FY 2020 HOSPITAL BUDGET GUIDANCE AND REPORTING REQUIREMENTS

Effective March 31, 2019

Prepared by:

GREEN MOUNTAIN CARE BOARD
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Reporting Timeline*

MARCH 13, 2019	GMCB provides hospitals with templates for providing information on quality improvement initiatives, access to care, and community health needs
MARCH 31, 2019	GMCB provides hospitals with annual budget guidance, including questions from the Office of the Health Care Advocate (HCA)
APRIL 30, 2019	Deadline for hospital submissions of information on quality improvement initiatives, access to care, and community health needs
APRIL/MAY 2019	GMCB provides Charge Schedule and Cost Shift Analysis to the hospitals
JULY 1, 2019	Hospitals submit budgets to GMCB, including answers to questions provided by the HCA in Appendix X
JULY-AUGUST 2019	GMCB staff review and analysis
JULY 24, 2019	GMCB staff provides preliminary budget overview at public board meeting
JULY 31, 2019	GMCB staff provides analysis/questions to the hospitals
AUGUST 9, 2019	Hospital responses to staff analysis/questions due
WEEKS OF AUG. 19 & 26	Hospital budget hearings (TENTATIVE)
WEEKS OF SEPT. 4 & 11	Board votes to establish each hospital's budget at public board meetings
SEPTEMBER 13, 2019	Board issues budget decisions
SEPTEMBER 30, 2019	Budget Orders (due by October 1) sent to hospitals

*In accordance with statute, the Office of the Health Care Advocate (HCA), representing the interests of Vermont health care consumers, receives hospital budget materials and other pertinent information and participates in the budget process and hearings.

REPORTING REQUIREMENTS

Introduction

For FY 2020, the Green Mountain Care Board will collect information on quality improvement initiatives, access to care, and community health needs in advance of the annual budget submission instead of at the same time (as was the case in most recent years). This change streamlines the budget submission to focus mainly on financial matters, while ensuring that the Board has the necessary quality, access, and community needs information available to inform the hospital's budget review. The Board also has substantial information about each hospital's participation in delivery system reform through the accountable care organization budget process and will use that information in the review to determine how and to what extent a hospital is committed to health care reform. In addition, enhanced financial reporting is required this year due to challenges facing community hospitals; bifurcating the reporting will assist hospitals in meeting these reporting requirements.

New Accounts and Definitions

The following accounts for reporting information related to the Accountable Care Organization (ACO) were created for FY 2019, and will continue for FY 2020:

- Fixed Prospective Payments (FPP) – fixed payments from the ACO that cover the cost of medical care provided to lives attributed to the ACO, net of value-based incentive program deductions. Participation fees are recorded in Operating Expenses.
- Other Reform Payments – payments related to payment reform initiatives managed through the ACO, which may or may not be related to the All-Payer Model (APM), including payments from the ACO's value-based incentive program based on quality performance.
- Reserves (risk portion) – any reserves or adjustments to reserves booked in the hospital's Income (Profit and Loss) or Balance Sheet statements related to participation in two-sided risk programs.

The following accounts will be added for FY 2020:

- Restricted Funded Depreciation,
- Unrestricted Funded Depreciation,
- Restricted Other Board Designated Assets, and
- Unrestricted Other Board Designated Assets.

Presentation Instructions

Presentations shall be standardized and include the following information in the order shown:

1. Introduction/Overview (not to exceed 5 minutes);

2. Summary of requests related to Net Patient Revenue/Fixed Prospective Payments (total dollars and growth rate) and Charges (growth rate; including for Commercial Charges);
3. Hospital issues;
4. Areas of risk/opportunity;
5. Financial health of the hospital using key metrics (see Appendix IV for list of Financial Health Indicators);
6. Financials to include:
    A. Profit and Loss, Cash Flow, Balance Sheet;
    B. Expense drivers and cost containment efforts (three to four specific high-level categories);
    C. An updated reconciliation between FY 2019 approved budget and FY 2019 full-year projection;
7. Other clarifying information to tell the hospital's financial story;
8. Capital budget plans – include both non-CON and CON capital plans (include routine replacement of nonmedical equipment and fixtures and information on performance of approved CONs, including capital budget performance);
9. Long range financial outlook (four to five years), including indication of how financial goals align with APM targets; and
10. Review of historical compliance with budget orders.

Narrative Instructions

The budget narrative, a key component of the budget submission, provides the hospitals an opportunity to explain any changes in their budgets and highlight areas of interest for the GMCB. We ask hospitals **to answer each question succinctly, and to strictly follow the format below** by responding in sequence to each of the listed sections.

1. *Executive Summary*. Summarize the changes in the hospital budget submission. Include any information the GMCB should know about programmatic, staffing, and operational changes.

2. *Payment and Delivery Reform*. Describe how the hospital is preparing for and investing in value-based payment and delivery reform and implementation of the All-Payer Model for FY 2019 and over the next five years. Include answers to the following questions:
    A. Has the hospital signed a contract with OneCare Vermont? If yes, use the table in Appendix V to indicate which payer programs the hospital is participating in during 2020, the budgeted monthly average number of lives to be attributed to the hospital for each program, and the budgeted monthly average amount of FPP. If no, explain (and skip B. and C., below).
    B. What is the maximum upside and downside risk the hospital has assumed?
        i. How is the risk (up-and downside) accounted for in the financials? How will the hospital manage financial risk while maintaining access to high quality care and appropriate levels of utilization?
        ii. How will the hospital track and ensure that provider financial incentives do not have a negative impact on patient care?

C. What amount of Other Reform Payments does the hospital expect to receive from OneCare Vermont by the end of calendar year 2020 (*e.g.*, payments from OneCare's Value-Based Incentive Program based on quality performance)?
D. Are the hospital's employees attributed to OneCare, either through participation in a OneCare self-insured program or, if fully-insured, through the hospital's insurer? If not, why not?
E. How is the hospital changing the allocation of resources in its budget to improve population health, under the All-Payer ACO Model and/or other initiatives?

3. *Reconciliation*. Provide a summary income statement that shows a reconciliation between FY 2019 approved budget and FY 2019 full-year projection, showing both positive and negative variances. Explain the variances.

4. *Budget-to-budget growth.*
A. Net Patient Revenue and Fixed Prospective Payments (NPR/FPP):
i. Explain the budgeted FY 2020 NPR/FPP increase over the approved FY 2019 budget and over the FY 2019 full-year projection. If the GMCB rebased the hospital's budget for the purpose of calculating FY 2020, provide the budgeted increase in NPR/ FPP for FY 2020 measured from the hospital's rebased budget.
ii. Describe any significant changes made to the FY 2019 budget (including, but not limited to, changes in anticipated reimbursements, physician acquisitions and certificates of need) and how they affect the FY 2020 proposed budget.
iii. Describe any cost saving initiatives proposed in FY 2020 and their effect on the budget.
iv. Explain changes in NPR/FPP expected for each payer source:
a. Medicare revenue assumptions: Identify and describe 1) any significant changes to prior year Medicare reimbursement adjustments (*e.g*. settlement adjustments, reclassifications) and their effect on revenues; 2) any major changes that occurred during FY 2019 that were not included in the FY 2019 budget, and 3) any anticipated revenues related to meaningful use and 340B funds in FY 2020.
b. Medicaid revenue assumptions: Budget for NPR/FPP expected from rate changes, utilization, and/or changes in services.
c. Commercial/self-pay/other revenue assumptions: Commercial insurance revenue estimates should include the latest assumptions available to the hospital and any other factors that may explain the change in NPR/FPP.
v. Complete Appendix VI, Table 1. If the hospital categorizes revenue differently than as indicated in the table, provide such categories, including labels and amounts, in the "Other" rows.
B. Expenses:
i. Explain changes in budgeted FY 2020 expenses over the approved FY 2019 budget net expenditure increase and the FY 2019 full-year projection. If the

GMCB rebased the hospital's budget for the purpose of calculating FY 2020, provide the budgeted changes in expenses for FY 2020 measured from the hospital's rebased budget.

ii. Describe any significant changes made to the FY 2019 budget (including, but not limited to, changes in costs of labor, supplies, utilization, capital projects) and how they affect the FY 2020 proposed budget. Provide assumptions about inflation and major program increases.

iii. Describe any cost saving initiatives proposed in FY 2020 and their effect on the budget.

iv. Complete Appendix VI, Table 2. If the hospital categorizes expenses differently than as indicated in the tables, provide such categories, including labels and amounts, in the "Other" rows.

5. *Bad Debt*.
   A. Provide the amount of bad debt carried by the hospital at the close of FY 2017 and FY 2018, using the table in Appendix VII.
   B. If the hospital contracts with a collection agency, provide the name of the agency.
   C. In your opinion, explain whether the agency adheres to "patient friendly billing" guidelines. *See* http://www.hfma.org/Content.aspx?id=1033

6. *Operating Margin and Total Margin.* Explain the hospital's Operating Margin and Total Margin in the FY 2020 proposed budget, including budgeted FY 2020 Operating Margin and Total Margin changes over the approved FY 2019 budget and the FY 2019 full-year projection.

7. *Charge Request.*
   A. Provide the hospital's budgeted overall charge increase or decrease and describe how the increase or decrease was calculated by payer type, including the calculation of the impact of the change in charge on gross revenue and net patient revenue. Explain how the charge was derived and what assumptions were used in determining the increase or decrease. Complete the table in Appendix VIII.
   B. For each payer, if the NPR/FPP budget-to-budget increase or decrease is different than the overall change in charge—for example, if the requested commercial "ask" differs from the change in overall charge—explain why they differ.
   C. In April/May, the GMCB will provide a Charge Schedule for reporting the change in charges for each major line of business and the gross and net revenues expected from each payer as a result of the change in charges.
   D. In April/May, the GMCB will provide each hospital with a hospital-specific Cost Shift Analysis. Explain how the hospital addressed the cost shift in FY 2018, especially given the hospital's payer mix.

8. *FY 2018 variances*. For those hospitals that received a letter regarding their FY 2018 budget-to-actual variance, specifically address the issues and requirements outlined in the letter.

9. *Capital budget investments*. Describe the major investments, including projects subject to certificate of need review, that have been budgeted for FY 2020 and their effect on the FY 2020 operating budget. In addition, describe investments in routine repairs and replacements.

10. *Technical concerns*. Explain any technical concerns or reporting issues the GMCB should examine for possible changes in the future.

Salary Information

1. Submit a full copy of the hospital's most recent Form 990 (for Actual 2017 or 2018), including the most current version of Schedule H (most likely filed in 2018) that has been submitted to the Internal Revenue Service as part of the hospital organization's Form 990 reporting obligations under Section 501(c)(3) of the Internal Revenue Code. Provide a single copy of these documents.

2. Complete the Table in Appendix IX. If staff in hospital-owned provider practices are included on a separate Form 990, include salaries for those positions in the table.

3. Submit the hospital's policy or policies on executive, provider, and non-medical staff compensation.

4. Identify:
   i. Outside consultants relied on for benchmarking;
   ii. Peer groups to which the hospital benchmarks;
   iii. Compensation targets in terms of percentiles for each staff category; and
   iv. The hospital's actual compensation level, compared to target, for each employee group (*e.g*. executive, provider, non-medical staff)

Organizational Structure

Provide the hospital's organizational chart including parent companies, subsidiaries, affiliated entities, etc. Describe all entities related financially to the hospital, the purpose of each entity, and the financial relationships between the entities (e.g., parent organization, subsidiary organization, membership organization, etc.). Identify any entities that the hospital or its parent organization owns in part or in full, identify any entities that own the hospital in part or in full, and indicate whether any members of the hospital's senior management team are paid by hospital-related entities other than the hospital. Identify and describe areas of financial risk associated with these organizational relationships.

Questions from the Office of the Health Care Advocate

Provide responses to the attached questions from the Office of the Health Care Advocate (Appendix X) in a separate document. If the responses have been provided elsewhere in the budget submission, indicate where.

Questions regarding the All-Payer TCOC Tables

Provide responses to the attached questions regarding the All-Payer TCOC tables (Appendix XI) in a separate document.

User Access to Adaptive Insights

Budget information should be provided through the Adaptive Insights (Adaptive) website. A maximum of three individuals (users) from each hospital are allowed to access Adaptive. To add or remove users, please use the following form found in the reports directory in Adaptive:

Reports>Shared Reports>FY 2020 BUDGET>HOSPITAL DIRECTORY>Hospital Budget Instructions >User Access Request Form for Adaptive Insights

Budget Schedules and Input Instructions

Instructions on how to input the budget into Adaptive can be found by logging into the website and going to:

Reports>Shared Reports>FY 2020 BUDGET>HOSPITAL DIRECTORY>Hospital Budget Instructions

The directory includes the following:

- FY 2020 Hospital Budget Submission Reporting Requirements (this document)
- GMCB-Import Guide
- GMCB-Reports Guide
- Oath Appendix II (also found in this document)

The following documents (Documents 1 through 3) are the most helpful for input of the budget:

1. GMCB Hospital Budget Checklist (a quick list for input of each sheet; also found in User Guide);
2. GMCB User Guide (a complete step-by-step guide to using Adaptive Insights software); and
3. GMCB Uniform Reporting Manual.

There are several reports that can be run (*e.g.* income statement, balance sheet, edits report) to review the input. These reports are in the following directory:

Reports>Shared Reports>FY 2020 BUDGET>HOSPITAL DIRECTORY>HOSPITAL REPORT PACKAGE

BUDGET GUIDELINES

Net Patient Revenue and Fixed Prospective Payments FY 2020

At its March 27, 2019 public meeting, the GMCB established a maximum growth target of 3.5% for individual hospitals' Net Patient Revenue and Fixed Prospective Payments (NPR/FPP) for FY 2020 (over FY 2019 budgeted). Should hospital budgets appear to be trending in 2019 and 2020 in alignment with the overall All-Payer Model target, the GMCB also established a tentative maximum NPR/FPP growth target of 3.5% for FY 2021 (over FY 2020 budgeted). Each hospital is required to submit an annual budget for each of the two fiscal years, by July 1 of the preceding year. In addition to considering the FY 2020 growth target, the GMCB will consider, and each hospital should carefully consider, the hospital's specific financial circumstances, including its Actual FY 2018 NPR/FPP and Expenses and its Year-to-Date and Projected FY 2019 NPR/FPP and Expenses; its historical ability to manage to its budget; its community needs; its operational investments for successful participation in the ACO program; and other relevant circumstances.

For hospitals with Actual FY 2018 and Projected FY 2019 NPR/FPP that is at least 2% below budgeted NPR/FPP, the GMCB expects NPR/FPP and Expenses in the FY 2020 budget submission to align with the hospital's Actual FY 2018 and Projected FY 2019 results. For these hospitals, the GMCB would not expect to see NPR/FPP more than 5% greater than Projected FY 2019 NPR/FPP unless there is a clear explanation and documentation describing why a larger increase in NPR/FPP is justified. For hospitals with Projected FY 2019 NPR/FPP that is greater than budgeted, the GMCB would not expect to see FY 2020 NPR/FPP greater than X% unless clearly justified.

The GMCB is not providing a health care reform investment allowance with a lower growth target in this guidance, because all but two small hospitals have joined the accountable care organization model. It is the Board's view that fixed prospective payments provide sufficient incentive for hospitals to focus on the operational changes necessary to meet the growth targets set forth in the Vermont All-Payer Accountable Care Organization Model Agreement with the Centers for Medicare and Medicaid Services, and that continuing a health care reform investment allowance is not needed at this time. The Board, however, reserves the right to modify the growth target in FY 2021 should these circumstances change.

The GMCB will also review proposed changes in hospital charges, including changes in charges for commercial payers. GMCB's hospital budget review process will include alignment with the transition of hospital revenues from fee-for-service to value-based payments, in support of the Vermont All-Payer Accountable Care Organization Model, financial sustainability of Vermont's hospital system, and affordable health care for Vermonters.

By setting hospital revenue targets and monitoring other financial health indicators (see Appendix IV), the Board can better track total system costs, identify areas of potential excess growth and priorities for data analysis, and utilize the information gathered to inform its review of health insurer rate increases. Through its ongoing oversight of hospital budgets in a transparent, public process, the Board believes that Vermont hospitals will be able to maintain their financial health so they can continue to provide needed, quality services to their communities.

Effective March 31, 2019

Budget Performance (previously Enforcement) for FY 2020 Hospital Budget Submissions

Background and Justification

Vermont law requires that the Green Mountain Care Board establish the budgets of Vermont's hospitals, and mandates that "[e]ach hospital . . . operate within the budget established." 18 V.S.A. §§ 9375(b)(7); 9456(d). The GMCB promulgated Rule 3.000 which outlines the review process and parameters that the GMCB will use to assess budget performance and adjustments. *See* GMCB Rule 3.000, § 3.401. In addition, the GMCB's annual Uniform Reporting Manual Supplement outlines a methodology to compare actual budget results for the fiscal year to what had been previously budgeted by the hospital and approved by the Board.

In adopting performance guidelines for FY 2014-2016, the GMCB found that Vermont hospitals' aggregate budget-to-actual performance had improved since the early 2000s, but that many hospitals nonetheless continued to exceed net revenue thresholds. Some of these budget-to-actual differences resulted from one-time events such as physician practice acquisitions, or from prior year Medicare settlements. Some hospitals, however, experienced greater reimbursement than had been forecasted. In such instances, prior to the GMCB's adoption of an enforcement policy in 2013, no meaningful regulatory action was taken.

The GMCB extended its FY 2014-2016 enforcement policy through FY 2019 because its enforcement mechanisms allowed it to initiate corrective action when a hospital's actual revenue diverged significantly from its budgeted revenue. In addition, the criteria in the policy proved transparent, understandable, and readily administrable.

For FY 2020:

1) Net Patient Revenue and Fixed Prospective Payments (NPR/FPP) amounts as ordered will be enforced.
2) The GMCB may review hospitals whose year-end NPR/FPPs exceed the NPR/FPP requirement by 1.0% above or below their approved NPR/FPP. This review will not necessarily lead to action by the GMCB.
3) Budget reviews will compare each outlier to results of the total system.
4) Reporting requirements for the review will be determined by the GMCB.

5) The GMCB will afford the hospital an opportunity for a hearing and will require a hearing if it deems one necessary.
6) If the GMCB determines that a hospital's performance has differed substantially from its budget, the GMCB may take actions including, but not limited to:
    a) Reduce or increase the hospital's rates;
    b) Reduce or increase net revenue and/or expenditure levels in the hospital's budget;
    c) Use its finding as a consideration to adjust the hospital's budget in one or more subsequent years;
    d) Allow a hospital to retain a percentage or all of the surplus funds; and
    e) Any other actions the Board deems appropriate.

See GMCB Rule 3.000, § 3.401(c).

In addition, consistent with the overarching goal to restrain health care spending, the Board may issue further guidelines, after consultation with stakeholders and discussion in a public meeting, to help provide the hospitals with clear expectations concerning application of the Board's enforcement mechanisms.

Effective March 31, 2019

Provider Transfers and Acquisitions

Introduction

Act 143 of 2016 outlined specific criteria that must be included in the GMCB's policy on physician transfers and acquisitions.[1] This document contains reporting guidelines for hospitals inclusive of those criteria and supersedes previous policy documents approved by the GMCB on this subject.

Background

The GMCB is charged with improving the health of Vermonters while controlling and managing costs in the state's health care system. Through the hospital budget review process, the GMCB can measure and track increases in health care spending for a segment of the system by focusing on the year-to-year growth of Net Patient Revenue and Fixed Prospective Payments (NPR/FPP). An underlying principle for this review is to limit growth to a pace comparable to the overall Vermont economy and/or to the total cost of care growth rate in the Vermont All-Payer ACO Model Agreement with the Centers for Medicare and Medicaid Services.

[1] Act 143 refers to both "physicians" and "health care providers." We construe the law to include practices that may employ non-physicians, such as, for example, advanced practice registered nurses or physician assistants, and therefore use the terms "provider" or "health care provider" throughout the policy. In addition, the Act's criteria appear only applicable to transfers *into* a hospital, rather than out, and this policy similarly does not expressly address provider departures. Because an outgoing transfer may substantially impact a hospital's budget, however, the hospital should notify the GMCB when such transfers are pending to determine the need for any additional reporting requirements.

When independent providers move from outside of the hospital system to within, the dollars associated with the provider practice also shift to the hospital. Though these are not "new" dollars in the overall health care system, they can have a substantial impact on the acquiring hospital's budget and NPR/FPP and must be appropriately accounted for in the GMCB's review process.

Accordingly, the GMCB needs a consistent method of examining hospital provider acquisitions and transfers to understand the net effect of these transactions on the growth in spending of the entire system and the impact on the NPR/FPP and overall budget.

Guidelines

The Board initially established this policy to better understand and recognize the effect on hospital budgets of provider transfers and acquisitions that occur during the course of the current fiscal year. Consistent with Act 143 of 2016, application of this policy is restricted to transfers and acquisitions of existing practices and does not apply to the expansion of a hospital's provider service line as a result of ongoing recruitment.

The GMCB clarifies this policy for FY 2020.

To appropriately document the budget effect of new provider affiliations, the hospital shall file as follows:

- Any new affiliation shall require filing of reporting documents as discussed below, to document the acquisition or transfer.
- Such documents shall be filed with the GMCB 30 days prior to formal establishment of the acquisition or transfer.
- No filings will be recognized by the GMCB for establishing a new budget base after May 1.
- The GMCB may issue an updated Budget Order within 30 days of its acceptance of an acquiring hospital's filing.
- Following issuance of an updated Budget Order, the acquiring hospital shall file its updated budget information through the Adaptive reporting tool, as directed by GMCB staff.
- Transfers occurring after May 1 shall be reported in the July 1 budget submission for the coming year. Reporting documents must be filed in addition to the budget submission.

Note that the GMCB is not imposing a requirement that each transfer be approved by the GMCB separate from or in addition to the hospital budget review process.

Confidentiality

The GMCB recognizes that pending transfers and acquisitions of provider practices generally cannot be made public during the negotiation stage. Disclosing details of a transaction before they are agreed upon could hamper the parties' ability to negotiate and could place the parties at a competitive disadvantage with respect to non-party hospitals or other providers. Vermont's Public Records Act specifically exempts from public disclosure "business records or information

. . . which gives its user or owner an opportunity to obtain business advantage over competitors who do not know it or use it," 1 V.S.A. § 317(c)(9), and records related to contract negotiations, 1 V.S.A. § 317(c)(15). Accordingly, hospitals may request that the GMCB keep provider transfer information confidential and, assuming it meets either or both statutory exemptions, the GMCB will treat the information as confidential.

Reporting Requirements and Documentation

1. Notice to patients

Act 143 requires a hospital to provide written notice about a new acquisition or transfer of health care provider(s) to each patient served by the health care provider(s). The notice shall:

- Notify the patient that the provider is now affiliated with the hospital;
- Provide the hospital's name and contact information;
- Notify the patient that the change in affiliation may affect the patient's out-of-pocket costs, depending on his or her health insurance plan and the services provided; and
- Recommend that the patient contact his or her insurance company with specific questions or to determine actual financial liability.

The hospital shall include one copy of the written notice, not including patient name, with the reporting documents outlined below.

2. Reporting documents

The GMCB requires hospitals to file Schedule A (available in Excel format at https://gmcboard.vermont.gov/content/2020-Budget) at least 30 days prior to the effective date of an acquisition or transfer occurring no later than May 1. Both a full annualized effect and a partial year effect must be completed for these "off-cycle" transfers. Acquisitions and transfers occurring after May 1 must be reported with the annual budget submission in accordance with the instructions outlined below.

In addition to the information requested here, a hospital may file any other information it deems appropriate to further describe the budget effect of the provider transfer. The GMCB may also request additional information to assist it in its review.

1) Off-cycle budget change (transfers occurring after budget approval but no later than May
    a. Budget Schedule A will be required to provide financial information about why the transaction is budget-neutral and the effect on the current year and next projected budget.
    b. A narrative must be submitted with the Schedule to describe the provider transfer and any related budgetary issues.
2) Annual Budget Submission
    a. Budget Schedule A will be required to provide financial information about why the transaction is budget neutral.
    b. Provider practice budget detail will be reported as described in the GMCB User's Guide for Adaptive Insights.
    c. The narrative will include a brief description of the transfer as outlined in this document.

APPENDIX I

CHANGES TO APPROVED BUDGET

A hospital requesting a modification to its approved budget before the end of that fiscal year must do the following:

a. Obtain approval of the change from its Board of Directors.
b. Submit a letter of intent regarding a revised budget. The submission should be delivered to the GMCB no less than 30 days prior to the date the budget adjustment or rate change will be effective.
c. Provide contact information for the available staff member with knowledge of the budget to answer questions.
d. Provide an updated full-year financial projection for FY 2020 (i.e., an updated Profit and Loss Statement comparing FY 2020 Projections to FY 2019 Year-End Actuals and to the approved FY 2020 Budget). Include the impact of the proposed changes, as well as any other changes that the hospital is anticipating.
e. Provide information on the impact of the proposed increase in charge on gross revenue as well as net patient revenue, describe the assumptions (e.g., contractual allowances by payer) that you are making to support the estimated impact on net patient revenue, and indicate why those assumptions are believed to be warranted and the level of certainty associated with each of them.

The Board's hospital budget staff will review the request within 15 days after the receipt of the complete "modified" budget information and will make its recommendations and forward them to the GMCB. A final decision will be provided within 14 days of the GMCB's receipt of the recommendations.

Note: The GMCB will not act upon any interim rate changes with effective dates after May 1.

APPENDIX II

VERIFICATION UNDER OATH FORM
TO BE COMPLETED BY HOSPITAL'S CEO and CFO

STATE OF VERMONT
Green Mountain Care Board

In re: FY 2020 Hospital Budget Submission [Hospital Name]

Exhibit A – Form of Verification Under Oath

[Officer or other deponent], being duly sworn, states on oath as follows:

1. My name is [name]. I am [title]. I have reviewed the [identify information/document subject to verification].

2. Based on my personal knowledge, after diligent inquiry, the information contained in [identify information/document subject to verification] is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading, except as specifically noted herein.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the [identify information/document subject to verification] is based upon either my actual knowledge of the subject information or, where identified below, upon information reasonably believed by me to be reliable and provided to me by the individuals identified below who have certified that the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading.

4. I have evaluated, within the 12 months preceding the date of this affidavit, the policies and procedures by which information has been provided by the certifying individuals identified below, and I have determined that such policies and procedures are effective in ensuring that all information submitted or used by [the hospital] in connection with the Hospital Budget program of the Green Mountain Care Board (GMCB) is true, accurate, and complete. I have disclosed to the [governing board of the hospital] all significant deficiencies, of which I have personal knowledge after diligent inquiry, in such policies and procedures, and I have disclosed to the [governing board of the hospital] any misrepresentation of facts, whether or not material, that involves management or any other employee participating in providing information submitted or used by [the hospital] in connection with the GMCB Hospital Budget program.

5. The following certifying individuals have provided information or documents to me in connection with [identify information/document subject to verification], and each such individual has certified, based on his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the certifying individual to be reliable, that the information or documents they have provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact necessary to make the statement made therein not misleading:

    (a) [identify each certifying individual providing information or documents pursuant to Paragraphs 3 and 4, above;
    (b) identify with specificity the information or documents provided by the certifying individual;
    (c) identify the subject information of which the certifying individual has actual knowledge, and identify the individuals and the information reasonably relied on by the certifying individual; and
    (d) in the case of documents identify the custodian of the documents]

6. In the event that the information contained in the [identify information/document subject to verification] becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify GMCB and to supplement the [identify information/document subject to verification], as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

_____

[Signature of the deponent]

On [date], [name of deponent] appeared before me and swore to the truth, accuracy and completeness of the foregoing.

_____

Notary public
My commission expires [date]
[seal]

APPENDIX II-1

VERIFICATION ON OATH OR AFFIRMATION
TO BE COMPLETED BY HOSPITAL'S BOARD CHAIR

STATE OF VERMONT
Green Mountain Care Board

In re: FY 2020 Budget Submission of [Hospital Name]

Exhibit B – Board Chair's Verification on Oath or Affirmation

I, [Name], make the following declarations based on my personal knowledge:

1. I am the Chair of the Board of Directors of [Hospital Name] ("Hospital"). I am a resident of [State], am over 18 years old, and am competent to testify to the information contained in this document.

2. I have reviewed the proposed FY 2020 budget and supporting materials to be submitted by Hospital to the Green Mountain Care Board ("Budget Submission").

3. On _____, 2019, the Budget Submission was presented by the Hospital's [Chief Executive Officer AND/OR Chief Financial Officer] to the [Finance] Committee of Hospital's Board of Directors and was reviewed and approved by that Committee on [the same date OR _____, 2019].

4. On _____, 2019, the Budget Submission was presented by the Hospital's [Chief Executive Officer AND/OR Chief Financial Officer] to the Board of Directors and was reviewed and approved by the Board of Directors on [the same date OR _____, 2019].

5. I have in good faith relied upon representations by one or more officers or employees of the Hospital who are reliable and competent on this subject matter as permitted under 11B V.S.A. § 8.30(b) that the information contained in the Budget Submission is true, accurate, and complete and does not omit material facts necessary to provide a full and complete understanding of the Hospital's financial standing. I do not have knowledge of or have a substantial reason to believe information that would make reliance on these representations unwarranted.

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/ / /

6. I acknowledge the Hospital's obligations to promptly notify the Green Mountain Care Board and supplement the Budget Submission in the event the information contained in the Budget Submission becomes untrue, inaccurate or incomplete in any material respect.

I swear or affirm that the forgoing declarations are true and correct under penalty of perjury pursuant to 18 V.S.A. § 9456(h)(3).

_____ Dated: _____

[Name]
Chair of Board of Directors of [Hospital]

To be completed by Notary Public

State of Vermont, County of _____

Signed and sworn (or affirmed) before me on _____ by _____

Date _____

Name of individual making statement: _____

Signature of notary public _____

Stamp

Title of office _____ [My commission expires: _____]

Note: For FY 2020 there will be no exemptions.

APPENDIX III

EXEMPTION FROM PUBLIC HOSPITAL BUDGET HEARING

Green Mountain Care Board Rule 3.000 allows the Board to exempt up to four hospitals from annual public budget hearings, and from budget adjustment, provided they meet established benchmarks. Recognizing the value of a transparent budget review process, this document more fully explains the Board's criteria and procedure for determining such exemptions.

A. Background

The Board may in its discretion annually exempt up to four Vermont hospitals from participating in annual public budget hearings, and from budget adjustments, provided they meet established benchmarks and criteria for exemption.

Pursuant to rule, the four largest hospitals, as determined by their net patient revenues (NPRs), are not exempt and must appear at public hearing even if they otherwise qualify for exemption. Absent mutual-agreement to the contrary, however, the Board will not adjust the budget of any hospital meeting all benchmarks and criteria, whether they appear at a public hearing or not.

B. Criteria for Exemption

A hospital that timely submits its budget may qualify for exemption from public hearing if the following criteria are met:

1. The budget includes all reporting requirements, including a budget narrative.
2. Budget assumptions are reasonable.
3. All related budget schedules can be reconciled.
4. The hospital has not undergone significant organizational changes or restructuring.
5. The budget meets the NPR target level as established by the Board.
6. The hospital has met its approved NPR target in two of the last three years.
7. The hospital was not exempted from public hearing for the two prior consecutive years.
8. The hospital did not experience an operating loss during the past two complete fiscal years and is not projected to experience an operating loss during the current fiscal year.

C. Application for Exemption

1. A hospital that believes it meets Criteria 1-7 must include with its budget submission a written request for exemption from public hearing that describes, with specificity, how it meets each criterion.
2. If more than four hospitals, excluding the four largest hospitals referenced in Section A, above, qualify for an exemption, the Board shall determine which if any of the four will be exempted.

APPENDIX IV

Financial Health Indicators

Metric	Flex Program Medians	2018 Almanac of Hospital Financial and Operating Indicators (Optum) 2016			
	US CAHs	Northeast CAH	25-99 beds	100-199 beds	Teaching
Profitability					
Total Margin %	2.7%	0.0%	1.9%	6.0%	3.7%
Operating Margin ($)					
EBIDA Margin %		7.3%	7.7%	10.7%	10.7%
Operating Margin %	0.9%	-2.1%	-0.5%	2.1%	2.1%
Return on Assets %		0.0%	2.0%	5.3%	3.7%
Liquidity					
Cash/Investments ($)					
Days Cash on Hand*	78	92.7	116.3	80.4	98.4
Expenses Per Day ($)					
Net Days in Accounts Receivable	51	46.3	48.6	42.8	42.3
Net Days in Accounts Payable*		66	48.8	65.2	67.7
Capital Structure					
Debt Service Coverage Ratio*	3.35	1.39	3.10	6.70	6.00
Long Term Debt/Capitalization %	27.2%	23.0%	26.6%	19.0%	32.8%
Cash to Long Term Debt %					
Average Age of Plant (yrs.)*	10.48	14.43	10.6	12.4	10.5
Capital Spending %*					
Equity Financing	59.8%				
Cost					
Salaries to NPR %	44.9				
FTE per Adjusted Occupied Bed	5.6		3.14	3.02	3.16
Compensation Ratio					

*Uses 12 month rolling calculation

Definitions for these metrics can be found here

APPENDIX V

PARTICIPATION IN HEALTH REFORM

Complete the following table if the hospital is participating in one or more of the OneCare Vermont programs. If the hospital is not participating with OneCare, please indicate in the narrative.

OneCare Program	Participating in Program in CY 2020? (Yes/No)	Budgeted Number of Attributed Lives (monthly average for CY 2020)	Budgeted Amount of FPP (monthly average for CY 2020)	Budgeted Maximum Upside/Downside Risk for CY 2020
Medicaid				
Medicare				
BCBSVT				
Self-Insured				
TOTAL				

Please complete in Excel. Excel version of this table is available at: FY 2020 Hospital Budget Documents

APPENDIX VI

BUDGET-TO-BUDGET VARIANCES ("BRIDGES" TABLES)

Table 1:
NPR Bridges – FY 2019 Approved Budget NPR to FY 2020 Proposed Budget

NPR	Total	% over/under	Medicare	Medicaid-VT	Medicaid-OOS	Commercial-Maj	Comm - Self/Sml	Workers Comp
FY 19 Approved Budget	$ -		$ -	$ -	$ -	$ -	$ -	$ -
Commercial Rate								
Rate - Non Commercial								
Utilization								
Reimbursement/Payer Mix								
Bad Debt/Free Care								
Physician Acq/Trans								
Changes in Accounting								
Changes in DSH								
Other (please label)								
Other (please label)	0		0	0	0	0	0	0
FY 20 Budget	$ -		$ -	$ -	$ -	$ -	$ -	$ -

Table 2:
Expense Bridges – FY 2019 Approved Budget Expenses to FY 2020 Proposed Budget

Expenses	Amount	% over/under
FY 19 Approved Budget		
New Positions		
Inflation Increases		
Salaries		
Fringe		
Physician Contracts		
Contract Staffing		
Supplies		
Drugs		
Facilities		
IT Related		
Health Reform Programs		
Depreciation		
Interest		
Health Care Provider Tax		
Other (please label)		
Other (please label)		
Cost Savings		
FY 20 Budget	$ -	

Please complete in Excel. Excel versions of these tables are available at FY 2020 Hospital Budget Documents

APPENDIX VII

BAD DEBT

[HOSPITAL NAME]	Amount (in $)
Total Bad Debt at End of FY 2017	
Total Bad Debt Incurred in FY 2018	
Total Bad Debt Sent to Collections During FY 2018	
Total Bad Debt Recovered from Collections During FY 2018	
Total Bad Debt Written Off During FY 2018	
Total Bad Debt at End of FY 2018	

Please complete in Excel. Excel version of this table is available at: FY 2020 Hospital Budget Documents

APPENDIX VIII

CHARGE REQUEST

		Projected Change in NPR Due to Change in Charge and Contractual Allowances, in %				
Category of Service	**Requested Change in Charge from FY19B to FY20B, in %**	**Projected Change in Total NPR**	**Projected Change in Commercial Payer NPR**	**Projected Change in Self-Pay/Other NPR**	**Projected Change in Medicaid NPR**	**Projected Change in Medicare NPR**
Hospital Inpatient						
Hospital Outpatient						
Professional Services						
Primary Care						
Specialty Care						
Skilled Nursing Facility						
Other (specify)						
Overall Change in Charge Across All Categories						

Please complete in Excel. Excel version of this table is available at: FY 2020 Hospital Budget Documents

APPENDIX IX

SALARY INFORMATION

Provide Headcount & Box 5 Wages from 2018 W2s				
Salary Range	**Total # of Staff**	**Total Salaries (includes incentives, bonuses, severance, CTO, etc.)**	**% of Total Staff in this Salary Range**	**% of Total Salaries in this Salary Range**
$0 - $199,999				
$200,000 - $299,999				
$300,000 - $499,999				
$500,000 - $999,999				
$1,000,000 +				
TOTALS				

Please complete in Excel. Excel version of this table is available at: FY 2020 Hospital Budget Documents

APPENDIX X

VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05401
(800) 917-7787 (TOLL FREE HOTLINE)
(802) 863-7152 (FAX)

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

March 8, 2019

Kevin Mullin, Chair
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: HCA Questions for Hospital Budget Guidance FY2020

Dear Chair Mullin:

Thank you for the opportunity to provide questions for inclusion with the Green Mountain Care Board (the Board)'s hospital budget guidance for fiscal year (FY) 2020. The Office of the Health Care Advocate (HCA) was created in Vermont law to support Vermonters navigating the health care system and to represent the interests of the people of Vermont in policy arenas, including before the Green Mountain Care Board.[1] The HCA has statutory authority to receive copies of all materials related to the Board's hospital budget review and may submit written questions to the Board that the Board will ask of hospitals in advance of the hospital budget hearings.[2]

We appreciate the Board's inclusion of the HCA's primary questions as an appendix to the hospital budget guidance to ensure that the hospitals have sufficient time to respond and that the HCA has sufficient time to review the responses in advance of the hearings. We look forward to receiving answers to our questions with each hospital's July 1 budget submission.

The HCA's questions to be included with the Board's FY2020 hospital budget guidance are below. Please feel free to contact Julia Shaw with any questions.

Health Care Advocate Hospital Budget Guidance Questions FY2020:

1. Please provide by payer (Medicare, Medicaid, BCBSVT, TVHP, MVP, and Cigna):
    a. Your budgeted net patient revenue (NPR) and proposed NPR change from FY2019.
    b. The formula(s) you used to calculate your budgeted NPR, the definition of each variable in the formula(s), and the budgeted value of each variable for FY2020.
    c. The average ratio of the payer's reimbursement rate to Medicare's reimbursement rate.

[1] 18 V.S.A. § 9603
[2] 18 V.S.A. § 9456

2. Please delineate the hospital's financial performance and patient distribution by capitated business, fee for service business, and any other payment methodologies. (If you only have one type of business please state which type.)
    a. Please indicate which entities the hospital has capitated or other alternative payment agreements with (e.g., insurer(s), ACO).

3. Please describe any initiatives that you have implemented to address the inadequate access to mental health treatment experienced by Vermonters.
    a. What other avenues are you pursuing to address this crisis in a sustainable way?

4. Please provide data on substance use treatment at your hospital, including:
    a. The number of patients currently enrolled in medication-assisted treatment at your hospital,
    b. The number of MAT providers employed by your hospital, and
    c. Other avenues that you are pursuing to address this crisis in a sustainable way.

5. Please provide the number of patient bed days attributable to patients awaiting placement in an appropriate Skilled Nursing Facility bed, and average bed days per patient, for:
    a. FY2018, and
    b. FY2019 to date.

6. Please provide the hospital's per unit profit margin on each 340B drug dispensed and the number of units of each drug dispensed.

7. Please describe any changes to the hospital's shared-decision making programs.
    a. For any new initiatives, please describe the initiative(s), which departments participate, how you chose which departments participate, and how you plan to identify cost savings and quality improvement.

8. Please provide copies of your financial assistance policy, application, and plain language summary (noting any changes from your last submission).
    a. Please provide detailed information about the ways in which these three items can be obtained by patients, including links if they are available online.
    b. Please provide the following data by year, 2014 to 2019 (to date):
        i. Number of people who were screened for financial assistance eligibility,
        ii. Number of people who applied for financial assistance,
        iii. Number of people who were granted financial assistance by level of financial assistance received,
        iv. Number of people who were denied financial assistance by reason for denial.
        v. Percentage of your patient population who received financial assistance.
    c. Please provide the statistics and analyses you relied on to determine the qualification criteria, including any geographic restrictions, and the amount of assistance provided under your current financial assistance program. For example, analysis of financial need in the community and analysis of how much people can afford to pay.

9. For the hospital's inpatient services, please provide your total discharges, case mix adjusted discharges, all payer case mix index, and average cost per case mix adjusted discharge for 2014 (actual) through the present (2019 budget and projected) and 2020 (budget).

10. Last year the Board's hospital budget orders instructed hospitals to negotiate with insurers rather than seeing the Board's approval as a specific set rate. Please describe how you implemented this directive.
    a. What average commercial rate increase did you implement for FY2019?
    b. What commercial rate increase did you get from each commercial payer (BCBSVT, TVHP, MVP, Cigna)?

Thank you,

s\ Mike Fisher, Chief Health Care Advocate

s\ Kaili Kuiper, Staff Attorney

s\ Eric Schultheis, Staff Attorney

s\ Julia Shaw, Health Care Policy Analyst
jshaw@vtlegalaid.org
(802) 383-2211

APPENDIX XI

The GMCB is responsible for tracking the change in population-wide spending of Vermont residents over the course of its All-Payer Model Agreement with the federal government. The following table shows the All-Payer Total Cost of Care (TCOC) per member per month along with the compounding growth rate from 2012 through 2017. The results include breakouts based on the Hospital Service Area where the patients live.

The results are raw, unadjusted estimates of spending regardless of the provider location (e.g. out-of-state spending is included). Differences in PMPM are impacted by demographics (e.g. age of the patients in that area), payer mix (e.g. proportion of Medicaid as a primary payer), and other factors.

The results are derived from medical claims data available in the state's All-Payer Claims Database, VHCURES. For example, VHCURES does not have complete information for self-insured employer spending. The spending excludes retail pharmacy and approximately half of Medicaid spending (i.e. funds that are not paid through the Department of Vermont Health Access).

The TCOC PMPM in the HSAs reflects more than hospital spending, however, it is the way that the State will be held accountable for its growth through the All-Payer Model Agreement. Also, a hospital's budget includes the costs of care for out-of-state residents, which is not included in these PMPMs. The intent in sharing this information is to provide hospitals with a different view of spending consistent with the APM Agreement and to begin to understand the complexities of cost containment efforts by hospitals.

1. In looking at the per member per month spending and growth for your hospital's service area, what observations can you share with the GMCB? In particular, if your HSA's spending level is above the state average, or if your HSA's growth rate is above 3.5%, can you share any insights or possible explanations?
2. What strategies will the hospital be undertaking to support the State's goal of limiting TCOC per member growth to 3.5% or less from 2017 to 2022? How are these strategies aligned with the goals of the APM Agreement?

Finally, as we look to better align our hospital budget process with our federal obligations, please provide any suggestions for how the GMCB could better assess the relationship between hospital spending and the All-Payer TCOC growth targets.

Hospital Service Area of Patient Residence	2012	2013	2014	2015	2016	2017	5-Year Compounding Growth Rate
Barre	$386.25	$412.15	$430.99	$445.12	$489.67	$479.57	4.4%
Bennington	$439.97	$453.64	$464.43	$479.16	$496.70	$508.14	2.9%
Brattleboro	$408.98	$409.73	$419.43	$420.34	$453.89	$486.41	3.5%
Burlington	$351.29	$378.03	$389.47	$402.99	$429.12	$445.53	4.9%
Middlebury	$377.55	$412.63	$415.64	$431.85	$464.06	$469.07	4.4%
Morrisville	$375.35	$378.53	$387.37	$388.78	$404.79	$420.88	2.3%
Newport	$416.06	$424.26	$426.08	$434.80	$452.52	$479.65	2.9%
Randolph	$434.81	$448.97	$467.31	$512.82	$522.98	$574.90	5.7%
Rutland	$459.60	$486.65	$487.80	$504.74	$528.24	$551.08	3.7%
Springfield	$470.82	$477.60	$472.21	$518.65	$527.10	$549.65	3.1%
St Albans	$393.96	$407.67	$432.73	$448.26	$456.28	$466.19	3.4%
St Johnsbury	$404.04	$423.11	$425.58	$441.02	$481.44	$495.53	4.2%
White River Jct	$419.70	$440.18	$451.56	$458.47	$450.32	$493.91	3.3%
Statewide	**$399.27**	**$418.51**	**$428.40**	**$443.13**	**$466.32**	**$483.50**	**3.9%**