Sent Via Email

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September 10, 2024

Re: UVMHN FY2025 Budget Review – Written Objections to September 9, 2024 Deliberations

Dear Mark:

Pursuant to the Green Mountain Care Board's (GMCB) agreement with the Vermont Association of Hospital and Health Systems (VAHHS),[1] I write to memorialize objections to the GMCB's budget deliberations on September 9, 2024, on behalf of the University of Vermont Health Network's (UVMHN) Vermont hospitals: the University of Vermont Medical Center (UVMMC), Central Vermont Hospital (CVMC) and Porter Hospital.

Although UVMHN is unable to identify all potential objections that may ultimately arise through the continuation of the GMCB's deliberations and issuance of a final written budget order, this letter reflects its current and anticipated objections to the proceedings to date. UVMHN reserves its right to raise additional objections or clarify the nature of its objections in response to further proceedings and written orders.

Budget Adjustment and Budget Enforcement Are Distinct

As a threshold issue, the September 9 deliberations, including the staff recommendations, make clear that the GMCB has impermissibly conflated its statutory powers to adjust hospital budgets with its enforcement powers in a manner that eliminates critical due process protections. By statute, the GMCB has authority to, "upon application, adjust a budget . . . upon a showing of

[1] This agreement is memorialized in Shireen Hart's August 6, 2024, letter to you on behalf of VAHHS, providing in relevant part that "[h]ospitals have two full business days to submit post-hearing written objections."

need based upon exceptional or unforeseen circumstances." 18 V.S.A. § 9456(f). In section 9456(h), the GMCB is granted the separate, and distinct, statutory authority to take enforcement action against a hospital that violates a provision of the hospital budget statutes. The GMCB can implement its enforcement power in several different ways, including instituting proceedings in Superior Court, imposing civil administrative penalties, and taking "corrective measures as are necessary to remediate the violation or deviation." 18 V.S.A. § 9456(h). Crucially, the GMCB can only exercise its enforcement powers "after notice and an opportunity for a hearing." 18 V.S.A. § 9456(h)(2)(A); *see also id.* § 9456(h)(2)(B)(ii) ("Orders issued under this subdivision (2)(B) shall be issued after notice and an opportunity to be heard . . . ."). The statutory text and structure make clear that enforcement actions require procedural protections for the responding party that are not contemplated in the budget adjustment process established in Section 9456(f).

The GMCB has impermissibly conflated and intermingled its budget adjustment and enforcement powers through its rules and, in so doing, has deprived respondents of their procedural rights. GMCB Rule 3.401 addresses budget adjustment and purports to empower the GMCB to take certain actions upon a determination that a hospital's performance "has differed substantially from its budget," including by "changing hospital rates or prices" and "changing the net revenue and/or expenditure levels of future budgets."[2] These actions—particularly modifying future budgets, rather than merely adjusting the budget for the year in which a deviation occurs—clearly fall within the scope of "corrective measures . . . to remediate the violation or deviation," as contemplated by the ***enforcement*** provision of the budget review statute. 18 V.S.A. § 9456(h). By granting itself the authority to take these enforcement actions through a budget adjustment and not a formal enforcement proceeding, the GMCB has arrogated a power to act without affording respondents the procedural protections to which they are entitled by statute (discussed more fully below). The GMCB's application of Rule 3.401 therefore exceeds the scope of its statutory authority.

The September 9 deliberations clearly demonstrated the problems with the regulatory framework the GMCB has created. In the deliberations, the GMCB staff recommended—for the first time—that the FY23 NPR surpluses for Porter Hospital and UVMMC be remediated by making corresponding cuts to the otherwise approved NPR rate increases for FY25 for those hospitals. Hospital leadership had no opportunity to substantively respond to the staff's recommendations and assumptions beyond cursory periods for public comment, much less to submit responsive evidence or argument. The GMCB's proposed actions fall within the scope of its enforcement powers, rather than its unduly expanded budget adjustment power, and the UVMHN hospitals must be afforded minimum procedural protections before they are subjected to sanction.

[2] As discussed below, Rule 3.401(c)(5) also permits the GMCB to "allow[] a hospital to retain a percentage of surplus generated primarily by volume in excess of that projected for a particular year[.]"

Budget Enforcement Proceedings Are Subject To Contested Case Requirements

The FY23 budget enforcement actions against UVMMC and Porter Hospital are also contested cases under the Vermont Administrative Procedures Act (VAPA), and therefore subject to numerous procedural requirements that were not satisfied.

A VAPA "contested case" is "a proceeding, including but not restricted to ratemaking and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing." 3 V.S.A. § 801(2). The GMCB is required by statute to provide a hospital notice and opportunity for a hearing before it takes budget enforcement action:

> (B)(i) ***The Board may order a hospital to****:*
>
> * * *
>
> (II) ***take such corrective measures as are necessary to remediate the violation or deviation [from the hospital's approved budget]*** and to carry out the purposes of this subchapter.
>
> (ii) Orders issued under this subdivision (2)(B) shall be issued ***after notice and an opportunity to be heard***, except where the Board finds that a hospital's financial or other emergency circumstances pose an immediate threat of harm to the public or to the financial condition of the hospital.

18 V.S.A. § 9456(h)(2) (emphasis added). A budget enforcement action is therefore a VAPA "contested case."

A hospital subject to potential enforcement action has important procedural rights in the contested case proceeding, including but not limited to the following:

- the opportunity to respond and present evidence and argument on all issues involved;
- the right to a decision based on the contested case record, including findings of fact based on the record evidence and matters officially noticed;
- the right to make objections to evidentiary offers; and
- the right to conduct cross-examinations required for a full and true disclosure of the facts.

3 V.S.A. §§ 809, 810.

The contested case record includes: "(1) all pleadings, motions, intermediate rulings; (2) all evidence received or considered; (3) a statement of matters officially noticed; (4) questions and offers of proof, objections, and rulings thereon; (5) proposed findings and exceptions; and (6) any decision, opinion, or report." 3 V.S.A. § 809(e). While the GMCB may take notice of "generally recognized technical or scientific facts" within its specialized knowledge, the hospital must be informed of "the material noticed, including any staff memoranda or data," and "shall be afforded an opportunity to contest the material so noticed." *Id.* § 810(4).

The GMCB issued its notice of FY23 Budget Violations to UVMMC and Porter Hospital on May 30, 2024, requesting certain information and informing the hospitals that they should be

prepared to discuss potential budget enforcement action at their FY25 budget hearings.[3] UVMHN CFO Rick Vincent responded to this notice on July 2, 2024, providing information as requested, and agreeing to address the issues at the FY25 budget hearings.[4]

UVMMC's and Porter Hospital's FY25 budget hearings were therefore also the hospitals' FY23 budget enforcement hearings pursuant to 18 V.S.A. § 9456(h)(2)(B) and VAPA. All of the evidence presented at those hearings supports the hospitals' request that the GMCB forego enforcement action. Both hospitals presented sworn evidence demonstrating that FY23 NPR/FPP in excess of the approved FY23 budgets resulted from increased utilization due to successful efforts to improve access per the GMCB's direction, as well as successful efforts to obtain increased reimbursement from non-commercial payers, also per the GMCB's direction; and the GMCB should not take any enforcement action that would jeopardize the hospitals' unbudgeted revenue, since that revenue was utilized to support care the hospitals provided.[5] The GMCB did not elicit any other evidence in opposition, sworn or otherwise. As a result, the record supports only one conclusion: no enforcement is appropriate.

At the meeting held on September 9, GMCB staff offered testimony and argument in support of FY23 budget enforcement action against UVMMC and Porter Hospital, which the GMCB did not elicit during the FY25 budget and FY23 budget enforcement hearings held in August. This included, but was not limited to:

- testimony that "efficient" hospitals have no more than 30% variable costs, and it is therefore "generous" for the GMCB to recover less than 70% of NPR exceedance from Porter Hospital;
- testimony that both hospitals should expect to "achieve economies of scale" as patient volumes increase over time;
- testimony that staff disagree with the hospitals' critique of the Rand study;
- the presentation of a new CMI-adjusted data for comparison to Rand data[6]; and
- testimony and argument that UVMMC improperly failed to budget certain revenue that it had a reasonable basis to anticipate collecting.

None of that testimony, analysis, or opinion is accurate, but the FY23 budget enforcement hearings closed on August 30, 2024, and UVMMC and Porter Hospital were provided no

[3] Letter from Chair Owen Foster to UVMHN CEO Sunil Eappen, RE: UVMMC and Porter Hospital FY23 Budget Violations (May 30, 2024).
[4] Letter from Rick Vincent to GMCB c/o Chair Foster, RE: May 30 GMCB Letter on UVMMC and Porter Hospital FY23 NPR Variance (July 2, 2024).
[5] *See* UVMMC PowerPoint presentation to the GMCB, FY 2025 Hospital Budget Hearing (August 28, 2024) at slide 55; Porter Hospital, PowerPoint presentation to the GMCB, FY 2025 Hospital Budget Hearing (August 30, 2024) at 13.
[6] UVMMC and Porter Hospital have not seen this analysis before, and the data and methodology the GMCB staff employed to produce it was neither presented nor explained.

opportunity to make evidentiary objections, cross-examine the witnesses, or otherwise respond.[7] The GMCB therefore may not take budget enforcement action based on this information in compliance with VAPA. *See* 3 V.S.A. §§ 809, 810.

The GMCB Has Conducted the Budget and Enforcement Actions In A Manner That Violates Its Statutory Obligations

The manner in which the GMCB and staff have conducted both the budget hearings and budget enforcement actions is unlawful because it is inconsistent with the GMCB's statutory purpose and its own rules, both of which require the GMCB to regulate hospitals in a manner that "reduce[s] the ***per capita*** rate of growth for 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 (emphasis added); GMCB Rule 3.101. Each year, UVMHN hospitals ask the GMCB to regulate their budgets by setting a per capita growth rate, rather than an overall NPR growth rate that does not account for changes in the volume of patients seeking care or desirable expansions of access to quality care. Each year, the UVMHN hospitals provide the GMCB with data showing that the per capita growth rate of healthcare expenditures is appropriate, especially in light of the mandate to ensure that access to quality care is not compromised. And each year, the GMCB declines to conform its budget regulation to its statutory charge. This year was no exception. Indeed, during the September 9 staff presentation, the GMCB's Director of Health Systems Finance acknowledged the hospitals' requests but responded by saying, in effect, "that's not how we regulate hospital budgets." Respectfully, the GMCB does not have complete freedom to choose the manner in which it regulates hospital budgets. It must follow the charge the legislature has given to it, and it has failed to do so by declining to regulate hospital expenditures on a per capita basis and by failing to ensure access to quality care in the process.

That same legal error has colored the GMCB staff and member discussions of UVMMC's and Porter Hospital's FY23 budget enforcement actions. This situation—where a hospital realizes unbudgeted revenue due to an unanticipated increase in patients' need for care—is expressly contemplated by the GMCB's own enforcement rules, which also seek to ensure access to quality care even when it is accompanied by increased revenue. In considering enforcement, the GMCB "shall" take account of "the hospital's ability to limit services to meet its budget, consistent with its obligations to provide appropriate care for all patients." GMCB Rule 3.401(a)(2). And after making a determination that a hospital's performance has differed substantially from budget, the GMCB may "allow[] a hospital to retain a percentage of surplus generated primarily by volume in excess of that projected for a particular year." GMCB Rule 3.401(c)(5). Both hospitals presented evidence that their unbudgeted NPR was due to an increased volume of patients—primarily Medicare and Medicaid patients—seeking access to necessary healthcare and, as a result, no enforcement action was appropriate. Providing unbudgeted access to more care for more patients does not increase the per capita cost of care; indeed, it usually reduces it. But GMCB staff has nonetheless recommended that the GMCB take enforcement action against both Porter Hospital and UVMMC by reducing their FY25

[7] Representatives of UVMMC and Porter were permitted to observe the GMCB's September 9, 2024 meeting and offer limited public comment, but the hospitals were not afforded the due process VAPA requires.

commercial rates to take back, in whole or in part, the unbudgeted NPR that resulted from providing more care to more patients, albeit at a financial loss to both hospitals. It is impossible to square that proposed action with the GMCB's statutory mandate to control the per capita cost of care while ensuring access to quality care. Indeed, it will have exactly the opposite effect: punishing and thereby restricting the provision of care to the patients who need it most, while raising, rather than lowering, the per capita cost of care.

The Proposed Enforcement Motions, If Approved, Would Constitute Arbitrary and Capricious Decision-making

The pending enforcement motions for both Porter Hospital and UVMMC, if approved by the GMCB, would also constitute arbitrary and capricious decision-making. Throughout this year's budget hearings, both the GMCB members and hospitals have emphasized the importance of increasing public financing for healthcare —mostly through enhanced Medicare and Medicaid reimbursement—in order to reduce the financial pressures on Vermont's relatively small number of commercial ratepayers. The GMCB has never suggested that more patient care revenue from Medicare and Medicaid is undesirable; to the contrary, it has repeatedly suggested that the hospitals should have sought more public funding and sooner.

The proposed enforcement actions against both UVMMC and Porter Hospital run directly contrary to the GMCB's clear direction in this regard, as well as its statutory obligation to base its decisions on the evidence presented. UVMMC has demonstrated that ***none*** of its unbudgeted FY23 patient care revenue came from major commercial payers; rather, UVMMC received $33.7m ***less*** from major commercial payers than it had budgeted, and virtually all of its unbudgeted revenue was from Medicare and Medicaid, due to increased utilization of care by those patients. (See UVMMC response to GMCB post-hearing question 7, excerpted below.)

NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY 2023 Approved Budget	$ 1,658,725,627					
Utilization	$ 121,231,384	$ 35,910,847	$ 10,220,678	$ 59,413,576	$ 15,686,283	
Rate	$ (15,511,292)	$ 10,586,135	$ (14,890,742)	$ (21,104,424)	$ 9,897,738	
Payer Mix	$ (59,705,167)	$ 18,206,432	$ 3,796,437	$ (85,688,009)	$ 3,979,972	
Bad Debt	$ 26,478,210	$ 10,190,879	$ 1,439,339	$ 11,496,151	$ 3,351,842	
Free Care	$ 6,866,039	$ 1,503,154	$ 2,801,639	$ 2,131,402	$ 429,844	
Changes in DSH	$ (11,826,485)					$ (11,826,485)
GME Reimbursement Change	$ 30,713,364		$ 30,713,364			
Administrative Write-Offs	$ (17,955,898)				$ (17,955,898)	
FY 2023 Actual Results	$ 1,739,015,783	$ 76,397,447	$ 34,080,715	$ (33,751,303)	$ 15,389,782	$ (11,826,485)

Porter Hospital's FY2023 "bridges" document tells a similar (if slightly less lopsided) story, with the bulk of its unbudgeted revenue coming from Medicare.

NPR	Total	Total Medicare	Total Medicaid	Total Major Comm	Total Self-Pay/Other	DSH
FY 2023 Approved Budget	$ 104,464,068					
Utilization	$ 9,724,820	$ 3,776,481	$ 1,003,321	$ 3,715,018	$ 1,230,000	
Rate	$ (1,118,443)	$ 3,693,476	$ (2,766,058)	$ (2,969,542)	$ 923,681	
Payer Mix	$ 1,169,982	$ 295,339	$ 561,043	$ 3,635,571	$ (3,321,970)	
Bad Debt	$ 2,828,280	$ (115,702)	$ (4,324)	$ (318,369)	$ 3,266,675	
Free Care	$ (189,147)	$ (412,340)	$ (2,007)	$ (167,076)	$ 392,275	
Changes in DSH	$ (3,712)					$ (3,712)
Administrative Write-Offs	$ (1,411,473)				$ (1,411,473)	
	$ -					
FY 2023 Actual Results	$ 115,464,374	$ 7,237,255	$ (1,208,026)	$ 3,895,603	$ 1,079,188	$ (3,712)

As a result, any budget enforcement action that takes back revenue from UVMMC or Porter Hospital in order to "enforce" the FY23 NPR cap would actually be requiring hospitals to forfeit the very public funding that the GMCB and the hospitals are seeking to maximize, while punishing the delivery of necessary care to patients who need it most—patients the hospitals are morally and sometimes legally obligated to serve. Viewed differently, the proposed action would impermissibly use Medicare and Medicaid dollars to subsidize commercial insurers. And however it is characterized, it would constitute an arbitrary and capricious exercise of the GMCB's enforcement powers.

Amendments to the GMCB's Standard Budget Conditions Raise Serious Concerns of Unintended Consequences

UVMHN objects to the following standard budget conditions and new definitions presented by the GMCB staff.

Condition 2/B

[Hospital]'s total commercial change in charge and negotiated rate increases are approved at not more than [x]% over current approved levels, with no commercial change in charge or negotiated rate increase for any payer at more than [x]% over current approved levels. ***Actual FY25 commercial growth may be less than [x]% but under no circumstance may it exceed [x]%****.*

("Condition 2/B") (emphasis added). This condition was listed as condition 2 during the September 6, 2024 GMCB meeting,[8] but it was listed as condition B during the September 9, 2024 GMCB meeting.[9] During its meeting on September 9, the GMCB discussed amending this condition to remove a reference to "commercial change in charge" (because a hospital has only one charge master rather than separate charge lists for each line of business) and refer instead to "total commercial charge and commercial negotiated rate increases."

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[8] *See* GMCB PowerPoint presentation "Hospital Budget Review: Review of Hospital Budget Requests & Key Metrics" (September 6 & 9, 2024), https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY25%20Hospital%20Budget%20Review%20-%20SEPT%20-%20Hospital%20Budget%20Details%20%28PART%201%29.pdf ("GMCB September 6 Meeting Slides") at 13.

[9] GMCB PowerPoint presentation "Hospital Budget Review: Review of Hospital Budget Requests & Key Metrics" (September 6 & 9, 2024), https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY25%20Hospital%20Budget%20Review%20-%20SEPT%20-%20Hospital%20Budget%20Details%20%28PART%202%29.pdf ("GMCB September 9 Meeting Slides") at 3.

Condition 3

The following condition ("Condition 3") was not introduced during the September 6, 2024 GMCB meeting, but it was included as condition 3 in the slides for the September 9, 2024 GMCB meeting.[10]

The commercial rate increase cap in Paragraph B is a maximum and is subject to negotiation between [Hospital] and commercial insurers. [Hospital] 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."

The rationale for including it in this year's standard conditions was that it had been included in prior years' budget orders, including FY24.

The GMCB presented a slide at the September 9 meeting to show how the standard conditions proposed for FY25 differed from those included in the FY24 budget orders.[11] However, that slide did not highlight the last sentence of Condition 2/B (bolded above), which raises matters of concern and, as explained below, makes the proposed condition materially different from that adopted in FY24. First, this sentence refers to "actual commercial growth" without defining that term. Second, in FY24, this sentence read: "[t]he commercial rate increase overall or with respect to any payer may be less than [x]% as negotiated between the hospital and payer." Third, this sentence (taken together with new definitions that GMCB staff presented during the September 6 meeting, which appear in both Conditions 2/B and C), blurs the line between regulated rate and regulated revenue, as those terms pertain to commercial payers. This blurring creates ambiguity such that FY25 negotiations with Vermont commercial payers would be impossible.

New Definitions

The new definitions the GMCB staff presented at the September 6 meeting in slide 19 include the following:

- **Commercial Effective Rate:** Growth in commercial net patient revenue, inclusive of price and volume.
- **Commercial Negotiated Rate:** Growth in the commercial net patient revenue, due to price only (See Rate Decomposition Workbook).[12]

UVMHN objects to these definitions because they improperly blur the distinction between rate and revenue. "Commercial effective rate" represents the aggregate of the service/item prices we must negotiate with payers to achieve the budgeted, aggregate NPR target. The effective rate does not translate to a specific amount of revenue growth for each payer, as patient volumes during the fiscal year might vary from previous years, especially if UVMHN

[10] *See* GMCB September 9 Meeting Slides at 3.
[11] *Id.*
[12] GMCB September 6 Meeting Slides at 19 (emphasis in original).

works to increase access. Similarly, "negotiated rates" are the service/item prices UVMHN sets with the payer. None of UVMHN's contracts with commercial payers include a specific net revenue cap.

If the GMCB's standard Condition 2/B utilizes the above definitions (which are taken from a source with which UVMHN is not familiar and has not had the opportunity to evaluate), it is not clear what the GMCB intends to accomplish. We are concerned that, without clarity, neither payers nor hospitals will understand how to implement this requirement, leading to confusion and unintended consequences.

If the GMCB intends to implement global commercial budgets or total commercial cost of care caps with this language – as recently suggested to the GMCB by one commercial payer -- UVMHN strongly objects to the GMCB's attempt to achieve this very substantial change in regulation through edits to the standard budget conditions at the eleventh hour. Instead, if the GMCB seeks to fundamentally change the way commercial rates and payments are regulated and implemented, it must engage in appropriate lawmaking and rulemaking, with sufficient opportunity for stakeholder notice and comment—which it has not done here. The GMCB may or may not have statutory authority to fix prices for specific hospital services, but it can only exercise any such authority pursuant to rules adopted in accordance with VAPA, which it has not adopted. *See* 18 V.S.A. §§ 9375(b)(1), 9376(b)(1). Rulemaking is necessary because (1) designing and implementing a global budget or cost of care cap will be a significant and complex undertaking that requires a reallocation of duties and responsibilities that is vastly different than the current regulatory or commercial contracting schemes contemplate (2) creating and monitoring and implementing global budgets will require extensive actuarial planning between payers and hospitals, and (3) consideration should be given to the GMCB's limited ability to oversee entities it does not regulate, including self-insured and out-of-state payers that are not subject to GMCB oversight.

In light of the above, we request modification of Condition 2/B as follows:

[Hospital]'s total change in charge and aggregate commercial negotiated rate increase are approved at not more than [x]% over current approved levels, with no change in charge or aggregate commercial negotiated rate increase for any payer at more than [x]% over current approved levels. Aggregate commercial negotiated rate increase refers to the net changes in allowed amounts for services and items, recognizing that some service or item prices may decrease and others may increase to achieve the aggregate adjustment. Allowed amounts refers to the amount to be paid to the hospital (insurance payments plus patient cost share). The total change in charge and aggregate commercial negotiated rate increase overall or with respect to any payer may be less than [x]% as negotiated between the hospital and payer.

If the GMCB or Staff Have Additional Questions for the Hospitals, They Should Ask Them

Finally, at several points during yesterday's presentations, staff suggested that the financial information submitted by the UVMHN's hospitals left them uncertain regarding important facts, such as the days cash held by the hospitals. If the GMCB or its staff has any remaining questions or requires additional information, they should ask the hospitals, which

stand ready to answer. But without first asking those questions, the GMCB should not and may not hold the hospitals responsible for any remaining uncertainty.

We understand the GMCB intends to review these objections before voting on the UVMHN's member hospital budgets. Please do not hesitate to contact me before the vote if the GMCB needs any additional information about these objections.

Very truly yours,

Eric S. Miller
SVP and General Counsel
The University of Vermont Health Network

Cc: Office of the Health Care Advocate