

VT Hospital Budgets

FY 2017 Budget Guidelines

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Hospital Budget Guidelines FY 2017

- December Staff preparation of hospital FY 2017 budget guidance
- January 6 Staff presents 2017 draft guidance elements to GMCB
- Jan 1 – 20 Staff meets with hospital CEOs
- Jan 21 Board votes on draft 2017 guidance
- Jan 21 – Feb 4 Public comment period on 2017 Guidance
- Feb 25 **Board finalizes FY 2017 Budget guidance & instructions**
- March 3 Board sent 2017 budget guidance to hospitals

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Period of guidelines

The guidelines are suggested for FY 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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Summary of Recommendations

Scope of Guidelines:	Recommend for this year only FY 2017
Current Policies:	
Inflation:	Recommend 3% for 2017 – <u>see background comments</u>
Health Care Reform:	Continue, 0.4% for 2017
Physician transfers:	Continue, no change– <u>see background comments</u>
Enforcement:	Continue, no change– <u>see background comments</u>
Community Health Needs Assessment:	Continue but expand to review some of the filed information – <u>see background comments</u>
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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NPR growth guideline

I recommend we adopt a 3% NPR growth increase for FY 2017.

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

The GMCB began a public discussion in December 2012 to establish a growth target for hospitals. Various indicators and information was examined and involved work and input from hospitals and other stakeholders, members of the public, and the GMCB itself. Upon completion of the public process, the Board established its present policy.

Background

- 1) The GMCB established a growth limit on overall hospital system **net patient revenues** for the period FY 2014-16.
- 2) Establishment of the growth target including a series of meetings and public comment regarding administering the policy and a consideration of various growth indicators.
- 3) The establishment of the 3% growth target was generally based upon growth of the overall Vermont GDP. It was noted that this was less than medical inflation (BLS) and lower than had been seen in recent years.
- 4) The establishment of the health care reform investment incentive follows the guidelines and action plan established for the period FY 2014-16.
- 5) Determination of new growth targets beyond this year will require hospitals to meet needs for the all payer CMS waiver and/or ACO payment reform.

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Physician transfer or acquisition guideline

I recommend we continue the same policy for FY 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 is delayed until we have more information on forthcoming reform changes.

Background

- 1) The physician transfer policy (adopted for FY 2014-16), was designed to reflect NPR changes with major acquisitions or transfers in and out of hospital budgets.
- 2) The policy was not designed to provide information to evaluate cost or pricing issues specific to physician activity.
- 3) A report on improved physician reporting was completed in FY 2014 and will be considered once reform changes are known.
- 4) Physician reporting changes will require a need to determine information needs to meet ACO, budget regulation, and other rate regulation.

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Enforcement guideline

I recommend we continue the same policy for FY 2017.

Three hospitals were found to be out of compliance during the review of the FY 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.

Background

- 1) The Enforcement policy (adopted for FY 2014-16), was designed to examine Budget to Actual hospital variances.
- 2) The GMCB adopted a narrow “variance corridor” of 0.5%. Any hospital with a variance exceeding 0.5% in NPR will be reviewed and subject to enforcement action.
- 3) The Enforcement policy was in force for the first time with review of the FY 2014 budgets.
- 4) Enforcement action as a result of the FY 2014 review was implemented in the FY 2016 budget submissions. Hospitals found out of compliance were required to reduce their rates and present the plan as part of their FY 2016 budget.

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Community Health Needs Assessment guideline

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

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

We have maintained and cataloged both the 990s and the strategy plans for all hospitals. This information is available for the public upon request. Also available is any hospital testimony provided to answer specific questions raised by the Board.

Background

- 1) This was a new requirement implemented by IRS beginning in 2012. The IRS provided a timeline for hospitals to meet and comply with its requirements.
- 2) The GMCB adopted a policy to collect this information beginning with the FY 2014-16 budget review process.
- 3) Collected information is maintained at the GMCB. Responses required in the 990 form are being examined to determine whether information is relevant to the budget process and whether any additional questions and responses will be needed from the hospitals.

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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.

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Next steps

- Deliberate Budget Guidance elements
- Discuss and identify any outstanding related issues
- Determine whether the FY 2017 Budget Guidelines should be adopted.
- End