VERMONT HEALTH CARE EXPENDITURE ANALYSIS MANUAL

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Introduction:

The Green Mountain Care Board shall develop The VT Health Care Expenditure Analysis (VHCEA) required under 18 V.S.A. § 9375a Chapter 220, subchapter 001.

The VHCEA is an annual report that depends upon numerous sources of data. A draft is typically available in mid-January and a final version is published in the spring.

The report is a consistent model that:

- establishes a base of health care spending and funding,
- examines spending and sources of funds over time,
- combines data from state and federal fiscal years and calendar years. The government payers typically report on a state or federal fiscal year. The private payers report data based on a calendar year. The VHCEA does not normally adjust for the non-calendar year data.
- collects data for analysis from the various payers and providers that pay for or provide health care services in Vermont. The report relies on the integrity of the information collected directly from the payers and providers. In cases where limited data are available, estimates are used.
- allows comparisons of Vermont spending to the National Health Expenditures (NHE) at the Centers for Medicare & Medicaid Services (CMS).

The VHCEA is two analyses in one report. The **Resident analysis** reports what payers spend on Vermont Residents for health care services within Vermont and out-of-state (OOS). The **Provider analysis** reports net revenues received by Vermont Providers for services delivered in Vermont which includes non-Vermonters. Both analytical constructs are necessary to manage and understand health care spending.

Payers, providers, legislators, and other interested parties may use the report to give context to Vermont's health care expenditures in relation to individual categories or national data, and to evaluate industry trends, etc.

In accordance with this, the Green Mountain Care Board has adopted the "Vermont Health Care Expenditure Analysis Manual". The manual will provide uniform accounts and definitions to assure that the analysis under review is consistent. This document reflects input from the Green Mountain Care Board along with other organizations and individuals. This manual is still under review. Your comments are welcome as we continually work to make this a more useful foundational document.

The following describes the information and accounts contained in the VHCEA. Descriptions of these accounts generally follow the CMS National Health Expenditure Accounts; though some accounts are unique to Vermont's reporting process. New and updated definitions will be adopted as necessary to meet the reporting requirements established by the GMCB. There is a schedule in the Appendix that shows the accounts and those unique to Vermont.

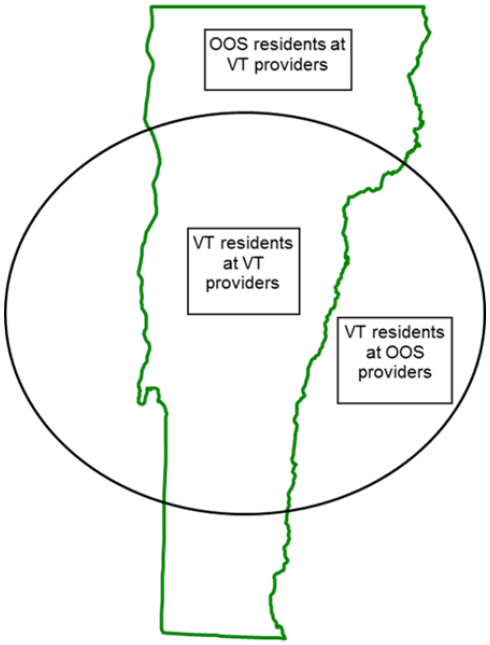
How the Two Perspectives Differ

The Resident analysis reports what payers spend on Vermont Residents for health care services within Vermont and out-of-state (OOS). The Provider analysis reports net revenues received by Vermont Providers for services delivered in Vermont which includes non-Vermonters. Both analytical constructs are necessary to manage and understand health care spending.

Chart 7

Populations	Resident Analysis	Provider Analysis
Vt Residents in state care	√	√
Vt Residents out of state care	√	
Out of state patients in state care		√

Recording Issues	Resident Analysis	Provider Analysis
Fiscal year issues related to reporting	√	√
Accounting differences	√	√
Taxonomy differences	√	√



I. Resident Analysis (Vermont Payers)

The resident analysis records annual spending[1] by all payers on behalf of Vermont residents regardless whether it occurs in or out-of-state. Payers are required to report spending for Vermont Residents based upon **provider service categories on health care services in and out-of-state as defined below.**

Spending is defined as all claims paid by each payer and all administrative costs. Certain payers do not have claims, so spending is based upon estimates or other sources. Estimates are derived from various sources for those payers where no direct data exists. Payers typically report spending based upon their fiscal year, which is calendar year in Vermont.

Chart 1 is a depiction of how to think about the payer reporting the data. The payers are requested to show their spending in the defined categories as a matter of standardizing the reporting.

Chart 1

Resident Analysis

Providers		TOTAL	Payers: Out-of-Pocket	Private Insurance	Medicare	Vermont Medicaid	Other Gov't
	Hospitals						
	Physician Services						
	Dental Services						
	Other Professional Svcs.						
	Home Health Care						
	Drugs & Supplies						
	Vision Products & DME						
	Nursing Home Care (SNF)						
	Other/Unclassified						
	Admin/Net Cost Health Ins.						
	Mental Health and Other Gov't Health Activities						
	TOTAL						

[1] Spending is the term used to convey all dollars earned by each payer that are used to pay the bills and operate the business. These include claims, surplus, and the administrative costs used to support the payer operations. In certain cases, spending is an estimate derived from disparate sources.

Resident Payer Sources-Definitions

A. Vermont Private Insurance

GMCB defines Private Health Insurance to include premiums or premium equivalents paid to traditional managed care, self-insured health plans and indemnity plans. (Indemnity plans allow you to direct your own health care and visit almost any doctor or hospital you like. The insurance company then pays a set portion of your total charges. Indemnity plans are also referred to as "fee-for-service" plans.) This category also includes the net cost of private health insurance which is the difference between health premiums earned and benefits incurred. The net cost consists of insurers' costs of paying bills, advertising, sales commissions, and other administrative costs; net additions to reserves; rate credits and dividends; premium taxes; and profits or losses. Self-Insured, Third-party administrators (TPA) and Administrative Services Only (ASO) are entities contracting to provide any combination of services in administering health benefits for a health insurer or other entity such as self-insured employer plans, to include claims processing, underwriting, premium collection, case management, authorizations and customer service. CMS NHE uses a similar definition to record spending.

- SOURCES
  - Annual Statement Supplemental Report (ASSR), which is an aggregate of the following: lives, member months, premiums/premium equivalent, and claims.
  - Special requests are received from insurers that are 85% of the market, to enrollment, claims by provider categories of service and net cost of insurance by the types of insurance. (BCBSVT, TVHP, MVP, CIGNA).
  - Enrollment and claims data from Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), are used to estimate premiums for Out of State insurers and Self-Insured, TPA/ASOs if ASSR data is not available.
  - Workers' Compensation reports from Department of Financial Regulation (DFR) are used to calculate medical premiums.

1. **Commercial Health Insurers** (aka Private) includes comprehensive major medical insurance, (refers to plans that cover a wide range of health services) Medicare supplement insurance, long-term care, and dental insurance. This category also includes expenditures by self-insured companies that assume financial risk and directly pay for health services for their employees. The ASSR collects accident only and disability insurance data but the VHCEA does not record this information.
2. **Workers' Compensation Insurance**-includes the medical component of workers' compensation claims. Some of these claims are self-insured and some are private insurance. Reports received from DFR & State of Oregon aid in calculating an estimate of medical and administrative charges associated with Workers compensation premiums and claims.

B. Medicaid

Medicaid includes health expenditures for beneficiaries of VT's medical assistance program, a federal-state health insurance program for certain low-income and medically needy people and aged, blind, and disabled residents. The program provides medical and prescription drug

coverage. The provider service categories to record spending for Vermont are structured like CMS NHE but some categories may be Vermont specific.

- SOURCES:
  - Data files received from Vermont Agency of Human Services. (VAHS)
  - Reporting reconciles to total spend as reported to CMS for the Global Commitment Waiver. Also reported are Managed Care Organization (MCO), State Children's Health Insurance Program (SCHIP) and Long Term Care. Federal and State spending that are not Medicaid but are reported through VAHS.
  - Health spending data file from VAHS is collapsed into the expenditure analysis provider categories of service in agreement with VAHS.
    - Administrative cost files for GC, MCO, SCHIP and Long Term Care are reported through VAHS.
    - Mental Health and Other Government Health Care Activities are included in the data file

C. Medicare

Expenditures made by the federal government on behalf of beneficiaries of the national Medicare program, including the elderly and disabled. Medicare offers prescription drug plan coverage through Part D, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

- SOURCES:
  - GMCB has a contract with the Dartmouth Institute for Health Policy & Clinical Practice (TDI) to receive an annual Medicare report with information experienced by Vermont beneficiaries. An important note: in 2014 CMS started redacting certain claims for substance and alcohol abuse starting with paid claims for 2013.[2]
  - Medicare Part D claims are also included in the 2014 TDI report for comparison. VHCURES claims data is used as these claims are reported as part of the data from commercial insurers. Currently, Medicare Part D is reported in Medicare instead of Commercial.
  - Administrative charges are calculated by using an NHE allocation for Medicare Admin. and claims.

D. Other Federal and State Gov't

Expenditures for public health activities and payments made by the state and federal government for health care services that are not covered through the Medicare or Medicaid programs.

- SOURCES:
  - VAHS - Other Federal and State spending from the Medicaid multiple department file (mentioned above).

[2] The report includes an executive summary and different tables for payments by claim/expenditure category, payment by state of provider, top 10% of spending by conditions (diagnosis codes), a table that stratifies inpatient care by age <65 or > 65. Another table reports the most common admissions grouped by Diagnosis Related Group (DRG), another has the same information but sorted by total payments and weights. Various Pareto analyses tables attributed to different subsets of Vermont's population. Tables that show the most common DRG. Other tables show a longitudinal analysis for payments, charges and percent change over a 5-year period.

- VAHS - Non-Medicaid Grants (State and Federal) Grants defined as health care administered by the VT Dept. of Health for health care services not covered through the Medicare or Medicaid program.
- Veteran's Administration Hospital -The VA provides the payer sources by resident. (Also, report information as a hospital provider for the Provider Analysis.
- Physician Federally Qualified Health Centers (FQHC)- Federal grant revenues from the U.S. Dept. of Health and Human Services (HRSA) website http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2014&state=VT#glist
- VAHS- Corrections - Inmate health expenses.

E. OUT OF POCKET(OOP)

Expenditures made directly by consumers to purchase health care services and supplies, which also includes deductibles and coinsurance. Excludes payments for insurance premiums that are included in the insurance expenditure category. The Out of Pocket calculation relies on Vermont data and less on the census and the NHE.

- SOURCES:
  - NHE allocations are used for unique provider populations and services.
  - Medicare claims expenditures reported to GMCB from TDI include out of pocket costs by Medicare enrollees.
  - VHCURES allows measurement of the insured enrollee's actual out of pocket costs for about 90% of the commercial market.
  - Vermont Household Health Insurance Survey (VHHIS) used to help estimate out of pocket costs for unique provider services.
  - All these sources are used to calculate a final OOP estimate.

RESIDENT PROVIDER SERVICE CATEGORIES

Definitions

1. **HOSPITALS-** includes VT resident expenditures for services provided in VT hospitals as well as out-of-state hospitals. These services include room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care. Rehabilitation and SUD Units are included. Expenditures for nursing home care is not in this category but *is* included in the VT provider analysis.
   - *Community Hospitals*-amounts include expenditures for all acute care services provided in hospitals that are neither specialty nor government. Tertiary hospitals and out-of-state community hospitals are included. Hospital owned physician practices are not included in this category in the VT resident analysis but *is* included in the VT provider analysis.

     Community Hospitals-Inpatient
     ~~Community Hospitals-Inpatient Physicians~~
     Community Hospitals-Outpatient
     ~~Community Hospitals-Outpatient Physicians~~
   - *Veterans Hospital*-includes VT resident inpatient and outpatient payments to White River Junction's Veterans facility and other Veterans hospitals. An estimated 35% of the patients at the Veteran's Hospital in White River Junction are not VT residents, the spending associated

with those patients is *not* included in the VT resident analysis but *is* included in the VT provider analysis

- *Psychiatric Hospital-* includes VT resident inpatient and outpatient expenditures for hospital care in establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services.
    - *State*- VT Psychiatric Care Hospital and/or other **state** psychiatric hospitals.
    - *Private-* Brattleboro Retreat and/or other private psychiatric institutions.

2. **PHYSICIAN SERVICES** (spending detail (logic) under review)
    - *Offices of Physicians-*includes all VT resident payments for services provided by MD and DO physicians, ophthalmologist, physicians assistants, and advance practice nurse practitioners regardless of for whom they work. This category includes hospital MD and DO services if billed independent of the hospitals. Hospital owned physician practices are included in this category.
    - *Ambulatory Clinics*
        - *CMHCs-*includes all VT resident payments for services provided by the community mental health centers or designated agencies in any state. A facility providing local mental health services run by a private, nonprofit organization. primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. Vermont's agencies can be found at Vermont's Agency of Human Services website at http://mentalhealth.vermont.gov/DAlist.
        - *Other Ambulatory Clinics- includes free standing outpatient care centers and or clinics.* These establishments primarily engaged in providing surgical services (e.g., orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (e.g., setting broken bones, treating lacerations, or tending to patients suffering injuries because of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment.
            - *FQHCs* outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include federally-supported health centers (both grantees and Look-Alikes) as well as certain outpatient Indian providers.
        - *Labs-*includes any independent laboratory and imaging center services that serve Vermont residents. Medical and diagnostic laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or to the patient on referral from a health practitioner.

3. **DENTAL SERVICES-** includes all VT resident payments for services provided by a dentist or dental practice. The health practitioners have the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.Sc. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery.

4. **OTHER PROFESSIONAL SERVICES**- includes all VT resident expenditures provided for health care professional services other than those that fall into the physician or dental category. *Categories defined below include those services provided in and outside Vermont for Vermont residents.* (spending detail (logic) under review)
    - *Chiropractor-* includes payments to chiropractic practitioners as compiled in the VHCURES data base (see Appendix)
    - *Physical Therapists*- includes expenditure for services performed by physical therapists or within physical therapy practices.
    - *Psychological Services*- includes Psychologists, clinical social workers, or other mental health providers in private practice. Psychiatrists are reported in the Physician Service category.
    - *Podiatrist Services-* includes expenditures for services performed by podiatrists or within podiatrist practices. These practitioners diagnose and treat diseases and deformities of the foot.
    - *Optometrists*-**(NEW)** includes expenditures for services performed by optometrists or within optometrist practices. health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. Ophthalmologist are reported as physicians and Optician is report under Vision and DME
    - *Other-* includes expenditures for services provided by health professionals that are not specifically identified. Services in this category include occupational and speech therapists, audiologists, ambulance services, private-duty nurses and other services provided by alternative practitioners.
5. **HOME HEALTH CARE-** includes VT resident expenditures for services provided by home health agencies (HHAs) including hospice. Hospice provided by non-HHA providers is included in their own category. Establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24- hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy. Medical equipment sales or rentals not billed through HHAs and non-medical types of home care are excluded. (spending detail (logic) under review)
6. **DRUGS AND SUPPLIES**
    - *Rx-* includes VT resident expenditures for human-use-dosage-form drugs, biological drugs, and diagnostic products available only by a prescription.
    - *Other supplies-* Includes Non- Prescription drugs and non-durable supplies
7. **VISION PRODUCTS & DURABLE MEDICAL EQUIPMENT (DME)**
    - *Vision-* includes VT resident expenditures for products that aid sight, including contact lenses, eyeglasses and other ophthalmic products, and other services provided by opticians. Optometrists are included as Other Professional.
    - *DME-* includes VT resident expenditures for Durable Medical Equipment purchased from independent venders. Covers "retail" sales of items such as, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals. DME purchased from hospitals or nursing homes should be excluded.
8. **NURSING HOME CARE-SKILLED NURSING FACILITY (SNF)-** includes VT resident expenditures for care provided by nursing homes and rehabilitative services (including intermediate and skilled

nursing facilities). Nursing home services owned by hospitals are recorded in this category. (spending detail (logic) under review)

9. **OTHER/UNCLASSIFIED HEALTH SERVICES-** includes VT resident expenditures not included in other categories, including health screening services, case management, drug and alcohol abuse counseling etc. Also, Residential treatment facility, SUD facility and ambulances services previously reported in Other Professional.
10. **ADMIN/NET COST OF HEALTH INSURANCE**- This includes VT resident administrative costs for each payer. Net cost is the difference of premiums earned and benefits incurred and includes administrative costs, as well as, additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses and is estimated separately.
11. **MENTAL HEALTH & OTHER GOVERNMENT HEALTH CARE ACTIVITIES**- includes VT resident expenditures for health activities through AHS, public mental health funding, case management services, and VT Department of Corrections health-related spending. State and Federal grants and GMCB expenditures are also included. (spending detail (logic) under review)

Example of the Resident Analysis report

Chart 2

2014 Vermont Health Care Expenditures - Resident Analysis

All dollar amounts are reported in thousands

PROVIDERS & FACILITIES	Percent of Total	Resident Total	Out of Pocket	Total Private	Medicare	Vermont Medicaid	Other Federal	State and Local
Hospitals	37.1%	$2,057,789	$174,823	$918,920	$559,036	$286,684	$107,101	$11,225
Community Hospitals	34.6%	$1,918,549	$173,626	$901,878	$556,299	$286,684	$26	$37
Inpatient	16.0%	$886,451	$75,692	$312,789	$322,915	$175,038	($0)	$17
Outpatient & ER	18.6%	$1,032,098	$97,933	$589,089	$233,384	$111,647	$26	$20
Inpatient-Physician	0.0%	$0	$0	$0	$0	$0	$0	$0
Outpatient-Physician	0.0%	$0	$0	$0	$0	$0	$0	$0
Veterans Hospital	2.0%	$113,295	$0	$5,990	$0	$0	$107,075	$230
Psychiatric Hosp: State	0.2%	$13,240	$0	$2,281	$0	$0	$0	$10,959
Psychiatric Hosp: Private	0.2%	$12,705	$1,197	$8,771	$2,737	$0	$0	$0
Physician Services*	13.4%	$740,994	$91,117	$343,847	$134,101	$157,963	$13,745	$222
Office of Physicians	13.0%	$722,744	$90,929	$343,828	$116,058	$157,963	$13,745	$222
Ambulatory Clinics	0.3%	$15,679	$0	$19	$15,660	$0	$0	$0
CMHCs	0.0%	$19	$0	$19	$0	$0	$0	$0
Other Ambulatory Clinics	0.3%	$15,660	$0	$0	$15,660	$0	$0	$0
Labs	0.0%	$2,571	$188	$0	$2,383	$0	$0	$0
Dental Services	4.2%	$233,333	$132,279	$77,382	$0	$23,407	$2	$263
Other Professional Services	3.4%	$190,769	$32,364	$94,537	$24,350	$39,517	$1	$0
Chiropractor	0.3%	$15,926	$4,278	$8,816	$1,797	$1,035	$0	$0
Physical Therapy Services	0.9%	$50,017	$10,105	$27,246	$8,324	$4,342	$0	$0
Psychological Services	1.1%	$59,606	$7,517	$25,314	$4,339	$22,436	$0	$0
Podiatrist Services	0.1%	$4,958	$1,059	$1,936	$1,679	$284	$0	$0
Optometrists	0.0%	$0	$0	$0	$0	$0	$0	$0
Other	1.1%	$60,262	$9,405	$31,225	$8,212	$11,419	$1	$0
Home Health Care	2.0%	$111,877	$13,452	$3,362	$64,833	$25,621	$2,699	$1,910
Drugs and Supplies	12.1%	$671,585	$127,193	$222,240	$237,758	$85,769	($1,771)	$396
Rx	12.1%	$671,518	$127,193	$222,240	$237,691	$85,769	($1,771)	$396
Other Supplies	0.0%	$67	$0	$0	$67	$0	$0	$0
Vision Products & DME	2.2%	$122,269	$68,311	$18,142	$25,146	$10,671	$0	($0)
Nursing Home Care (SNF)	5.1%	$284,456	$74,897	$8,481	$72,605	$120,096	$0	$8,377
Other/Unclassified Health Services	1.2%	$66,872	$8,785	$18,216	$18,849	$5,075	$0	$15,948
Mental Health & Other Govt Activities	12.7%	$705,099	$0	$0	$0	$648,884	$23,415	$32,800
Other Unassigned	0.0%	$0	$0	$0	$0	$0	$0	$0
Admin/Net Cost of Health Insurance	6.4%	$355,584	$0	$214,707	$54,889	$85,988	$0	$0
Change in surplus	0.2%	$11,818	$0	$11,818	$0	$0	$0	$0
Administration	6.2%	$343,766	$0	$202,889	$54,889	$85,988	$0	$0
TOTAL VERMONT EXPENDITURES	100.0%	$5,540,629	$723,221	$1,919,833	$1,191,567	$1,489,676	$145,191	$71,141
Per cent of total expenditures	0	100.0%	13.1%	34.7%	21.5%	26.9%	2.6%	1.3%

* Hospital-employed physician practices are included in the Physician Services category in the Resident Matrix.

** See Government Health Care Activities in this report for further detail.

	Payer reported data
	Allocations estimated from VT specific data
	Amounts imputed from National Health Expenditures or other indirect sources
N/A	Not Applicable
n.a.	Not Available

Example of Health Insurance Coverage Chart

Part of developing the Resident Expenditure Analysis requires collecting enrollment from the different payer sources. This data is a variety of sources collected from Annual Statement Supplemental Report (ASSR), Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), the Dartmouth Institute for Health Policy & Clinical Practice (TDI) and Vermont Household Health Insurance Survey (VHHIS), the Dept. of Vt. Health Access (DVHA) and the Vermont Dept. of Health (VDH).and is used to provide a summary of the health care coverage of all Vermonters. Chart 3 shows the coverage profile of Vermonters for the last few years and is under review.

ENROLLMENT DATA SOURCES:

- Private Insured - ASSR, the VHHIS, and VHCURES
- Medicaid - DVHA and the VHHIS
- Medicare - TDI and the VHHIS
- Uninsured - DVHA and the VHHIS
- Total population counts -VDH

Chart 3

Health Insurance Coverage Profile
Vermont Residents 2013-2014

		Under Review	
Category	**2013**	**2014**	**% change**
Private Insured Market			
Non-group	4,387	32,041	
Large Employer group	52,397	47,400	
Small Employer group	31,122	37,231	
Association	63,846	39,758	
Insured Market Subtotal	**151,752**	**156,430**	
Self-insured Employer Plans			
Self-insured Employer Plans	127,048	137,327	
Federal Employee Plan	14,521	14,535	
Military	15,478	18,578	
Self Insured Market Subtotal	**157,047**	**170,440**	
Other			
VT residents covered by insurers outside VT	24,165	25,143	
Catamount Health	17,026	0	
Other	**41,191**	**25,143**	
Private Insured Market	**349,990**	**352,013**	**0.6%**
Government Coverage			
Medicaid	127,342	**146,273**	14.9%
Medicare	111,954	115,649	3.3%
Government Coverage	**239,296**	**261,922**	**9.5%**
Uninsured			
Uninsured	**37,344**	**26,071**	**-30.2%**
Total of Assigned Lives	**626,630**	**640,006**	
Duplicated Count		**-13,444**	
Total Vermont Population	**626,630**	**626,562**	**0.0%**

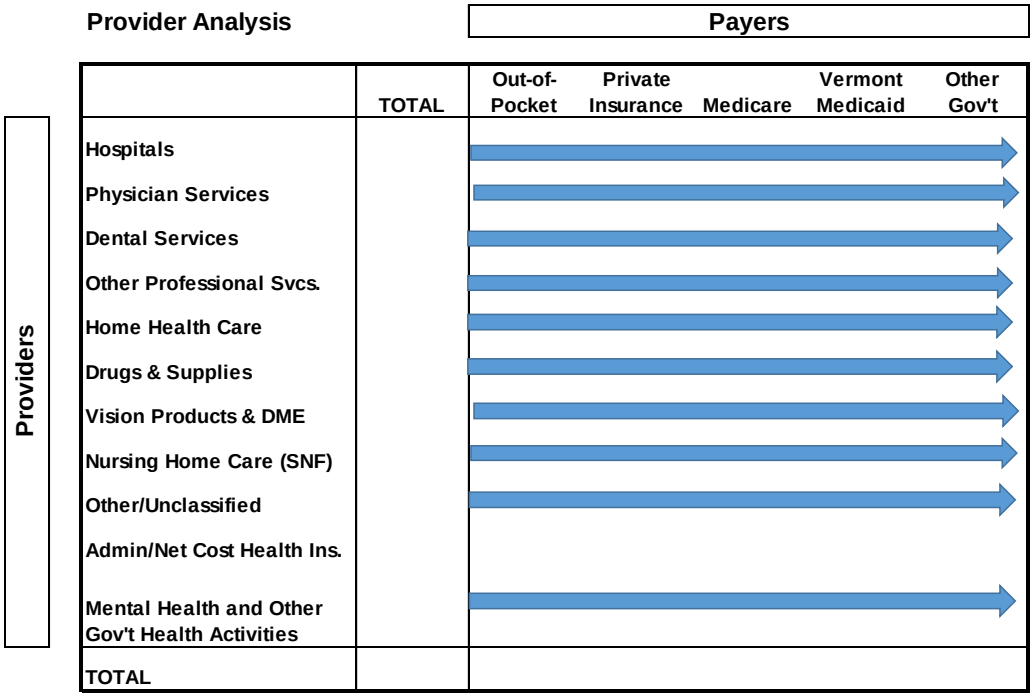
II. Provider Analysis (Vermont Providers)

Net revenues earned, including both residents and non-residents services

Providers report **net revenues** instead of expenditure data by Payer for services delivered **in Vermont no matter the residency of the patient.** Providers report payer data as defined by the GMCB.

Chart 4 is a depiction of how the provider and service categories are requested to report the data. The providers are requested to show their spending in the defined payer categories as a matter of standardizing the reporting.

Chart 4



Provider Payer Sources:

A. *Commercial Insurers* (Private)
B. *Medicaid*
C. *Medicare*
D. *Other Federal and State Gov't*
E. Out of Pocket

PROVIDER SERVICE CATEGORIES

Provider Service Categories for the Provider Analysis are classified primarily per their National Provider Identifier (NPI).

Definitions

1. **HOSPITALS-** includes net revenues for services provided in VT hospitals. These services include room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care. Rehabilitation and SUD Units are included. Net Revenues for nursing home care owned by a hospital is in this category.
   Sources of revenues by payer types is accounted for as reported by hospitals.
   - *Community Hospitals-*reported in the regulated hospital budget process-amounts include revenues for all acute care services provided in hospitals that are neither specialty nor government, including Tertiary care hospitals. Non-residents served in Vermont hospitals are also included. Hospital owned physician practices are included in this category, but recorded separately.
     Community Hospitals-Inpatient
     Community Hospitals-Inpatient Physicians
     Community Hospitals-Outpatient
     Community Hospitals-Outpatient Physicians
   - *Veterans Hospital-*includes VT resident inpatient and outpatient revenues to White River Junction's Veterans facility. An estimated 35% of the patients at the Veteran's Hospital in White River Junction are not VT residents, the revenues associated with those patients are *not* included in the VT resident analysis but are included in the VT provider analysis.
   - *Psychiatric Hospital-* includes VT resident inpatient and outpatient revenues for hospital care in establishments known and licensed as psychiatric and substance abuse hospitals within the state of Vermont. These establishments are primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services.
     - *State*- VT Psychiatric Care Hospital and other in-**state** psychiatric hospitals.
     - *Private-* Brattleboro Retreat.
2. **PHYSICIAN SERVICES** - Represents total net practice revenue, not physician net income. Includes revenues for resident and non-resident care provided in Vermont(spending detail (logic) under review, may include Census and NHE sources) Payer allocation based on resident matrix
   - *Offices of Physicians-*includes revenues for services provided by MD and DO physicians, ophthalmologist, physicians assistants, and advance practice nurse practitioners regardless of for whom they work. This category includes hospital MD and DO services if billed independent of the hospitals. Hospital owned physician practices are **not** reported in this category. Those revenues are included in the individual hospital budgets along with other physician revenues but do not yet include detailed practice information.
     - *Ambulatory Clinics*

- *CMHCs-*includes revenues for services provided by Vermont's community mental health centers. A facility providing local mental health services run by a private, nonprofit organization. primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary. See Designated Agency listed on Vermont's Agency of Human Services website at http://mentalhealth.vermont.gov/DAlist.
- *Other Ambulatory Clinics-includes free standing outpatient care centers and or clinics.* These establishments primarily engaged in providing surgical services (e.g., orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (e.g., setting broken bones, treating lacerations, or tending to patients suffering injuries because of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment.
- *FQHCs -* outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include federally-supported health centers (both grantees and Look-Alikes) as well as certain outpatient Indian providers.
  - *Labs-*includes independent laboratory and imaging center services within Vermont. Medical and diagnostic laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or to the patient on referral from a health practitioner.

3. **DENTAL SERVICES-** Includes revenues for resident and non-resident care provided in Vermont by a dentist or dental practice. The health practitioners have the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.Sc. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. (spending detail (logic) under review, may include Census and NHE sources) Payer allocation based on resident matrix
4. **OTHER PROFESSIONAL SERVICES-** Represents total net practice revenue, not professional net income includes revenues provided for health care professional services other than those that fall into the physician or dental category. *Categories defined below include only those services provided in Vermont, including both resident and non-resident care.* (spending detail (logic) under review, may include Census and NHE sources) Payer allocation based on resident matrix
   - *Chiropractor-* includes payments to chiropractic practitioners as compiled in the VHCURES data base (see Appendix)
   - *Physical Therapists*- includes expenditure for services performed by physical therapists or within physical therapy practices.
   - *Psychological Services*- includes Psychologists, clinical social workers, or other mental health providers in private practice. Psychiatrists are reported in the Physician Service category.
   - *Podiatrist Services-* includes expenditures for services performed by podiatrists or within podiatrist practices. These practitioners diagnose and treat diseases and deformities of the foot.

- *Optometrists*-**(NEW)** includes expenditures for services performed by optometrists or within optometrist practices. health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. Ophthalmologist are reported as physicians and Optician is report under Vision and DME
- *Other-* includes expenditures for services provided by health professionals that are not specifically identified. Services in this category include occupational and speech therapists, audiologists, ambulance services, private-duty nurses and other services provided by alternative practitioners.

5. **HOME HEALTH CARE-** Establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24- hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy. Medical equipment sales or rentals not billed through HHAs and non-medical types of home care are excluded. Includes revenues for resident and non-resident care provided in Vermont.
   Payer as reported by VAHS-Dept. of Disabilities, Aging & Independent Living (DAIL) includes revenues for services provided by home health agencies (HHAs) including hospice.
6. **DRUGS AND SUPPLIES-** Includes revenues for resident and non-residents provided in Vermont. (spending detail (logic) under review, may include Kaiser Foundation and NHE sources) Payer allocation based on resident matrix
   - *Rx-* includes revenues for human-use-dosage-form drugs, biological drugs, and diagnostic products available only by a prescription.
   - *Other supplies-* Includes Non- Prescription drugs and non-durable supplies
7. **VISION PRODUCTS & DURABLE MEDICAL EQUIPMENT (DME)-** Includes revenues for resident and non-resident care provided in Vermont. (spending detail (logic) under review, may include Census and NHE sources) Payer allocation based on resident matrix.
   - *Vision-* includes revenues for products that aid sight, including contact lenses, eyeglasses and other ophthalmic products, and other services provided by opticians. Optometrists are included as Other Professional.
   - *DME-* includes revenues for Durable Medical Equipment purchased from independent venders. Covers "retail" sales of items such as, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals. DME purchased from hospitals or nursing homes should be excluded.
8. **NURSING HOME CARE-SKILLED NURSING FACILITY (SNF)-** Government payers allocated as reported by nursing homes to VAHS-Rate Setting Division. Private revenues distributed based on resident matrix. includes revenues for care provided by nursing homes and rehabilitative services (including intermediate and skilled nursing facilities). Excludes nursing home services provided by a hospital. Includes revenues for resident and non-resident care provided in Vermont.
9. **OTHER/UNCLASSIFIED HEALTH SERVICES-** Includes revenues for resident and non-resident care provided in Vermont. Payer allocation based on resident matrix includes revenues not included in other categories, including health screening services, case management, drug and alcohol abuse counseling etc. Also, Residential treatment facility, SUD facility and ambulances services previously reported in Other Professional. (spending detail (logic) under review)
10. **ADMIN/NET COST OF HEALTH INSURANCE**- N/A. Not included in Provider Expenditure Analysis.
11. **MENTAL HEALTH & OTHER GOVERNMENT HEALTH CARE ACTIVITIES**- (this category is a mirror of what is reported by the Payers in the Resident Analysis due to lack of documentation.)

Summary of Provider Reported Payer Allocations.

Chart 5

Provider Service Category-Provider Analysis	Payer Allocation
Hospitals Community Hospitals Veterans Hospital of Vermont Vermont Psychiatric Hospitals Vermont State Hospitals Brattleboro Retreat	 Direct Report-Hospital Budget Direct Report ------- Direct Report Direct Report
Physicians Services	Based on Resident Matrix
Dental Services	Based on Resident Matrix
Other Professional Services	Based on Resident Matrix
Home Health Care	Direct Report from VAHS-DAIL
Drugs and Supplies	Based on Resident Matrix
Vision Products & DME	Based on Resident Matrix
Nursing Home Care-SNF	Direct Report fromVAHS-Rate Setting Division
Other Unclassified Health Services	Based on Resident Matrix
Admin/ Net Cost of Health Insurance	N/A
Mental Heatlh & Other Government Health Care Activities	Based on Resident Matrix

Example of the Provider Analysis matrix

Chart 6

2014 Vermont Health Care Expenditures - Provider Analysis

All dollar amounts are reported in thousands

PROVIDERS & FACILITIES	Percent of Total	Provider Total	Out of Pocket	Total Private	Medicare	Medicaid	Other Federal	State & Local
Hospitals	45.9%	**$2,547,132**	$211,775	$1,117,779	$713,914	$321,896	$165,338	$16,430
Community Hospitals	41.4%	**$2,293,620**	$207,569	$1,084,634	$698,183	$303,235	$0	$0
Inpatient	11.0%	$610,831	$46,078	$237,355	$240,432	$86,967	$0	$0
Outpatient & ER	22.9%	$1,271,443	$124,265	$640,114	$355,568	$151,496	$0	$0
Inpatient-Physician	2.4%	$130,951	$11,851	$65,951	$32,530	$20,620	$0	$0
Outpatient-Physician	5.1%	$280,395	$25,375	$141,214	$69,653	$44,153	$0	$0
Veterans Hospital	3.2%	**$180,145**	$3,963	$11,221	$0	$0	$164,731	$230
Psychiatric Hosp: State	0.2%	**$10,960**	$2	$0	$0	$0	$0	$10,959
Psychiatric Hosp: Private	1.1%	**$62,406**	$241	$21,925	$15,731	$18,661	$607	$5,242
Physician Services*	7.5%	**$413,740**	$50,876	$187,328	$102,777	$65,150	$7,488	$121
Office of Physicians	7.5%	$413,740	$50,876	$187,328	$102,777	$65,150	$7,488	$121
Ambulatory Clinics	0.0%	$0	$0	$0	$0	$0	$0	$0
CMHCs	0.0%	$0	$0	$0	$0	$0	$0	$0
Other Ambulatory Clinics	0.0%	$0	$0	$0	$0	$0	$0	$0
Labs	0.0%	$0	$0	$0	$0	$0	$0	$0
Dental Services	4.7%	$261,895	$148,471	$86,854	$0	$26,273	$3	$295
Other Professional Services	4.5%	**$251,351**	$43,705	$127,975	$33,166	$46,503	$2	$0
Chiropractor	0.5%	$28,150	$7,561	$15,582	$3,175	$1,830	$0	$0
Physical Therapy Services	0.9%	$52,385	$10,583	$28,536	$8,718	$4,548	$0	$0
Psychological Services	0.8%	$44,324	$5,590	$18,824	$3,226	$16,684	$0	$0
Podiatrist Services	0.1%	$3,993	$853	$1,559	$1,352	$229	$0	$0
Optometrists	0.0%	$0	$0	$0	$0	$0	$0	$0
Other	2.2%	$122,500	$19,118	$63,474	$16,694	$23,213	$2	$0
Home Health Care	2.3%	**$127,551**	$5,346	$12,283	$65,726	$39,587	$2,699	$1,910
Drugs and Supplies	14.7%	**$817,497**	$154,827	$270,525	$289,414	$104,404	($2,156)	$482
Rx	12.9%	$717,719	$135,930	$237,507	$254,090	$91,661	($1,893)	$424
Other Supplies	1.8%	**$99,777**	$18,897	$33,018	$35,324	$12,743	($263)	$59
Vision Products & DME	2.1%	**$116,556**	$65,119	$17,294	$23,971	$10,172	$0	($0)
Nursing Home Care	4.9%	$271,389	$40,602	$3,832	$82,448	$128,680	$7,270	$8,558
Other/Unclass. Health Services	0.6%	$34,213	$15,373	$2,392	$0	$500	$0	$15,948
Mental Health & Other Govt Activities	12.7%	**$705,099**	$0	$0	$0	$648,884	$23,415	$32,800
Other Unassigned	0.0%	**$0**	$0	$0	$0	$0	$0	$0
Admin/Net Cost of Health Ins.	N/A	**n.a.**	n.a.	$0	n.a.	n.a.	n.a.	n.a.
Change in surplus	N/A	**n.a.**	n.a.	$0	n.a.	n.a.	n.a.	n.a.
Administration	N/A	**n.a.**	n.a.	$0	n.a.	n.a.	n.a.	n.a.
TOTAL VERMONT EXPENDITURES	100.0%	**$5,546,422**	**$736,094**	**$1,826,262**	**$1,311,416**	**$1,392,049**	**$204,057**	**$76,544**
Percent of total expenditures		**100.0%**	**13.3%**	**32.9%**	**23.6%**	**25.1%**	**3.7%**	**1.4%**

* Hospital-employed physician practices are included in the Physi
** See Government Health Care Activities in this report for further detail.

	Provider reported data
	Allocations estimated from Vermont specific data
	Amounts imputed from National Health Expenditures or other indirect sources
N/A	Not Applicable
n.a.	Not Available

III. Comparisons to CMS national analysis

Vermont data is compared to the national data in total spending, per capita spending, annual percent change of per capita spending, percent change over time, and healthcare expenditures percent or share of the gross state or domestic product.

NATIONAL HEALTH EXPENDITURES:

The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. The NHEA is prepared by CMS, the Office of the Actuary, and National Health Statistics Group.

Since 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data are presented by type of service, by source of funding, and by type of sponsor. Sponsors provider information needed to identify spending by employers (private or government), households, and federal, state and local governments. For example, Employee share of Employer-sponsored private health insurance would be reported as a household spending sponsor.

Chart 8 describes how the NHEA assigns categories of spending to present different perspectives.

Chart 8

Personal Health Care (PHC)
-Hospital
-Professional Services
-Physician and clinics
-Other professionals
-Dental
-Other health, residential, and person care
-Home Health
-Nursing care facilities and continuing care retirement communities
-Retail outlet sales of medical products
-Prescription drugs
-Other medical products
-Durable medical equipment
-Non-durable medical equipment

Health Consumption Expenditures (HCE)
Personal Health Care plus:
-Administration and the net cost of private insurance
-Public health activity

National Health Expenditures (NHE)
Health Consumption Expenditures plus:
-Investment
-Research
-Structures
-Equipment

Source: National Health Statistics Group, Office of the Actuary, Centers for Medicare & Medicaid Services
Vermont expenditures do not include investments in research, structures and equipment as defined in the NHE

- "Personal Health Care (PHC) comprises of the medical goods and services that are rendered to treat or prevent a specific disease or condition in a specific person. These include hospital care; professional services; other health, residential, and personal care; home health care; nursing care facilities and continuing care retirement communities; and the retail outlet sales of medical products. Personal Health Care Payers and Programs are directly responsible for purchasing or providing medical goods and services that are rendered to treat or prevent a specific disease or condition in a specific person in the U.S. Often several types of payers or programs combine to pay for an individuals' health care. These include out-of-pocket, health insurance, and other third party payers and programs. The PHC level do not include government administration and net cost of private health insurance expenditures"
- "Health Consumption Expenditures (HCE) include all personal health care spending (PHC), government administration and the net cost of private health insurance (PHI), and public health activities. Premiums for third party payers and programs equal personal health care plus all applicable net cost and administrative costs. This category includes the administrative costs of health care programs such as Medicare and Medicaid as well as the net cost of PHI."
- "National Health Expenditures (NHE) includes health consumption expenditures (HCE) as well as investment in the medical sector for future consumption. Investment includes non-commercial research as well as purchases of medical structures and equipment."

PHC + Government Administration + Net Cost of PHI + public health activities = HCE

State provider and resident data are prepared only every 5 years because the primary source of data is the quinquennial Economic Census. 2009 was the most recent year reported for the state of provider and resident data. As explained in the following, NHEA may differ from Vermont state data:

Different sources: CMS NHEA builds their cost estimates of Vermont residents by using provider-based data and then adjusting for state border-crossing patterns (migration). Those adjustments are based on unique data sets that include Medicare claims data, private hospital discharge information, and physician claims records. This method of building the resident costs is less specific than the GMCB methodology. For example, GMCB gets Vermont resident spending data directly from private insurers, Medicare and Medicaid data. Payments made to out-of-state providers on behalf of Vermonters are included in that spending information. This is a level of detail that CMS does not have.

Definitional issues: GMCB and CMS define certain health care expenditures and categories differently. In comparison to the CMS national estimates, **when doing state estimates,** CMS does not include the categories of administration, net cost of private health insurance, certain government health activities spending and investments (research, structures, and equipment). Another difference is in the hospital category; CMS includes hospital non-operating revenue in its estimates while GMCB does not. The Health Consumption Expenditures (HCE) are a subset of the NHE and has the array of categories of service most comparable to Vermont.

Population counts: There are also differences in estimating population: GMCB uses population estimates as calculated by the Vermont Department of Health (VDH) and the Vermont Household Health Insurance Survey; CMS uses U.S. Census data for Vermont. This difference is relatively minor, but can alter actual per capita values.

Other provider spending categories: Because CMS builds their resident estimates from their provider estimates, understanding how CMS estimates provider spending is important to help value per capita differences.

Appendix

Sources of Research and data

a. CMS-National Health Expenditure Data (NHE) Projected and Historical--
   Comparisons to the US government and for inflation factors for the Provider Analysis https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html
b. US Economic Census-provider statistics (VT Census) http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
   Provider Analysis categories of service not directly received from the provider
   Providers' number of establishments and revenue receipts
c. Kaiser Family Foundation-Provider Analysis -Prescription Drug statistics for VT, other healthcare cost research http://kff.org/statedata/
d. US Bureau of Economic Analysis-Resident Analysis-Gross State Product (GSP), or Gross Regional Product (GRP), is a measurement of the economic output of a state. The sum of all value added by industries within the state and serves as a counterpart to the Gross Domestic Product (GDP). Also, the source for personal income statistics in VT and the U.S. http://www.bea.gov/iTable/iTable.cfm?reqid=70&step=1&isuri=1&acrdn=1#reqid=70&step=1&isuri=1&7003=200&7004=naics&7005=-1&7006=50000&7001=1200&7002=1&7090=70&7093=levels
e. VT Dept. of Labor- Provider Analysis - provider employment information http://www.vtlmi.info/occupation.cfm
f. US Dept. of Labor, Bureau of Labor Statistics _Resident and Provider Analysis http://stats.bls.gov/oes/current/oes_nat.htm
g. VT Dept. of Health- Provider Analysis http://healthvermont.gov/research/index.aspx
   provider surveys,
   uniform hospital discharge dataset-used to research **in and out migration**
   population counts
h. VT Household Health Insurance Survey http://hcr.vermont.gov/survey-Resident Analysis

Aids in enrollment calculations
Aids in out of pocket calculations

i. Health Affairs-articles http://www.healthaffairs.org/
j. VT Primary Care Workforce http://www.med.uvm.edu/ahec
k. VHCURES-Resident Analysis-Payers - data comparison of enrollment and claims http://gmcboard.vermont.gov/hit/vhcures

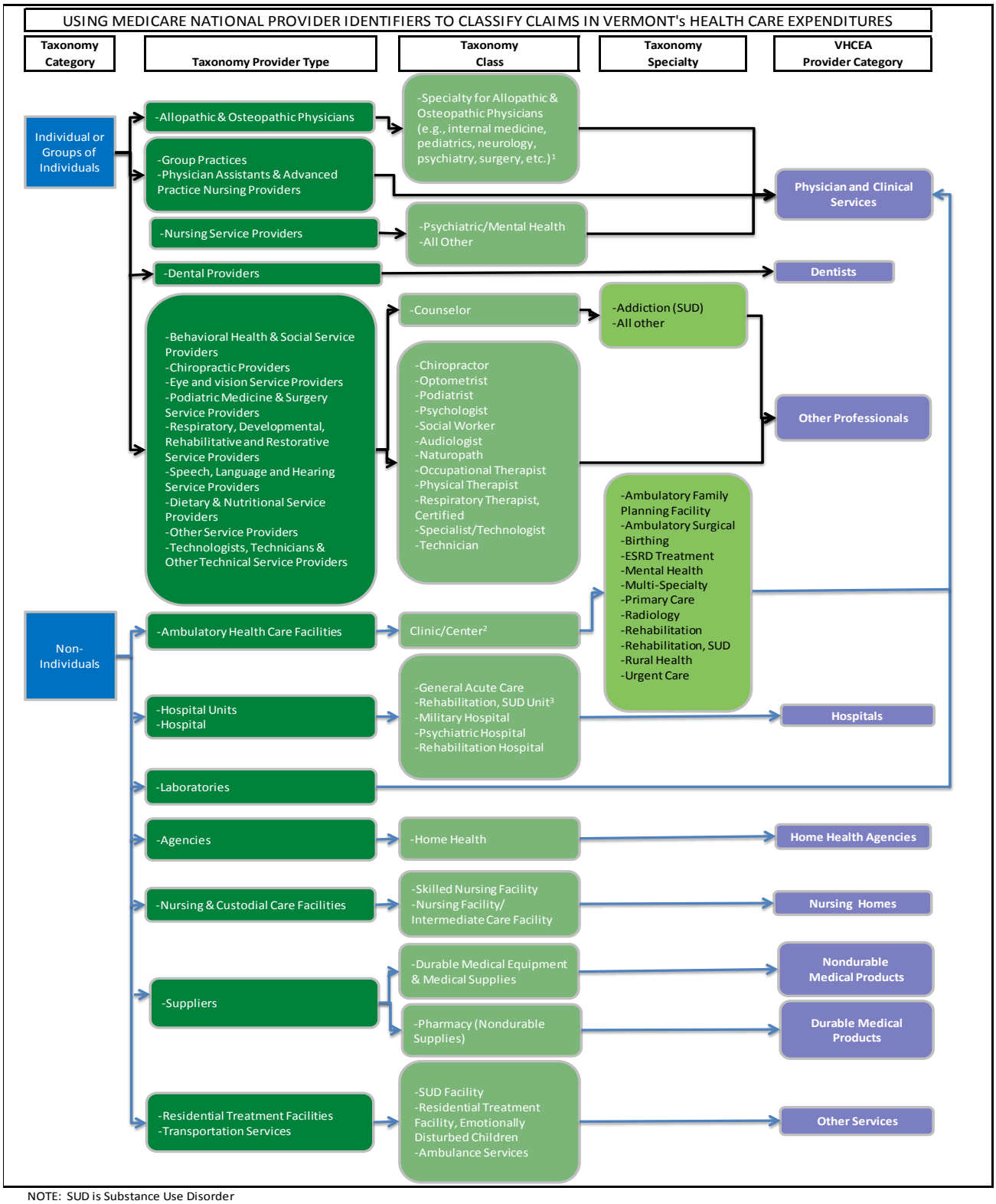
Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) data is used to supplement reporting needs for the VHCEA and compared to what the payers reported aggregately from their individual financial systems for reasonableness and trends.

For the Vermont Health Care Expenditure Accounts (VHCEA), Truven Health Analytics classified claims into provider types using the National Provider Identifier (NPI). **Changes to provider service categories are under review for possible future changes.**

Chart 9 below refers to the Taxonomy Category, Provider Type, Class and Specialty that is present on each claim in VHCURES. The schematic shows how each claim is translated from the Taxonomy Codes into the VHCEA provider categories. It also shows the level of detail that is available for each provider type. For cases where the taxonomy codes are not present or are invalid, BILL_TYPE, CLAIM_TYPE, or SERVICE_SITE was used to identify the provider.

..\..\..\HCA-Special\HOME\ReformBoard\Truven\Katie\Documentation\VHCEA Classification Scheme Using NPI FINAL drop last tab.xls

Chart 9



NOTE: SUD is Substance Use Disorder

Frequently Asked Questions

18 V.S.A. § 9375a Chapter 220, subchapter 001see appendix

What is the genesis of the Vermont Health Care Expenditure Analysis?

The *Vermont Health Care Expenditure Analysis* (VHCEA) is an annual publication that began with a report for 1990 and 1991. It provides a description of the dollars that were spent on health care on behalf of Vermonters as outlined in 18 V.S.A. § 9375a Chapter 220, subchapter 001. The law requires spending to be analyzed from two different perspectives.

What is the difference between the resident analysis and the provider analysis?

The **Resident** analysis reports what payers spend on Vermont Residents for health care services within Vermont and out-of-state (OOS). The **Provider** analysis reports net revenues received by Vermont Providers for services delivered in Vermont which includes non-Vermonters. Both these analytical constructs are necessary to manage and understand health care spending.

Who produces the VHCEA?

The Green Mountain Care Board (GMCB) creates the report to comply with Vermont law; statute reference 18 V.S.A. § 9375a Chapter 220, subchapter 001.

When is the VHCEA published?

The report is currently published annually. A draft is typically available in mid-January and a final version is published in February.

Where does the data come from?

The data collected by GMCB for analysis in the report comes from numerous sources that include the various payers and providers that pay for or provide health care services in Vermont. For example, payers include Medicare, Medicaid, Blue Cross/Blue Shield, self-insured, etc. and providers include hospitals, physicians, nursing homes, government programs, etc. Complete documentation is available in the Expenditure Analysis manual.

Why is 2014 data being published in 2016?

There is a data lag because of the natural operation delays from the sources that provide the data. Annual reports, audits, and different reporting cycles all effect this timing.

Is the data fiscal year or calendar year?

The data is a combination of state and federal fiscal years and calendar years.

The government payers typically report on either a state (period ending 6/30) or federal fiscal year (period ending 9/30). The private payers typically report data based on a calendar year. Providers report data on state, federal, and calendar fiscal years. The VHCEA report does not typically adjust for the non-calendar year data as sources and fiscal years have changed over the years.

How accurate is the data?

GMCB relies on the integrity of the information collected directly from the payers and providers. In cases where limited data are available, estimates are used. The quality of the data is constantly tested to improve the quality. Each Resident and Provider VHCEA matrix describes whether data is reported or estimated.

Who uses the VHCEA?

GMCB uses the data:

1) to evaluate health insurance rate and trend filings, and
2) uses it for consideration with hospital budgets and the certificate of need process,
3) To give context to Vermont's health care expenditures in relation to individual categories or national data, evaluate industry trends, etc, for payers, providers, legislators, and other interested parties.

Vermont Statute: 18 V.S.A. § 9375a Chapter 220, subchapter 001

Annually, the board shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in sections 9371 and 9372 of this title.

(1) The budget shall:

(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.

(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont and for all health care services provided to residents of this state.

(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.

(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

(2) The board shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title

concerning matters related to the unified health carebudget.

(b)(1) Annually the board shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the board under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:

(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organization, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and

(B) expenditures for Medicare, all self-insured employers, and all other health insurance.

(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the board's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year and an evaluation of the efficacy of any cost containment efforts the plan hasmade.

(3) The board's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department of financial regulation, and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.

(4) The board shall prepare a report of the final projections made under this subsection and file the report with the general assembly on or before January 15 of each year. (Added 2011, No. 171 (Adj. Sess.), § 11, eff. May 16, 2012.)