

VT Hospital Budgets

FY 2017 Budget Guidelines

January 27, 2016

VT Hospital Budgets FY 2017

Summary of Recommendations

Scope of Guidelines:	Recommend for this year only FY 2017
Current Policies:	
Inflation:	Recommend 3% for 2017
Health Care Reform:	Continue, 0.4% for 2017
Physician transfers:	Continue, no change
Enforcement:	Continue, no change
Community Health Needs Assessment:	Continue but expand to review some of the filed information
Other research	
Administration measure:	Begin process with CFOs to examine
Critical Access vs PPS:	Begin process to examine pros and cons

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Period of guidelines

The guidelines are suggested for 2017 only.

There are a number of unknowns around the all payer waiver and how that will operate. Also, it is unclear how budgeting and/or payments to providers will operate with the addition of the ACO construct. The hospitals will need time to continue to adapt to reporting needs and system budget process changes over the next year.

Also, in my initial discussions with hospital representatives, they expressed concerns with the unknowns around timelines during this transition period. Drastic changes in the current process would be seen as problematic.

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Inflation guideline

I recommend we adopt a 3% inflation indicator for 2017.

I recommend you continue the health care reform investment incentive – 0.4% for 2017.

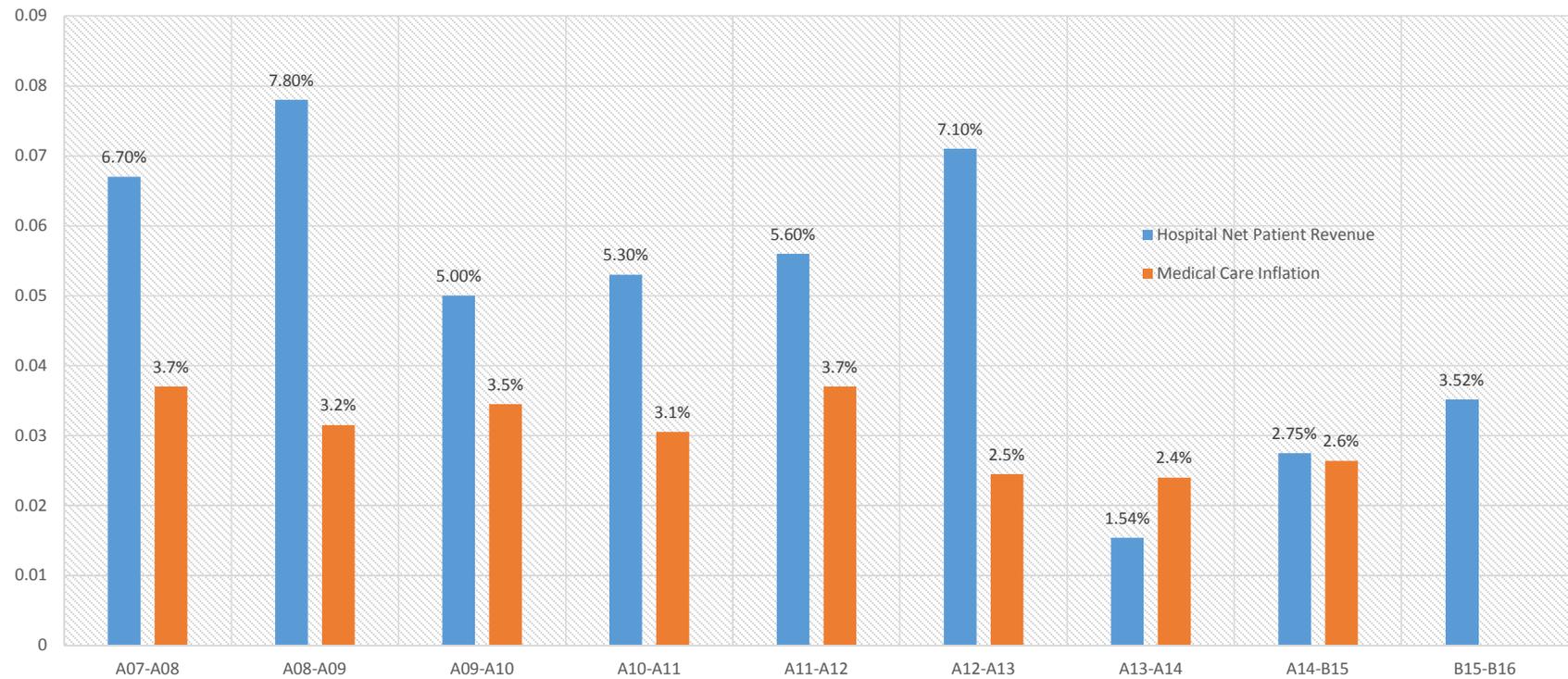
A review of the Maryland **Health Services Cost Review Commission (HSCRC)** found that they use inflation forecasting and monitoring from a company called Global Insight. That is the same company that provides ongoing services to CMS for purposes of Medicare reimbursement. My research found that the HSCRC provided update factors of 3.84% and 4.15% respectively for their 2015 and 2016 hospital budget years in Maryland. FY 2017 has not yet been developed.

The update factor development is quite sophisticated and goes beyond the scope of my research. However, since we established 3% as a broad inflation guideline in 2014-2016, inflation began a downward trend until 2015, when the inflation began to show upward trends. That fact is established by indicator increases seen by the Bureau of Labor Statistics as well as the National Health Expenditures Accounts (NHEA) (as reviewed by the Altarum Institute). Given those trends, and the update factor increases established in Maryland, I believe the 3% growth factor is still reasonable for this coming year.

Health care reform investments provides transition funding as hospitals shift towards payment reform and other activities. Funding will support staff and other needs to redevelop reporting and evaluation needs for such reform. A review of the Maryland hospital budget system found that they also include infrastructure funds as part of their inflation guideline as well, though they may very well consider that more broadly than the GMCB.

Inflation Guideline

Vermont Community Hospitals
Net Patient Revenue Increase compared to U.S. Medical Inflation



Medical inflation - Bureau of Labor Statistics
Hospital data adjusted to reflect bad debt reporting change in 2012

Inflation Guideline

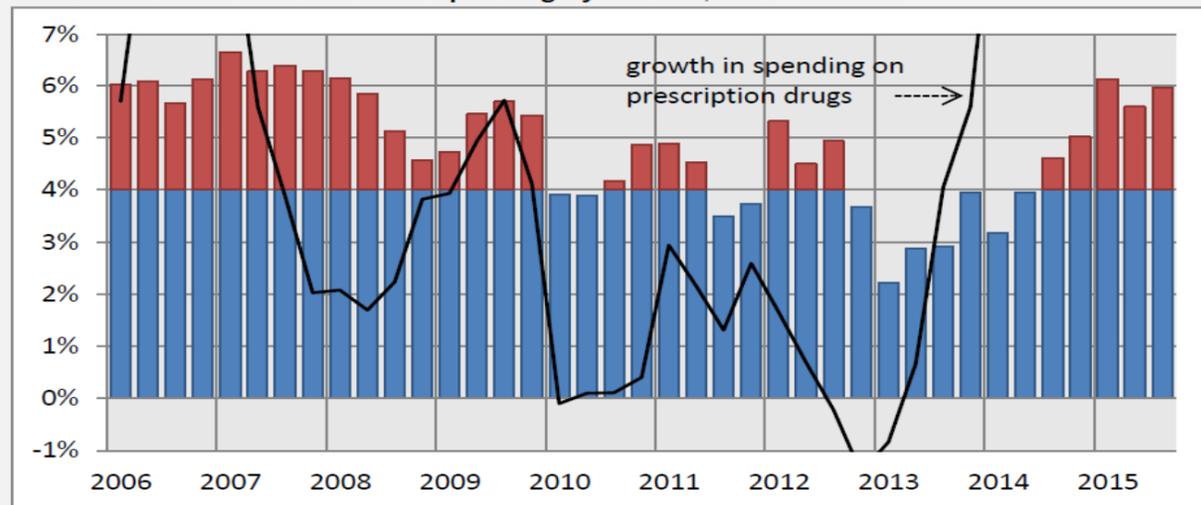
Health spending in 2015 is on track for 6.3% growth, a percentage point faster than 2014 growth

- December QSS data, combined with the most recent HSEI results, show health spending growth of 6.2% in Q3 2015 compared to Q3 2014.
- This brings the average for the first three quarters of 2015 to 6.3%, a percentage point faster than the 5.3% growth in 2014 [recently reported by the Centers for Medicare & Medicaid Services \(CMS\)](#).

The percentage point increase in the 2015 growth rate is likely due to the impact of expanded coverage

- As discussed in our [November Trend Report](#), coverage expansion occurred incrementally during the first three quarters of 2014. Expanded coverage increases the demand for health care services, but, as shown in the chart below, the impact on health services spending was not immediate and does not appear to have begun in earnest until 2015.

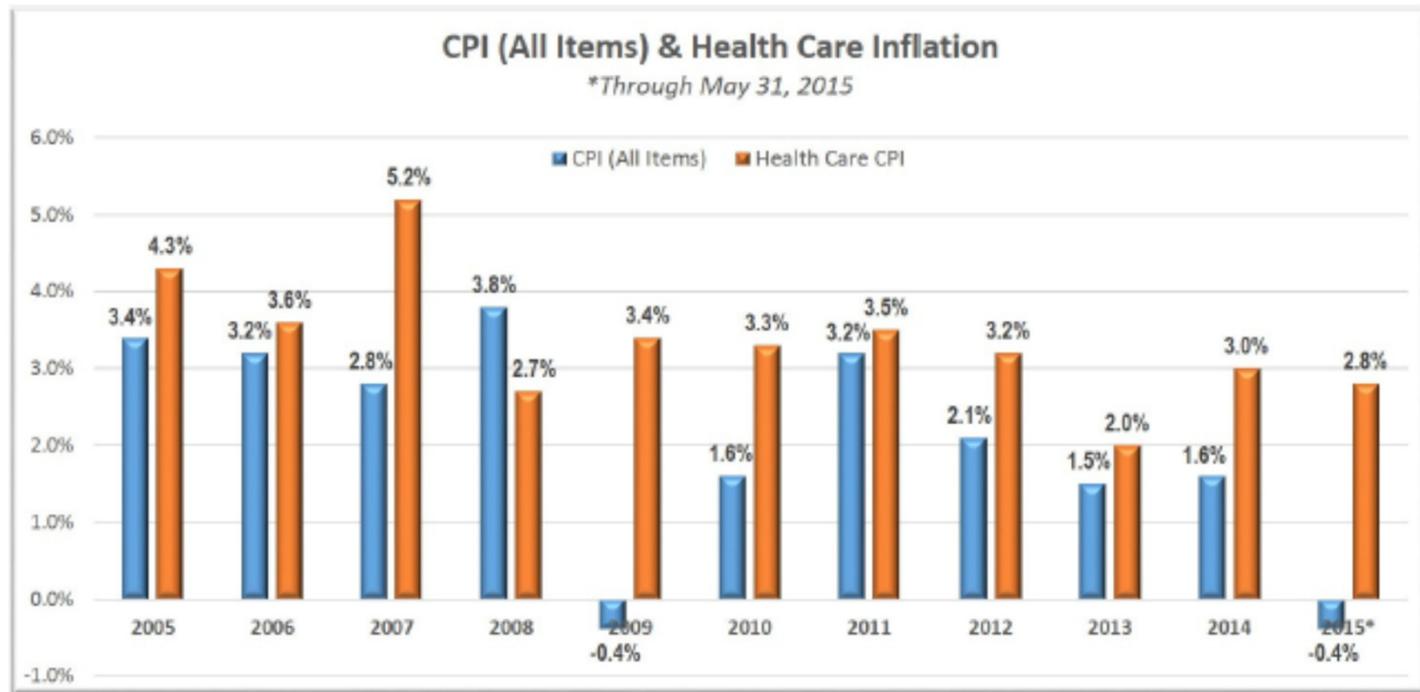
Growth in Health Care Services Spending by Quarter, 2006–Q3 2015



Source: Altarum analysis of HSEI and QSS data. Growth above 4% is highlighted in red.

Inflation Guideline – health care spending on the increase

U.S. Health Care Costs Rise Faster Than Inflation - Forbes



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Physician transfer or acquisition guideline

I recommend we continue the same policy for 2017.

Over the three year period we have updated the reporting documents but have not materially changed how we report and present this information. We still have plans to improve physician reporting but this will be delayed until we have more information on changes forthcoming in the next year.

Enforcement guideline

I recommend we continue the same policy for 2017.

We have been able to apply our enforcement policy only one time since the policy went into effect. As you may recall, three hospitals were found to be out of compliance during the review of the 2014 budgets. As a result of that review, the GMCB sent letters to the hospitals and required that they present a plan to remedy their out of compliance. Those plans were reviewed and approved as part of the Board's subsequent approval of their FY 2016 budget. In the next few months, we will be examining the FY 2015 hospital budgets. This will give us another opportunity to apply that process.

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Community Health Needs Assessment guideline

I recommend we continue the same policy for collecting information in 2017.

We have maintained and cataloged this information for all hospitals.

I recommend we examine the reported 990 forms (schedule H) to determine an understanding of the hospitals' reporting requirements.

We have prepared an analysis that describes the hospital responses to a series of IRS questions (Form 990) around their CHNA filings and how and what free care services are provided. The office of the Health Care Advocate has raised questions about these filings. Once we complete our review, we will meet with the HCA to discuss whether any next steps are necessary, either a part of or outside the budget process.

I recommend we do not pursue an examination of strategy and implementation plans until resources are available.

A consideration has also been raised whether to examine their processes for consistency and integration with the hospitals' budget preparation. In my opinion, this review would require a legal review of the 64 page rule that has been promulgated to administer this program and a discussion with the hospitals to develop a better understanding of the information they have filed around implementation and strategy. I am concerned that we do not have the resources to accomplish that for this coming year.

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Areas for future consideration

I recommend we develop a timeline and process to define Administration for hospitals.

I have attached a slide show presented to the legislature last year that describes hospital administration.

As you see, the measure for administrative costs follows the definitions of the Medicare cost report. While comparable across hospitals, this measure creates confusion when compared with other providers or when trying to compare to insurance administration measures. We should be able to develop a more robust and meaningful measure, but this will require our working with the hospital CFOs. This work could begin this year.

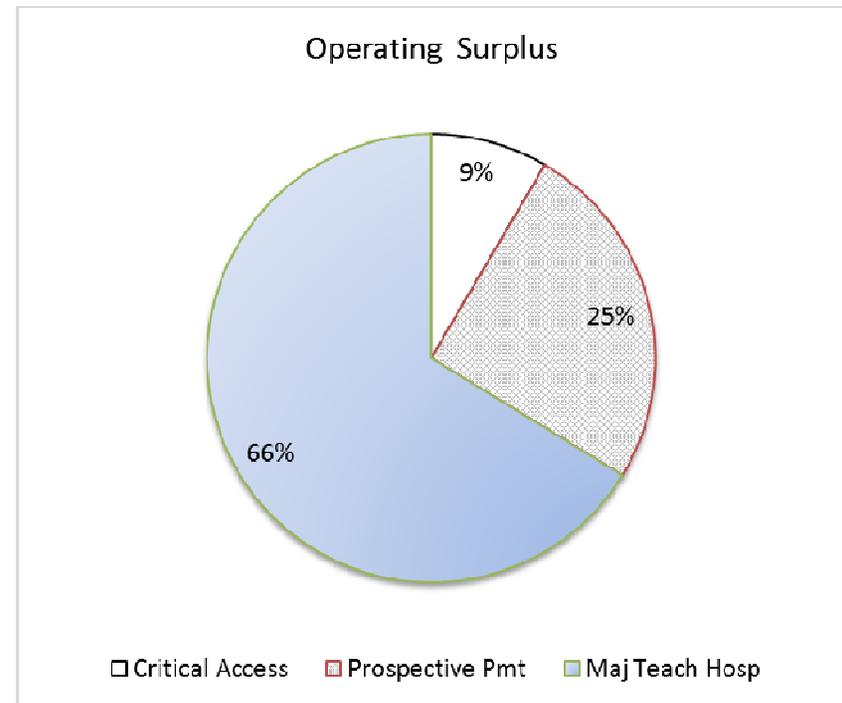
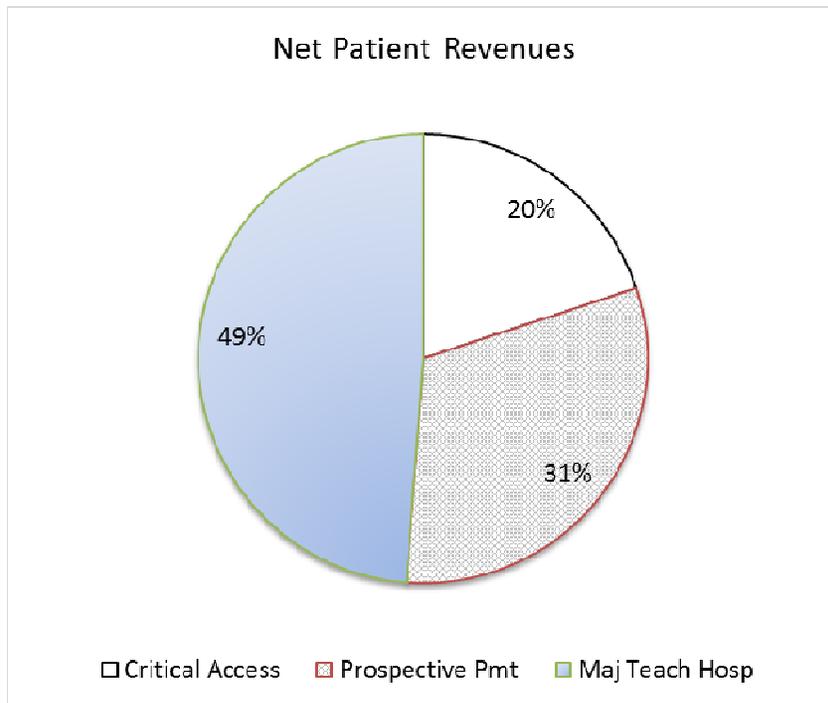
I recommend we develop a timeline and process to consider whether it makes sense to examine and approve hospital budgets differently because of their Medicare designation - Critical Access Hospitals (CAH) vs. Prospective Payment System (PPS)?

A question was raised whether it might make sense to develop different or more pertinent criteria for reviewing hospitals because their revenue reimbursement streams differ and their scope of services or organizational structure can often differ. We currently have eight CAH and six PPS hospitals (one of which is a Major Teaching Hospital). The following slides provide comparative looks on some key measures. Again, there may be some value in exploring this idea, but it will require some discussion and time in order to consider change. Work could begin this year to start building measures – but it would be useful to decide the purpose for doing this.

VT Hospital Budgets FY 2016 Analysis by Medicare Designation Per cent of Total

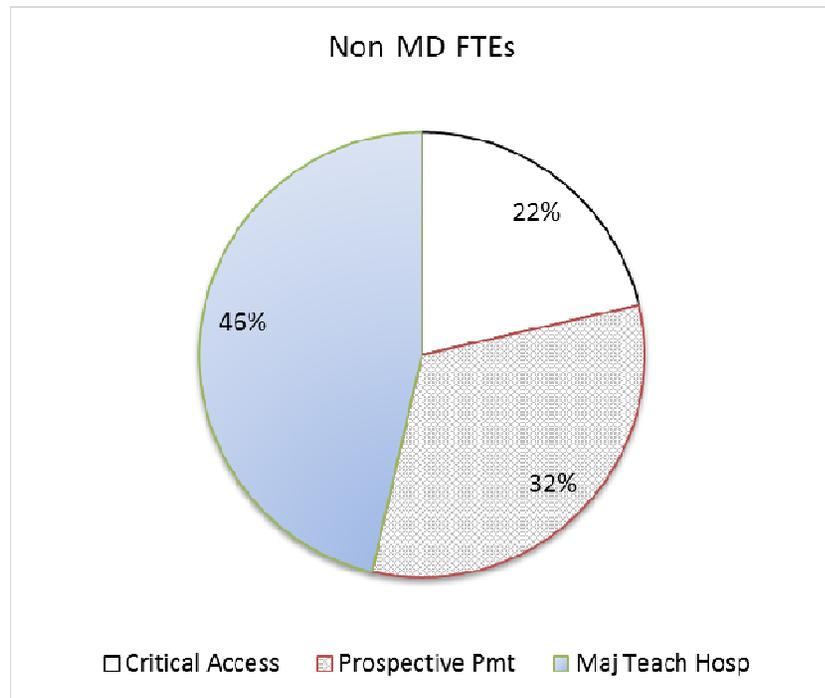
Total net patient revenues = \$2.3 billion

Operating Surplus = \$69.6 million

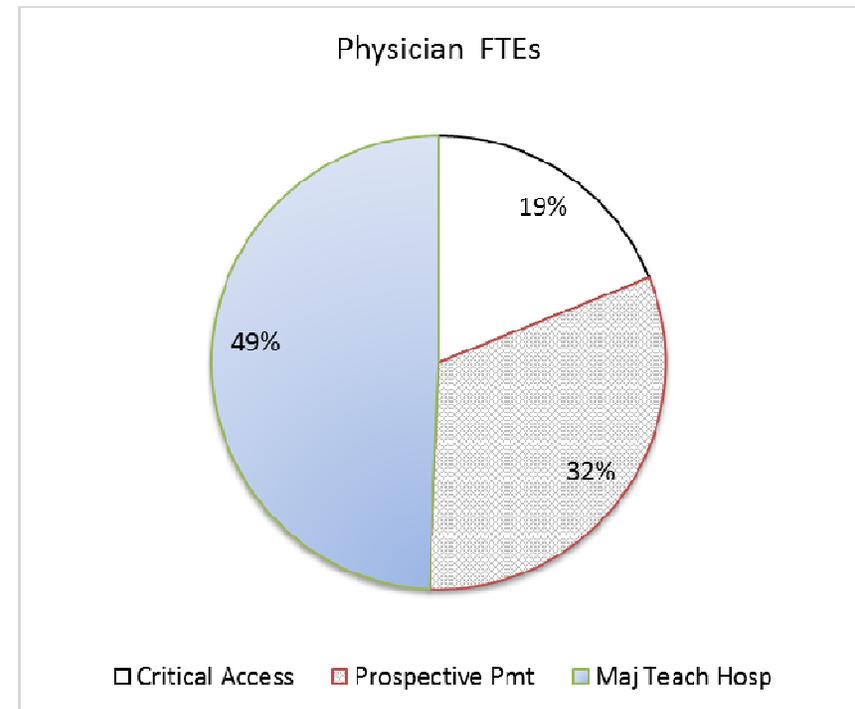


VT Hospital Budgets FY 2016 Analysis by Medicare Designation Per cent of Total

Total non MD FTEs = 12,684

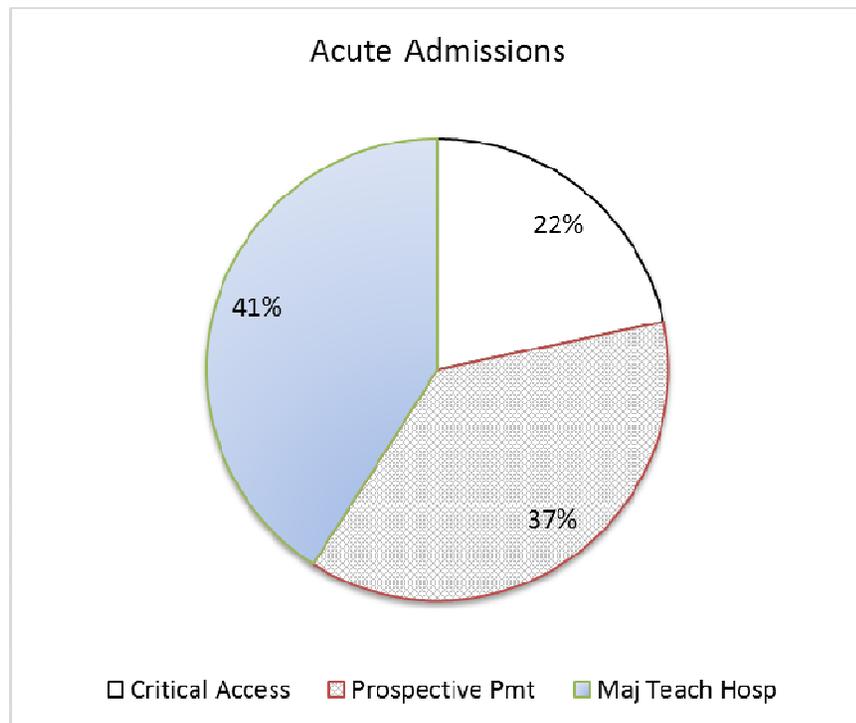


Total physician FTEs = 1,089

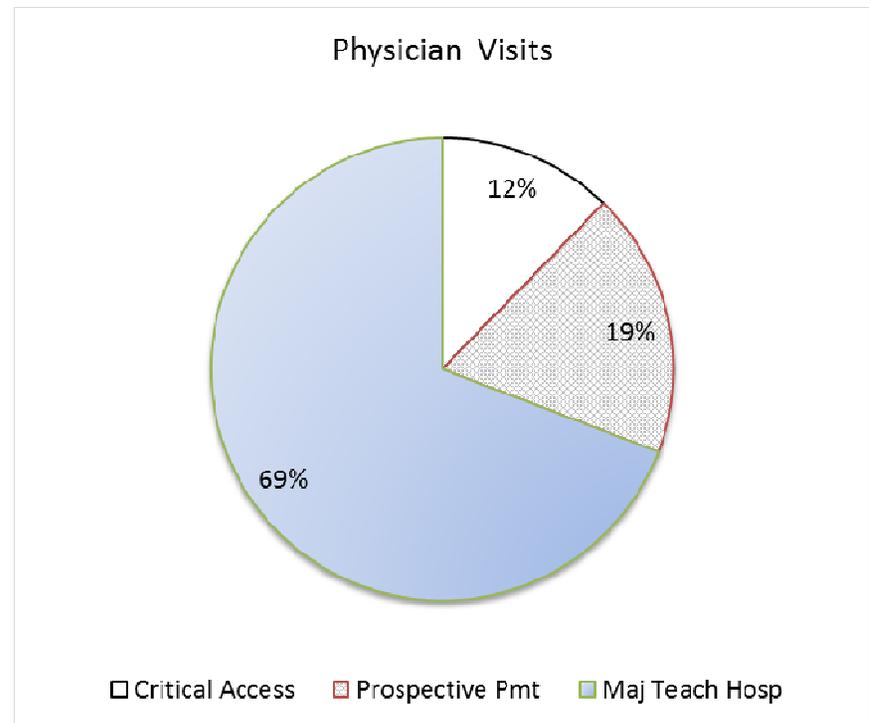


VT Hospital Budgets FY 2016 Analysis by Medicare Designation Per cent of Total

Total acute admissions = 43,868



Total physician visits = \$3.7 million



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Hospital initial responses to Recommendations

CFOs support a FY 2017 budget reporting process that is consistent with FY 2016

CFOs support a 3% inflation and a HCR investment at least equal to FY 2016

CFOs request to work with Mike Davis to develop a consistent definition of administrative costs. The group felt the implementation should be for 2018, but recognized that there might be some legislative pressure to do this earlier.

CFOs believe that the shift of insurance risk to providers needs to be addressed sooner rather than later and is seeking GMCB guidance. Clearly this issue trickles into the space of the ACO structure, business planning and payer partner relationships. The sentiment was that hospitals should not have to fund the reserves necessary to cover this risk out of their current 3%. The group discussion suggested that the funds already exist in the balance sheets of commercial carriers.

CAH CFOs suggested that the ACO in conjunction with the GMCB regulatory process needs to develop a method that recognizes that 3% funding is not a sustainable model for CAH hospitals. The cost of labor, supplies and equipment are certainly equal to or greater than what larger institutions pay. In the future, these economies of scale issues will only become more challenging. The CAH hospitals are very concerned about meeting the needs of their communities under a payment model that does not address this issue.