VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

March 8, 2018

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

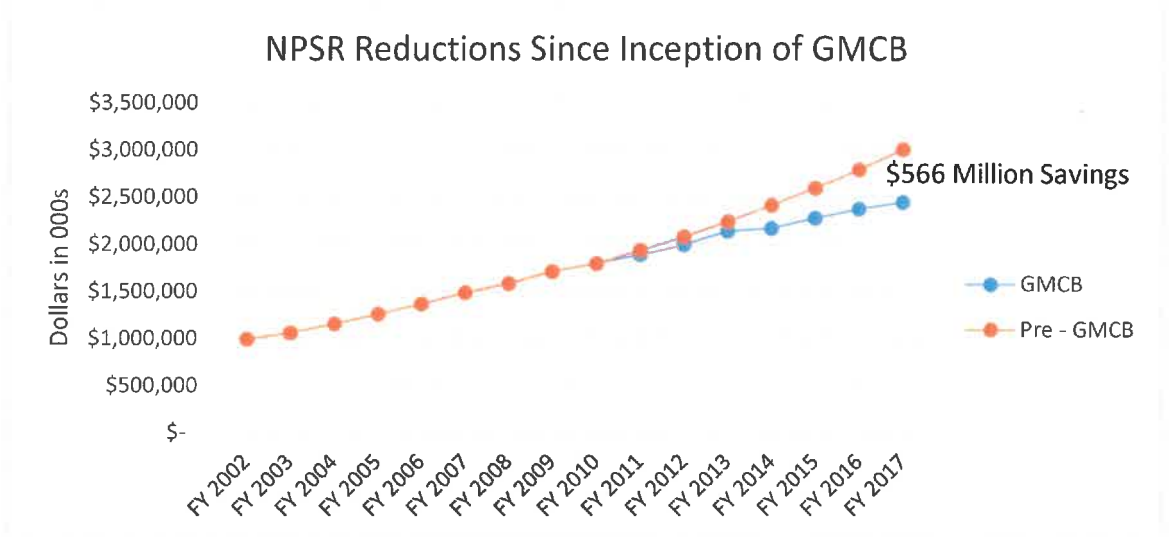
Dear Chair Mullin:

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FY 2019 proposed budget guidance, as well as to provide alternative proposals to those that have been outlined in the draft guidance.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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