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March 27, 2018

Pat Jones
Interim Director of Health Systems Finance
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Subject: Fiscal Year 2019 Hospital Budget Guidance

Dear Pat:

Per your request, we are providing documentation of our concerns with the Green Mountain Care Board (GMCB) proposal to separate ACO Fixed Prospective Payment revenue from Fee-for-Service revenue in FY 2019 hospital budget net patient revenue guidance.

By way of background, BCBSVT has contracted with OneCare Vermont (OCV) for the participation of a subset of our Qualified Health Program (QHP) population in the OCV Accountable Care Organization (ACO). The financial risk/savings component of our 2018 contract does not alter underlying reimbursement to network hospitals. Notably, while the underlying OCV reimbursement model includes a hospital fixed payment evaluation, and for Medicaid a separate process, actual expenditures will be reconciled at year end with fee-for-service claims. The OCV shared savings or risk payment will be based on the fee-for-service claims. The 2019 contract has not yet been negotiated, but it is BCBSVT's intention that claims will continue to be reconciled to fee-for-service even when a different payment process is implemented.

Separating hospital budget guidance for the ACO and non-ACO components does not reduce the overall NPR rate of increase. We applaud the goal of the GMCB to introduce incentives for hospitals to participate with the All-Payer Model (APM), we note that providing higher increases for fixed prospective payment revenue may place cost pressures on the ACO making it less viable. It also may disadvantage BCBSVT relative to QHP carriers who do not participate in the APM.

Additionally, allowing for a separate rates of increase for ACO portions of hospital revenue will reverse a core component of ACO target setting, wherein the ACO target naturally flows from the GMCB approved premium and underlying assumptions. Connecting ACO's performance to the premiums paid by our members creates a direct link between the risk or savings shared by the ACO and our members. Approving ACO specific portions of hospital revenue translates to presetting of an ACO target disconnecting this important linkage.

Finally, establishing specific guidance for the fixed prospective payment portion of hospital budgets could create a highly leveraged cost shift for that portion of the budget. While this may be helpful to commercial rates in years where government payers have increases exceeding the guidance, it could be tremendously harmful in years where government payers offer small increases.

We recommend that the GMCB take time to fully study the possible impacts of separating guidance for fixed prospective payments and fee-for-service revenue before considering implementation of

the recommended change. We would further encourage the GMCB to engage with Lewis & Ellis regarding this and other hospital budget considerations, particularly the relationship between net patient revenue, utilization trend, and commercial rate increases.

Please let me know if we can answer any questions or provide further information.

Sincerely,

Kelly Lange
Director, Health Care Reform

cc: Paul Schultz/BCBSVT
Ruth Greene/BCBSVT
Sara Teachout/BCBSVT
Judy Henkin/GMCB

VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

March 22, 2018

Kevin Mullin, Chairman
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Dear Chair Mullin,

As the Green Mountain Care Board nears completion of FY19 budget guidance, we want to make clear our opposition to an insufficient NPSR target that will threaten the hospital-led innovation, investment and integration of Vermont's patient care. Hospitals will not compromise their missions, or sacrifice quality or patient safety, to meet a revenue target.

The current NPSR draft proposal of 2.75 percent directly threatens the transformative work being done under the All-Payer Model (APM). A signed contract with the federal government, the APM calls for an ambitious and historically low 3.5 percent per-capita growth rate. Hospitals need a stable regulatory environment, secure financial footing and the space to innovate to achieve the goals of the APM. Recent GMCB proposals backtrack on the target set by the APM—and break with the APM's tough but predictable growth rate.

Hospital and regulator efforts to control expenses and build sustainable budgets have produced nearly $600 million in expense savings over the last seven years. Now, Vermont's hospitals are making strategic investments in primary care and prevention, care coordination and community collaboration—advancing health reform objectives and assuming real financial risk in the process. We are dedicated to continuing the work of bending the cost curve, but without adequate resources and the ability to make the proper investments, that promise becomes much harder to fulfill.

Anything below a 3.4% target jeopardizes the progress we are making and attempts to move us too far too fast when we are already on a productive and promising path. Vermont's non-profit hospitals are driven by the needs of our patients and communities, and hospital budgets are built to ensure that Vermonters have the right place to turn when they need compassionate, trusted care.

Our constituencies expect us to be reliable caregivers, stable employers, and vital contributors to community development. These expectations do not go away, no matter the financial situation of our hospitals. As a result, hospitals will work towards the budget guidance adopted by the Board, but will also carefully evaluate possible implications.

I hope the Green Mountain Care Board will hear our call for a reasonable and responsible path forward that incrementally and wisely advances the progress we have already achieved together. Vermonters are relying on us to get this right. Thank you for your careful consideration.

Respectfully,

Jeff Tieman
President and CEO

Jill Berry Bowen
CEO, Northwestern Medical Center

VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

March 8, 2018

Kevin Mullin, Chairman
Green Mountain Care Board
144 State Street
Montpelier, VT 05620

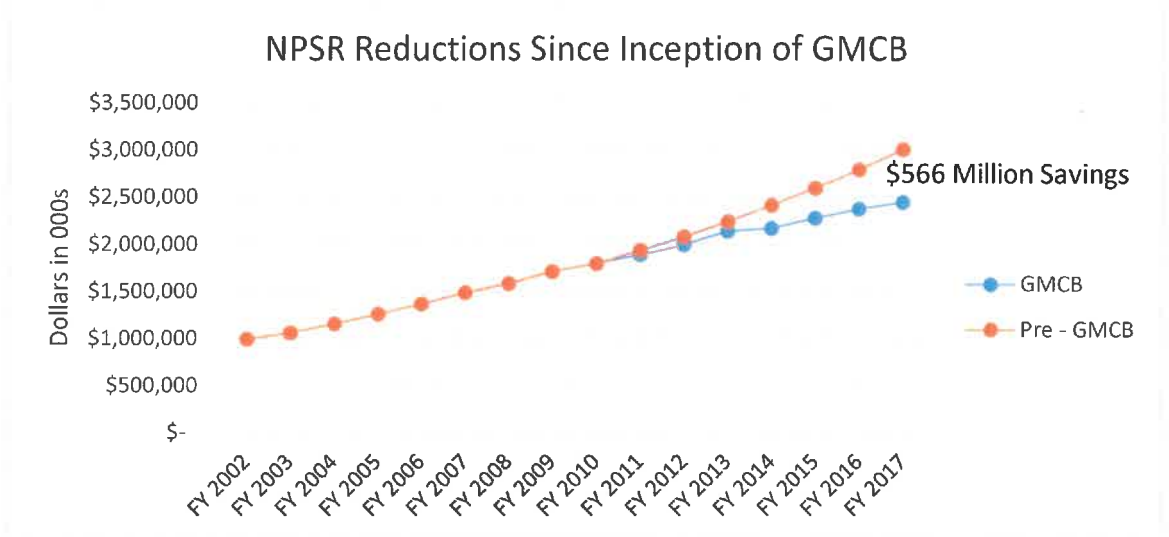
Dear Chair Mullin:

The following is to provide comment related to the FY 2019 proposed budget guidance, as well as to provide alternative proposals to those that have been outlined in the draft guidance. We share the same goal of access to the highest quality, most affordable care. We are concerned, however that the current proposed growth rate below medical inflation may affect our shared goals and the communities that Vermont's not-for-profit hospitals serve.

- **Net Patient Service Revenue (NPSR) targets [Pages 8 and 9]** – The two-year proposal does not cover medical inflation. According to new estimates from the Centers for Medicare and Medicaid Services, health spending in 2018 will increase by 5.3%, and by 5.5% between 2019 and 2026. These trend lines significantly imperil hospitals' ability to manage to a 2.8% increase. We strongly believe the basis of inflation should include adjustments to address trends outside the control of the hospital industry, such as pharmaceutical inflation that is estimated to grow at 6.3% per year. Other inflationary concerns include salaries necessary to hire and retain both administrative and clinical staff, benefits, medical malpractice, fuel and utility costs and medical supplies, each of which is estimated to grow from 3% to 9% in the upcoming years. We are also concerned that with so much uncertainty at both the federal and state level, a multi-year target is problematic.

2019 - Projected Inflation		
Inflation Drivers of Concern	**Percent**	**Description / Price Estimates From Suppliers**
Salaries	3% - 4%	Admin and Clinical workforce retention and recruitment
Purchased Labor	5%	Workforce shortages; example RN and hospitalists
Benefits	5%	Admin and Clinical workforce retention and recruitment
Supplies	2%	Medical Supply Costs
Utilities/Fuel/Transportation	7% - 9%	Impact of inflation and projections for fuel costs
Pharmacy	6% - 8%	Impact of pharmaceutical cost
***** CMS Projections**	**5.3% - 5.5%**	**CMS Report - Medical Inflation between 2019 - 2026**

Since the GMCB's inception, the hospital delivery system has reduced NPSR growth by an estimated $566 million; operational efficiency and expense reductions have been critical to slowing growth.



Vermont Hospital Estimated Saving to Vermonter's

Actual Average Net Patient Service Growth Rates	
Average Increase FY02 - FY10 (Pre GMCB)	7.7%
Average Increase FY11 - FY17 (Post GMCB)	4.5%

	NPSR	% Change	Growth at Pre-GMCB Average
FY 2002	$ 992,883,060		
FY 2003	$ 1,061,385,376	6.9%	
FY 2004	$ 1,154,046,727	8.7%	
FY 2005	$ 1,255,283,169	8.8%	
FY 2006	$ 1,365,889,700	8.8%	
FY 2007	$ 1,484,480,845	8.7%	
FY 2008	$ 1,583,760,011	6.7%	
FY 2009	$ 1,707,825,416	7.8%	
FY 2010	$ 1,793,939,712	5.0%	
FY 2011	$ 1,889,301,635	5.3%	$ 1,931,757,375
FY 2012	$ 1,994,313,774	5.6%	$ 2,080,162,746
FY 2013	$ 2,136,485,447	7.1%	$ 2,239,969,214
FY 2014	$ 2,169,453,746	1.5%	$ 2,412,052,658
FY 2015	$ 2,278,270,306	5.0%	$ 2,597,356,243
FY 2016	$ 2,378,206,818	4.4%	$ 2,796,895,596
FY 2017	$ 2,445,509,709	2.8%	$ 3,011,764,364
Saving to Vermonter's			**$ 566,254,655**

For the eight year period preceeding the GMCB, Vermont hospital average net patient service revenue increase was 7.7%
If the growth rate of 7.7% was held constant from FY 2011 - FY 2017, Vermont hospital NPSR would have been $566m higher

- **Proposal:** With significant uncertainly in the delivery system we recommend adopting a one-year NPSR growth rate of 3.4%—equal to last year's inflation amount and below the APM target of 3.5%. The Board could then establish the appropriate investment percentage for items such as reform incentives, primary care and prevention, as well as investments in lower cost alternatives.

  Additionally, NPSR paid to hospitals by the ACO, as well as increases in out-of-state (OOS) revenues, should be excluded from the NPSR growth percentage. Similarly, the Board should consider ways to recognize unanticipated utilization increases that could put hospitals over NPSR targets.

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- **Expenses Control** –The Board has discussed the connection between expense control and NPSR growth. It is appropriate for the Board to understand expense management objectives/achievements, but the NPSR target should not include an expense reduction target.

  Vermont hospitals work tirelessly on operational efficiencies and limiting expense growth, without these efforts, we would have never been able to reduce cost growth by $566 million. The financial situation of our critical access hospitals is very fragile; they have high direct cost structures and while they continue to focus of operation efficiencies, expense reductions are easier said than done. All Vermont hospitals are constantly evaluating how to reduce expenses as well as what programs may be affected. Our members will not sacrifice quality in the pursuit of lower NPRSR targets. Finally, if it were not for other operating revenues, most Vermont hospitals would face significant financial challenges.

  Proposal: Ask hospitals to report on expense management initiatives along with historical reductions achieved and current year initiatives. The NPSR target should not include an expense reduction target.

- **Bridges Charts [Page 6, # 9]** - We are concerned about the alignment of GMCB expectations with what hospitals can accurately report. While acknowledging that some of this data is not available, the Board remains steadfast on collecting information that does not exist. For example, the payments that insurers send to providers do not include an allocation by ancillary departments; payments are recorded as an episode of care and not broken out by ancillary service area.

  Proposal: Eliminate this chart from the budget guidance, but ask for information pertaining to the service lines and utilization that are impacting changes to NPSR/expense performance

- **Budget Performance [Page 12]** - The section states that the initiation of corrective action is to occur when a hospital's actual revenue diverges "significantly" from its budgeted revenue, yet the threshold being used is 0.5%, which does not represent a significant divergence.

  Proposal – Reconsider and increase the level of the threshold to one that identifies "true" variances as opposed to the 0.5% that may just be capturing normal variation from budget to actual. Additionally, when available, hospitals should break down the variance between rate, utilization and patient volume.

- **Other Questions Pertaining to Guidance:**

  - **Presentation Instructions [Page 3, #4]** – Wait time and quality was discussed, but there was no final recommendation.

    Proposal: The GMCB needs to define how to collect data to measure wait time or access. Our suggestion is to gather the input from hospitals necessary to develop a standardized method for calculating the measure. A suggestion for quality reporting would be to utilize the 33 CMS ACO measures.

  - **Presentation Instructions [Page 3, #12]** – The historical compliance should not be limited solely to budget orders.

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Proposal: The GMCB should allow for the explanation of drivers of the changes related to utilization and new investments to address mental health and addiction issues (e.g., SBIRT) as well as other variables that may not be apparent in simple variance calculations.

- **Salary Reporting [Page 7]** – The hospital reporting process is highly transparent; the request to report person-specific information into the salary chart seems redundant with the IRS Form 990 request. The chart's intent is not clear—is it supposed to match the 990, which includes only the top salaries, or is this a budget reconciliation for all FTEs? Also, the definitions of Medical Staff and Administrative Staff need clarity.

  Proposal: The salary chart should collect total FTE information in aggregate and should not include individual salary information. Capturing al FTEs would also eliminate the discrepancies around the definitions of medical staff and administrative. All individual earners information should be collected within the 990 reporting structure.

- **Capital Budget Investment [Page 8, item 12b]** – It is unclear what is meant by "Provide the estimated NPR and expense effect for any proposed Certificate of Need that may be approved during FY 2019." Historically, unapproved CONs were not submitted as part of a hospital's budget.

  Proposal: Reporting of revenues and associated expenses should remain outside the current budget process or until the CON is approved.

- **Physician Transfers and Acquisition [Page 14]** - The section only addresses physicians and should recognize Advance Practice Providers that also may move from the community to a hospital setting.

  Proposal – Include language in this section that adds Advanced Practice Providers to the reporting requirement.

- **Appendix V [Page 25]** – Questions 1a), 3 and 7 are duplicative to information that is already captured through the GMCB budget requirements.

  Proposal: The GMCB should provide this information to the HCA.

- **Question 7** – Please provide clarity on this question.

We appreciate all the work that you and your team have done related to the FY 2019 budget process, and we are hopeful that these comments are considered when finalizing the FY 2019 guidance. Thank you for listening—and for your consideration of our perspective on these important issues.

Sincerely,

Mike Del Trecco
Senior VP, Finance and Operations
Vermont Association of Hospitals and Health Systems

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Name: Gregory MacDonald MD
Town: East Montpelier
Topic: Hospital Budgets

I encourage the GMCB to require the UVM Health Network to refund 100% of their excess revenue to rate payers.

The excess revenue is in violation of the Board's guidelines to UVMHN and in each of the last 2 years has seen the Network rewarded for this behavior. When UVMHN is able to redistribute a large portion of this money (about $12 million in fiscal 2016 and 2017) to the remaining health care organizations it doesn't already control, it's influence increases further, quieting the voices that might better inform the board and healthcare planning in Vermont. Allowing UVMHN to keep 50% of last years $24.5 million excess revenue for its own vaguely defined use ,virtually guaranteed this years $43 million excess.

I don't think the GMCB should fashion itself into a shadow "appropriation committee " spending tens of millions of dollars of ratepayer's money on their and UVMHC 's priorities.

Please return all of this years excess revenue to the ratepayers thru the insurers and make sure this does not happen next year by imposing the 3% rate cut fully and not allowing UVMHN access to this ill gotten revenue.

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March 9, 2018

Chair Kevin Mullin
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Hospital Budget Policy Proposals

Dear Chair Mullin,

The Office of the Health Care Advocate (HCA) is writing to comment on two recent proposals presented at Green Mountain Care Board meetings:

- The Green Mountain Care Board (the Board)'s proposal to decrease the Hospital Budget Guidance net patient revenue (NPR) increase cap for 2019 as compared to recent years, and
- The University of Vermont Medical Center (UVMMC)'s proposal to address its 2017 budget overage by foregoing rate increases in 2019.

The HCA asks the Board to reduce the hospital budget NPR increase cap for 2019.

We appreciate the Board's ongoing efforts to slow the growth of health care costs in Vermont. These efforts directly affect the affordability of health care for consumers through both health insurance rates and the prices of services provided at the state's hospitals. We support the Board's proposal to set a lower cap on hospital net patient revenue growth for fiscal year 2019 than in recent years and ask the Board to fully enforce its NPR caps.

We appreciate the Board's consideration of affordability to Vermonters in setting the 2019 NPR increase cap. Given the substantial overages demonstrated by hospitals in recent years, we believe it is necessary to aim lower than the all-payer model trend rate. There is clearly significant work to be done by Vermont's hospitals to slow the growth of health care costs and meet the goals of the all-payer model.

Aggressively limiting the hospitals' NPR growth should encourage the hospitals to invest in areas that will prevent costly hospital care, and to carefully consider the commercial rates they set. These changes would benefit Vermonters as well as the state. We ask the Board to continue to lower the NPR increase cap in future years and to ensure that the cap is meaningful by strictly enforcing it.

The Board should require UVMMC to reduce its 2018 commercial rates.

We ask the Board to require UVMMC to reduce its commercial rates for 2018, effective immediately, to rectify its 2017 overage. We do not believe UVMMC's proposal to address its 2017 budget overage simply by foregoing a future rate increase is sufficient. An NPR increase cap is only meaningful if there is a significant consequence to exceeding it. The excess revenue collected by UVMMC in 2017 should be returned to Vermont ratepayers completely and as promptly as possible.

Until UVMMC's rates go down, Vermonters will continue to overpay for UVMMC services and for health insurance premiums. Cutting UVMMC's 2018 commercial rates will have immediate and ongoing benefits for Vermonters. Vermonters with deductibles and/or coinsurance who receive care at UVMMC in 2018 will save money on out of pocket costs. Further, the Board can, and should, ensure through its rate review and hospital budget processes that future health insurance premiums and hospital commercial rates adequately reflect these lower rates.

Thank you for considering these comments. Please feel free to contact us with any questions.

Sincerely,

s\ Mike Fisher, Chief Health Care Advocate

s\ Julia Shaw, Health Care Policy Analyst

s\ Kaili Kuiper, Staff Attorney

Name: Liz Curry
Affiliation, if applicable: Efficiency Vermont
Town: Burlington
Topic: Hospital Budgets

Recently, Vermont hospitals have demonstrated that investing hospital community benefits in affordable housing for the homeless immediately reduces the emergency and admitted care costs associated with ailments and serious illnesses resulting from living outside and in shelters. Efficiency Vermont applauds this unconventional approach to reducing health care costs and improving health outcomes through hospital community benefits planning. The comments submitted herein follow the same vein, to suggest that serious health conditions can be relieved and even prevented, economically and efficiently through investments that treat root causes rather than symptoms.
Towards this end, Efficiency Vermont is writing to propose that Vermont hospitals apply Health Care Reform funds to patient home energy efficiency improvement initiatives.

Research on energy efficiency investments in housing occupied by households with limited access to health care coverage and treatment demonstrates that weatherization and efficient heating and ventilation equipment alleviates chronic conditions and hazards associated with asthma, respiratory illnesses, allergies, cancer, and thermal stress. Energy efficiency changes the way a home functions, and the result can forestall or reverse dangerous health conditions of people who contend with asthma, allergies, chronic respiratory illness, radon poisoning, thermal stress, arthritis, depression, and risk of fire and carbon monoxide poisoning.

Recently published primary research from Dr. Bruce Tonn, Energy & Environment Fellow with the Howard H. Baker Center for Public Policy at the University of Tennessee in Knoxville, on health care savings from residential weatherization programs in Massachusetts, documented that energy efficiency from weatherization activities resulted in a range of improved health outcomes with approximately $1,382 annually in monetized health benefits per low-income household.

The health improvements in over 200 homes included:
- 50% reduction in medical attention from thermal stress related to chronic chill.
- Over 50% of participants received a working carbon monoxide detector which avoided deaths.
- Nearly two-thirds of the participants stopped missing work as much.

For those with asthma the post-weatherization results included:
- Nearly 30% fewer emergency department asthma-related visits.
- 3% fewer asthma-related hospitalizations.
- An 11% decrease in asthma symptoms after three months.

The energy improvements included:
- air sealing and insulation
- replacement of refrigerators and freezers
- sealing of heat and ventilation system ducts
- repair or replacement of heating and hot water systems
- LED lighting
- pipe insulation
- water saving faucet and showerhead devices
- programmable thermostats

The post-weatherization treatment health improvements resulted from:

- indoor air quality improvements
- thermal regulation
- prevention of using ovens and space heaters as heat source
- prevention of vermin/pests
- fire and carbon monoxide safety from repairs or replacements to combustion equipment like stoves and furnaces
- cost savings to free up money for health care treatments and better nutrition

Dr. Tonn's research is the most recent of decades of studies that demonstrate the links between clean energy efficiency measures and resident health. In Vermont, Efficiency Vermont recently embarked on a multipronged strategy to educate health care and other partners on the health benefits from weatherization and energy efficient equipment in the home. Efficiency Vermont has engaged the Vermont Office of Economic Opportunity's Weatherization Assistance Program and Northeastern Vermont Regional Hospital to conduct a quality valuation pilot with chronically ill COPD and asthma patients with the goal to better understand how energy efficiency measures installed in Vermont homes achieve better patient health and reduce health care and energy costs for Vermont.

Investments from Vermont's hospitals in energy efficiency combined with in-home health visits will leverage the annual $10M in investments currently made by Vermont's five weatherization agencies, Efficiency Vermont, Burlington Electric Department and Vermont Gas to integrate health measures into efficiency programs and will increase the 2,000 households treated annually by these entities. By participating in clean energy investments, Vermont's healthcare community could also help reduce reliance on the Low-Income Home Energy Assistance Program (LIHEAP), which supports low-income households' ability to pay utility bills. Weatherization and energy efficiency typically reduces household utility costs by a conservative number of over $200 annually, which creates a more financially resilient household on top of strengthening overall household health.

Energy efficiency measures also support the goal to reduce the "prevalence and morbidity of chronic disease," identified in the All-Payer Model for use of Medicaid and Medicare funding. Other states have begun integrating, or already implemented a Medicaid code for specific energy efficiency measures that reduce or eliminate the in-home conditions that lead to reliance on emergency or primary health care treatments associated with asthma, chronic respiratory illness, chronic chill, heat stress/ regulation, and allergies. Energy efficiency work delivered by community-based organizations such as the Community Action Program weatherization agencies could be coded as an eligible activity under this model.

Efficiency Vermont looks forward to higher engagement with Vermont's hospital community to explore these new opportunities for achieving better population health in Vermont. We hope that the Green Mountain Care Board will provide clarification language that allows hospitals to count investments in energy efficiency combined with in-home health programs as part of the hospital's work on Health Care Reform. Additionally, Efficiency Vermont asks the Green Mountain Care Board to consider the use of Medicaid waivers under the All-Payer Model to reduce health care system costs and dramatically improve Vermonters' health outcomes, financial resiliency, productivity, and overall quality of life.

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March 27, 2018

Chair Kevin Mullin
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Hospital Budget Rebasing Proposal

Dear Chair Mullin,

The Office of the Health Care Advocate (HCA) is writing to comment on the Green Mountain Care Board (Board) proposal, presented at the Board's March 21st meeting, to rebase FY2018 budgets for hospitals with a variance of over 2 percent between FY2017 budget and actual.

Our comments on this matter are threefold. First, we agree with Board staff's recommendation that hospital budgets should only be rebased if the budget to actual variance persists in 2018. We do not believe that a hospital's experience for a single fiscal year can be used to accurately predict future budget trends. Second, we ask the Board to make any rebasing decisions during the Board's regular hospital budget review process to ensure transparency and allow for public engagement. Third, we believe that any decision to rebase hospital budgets must explicitly include an analysis of how budget rebasing affects hospital accountability for complying with Board cost containment orders.

The HCA asks the Board to consider rebasing hospital budgets only if the 2 percent variance between budget and actual continues in 2018.

We applaud the Board's efforts to develop a more responsive regulatory system. We believe that a responsive regulatory system must be rooted in appropriate analysis of the regulatory action under consideration, supported by reliable data. In the present case, the magnitude of the observed variance coupled with the time period evaluated is insufficient to justify a hospital budget rebasing. We note that such rebasing might be appropriate in a business setting, however, we assert that basing regulation on a single data point abstracted from the larger historical context will likely result in budget rebasing that is unjustified by the data and not responsive to the needs of Vermonters.

Therefore, we concur with staff's recommendation that the Board only consider rebasing hospital budgets if the variance persists in 2018.

The HCA asks the Board to implement any rebasing of hospital budgets during the annual hospital budget review process.

We appreciate the Board's demonstrated commitment to the robust and public hospital budget review process required by Vermont law. We believe that ensuring a robust and public process helps make Board actions transparent to and understandable by the public. Conducting rebasing decisions on an accelerated time frame in which concrete staff recommendations are only made available one week in advance of a Board vote does not allow for meaningful public engagement. This lack of public engagement is further exacerbated when such decisions are contemplated outside of the annual hospital budget review process.

Therefore, we ask the Board to make hospital budget rebasing decisions during the annual hospital budget review process to ensure sufficient transparency and public engagement. Further, if the Board chooses to rebase hospital budgets in the future, we suggest approving NPR changes for individual hospitals above or below the Board's general NPR allowance. This would give the Board and the public a clear picture of the changes being made and would provide context for the proposed changes.

The HCA asks the Board to evaluate whether rebasing holds hospitals accountable to Board cost containment orders.

We believe that the Board plays a critical role in both reducing overall health system cost growth and improving the affordability and quality of health care services for Vermonters. Containing hospital costs requires regulation that is both enforced and meaningful. A hospital budget cap is only meaningful if there is a significant consequence to exceeding it (i.e. enforcement). The rebasing of hospital budgets that do not conform to Board orders undermines the accountability of hospitals to the Board for their cost containment obligations. Further, a rebasing ultimately also reduces a hospital's accountability to the public for failing to conform their budgets to Board orders. After such a rebasing, particularly if done outside the budget review process, it will appear that a hospital is complying with Board regulations more than it actually is.

Therefore, we ask the Board not to rebase hospital budgets without explicitly recognizing and evaluating the impact of the rebasing on future hospital conformance with Board cost containment orders.

Thank you for considering these comments. Please feel free to contact the Office of the Health Care Advocate with any questions.

Sincerely,

s\ Mike Fisher

Mike Fisher
Chief Health Care Advocate
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