The Green Mountain Guide to

Hospital Budget Review

A publication of Vermont's Green Mountain Care Board

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Inside:

The Law in Vermont

In 1983, Title 18 established the hospital budget review process as a way to slow the risings costs of health care and ensure hospital budgets were reasonable and fair.

In 2011, Act 48 gave Vermont new tools to apply to the hospital budget review process designed to manage costs.

In 2012, Act 171 assigned the Green Mountain Care Board responsibility for hospital budget oversight as it looks toward a unified health care budget for the State of Vermont.

In 2012, the Green Mountain Care Board set a target for system-wide and per-hospital net patient revenue growth of no more than 3.75%

Introduction to Vermont's Hospital Budget Review

Hospital budget review is intended to help "bend the curve" of health care costs — in other words, to stop the cost of health care from rising so quickly. Because hospitals account for around 40% of the total amount of money spent on health care in Vermont, hospital budgets have a big impact on the cost of health care for everyone.

Vermont's Legislature assigned the Green Mountain Care Board (the Board, also called GMCB) the responsibility to see that Vermont's health system improves the health of Vermonters while limiting cost increases. One way the Board is doing this is by conducting its first round of budget reviews for fiscal year 2013, which begins at hospitals in October.

The Board created this guide to help Vermonters cut through some of the complexity in hospital budgeting and understand the Board's budget review process so that you can take an active role in shaping the state's health care system. "Part of the reason hospital budgets are so complicated is that each hospital is like many businesses in one," says Mike Davis, the Board's Director of Health System Finance. "It's also tricky to compare hospitals because the size of a hospital and its different specialties make big differences for a hospital's budget." In Vermont, we have a whole range of hospital types, from smaller community hospitals to a large teaching hospital.

The Board will look at dozens of measures to understand each hospital's budget. These include things like a hospital's plan for buying equipment, the amount of unpaid bills, the money set aside for emergency expenses, the age of a hospital building, the number and type of physicians, nurses and staff, the kind of technology a hospital uses, the price of services and the overall amount of money a hospital collects.

In this guide, we focus on two broad measures the Board uses to understand hospital budgets: **rate** and **net patient revenue**. A rate is basically a change in the "sticker price" a hospital sets for each service or procedure. Net patient revenue is one way of adding up the money hospitals make from caring for patients. Both rates and net patient revenue impact your health insurance premium.

The Process

March - April

The Board provided hospitals written guidelines for the upcoming budget, including the target for **net patient revenue** increases of 3.75%.

April - July

Hospitals develop their proposed budgets, including details on **rates** and **net patient revenue**, as well as a three-year spending plan for major "capital" items like buildings and high-tech equipment.

July - September

The Board receives and reviews budgets, meets with hospital administrators to discuss any questions or concerns, has a public board meeting in mid-August, hears public comment and approves, modifies or disapproves each budget by mid-September.

October 1

The Board's hospital budget decisions are published and the new hospital fiscal year begins.

Rate vs Net Patient revenue

The Board has the responsibility to establish hospital rates and regulates the average change in rate for each year. A **rate** is the change in the average charge for all services. So if a hospital charged $100 for an arm x-ray one year and then $105 the next, the rate of increase is 5%.

This all becomes more complicated when we look at how much a hospital makes from all its patient services combined, or the **net patient revenue**. Patient services include tests, procedures, prescription medication and time with a doctor or nurse. If everyone paid the sticker price for these services, then it would be easy to figure out how much hospitals make: Just multiply the **utilization**—the number of times a particular service is used—by the sticker prices.

What actually happens is that different payers pay different prices. Medicare and Medicaid get certain discounts and private insurance companies negotiate with hospitals to get their own discounts from the sticker price. So, even if a hospital's sticker price for an arm x-ray is $100, Medicare might actually pay the hospital only 80%, or $80, for this procedure. A private insurance company might pay 90%, or $90, for the same x-ray.

This means that when **net patient revenue** gets added up, hospitals have to consider how many patients got what "discount" and subtract all discounts from the total. The hospital also subtracts the cost from unpaid bills and care the hospital donated to those who could not pay. The "net" of all the incoming money, minus all these things, is the **net patient revenue.**

For the upcoming budget year, the Board has set a target for hospitals to limit the increase in their net patient revenue to no more than 3.75%. A hospital might be permitted to go over this amount if the extra money is needed to fulfill government mandates or if the expense meets other standards that the Board has set and will be closely reviewing.

As it reviews hospital budgets, the Board will closely watch both rates and net patient revenue (and the many other measures listed in the introduction) because one measure alone doesn't show the full picture.

For example, a hospital's net patient revenue could decrease simply because fewer patients came for care—even if the hospital is charging more. On the other hand, a hospital's net patient revenue could go up even if a hospital charges less, if patients get more tests or procedures done.

By looking at multiple measures, including both rate and net patient revenue, the Board can make sure the balance is right.

What's the price?

Confusing hospital bills and insurance statements are just the tip of the iceberg: You need to look beneath the surface to understand health care prices – and the insurance premiums that often foot the bill.

The prices hospitals set are often not based on true cost, or even value. They are based on what's been charged in the past, what's needed to make up for losses on other prices, and other factors rolled into the pricing system.

> ***"Look beneath the surface to understand health care prices—and the insurance premiums that often foot the bill."***

Different payers get different discounts. Sometimes these discounts are so big that some payers (usually Medicare and Medicaid) actually pay less than it costs the hospitals to deliver the service. Hospitals then make up for the loss through **cost shifting:** They increase the charge to patients who have private insurance or who pay out of pocket.

Sometimes hospitals shift costs between services. This is called **cross-subsidization** and it happens when the amount of money collected for one service or procedure doesn't cover the costs, so the hospital makes up for it by charging more for a completely different service.

Q: What happens if a hospital doesn't meet its budget?

A: The review process recognizes that once the Board determines a hospital's budget, things can change. If the hospital becomes concerned that things are going differently than expected, it can request permission from the Board to deviate from its budget.

For example, if a hospital is spending more than expected and fears it will run out of budgeted money to provide services, it may choose to reach into its "cash on hand." Or it may ask the Board to consider a revised budget that allows it to increase rates or net patient revenue to avoid having to reduce services.

During the year, the Board will be monitoring hospital performance and may ask a hospital for information. By law, the Board also has strong enforcement authority to keep a hospital within its budget, and if needed the Board can take action in court, order a hospital to pay financial penalties, or simply issue an order telling the hospital to get its budget back on track.

Either way, the system is being designed so that hospitals and the Board have ongoing discussions to ensure that Vermonters get the quality care they need at an affordable cost.

Glossary

Payer
What person, company or government agency pays the hospital bill. Payers are categorized into type, since different payers often pay different amounts. The percent of each type of payer is the "**payer mix**."

Provider
An individual or organization that performs medical care. This usually refers to hospitals, clinics, doctors, nurse practitioners, etc.

Utilization
How much a particular service is used. In many cases, the cost for a service decreases when utilization goes up because more **payers** split fixed costs.

Bad Debt & Charity Care
The terms hospital budgets use for providing care to patients who don't or can't pay.

Cash on Hand
The amount of money saved by hospitals that covers what they need to operate for a certain number of days in case there's an emergency or they don't get paid quickly for services. This buffer ensures the hospital can always provide necessary care and pay its bills.

About The Green Mountain Care Board

Vermont's 2011 health reform law, Act 48, created the Green Mountain Care Board (GMCB) – an independent group of Vermonters charged with ensuring that changes in the health system improve quality while stabilizing costs. Nominated by a broad -based committee and appointed by Governor Peter Shumlin, the Board is led by chair Anya Rader Wallack, a long-time leader in Vermont health reform, and includes two doctors, Karen Hein, M.D. and Allan Ramsay, M.D.; a business owner, Alfred Gobeille; and former Vermont Secretary of Human Services Cornelius Hogan. The current members of the Board serve terms ranging from three to six years.

The most unique thing about Vermont's Board is that the Legislature assigned it unprecedented responsibility for all the major factors influencing the cost of health care. This includes hospital budgets, health insurance rates, benefit decisions and major expenses, rates paid by insurance companies and Medicaid, and plans to ensure Vermont has enough of the right health professionals and uses health technology to decrease costs. While in other states responsibility for oversight of these different parts of the health system is split among different agencies, Vermont's Legislature created one Board to consider all the variables.

In 2012, the Board has focused on reviewing insurance rates, approving an insurance benefits package, regulating hospital budgets, and launching "pilot projects" that test different methods for paying for health care to improve quality and minimize costs. This work lays the groundwork for moving in a careful, deliberate way toward the broader goals of Act 48: to provide all Vermonters with health coverage, increase the quality of care, keep costs sustainable, cut the link between employment and health insurance, and build a publicly financed health care system.

The Board wants to hear from Vermonters and continues to travel around the state to listen to your questions, ideas and concerns.

Make your comments count

The Board encourages comments on any of its areas of responsibility. If you have comments about Hospital Budgets, the Green Mountain Care Board wants to hear from you.

Comment online at : www.gmcboard.vermont.gov

E-mail: Sam.Lacy@state.vt.us

Call: 802.828.2177

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