

FY 2019 HOSPITAL BUDGET SUBMISSIONS REPORTING REQUIREMENTS

March 2018

Prepared by:

**GREEN MOUNTAIN CARE BOARD
144 State Street
Montpelier, Vermont 05602**

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Reporting Timeline*

| | |
|--------------------|--|
| MARCH | GMCB provides hospitals with annual budget guidance, including questions from the Office of the Health Care Advocate (HCA) |
| APRIL/MAY | GMCB provides Rate Schedule to the hospitals |
| JUNE 18-JULY 2 | Hospitals submit budgets to GMCB |
| JULY-AUG | GMCB staff review and analysis |
| JULY 25 | GMCB staff provides preliminary budget overview at public board meeting |
| JULY 30 | GMCB staff provides analysis/questions to the hospitals |
| AUGUST 10 | Hospital responses to staff analysis/questions due |
| AUG 20, 22, 27, 29 | Hospital budget hearings |
| SEPT 5, 12 | Board votes to establish each hospital's budget at public board meetings |
| SEPT 14 | Board issues budget decisions |
| SEPT 28 | 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

New Accounts and Definitions

GMCB staff has created the following new accounts for reporting information related to the Accountable Care Organization (ACO):

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 participation deductions and value-based incentive program deductions.

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 financial or balance sheet statements related to participation in two-sided risk programs.

Presentation Instructions

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

1. Introduction/Overview (not to exceed 5 minutes)
2. Hospital issues
3. Areas of risk/opportunities
4. Access – wait times for third next available appointment (*see* Narrative ¶ 6)
5. Reaction to All-Payer Model quality measure results, attached at Appendix IV (*see* Narrative ¶ 4)
6. Financials to include:
 - A. Profit and Loss, Cash Flow, Balance Sheet;
 - B. In-state vs. out-of-state payer mix;
 - C. Expense drivers and cost containment efforts (three to four specific high-level categories);
 - D. An updated reconciliation between FY18 approved budget and FY18 YTD; and
 - E. Other clarifying information to tell the hospital's financial story
7. Community Health Needs Assessment (CHNA) update – Describe the population health goals identified in the hospital's CHNA, initiatives addressing those goals, and the costs associated with these initiatives
8. Health reform investment progress and outcomes – explain the response to Narrative, ¶ 8
9. Capital budget plans – include both non-CON and CON capital plans (include routine replacement of nonmedical equipment and fixtures). Include information on performance of approved CONs
10. Long range financial outlook; indicate where financial goals align with APM targets
11. 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 (1-15).

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, for which payers? If not, explain (and skip B. through E., below.)
 - B. What is the amount of FPP the hospital expects to receive in FY 2019 based on estimated attributed lives?
 - C. What is the maximum upside and downside risk the hospital has assumed?
 - D. How is the risk (up-and downside) accounted for in the financials?
 - i. 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?
 - E. What amount of Other Reform payments does the hospital expect to receive from OneCare Vermont by the end of calendar year 2018? (*e.g.*, payments from OneCare's Value-Based Incentive Program based on quality performance)
3. *Community Health Needs Assessment*. Describe the hospital's initiatives addressing its population health goals as identified in the CHNA.
4. *Quality Measure Results*. Review Appendix IV, and provide a response to health service area, county or regional performance results for each of the All-Payer Model quality measures. Discuss outcomes, goals, and plans for improvement.
5. *Mental Health*. Provide the following information:
 - A. The number of mental health beds;
 - B. The number of patients who waited in the emergency department for an available mental health bed at this hospital or at another facility;
 - C. The range and average time patients spend in the emergency department awaiting an appropriate mental health placement;
 - D. Average cost per day for patients awaiting transfer;

- E. List and describe each initiative, program or practice the hospital has implemented, or plans to implement, that focuses on ensuring that Vermonters have access to high quality, timely, and appropriate mental health treatment.
6. *Patient access.* Provide wait times, by medical practice area, for the “third next available appointment,” as defined by the Institute for Healthcare Improvement (IHI) <http://www.ihl.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx>. For hospitals that do not use this measure, describe wait times and how they are currently measured.
 7. *Substance use disorder treatment programs.* Describe the hospital’s substance use disorder (SUD) treatment programs, and provide the following information:
 - A. A description of the hospital’s full range of SUD treatment programs;
 - B. The number of patients currently enrolled in medication-assisted treatment (MAT) programs and other SUD programs; and
 - C. The number of MAT providers and other SUD providers employed by the hospital.
 8. *Health Reform Investments.*

Part I: Provide updates on all health reform activities submitted under the GMCB’s extended NPR cap for FYs 2016 - 2018 including:

 - A. The amount of the investment;
 - B. The goals of the program;
 - C. Metrics and other evidence demonstrating the program’s ability to meet these goals, highlighting metrics and other evidence that demonstrate alignment with the goals of the All-Payer Model;
 - D. Any other program outcomes, positive or negative;
 - E. Whether the program is ongoing or of limited duration, and why;
 - F. For any program that has been discontinued, describe how ending the program has or will be accounted for in past, current or future budgets.

Part II: Complete the Table at Appendix V.
 9. *Reconciliation.* Provide a reconciliation between FY 2018 approved budget and FY 2018 YTD, showing both positive and negative variances. Explain the variances.
 10. *Budget-to-budget growth.*
 - A. Net patient revenues:
 - i. Provide the budgeted FY 2019 NPR increase over the approved FY 2018 budget. If the GMCB rebased the hospital’s budget for the purpose of calculating FY 2019, provide the budgeted increase in NPR for FY 2019 measured from the hospital’s rebased budget.
 - ii. Describe any significant changes made to the FY 2018 budget (including, but not limited to, changes in anticipated reimbursements, physician acquisitions and certificates of need) and how they affect the FY 2019 proposed budget.

- iii. Describe any cost saving initiatives proposed in FY 2019 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 2018 that were not included in the FY 2018 budget, and 3) any anticipated revenues related to meaningful use and 340B funds in FY 2019.
 - b. Medicaid revenue assumptions: Budget for net patient revenues 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 net patient revenues.
- v. Complete Appendix VI, Tables 1A and 1B. If the hospital categorizes revenue differently than as indicated in the tables, provide such categories, including labels and amounts, in the “Other” rows.

B. Expenses:

- i. Provide the budgeted FY 2019 net expenditure increase over the approved FY 2018 net expenditure increase.
- ii. Describe any significant changes made to the FY 2018 budget (including, but not limited to, changes in costs of labor, supplies, utilization, capital projects) and how they affect the FY 2019 proposed budget. Provide assumptions about inflation and major program increases.
- iii. Describe any cost saving initiatives proposed in FY 2019 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.

11. *Bad Debt.*

- A. Provide the amount of bad debt carried by the hospital at the close of FY 2017 that was incurred prior to FY 2016.
- 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>

12. *Rate Request.*

- A. Provide the hospital’s budgeted overall rate/price increase or decrease. Explain how the rate was derived and what assumptions were used in determining the increase or decrease.
- B. For each payer, if the net patient revenue budget-to-budget increase or decrease is different than the overall rate/price change—for example, if the

requested commercial “ask” differs from the rate/price change—explain why they differ.

C. In April/May, the GMCB will provide a rate schedule for reporting the rate/price change for each major line of business and the gross and net revenues expected from each payer as a result of the rate/price change.

13. *FY 2017 overages.* For those hospitals that received a letter regarding their FY 2017 budget-to-actual overages results, specifically address the issues and requirements outlined in the letter.

14. *Capital budget investments.* Describe the major investments, including projects subject to certificate of need review, that have been budgeted for FY 2019 and their effect on the FY 2019 operating budget.

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

Salary Information

Submit a full copy of the hospital’s Form 990 (for Actual 2017), including the most current version of Schedule H (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. *(Note that this information is required under the GMCB Guidelines for the Community Health Needs Assessment, attached. Provide a single copy of these documents.)*

A. Complete the following table*:

| Salary Range | Total # of FTE Staff | Total Salaries | Other Compensation | Total Compensation |
|-----------------------|----------------------|----------------|--------------------|--------------------|
| \$0 - \$199,999 | | | | |
| \$200,000 - \$299,999 | | | | |
| \$300,000 - \$499,999 | | | | |
| \$500,000 - \$999,999 | | | | |
| \$1,000,000 + | | | | |

*The information in this table should match Actual FY 2017.

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

C. 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.

Questions from the Office of the Health Care Advocate

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

User Access to Adaptive Insights

Budget information should be provided through the Adaptive Insights (Adaptive) website. A maximum of two 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 2019 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 2019 BUDGET>HOSPITAL DIRECTORY>Hospital Budget Instructions

The directory includes the following:

- FY 2019 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)
3. Data dictionary (explains the mapping of each account of the old Excel sheets to Adaptive Insights)

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 2019 BUDGET>HOSPITAL DIRECTORY>HOSPITAL REPORT PACKAGE

BUDGET GUIDELINES

➤ Net Patient Revenue FY 2019

At its March 28, 2018 public meeting, the GMCB established a X.X% growth target for hospital Net Patient Revenue (NPR) for FY 2019.

A hospital may also qualify for an NPR allowance of X.X% above the X.X% growth target for health care reform investments and activities, regardless of whether it is participating in the ACO. To qualify, the hospital must link the investments to health care reform activities that reduce health care costs and improve quality of care over the long term and 1) support the transition toward value-based purchasing, 2) increase access to primary care, 3) reduce deaths from suicide and/or drug overdose, or 4) reduce the prevalence and/or morbidity of chronic disease. Each of the financial investments in these activities must be specifically identified in the budget and accompanied by a detailed plan to measure the return on the investment.

By setting hospital revenue targets and monitoring other key performance indicators (KPIs), 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, 2018

➤ Community Health Needs Assessment FY 2019

Section 9007 of the Patient Protection and Affordable Care Act (ACA) called for strengthening and clarifying the community benefit obligations of nonprofit hospitals that seek federal tax-exempt status. The ACA provisions added a Community Health Needs Assessment (CHNA) requirement to the Internal Revenue Code to promote hospital investments that reflect community health priorities. The ACA provisions require all nonprofit hospitals to adopt an Implementation Strategy, describe how the Implementation Strategy meets the identified community health needs, and include a description of how public input was solicited and considered.

Under the ACA, the CHNA must be made “widely available,” which has been construed by the Internal Revenue Service (IRS) to mean, at minimum, the document must be posted to the

hospital's web site. The IRS has also encouraged hospitals to post the CHNA on other organizational websites along with clear instructions for obtaining the report from the hospital. Furthermore, a hospital organization and its facility must make the document available to any individual who requests it.

The Implementation Strategy described in Section 501(r)(3)(A)(ii) of the Internal Revenue Code links hospital community benefit expenditures to assessed community health needs. The Implementation Strategy describes (i) how the hospital organization is addressing the needs identified in each CHNA, and (ii) any needs that are not being addressed, together with the reasons why such needs are not being addressed.

The Board requests that hospitals submit the following information concerning their communities' needs and priorities, for review with their FY 2019 budgets:

- The most recent version of the hospital's CHNA report;
- The Implementation Strategy that has been adopted by the hospital organization's governing board pursuant to IRS guidelines; and
- The most current version of Schedule H (filed in 2018) that has been submitted to the Internal Revenue Service (IRS) as part of the hospital organization's Form 990 reporting obligations under Section 501(c)(3) of the Internal Revenue Code.

Hospitals are expected to provide any updated or new implementation strategies, and to identify any new expenditures that are being requested to address the hospital's CHNA or Implementation Strategy, as part of the FY 2019 Budget Narrative. The Board's staff will review the hospital's 990 Schedule H filings, including the hospital's responses to questions posed by the IRS, and summarize for the Board the status of each hospital's CHNA report. If the Board requires additional information or clarification, it may require a hospital to respond in writing to additional questions concerning its community needs.

Taken together, these reporting obligations offer transparent information about the hospitals' expenditures on community benefit activities and initiatives, as well as specific hospital expenditures intended to implement the CHNA. This information is essential to the Board's hospital budget review process and commitment to advancing community health improvement and population health through all sectors of the Vermont health care system.

Effective March 31, 2018

➤ **Budget Performance (previously Enforcement) for FY 2019 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, enjoyed 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 2018 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 2019:

- 1) Net patient revenue (NPR) amounts as ordered will be enforced.
- 2) The GMCB may review hospitals whose year-end NPRs exceed the NPR requirement by 0.5% above or below their approved NPR. 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 current year budget;
 - c) Use its finding as a consideration to adjust the hospital's budget in a subsequent year or years; and
 - d) Establish full budget review of actual operations for that budget year.

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, 2018

➤ **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 (NPR). An underlying principle for this review is to limit growth to a pace comparable to other sectors of the Vermont economy.

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, 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 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 2019.

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

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.

- 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 Schedules A and B (available in Excel format at <http://gmcboard.vermont.gov/hospital-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 1)
 - a. Budget Schedule A will be required to provide financial information about why the transaction is budget-neutral.
 - b. Budget Schedule B will be required to provide financial information about the effect on the current year and the next projected budget.
 - c. A narrative must be submitted with the Schedules 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 on page 6 of this document.

Provider Practice Transfer and/or Acquisitions Worksheet* - Budget Schedule A

* For the purpose of entering information in Budget Schedules A and B, the term "physician" shall include other health care providers such as advanced practice registered nurses and physician assistants, consistent with FY 2019 GMCB budget guidelines.

| | | | |
|--|--|--|--|
| Hospital Name: | | | |
| Provider Practice Name: | | | |
| Effective Date of Transfer or Acquisition: | | | |

Note: This information should be submitted 30 days prior to the effective date of the transfer/acquisition. Please include a brief letter or narrative explaining the transfer/acquisition.

Physician Practice Financial Information

| | A | B | C |
|--|----------------------|-----------------------------------|----------------------------------|
| | Prior Year 12 Months | Current Year Projection 12 Months | Partial Current Year Projections |
| Gross Patient Care Revenue | | | |
| Deductions from Revenue | | | |
| Net Patient Revenue - Physician | | | |
| Provider Salaries | | | |
| Provider Fringe Benefits | | | |
| Staff Wages & Benefits (Non MD) | | | |
| Malpractice | | | |
| Depreciation/Amortization | | | |
| Rent | | | |
| Billing Service | | | |
| Medical/Surgical Supplies | | | |
| Other Costs | | | |
| Total Operating Expense | \$ - | \$ - | \$ - |
| Net Operating Income/Loss | \$ - | \$ - | \$ - |
| Utilization | | | |
| Relative Value - Units of Service | | | |
| Total Physician FTEs Acquired or Transferred | | | |

A: The operations of the practice for the previous 12 months.

B: The operations of the practice for the projected year (12 months).

C: The operations of the practice from the beginning effective date of transfer to year end.

Provider Practice Transfer and/or Acquisitions Worksheet - Budget Schedule B

| | | | | | |
|--|--|--|--|--|--|
| Hospital Name: | | | | | |
| Provider Practice Name: | | | | | |
| Effective Date of Transfer or Acquisition: | | | | | |

Note: This information should be submitted 30 days prior to the effective date of the transfer/acquisition.
Please include a brief letter or narrative explaining the transfer/acquisition.

Hospital Budget and Provider Practice Financial Information

| Partial Year Effect | | | | | |
|---------------------------------|-----------------------------|--|----------------------------------|--|---------------------------|
| | Prior Year 12 Months Actual | Current Year Approved Budget (12 Months) | Partial Current Year Projections | Final Current Year Budget Including Change | % Change from Orig Budget |
| Net Patient Revenue - Hospital | | | \$ - | \$ - | #DIV/0! |
| Net Patient Revenue - Physician | | | | \$ - | #DIV/0! |
| Total Net Patient Revenue | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| Other Operating Revenue | | | | | #DIV/0! |
| Expenses - Hospital | | | \$ - | \$ - | #DIV/0! |
| Expenses - Physician | | | | \$ - | #DIV/0! |
| Total Expenses | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| Surplus | \$ - | \$ - | \$ - | \$ - | |
| | | | | | |
| | | | | | |
| Annualized Effect | | | | | |
| | | Current Year Approved Budget (12 Months) | Annualized | Budget for Next FY Including Change | % Change from Orig Budget |
| Net Patient Revenue - Hospital | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| Net Patient Revenue - Physician | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| Other Operating Revenue | | | | | #DIV/0! |
| Expenses - Hospital | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| Expenses - Physician | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| | \$ - | \$ - | \$ - | \$ - | #DIV/0! |
| Surplus | \$ - | \$ - | \$ - | \$ - | |
| | | | | | |
| | | | | | |

Excel versions of these worksheets are available at <http://gmcboard.vermont.gov/hospital-budget>.

Act 143 of 2016 § 1.

Sec. 1. GREEN MOUNTAIN CARE BOARD; NOTICE TO PATIENTS OF NEW AFFILIATION

The Green Mountain Care Board shall maintain a policy for reviewing new physician acquisitions and transfers as part of the Board's hospital budget review responsibilities. The policy shall require hospitals to provide written notice about a new acquisition or transfer of health care providers to each patient served by an acquired or transferred health care provider, including:

- (1) notifying the patient that the health care provider is now affiliated with the hospital;
- (2) providing the hospital's name and contact information;
- (3) notifying the patient that the change in affiliation may affect his or her out-of-pocket costs, depending on the patient's health insurance plan and the services provided; and
- (4) recommending that the patient contact his or her insurance company with specific questions or to determine his or her actual financial liability.

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. Submit to GMCB within a time to be determined by GMCB, a complete “modified” budget in the same form as required during the regular budgeting process, along with an explanation as to the purpose of any changes and variances.
- d. Provide contact information for the available staff member with knowledge of the budget to answer questions.

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

STATE OF VERMONT Green Mountain Care Board

In re: FY 2019 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]

Note: For FY 2019 there will be no exemptions.

APPENDIX III

STATE OF VERMONT Green Mountain Care Board

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.

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

All-Payer Model Quality Measures: Regional Performance Results

1. Vermont All-Payer Model Quality Measures by Hospital Service Area

Table 1a: Blueprint Profiles – Blueprint-Attributed Vermont Residents (2016)

| Measure | Statewide Rate (All-Payer Model Target) ² | Barre | Bennington | Brattleboro | Burlington | Middlebury | Morrisville | Newport | Randolph | Rutland | Springfield | St. Albans | St. Johnsbury | White River |
|--|--|-------|------------|-------------|------------|------------|-------------|---------|----------|---------|-------------|------------|---------------|-------------|
| Percentage of <u>Medicaid</u> adolescents with well-care visits | 50% | 49% | 51% | 41% | 53% | 52% | 45% | 56% | 48% | 44% | 49% | 47% | 60% | 49% |
| Initiation of alcohol and other drug dependence treatment | 36% | 40% | 45% | 43% | 33% | 39% | 30% | 25% | 49% | 37% | 31% | 36% | 33% | 41% |
| Engagement of alcohol and other drug dependence treatment | 17% | 15% | 22% | 20% | 17% | 17% | 16% | 11% | 18% | 19% | 13% | 20% | 20% | 20% |
| 30-day follow-up after discharge for mental health | 68% (60%) | 73% | 78% | 75% | 58% | 58% | 75% | 68% | 69% | 74% | 68% | 67% | 58% | 70% |
| 30-day follow-up after discharge for alcohol or other drug dependence | 27% (40%) | 38% | | | 26% | | 26% | | | 28% | | 38% | | |
| Diabetes HbA1c poor control (part of <u>Medicare</u> composite measure) ³ | 10% | 8% | 9% | 10% | 9% | | 11% | 10% | | | 9% | 11% | 12% | |
| Controlling high blood pressure (part of <u>Medicare</u> composite measure) | 67% | 73% | 64% | 69% | 64% | 72% | 63% | 64% | 70% | 67% | 67% | 67% | 75% | 71% |
| Appropriate asthma medication management (75% compliance) | 52% | 50% | 56% | 49% | 49% | 48% | 52% | 50% | 60% | 58% | 57% | 51% | 56% | 48% |

² Measures with no target listed are those measures that have targets based on national percentiles rather than rates.

³ Lower scores indicate better performance.

Table 1b: Behavioral Risk Factor Surveillance System Survey – Respondents to Survey of Random Sample of Vermont Residents (2016)

| Measure | Statewide Rate (All-Payer Model Target) | Barre | Bennington | Brattleboro | Burlington | Middlebury | Morrisville | Newport | Randolph | Rutland | Spring field | St. Albans | St. Johnsbury | White River |
|---|---|-------|------------|-------------|------------|------------|-------------|---------|----------|---------|-----------------|------------|------------------|----------------|
| Percentage of adults reporting that they have a usual primary care provider | 88% (89%) | 89% | 93% | 88% | 90% | 86% | 90% | 91% | 93% | 88% | 87% | 89% | 86% | 86% |
| Prevalence of chronic disease: COPD | 6% (≤7%) | 7% | 8% | 6% | 4% | 5% | 6% | 10% | 4% | 9% | 7% | 6% | 6% | 7% |
| Prevalence of chronic disease: Hypertension | 25% (≤26%) | 28% | 27% | 25% | 24% | 26% | 27% | 27% | 27% | 28% | 31% | 28% | 27% | 28% |
| Prevalence of chronic disease: Diabetes | 8% (≤9%) | 8% | 9% | 8% | 6% | 10% | 7% | 13% | 9% | 10% | 11% | 10% | 9% | 11% |

1. Vermont All-Payer Model Quality Measures by County

Table 2a: Blueprint for Health Hub and Spoke Profiles - All Vermont Residents Utilizing Services (2016)

| Measure | Statewide (Rate/10,000) (All-Payer Model Target) | Addison | Bennington | Caledonia | Chittenden | Essex | Franklin | Grand Isle | Lamoille | Orange | Orleans | Rutland | Washington | Windham | Windsor |
|---|---|---------------|----------------|----------------|------------------|-------------------|--------------------|---------------|----------------|--------------------|--------------------|--------------------|----------------|----------------|----------------|
| # per 10,000 population ages 18-64 receiving Medication Assisted Treatment for opioid dependence ⁴ | 6,110 (155.4) <i>150</i> | 183 (77.1) | 362 (170.5) | 291 (157.6) | 1,387 (126.6) | 41 (11 5.8) | 635 (207.8) | 58 (135.2) | 256 (160.3) | 224 (125.2) | 337 (212.8) | 732 (202.1) | 596 (163.3) | 422 (160.9) | 584 (176.8) |

Table 2b: Vermont Department of Health Vital Statistics Data - Vermont deaths by county of residence (2017 – released 3/16/18)

| Measure | Statewide (Rate/10,000) (All-Payer Model Target) | Addison | Bennington | Caledonia | Chittenden | Essex | Franklin | Grand Isle | Lamoille | Orange | Orleans | Rutland | Washington | Windham | Windsor |
|--|--|------------|------------|------------|-------------|------------|-------------|---------------|------------|------------|------------|-------------|-------------|-------------|-------------|
| Deaths related to drug overdose ⁵ | 122 (2.2) (115) | 1 (0.3) | 4 (1.2) | 8 (3.0) | 34 (2.4) | 0 (0.0) | 12 (2.9) | 1 (1.7) | 3 (1.4) | 7 (2.8) | 2 (0.8) | 11 (2.1) | 12 (2.3) | 17 (4.4) | 10 (2.0) |

⁴ The State reports these rates for Hubs & Spokes per 100,000. For consistency with the APM, counts and rates have been calculated per 10,000 using 2016 population estimates (ages 18-64).

⁵ Rates calculated using 2016 population estimates (ages 14+).

3. Vermont All-Payer Model Quality Measures by Hospital

Table 3: Vermont Uniform Hospital Discharge Data Set (VUHDDS) - Vermont Residents and Non-Residents Utilizing Services

| Measure | Statewide Rate <i>(All-Payer Model Target)</i> | BMH | CVMC | CH | GMC | GCH | MAHHC | NCH | NMC | NVRH | PMC | RRMC | SVMC | SH | UVMC |
|--|---|-----|------|-----|-----|-----|-------|------|-----|------|------|------|------|-----|------|
| Rate of Growth in number of mental health and substance use-related ED visits⁶ | 6% <i>(3%)</i> | 13% | 0% | 13% | -8% | -4% | -5% | -11% | 14% | 8% | -13% | 9% | -11% | 11% | 10% |

Table 4: Health Service Area/Hospital Crosswalk

| Health Service Area | Hospital(s) located in HSA |
|----------------------|---|
| Barre | Central Vermont Medical Center |
| Bennington | Southwestern Vermont Medical Center |
| Brattleboro | Brattleboro Memorial Hospital; Grace Cottage Hospital |
| Burlington | University of Vermont Medical Center |
| Middlebury | Porter Medical Center |
| Morrisville | Copley Hospital |
| Newport | North Country Hospital |
| Randolph | Gifford Medical Center |
| Springfield | Springfield Hospital |
| St. Albans | Northwestern Medical Center |
| St. Johnsbury | Northeastern Vermont Regional Hospital |
| White River Junction | Mount Ascutney Hospital |

⁶ Shown as percent change from 2015-2016.

APPENDIX V

| APPENDIX V: HEALTH REFORM INVESTMENTS (excel version available at http://gmcboard.vermont.gov/hospital-budget) | | | | | | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|---|---|---|--|--|
| Hospital: ___Hospital Name | | | | | | | | | | | | |
| Total Amount Across All Activities/Investments: _____ | | | | | | | | | | | | |
| Per GMCB budget guidance, indicate which health care reform goals the activity/investment meets (see Columns G-K) | | | | | | | | | | | | |
| | Activities, investments, or initiatives within the X.X% health care reform investment | Allocation for the investment | Was this activity in last year's budget? | If yes, describe how the 2019 investment differs from previous investments in the same activity | Is this investment supplanting previous costs, or does it represent new costs? | Is this activity intended to address the goal of reducing health care costs? | Is this activity intended to support movement toward value-based purchasing? | Does this activity support APM Population Health Goal 1: Increase Access to Primary Care | Does this activity support APM Population Health Goal 2: Reduce Deaths from Suicide and Drug Overdose | Does this activity support APM Population Health Goal 3: Reduce Prevalence and Morbidity of Chronic Disease | List APM quality measure(s) that the activity is intended to improve | Summary of evidence base or rationale that the activity will achieve the intended improvement(s) |
| Example | We are hiring an SBIRT social worker for the Emergency Department to triage substance use for referral to treatment. | \$150,000 | Yes | We are expanding our SBIRT social worker staff in Emergency Department from 1 to 2 FTE. 1 FTE, salary and benefits, is \$150,000. | new | | | | Yes | | | |
| Example | ACO dues | \$250,000 | Yes | We paid \$100,000 in dues last year. We owe \$350,000 this year. | new | | Yes | | | | | |
| Examples of activities that address the goal of reducing health care costs: | | | | | | | | Note: The GMCB anticipates that hospitals participating with the ACO will work with the ACO to identify activities tailored to the health service area that address reduction of health care costs, movement toward value-based purchasing, and the three APM Population Health Goals. | | | | |
| 1. Providing post-discharge follow-up, in order to reduce hospital readmissions. | | | | | | | | | | | | |
| 2. Increasing primary care office hours, to reduce evening and weekend emergency department visits. | | | | | | | | | | | | |
| Examples of activities that support movement toward value-based purchasing: | | | | | | | | | | | | |
| 1. Participating in the ACO, including payment of dues. | | | | | | | | | | | | |
| 2. Negotiating alternative payment contracts with insurers, based on quality performance. | | | | | | | | | | | | |
| Examples of activities that support increasing access to primary care: | | | | | | | | | | | | |
| 1. Hiring additional primary care providers and/or increasing payments to existing primary care providers to address shortages in primary care. | | | | | | | | | | | | |
| 2. Establishing case managers in the emergency department to ensure that all patients have a primary care provider. | | | | | | | | | | | | |
| Examples of activities that support reductions in deaths from suicide and drug overdose: | | | | | | | | | | | | |
| 1. Hiring an SBIRT (Screening, Brief Intervention, and Referral to Treatment) social worker for the emergency department to ensure that all patients are screened for substance use disorder and referred to treatment when appropriate. | | | | | | | | | | | | |
| 2. Supporting training and staffing to ensure that patients are assessed for risk of suicide; providing educational programs on signs of suicide risk and how to seek help. | | | | | | | | | | | | |
| Examples of activities that support reductions in prevalence and morbidity of chronic disease: | | | | | | | | | | | | |
| 1. Investing in new health promotion activities. | | | | | | | | | | | | |
| 2. Establishing partnerships with employers to engage in health screening programs, to support early detection of chronic illness. | | | | | | | | | | | | |

APPENDIX VI

Table 1A:

NPR Bridges - FY18 Approved Budget to FY19 Proposed Budget

| NPR | Total | % over/under | Medicare | Medicaid-VT | Medicaid-OOS | Commercial-Maj | Comm - Self/Sml | Workers Comp |
|-------------------------|-------|--------------|----------|-------------|--------------|----------------|-----------------|--------------|
| FY 18 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 19 Budget | \$ - | | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - |

Table 1B:

| NPR | 2018 NPR | 2019 Before Rate | Vol/Mix | Variance | 2019 NPR | Impact of Rate |
|-----------------------------|----------|------------------|---------|----------|----------|----------------|
| | \$ - | | \$ - | \$ - | \$ - | \$ - |
| Major NPR Contributors | | | | | | |
| Imaging | | | | | | |
| Perioperative & Anesthesia | | | | | | |
| Physician Practices | | | | | | |
| Lab | | | | | | |
| Drugs & IV Therapy | | | | | | |
| Emergency | | | | | | |
| Med/Surg/SCU | | | | | | |
| Medical/Surgical supplies | | | | | | |
| ER & Hospitalist Physicians | | | | | | |
| Birth Center | | | | | | |
| Clinics | | | | | | |
| Rehabilitation Services | | | | | | |
| Other (please label) | | | | | | |
| Other (please label) | 0 | | 0 | 0 | 0 | 0 |
| | \$ - | | \$ - | \$ - | \$ - | \$ - |

Table 2:

FY 2018 Approved Expenses to Budget FY 2019

| Expenses | Amount | % over/under |
|--------------------------|--------|--------------|
| FY 18 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 | | |
| FY19 Budget | \$ - | |

Excel versions of these tables are available at: <http://gmcboard.vermont.gov/hospital-budget>.

APPENDIX VII
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

January 31, 2018

Andy Pallito
Director of Health Systems Finance
Green Mountain Care Board
144 State Street
Montpelier, VT

Re: Hospital Budget Guidance FY 2019

Dear Mr. Pallito:

Thank you for the opportunity to provide input into the Green Mountain Care Board (GMCB)'s development of hospital budget guidance for fiscal year 2019. We believe that including the Office of the Health Care Advocate (HCA)'s primary information requests in the guidance rather than in our written questions to the hospitals will allow us to more effectively participate in the hospital budget review process. It will save the HCA, the hospitals, and the Board significant time during the review and will give us necessary information earlier in the process so we can effectively review it and ask follow-up questions.

We request that the following items be included in the FY2019 Hospital Budget Guidance:

1. Please describe all entities related financially to the hospital, the purpose of each entity, and the financial relationships between the entities (e.g., parent organization(s), subsidiary organization(s), membership organization(s), etc.). In particular:
 - a. What non-profit and/or for-profit entities does the hospital or its parent organization own in part or in full and/or is the hospital owned by in part or in full?
 - b. Are hospital senior management paid by hospital-related entities other than the hospital?
 - c. Are the revenues of these entities included in your budget submission?
2. Please describe any financial incentives/bonuses that your executives, providers, coders, and other personnel are eligible to receive that are tied to services that have the potential to increase your hospital's revenue. Please include both staff and subcontractors.
 - a. As a part of your answer, please disclose for which procedures the hospital pays providers volume-based incentives.

- b. Are these incentives the same for OneCare attributed patients as for non-attributed patients?
3. 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(s)).
4. Please provide data on the experience of mental health patients at your hospital, including:
 - a. The total number of mental health beds at your hospital;
 - b. The range and average wait time for placement of mental health patients who report to your hospital in need of inpatient admission;
 - c. The range and average time patients have spent in your emergency department awaiting an appropriate mental health placement;
 - d. The total number of patients who waited in your emergency department for an available mental health bed at your hospital or at another facility.
5. 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?
6. 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;
7. Please describe the hospital's plans for participation in payment reform initiatives in this fiscal year and over the next five years.
 - a. How do you plan to manage financial risk, if applicable, while maintaining access to care, high quality care, and appropriate levels of utilization?
 - b. How much money will the hospital be at risk for in FY19?
 - i. What will happen if a hospital loses that money?
 - ii. How will the hospital fill in this gap, if necessary, without increasing rates?
 - iii. How does the hospital track access to care, utilization, and quality of care to ensure that provider financial incentives do not have a negative impact on patient care?
8. Please describe the hospital's shared-decision making programs, if any, and any plans for expanding those programs.
 - a. Please describe the initiative(s), which departments have participated, how you have chosen which departments participate, which of these initiatives, if any, have

- led to identifiable cost savings and/or quality improvement, and the number of patients served by these programs.
- b. What is the extent of your Choosing Wisely initiative(s), if any?
 - c. What are you doing to ensure/increase provider buy-in in these programs?
9. Please provide copies of your financial assistance policy, application, and plain language summary (noting any changes from your last submission) as well as detailed information about the ways in which these three items can be obtained by patients.
- a. Please provide the following data by year, 2014 to 2018 (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. What percentage of your patient population received financial assistance?
 - b. Please provide the statistics and analyses you relied on to determine the qualification criteria and the amount of assistance provided under your current financial assistance program.
10. For the hospital's inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2018 budget and projected) and 2019 (budget).
11. As part of the GMCB's rate review process during the summer of 2017, Blue Cross Blue Shield of Vermont (BCBSVT) was asked to "explain how the cost shift factors into your approach when negotiating with providers." BCBSVT responded: "Since the creation of the GMCB hospital budget and the greater transparency that it has created, providers insist that it is the responsibility of BCBSVT's members to fund the cost shift. Providers acknowledge that they manage to a revenue target, insist that commercial members must fund the cost shift in order for providers to meet their revenue targets, and remind BCBSVT that the GMCB has approved the revenue target." (GMCB 08-17rr, SERFF Filing, July 5, 2017 Response Letter). Do you agree with this statement? Please explain why or why not. If you disagree, please point to any data available that supports your position.
12. Please provide updates on all health reform activities that you have submitted under the GMCB's extended NPR cap during previous budget reviews including
- a. The goals of the program;
 - b. Any evidence you have collected on the efficacy of the program in meeting these goals;
 - c. Any other outcomes from the program, positive or negative;
 - d. Whether you have continued the program and why.
 - e. If you have discontinued one or more of these programs, please describe how you have accounted for this change in past or current budgets.