

FY24 Hospital Budget Guidance

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Agenda



- Review landscape
- FY24 Budget Guidance
 - Overview
 - Budgetary factors and benchmarks
 - Staff plan for submission review and analysis

US Hospital Sector

- Hospitals are experiencing substantial financial challenges:
 - About half of hospitals in the US ended 2022 in the red.
 - The big 3 credit rating agencies have negative/deteriorating outlooks for the industry.
 - While 2023 appears to be off to a more favorable start than 2022, results are still significantly below pre-pandemic levels.

Headwinds: US Hospitals



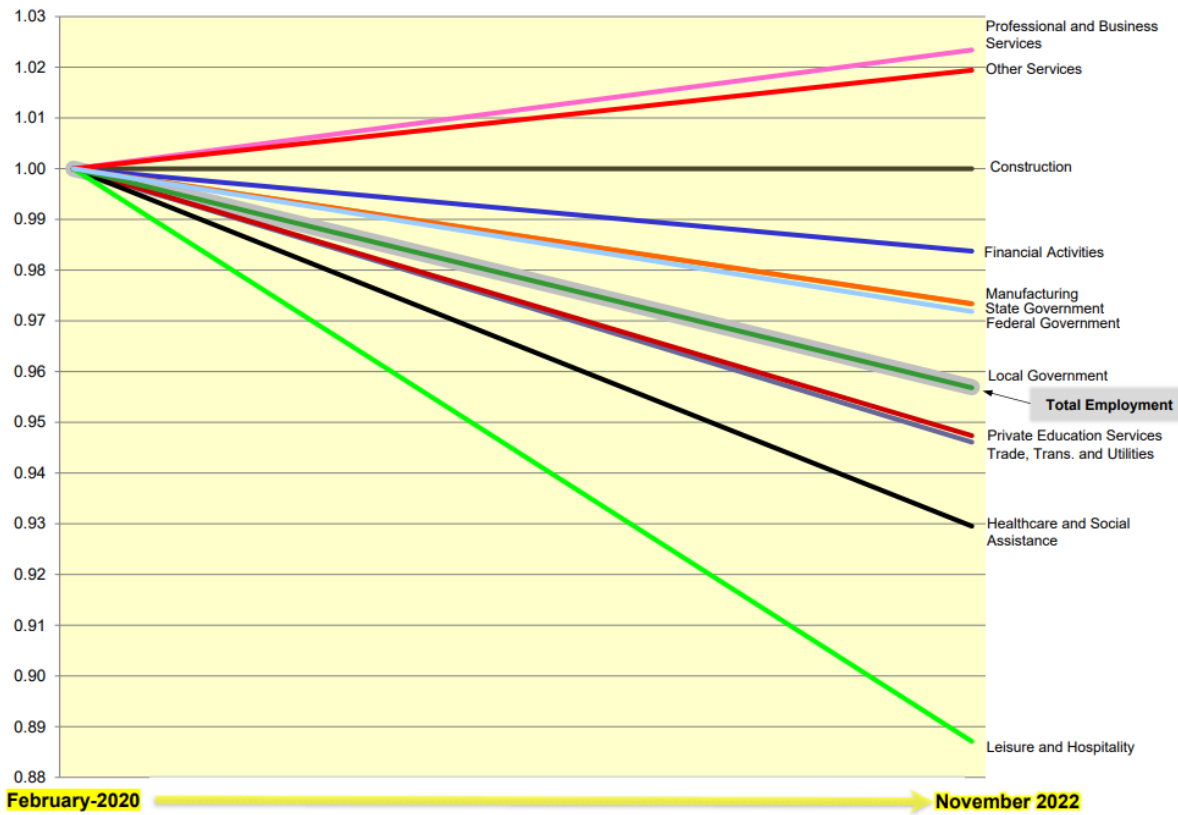
- Workforce
 - Reliance on contractual labor at significantly higher rates
 - Increasing employment vacancies in highly competitive market
 - Exits from health care workforce – retirement and burn out
- Other expense growth
 - Inflation increasing cost of supplies, insurance, and utilities
 - Pharmaceutical costs
- Capacity
 - Patients are staying longer
 - Need for post-acute placements is outpacing availability, increasing uncompensated care for patients who cannot be safely discharged
 - Emergency department boarding continues to increase

VT Labor Market



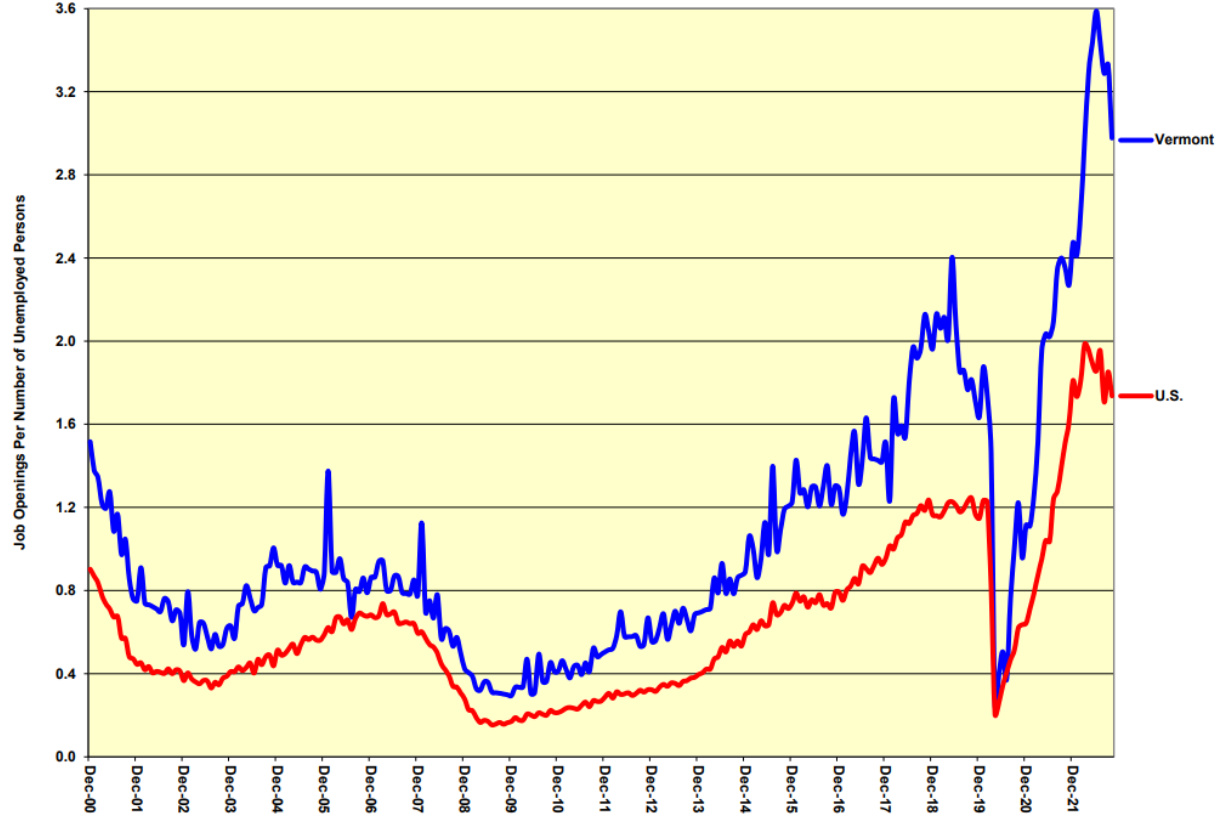
Pandemic Reshuffles Vermont Employment

Employment by Industry in November 2022 Relative to Pre-Pandemic Employment in February 2020, Indexed to 1.00, Seasonally Adjusted Data, BLS



With Three Job Openings for Every Unemployed Worker, Vermont Far Exceeds U.S. Ratio

(Seasonally adjusted data, Source: Bureau of Labor Statistics, U.S. Department of Labor)

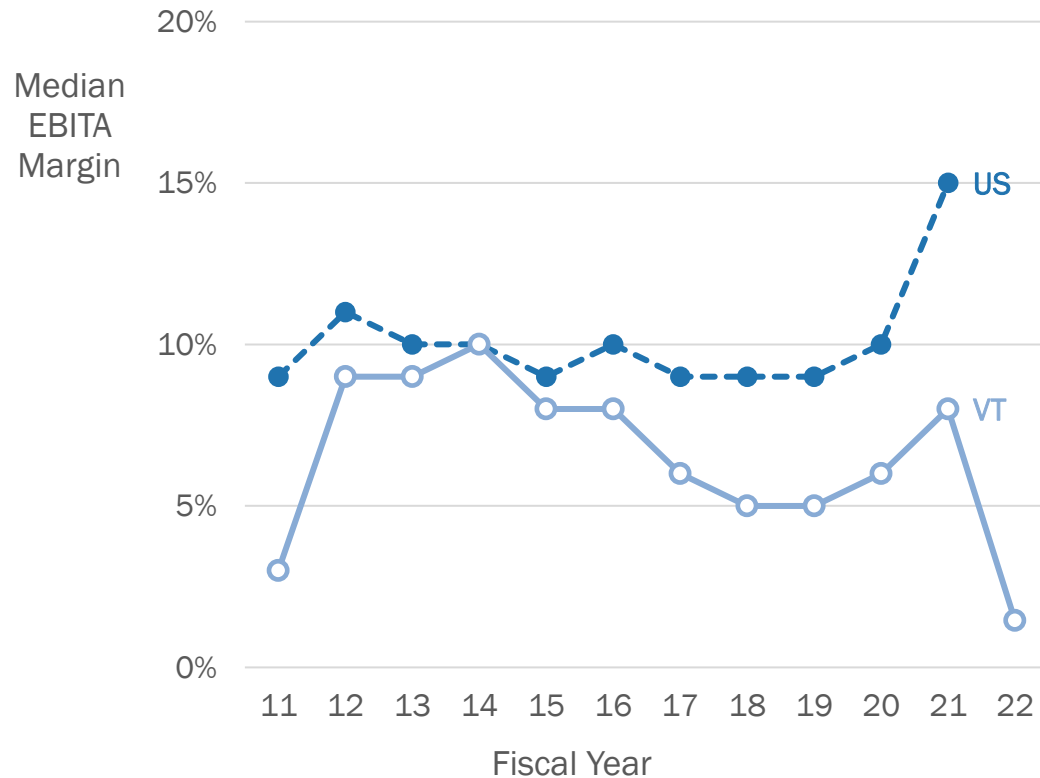


Source: January 2023 Economic Review and Revenue Forecast Update

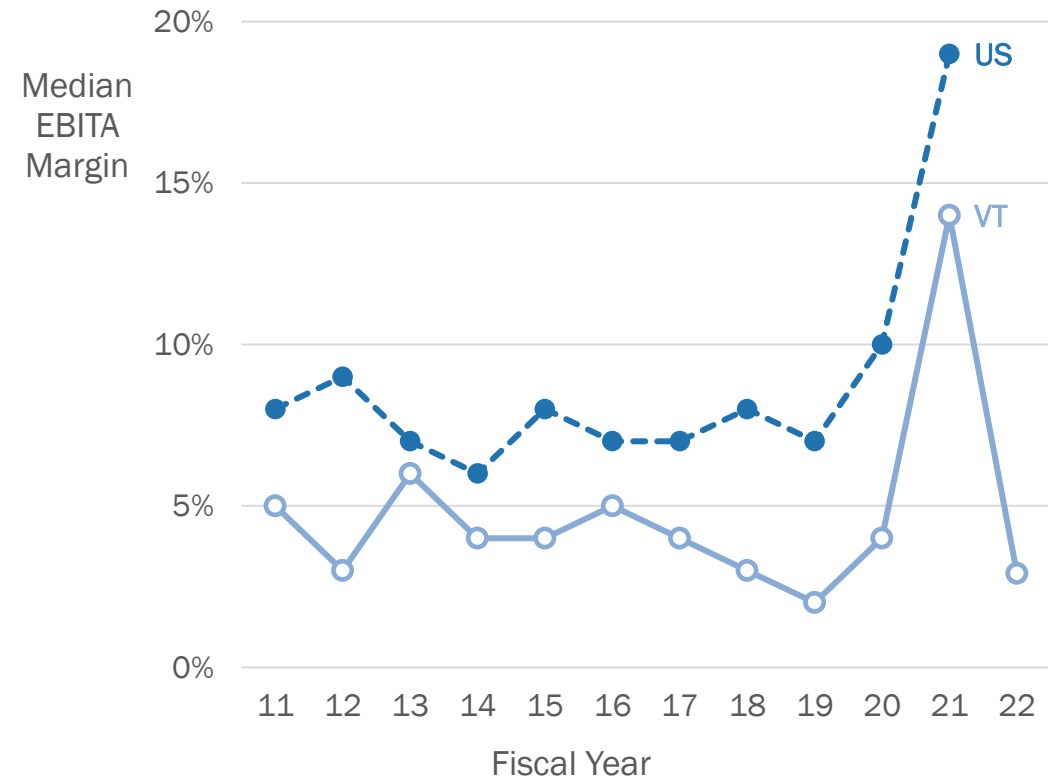
US vs VT: Median EBITDA Margins



Acute Care Hospitals



Critical Access Hospitals

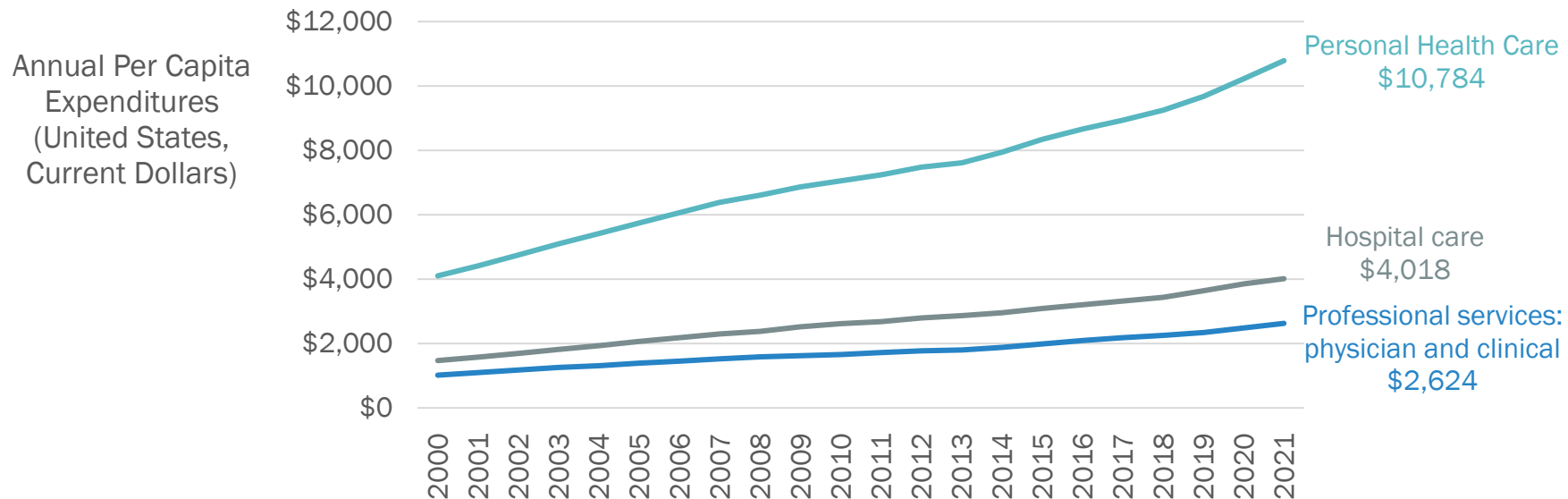


US data from [Healthcare Cost Report Information System](#) for hospitals with a Federal Fiscal Year
 VT data from actuals reported to GMCB by regulated hospitals (GMCB data within +/- 1 percentage point of HCRIS)

Growth in Per Capita Expenditures



- Per capita Personal Health Care Expenditures more than doubled from 2000 to 2021 (+263%).
 - Expenditures associated with hospitals and physician and clinical services represented 62% of (PHC) expenditures in 2021.

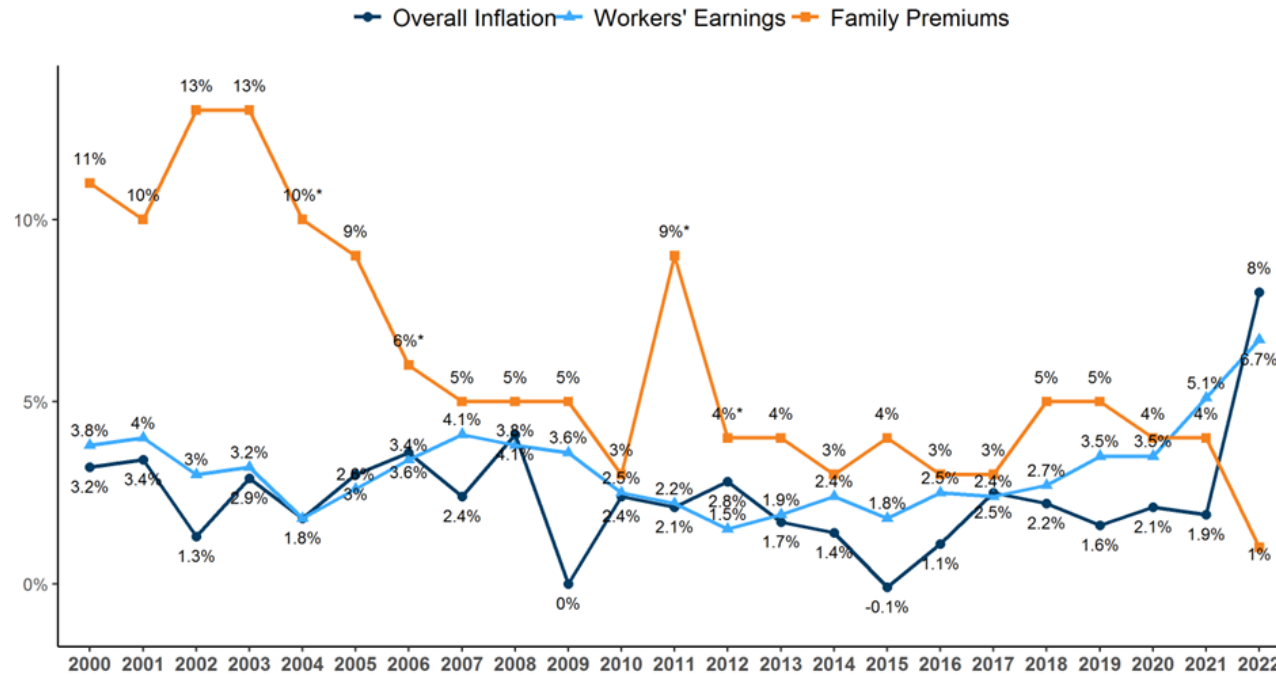


[Source: CMS National Health Care Expenditure Data](#)

Affordability for Consumers



Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2000-2022



* Family Premiums Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2022.



<https://www.kff.org/private-insurance/press-release/annual-family-premiums-for-employer-coverage-average-22463-this-year/>

Employer-Sponsored Health Insurance Premium Growth: VT vs US



Among private firms, Vermont’s per enrolled employee premiums are higher than observed nationally. Vermont premiums have gone up 21% in constant dollars from 2011 to 2021 versus 19% nationally. However, the share of premium paid by employees increased by 27% nationally (versus 21% in Vermont).

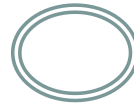
The tables below highlight estimates for the average per employee premiums for single coverage:

VERMONT	2011 (in 2021 \$)	2021	% change
Avg Annual Premium	\$5,582 (\$6,630)	\$8,050	+ 44%
Avg Employee Share	\$1,222 (\$1,452)	\$1,755	(+ 21%)

UNITED STATES	2011 (in 2021 \$)	2021	% change
Avg Annual Premium	\$5,222 (\$6,203)	\$7,380	+ 41% (+ 19%)
Avg Employee Share	\$1,091 (\$1,296)	\$1,646	+ 51% (+ 27%)

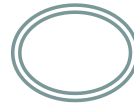
Data source: [Medical Expenditure Panel Survey Insurance Component](#). Constant 2021 dollars computed using CPI-U.

Affordability Challenges in Vermont



- **Background: VT-Specific Data on Underinsured & Uninsured**
 - The 2021 Household Health Insurance Survey found that 44% of privately insured Vermonters are underinsured in addition to the 3% of Vermonters who are uninsured.
- **Key Findings: HCA Medical Debt Survey Project**
 - Medical debt impacts Vermonters of all ages, income levels, and insurance types.
 - Vermonters often told us that they trust their providers and want to pay back their debt but cannot because the costs exceed their financial means.
 - Vermonters avoid getting care even when it is recommended by their provider because they have medical debt or live in fear of taking on medical debt.
 - Medical debt and lack of consumer affordability make the Triple Aim an unattainable goal.

Voices of Vermonters



- “I have taken money from savings, and I am currently working 4 jobs to pay off [medical] debt... It is embarrassing to ask for help and to know that you are unable to pay your bills yet be told that you make too much money for help.”
(18-26, Orange, Insured)
- “My medical debt is the biggest challenge in my life right now, and I want to get rid of it as soon as possible. I have to do more... It scares me, because the increase in debt is incalculable, but I have to ensure the health of my family.”
(27-40, Orleans, Uninsured)
- “We worry a lot if we will die sooner than we would if we could have preventative medical care.” *(41-60, Chittenden, Insured)*
- “The ding medical debt made on my credit score made it hard for me to secure housing and left me homeless for a period of time during Covid-19.” *(18-26, Chittenden, Insured)*
- “Medical debt impacts my life. No food, no internet for school, no car insurance. The list goes on. Especially as a college student (that worked full time), you had to choose between the collections calls or getting food.” *(27-40, Windsor, Insured)*

FY24 Budget Process



- The GMCB is in the process of reviewing and updating its hospital budget regulatory process. The FY24 cycle is intended as a bridge between the way Vermont has historically regulated hospitals and a new, standard process that will begin rolling out in FY25.
- FY24 is meant to start conversations about moving away from caps on patient revenue to using evidence-based approaches to understand and regulate hospital expenses and their relative growth.

Responding to Feedback

- Mathematica Policy Research conducted interviews with GMCB members, the Health Care Advocate, and almost all Chief Financial Officers at Vermont's hospitals to assess the historical process. Suggested improvements include:
 - Use consistent, evidence based key performance indicators to guide decision making
 - Specifying a standard framework that incorporates appropriate benchmarks
 - Increase efficiency of the process and reduce administrative burden on regulated entities
 - Consider tailoring aspects of the process based on hospital characteristics (e.g. type of hospital, resources, patient populations)

Alignment with Payment Reform



- Staff's approach in FY24 is designed to understand changes in budgeted revenue, as they are driven from hospitals' expenses.
- By pivoting to review and understand expense drivers, the GMCB will be better positioned to incorporate potential new payment mechanisms and models.

Notable Changes

- Instead of an overall cap on Net Patient Revenue Growth, staff recommend using thresholds of expense growth established by the Board based on publicly-available data.
- Staff also recommend basing budget decisions on **FY22 actuals** instead of changes from the approved FY23 budgets.

Works in Progress for FY25



- Quality
 - Staff recommend continuing to develop the [Hospital Quality Framework](#) monitoring quality outcomes across the delivery system.
- Productivity
 - Indicators are difficult to develop and validate. Substantial analysis and research is required to determine accurate and evidence-based metrics for hospital accountability.
- Patient Access
 - While the FY24 guidance will include a measure, staff recommend considering a partnership with another organization for more comprehensive indicators of patient access.
- Equity
 - Many measures are emerging, including some proposed by CMS. Staff recommend further exploration for GMCB's monitoring.
- Consumer Affordability
 - While not explicitly identified in GMCB's duties in hospital budget regulation, it is part of the organization's purpose. Staff recommend work in this area is developed to help inform the Board's larger regulatory work and determine how to consider it in hospital budget regulation.
- Per Capita Budgeting
 - These ideas are being explored as part of larger payment reform. GMCB will work on developing measurement in this area.

FY24 Guidance: Overall Approach



- Staff recommend a series of budgetary assumptions with thresholds set in the GMCB guidance.
- The Board should determine what to do for proposed budgets that fall below the thresholds established in guidance.
 - For budgets exceeding thresholds, hospitals would provide their evidence for the alternative value(s) for consideration by the Board as part of hearings.
- Staff will prepare a series of planned analyses outlined in the guidance.
 - These analyses will be developed and shared prior to the July 1st submissions to allow for refinement and validation of methods.

Budgetary Factors

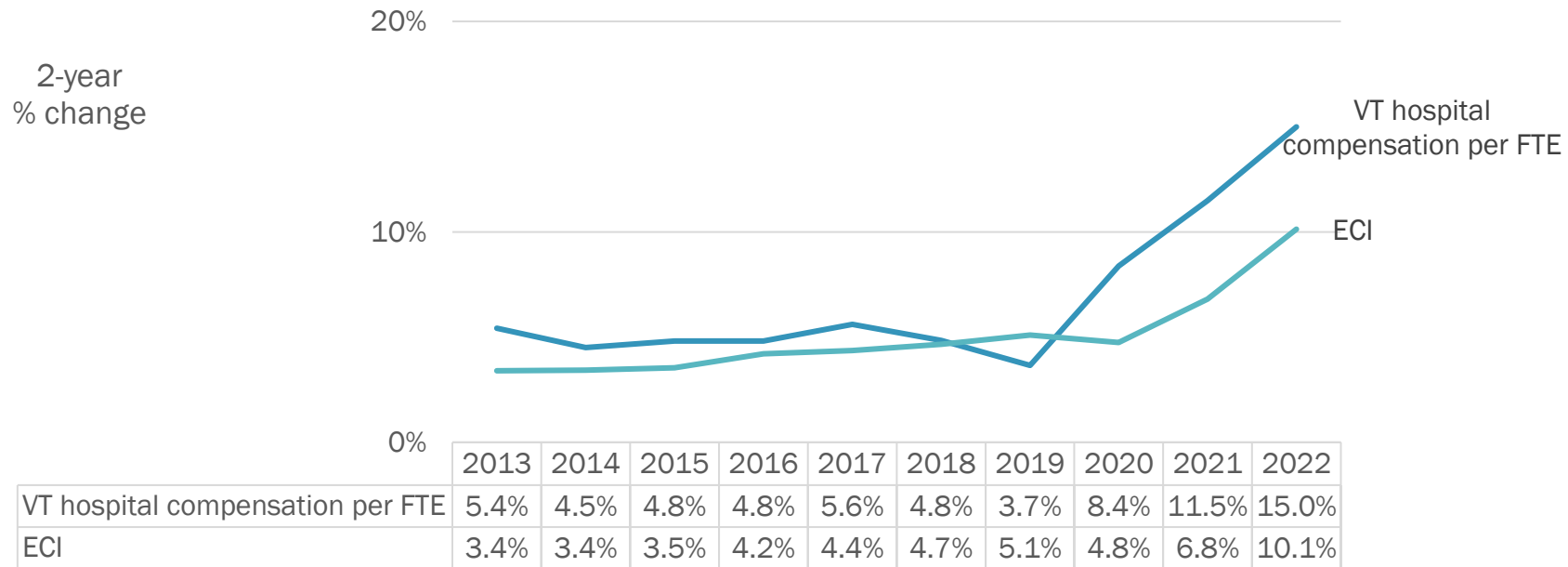
- Recommended areas for expense growth in the FY24 guidance:
 - Labor
 - Utilization
 - Pharmaceutical costs
 - Cost inflation
 - Commercial price
 - Financial benchmarks
 - Known pricing changes: Medicare and Medicaid
 - Uncompensated care
 - Other

Budgetary Factors: Labor



Over time, the 2-year change in total compensation per FTE in Vermont tends to be higher than the change in the index. Since 2020, Vermont hospitals' 2-year increase has been higher than the Bureau of Labor Statistic's Employment Cost Index (ECI) changes.

Since 1986, the average 2-year increase in ECI was 7.0% (ranging from 3.3% to 14.4%) and a standard deviation of 3.2%. (Note: 2022 estimated due to missing data)



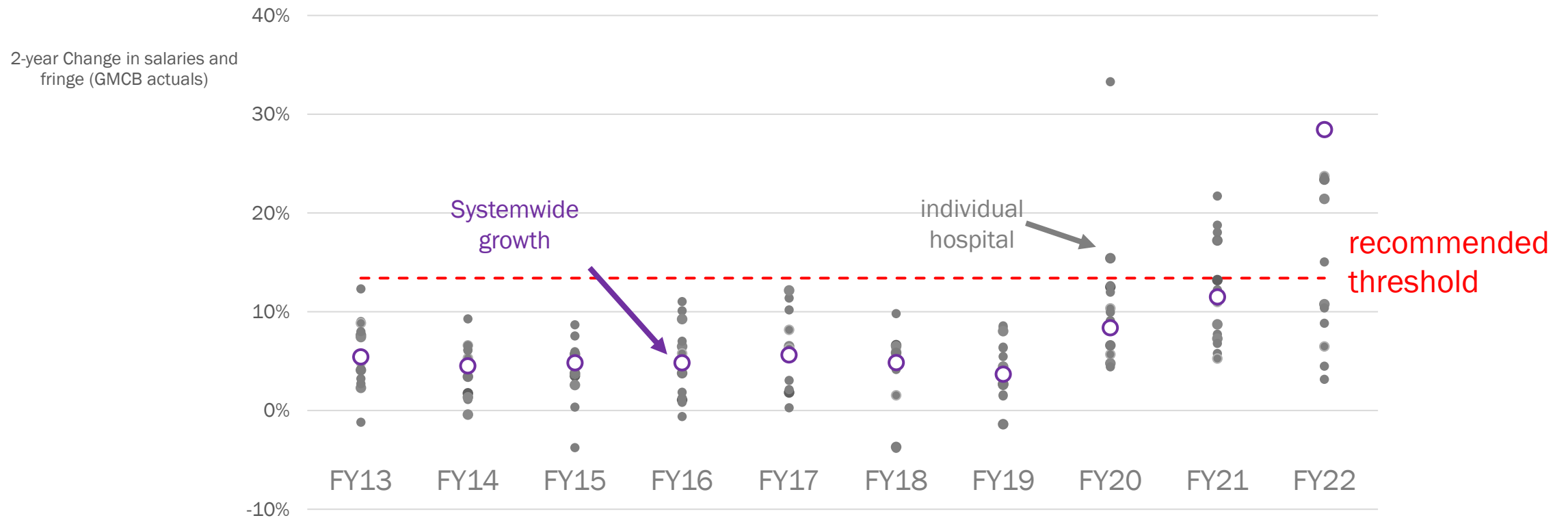
Budgetary Factors: Labor

- Staff recommendation:
 - Set a target of no more than 13.4% growth (i.e. average ECI 2-year growth rate + 2 standard deviations) in per FTE salary and benefit expenses from FY22 actuals to FY24 budgets.
 - Due to the relatively small size of Vermont hospitals, there is quite a bit of volatility in this information.
 - Since hospitals are highly motivated to reduce reliance on contractual labor, staff do not recommend any specific guidance related to this factor.

Budgetary Factors: Labor

Here is how the recommended threshold (13.4%) compares with observed growth in hospital expenses over time.

Note: some FTE data are missing, distorting the systemwide value for FY22.



Budgetary Factors: Labor

- Potential Alternative:
 - Set targets based on direct patient labor and contracted labor from Cost Reports. (Note: these data are limited to PPS hospitals and will be driven by number of FTEs, in addition to wages.)

2-Year % Change in Total Cost (Medicare Cost Reports)						
	Direct Patient Care			Direct Patient Care: Contracted Labor		
	National	New England States	VT	National	New England States	VT
2013	7.8%	8.1%	7.8%	14.3%	19.4%	242.4%
2014	4.6%	3.3%	7.3%	11.0%	4.2%	90.0%
2015	6.4%	3.9%	9.6%	21.6%	-1.3%	48.4%
2016	9.9%	6.0%	9.1%	33.8%	21.3%	63.8%
2017	10.8%	5.5%	9.7%	26.8%	42.6%	43.8%
2018	7.4%	3.7%	3.9%	8.8%	5.9%	43.8%
2019	6.7%	7.0%	4.6%	4.9%	-4.7%	14.0%
2020	5.9%	6.9%	9.9%	15.9%	51.1%	3.2%
2021	7.8%	5.4%	14.1%	82.9%	76.4%	143.1%

Budgetary Factors: Utilization

- Staff recommend using historical trends based on the actual data filed with the GMCB.
- While not perfect, it represents the most complete information currently available.
- Utilization has a great deal of variation over time and within hospitals.

Budgetary Factors: Utilization

- Recommended approach:
 - Divide gross inpatient revenue by inpatient admissions to get average charge per admission.
 - Divide gross revenue for other cost centers by the average charge per admission to get estimate of inpatient-equivalent utilization. This gives estimates of total utilization with break outs for:
 - Inpatient
 - Outpatient
 - Chronic care / Skilled Nursing Facility
 - Swing beds
 - Physician
 - Note that this method assumes that changes in case mix or intensity are commiserate with inpatient utilization.

Budgetary Factors: Utilization



2-year changes in the utilization measure are highly variable, especially since FY2020.

	Measure	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22
TOTAL	System Change	3.7%	-2.6%	-1.3%	3.1%	0.5%	-2.2%	-1.7%	-12.8%	-12.3%	8.2%
	Hospital Median	-0.7%	0.7%	1.6%	1.6%	0.3%	0.0%	5.7%	-6.1%	-0.5%	17.7%
	Hospital IQR	18.7%	16.9%	14.1%	14.9%	10.6%	10.0%	8.5%	7.5%	24.4%	27.4%
INPATIENT	System Change	-0.8%	-6.1%	-2.1%	5.9%	2.9%	1.3%	-1.1%	-8.6%	-6.4%	-3.0%
	Hospital Median	-3.8%	-6.0%	0.8%	3.4%	0.0%	0.7%	3.8%	-5.6%	-5.4%	1.1%
	Hospital IQR	10.1%	8.1%	14.8%	8.1%	7.2%	6.9%	9.7%	8.4%	6.0%	11.6%
OUTPATIENT	System Change	2.1%	-0.1%	3.3%	4.4%	-0.5%	-1.0%	0.5%	-11.9%	-12.2%	14.3%
	Hospital Median	0.1%	-1.5%	1.9%	5.0%	-1.2%	1.1%	8.7%	-3.2%	9.2%	27.8%
	Hospital IQR	17.5%	17.5%	10.8%	18.5%	15.4%	12.1%	4.8%	11.9%	24.2%	36.8%
PHYSICIAN	System Change	12.1%	-4.5%	-12.4%	-2.1%	2.4%	-9.9%	-10.1%	-20.0%	-17.5%	4.7%
	Hospital Median	8.6%	1.5%	-2.6%	0.1%	0.0%	0.0%	0.5%	-12.8%	-4.8%	7.2%
	Hospital IQR	80.3%	46.5%	25.9%	34.8%	18.0%	20.1%	10.0%	8.7%	36.9%	48.3%
OTHER	System Change	15.5%	-5.1%	-1.3%	-4.8%	-9.1%	-2.5%	3.5%	-20.2%	-28.4%	5.1%
	Hospital Median	0.0%	-4.5%	-14.7%	6.5%	-1.3%	4.8%	3.0%	-3.9%	-15.4%	9.3%
	Hospital IQR	27.8%	40.2%	32.5%	61.7%	17.3%	40.8%	20.2%	38.2%	60.0%	104.2%

IQR = Interquartile range = 75th percentile value minus 25th percentile value

Budgetary Factors: Utilization

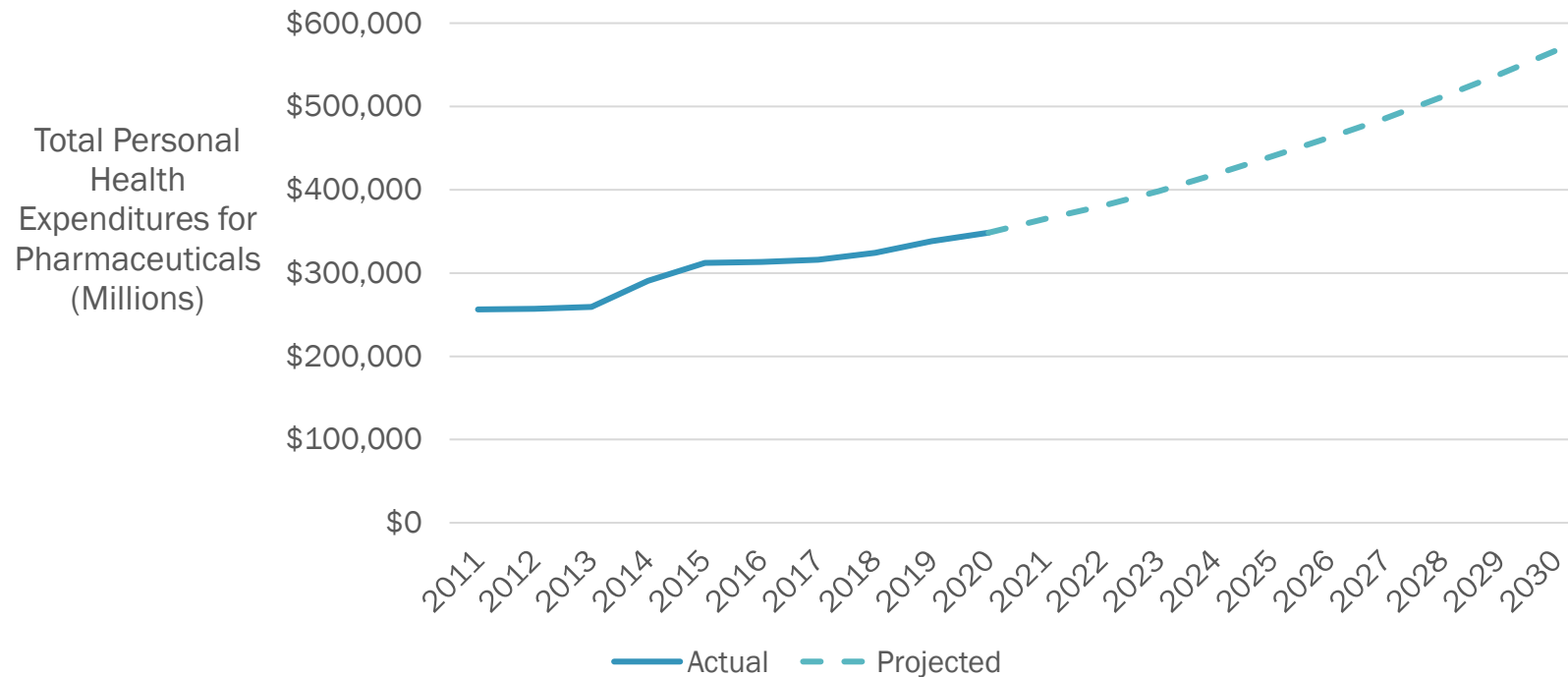
- National Health Care projections forecasted that the heightened demand for care in 2022 will normalize in 2023 and 2024 with slower growth from 2025 to 2030.
 - The utilization growth is projected to remain high for private health insurance in 2023 and 2024, though close to 2021 and 2022 levels.
- Staff recommend a conservative threshold (e.g. 2%) for utilization-based changes from FY22 to FY24 budgets.

Budgetary Factors: Utilization

- Other factors may influence future utilization patterns:
 - Patient behavior
 - Redeterminations in eligibility for Medicaid benefits at the end of the public health emergency
 - Demographics
 - Service offerings
 - Staffing levels
- Staff recommend allowing hospitals to provide an analysis to support these types of adjustments, if the budgeted utilization exceeds the guidance threshold.

Budgetary Factors: Pharmaceutical Costs

- Pharmaceutical costs are one of the highest growing categories in health expenditures.



[Data source: CMS, National Health Expenditure Data](#)

Budgetary Factors: Pharmaceutical Costs



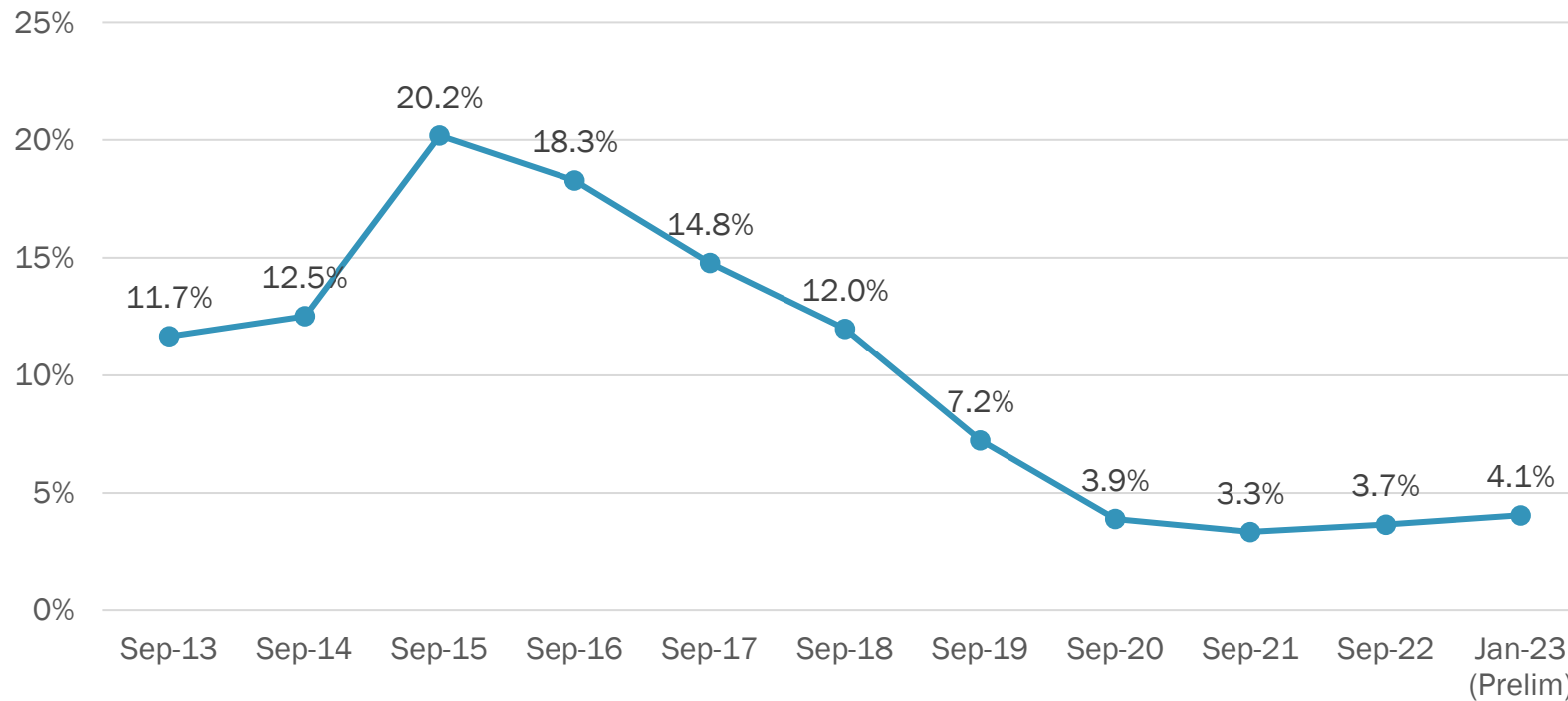
- Measuring the costs and revenue associated with pharmaceuticals may differ depending on the type of arrangement or the point at which they are measured.
- Hospitals may be both a purchaser and supplier of prescription medication, which is not captured well in the data as GMCB has historically collected it.
- Some new medications have extremely high costs, which is an issue both payers and providers struggle to balance in caring for patients.

Budgetary Factors: Pharmaceutical Costs

- Pharmaceutical costs increases are likely to be material to FY24 budgets.
- Hospitals' expenses and revenue associated with pharmaceuticals will depend both on price, but also utilization.
- Staff believe this area should be further developed for FY25, which will allow for an opportunity to refine our data model.

Budgetary Factors: Pharmaceutical Costs

- For FY24, staff recommend using the Producer Price Index for prescription drugs.



Source: US Bureau of Labor Statistics, PPI Commodity data for Special indexes-Pharmaceuticals for human use, prescription, not seasonally adjusted, series ID WPUSI07003

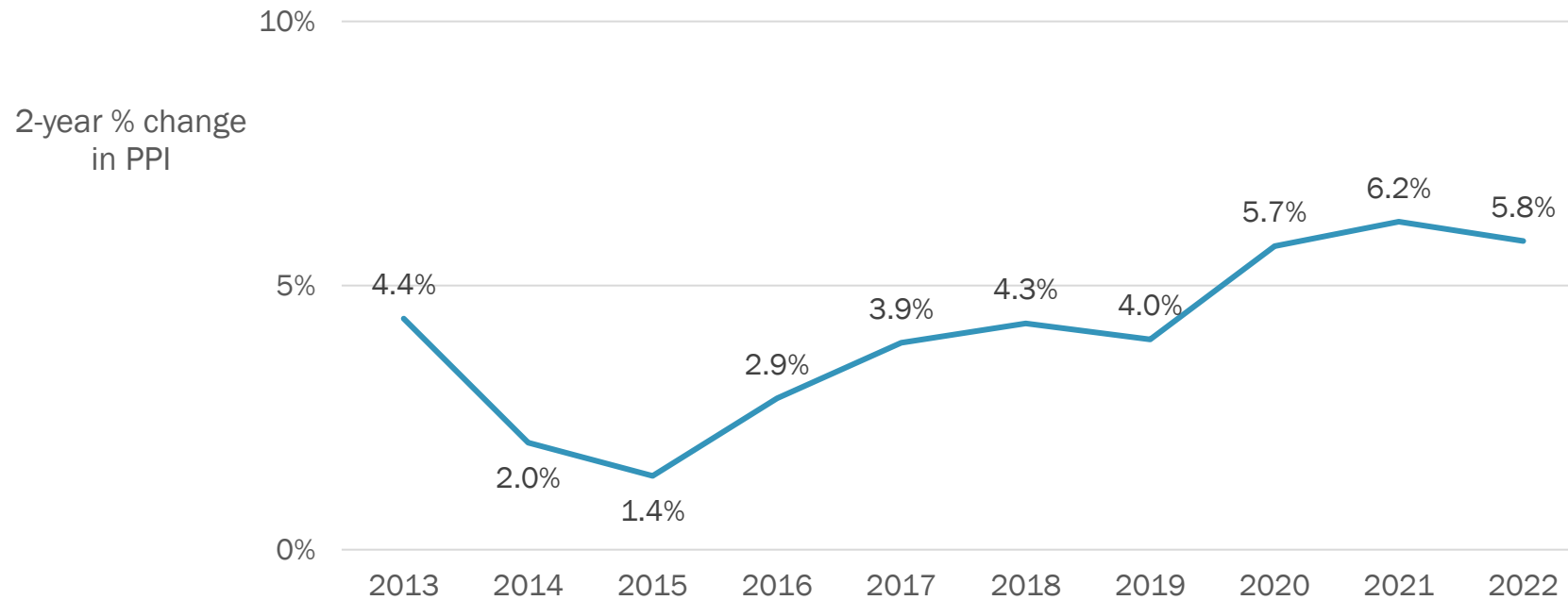
Budgetary Factors: Pharmaceutical Costs



- Staff recommend a threshold of 4.4% for expense growth due to drug *price*. This represents the average 2-year change since 2019.
- Changes due to utilization or the mix of pharmaceuticals purchased should be isolated and provided by hospitals in their narratives.

Budgetary Factors: Cost Inflation

- Staff recommend using the Producer Price Index (PPI) for general medical and surgical hospitals. Staff recommend a threshold of 6% in inflationary growth from 2022 to 2024.



Budgetary Factors: Commercial Price



For reference, Medicare’s market baskets are forecasted to increase 13% for inpatient from Q4 of 2022 to Q4 of 2024 and physician practices at 12%.

Market Basket	2019 Q4	2020 Q4	2021 Q4	Forecast 2022 Q4	Forecast 2023 Q4	Forecast 2024 Q4	Forecast 2025 Q4
Inpatient Hospital	2.20%	2.00%	3.70%	5.80%	3.70%	3.00%	2.90%
Cumulative over 2022					9.71%	13.01%	
Medicare Economic Index	1.70%	2.00%	2.80%	4.50%	3.90%	2.90%	2.70%
Cumulative over 2022					8.58%	11.72%	

Historical Data through 2022Q2
 Released by CMS, OACT, National Health Statistics Group, dnhs@cms.hhs.gov
 12/6/2022

Budgetary Factors: Commercial Price



- [RAND's Hospital Transparency Study \(Round 4\) included Vermont data to help gauge the relative and standardized prices by hospital \(2018 to 2020\).](#)

	Relative price - OP		Standardized price per OP service		Relative price - IP		Standardized price per IP stay		Relative price for professional services (IP and OP)	
	value	z-score	value	z-score	value	z-score	value	z-score	value	z-score
Brattleboro	325%	0.52	\$352	0.23	165%	-0.60	\$16,247	-0.42	165%	0.03
Central VT	279%	0.12	\$303	-0.09	160%	-0.66	\$17,892	-0.30	180%	0.28
Copley	148%	-0.99	\$246	-0.46	130%	-1.02	\$18,305	-0.28	145%	-0.31
Gifford	200%	-0.55	\$452	0.90	148%	-0.81	\$21,099	-0.08	115%	-0.82
Grace Cottage	218%	-0.40	\$366	0.33					128%	-0.60
Mt Ascutney	149%	-0.99	\$289	-0.18	94%	-1.46	\$28,152	0.41	254%	1.53
North Country	295%	0.26	\$477	1.06	178%	-0.44	\$24,523	0.16	157%	-0.11
Northeastern VT	206%	-0.50	\$418	0.67	152%	-0.76	\$22,634	0.03	147%	-0.28
Northwestern	213%	-0.44	\$227	-0.59	133%	-0.99	\$14,332	-0.55	148%	-0.26
Porter	168%	-0.82	\$314	-0.02	119%	-1.16	\$18,609	-0.25	153%	-0.18
Rutland	321%	0.48	\$330	0.09	216%	0.01	\$22,665	0.03	206%	0.72
Southwestern VT	309%	0.38	\$331	0.10	219%	0.05	\$20,397	-0.13	148%	-0.26
Springfield	195%	-0.59	\$277	-0.26	125%	-1.08	\$14,908	-0.51	148%	-0.26
University of VT	356%	0.78	\$351	0.23	256%	0.50	\$28,896	0.46	250%	1.46

Budgetary Factors: Financial Benchmarks

- Recommended Key Performance Indicators for Financial Health:
 - Operating margin
 - Operating EBIDA margin
 - Debt service coverage ratios
 - Days Cash on Hand
 - Average age of plant
- Staff are still compiling evidence for recommendations for standard thresholds for these factors.

Budgetary Factors: Known Pricing Changes



- Staff will track and keep the Board apprised of any known changes to Medicare or Medicaid reimbursement.
- The decision point is what should happen with this information in August as the Board reviews budgets.
- If the GMCB plans to incorporate these changes in their deliberations, a consistent approach should be codified in guidance.

Budgetary Factors: Uncompensated Care



- These budgeted areas will be highly sensitive to assumptions related to redeterminations for Medicaid eligibility with the end of the public health emergency.
- In the past, the Health Care Advocate suggested more attention on the ratio of bad debt to charity care. Is this an avenue the GMCB would like to pursue?
- Are there any thresholds the Board would like to codify in guidance for these values?

Budgetary Factors: Other?

- The categories outlined are not intended to be comprehensive. Rather, they represent the areas most likely to influence FY24 budgets and areas where budgets have missed in the past.
- Hospitals should feel free to outline other factors that are important to understanding their proposed budgets.

Staff Analysis

- Regulatory Compliance
 - Are filings complete and on time?
- Assessment of Financial Health
 - What is the picture of hospitals' current financial health relative to benchmarks established in the guidance?
- Historical Budget Performance
 - How do budgets and actuals historically compare for the hospital?
- Similarly Situated Hospitals
 - How do Vermont's hospitals compare with hospitals with similar characteristics in other states?
- Cost and Reimbursement Variation
 - How do costs and reimbursement vary?
- Volume and Market Share
 - Are patients changing care patterns? Is market share changing over time for certain services? How does market concentration compare within Vermont and to other health service areas?
- Other Data Sources
 - Other available data to review and understand filings.

Next Steps

- Staff will incorporate feedback and produce a full draft of the FY24 guidance to review at the next meeting.
- Reminder: Guidance must be adopted by **March 31st**