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March 18, 2025

Via E-Mail Only

Owen Foster
Chair, Green Mountain Care Board
112 State Street, 5th Floor,
Montpelier, VT 05601

RE: HCA Comment on Proposed FY26 Hospital Budget Guidance

Dear Chair Foster and Members of the Green Mountain Care Board:

Pending legislation creates significant unknowns regarding the future of the hospital budget review process. Given this uncertainty, the HCA's public comment focuses on high-level changes we believe should be made to the FY26 guidance to set the stage for needed structural changes in coming years.

The Board has made clear that there is consistent and compelling evidence that high hospital prices and low efficiency, particularly at our largest hospital and health network, are major drivers of Vermont's various health care crises. The Board needs to take actionable steps in the FY26 guidance to better address these drivers. The HCA recommends five high-level changes, which we further detail in the rest of this comment:

1. Deny commercial rate increases for any non-CAH hospitals that exceed the sixth decile of RAND standardized price nationally (i.e., implement a commercial rate "freeze");
2. De-emphasize the importance of Net Patient Revenue (NPR);
3. Prioritize the use of metrics from audited financials;
4. Establish a minimum standard of community benefit for hospitals;
5. Exercise strong enforcement authority for non-compliance with budget orders, prioritizing enforcement of non-CAH hospitals.

Regarding the recommendation on commercial rate, Vermont's median household income is around the national median. However, several Vermont hospitals are well above the median in terms of price. There is no reason the Board should continue to allow expensive hospitals to further raise prices when we know their prices already exceed those of peer hospitals and Vermonter's ability to pay them. It is imperative that overpriced Vermont hospitals are placed, starting now, on a price reduction "glide path" to match Vermonter's ability to pay.

Regarding de-emphasizing NPR, the HCA recognizes that the Board wants to understand if high hospital costs are being driven more by prices or utilization because it directly informs what types of regulatory interventions are appropriate. NPR, because it combines price and utilization, will always be an insufficient metric to accomplish this goal. One benefit of the Board historically relying on NPR as a primary metric for regulating hospital budgets is that we know what happens from its use: hospital expense, price, and overall cost growth exceeds inflation and Vermont wage growth.

Undoubtedly, regulating NPR is not solely responsible for the fact that our hospital and premium costs are now among the highest in the country. At the same time, there is consistent evidence that costs have not been sufficiently contained during the years when NPR was the primarily metric used to regulate hospitals. An alternative approach is to cap hospital prices at a level aligned with Vermonter's ability to pay paired with a predictable adjusted annual growth rate (like CPI-U).

Caping prices, however, might result in hospitals inducing utilization and or upcoding to achieve desired margins. One way to address this would be to set a service utilization benchmark and only compensate hospitals for the marginal cost of services provided if it exceeds that benchmark.[1] To mitigate the risk that this approach could disincentivize the provision of "high-value care," the GMCB could provide marginal cost plus some percentage for services identified as priorities in the state health improvement plan (e.g., primary care, mental health, substance use disorder treatment). Further, the

[1] Robert Berenson and Robert Murray, *How Price Regulation is Needed to Advance Market Competition*, 41 HEALTH AFFAIRS (2022). 26 – 34 (Although the authors are talking about controlling utilization increases due to global budgets their insights are applicable to price caps, too).

Board could further modify the "cost plus" factor if a hospital meets measurable quality metrics, such as wait times.

The Board should, as it de-emphasizes NPR, further prioritize measures taken from a hospital's audited financials (which follow GAAP) as opposed to relying on self-reported, unstandardized, and unverifiable hospital financial data reported in Adaptive. The Adaptive data has repeatedly been shown to contain significant unexplained variances between what hospitals report to the Board and the federal government for the same measures. While we do not imply any bad action on the part of data reporters, it is not advisable for the Board to privilege lower quality data when higher quality data exists.

In addition to regulating prices and deriving metrics from audited financials, the GMCB should ensure that hospitals provide a minimum amount of community benefit. IRS Form 990, Schedule H, Part II, provides a good categorization of community benefit expense categories. The money spent on these activities plus the cost of financial assistance reported on IRS 990, Schedule H, Part I, item 7, line a, column e, should be counted as the community benefit provided by a hospital. While we are aware the IRS 990 counts unreimbursed Medicaid costs as community benefit, we agree with the Lown Institute and others that such costs should not be counted as they do not improve health or directly impact a patient's finances like patient financial assistance does.

Lastly, the GMCB should continue its efforts to enforce hospital budget overages. It is critical for the legitimacy of the GMCB and its regulatory process to enforce budget order violations, as it did last year. We encourage the Board to also take enforcement action when hospitals fail to submit documents in a timely fashion to all parties as required in the guidance.

Thank you,

/s/ Sam Peisch, Health Policy Analyst

/s/ Eric Schultheis, Staff Attorney

/s/ Mike Fisher, Chief Health Care Advocate