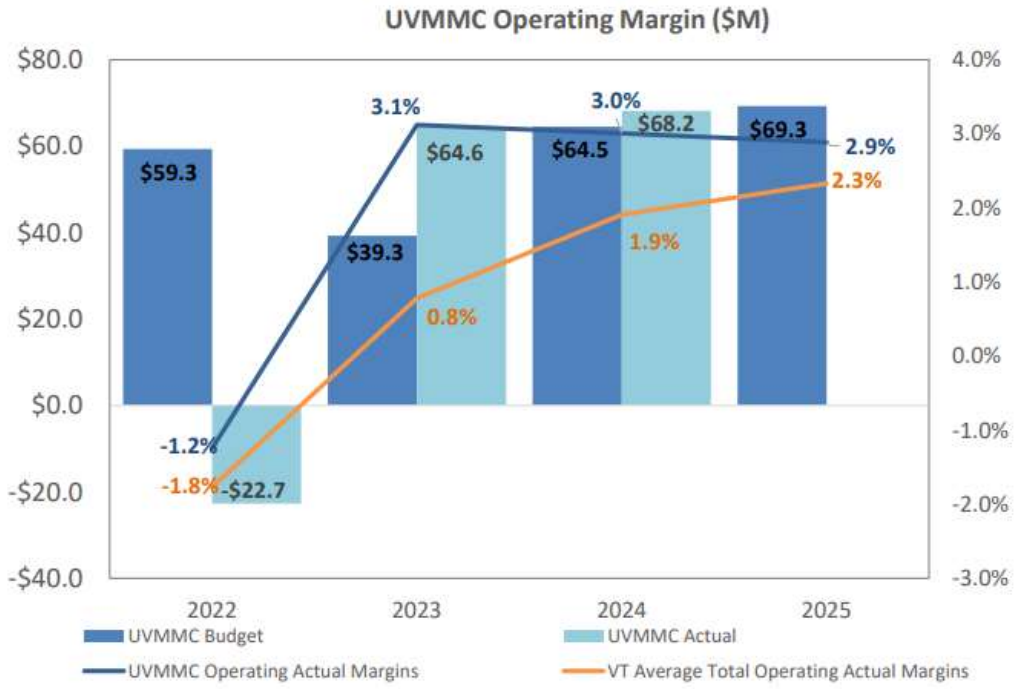
23. Days cash on hand (DCOH) is a measure of a hospital's financial health. UVMMC's DCOH is budgeted at approximately 119.7 days for FY25. *Id.* at 111.



24. Days in patient accounts receivable, which reflects the average time it takes a hospital to collect revenues for patient services rendered, is relevant to analyzing a hospital's financial health. UVMMC's days in patient accounts receivable has been hovering around 50 days. *Id*. An improvement in this metric is typically accompanied by an improvement in DCOH. This figure is budgeted to improve slightly in FY25. *Id.*

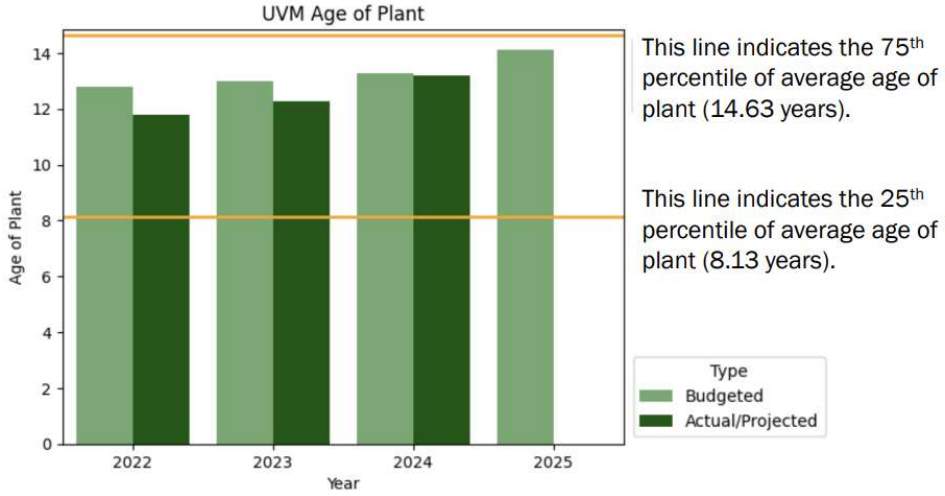


25. A hospital's operating margin is another evaluation of its financial health. Operating margins demonstrate a hospital's ability to cover expenses with revenues, but do not demonstrate that a hospital is efficiently delivering care or being adequately reimbursed. UVMMC shows operating margins that have exceeded budgeted expectations in FY23 and projected FY24, as shown below. *Id*. at 109. Operating margin growth for UVMMC has been higher than the state average since FY22. *Id*.

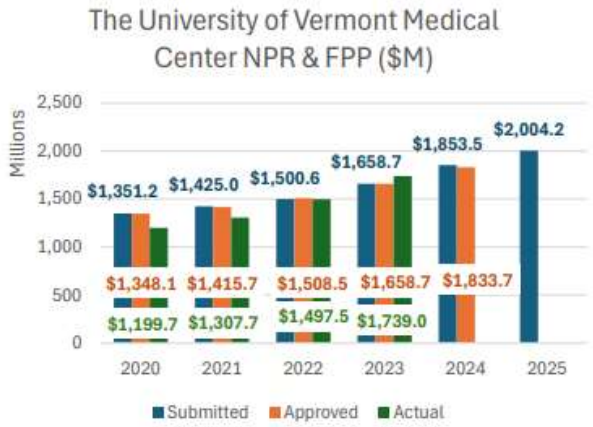


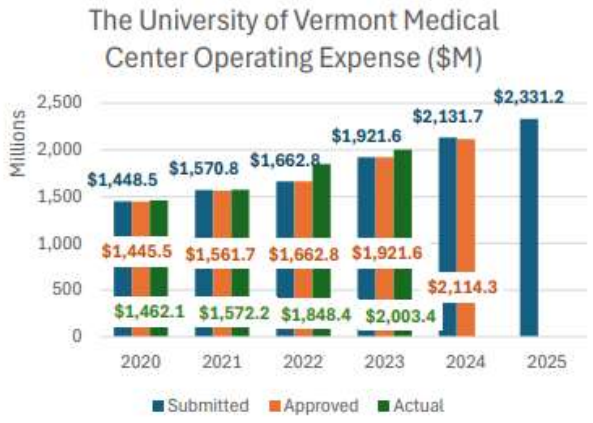
26. A hospital's ratio of current assets to current liabilities is another method of evaluating its financial health. UVMMC's current ratio of assets to liabilities, including funded depreciation, is well above breakeven and is above the US median. Its current ratio of assets to liabilities without funded depreciation is also above breakeven and US median. *Id.* at 112.

27. Average age of plant, a ratio that measures the age of a hospital's fixed assets, is another assessment 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. UVMMC's average age of plant is below the 75th percentile, as shown below. *Id.* at 113.

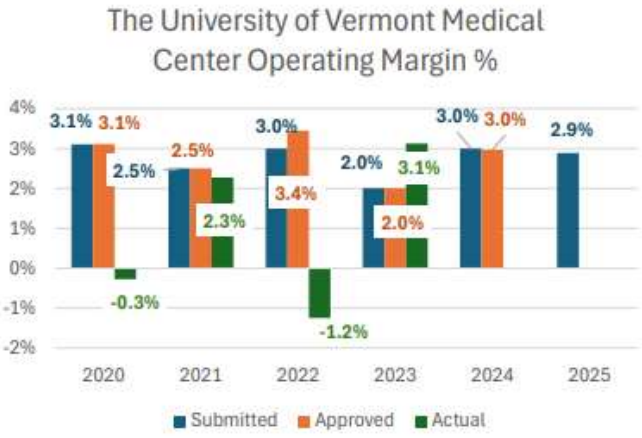


28. UVMMC's prior years submitted net patient revenue (NPR), approved NPR, and actual NPR and operating expenses are shown below. *Id.* at 121. UVMMC's actual operating expenses have exceeded the hospital's approved budget since FY20. *Id.*





29. UVMMC's prior years submitted operating margin, approved operating margin, and its actuals for FY20 through FY23 are shown below. *Id.* Actual operating margins have fluctuated above and below budget since FY22. *Id.*



30. UVMMC's cumulative expense growth from FY20 to FY25 budget was the highest in the state at nearly 60%. Vermont's second largest hospital, Rutland Regional Medical Center, had approximately half of UVMMC's cumulative expense growth over this period (less than 30%). *See* Hospital Budget Review: Overview of FY25 Budget Requests (Aug. 6, 2024), 59.

31. In FY23 UVMMC budgeted $25 million in free care but only provided $18.2 million in free care—a difference of $6.8 million or 27%. *See* UVMMC FY23 Bridges.[30] Similarly, in FY23 UVMMC budgeted $44.6 million in bad debt but only experienced $18.1 million—a difference of $26.4 million or 146%. *Id.; see also* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 11. UVMMC's budgeted FY23 bad debt/free care missed the mark by over $33 million, or 91%. *Id.* In FY22 UVMMC overbudgeted bad debt/free care by $7.5 million. *See* UVMMC FY22

[30] UVMMC_Bridges_for_FY_2023_Actuals.pdf (vermont.gov)

Actuals Report Package.[31] In FY21 UVMMC overbudgeted bad debt/free care by $20.6 million. *See* UVMMC FY21 Actuals Report Package.[32]

32. Medicare Star ratings are based on safety of care delivered, the quality of care, and patient satisfaction surveys. Testimony of Stephen Leffler, Hearing Tr. (Aug. 28, 2024), 186:16-188:16. UVMMC previously received 5-star ratings, however its rating dropped in July 2024 to 4 stars. *Id.* UVMMC believes its rating could stay at 4 stars for some time. *Id.*

33. UVMMC was penalized by Medicare due to quality and safety issues, specifically the level of hospital acquired conditions (HAC) experienced by UVMMC patients around 2021-2022. *See* Testimony of Stephen Leffler, Hearing Tr. (Aug. 28, 2024), 175:22-177:15. UVMMC described its current performance as variable and mixed. *Id. at* 179:1-25.

34. Under Medicare's Hospital Acquired Condition Reduction Program, payments are reduced for "hospitals with a Total HAC score greater than the 75th percentile of all Total HAC scores (that is, the worst-performing quartile) by 1 percent." *See* UVMMC Post-Hearing Response: CMS Program Performance (Sept. 6, 2024). UVMMC's HAC performance for January 1, 2021, through December 31, 2023, was in the worst quartile nationally, which exceeded penalty thresholds by a large margin and thus made UVMMC subject to payment reduction. *Id.* For the performance period of January 1, 2021, through December 31, 2022, the threshold for a HAC penalty (the bottom quartile nationally) was .3751. UVMMC had a total HAC score of .7253. *Id.* For the performance period of July 1, 2021, through December 31, 2023, the threshold for a HAC penalty (the bottom quartile nationally) was .3661. UVMMC had a total HAC score of .9255. *Id.* UVMMC's quality and safety performance will result in CMS downwardly adjusting payments to UVMMC in FY25. *Id.*

35. UVMMC was additionally penalized under CMS's Hospital Value-Based Purchasing (VBP) Program, pursuant to which hospitals may be rewarded or penalized based on quality of care provided. *Id.* For FY24, UVMMC had a *negative* adjustment to its Medicare DRG payments because of its prior performance under this quality program. *Id.* UVMMC had a score of 19.417, the state had a score of 25.75, and the national score was 22.597. *Id.*

36. The Leapfrog Group is a paid quality and safety survey that UVMMC does not participate in. UVMMC received a "B" grade from Leapfrog in 2023 but was downgraded to a "C" in spring 2024. *See* Testimony of Stephen Leffler, Hearing Tr. (Aug 28, 2024), 189:1-12.[33]

37. UVMMC's CMI-adjusted average payment per inpatient discharge in FY23 was the highest amongst Vermont hospitals and Dartmouth. *See* Hospital Budget Review: Review of Hospital Budget Requests & Key Metrics (Sept. 9, 2024), 117. UVMMC's average payment per outpatient APC service in FY23 was also in the upper range. *Id.*

[31] B22A UVMMC_0.pdf (vermont.gov).
[32] A21_H21_UVMMC.pdf (vermont.gov)
[33] *See also* The University of Vermont Medical Center - VT - Hospital Safety Grade.

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

CONCLUSIONS

While UVMMC met the GMCB's benchmark for positive operating margin, its proposed budget includes NPR growth of 9.3%, which exceeds the benchmark of 3.5%, and a commercial rate request of 6.8% (which UVMMC amended to 7.91%), which exceeds the benchmark of 3.4%. *See* Findings, ¶¶ 2-3. As such, we review UVMMC's budget submission consistent with the factors set out in FY25 Guidance, in GMCB Rule 3.000, and pursuant to statute to determine whether it has satisfied its burden of persuasion in justifying its request. *See* GMCB Rule 3.000, § 3.306(a); 18 VSA § 9371; 18 VSA § 9456. UVMMC's budget request is not approved for, *inter alia*, the hospital's inefficient operation, unreasonable and unsupported budget assumptions, low provider productivity and clinical efficiency, declining and concerning quality and safety scores, and excessive commercial costs.

I. UVMMC FAILED TO DEMONSTRATE ECONOMIC AND EFFICIENT HOSPITAL OPERATION

Vermont statute requires the GMCB to consider whether a hospital is economically and efficiently operated. 18 V.S.A. § 9456(c)(3). UVMMC did not establish economic and efficient operation of the hospital due to excessive expense growth, low provider productivity and clinical efficiency levels, lengthy wait times, and poor cost coverage. With these findings in mind, it is appropriate for the hospital to focus on managing expenses and reducing inefficiencies to obtain a positive margin rather than increasing its commercial rate above the benchmark. Moreover, UVMMC has significant opportunity to lower its revenue needs by improving access to, and productivity of, preventative care. UVMMC has made sizeable investments in its population health services organization (PHSO) and accountable care organization (ACO). Such investments should be expected to improve population health and drive care to more affordable and appropriate settings, thus reducing UVMMC's NPR needs. This strategy is consistent with the State's population health goals and emphasis on promotion of efficient and economic operation of hospitals. *See* 18 V.S.A. §§ 9371, 9456(c)(3). UVMMC has not met its burden to justify its budget, and its commercial rate request was not established as a reasonable or necessary cost to impose on Vermonters at this time.

A. UVMMC'S EXCESSIVE OPERATING EXPENSE GROWTH

The record demonstrates that UVMMC has unacceptable cost management and operational expense growth. Findings, ¶¶ 10, 13. UVMMC's cumulative expense growth from FY20 to FY25 budget was the highest in the state at nearly 60%. Vermont's second largest hospital, Rutland Regional Medical Center, had approximately half of UVMMC's cumulative expense growth over this period. Findings, ¶ 30. According to UVMMC, its expense per adjusted discharge has grown from approximately $15,000 in Q1 2021 to around $25,000 in Q4 2023. UVMMC FY25 Budget Presentation, 38. In less than three years, UVMMC's expense per adjusted discharge has risen from below the 25th percentile in Q1 2021 to at or slightly above the 50th percentile by Q4 2023. This indicates that UVMMC's expense per adjusted discharge is rising significantly faster than

other teaching hospitals (the benchmarked peer group). UVMMC's FY24 projections suggest that the hospital has failed to address this concerning trend. Findings, ¶ 11.

Notably, UVMMC's operating expenses have significantly surpassed the expense growth levels of other Vermont hospitals. In 2022, UVMMC's year-over-year expense growth was 17.6% compared to the state average (dragged up by UVMMC's performance) of 13.7%. In 2023 UVMMC's expense growth was 8.4% while the state average was 6.4%. In 2024 UVMMC's expense growth of 9.8% was significantly higher than the state average of 7.4%. UVMMC's budgeted expense growth for 2025 is likewise higher than other Vermont hospitals. Findings, ¶ 13. This rapid and immense expense growth equates to enormous additional health care spending and is a driver of UVMMC's significant commercial rate and NPR requests over the last several years. *See* Findings, ¶¶ 21, 28.

B. UVMMC HAS NOT DEMONSTRATED ADEQUATE CLINICAL EFFICIENCY AND PRODUCTIVITY, WHICH CONTRIBUTES TO LENGTHY WAIT TIMES AND EXCESSIVE COMMERCIAL COSTS

Wait times at UVMMC are lengthy and have historically significantly exceeded those at other Vermont hospitals and Dartmouth, a nearby peer academic medical center. Findings, ¶ 18; *see also* Health Services Wait Times Report, AHS, GMCB & DFR (Feb. 16, 2022).[34] UVMMC's FY25 budget submission indicates ongoing concerns with wait times and patient access. *See* Findings, ¶¶ 17-18. UVMMC's wait times, coupled with low clinical productivity, indicate a meaningful opportunity to enhance access and reduce financial burden to commercially insured Vermonters.

At its budget hearing, UVMMC stated that its goal for clinical productivity levels is, generally, around the 50th percentile. *See* Testimony of Judy Peek-Lee, Hearing Tr. (Aug. 28, 2024), 232:17-233:25. However, UVMMC does not hold itself accountable to that level as it budgets at significantly lower levels. *See* Testimony of Bradley Krompf, Hearing Tr. (Aug. 28, 2024), 234:22-235:2. Indeed, UVMMC's benchmarked budgeted productivity levels reveal that dozens of clinical service areas are budgeted below the 30th percentile productivity level, and only a small number are budgeted above the 65th percentile. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 18-28. UVMMC's historical benchmarked provider productivity shows similar low overall productivity levels. A full 36.6% of UVMMC's physician FTEs were in specialty areas performing below the benchmarked 25th percentile, and 79.2% of physician FTEs were in areas performing below the benchmarked 50th percentile. Findings, ¶ 17. UVMMC's data and calculations of wait times were also not reliable or credible and GMCB has concerns that UVMMC wait times are likely longer than reported by the hospital. Findings, ¶ 18.

Low clinical efficiency and provider productivity negatively impact Vermonters' access to care, which harms individual and population health. Importantly, several areas where UVMMC has opportunity to improve productivity and access are preventative health, including mental health care and primary care. Findings, ¶¶ 17-18. Addressing these areas should drive down costs, improve affordability, and lower NPR by reducing avoidable and unnecessary utilization and

[34] Vermont Wait Times Report_FULL WEB; Microsoft Word - UVMMC Referral and New Patient Visit Wait Times - 8 04 2022 (vermont.gov).

shifting care to more appropriate and less expensive settings. Relatedly, UVMMC's low clinical efficiency causes the hospital to request excessive commercial rate increases to allow it to meet its budgeted expense levels—which as described earlier are problematic. Lastly, Vermont has serious health care affordability challenges. While UVMMC needs to improve patient access, doing so at UVMMC's high commercial prices will further exacerbate our affordability crisis. *See* Findings, ¶¶ 18, 20-22. UVMMC therefore must use its significant administrative resources to address its expense growth and clinical productivity. Moreover, increased utilization at UVMMC must be offset by a reduction in commercial prices to protect Vermonters from unaffordable health care.

C. UVMMC'S INSUFFICIENT MEDICARE COST COVERAGE

UVMMC's considerable expense growth, inadequate clinical productivity, and, as discussed *infra*, significant contributions to non-UVMMC entities (including New York hospitals) contribute to its poor Medicare cost coverage. According to MedPac's March 2024 Report to Congress, Medicare payment to cost ratios above 97% indicate an efficient hospital. *See* Financial Analysis for Vermont Hospitals, Bartholomew & Nash (Aug. 6, 2024), 14, 17 (noting "relatively efficient hospitals could achieve a 97% Medicare payment to cost ratio for the Medicare FFS population."). [35] Payment to cost ratios indicate the percentage of the cost of care that is paid for by Medicare. *See* Findings, ¶ 16. UVMMC's 2022 Medicare payment to cost ratio was reported at 72% (down from 94% in 2011). *Id.* UVMMC's FY25 presentation to GMCB calculated UVMMC's 2022 cost coverage at 75%. UVMMC Hearing Presentation (Aug. 28, 2024), 42. However, in recent submissions, in connection with its outpatient surgery center certificate of need application, UVMMC utilized its own, internal cost coverage calculations and represented its Medicare cost coverage at just 67%. *See* Testimony of Rick Vincent, Hearing Tr. (Aug. 28, 2024), 99:3-100:15. Regardless, Medicare cost coverage of 67-75% is poor and reflects UVMMC's excessive operating expense growth and low clinical throughput. Moreover, as Vermont continues to age, efficient economic operation of UVMMC will be imperative as there will be greater Medicare patient volumes. An inability to efficiently operate a hospital will cause it future financial challenges, reduced patient access, or require significant financial contributions from Vermont's commercially insured population or government payers.

II. UVMMC'S BUDGET ASSUMPTIONS ARE NOT REASONABLE

UVMMC has recently struggled to reliably budget expenses and revenue. The absence of reliable budget assumptions has led to not only excess revenue, but also greater commercial rate requests than necessary. These trends also cast doubt on the credibility of UVMMC's FY25 commercial rate and NPR requests. Indeed, a higher commercial rate could again result in greater than budgeted revenues and exorbitant costs to Vermonters.

UVMMC historically and consistently asserts that if GMCB does not approve, and Vermonters do not pay, UVMMC's full commercial rate requests that access to care will be compromised and that UVMMC will be forced to shutter services. In September 2020, UVMHN stated that GMCB's FY21 budget decisions "will harm Vermont's patients and hospitals,"

[35] Hospital Costs, Price, and Profit Analysis: The Colorado Story (vermont.gov).

"jeopardiz[e] patient care," and that the hospital "will have no choice but to reassess whether we can continue to provide the full array of specialized services . . . ." UVMHN Ltr, Sept. 23, 2020.[36] UVMMC's premonitions were incorrect. Although its revenue was below budget, UVMMC ended FY21 with a positive operating margin, a total margin more than double what it budgeted, and its DCOH increased to 198.8 days (up from 169.4 in FY19). FY21 Actuals, Staff Presentation (Mar. 9, 2022), 18-19, 58.[37]

In FY23 GMCB reduced UVMMC's commercial effective rate request from 19.9% to 14.77%. UVMMC characterized the budget decisions as "deep, arbitrary cuts" that "are a severe blow to our ability to serve our patients, improve access, and increase health equity."[38] This, too, was false. UVMMC did not need to reduce patient care and significantly *exceeded* its FY23 budget cap by over $80 million. *See* FY23 Actual-to-Budget Narrative. Moreover, and as identified and directed by GMCB, UVMMC was able to reduce administrative costs by millions. *Id.* at 4 ($7.4 million expense favorability "mainly driven by lower Shared Service expenses within Finance Administration and Revenue Cycle."), Exhibit D, at 4 (noting "shared service efficiency" of $21.5 million).

Similarly, in FY24 GMCB reduced UVMMC's 13.5% commercial effective rate request to a 3.1% change in charge. At its budget hearing, UVMMC claimed that its 13.5% request was necessary to ensure access and prevent service line cuts. *See* UVMMC FY24 Budget Decision, at 21. Contrary to UVMMC's assertions, GMCB's order did not compromise patient access and in fact UVMMC's FY24 projections indicate it will again exceed its budget cap. Findings, ¶ 11.

UVMMC is required by this Order to focus on and prioritize performance and improve its expense management, clinical efficiency and productivity, and clinical quality and safety.

A. UVMMC's Inaccurate Revenue And Expense Budgeting

Recent UVMMC budget requests have significantly underbudgeted revenue. Findings, ¶¶ 10-12. UVMMC underestimated operating revenues in FY22 and FY23 and is currently projected to have underbudgeted operating revenues again in FY24 by 4.1%. *Id.* ¶ 11. UVMMC has also recently inaccurately underbudgeted its utilization and Medicare and Medicaid revenues. Findings, ¶¶ 6-7, 10-12. In FY23 UVMMC underbudgeted its utilization by over $121 million, or 7.3%. Findings, ¶ 8. UVMMC has also underbudgeted government payer revenue in the form of Graduate Medical Education (GME) revenue. UVMMC's FY23 budget submission underbudgeted GME revenue by tens of millions of dollars. *See* UVMMC FY23 Hospital Budget Decision and Order, 9, 11 (noting UVMMC did not budget for $11.9 million in GME revenue);[39] *see also* UVMMC FY23 Actual-to-Budget Narrative, 1 (GME reimbursement change of $30.7 million over FY23 budgeted). [40]

[36] FY2021 Reconsideration Letter 9.23.20 Proposed 9.23.20.pdf (vermont.gov)
[37] PowerPoint Presentation (vermont.gov)
[38] UVM Health Network Slams Regulators Over Budget Decision | Seven Days Vermont (sevendaysvt.com)
[39] Microsoft Word - FY23 Hospital Budget Order - UVMMC - DRAFT 9.26.22 (vermont.gov)
[40] UVMHN_narrative_1.31.24_-_final.pdf (vermont.gov)

UVMMC has also had difficulty accurately budgeting expenses and contra care, which also has contributed to requests for more commercial rate than necessary. UVMMC underestimated operating expenses by a wide margin in FY22, FY23, and FY24. Findings, ¶ 11. UVMMC's actual operating expenses have exceeded the hospital's approved budget every year since FY20. Findings, ¶ 28.

In FY23, UVMMC budgeted $25 million in free care but only provided $18.2 million in free care—a difference of $6.8 million or 27%. Findings, ¶ 31. Similarly, in FY23 UVMMC budgeted $44.6 million in bad debt but only experienced $18.1 million—a difference of $26.4 million or 146%. *Id.* UVMMC's budgeted FY23 bad debt/free care missed the mark by over $33 million, or 91%. *Id.* Similarly, in FY22 UVMMC overbudgeted bad debt/free care by $7.5 million. *Id.* FY21 saw UVMMC overbudget bad debt/free care by $20.6 million. *Id.* To the extent UVMMC relies on a cost shift methodology to calculate its commercial revenue needs, this consistent overbudgeting of bad debt/free care will lead to higher than necessary commercial requests.

UVMMC has likewise been unable to reliably budget its staffing. Adequate staffing is a challenge for many hospitals, aggravated by Vermont's aging demographics, state-wide affordability challenges, and lack of housing. Nonetheless, UVMMC's staffing issues are an outlier, which may reflect difficulty in managing its workforce and/or cultural challenges. UVMMC's recent budgets compared to its actuals show excess spending on temporary workers and lower spending on permanent clinical employees. In FY23, UVMMC went $43.5 million over its budget on contract staffing, and $4.5 million over its budget on locum tenens. *See* UVMMC FY23 Bridges. In FY23, UVMMC's total contract labor spend was above the 75th percentile of other academic medical centers nationally. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 15. UVMMC plainly has opportunities to improve its recruitment and retention of physicians and staff. Doing so will lessen the need for significant NPR and commercial rate increases.

UVMMC's contract labor reliance is an outlier (Findings, ¶ 19), and the hospital has a well-documented, complicated relationship with its support staff. Notably, GMCB disclosures reveal that UVMHN's CEO received a $481,648 "VPP Payment" and has a current base salary plus VPP payment of $1,836,360. UVMHN-Salary Information; UVMMC-Salary Information.[41] Numerous UVMHN and UVMMC executives received significant "VPP payments" in December 2023. *Id.* While our order this year does not directly address executive compensation, we question the appropriateness of such executive largesse at a time when Vermonters struggle to afford health care, and the hospital has difficulty recruiting and retaining nursing staff, experiences excessive operating expense growth, exceeds budget orders, has poor and inadequate cost coverage, and faces federal financial penalties associated with its quality and safety scores. *See* 18 V.S.A. § 9456(b)(13) (GMCB to consider "salary spread, including a comparison of median salaries to the medians of northern New England states"); § 9456(b)(12) (GMCB consideration of hospitals' investments in workforce development).

B. UVMMC's FY25 Budget Assumptions Are Not Reasonable And Were Not Adequately Supported

[41] gmcboard.vermont.gov/sites/gmcb/files/documents/UVMHN - Salary Information %28Redacted%29.pdf; UVMMC - Salary Information (Redacted).pdf (vermont.gov)

UVMMC's budget assumptions are additionally not adequately supported or reasonable due to reliance on insufficient efficiency and performance expectations. First, despite expending large—and growing—sums on its PHSO, and having a subsidiary ACO, UVMMC did not budget any savings or reduction in NPR from these investments. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 3. UVMMC's PHSO employed 134 employees in FY24 and had a total expense of $21.5 million. *See* UVMMC Network Shared Services.[42] In FY25, UVMMC is increasing PHSO FTEs to 162, for a total PHSO expense of $29.3 million (a 36% year-over-year expense increase). *Id.* These are considerable investments at a time when Vermonters face a health care affordability crisis; it is not reasonable for UVMMC to expend these kinds of sums and (a) not hold itself accountable for meaningful results, and/or (b) not budget for these investments having a positive impact, including lowering NPR as care is better managed and moved to more appropriate settings, and to lessen the need to further burden Vermont's struggling commercially insured population.

UVMMC's budget assumptions are also not acceptable or reasonable because UVMMC's budget is based on low physician productivity expectations. UVMMC testified that its percentile goal for clinical productivity is generally the 50th percentile. Testimony of Judy Peek-Lee, Hearing Tr. (Aug. 28, 2024), 232:17-233:25. However, UVMMC does not "budget at the 50th percentile. We budget at what we predict is possible, you know, given constraints." Testimony of Bradley Krompf, Hearing Tr. (Aug. 28, 2024), 234:22-235:22, 236:1-13. Yet UVMMC generally targets the 50th percentile for compensation, and above the national median (65th percentile) for positions that are in high demand. *See* Findings, ¶ 17. UVMMC's data also reveals that dozens of clinical service areas are budgeted to *below* the 30th percentile productivity level, and only a few are budgeted to be above the 65th percentile. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 18-28. UVMMC's data reveal that 36.6% of physician FTEs are in specialty areas performing below the benchmarked 25th percentile, and 79.2% of physician FTEs are in specialty areas performing below the benchmarked 50th percentile. *See* Findings, ¶ 17.

Low clinical productivity has deleterious impacts on Vermonters' access to care, which harms individual and population health. UVMMC's productivity levels significantly contribute to its extended wait times. Moreover, UVMMC's low clinical productivity causes the hospital to request excessive commercial rate increases to allow it to meet its budgeted expense levels—which as described earlier are also problematic. Lastly, as is widely recognized, Vermont has some of the greatest health care affordability challenges in the country. UVMMC must increase its access to care but doing so at extremely high commercial prices will further our affordability challenges. *See* Findings, ¶¶ 18, 20-22. Accordingly, we find UVMMC's large NPR and rate requests inconsistent with our duties and obligations to promote accessible and affordable health care and to promote the economic and efficient operation of hospitals. 18 V.S.A. §§ 9371, 9375(a), 9456(c)(3).

III. UVMMC'S QUALITY RESULTS AND CMS QUALITY AND SAFETY PENALTIES

Pursuant to 18 V.S.A. § 9371(9), "Vermont's health delivery system must seek continuous improvement of 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,

[42] UVMMC Network_Shared_Services.xlsx (live.com)

quality, and cost containment." *See also* 18 V.S.A. § 9371(1), (10). Review of UVMMC's budget and performance reveal concerns of declining quality and safety at Vermont's only tertiary, academic medical center. Despite significant commercial rate and revenue growth the last several years, UVMMC's quality and safety has declined and resulted in a ratings downgrade and federal financial penalties.

Medicare Star ratings are based on safety of care delivered, the quality of care, and patient satisfaction surveys. *See* Findings, ¶ 32. UVMMC previously received 5-star ratings; however its rating dropped in July 2024 to 4 stars. *Id.* UVMMC believes its rating could stay at 4 stars for some time. *Id.* While there may be multiple causes for declining quality and safety scores, it is UVMMC's responsibility to maintain high quality and safety.

Furthermore, UVMMC was penalized by Medicare due to quality and safety issues, specifically the level of hospital acquired conditions (HAC) experienced by UVMMC patients around 2021-2022. *See* Findings, ¶ 33. UVMMC described its current performance as variable and mixed. *Id.* Under Medicare's Hospital Acquired Condition Reduction Program, payments are reduced for "hospitals with a Total HAC score greater than the 75th percentile of all Total HAC scores (that is, the worst-performing quartile) by 1 percent." Findings, ¶ 34. UVMMC's HAC performance for January 1, 2021, through December 31, 2023, was in the worst quartile nationally, which exceeded penalty thresholds by a large margin and thus made UVMMC subject to payment reduction. *Id.* For the performance period of January 1, 2021, through December 31, 2022, the threshold for a HAC penalty (the bottom quartile nationally) was .3751. UVMMC had a total HAC score of .7253. *Id.* For the performance period of July 1, 2021, through December 31, 2023, the threshold for a HAC penalty (the bottom quartile nationally) was .3661. UVMMC had a total HAC score of .9255. *Id.* UVMMC's quality and safety performance will result in CMS downwardly adjusting payments to UVMMC in FY25. *Id.*

UVMMC was additionally penalized under CMS's Hospital Value-Based Purchasing (VBP) Program, pursuant to which hospitals may be rewarded or penalized based on quality of care provided. Findings, ¶ 35. For FY24, UVMMC had a *negative* adjustment to its Medicare DRG payments because of its prior performance under this quality program. *Id.* UVMMC had a score of 19.417, the state score was 25.75, and national was 22.597. *Id.* Another source of hospital quality and safety is the Leapfrog Group, a paid survey that UVMMC does not participate in. Findings, ¶ 36. Leapfrog Group's hospital safety grade for UVMMC similarly showed a decline. UVMMC received a "B" grade from Leapfrog in 2023 but was downgraded to a "C" in the spring of 2024. *Id.*

UVMMC's declining quality does not support a large increase in NPR and commercial rate as requested by the hospital, particularly considering its "cost shift" approach to increasing Vermont commercial insurance costs to cover for lower Medicare payments.

IV. UVMMC'S EXCESSIVELY HIGH COMMERCIAL PRICES

UVMMC's commercial prices are excessively high and its budget request, if approved, would unnecessarily place additional financial strain on Vermonters. According to RAND's most recent analysis—which includes data through 2022 and precedes UVMMC's large FY23 commercial effective rate increase of 14.77%—UVMMC's outpatient relative price was 427% of

Medicare, which ranks in the highest (10th) decile nationally. Findings, ¶ 22. UVMMC's inpatient relative prices are in the 6th decile, and its combined inpatient and outpatient are in the 9th decile. UVMMC's professional, inpatient facility, and outpatient facility relative prices are each in the 10th decile. *Id.* Noting that the majority of UVMMC commercial revenue is from outpatient services, the impact of these high outpatient prices disproportionally impacts UVMMC's revenue as compared with its high, but relatively lower inpatient prices.

UVMMC's standardized prices are also some of the highest in the nation. The RAND analysis demonstrates that UVMMC's standardized price is in the 10th decile for outpatient, the 9th decile for inpatient, the 9th decile for inpatient facility, and the 8th decile for outpatient facility. *Id*. Weighting inpatient and outpatient standardized prices by their proportion of commercial revenue generation, UVMMC's prices are substantially higher than all hospitals in its peer group (hospitals UVMMC compared itself to in its budget submission). UVMMC's CMI-adjusted average payment per inpatient discharge in FY23 was the highest amongst Vermont hospitals and Dartmouth. Findings, ¶ 37. UVMMC's payment per outpatient APC service, HFY 2023, was also in the upper range. *Id*. UVMMC's commercial revenue has increased dramatically in the last five years. *See* Findings, ¶¶ 20-21.

UVMMC's claim that its commercial prices were not high compared to its peers was not credible. First, UVMMC compared its commercial prices to only a few other hospitals and in connection with only a handful of CPT codes. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 31. Plainly such a limited data set provides little, if any, support for UVMMC's assertion that its commercial prices are not unduly high. Moreover, GMCB requested UVMMC submit the entirety of its price transparency data (which UVMMC procures through the Clarify tool), but UVMMC did not, or was unable, to do so. *Id.* Similarly, UVMMC's reliance on an academic study based on commercial pricing information *more than a decade old* that was not specific to UVMMC, did not include the largest Vermont commercial insurance companies, and was not designed to evaluate this question, was unhelpful and again impacted the Board's view of the credibility of UVMMC's assertions. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 30 (arguing the "Cooper study, while dated and included limited payers, tells the correct story . . . ."). UVMHN notes that "UVMMC outpatient prices are high nationally," but the justification for this, that there are unique circumstances in the Vermont health care market, is not credible. *See* Narrative, Appendices, 122, 125. Taken together, there is strong evidence indicating that UVMMC's commercial prices are extremely high, particularly its outpatient prices, with no credible data presented by UVMMC countering this finding.

V. UVMMC's FINANCIAL HEALTH

UVMMC's good financial health also supports a guidance level budget approval. UVMMC's days cash on hand is budgeted at approximately 119.7 and has been improving. Findings, ¶ 23. Days in accounts receivable is improving and UVMMC has further room to enhance its collections. Findings, ¶ 24. UVMMC's operating margins have exceeded budget expectations in FY23, its FY24 operating revenue is again projected to exceed budget, and its operating margins have been higher than state average since FY22. Findings, ¶¶ 11, 25. UVMMC's current assets to current liabilities, including funded depreciation, is well above breakeven and exceeds US median. Findings, ¶ 26. Average age of plant is below the 75th percentile and should decline as UVMMC builds its outpatient surgery center. *See* Findings, ¶ 27.

Moreover, UVMMC is owed enormous sums from other network hospitals. In FY22 UVMMC was owed $48,249,000 from related hospitals, and as of September 30, 2023, UVMMC was owed $87,000,000 from other network hospitals—including large sums from New York hospitals owned by the UVMHN. *See* Testimony of Rick Vincent, Hearing Tr. (Aug. 28, 2024), 156:19-157:6. Champlain Valley Physicians Hospital, based in Plattsburgh, NY, owed UVMMC $29,036,000 as of September 2022, which swelled to $60,000,000 as of September 2023. *Id.* at 157:17-19. UVMMC's provision of financial support to New York hospitals is significant and as to CVPH includes approximately $10 million for shared services, $30 million in pharmacy expenses, and $20 million for physician salaries and fringe benefits. *See* UVMMC Post-Hearing Resp. (Sept. 6, 2024), 12. According to UVMMC, Medicare and Medicaid do not cover the cost of care for patients, which suggests that Vermont's commercially insured population may be funding costs on behalf of CVPH.

Lastly, UVMMC pays the University of Vermont Medical School tens of millions of dollars annually, including in the form of a commitment payment, academic support payment, dean's tax, and an additional dean's tax. In FY22, UVMMC's "commitment payment" was $59.6 million, which increased to $77.5 million in FY23. *See* Testimony of Rick Vincent, Hearing Tr. (Aug. 28, 2024), 152:1-153:25. In FY23, UVMMCs total support for the University of Vermont Medical School exceeded $90 million. *Id.* This increasing expenditure is relevant to assessing UVMMC's financial health.

For the reasons set forth above, we find that UVMMC 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% are appropriate, as limited in the conditions below. UVMMC'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, UVMMC's budget is approved for FY25 subject to the following terms and conditions:

A. UVMMC'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 $1,897,836,464 for FY25 and a commensurate reduction in operating expenses.

B. UVMMC'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.[43]

[43] UVMMC's 3.4% overall change in charge and commercial negotiated rate increase are further reduced by 4.4% due to Board enforcement of the hospital's FY23 budget overage. *See* Hospital Budget Review,

C. The commercial rate increase cap in Paragraph B is a maximum and is subject to negotiation between UVMMC and commercial insurers. UVMMC 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. UVMMC's expected commercial NPR, based on its budget as adjusted in this Order, is $980,130,705. UVMMC 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. UVMMC 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. UVMMC 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, UVMMC 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, UVMMC 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. UVMMC 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. UVMMC 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.

GMCB Staff Presentation (Sept. 13, 2024), 1-9, 12-13. Accordingly, UVMMC's overall FY25 change in charge and commercial negotiated rate increase are approved at not more than 1.0% under current approved levels (-1.0%), with no commercial negotiated rate for any payer at more than 1.0% under current approved levels, as explained in this Board's forthcoming Budget Enforcement Order for UVMMC.

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

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

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

R. UVMMC 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

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