FY 2025 HOSPITAL BUDGET GUIDANCE & REPORTING REQUIREMENTS

Effective: March 29, 2024
Draft Last Updated: March 13, 2024

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FY2025 HOSPITAL BUDGET REVIEW TIMELINE

**This timeline is subject to change*

Date (2024 unless otherwise noted)	
Nov – Dec (2023)	GMCB meets with VAHHS, the Office of the Health Care Advocate (HCA), and other interested parties to debrief the prior year Budget Review Process.
Jan – Mar	GMCB develops Hospital Budget Guidance
Jan – Mar	GMCB meets with VAHHS, the HCA, and other interested parties to discuss proposed budget targets for FY2025.
March 13	GMCB staff publish DRAFT FY25 guidance for public comment.
Feb 21 – Mar 25	Public comment period
March 27	GMCB votes on FY25 guidance.
March 29	GMCB issues Hospital Budget Guidance, including questions from the HCA.
Mar – Jul	Hospitals develop budgets for FY25
July 1	Hospitals submit budgets and other required documentation to GMCB.
July 2	GMCB staff publish the hospital budget request summary
Jul – Aug	GMCB staff review and analyze hospital budgets
Aug 6	GMCB staff present FY25 requests and preliminary analysis
Aug 7 – Aug 28	Hospital Budget Hearings (Remote)
Sept 3 – Sept 13	GMCB staff issue final recommendations & the Board conducts deliberations
Sept 13	Deadline for GMCB to vote on hospital budgets (Sept. 15 falls on a Sunday)
Oct 1	GMCB issues written budget orders to the hospitals

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INTRODUCTION

The mission of the Green Mountain Care Board (GMCB or Board) is to drive system-wide improvements in access, affordability, and quality of health care to improve the health of Vermonters. The Board's hospital budget review is one lever through which the state may facilitate continuous improvement of health system performance to improve access, quality, and affordability of care. Given the dynamic nature of health and health care in Vermont, the GMCB reviews its hospital budget guidance annually and makes updates to guidance as necessary, balancing the evolving needs of Vermonters with the stability and sustainability of Vermont's health care system.

The purpose of the Board's hospital budget guidance is to communicate the GMCB's planned approach to evaluating hospitals' proposed budgets, assessing hospital performance, and establishing hospital budget orders. The FY25 guidance continues to focus on facilitating improvement in access, quality, and affordability of care. The guidance seeks to promote predictability of the benchmarks that will be evaluated, and adaptability to account for hospital-specific circumstances, and a dynamic economic environment. The guidance aims to improve Vermont's evidenced-based regulation of hospitals and deepen understanding of community needs, pressures across the broader delivery system, and health system performance.

The GMCB will execute its statutory duties consistent with its purpose to promote the general good of Vermont, as set forth in 18 V.S.A. § 9372, to review and establish hospital budgets consistent with the principles of health care reform in 18 V.S.A. § 9371, as required by 18 V.S.A. §9375(a) and (b)(7), and the GMCB will review and establish hospital budgets in adherence to the requirements of
18 V.S.A. § 9456. Information relevant to and bearing on the GMCB's statutory purpose and principles may be reviewed and considered by the GMCB, as will any testimony and public comment provided to the Board.

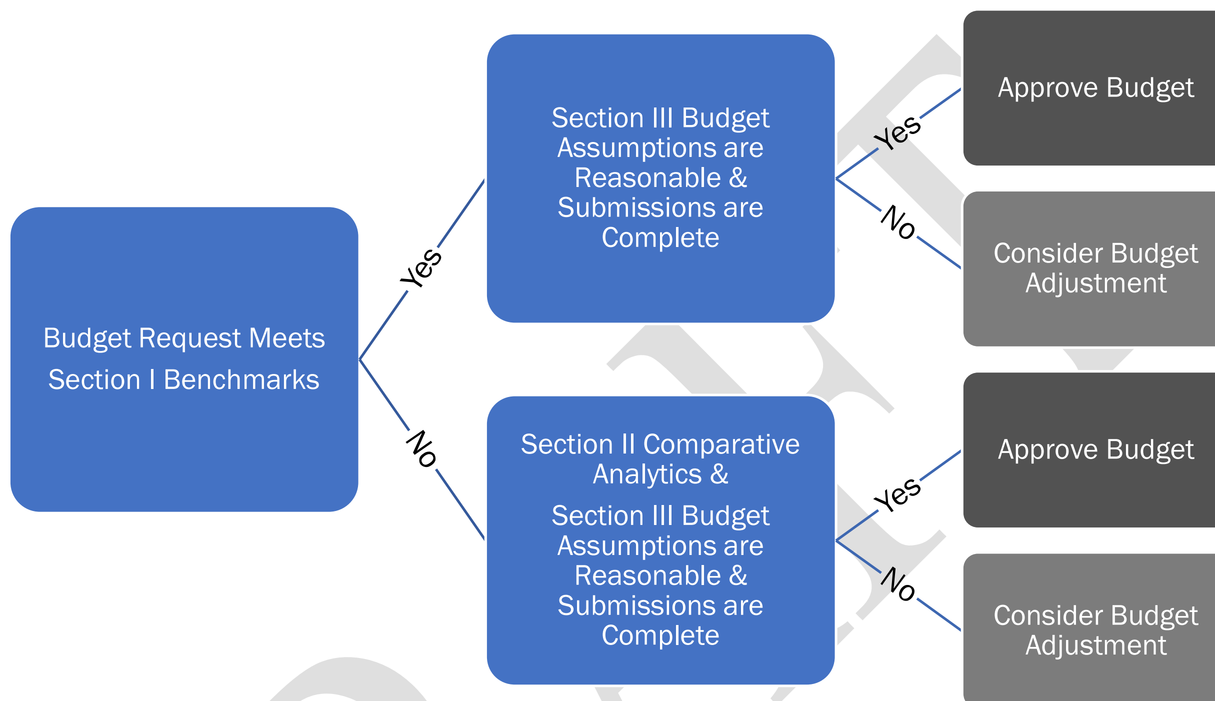
A. Hospital Budget Review Organizing Framework

To bring health care spending in line with economic growth and improve the affordability of high-quality care for Vermonters, *Section I* establishes benchmarks against which hospital budgets will be reviewed and evaluated. Though each hospital's budget will be reviewed on its own merit, *Section I* benchmarks recognize the system-wide approach necessary for improving health care affordability. *Section I* benchmarks also underscore the importance of hospital financial sustainability to ensure Vermonters' continued access to high quality care. The Board recognizes that the relationship between healthcare affordability and hospital financial sustainability is complex, affected by a variety of factors (e.g. hospital transformation, hospital efficiency, local market factors etc.), and in the long term these two factors are likely interdependent.

Section II includes details on the comparative metrics and data sources that the GMCB will use to evaluate hospital budgets and assess opportunities to improve affordability and hospital financial sustainability. *Section III* solicits information on assumptions, measures, and data sources upon which hospitals rely to construct their proposed budgets. *Section IV* includes information and contextual data to better understand the needs of the community, the ability of the hospitals to

meet those needs, and local delivery system pressures. *Section V* specifies sections to be included in hospital budget narratives.

Each hospital's budget request will be reviewed by GMCB staff in accordance with the following decision tree:



GMCB staff will review and analyze the entire budget submission for each hospital. If the hospital budget does not meet the Section I benchmarks, staff will review budget assumptions and comparative analytics, and may consider other information in other sections when evaluating the budget submission and determining how to establish a hospital's budget. Regardless of whether a hospital's proposed budget meets the established benchmarks or the hospital's budget is approved or modified, insights gained from data associated with any of the sections of this guidance may be used to facilitate conversations around improvement opportunities and may lead to additional reporting requirements. Hospitals that are a part of a network (whether through ownership or affiliation) must submit a budget and supporting materials separately for each individual hospital and provide details on the nature and impact of affiliation and/or network participation.

The Board's review process will promote the general good of Vermont, as set forth in 18 V.S.A. § 9372. The Board's review process will be consistent with the principles for health care reform in 18 V.S.A. § 9371, as required by 18 V.S.A. § 9375(a) and (b)(7), including considering the extent to which a hospital's budget advances the principle that all Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting (18 V.S.A. § 9371(1)), the principle that overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay

for such care (18 V.S.A. § 9371(2)), and will adhere to the hospital budget review requirements of 18 V.S.A. § 9456(c), including the requirement that established budgets shall promote efficient and economic operation of the hospital (18 V.S.A. § 9456(c)(3)).

B. Overview of Hospital Budget Review Process

Budget Submission
Hospitals are required to submit all required budget review materials by July 1, or as indicated in the filing checklist below. Staff will review and analyze submitted materials and present a summary of hospital requests to the Board prior to hospital budget hearings. Staff, and the HCA, may follow up with questions to hospitals on their budget materials. Hospitals will answer questions honestly, candidly, and completely, and return questions in a timely fashion, through the medium indicated by staff.

Budget Hearing
Each hospital will be offered an opportunity for a budget hearing. These hearings will be scheduled in advance. Hospital budget hearing presentations should cover the key content and hospitals will comply with the one-hour time limitation for presentations unless directed otherwise by the Chair. Academic Medical Centers and hospital networks will be allotted additional time, given the additional complexity of their budgets. There will also be time for Board and staff questions, as well as questions from the HCA, and public comment.

In accordance with GMCB Rule 3.000 §3.304, the Board may exempt a hospital from a public hearing if the hospital's proposed budget meets the benchmarks established in this guidance. In any given year, no more than four hospitals may be exempted from that year's public hearing, and the four largest hospitals (measured by NPR) may not be exempted. For those hospitals who meet the Section I benchmarks, who are not exempted from public hearing, budget hearing presentations shall focus on the hospital's improvement activities related to increasing access to high quality affordable care for Vermonters. For those hospitals who do not meet Section I benchmarks, budget hearing presentations shall additionally discuss the evidenced-based justifications for failing to meet those benchmarks. All Hospitals will discuss their insights from the state's Act 167 community engagement process, and steps taken or planned to be taken by the hospital in light of those recommendations and their efforts to ensure an affordable and sustainable health care system. If a hospital is exempt from a public hearing, they shall instead send a letter to the Board discussing the points noted above on Act 167 Community Engagement by Wednesday, August 28, 2024.

Budget Order
Following the budget hearings, Board staff will make recommendations to the Board for their consideration and the Board will deliberate and decide whether to approve or modify each hospital's budget. The GMCB will issue written budget orders to each hospital, which will contain both general and hospital-specific conditions representing the Board's decision.

Adjustment/Enforcement

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More information on GMCB policies related to budget enforcement, as well as amendments or adjustments to budgets can be found on GMCB's website:

1. Policy on Budget Amendments and Adjustments
2. Policy on Hospital Budget Enforcement

C. Hospital Budget Submission Requirements

When submitting budget materials, hospitals must use definitions, and follow submission instructions included in this document and in the accompanying materials:

1. Uniform Reporting Manual: resource used to document account definitions and non-financial reporting requirements. Issued in conjunction with this guidance by March 31st. Hospitals will be notified promptly of any changes.

2. Hospital Budget Review Measures Inventory: a list of measures, data sources, methodologies, limitations etc. referenced in this guidance, published in conjunction with this guidance by March 31st. This inventory may be updated subsequent to March 31st. Hospitals will be notified promptly of any changes.

3. Adaptive Insights User Guide: a step-by-step guide for the software used by hospitals to submit information related to their proposed budget. To be published before April 30, 2024.

All filings will be assessed for regulatory compliance. Filings will be deemed compliant if all the following conditions are met:

1. All exhibits filed with the GMCB and through Adaptive as indicated in the filing checklist. Any submissions not filed through Adaptive should be labeled with the submission date.
2. All filed exhibits are complete.
3. Filings are all submitted on time. Extensions may be requested for extenuating circumstances. Extension requests must be made at least two days in advance of the filing deadline and submitted in writing to GMCB.HealthSystemsFinances@vermont.gov, copying the Health Care Advocate (hcapolicyteam@vtlegalaid.org). Requests must include a rationale for extension, and a proposed timeline for submitting the delayed materials.

In accordance with 18 V.S.A. § 9456(d)(3)(A), the Health Care Advocate, which represents the interests of Vermont health care consumers, must receive the hospital's budget filings and other materials, and will participate in the budget review process, including hearings.

D. Requests for Confidentiality

Regulated entities may wish to provide support for their proposed budget that includes potentially confidential or proprietary information. If a hospital believes that materials provided to the GMCB are exempt from public inspection and copying under Vermont's Public Records Act, the hospital must submit to the GMCB a written request that the GMCB treat the materials as confidential and copy the HCA when making its request. The request must be made at the time the information is submitted to the Board. A request for confidential treatment must specifically identify the

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materials claimed by the requestor to be exempt from public inspection and copying and must include a detailed explanation supporting that claim, including references to the applicable provisions of 1 V.S.A. § 317(c) and other law. The hospital requesting confidential treatment of materials submitted to the Board bears the burden of establishing that the materials are exempt from copying and inspection under the Vermont Public Records Act. Board staff will provide a written decision to the hospital in response to a request for confidential treatment. Pending a final decision by the Board, the materials identified in the request will be treated as confidential and will not be made available for public inspection and copying. If the Board grants in full or in part a request for confidential treatment, the Board will not make the confidential materials available for public inspection and copying and will omit references to the materials in the records of any public deliberations.

SECTION I: BENCHMARKS

This section summarizes benchmarks for hospital budgets, including any relevant methodologies and data sources used in their calculation. If met, assuming valid, reasonable, and appropriate budget assumptions and a complete submission, these benchmarks are expected to reflect a budget that considers both health care affordability and hospital financial sustainability. The Board will also consider the validity, reasonableness, and appropriateness of budget assumptions in assessing hospital budgets relative to these benchmarks.

A. Benchmarks for Improving Affordability

There are two primary ways in which health care spending affects affordability, (1) more **aggregate health care spending** (i.e. price x utilization) translates into higher costs of health insurance, which means higher premiums and out of pocket payments by both insured and uninsured, and (2) the **price of health care services**, which affects not only premiums, but also copays and direct expenses borne by patients. Because government payers set prices directly, discretionary price growth is observed in the commercial market.

(1) *Net Patient Service Revenue Growth (NPR) Growth*: Growth in net patient revenues for hospital services is benchmarked at the system-level at an amount of 3.5%-4.3% over the FY24 system-wide approved budget, in line with the total cost of care (TCOC) growth target in the Vermont All Payer Model. For the purposes of this benchmark, the growth rate is allocated across hospitals at an equivalent rate, though the Board recognizes that it may be appropriate for some hospital budgets to be above or below this system-wide target. For budgets that request NPR growth exceeding this benchmark, hospitals must provide justification, including credible and sufficient supporting evidence that the excessive growth reflects an improvement in access or quality of care (e.g., increased access as justified by lower projected wait times and a means to achieve them, population growth as justified by demographic trends and projected increases in new patient volumes, etc.).

(2) *Commercial Rate Growth*: Commercial rate growth by payer shall be no more than the [PCE price index plus 1% as of DATE], over FY24 approved budget, which amounts to X% for FY25. The GMCB anticipates establishing a cap on any commercial rate increases for each hospital, which will also apply as a cap on the increase that the hospital may receive from any individual commercial payer. Any GMCB approved rate increase is a cap subject to negotiation between a

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hospital and commercial insurers and is not an amount set or guaranteed by the GMCB. Hospitals proposing budgets that exceed this growth rate will be required to justify this request with sufficient and credible evidence of hospital efficiency and maximized productivity of resources (i.e. average work RVUs per clinical FTE by department – both the level and the associated percentile of national benchmarks, or similar, measures of hospital cost and efficiency used by leadership to assess operational efficiency-both the level and the associated percentile of national benchmarks, or similar etc.).

B. Benchmark for Financial Sustainability

Hospital financial sustainability may help Vermonters maintain access to essential services. While there are many indicators that are important for evaluating financial health, a key metric for private entities is operating margin, as it expresses the ongoing ability of an organization to cover its operating costs with its expected revenues from operations. Hospitals proposing budgets with margins at or less than 0% will be required to explain key drivers of their sustainability challenges, and report on clinical productivity by core service line.

(1) *Operating Margin*: a hospital's operating margin shall be greater than zero. The Board recognizes that achieving a positive operating margin requires generating sufficient revenue, managing expenses and expense growth, and performing efficiently.

SECTION II: COMPARATIVE ANALYTICS

The purpose of this section is to outline the key measures and data sources that will be used to further analyze and evaluate budget requests, and provides a basis for understanding operating factors that might play a role in a hospital's ability to meet the benchmarks established in *Section I*. Where appropriate, the GMCB will compare Vermont hospitals to peer groups. There are no specific performance benchmarks established for measures in this section as many of these measures must be considered collectively and may apply differently to different hospitals.

A. Methodology for Establishing Hospital Peer Groups

The peer groups established in the FY24 hospital budget review process largely consist of regional New England peers, varying by hospital size and other factors. Staff may review the comparator groups and propose changes, which will be shared with hospitals and the public for input. Final publication of comparison groups will occur by July 1.

On the next page are the anticipated FY24 peer groups.

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Vermont Hospital Peer Group	Comparator Hospitals	
<u>Academic & Community Medical Centers</u> University of VT[1]	• St. Francis Hospital • Yale-New Haven Hospital • UMass Medical Center • Maine Medical Center	• Dartmouth Hitchcock • Albany Medical Center • Geisinger Medical Center • Rhode Island Hospital
<u>Mid-sized Community Hospitals</u> Rutland Central VT	• Champlain Valley Physicians Hospital • Bristol Hospital • Charlotte Hungerford Hospital • Griffin Hospital • Anna Jaques Hospital • Beth Israel - Milton • Cooley Dickenson • Central Maine Medical Center • Mid Coast Hospital • Southern Maine Health Center	• Cheshire Medical Center • Exeter Hospital • Portsmouth Regional Hospital • Auburn County Hospital • Canton-Potsdam Hospital • HealthAlliance • Delaware County Hospital • Evangelical Hospital • Geisinger Lewistown • Landmark Health • Newport Hospital • South County Health
<u>Small Rural Hospitals</u> Southwestern Northwestern Brattleboro	• Alice Hyde Medical Center • Bradley Hospital • Johnson Memorial Hospital • Windham Hospital • Wing Hospital • Falmouth Hospital • Marlborough Hospital • Laconia Hospital • Frisbie Hospital • Nason Medical Center • Geisinger Bloomsburg • Huntington Hospital	• Exeter Hospital • Corning Hospital • Mount Vernon • St. Anthony Community Hospital • Franklin Memorial Hospital • Maine Coastal Hospital • York Hospital • Westerly Hospital

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[1] University of Vermont Medical Center has 2 different peer groups, one based on their status as an Academic Medical Center and another more reflective of hospitals of a similar size operating in similar communities.

Critical Access Hospitals		
Northeastern VT Porter Copley North Country Mt. Ascutney Gifford Springfield Grace Cottage	• Elizabethtown Community Hospital • Johnson Hospital • Sharon Hospital • Athol Hospital • Fairview Hospital • Martha Vineyard's Hospital • Houlton Regional Hospital • Redington-Fairview Hospital • Stephens Memorial Hospital	• Littleton Regional Healthcare • Monadnock Hospital • Speare Memorial Hospital • The Memorial Hospital • Carthage Area Hospital • Canton-Potsdam Hospital • Lewis County Health System • UPMC Coudersport Hospital • Central Highlands Hospital

B. Key Performance Metrics

Measures included in this section describe revenue trends, operating efficiency, financial health, and other key performance metrics. The data used to calculate these measures will come from a variety of sources, including hospital reported data in Adaptive, Medicare Cost Reports, and other sources. Measure specifications, including the method of calculation, source data, and approach to statistical comparison, as well as information on inferences associated with each measure and potential limitations, are included in the **Hospital Budget Review Measures Inventory.** These metrics will be calculated based on the most recently available data and will be displayed in either the Hospital Budget Review Tool or the Hospital Profiles, currently under development. The Hospital Budget Review Tool is on track to being published and shared with hospitals for data validation prior to the July 1 budget submission date. The Board may review and consider other relevant factors proposed during the budget review process.

C. Other Comparative Metrics Data Sources

GMCB may use other publicly available data sets that may not be explicitly listed in the Hospital Budget Review Measures Inventory, to understand trends and budgetary pressures. These data sources are meant to supplement staff and Board understanding of factors influencing hospitals and their budgetary requests. The Board may review and consider other relevant measures and datasets proposed during the budget review process. Other publicly available data sources may include:

i. NASHP Hospital Cost Tool
ii. Peterson-KFF Health System Tracker
iii. Congressional Budget Office
iv. Bureau of Labor Statistics
v. Sage Transparency

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vi. Hospital Price Transparency Data
vii. Lown Institute
viii. Hospital Compare

SECTION III: BUDGET ASSUMPTIONS

Understanding the assumptions included in a budget is essential to budgetary evaluation. Proposed budgets shall make their assumptions clear, whether reported through Adaptive in accordance with a standard definition, and/or in the narrative. Where uncertainty exists, budget assumptions should reflect the hospital's most accurate expectations, noting and quantifying any uncertainty. The burden is on hospitals to identify those assumptions and describe them in sufficient detail that they may be considered as a factor in the budget submission. Assumptions shall be as reliable, objective, and accurate as possible, and not self-serving or overly favorable one way or the other.

Hospitals shall report budget assumptions associated with the following list (for any standard definitions, please see the Uniform Reporting Manual), though there may be other substantive budget assumptions not included in the list: government reimbursement rate changes (e.g. Vermont Medicaid, out-of-state Medicaid), payment design (e.g. fee for service vs. capitation), payer mix, service mix, patient acuity (i.e. case mix index by payer), utilization/market share, etc.

The GMCB may also use external data sources to evaluate hospital budget assumptions. For example, though hospitals will submit utilization assumptions along with their proposed budget, staff may make comparisons to actual utilization as reported by hospitals in the Vermont Uniform Hospital Discharge Data System. Other data sources GMCB may use when evaluating budget assumptions include, but are not limited to:

ix. GMCB patient migration report;
x. Demographic changes according to census records;
xi. Wait times information provided by hospitals (visit lag and referral lag) and other available or independently collected data that measures patient wait times or access to care;
xii. Information from the Dartmouth Atlas and other data sources that allow benchmarking of utilization metrics;
xiii. Hospital prior year financials, for example, budget vs. actual performance overtime; and
xiv. Other relevant measures and datasets proposed during the budget review process.

SECTION IV: CONTEXTUAL INFORMATION

Measures and other qualitative information in this section will be used to provide insights about the broader context of healthcare needs in the community, the hospital's role and ability to meet those needs, as well as external pressures on hospital care delivery. The measures include but are not limited to data from hospitals Community Needs Health Assessments as well as data on Vermonters' demographics, socioeconomics, risk behaviors, insurance coverage, health care resources, health care utilization, health care accessibility, health care quality, disease rates,

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death rates, and more. Where possible, the Board plans to review such data at various levels including the HSA-level as well as the state-level.

GMCB staff has also established a list of quality measures to monitor on an annual basis, recruiting input from a variety of stakeholders, including the Vermont Department of Health (VDH) and Vermont Program from Quality in Health care (VPQHC). These measures closely align to other health care initiatives and address the most prominent health care needs of Vermonters. Where possible, a hospital's quality performance will be compared to peer hospitals, with the understanding that a single quality measure may not alone capture the complexities of improvement activities happening on the ground.

Other contextual measures may be captured from administrative data, hospital self-report, or other means, including hospital participation in quality improvement programs, history of regulatory compliance, payment and delivery system reform participation, uncompensated care strategies, and more. As in other sections, the Board may consider other publicly available data and information not explicitly listed in the Hospital Budget Review Measures Inventory (e.g. Vermont Household Health Insurance Survey, CMS Hospital Compare, Vermont Blueprint for Health Community Profiles etc.).

SECTION V: BUDGET NARRATIVE

This section outlines the elements required to be included in the budget narrative. The budget narrative provides an opportunity to provide context for proposed budgets and highlight areas of interest and/or concern. The GMCB asks hospitals to answer each question succinctly and to strictly follow the format below by responding in sequence to each question. Hospitals that are part of a network must provide separate narratives for each hospital.

A. Executive Summary

Provide a high-level overview of key considerations for the proposed budget. Include discussion of variations from the current year approved budget, including any assumptions about current year projections relative to the approved budget. Indicate areas where the proposed budget deviates from parameters specified in this Guidance, providing justifications for such deviations, including credible and substantive evidence to support those justifications. For hospitals that are part of a network, affiliation, or have a financial arrangement with another legal entity (e.g. nursing home), explain any differences in what is happening at the hospital versus the network level, and quantify any financial impact on the hospital budget as a result of the relationship with any non-hospital entities.

B. Background

a) Explain any changes that occurred to your corporate structure within the last year.
b) Explain your approach to considering and participating in any corporate affiliations in which you or the other organization may have a financial stake.
c) Describe and quantify the impact of any participation in regional collaborations with other service organizations or providers.
d) Explain and quantify any service-line closures, transfers, or additions since the prior year budget review, please explain.

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C. Budget Questions

a) Concisely describe substantive variations from current year approved budget to current year projected, and to the proposed budget, in terms of service line changes (differentiate between new or divested services, and volume changes that necessitate changes in staffing), physician transfers, accounting adjustments etc.

b) For each of the *Section I* benchmarks not met in the budget submission, explain and justify the deviation using credible and sufficient evidence.

c) Explain the assumptions embedded in your proposed budget for the following, providing evidence to support your assumption(s), as well as any substantive variations from FY24 (budget & projected). Please list any other factors not included below that may be material to your budget along with supporting material. This includes any assumptions that are uncertain but could have a potential budgetary impact. For such assumptions that are not reflected in your budget, please quantify the range of potential impact.

    a. Labor expenses. Differentiate between the use of employed versus contracted labor, separating nursing from other clinical, and non-clinical staff. Please highlight any trends that are specific to particular clinical domains.
    b. Utilization. Explain and quantify any anticipated changes in utilization across care settings (e.g. inpatient/outpatient), or any other expected deviations from historical trends. Indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases associated with hiring additional staff or other capacity changes, provide evidence to support estimated impact on utilization.
    c. Pharmaceutical expenses. Differentiate assumptions regarding growth due to price from volume, or product mix. Please quantify reimbursements received in excess of the cost of pharmaceuticals (FY23 actuals, FY24 budget, projection, & proposed budget)? Include estimates for rebates associated with the 340B program.
    d. Cost inflation. Please explain any substantive changes and break out by medical and non-medical supplies and isolate the price effect separately from the utilization effect.
    e. Case Mix Index (CMI). Explain any substantive changes in CMI by Payer, providing evidence to justify anticipated changes. Quantify any impacts on your budget by payer.
    f. Rate Changes by Payer. Explain any assumptions related to rate changes for Medicare, Medicaid (e.g. In State/Out of State), and Commercial Payers overall and by setting of care (inpatient, outpatient, professional services).
    g. Capital Expenses. Explain any anticipated capital expenditures in the proposed budget, including a description of funding sources.
    h. Financial indicators. Explain any changes (key drivers) to your Operating Margin, Days Cash on Hand, and Debt Service Coverage Ratio relative to your FY24 projections, as well as any other key financial indicators that are important to consider in relation to your budget request.
    i. Uncompensated care. Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care.
    j. Community Benefit. Differentiate between the various drivers of community benefit.

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d) Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.
e) Administrative vs. Clinical Expenses: using the Medicare Cost Report definition of administrative clinical, and mixed expenses in Wang & Bai (2023)[2], also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time. If you believe the Medicare Cost Report definition does not accurately reflect your organization, please articulate how you would adjust the calculation and why, and provide an alternative estimate with sufficient detail that it can be cross-walked to the standard definition. Further, to the extent you make modifications specific to your hospital, indicate which of your peers require such modification and the impact of such modification on each such hospital.
f) Facility Fees: Please describe how your hospital establishes any facility fees and how much they totaled in FY24 and are expected to total in FY25.
g) Does your budget increase request consider consumer affordability, and if so, how?
h) If your proposed rate and/or NPR increase request were to be reduced, provide a high-level description of your hospital's contingency plan for maintaining access to essential services and generating a positive margin.
i) Provide all costs associated with (i) lobbying and (ii) marketing, advertising, and branding, and identify the amount paid to each entity that performed such services on your behalf.
j) Describe planned fundraising efforts and anticipated donations for FY25.
k) Describe projected investment income and, if projected to be zero, please provide a 3-year summary of annual investment income.
l) Has your hospital had to pay any penalties to CMS in the last year, and if so, how much? Please explain the nature of the penalty and what your hospital is doing to remediate the situation.

D. Hospital & Health System Improvement

a) Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate.
b) How do you identify and select priorities for performance improvement?
c) Against which organizations do you benchmark yourself, for what and why?
d) Identify and provide summary results from any patient experience or patient engagement surveys that your organization utilizes and describe key findings.
e) Identify and provide any provider satisfaction or experience surveys that your organization utilizes and describe key findings.
f) Describe how you work with other providers in your community, including the FQHC, designated agencies, other community-based services etc., being sure to include

[2] Wang Y, Bai G, Anderson G. U.S. Hospitals' Administrative Expenses Increased Sharply During COVID-19. J Gen Intern Med. 2023 Jun;38(8):1887-1893. doi: 10.1007/s11606-023-08158-8. Epub 2023 Mar 23. PMID: 36952083; PMCID: PMC10035469.

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opportunities and obstacles to ensuring smooth transitions of care along the care continuum.

g) Act 167 (2022) Community Engagement to Support Hospital Transformation Project
    a. Describe your experience to date with this project.
    b. How does your organization plan to review and consider the options/recommendations shared after the project concludes?
    c. Describe the actions your organization is planning to take thus far as a result of this project.
    d. How is your organization thinking about hospital sustainability planning and transformation in the future?

h) Describe your plan to remain financially solvent if commercial rate increases are tied more closely to Vermonters' wage growth and ability to pay for hospital expenses, being sure to reflect the reality that the number of commercially insured lives in Vermonter continues to decline.

i) Describe how your organization ensures health care in Vermont is affordable.

j) If your hospital was asked to submit a Performance Improvement Plan, please provide an update on progress or challenges relative to that plan.

k) Describe the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors, residency programs, and any other workforce development initiatives in which you are participating.

l) Hospital Networks: Explain your shared services strategy, any additional revenues associated with such investments and methodologies for allocating associated costs. Quantify any efficiencies to date, and when you expect to achieve any future efficiencies.

<u>F. Other</u>

a) Is this a zero-based budget? If not, when was the last time your organization developed a true zero-based budget (creating a budget from scratch and then justifying every expense rather than basing the budget on prior spending)?

b) Patient Financial Assistance
    a. If a contract with a third party exists to collect payments from patients, please provide this contract and disclose the amount paid for such collection efforts and the revenue generated therefrom.
    b. If you have a contract with a third party, please describe the return on investment for this decision compared to managing these activities internally as a part of Patient Financial Assistance Programs?
    c. Please describe how patients are screened for Patient Financial Assistance at your hospital.
    d. When patients receive a bill – either paper or electronic – are they made aware of the hospital's patient financial assistance policy and how to apply?

c) For reporting on boarding as required in *Section VI*, please explain how you derived your estimates and explain key drivers and trends over time.

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SECTION VI: HOSPITAL REPORTING REQUIREMENTS

This section details requirements for hospital reporting for consideration of their FY25 budget request. All submitted materials must include page numbers and citations to outside information referenced or discussed. The filing checklist identifies all the required exhibits that must be filed with the Board for a hospital's budget request to be considered complete.

Filing Checklist

Exhibit Name	Due Date	Purpose	Location
1. FY2023 Medicare Cost Report	4/1/2024	Financial Monitoring	Upload[3]
2. Verification under Oath	7/1/2024	Attestation to truth of filing	Upload
3. Budget Narrative		Detailed explanation of budget and justification for budgets not meeting Section I benchmarks (see Guidance *Section V*)	Upload
4. FY2025 Budget Request		Details of budget request and underlying assumptions: Income statement, Balance Sheet, Other Operating Revenue, Payer Revenue, Case Mix, Utilization and Rate Assumptions, Staffing etc.	Adaptive[4]
5. Hospital Operations		Complements budget request data highlighting internal and external budget pressures	Adaptive
6. Community Health Needs Assessment & Implementation Plan		Community Benefit	Upload
7. Financial Assistance Policy & Reporting		Act 119 of 2022	Upload
8. Affiliations & Third-party Contracts		Financial & Legal Relationships	Upload
9. Corporate Structure		Financial & Legal Relationships	Upload
10. Salary Information		Statutory Requirement 18 V.S.A. § 9456(b)(12)	Upload
11. Net Revenue & Public Payer Reimbursement		Statutory Requirement	Upload
12. Capital expenditures	8/1/2024	Compliance with CON program	

[3] Upload a pdf to the Adaptive Report Folder

[4] Input data into Workday Adaptive database in accordance with reporting requirements outlined in the Uniform Reporting Manual

Exhibit Name	Due Date	Purpose	Location
13. IRS Form 990 for CY2022(including Schedule H)	9/30/2024	Financial Monitoring	Upload

1. FY2023 Medicare Cost Report

Submit a pdf of your full FY23 Medicare Cost Report as submitted to the Centers for Medicare and Medicaid Services (CMS).

2. Verification under Oath

Attestation to truth of filing on which the hospital Board, CEO and CFO, swears and affirms that the information provided is true and accurate to the best of their knowledge. The hospital should submit an individual document for each of these Executives.

3. Budget Narrative

For each hospital, submit a budget narrative (see Section V for specific requirements and questions to be answered).

4. FY2025 Budget Request

Each hospital must submit details of its budget request in the Adaptive database using the following Sheets. Projections for FY24 should also be provided in those same sheets. These Adaptive sheets are listed below in the most efficient order of completion since some accounts populate accounts in other sheets. More detailed definitions and requirements can be found in the Uniform Reporting Manual and Adaptive User Guide.

Hospital and Physician Revenue

The Hospital and Physician Revenue Sheet includes units of service and Gross Patient Revenues and Fixed Prospective Payments, Reserves and Other Payments for Departments in each Service Area.

Payer Revenue

The Payer Revenue sheet records Gross Patient Revenues and Deductions by Payer.

Other Revenue

The Other Revenue sheet includes both Other Operating Revenues (for example, grant income, 340B pharmacy, etc.) and Non-Operating Revenues.

Staff/FTE

The Staff/FTE (Full Time Equivalent) sheet should show all budgeted FTEs for each Hospital by department/service area.

CON Sheets (Non-CON Detail, CON Detail, Capital Summary)

The CON sheets provide information on hospitals' planned capital expenses. The Non-CON detail sheet includes information on projects costing more than $500K but not triggering a Certificate of Need reviews, while the CON Detail sheet includes all CON projects. The Capital Summary sheets

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combines the Non-CON and CON detail sheet while also entry of the aggregated cost of non-CON projects less than $500K each.

Rate

The Rate sheet requires the input of the annual rate increase requested by the hospital to be entered in the fields labeled “Submitted Rate” and/or “Submitted Commercial Ask Rate.” Change in charge and commercial rate asks should be reported by payer category, and core service line (inpatient, outpatient, professional services).

Balance Sheet

If your budget is entered in the order above, several accounts in the Adaptive balance sheet will be populated by entries made on other sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions.

Income Statement

Like the balance sheet, several accounts will be automatically populated if your entries are made in the order above. Where accounts are not linked, please ensure that all figures reported on your income statement tie to the relevant figures on the Other Revenue and Payer Revenue sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions.

Network Shared Services Financials

Adaptive sheets will be used to collect financial details associated with network-level shared services.

Supplemental Exhibits

Adaptive sheets will be used to collect supplemental information including referral and visit lags for hospital-owned services and imaging procedures, clinical productivity (using wRVUs), and staff turnover/vacancies and more. Detailed instructions for completing these sheets are included in the Adaptive User Guide.

5. Hospital Operations

While the data requested below are not viewed as being wholly reflective of a hospital’s operating performance, it will be considered in the broader context of administrative data and other types of data noted in other sections of this guidance.

Referral and Visit Lags

Each hospital must submit data on referral and visit lags (see definitions below) for all referrals or appointments requested from March 1, 2024 - March 14, 2024. Please report such lags for each hospital-owned primary care practice, each hospital-owned specialty care practice, and the same imaging procedures as the hospital reported in FY24. If the five most frequent imaging procedures have changed, please add the new imaging procedures as well.

Referral lags: the percentage of appointments scheduled within 3 business days of referral (that is, the percentage of all referrals where the clinic or hospital has completed scheduling

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an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place).

Visit lags: the percentage of new patient appointments scheduled for the patient to be seen within 14 days, 30 days, 90 days, and 180 days of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received.) This metric only concerns appointments for new patients. Please include all holidays and weekends in your calculation.

Staffing Turnover and Vacancies

Please report the following staffing data for FY2024.

1. The total number of FTE physicians, FTE mid-level providers, and FTE nurses employed by the hospital as of May 31, 2024. Please note that positions do not include travelers.
2. The total number of FTE physicians, FTE mid-level providers, and FTE nurses who terminated their employment between June 1, 2023, and May 31, 2024. Please note that FTE positions do not include travelers.
3. The total number of vacancies for FTE physicians, FTE mid-level providers, and FTE nurses that exist at the hospital as of June 1, 2024 (that are included in the approved budget). Please note that FTE positions do not include travelers.

Boarding

1. Please estimate total number of discharges, patient days, associated expenditures and reimbursements for FY22 (Actuals), FY23 (Actuals), FY24 (Projected) and FY25 (Budget):
    a. Provision of care due to the inability to discharge patients home due to lack of services or transfer patients to post-acute or other more appropriate care settings. Examples might include hospital stays beyond what is clinically indicated due to difficulties discharging/transferring after patients are deemed safe and appropriate for discharge/transfer or stays for which patients received care that would not generally be provided in a hospital setting (i.e. admissions for social reasons).
2. Assuming the majority of patients who stay in emergency departments for greater than 24 hours without an admitted disposition are patients boarding for a mental health evaluation, please define the LOS in patient hours for patients who have a LOS greater 24 hours without an admitted disposition and the total number of episodes this represents. Please estimate the associated expenditures and reimbursements associated with these encounters.

Clinical Productivity

Please report average work RVUs per clinical FTE by department – both the level and the associated percentile of national benchmarks, or similar, for the most recent year available. Report the number of clinical and budgeted FTEs (if different) that are included in the denominator. Hospitals only need to supply these data if their budget does not meet the *Section I* benchmarks for Commercial Rate growth or Operating Margin requirement.

6. Community Health Needs Assessment (CHNA) and Implementation Plan

Submit a complete copy of the hospital's most recent Community Health Needs Assessment (CHNA) and, if applicable, the most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.

7. Financial Assistance Policy & Reporting

In accordance with Act 119 of 2022, hospitals are required to submit a plain language summary of their financial assistance policy (FAP). In addition, please report the following:

- Total number of applicants granted any amount of FAP
- Number of applicants granted 100% FAP
- Number of applicants granted less than 100% FAP
- Total applicants denied FAP
- Breakdown of reason for denial (% or #)

8. Affiliations & Third-party Contracts

Submit copies of contracts you have with any Medicare Advantage Plans or Management Companies.

9. Corporate Structure

Provide an up-to-date chart or graphic outlining the corporate structure associated with the Hospital.

10. Salary

Provide the salaries for the hospital's executive and clinical leadership and the hospital's salary spread, so that the Board may consider that salary information, and including a comparison of median salaries to the medians of northern New England states in accordance with 18 V.S.A. § 9456(b)(12). Provide any benchmarks and/or bases on which such compensation was established.

11. Net Revenue & Public Payer Reimbursement

File an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals as specified in 18 V.S.A. § 9456(b)(8) and (b)(9).

12. Capital Expenditures

Per the rule, hospitals must submit a 3-year capital expenditure budget 3.203(f). Submit a summary describing all funds that will be invested in acquiring, maintaining, or improving long-term assets for the period of FY25 though FY27. Differentiate between those which are necessary for operations versus those that are ancillary (e.g. investments in housing). These assets will have a useful life extending beyond the current accounting period and are not intended for immediate consumption. For ancillary capital expenditures, please describe how these projects will be funded. Examples of capital expenditures include but are not limited to:

- Purchase of property, plant, and equipment

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- Investments in infrastructure(s)
- Research and development of new processes or technologies, software development

13. IRS Form 990

Submit your 990 annual information. This form is your annual return that tax-exempt organizations must file with the Internal Revenue Service (IRS). The purpose of the Form 990 is to provide GMCB and Vermonters with information about your organization's mission, programs and finances. For FY25 you should submit your CY2022 Form (beginning on 10/01/2022 ending on 9/30/2023).

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