FY 2024 HOSPITAL BUDGET GUIDANCE AND REPORTING REQUIREMENTS

Effective March 31, 2023

Prepared by:

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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)
JUNE 30, 2023	Hospitals submit budgets and accompanying documentation to GMCB
JULY-AUGUST 2023	GMCB staff review, analyze, and ask technical budget submission questions
AUGUST 1, 2023	Hospital submission of Capital Expenditure sheets in Adaptive due by August 1st, 2023
AUGUST X, 2023	GMCB staff provides preliminary budget overview at public board meeting
WEEKS OF TBD	**Remote** Hospital budget hearings and deliberations (TBD)
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 (the 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.

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. If any adjustments need to be made to FY22 to make it a more appropriate base for changes in the proposed budget (e.g. provider transfers), they should be explained in narrative (see Section III, Part A).

The FY24 budget guidance does not include an overall cap for hospitals' growth in net patient service revenue (NPSR). While changes in revenue and expenses over time will be considered, budgets will instead be reviewed in relationship to the benchmarks outlined in Section I. The benchmarks listed will serve as the reference point by which budgets will be reviewed. Other measures or indicators may be explained in narratives to provide evidence for the budget as proposed, as well as how the alternative measures compare with those identified in Section I.

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 and 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 trainings on the new materials and associated changes to Adaptive in May 2023.

In accordance with 18 V.S.A. § 9456(c)(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:

Budget Amendments and Adjustments Policy

Commented [LS1]: Sent separately

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.

Exhibit Name	Due Date	Purpose	Filing Location
1. Narrative	6/30/2023	Detailed explanation of budget	Upload to Adaptive Report folder
2. Verification under oath		Attestation to truth of filing	
3. Most recent IRS Form 990 (including Schedule H)		Financial Monitoring	
4. Most recent Community Health Needs Assessment and/or Implementation Plan		Community Benefit	
5. Income statement		Financial review	Input through Adaptive
6. Balance sheet		Financial review	

7. Other operating revenue		Financial review; assess budgetary assumptions	
8. Payer and case mix		Comparative review of payer populations and clinical acuity	
9. Utilization and price assumptions		Review budgetary assumptions by service tier (i.e. inpatient, outpatient, professional, other)	
10. Staffing summary		Review high-level staffing resources and wage growth assumptions	
11. Capital expenditures	8/1/2023	Compliance with CON program	

SECTION I: BUDGETARY ASSUMPTIONS

This section will summarize the GMCB's benchmarks for changes from FY22 actuals to FY24 proposed budgets, including rationale and sources of data. Hospital budget submissions will be assessed against these benchmarks. Hospitals shall document how their proposed budget compares with these benchmarks in their accompanying narrative or provide alternate evidence to support their proposed budget (see Section III, Part A). The GMCB will continue to monitor and update these data sources as more recent information is released.

A. LABOR EXPENSES

BENCHMARK: 7.0% ± 3.2% (average 2-year change through Q4 of 2022)

The GMCB will assess the per FTE growth in salary and benefits from FY22 to FY24 compared with the average 2-year growth in 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.

The 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 (see Section II.A.II.c.).

B. UTILIZATION

BENCHMARK: 2.0% increase in utilization

The most comprehensive and up-to-date information related to hospital utilization currently available to the GMCB comes from hospital's reporting. The information has a high degree of variation within and across hospitals.

For FY24, the GMCB will review changes in utilization by scaling changes in gross revenue by the average gross revenue per inpatient discharge. As summarized in Table 1, there is a great deal of variation in the data and patient utilization patterns have been unlike those observed historically, largely to do the global pandemic and its aftermath.

Narratives shall indicate the methods used for assumptions related to proposed budgets.

Table 1: 2-Year Change in Equivalent Utilization by Cost Center

	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%

C. PHARMACEUTICAL EXPENSES

BENCHMARK: 4.4% ± 1.6% (average 2-year change since 2019)

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 benchmark is designed to isolate increases in costs to hospitals 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

BENCHMARK: 5.5% ± 2.3% (average annual 2-year change since 1993)

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

E. COMMERCIAL PRICE CHANGES

Commented [LS2]: Awaiting additional feedback from GMCB

F. FINANCIAL INDICATORS

Commented [LS3]: Awaiting additional feedback from GMCB

- Margins
  - Operating
  - Operating EBIDA
  - Total
- Days cash on hand
- Debt service coverage 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 those Medicare.

Commented [LS4]: Awaiting additional feedback from GMCB

H. UNCOMPENSATED CARE

Commented [LS5]: Awaiting additional feedback from GMCB

I. OTHER

SECTION II: GMCB REVIEW OF FILINGS AND PERFORMANCE BENCHMARKS

This section provides an overview of how GMCB staff will review and analyze filings in conjunction with other available data sources.

A. 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.

B. ASSESSMENT OF FINANCIAL HEALTH

List benchmark and KPIs for financial health

Commented [LS6]: Will incorporate financial indicators outlined above.

C. HISTORICAL BUDGET PERFORMANCE

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

D. SIMILARLY SITUATED HOSPITAL COMPARISON

The GMCB will use Medicare Cost Reports to review how hospitals compare with a select list of similarly situated hospitals. The initial peer groups were selected to resemble hospitals on size, rurality, regulatory environment, and case mix. The methodology for identifying similarly situated hospitals will be outlined and refined. Hospitals may request additions to the list of peer groups.

The GMCB will create 5 peer groups of similarly situated 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 designed to be 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.

E. COST AND REIMBURSEMENT VARIATION

The analysis will use the previously shared methodology by Burns and Associates to review cost and reimbursement variation among Vermont hospitals and others with sufficient claims volume in VHCURES.

The analysis will include the calculated case mix intensity for inpatient (MS-DRG) and outpatient (APCs) services provided.

The analysis will also leverage the relative pricing project conducted by RAND, Yale Health Care Pricing Project, and GMCB reimbursement variation report to further contextualize reimbursement variation.

F. VOLUME and MARKET SHARE

The analysis will review hospital-submitted data, hospital discharge records, and the patient migration report to review relative utilization and market share by hospital.

G. OTHER DATA SOURCES

Staff may use other publicly available data sets to understand trends and factors identified by hospitals, such as the Dartmouth Atlas of Health, All-Payer Model Total Cost of Care, 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.

SECTION III: 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. GMCB PROMPTS

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 how your proposed budget compares with the benchmarks outlined in Section I of the FY24 GMCB Hospital Budget Guidance, providing evidence to support your assumption(s).

c. Briefly summarize known risks in the budget as submitted and indicate how the risks are being addressed. Include the cost 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. Request VAHHS to recommend wait time measure

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.

Commented [LS7]: From HCA:

It would be useful to have a wait time measure by service type and by hospital type.

III. HCA PROMPTS

a. **Facility Fees:** Does your institution charge "facility fees"? Facility fees are defined as designating a facility as out of network that is adjacent or physically a part of the hospital.? If so, provide an estimate of the total sum of facilities fees in FY22.

b. 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.

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, efforts does the hospital undertake to evaluate whether a patient can pay money owed to the hospital?

vi. What, if any, efforts 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.

c. 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.