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MEMORANDUM

TO: Senate Committee on Health & Welfare
FROM: Green Mountain Care Board
RE: H.482
DATE: April 30, 2025

This Q&A provides context and clarity on key provisions of H.482 from the perspective of the Green Mountain Care Board (GMCB). It addresses how GMCB determined the Days Cash on Hand (DCOH) threshold, the use of financial health metrics, considerations around Critical Access Hospitals (CAHs), the role of bonding and contractual obligations, and the definition of material compliance with hospital budgets.

The responses reflect the GMCB's current regulatory approach and are intended to assist stakeholders in understanding how the Board interprets and applies financial oversight tools in support of Vermont's healthcare system.

Question #1. How did GMCB land on 135 days cash on hand?

Answer: *The Green Mountain Care Board (GMCB) recommended a Days Cash on Hand (DCOH) threshold of 125, which reflects a level we, as regulators, consider acceptable and would not want hospitals to fall below. During testimony on March 14 (approximately 55 minutes in), VAHHS referenced the Kaiser Family Foundation (KFF) report and suggested that a DCOH of 125 was concerning. The KFF report, which draws on S&P's standard rubric for bond ratings (see Table 14), defines an "adequate" DCOH range for standalone hospitals as between 100 and 160. Selecting 135 as a target figure places it squarely within this "adequate" range. It appears the number was determined by averaging the lower and upper bounds of that range, aligning both with our regulatory comfort level and with industry benchmarks referenced by VAHHS.*

Question #2. Is there a more stable metric than DCOH

Answer: *Days Cash on Hand (DCOH) and operating margin are considered two of the most stable and widely accepted metrics for assessing hospital financial health. These measures are consistently used across the healthcare industry and provide meaningful insight into a hospital's financial sustainability.*

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While Professor Kane raised concerns about the potential for hospitals to manipulate DCOH, the GMCB calculates this metric using unrestricted assets, which limits opportunities for manipulation. In addition, the GMCB has the authority to request clarifying information from hospitals and can require formal attestations to ensure that no actions were taken to artificially inflate or alter reported DCOH figures.

Question #3. Critical Access Hospital (CAH) Exemption

Answer: *GMCB does not recommend eliminating Critical Access Hospitals (CAHs) from section 1 of the bill. Doing so could create a loophole allowing network-affiliated hospitals, such as UVM and Dartmouth, which both own CAHs, to shift assets to those facilities to avoid enforcement.*

Additionally, because enforcement authority under the bill is triggered only after certain financial thresholds are met, the financial health of CAHs remains an important factor. In scenarios where Vermonters need protection from an insolvent insurer, excluding CAHs from consideration could hinder the Board's ability to act effectively.

If CAH exclusion becomes necessary to secure passage of this bill, one option could be to exempt only those CAHs that are not part of a broader hospital network. However, this approach risks undermining the bill's purpose, particularly if a standalone CAH holds substantial assets and posts positive margins, yet remains outside the framework intended to protect Vermonters.

Question #4. Relationship w DFR, contracts?

Answer: *We do not understand the question. If you can clarify the question for us, we would be happy to provide a follow-up response.*

Question #5. Bonding questions and how the Board looks at bonding and impact on its decisions for budgets, this bill.

Answer: *The GMCB may consider the financial impacts of bonding and contractual obligations as they relate to both hospitals and insurers. However, it would be inappropriate to prohibit the Board from exercising emergency authority solely to protect one entity's bond rating or financial standing at the expense of another. For example, preserving a hospital's AAA bond rating while causing an insurer's rating to drop to a C, or potentially pushing the insurer toward insolvency,*

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would not serve the broader interests of Vermont's healthcare system. The Board must balance these considerations to ensure overall system stability.

Question #6. Define material compliance with budgets.

Answer: *"Material compliance" with hospital budgets could be defined by linking it to existing statutory language in 18 V.S.A. § 9456(h)(2)(B), which authorizes the Board to require a hospital to "cease material violations" of its orders. The statute also allows the Board to take action when a hospital operates contrary to its approved budget, provided such a deviation from the budget is material. Aligning with this language would provide clarity and legal consistency.*

To strengthen this connection, we could propose amending the bill to include the following: "The Board may, upon finding that a hospital has made a material misrepresentation in information or documents provided to the Board, or that a hospital is materially noncompliant with, or materially violates, the budget established by the Board pursuant to this section…"