State of Vermont
Green Mountain Care Board
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Report to the Legislature

REPORT ON THE GREEN MOUNTAIN CARE BOARD'S FINDINGS REGARDING ANY "STRANDED DOLLARS" IN THE FISCAL YEAR 2016 BUDGETS PROPOSED BY VERMONT HOSPITALS

In accordance with Act 54 of 2015, Section 47

Submitted to the
House Committee on Health Care; the Senate Committees on Health & Welfare and Finance; the Health Reform Oversight Committee; and the Joint Fiscal Committee

Submitted by the
Green Mountain Care Board

October 15, 2015

Introduction

Act 54 of 2015 requires the Green Mountain Care Board to analyze the fiscal year 2016 proposed budgets of Vermont's hospitals in order "to identify any stranded dollars" in those budgets. The Board must report its findings to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, the Health Reform Oversight Committee, and the Joint Fiscal Committee by October 15, 2015. 2015 Vt. Acts & Resolves No. 54, § 47(b).

The General Assembly's intent in seeking this information is "to repurpose the stranded dollars to enhance State spending on the Blueprint for Health." *Id.* By "stranded dollars," the General Assembly refers to Disproportionate Share Hospital (DSH) payments and "free care" charges "allocated in hospital budgets to serve those Vermonters" who were uninsured in 2012 but obtained coverage by 2014. *Id.* § 47(a) (citing a decrease in the number of uninsured Vermonters from 6.8% in 2012 to 3.7% in 2014, as reflected in the 2014 Vermont Household Health Insurance Survey). Noting that DSH payments "have remained unchanged" and free care charges in approved hospital budgets increased from $53,034,419.00 in fiscal year 2013 to $58,652,440.00 in fiscal year 2015, Act 54 states that "these funds are stranded in the hospital budgets to pay for 'phantom' uninsured patients." *Id.*

The Board agrees with the overarching strategic intent reflected in this legislation. Through rigorous guidance, public hearings, staff analysis and open public debate, the Board attempts to reconcile a myriad of fiscal impacts to the 14 hospital budgets. While Act 54 appears to focus on two specific elements (disproportionate share (DSH) payments and hospital free care), the totality of a hospital's budget actually depends on the complex interactions between these and many other inputs, including the impact of the Affordable Care Act on payer mix. In addition, external factors like the sun-setting of state health insurance programs Catamount and the Vermont Health Access Plan, the increase in high deductible health plans, the Medicaid reimbursement "bump" and sunset, and changes to DSH payments at the individual hospital level combine to obscure the accurate identification of cause and effect influencers on these budgets. As a result, it is not possible to isolate the impact of any one driver and reconcile these capital flows.

The Board is committed to reducing the cost of health care to Vermonters, and we believe our process, in the aggregate and over time, is moving us towards this goal. As explained below, the Board analyzed the FY16 budgets proposed by Vermont's hospitals and, while it did not find evidence of "stranded dollars" as defined in Act 54, it did see continued progress on containing cost growth in our hospitals.

Background

Every year, the Board must review and establish each hospital's budget by September 15, and must issue a written order reflecting its decision by October 1. 18 V.S.A. § 9456(a), (d)(1). To that end, the Board requires the hospitals to submit their proposed budgets for the upcoming fiscal year[1] on or before July 1. GMCB Rule 3.000: Hospital Budget Review, § 3.203. The Board may adjust a budget established under this section upon a hospital's showing of need based upon exceptional or unforeseen circumstances, 18 V.S.A. § 9456(f), or based on the Board's independent

[1] The hospitals' fiscal year is defined in statute as beginning on October 1. 18 V.S.A. § 9454(b).

review of a hospital's performance under its budget. GMCB Rule 3.000, § 3.401.

Net patient revenue targets

After a robust public process in late 2012 and early 2013, the Board adopted a policy governing hospital budget review for fiscal years 2014-2016, as well as separate policies on hospital budget enforcement, provider practice transfers, and community needs assessments.[2] The hospital budget review policy established two key parameters for the hospitals' FY16 budgets: First, the Board set a net patient revenue (NPR) growth cap of 3.0% over the hospitals' FY15 budget bases. NPR includes payments hospitals receive from patients, government, and insurers for patient care, but does not include revenues from activities such as cafeterias, parking, and philanthropy. A key indicator used to assess changes in hospital budgets, NPR generally tracks closely with hospital expenditures.

Second, the Board established an additional NPR growth allowance for FY16 of up to 0.6% for "credible health reform proposals." Hospitals bear the burden of convincing the Board that such revenue will be invested in building a reformed delivery system. The Board offered the following categories as examples of reform initiatives that the Board may deem credible:

a. Collaborations to create a "system of care"
b. Investments in shifting expenditures away from acute care
c. Investments in population health improvement
d. Participation in approved payment reform pilots
e. Enhanced primary care and Blueprint initiatives
f. Shared decision making and "Choosing Wisely" programs

The Board chose NPR as its key budget measure and target for FY14-16 because it is a good proxy for the amount of "new money" each hospital intends to spend in a given year. The review process, supported by the Board's policy on provider transfers and acquisitions, enables the Board to keep NPR growth within its target, taking into account the movement of practices or service lines in and out of hospitals' budgets.

The FY16 budgets, as submitted, requested a system-wide NPR increase of 3.6%, or approximately $79.8 million, over the hospitals' FY15 budgets. As approved by the Board, system-wide NPR would grow by no more than 3.5%, or $78.4 million, over FY15. Therefore, the aggregate increase sought by the hospitals for FY16 was consistent with the 3.6% growth cap imposed by the Board's policy. In addition, the approved FY16 budgets included six acquisitions or divestitures of service lines or practices. Accounting for those changes yields an adjusted NPR growth figure for FY16 of 3.2%, or $71.8 million. This adjusted figure more accurately reflects actual growth—"new money"—in the health care system at large.

Overall system weighted average rate increases

In addition to NPR, the Board establishes each hospital's proposed "rate increase": the overall average amount by which a hospital must increase its prices to attain its NPR increase. The actual

[2] The policies are available at: http://www.gmcboard.vermont.gov/hospital_budgets/policies

changes in prices charged by each hospital will vary across service lines and goods and services provided by the hospital. The actual prices paid by each commercial payer can vary because prices are established through contract negotiations. Medicaid and Medicare prices are not typically negotiable, and reimbursement is instead established through those payers' unique fee schedules and update factors. In addition, rates can vary based on changes in other elements of a hospital's budget, including the distribution of Medicaid's disproportionate share hospital payments and changes in bad debt and free care.

In our review this year, we approved an overall system weighted average rate increase of 4.37%, the lowest aggregate rate increase in Vermont since 2001. Most of this increase will be collected from commercial insurers, because Medicare and Medicaid reimbursement generally does not vary with hospital price changes. Therefore, the lower the rate increase, the lower the costs that must be covered by commercial insurance plans.

Free care & "stranded dollars"

Free care "consists of services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay." American Hosp. Ass'n, Uncompensated Hospital Care Cost Fact Sheet (Jan. 2015), at 2, *available at* http://www.aha.org/content/15/uncompensatedcarefactsheet.pdf. In Vermont, free care comprises approximately 1% of gross patient revenue, a figure that has been stable over time.[3] In developing its budget, each hospital estimates the demand for free care it will face in the upcoming fiscal year. The hospital uses that estimate, along with numerous other factors, to build a rate increase sufficient to generate revenue that will cover the hospital's costs. These estimates—constructed approximately six months before the beginning of the fiscal year—may turn out to be higher or lower than the actual demand for free care faced by the hospital during the fiscal year. The hospital, however, does not typically adjust its revenues or expenses in the middle of the fiscal year to correct for these changes and other unexpected events as they unfold. Therefore, if a hospital provides less free care than it estimated, the most direct way to correct for any excess revenue would be to lower the prices charged to commercial payers (and, in turn, ratepayers) for a future period.

Act 54's definition of "stranded dollars" does not square with the reality of how hospitals construct their budgets or how the budgets function. Act 54 correctly states that the reduction in the number of uninsured Vermonters has increased costs to the General Fund. There is, however, no direct, measurable correlation between Vermonters obtaining insurance coverage and how hospitals budget for free care, in part because hospitals provide free care to both insured and uninsured Vermonters.[4]

Rather than hunt for "stranded dollars" by scrutinizing isolated components of the hospitals' budgets, the Board has chosen to first exert downward pressure on NPR and, secondarily,

[3] For the period 2010-2016, Vermont hospitals budgeted, on average, 1.1% of gross patient revenue for free care. That percentage ranged from 0.9% to 1.3% over that time span.

[4] Assume a patient receives services for which she is billed $1000, half of which is covered by her insurance plan. If, despite the insurance coverage, that patient still qualified under the hospital's free care policy, the hospital would then write off some or all of the remaining $500 as free care. The fact that a patient has insurance does not mean that the patient will not receive free care, just as insurance does not pay all of every bill.

commercial rate increases. By doing so, the Board has encouraged the hospitals to control revenue growth and in turn the growth of price increases to commercial payers. NPR growth for FY14-16 has been historically low, as is the hospitals' overall rate increase for FY16.

Moreover, the Board's regulatory process prevents hospitals from gaining at the expense of ratepayers by over- or under-estimating elements of their budgets. First, the Board's detailed review of the proposed budgets enables the Board to question and, if appropriate, adjust the hospitals' assumptions. The Board typically adjusts several hospitals' budgets before approving them; the Board made five such adjustments this year.

Second, the Board has adopted an enforcement policy[5] under which it reviews differences between hospitals' budgets and their performance during the fiscal year in question. For example, in the spring of 2015, the Board examined FY14 performance and required three hospitals to correct for actual revenue in excess of their budgeted revenue by instructing each hospital to address the discrepancy in its next budget. And in each case the hospital did so by lowering its rate increase for the upcoming fiscal year. This enforcement mechanism enables the Board to initiate corrective action when a hospital's actual revenue diverges significantly from its budgeted revenue, whether the cause relates to free care, disproportionate share payments, the migration of uninsured Vermonters into insurance plans, or any of the other myriad factors that impact a hospital's revenue and expenses.

Findings

1. As discussed above, the overall system weighted average rate increase for FY16 is 4.37%. *See* Table 1 (charting the overall system weighted average rate increases for FY01-16). As explained above, most of that increase will be collected from commercial insurers, and, in turn, ratepayers.

2. Based on the Board's review of the information submitted by the hospitals in their FY16 budgets, a 1% change in the overall system weighted average rate increase would result in a $10.6 million change in overall NPR.

3. Total free care across the hospital system is budgeted to decline by $12.8 million in FY16, from $58.7 million to $45.9 million, though not every hospital expects to see a budgeted decline. *See* Table 2 (showing budgeted free care for FY15-FY16 as well as the difference between the two for each hospital).

4. Total operating surplus across the hospital system is budgeted to decline by $6.6M in FY16, from $76.3 million to $69.7 million. Expressed as a percentage, total budgeted operating surplus across the hospital system declined from 3.2% of total net operating revenues in the FY15 budgets to 2.9% in the FY16 budgets.

5. The decline in operating surplus indicates that the hospitals did not use the reduction in projected free care to enhance surplus. This follows because if free care decreases, and no other changes occur in the budget, the free care decrease would flow to operating surplus.

[5] The enforcement policy is available at: http://www.gmcboard.vermont.gov/hospital_budgets/policies

6. Using Finding 2 as the conversion factor, the overall system weighted average rate increase (most of which would be borne by commercial ratepayers) would have been 1.2% higher but for the budgeted $12.8 million decline in free care in FY16.

7. Because we do not see an increase in operating surplus resulting from the decrease in free care, we believe it is reasonable to conclude that the hospitals used the free care decline to suppress the overall system weighted average rate increase, as described in Finding 6.

8. Based on our observations and analysis described above, we do not find any “stranded dollars,” as that term is defined in Section 47 of Act 54, in the FY16 budgets.

Table 1

Vermont Hospital System
Overall Weighted Rate Increase

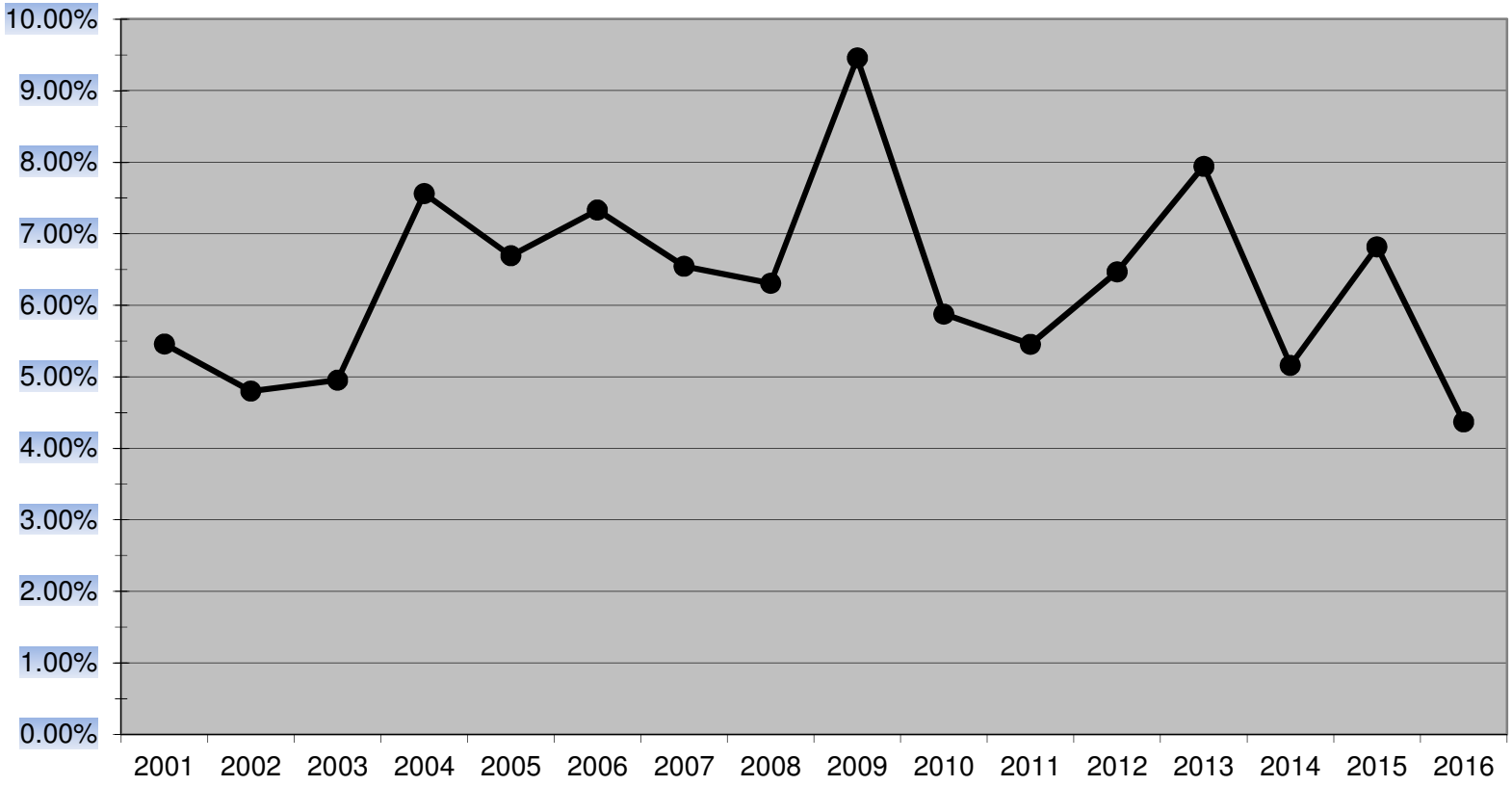

Table 2

Vermont Community Hospitals

Free Care	2015B	2016B	$ Change 2015B-2016B
Brattleboro Memorial Hospital	$ (2,819,482)	$ (3,122,313)	$ (302,831)
Central Vermont Medical Center	$ (4,162,040)	$ (3,883,000)	$ 279,040
Copley Hospital	$ (1,405,955)	$ (1,063,893)	$ 342,062
Gifford Medical Center	$ (1,243,823)	$ (1,285,389)	$ (41,566)
Grace Cottage Hospital	$ (480,015)	$ (261,236)	$ 218,779
Mt. Ascutney Hospital & Health Ctr	$ (766,950)	$ (894,968)	$ (128,018)
North Country Hospital	$ (1,310,379)	$ (1,315,045)	$ (4,666)
Northeastern VT Regional Hospital	$ (2,709,800)	$ (2,900,000)	$ (190,200)
Northwestern Medical Center	$ (1,794,212)	$ (1,621,948)	$ 172,264
Porter Medical Center	$ (1,383,920)	$ (1,354,675)	$ 29,245
Rutland Regional Medical Center	$ (7,391,288)	$ (5,627,667)	$ 1,763,621
Southwestern VT Medical Center	$ (2,360,000)	$ (2,000,000)	$ 360,000
Springfield Hospital	$ (3,461,100)	$ (3,083,706)	$ 377,394
The University of Vermont Medical Center	$ (27,363,476)	$ (17,449,060)	$ 9,914,416
Total All Vermont Community Hospitals	$ (58,652,440)	$ (45,862,900)	$ 12,789,540

Note: Dollars reflected as negative since "free care" is recorded as a contra revenue account .