BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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VIA EMAIL

August 21, 2024

Owen Foster, J.D., Chair
Jessica Holmes, Ph.D., Member
Robin Lunge, J.D., MHCDS, Member
David Murman, M.D., Member
Thom Walsh, Ph.D., MS, MSPT, Member
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Re: UVMMC's compliance with Board-ordered commercial effective rate increases

Dear Chair and Members of the Green Mountain Care Board:

I write on behalf of Blue Cross and Blue Shield of Vermont (Blue Cross VT) to present the Board with a concrete opportunity to take a step towards making health care more affordable for Vermonters. After this year's hearing, the Board asked us to "[p]rovide a breakdown of each Vermont hospital's commercial rate commitments over the past five years, whether those commitments were exceeded, and, for each commitment that was exceeded, whether relief was granted by the hospital." Post-Hearing Question #3 (July 24, 2024). Our response to that question indicated that University of Vermont Medical Center's (UVMMC) actual commercial effective rate increase for FY22 and FY23 exceeded the corresponding Board-ordered commercial effective rate increases. Blue Cross VT Response to Post-Hearing Question #3 (Aug. 2, 2024).

The Board's annual hospital budget orders, including the commercial effective rate increases, bind the hospitals within the Board's jurisdiction. As explained below, we have observed repeated multi-million dollar overages between UVMMC's Board-ordered commercial rate increases and the actual increases we experienced. Those overages deplete our reserves and over time contribute to larger prospective increases in our premiums. That happens because the overages are not reflected in the premium rates we develop and propose to the Board each year.

Over the past month, we have been engaged in a frank and productive dialogue with our colleagues at UVMMC to specifically address the FY22 and FY23 overages. Consistent with the Board's inquiries on this issue at hearing and in Post-Hearing Question 3, we have asked UVMMC to return those overages to Blue Cross VT ratepayers. While we appreciate UVMMC's willingness to have that dialogue, we find ourselves at impasse. And this impasse presents an ideal opportunity for the Board to promote affordability across its regulatory purview by ensuring that its ordered commercial effective rate increases have the intended impact across Vermont's health care system.

Statutory Framework

The Board is empowered, and required, to "promote the general good of the State by," among other things, "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." 18 V.S.A. § 9372(2). The Legislature created the Board within a "framework for reforming health care in Vermont" that mandates that "[a]ll Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting" and that "[o]verall 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." *Id.* § 9371(1), (2).

The Board is well aware of the interrelationship between hospital budget review and rate review: the allowed increases in hospital budgets, including commercial rate increases, directly impact Blue Cross's rate increases. But the playing field is not level. Commercial health insurance rates vary with the amount of money hospitals are permitted to collect from commercial payers, but not the other way around. When the Board orders a health insurance rate, the carrier is locked into that rate, no matter how much money hospitals and other providers end up requiring the carrier to pay.

The Board's hospital budget review process is the much-needed leveler of this playing field. The Board is required by statute to "establish a budget for each hospital," and the law then requires that "[e]ach hospital shall operate with the budget established" by the Board. 18 V.S.A. § 9456(d)(1). In order to level the playing field, the Board has adopted a practice of capping each hospital's "commercial effective rate increase." *See, e.g., In re UVMMC Fiscal Year 2023*, Decision & Order at 12 ¶ B (Sept. 30, 2022) (capping increase at 14.77%). And there is only one interpretation of that language that enables it to serve its leveling function: With respect to unit costs, the net effect of a hospital's year-over-year changes to its financial relationship with a commercial payer – whether changes to the applicable fee schedule or to other payment methods like discounts-off-charges – cannot exceed the ordered percentage.

UVMMC exceeded its Board-ordered commercial effective rate increases for FY22 and FY23

As explained below, in FY22 and FY23, UVMMC exceeded the commercial effective rate increases ordered by the Board. In order to level the playing field and, more importantly, promote affordability on both the hospital budget and health insurance rate sides of the equation, the Board must step in and hold UVMMC to the Board-ordered increases. To that end, Blue Cross VT respectfully requests that the Board obtain the information it needs from UVMMC to test our position and then order UVMMC to return any overage to Blue Cross VT.

In FY22 and FY23, Blue Cross VT calculated that UVMMC exceeded the Board-ordered increase by $16.7M and $11.6M, respectively. To do so, Blue Cross VT compared its total actual allowed claims payments (which it obtained directly from its claims data) to a utilization and severity-adjusted expected payment consistent with the Board-ordered limit on commercial rate increases. Blue Cross VT calculated the expected payment by comparing year over year allowed amounts paid to UVMMC, then adjusting for changes in member volume, utilization and intensity of services. Please see Attachment 1 for a description of the methodology we used.

The tables below show the results of our analysis:

FY 2023

UVMMC Claims Incurred 01/01/2022 - 12/31/2022 vs. Claims Incurred 01/01/2023 - 12/31/2023, Paid through 03/15/2024
All Networks

Table 1
Calculated Variance from Expected

Inpatient	Outpatient	Professional	Total
$ 1,368,087	$ 12,577,513	$ (2,350,929)	$ 11,594,672

Table 2
Summary of Total Claims

	2022	2023	% inc
Total Allowed Amount	$ 262,417,927	$ 329,391,283	25.5%
Hospital Members	40,750	42,967	5.4%
Services	289,161	325,435	12.5%
Allowed/Service	$ 907.51	$ 1,012.16	11.5%
Allowed/Hospital Member	$ 6,439.70	$ 7,666.15	19.0%
Services/Member	7.10	7.57	6.7%

Table 3
Calculation of Expected vs Actual

Line		Inpatient	Outpatient	Professional
1	Unit Cost Increase	114.8%	114.8%	114.8%
2	2022 Services	1,961	81,995	205,205
3	2022 Allowed/Service	$28,317.57	$1,882.98	$255.81
4	2023 Expected Allowed/Service *(2022 Allowed/Service x Unit Cost Increase)*	$32,500.07	$2,161.09	$293.59
5	2023 Services	1,933	83,883	239,619
6	Severity Adjustment	$2,745,930	$677,483	-$77,518
7	2023 Expected Claims	$65,568,566	$181,956,415	$70,271,630
8	2023 Performance Year Total Actual Allowed	$66,936,653	$194,533,928	$67,920,702
	Over/Under	**$1,368,087**	**$12,577,513**	**-$2,350,929**

FY 2022

UVMMC Claims Incurred 01/01/2021 - 12/31/2021 vs. Claims Incurred 01/01/2022 - 12/31/2022, Paid through 03/15/2024
All Networks

Table 1
Calculated Variance from Expected

Inpatient	Outpatient	Professional	Total
$ (1,003,287)	$ 17,616,073	$ (87,755)	$ 16,525,031

Table 2
Summary of Total Claims

	2021	2022	% inc
Total Allowed Amount	$228,159,239	$262,417,927	15.0%
Hospital Members	39,643	40,750	2.8%
Services	272,849	289,161	6.0%
Allowed/Service	$836.21	$907.51	8.5%
Allowed/Hospital Member	$5,755.35	$6,439.70	11.9%
Services/Member	6.88	7.10	3.1%

Table 3
Calculation of Expected vs Actual

Line		Inpatient	Outpatient	Professional
1	Unit Cost Increase**	109.4%	108.9%	109.4%
2	2021 Services	1,914	86,989	183,946
3	2021 Allowed/Service	$26,510.15	$1,543.48	$234.59
4	2022 Expected Allowed/Service *(2021 Allowed/Service x Unit Cost Increase)*	$28,993.98	$1,681.38	$256.74
5	2022 Services	1,961	81,995	205,205
6	Severity Adjustment	-$323,156	-$1,085,790	-$104,797
7	2022 Expected Claims	$56,534,034	$136,778,620	$52,580,241
8	2022 Performance Year Total Actual Allowed	$55,530,747	$154,394,693	$52,492,487
	Over/Under	-$1,003,287	$17,616,073	-$87,755

Note: UVMMC received a mid-year commercial rate increase in 2022. We accounted for this mid-year increase in our methodology.

In our attempts to negotiate a resolution, UVMMC has taken the position that these overages result from increased access to health care that yielded unbudgeted utilization-driven revenue. However, our data shows that our claims spend was considerably higher when controlled for the factors claimed by UVMMC to be responsible for the overage: utilization, acuity, and membership.

After the Board establishes each hospital's annual commercial effective rate increase, Blue Cross

VT seeks to negotiate unit cost terms with each hospital, including UVMMC, that in aggregate are informed and bounded by the Board's orders. In these negotiations, Blue Cross VT steadfastly maintains that aggregate unit cost increases cannot exceed the limit ordered by the Board. Hospitals, on the other hand, generally insist that aggregate unit cost increases can be no lower than the Board's order. With historical claims data in hand, the Blue Cross VT team is usually able to confirm that a hospital's proposed unit cost increase is in line with the mutually agreed upon aggregate increase. This process, though imperfect, generally results in unit cost increases that track closely with the Board's orders.

UVMMC's approach is more challenging for Blue Cross VT to assess during negotiations. UVMMC does not apply the cap equally across the numerous payment methodologies it uses for different service types. Instead, UVMMC proposes a wide range of unit cost changes, discount changes, and changes to DRG coefficients, while at the same time making changes to its chargemaster, which affects how some services are paid. UVMMC's fee schedules consist of thousands of lines. When it proposes a new fee schedule each year, it proposes increases on many codes that are far above the Board's ordered cap, paired with increases at or below the cap for other

services on the schedules. It insists that in the aggregate, all of these proposed changes average back to the cap. Blue Cross VT analyzes these proposals using historical claims data in an attempt to verify that the proposed changes to thousands of fees will conform to the Board's cap on the commercial rate increase. But that analysis using historical claims data has proven inadequate to evaluate these complex and opaque charge changes in advance. That's because UVMMC has information that Blue Cross VT does not have, namely, a much richer *prospective* understanding of expected changes in its operations and anticipated changes in billing practices or care delivery strategies.

The key point here is that the Board-ordered commercial rate increase must be viewed and implemented by all hospitals, including UVMMC, as an absolute cap on unit rate increases. It is not being implemented that way by UVMMC and as a result Blue Cross VT's ratepayers are overpaying.[1] Further, the actual impact on Blue Cross VT and its ratepayers is cumulative and larger than the individual FY2022 and FY2023 overages. That's because the starting point for the FY2023 calculation are the actual allowed charges per service in FY2022. And those actual, allowed charges exceeded the Board-ordered commercial rate increase for FY2022.

In light of the information disparity between Blue Cross VT and UVMMC, and the repeated overages we have observed, it appears to Blue Cross VT that the increases in UVMMC's claims costs – over and above the expected results of the Board's annual commercial effective rate increases – result from UVMMC's incorrect implementation of the Board-ordered aggregate rate increase. Therefore, we respectfully request that the Board gather the information it needs from UVMMC to analyze the FY2022 and FY2023 overages and take appropriate action to restore any unwarranted overpayments to Blue Cross VT ratepayers.

* * *

[1] UVMMC does not appear to agree that the ordered commercial rate increase is an absolute cap. For example, after the Board capped CVMC's FY2022 commercial rate increase at 6%, UVMMC's chief negotiator advised us that the GMCB order "was taken particularly hard" and "impacts financial stability," and offered as a "compromise" a 7% increase.

We appreciate the time and energy our colleagues at UVMMC have invested to date in the productive dialogue that crystallized this opportunity for the Board to help promote affordability at the system-cost level. We look forward to continuing that conversation with the Board and the HCA. We are available to discuss and answer questions at your convenience.

Sincerely,

Rebecca C. Heintz
Rebecca C. Heintz (Aug 21, 2024 13:51 EDT)

Rebecca C. Heintz
Vice President and General Counsel

cc: Eric Miller, General Counsel, UVMHN
Office of the Health Care Advocate

BlueCross BlueShield of Vermont
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Attachment 1
Hospital Contract Unit Cost Implementation Analysis

Purpose

Every year, the Green Mountain Care Board establishes an annual budget for each Vermont hospital. As part of that process, the Board orders a limit on each hospital's commercial effective rate increase; that limit puts a cap on each hospital's annual unit cost increases. Blue Cross and Blue Shield of Vermont (Blue Cross VT) developed the Hospital Contract Unit Cost Implementation Analysis to assess the increase in a hospital's total claims that results from year-over-year unit cost increases. A hospital's year-over-year increase in total claims is affected by unit cost increases as well as changes in utilization and severity. To isolate the portion of each hospital's total increase in claims that results from unit cost increases (and not changes in utilization or severity), we analyze each hospital's total increase in claims while controlling for changes in utilization and severity, using the methodology described below. This enables us to assess whether a hospital is correctly implementing the Board-ordered limit on unit cost increases.

Methodology

We compare the actual claims (in the performance year or the year being assessed) to the expected claims (prior year or baseline claims) adjusted for unit cost, utilization and severity.

We start by grouping the claims paid to a hospital in the baseline and performance years into three categories: inpatient, outpatient, and professional claims. Within each category, we make the three adjustments described below to the baseline year to derive the *expected* performance year claims, controlled for changes in utilization and severity. Then we compare that result to the *actual* claims from the performance year across the three categories.

- Within each category, we calculate the average allowed amount per service in the baseline year. We then increase that average allowed amount by the unit cost increase approved by the GMCB. This is the first adjustment, for unit cost.
- The baseline-year's average allowed per service adjusted for unit cost is then multiplied by the number of services performed in the performance year. This accounts for the difference in service counts between the two years. This is the second adjustment, for utilization.
- We then evaluate the types of services performed in each period using DRG weights for inpatient claims, facility relative value units (RVUs) for outpatient services and non-facility RVUs for professional services as a measure of the intensity of the service. If the services performed in the performance year are more intense, the adjustment is an increase. If the services performed in the performance year are less intense, the adjustment is a decrease. This is the third adjustment, for severity/intensity.

The adjustments described above account for the variation that a hospital may see year to year as more or fewer services are performed and the severity of those services increases or decreases. The adjustments for utilization and severity, taken together, also account for changes in Blue Cross VT's membership. By making those adjustments, Blue Cross VT is able to determine the portion of

the increase in total claims that is attributed to unit cost increases. If a hospital has implemented the GMCB-ordered limit on unit cost increases, the *expected* performance year claims, which reflect these three adjustments, should match closely to the *actual* paid claims for the performance year.

If the actual performance year claims exceed the expected performance year claims, the hospital has exceeded the GMCB-ordered limit on unit cost increases. It has raised its unit costs beyond what the GMCB has authorized.

Illustration

The tables below illustrate how we performed this Analysis for UVMMC for performance year 2023. First, Table 1 summarizes the calculation by showing the variance between expected and actual performance year claims for each category, and the total overage of $11.6 million:

Table 1: Calculated Variance from Expected (UVMMC Claims Incurred 01/01/2022 - 12/31/2022 vs. Claims Incurred 01/01/2023 - 12/31/2023, Paid through 03/15/2024, all networks)

Inpatient	Outpatient	Professional	Total
$ 1,368,087	$ 12,577,513	$ (2,350,929)	$ 11,594,672

Next, Table 2 shows the aggregate data for 2022 and 2023:

Table 2: Summary of Total Claims

	2022	2023	% inc
Total Allowed Amount	$ 262,417,927	$ 329,391,283	25.5%
Hospital Members	40,750	42,967	5.4%
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Allowed/Hospital Member	$ 6,439.70	$ 7,666.15	19.0%
Services/Member	7.10	7.57	6.7%

Finally, Table 3 shows the calculation:

Table 3 Calculation of Expected vs Actual

Line		Inpatient	Outpatient	Professional
1	Unit Cost Increase	114.8%	114.8%	114.8%
2	2022 Services	1,961	81,995	205,205
3	2022 Allowed/Service	$28,317.57	$1,882.98	$255.81
4	2023 Expected Allowed/Service *(2022 Allowed/Service x Unit Cost Increase)*	$32,500.07	$2,161.09	$293.59
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8	2023 Performance Year Total Actual Allowed	$66,936,653	$194,533,928	$67,920,702
	Over/Under	**$1,368,087**	**$12,577,513**	**-$2,350,929**

*An adjustment for the severity of services in the performance year versus the baseline year. The severity adjustment uses DRG weight for inpatient claims, facility 2022/2023 RVU for outpatient claims and non-facility 2022/2023 RVU for professional claims.

The first line of Table 3 is the Board-ordered unit cost increase, which was capped at 14.8%. Lines 2 and 3 show the number of services and the average allowed amount per service in 2022 (the baseline year), for each category.

Line 4 shows the first adjustment, for the unit cost increase: the allowed amount per service in 2022 (Line 3) is multiplied by 114.8% (Line 1), which implements the Board-ordered unit cost increase. Line 5 shows the actual number of 2023 services (the utilization adjustment) and Line 6 shows the severity adjustment.

Line 7 shows the result of multiplying the allowed amount per service adjusted for the Board-ordered unit cost increase (Line 4) by the actual number of 2023 services (Line 5) and adding the severity adjustment (Line 6) to that product. Line 7 thus shows the expected performance year claims, reflecting the unit cost increase and the utilization and severity adjustments. Line 8 shows the actual performance year (2023) claims.

Finally, Line 9 shows the difference between actual and expected performance year claims in each category. The sum of those amounts is the total overage for performance year 2023.

Additional Details

- Allowed amount is inclusive of both BCBSVT payments and member cost share.
- This analysis excludes claims with other party liability (including Medicare), denials and adjusted claims.
- Excludes UVMMC and CVMC employer groups with special payment rates for services at UVMMC.

- Hospital members provided service is the total number of unique member IDs receiving a service at the facility within the period indicated.
- Inpatient services are admissions.
- Outpatient/professional service are the count of individual claim lines after excluding adjustments and denials.
- Inpatient severity adjustment is derived using the Centers for Medicare & Medicaid Services (CMS) Diagnosis Related Group (DRG) relative weights.
- Outpatient severity adjustment is derived using the Centers for Medicare & Medicaid Services (CMS) facility total Relative Value Units (RVUs).
- Professional severity adjustment is derived using the Centers for Medicare & Medicaid Services (CMS) non-facility total Relative Value Units (RVUs).