FY 2024 HOSPITAL BUDGET GUIDANCE AND REPORTING REQUIREMENTS

Effective March 31, 2023
Updated: May 8, 2023

Prepared by:

GREEN MOUNTAIN CARE BOARD
144 State Street
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THIS TIMELINE IS SUBJECT TO CHANGE

Reporting Timeline

MARCH 31, 2023	GMCB provides hospitals with budget guidance, including questions from the Office of the Health Care Advocate (HCA)
MAY 1-14, 2023	Data collection for referral and visit lag (or 3rd next available) for narrative response to question II.e.
JUNE 30, 2023	Hospitals submit budgets and accompanying documentation to GMCB
JULY-AUGUST 2023	GMCB staff review, analyze, and ask questions
AUGUST 1, 2023	Hospital submission of Capital Expenditure sheets in Adaptive due
AUGUST 9, 2023	GMCB staff provides preliminary budget overview at public board meeting
AUGUST 9, 14, 18, 21, and 23, 2023	**Remote** Hospital budget hearings
AUGUST 30, SEPTEMBER 6, 11, 13	Board deliberations (as needed)
SEPTEMBER 15, 2023	Board must complete budget decisions
OCTOBER 1, 2023	Budget orders must be sent to hospitals

INTRODUCTION

The Green Mountain Care Board (GMCB or the Board) is reviewing and updating its hospital budget regulatory process. The Fiscal Year 2024 (FY24) Hospital Budget Guidance and Reporting Requirements (guidance) represents a bridge between GMCB's historical processes and the new standard processes it envisions beginning to implement in FY25.

The FY24 guidance is designed to further focus the budget review process, communicate the GMCB's planned approach to assessing hospitals' performances, and provide opportunity to engage in foundational conversations informed by publicly available data sources. The goal of these conversations and this year's process is to develop measures supported by evidence to strengthen Vermont's regulatory approach.

The GMCB will execute its statutory duties consistent with its purpose to promote the general good of Vermont, as set forth in 18 V.S.A. § 9372, to review and establish hospital budgets consistent with the principles for health care reform in 18 V.S.A. § 9371, as required by 18 V.S.A. §9375(a) and (b)(7), and the GMCB will review and establish hospital budgets in adherence to the requirements of 18 V.S.A. § 9456. Information relevant to and bearing on the GMCB's statutory purpose and principles may be reviewed and considered by the GMCB, as will any testimony and public comment provided to the Board.

FY24 NOTABLE CHANGES

The FY24 budgets shall use **FY22 actuals** as their reference point. FY24 budgets will therefore use 2-year changes from realized revenue and expenses to the proposed budget instead of using annual changes from the previously approved budgets. Experience during FY23 and elements of approved FY23 budgets may be incorporated as hospitals develop their budget proposals for FY24. Narratives should include explanations for adjustments to FY22 actuals to make it a more appropriate base for changes relative to the proposed budget (e.g. provider transfers).

The FY24 budget guidance incorporates the net patient service revenue, fixed prospective payments, and reserves (NPSR or NPR) benchmark established in the FY23 guidance. Hospitals' budgets will be reviewed for compliance with the NPSR benchmark. Hospitals whose budgets comply with the NPSR benchmark will be reviewed for reasonableness of the factors and assumptions outlined in Section I and compliance with the filing requirements of the guidance (i.e., completeness and timeliness). Staff will recommend approval without modification for all hospital budgets that comply with the NPSR benchmark, are based on reasonable assumptions, and meet the administrative filing requirements of the guidance. Hospitals proposing budgets that exceed the benchmark must provide evidence to support the need for additional NPSR, which will be assessed by the GMCB using the factors set out in Section I of this guidance and consistent with the GMCB's statutory obligations. The GMCB will also review and consider information identified in Section II.

As new processes are operationalized, the GMCB in collaboration with the Health Care Advocate and regulated entities may refine methodology, comparison groups, and calculations to optimize their ability to assess the performance of Vermont hospitals. Any such technical refinements will not alter the intended use described in FY24 guidance.

There are also changes to accompanying materials:

- Uniform Reporting Manual will serve as a resource for documenting definitions and methods.

- Adaptive Insights User Guide will serve as a step-by-step guide for the software as it pertains to the guidance.

- An excel workbook containing the data being used by the GMCB will be populated with the most up-to-date information available on the GMCB website.

  NOTE: Due to updates to GMCB's configuration of Adaptive and ongoing release of data, these draft materials will be posted in their final form by May 5, 2023, for use in the FY24 budget process. Staff will conduct training on the new materials and associated changes to Adaptive in May 2023.

In accordance with 18 V.S.A. § 9456(d)(3)(A), the Office of the Health Care Advocate (HCA), which represents the interests of Vermont health care consumers, must receive the hospital's budget filings and other materials, and will participate in the budget review process, including hearings.

Reference GMCB policies for information related to budget enforcement, as well as amendments or adjustments to budgets:

Policy on Budget Amendments and Adjustments

Policy on Hospital Budget Enforcement

REQUESTS FOR CONFIDENTITALITY

Regulated entities may wish to provide support for their proposed budget that includes potentially confidential or proprietary information. If a hospital believes that materials provided to the GMCB are exempt from public inspection and copying under Vermont's Public Records Act, the hospital must submit to the GMCB a written request that the GMCB treat the materials as confidential. A request for confidential treatment must specifically identify the materials claimed by the requestor to be exempt from public inspection and copying and must include a detailed explanation supporting that claim, including references to the applicable provisions of 1 V.S.A. § 317(c) and other law.

FILING CHECKLIST

To facilitate and expedite analysis and discussion, materials must include page numbers and citations to outside information referenced or discussed.

<table>
<tr><th>Exhibit Name</th><th>Due Date</th><th>Purpose</th><th>Filing Location</th></tr>
<tr><td>1. Data collection for referral and visit lag (or 3rd next available)</td><td>5/1/2023 to 5/14/2023</td><td>Timely access to care</td><td>Narrative (response to question II.e.)</td></tr>
<tr><td>2. Narrative</td><td rowspan="10">6/30/2023</td><td>Detailed explanation of budget</td><td rowspan="4">Upload to Adaptive Report folder</td></tr>
<tr><td>3. Verification under oath</td><td>Attestation to truth of filing</td></tr>
<tr><td>4. Most recent IRS Form 990 (including Schedule H)</td><td>Financial Monitoring</td></tr>
<tr><td>5. Most recent Community Health Needs Assessment and/or Implementation Plan</td><td>Community Benefit</td></tr>
<tr><td>6. Income statement</td><td>Financial review</td><td rowspan="3">Input through Adaptive</td></tr>
<tr><td>7. Balance sheet</td><td>Financial review</td></tr>
<tr><td>8. Other operating revenue</td><td>Financial review; assess budgetary assumptions</td></tr>
<tr><td>9. Payer and case mix
Used in place of Payer Revenue (Input) for budget submissions</td><td>Comparative review of payer populations and clinical acuity</td><td rowspan="3">Upload completed excel workbook to Adaptive Report folder</td></tr>
<tr><td>10. Utilization and price assumptions
Used in place of Rate (Input) for budget submissions</td><td>Review budgetary assumptions by service tier (i.e., inpatient, outpatient, professional, other)</td></tr>
<tr><td>11. Staffing summary
Used in place of Hospital and Physician Revenue (Input) for budget submissions</td><td>Review high-level staffing resources and wage growth assumptions</td></tr>
<tr><td>12. Capital expenditures</td><td>8/1/2023</td><td>Compliance with CON program</td><td>Input through Adaptive</td></tr>
</table>

SECTION I: BUDGET GUIDELINES & BENCHMARKS

This section summarizes the benchmarks, factors, and data sources the GMCB may consider and use to review changes from FY22 actuals to FY24 proposed budgets. Hospitals shall document and explain these factors in the narrative accompanying the proposed budget (see Section II Part A). The GMCB will continue to monitor and may update data sources as more recent information is released.

All filings will be assessed for regulatory compliance. Filings will be deemed compliant if all the following conditions are met:

1) All exhibits filed on time with GMCB
   a. Extensions may be requested within two business days of the filing deadline by emailing GMCB.HealthSystemsFinances@vermont.gov indicating why the extension is necessary.

2) All filed exhibits are complete.

The GMCB will review observed growth in expenses and revenue over time for each hospital and considered in relationship with other Vermont hospitals. GMCB staff will also review how closely budgets have approximated actual results over time.

A. NET PATIENT REVENUE/FIXED PROSPECTIVE PAYMENT GROWTH GUIDANCE

At its March 30, 2022, public meeting, the Board established a Net Patient Revenue/Fixed Prospective Payment (NPR/FPP) growth guidance of up to an aggregate of 8.6% for FY23 and FY24 combined (over each hospital's FY22 budget). Pursuant to its authority under Act 85, on August 31, 2022, the GMCB voted to allow each hospital's FY23 NPR/FPP to be reviewed based on its growth from the hospital's projected FY22 NPR/FPP, as provided by the hospital, in addition to comparing the NPR/FPP on a budget-to-budget basis, to determine how the hospital aligns with the Board's guidance. For FY23, the Board voted at its meeting on March 29, 2023, to extend that process and allow the aggregate 8.6% NPR/FPP growth to be reviewed based on growth from actual FY22 NPR/FPP to budgeted FY24 NPR/FPP. If a hospital's budget exceeds the NPR/FPP growth guidance, the Board will review the specifics and support for that NPR/FPP growth provided by the hospital in its FY24 budget submission using the factors and criteria set out in this guidance.

In connection with establishing a hospital's NPR/FPP growth limit, the Board may review and adjust the hospital's proposed operating expense growth in the aggregate commensurate with any adjustments made to the hospital's NPR/FPP in order to protect margins.

B. COMMERCIAL RATE INCREASE

The GMCB will also review and may adjust requested hospital commercial rate increases.

FACTORS CONSIDERED DURING REVIEW

A. LABOR EXPENSES

The GMCB will assess the per FTE growth in salary and benefits from FY22 to FY24 compared with the US Bureau of Labor Statistics' Employment Cost Index for the current dollar index for total compensation in the private industry for all workers in hospitals. This indicator was recommended to the GMCB for assessing growth in the cost of employment to employers.

Contractual labor expenses have been a significant expense for hospitals in recent years. The GMCB will review the expected contractual labor expense in proposed budgets compared with FY22. If the proposed budget includes risk related to these assumptions, they should be addressed in hospitals' narratives.

B. UTILIZATION

For FY24, the GMCB will review changes in utilization by scaling changes in gross revenue by the average gross revenue per inpatient discharge. The most comprehensive and up-to-date information related to hospital utilization currently available to the GMCB comes from hospital reporting.

Narratives shall indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases due to hiring additional staff or other capacity changes, document the information behind their estimated effects on utilization (e.g. past hires).

In addition to data submitted to the GMCB will also consider:

i. hospital discharge records,
ii. GMCB patient migration report
iii. demographic changes according to census records, and
iv. wait time information submitted in narrative (see Section II Part A).

The data may be used by the GMCB to review relative utilization and market share by hospital.

C. PHARMACEUTICAL EXPENSES

For FY24, the GMCB will review changes in pharmaceutical expenses. The Producer Price Index's commodity index for prescription drugs offers the most representative producer price index for prescriptions purchased and distributed by hospitals. This factor is designed to isolate increases in costs associated with *price changes* in pharmaceuticals. Hospitals should provide other factors driving these costs, such as the volume or changes in the mix of prescriptions purchased.

D. COST INFLATION

For FY24, the GMCB will review changes in cost inflation. This factor is designed to isolate increases in costs associated with *price changes* for medical supplies and materials. Hospitals should provide other factors driving these costs, such as the volume or changes in the mix of products purchased.

i. The Producer Price Index for general medical and surgical hospitals to assess the relative growth in expenses associated with supplies and materials, as recommended to the GMCB last year.

ii. The Medicare Healthcare Cost Report Information System to use the best available source for comparing hospital-level indicators for Medicare-participating hospitals.

The GMCB will compare Vermont hospitals within peer groups of comparator hospitals. The University of Vermont Medical Center will have 2 different peer groups, one based on their status as an Academic Medical Center and another more reflective of hospitals of a similar size operating in similar communities:

Peer Group	Vermont Hospitals
Academic Medical Centers Community Medical Centers	University of VT
Mid-sized Community Hospitals	Rutland Central VT
Small Rural Hospitals	Southwestern Northwestern Brattleboro
Critical Access Hospitals	Northeastern VT Porter Copley North Country Mt. Ascutney Gifford Springfield Grace Cottage

Key comparisons will include volume, costs per discharge, staffing levels, case mix, payer mix, quality, and financial metrics. Staff will also compare hospitals' salary allocations between clinical and administrative FTEs.

The GMCB will add hospitals to peer groups upon request.

iii. Analyses produced by Burns and Associates to review cost and reimbursement variation among Vermont hospitals and others with sufficient claims volume in VHCURES. For this factor, the study is anticipated to be updated through FY22 and will include review of variation in Medicare-allowable costs, payments, and cost coverage.

E. COMMERCIAL PRICE CHANGES

i. Analyses produced by Burns and Associates to review cost and reimbursement variation among Vermont hospitals and others with sufficient claims volume in VHCURES. For this factor, the study is anticipated to be updated through FY22 and will include review of variation in Medicare-allowable costs, payments, and cost coverage for commercial payers.

ii. Other relative price and variation sources that will be considered by the GMCB include:

a) Relative pricing project conducted by RAND

b) Yale Health Care Pricing Project

c) GMCB reimbursement variation report

iii. Previously approved changes in charge and/or effective commercial rate by the GMCB.

F. FINANCIAL INDICATORS

GMCB will review hospitals' financial condition based on the following indicators. Financial indicators will be reviewed based on their relativity to national and regional peers. Available comparisons based on benchmarks used by ratings agencies, National Flash Reports produced by KaufmanHall, indicators produced by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina and the Flex Monitoring Team. Financial health may be assessed at the hospital and consolidated levels.

- Margins
  - Operating
  - Operating EBIDA
  - Total
- Days cash on hand
- Debt service coverage ratio
- Long-term debt to capitalization ratio
- Average Age of Plant

G. KNOWN PRICING CHANGES: MEDICARE AND MEDICAID

The GMCB will monitor the release of known pricing changes for Vermont Medicaid and Medicare.

H. UNCOMPENSATED CARE

The GMCB will review assumptions related to bad debt and free care, including their relationship with the planned "unwinding" of continuous coverage in Vermont Medicaid. The ratio of free care to bad debt will be reviewed, as well as the uncompensated care values reported on Medicare Cost Reports.

I. OTHER

- Staff may use other publicly available data sets to understand trends and factors identified by hospitals, such as the Dartmouth Atlas of Health Care, All-Payer Model Total Cost of Care, the Vermont Agency of Human Services' study on primary care wait times (if and when it becomes available), and measures of Potentially Avoidable Utilization (e.g. Mathematica Policy Research's Rural Health PAU Dashboard). These data sources are meant to supplement staff and Board understanding of factors influencing hospitals and their budgetary requests.
- The Board may consider productivity and efficiency indicators, which may include a hospital's administrative costs, costs per discharge, salary allocations, and ratio of administrative salaries and expenses to clinical or other salaries and expenses.
- The Board's review process will promote the general good of Vermont, as set forth in 18 V.S.A. § 9372.
- The Board's review process will be consistent with the principles for health care reform in 18 V.S.A. § 9371, as required by 18 V.S.A. § 9375(a) and (b)(7), including considering the extent to which a hospital's budget advances the principle that all Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting (18 V.S.A. § 9371(1)), the principle that overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care (18 V.S.A. § 9371(2)), and will adhere to the hospital budget review requirements of 18 V.S.A. § 9456(c), including the requirement that established budgets shall promote efficient and economic operation of the hospital (18 V.S.A. § 9456(c)(3)).
- The Board may review and consider other relevant factors proposed during the budget review process.

SECTION II: ADDITIONAL FILINGS

A. NARRATIVE

The budget narrative provides an opportunity to provide context for proposed budgets and highlight areas of interest and/or concern. The GMCB asks hospitals **to answer each question succinctly and to strictly follow the format below** by responding in sequence to every question.

I. EXECUTIVE SUMMARY

Provide a high-level overview about key considerations for the proposed budget, highlighting any adjustments required to the budget reference year (FY22 actuals). Indicate areas where the proposed budget deviates from parameters specified in this Guidance.

For hospitals whose budget interacts with or includes other entities, explain any differences in what is happening at the hospital versus consolidated level.

II. QUESTIONS

a. Concisely describe necessary adjustments to your FY22 actuals or other considerations required for the proposed budget. Examples may include physician transfers, accounting adjustments, or changes to service offerings, staffing, or infrastructure.

b. Clearly and succinctly explain the factors used in your proposed budget and how they compare with those outlined in Section I of the FY24 GMCB Hospital Budget Guidance, providing evidence to support your assumption(s). Each factor should be addressed:

   i. Labor expenses
   ii. Utilization
   iii. Pharmaceutical expenses
   iv. Cost inflation
   v. Commercial price changes
   vi. Financial indicators
   vii. Known pricing changes for Medicare and Medicaid
   viii. Uncompensated care

   Hospitals should include other factors material to the proposed budget along with supporting material.

c. Briefly summarize known risks in the budget as submitted and indicate how the risks are being addressed. Include the cost, any realized benefit, and descriptions of new or ongoing measures used to reduce or otherwise manage budgeted expenses. Understanding the dollars associated with efforts to decrease or slow the increase in specific categories of expenditures is most helpful in understanding implications for the proposed budget.

d. Provide an up-to-date chart or graphic outlining the corporate structure associated with the hospital.

e. For any referrals or appointments requested in the **first two weeks of May 2023**, report the following metrics separately for each hospital-owned primary and specialty care practice as well as the top five most frequent imaging procedures:

1. **Referral lag**, the percentage of appointments scheduled within 3 business days of referral (percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place), and

2. **Visit lag**, the percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received or the date the patient will be seen.)

If you are unable to report these metrics, explain what is preventing the calculation and when you will be able to report them. In their place, provide the third next available appointment for practices and imaging procedures identified above along with those for comparable hospitals or other industry benchmarks.

f. In accordance with 18 V.S.A. § 9435(a)(6), indicate the known depreciation schedules on existing buildings, a four-year capital expenditure projection, and a one-year capital expenditure plan. Indicate any planned expenditures associated with regulatory compliance and/or accreditation.

g. Describe planned expenditures related to cybersecurity.

h. Indicate the estimated annual expenditures associated with providing care that cannot be reimbursed due to the inability to transfer patients to post-acute or other more appropriate care settings. Examples include stays that exceed length of stay requirements for reimbursement or other care that would not generally be provided in a hospital setting. Provide these estimates for as many fiscal years as possible, including the estimates for FYs 23 and 24. Indicate how the values are derived or otherwise estimated. How are these unreimbursed expenses captured in the proposed budget? Include an estimate of how many boarding episodes occurred in your Emergency Department for that period, the associated total patient days and charges, and the proportion of each associated with a primary diagnosis related to mental health.

i. How much revenue did the hospital net for reimbursements above cost for pharmaceuticals in FY22 actuals, FY23 projections, and in estimates used for the proposed budget? Include estimates for rebates associated with the 340B program. How does the hospital spend or otherwise account for the net revenue?

j. **Facility Fees:** Does your institution charge "facility fees" to patients who access your emergency department? Facility fees have been defined as "the cost of walking in the door" that are billed separately to cover overhead and other costs to provide care in addition to the charges for specific services received by the patient. If your institution charges facility fees, please provide an estimate of the total sum of facilities fees billed and collected in FY22.

k. **Patient Financial Assistance:**

   i. Are patients given a financial assistance plan or policy with the first attempt to collect a debt?

   ii. If a contract with a third party exists to collect payments from patients, please provide this contract and disclose the amount paid for such collection efforts and the revenue generated therefrom.

   iii. At what point of non-collection does the hospital write off the money owed as bad debt?

   iv. What happens if a debt is collected outside of the allowed payment window? Does it show up as revision of the FY in which the services were provided or does it show up in some revenue line in the FY it was collected?

   v. What, if any, effort does the hospital undertake to evaluate whether a patient can pay money owed to the hospital?

   vi. What, if any, effort does the hospital undertake to proactively evaluate whether a patient, prospective, current, or past, is eligible for the hospital's free care program?

   vii. Please provide the quantitative and/or qualitative evidence the hospital used to determine the appropriate Federal Poverty Limit ranges used for free care eligibility.

l. **Administrative Costs:**

   i. Please provide a breakdown of administrative costs by activity type and title (billing and insurance, non-billing and insurance, Executive, VP, Director, etc). If no such disaggregation can be provided or a different breakdown more accurately reflects the specific structure of your hospital, please explain.

   ii. Please provide the number of FTEs by type by average and median salary and total compensation (i.e. total cost of FTE to the organization) by clinical (physicians, PAs, NPs, nurses, etc.) and non-clinical (C-suite, managerial, other).

B. FORM 990 (TAX YEAR 2022)

No later than June 30, 2023, file a complete copy of hospital's most recent Form 990 (for FY21), including the most current version of Schedule H 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.

C. COMMUNITY HEALTH NEEDS ASSESSMENT

No later than June 30, 2023, file a complete copy of hospital's most recent Community Health Needs Assessment (CHNA) and/or most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.