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Hospital Budget Review: FY25 Guidance & Staff Benchmark Proposal

Overview for Primary Care Advisory Group (PCAG)

March 20th, 2024

Agenda - PCAG

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1. Update on GMCB FY25 Hospital Budget Guidance and s*ome questions for you…*
2. Going forward (FY26 and beyond)

Hospital Budget Guidance Materials

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Three separate documents: why? And how do they work together?

FY25 Guidance: Specifies how budgets will be evaluated and criteria for whether they will be adjusted.

Uniform Reporting Manual: Standard definitions for financial and non-financial reporting required by hospitals

Hospital Budget Review Measures Inventory: list of measures that staff will use to assess hospital budgets, including specifications so key analyses can be replicated (does not preclude the Board and staff from leveraging other publicly available data – e.g. Sage Transparency Dashboard ETA May 13, 2024)

REMINDER: Hospital Budget Review Decision Tree

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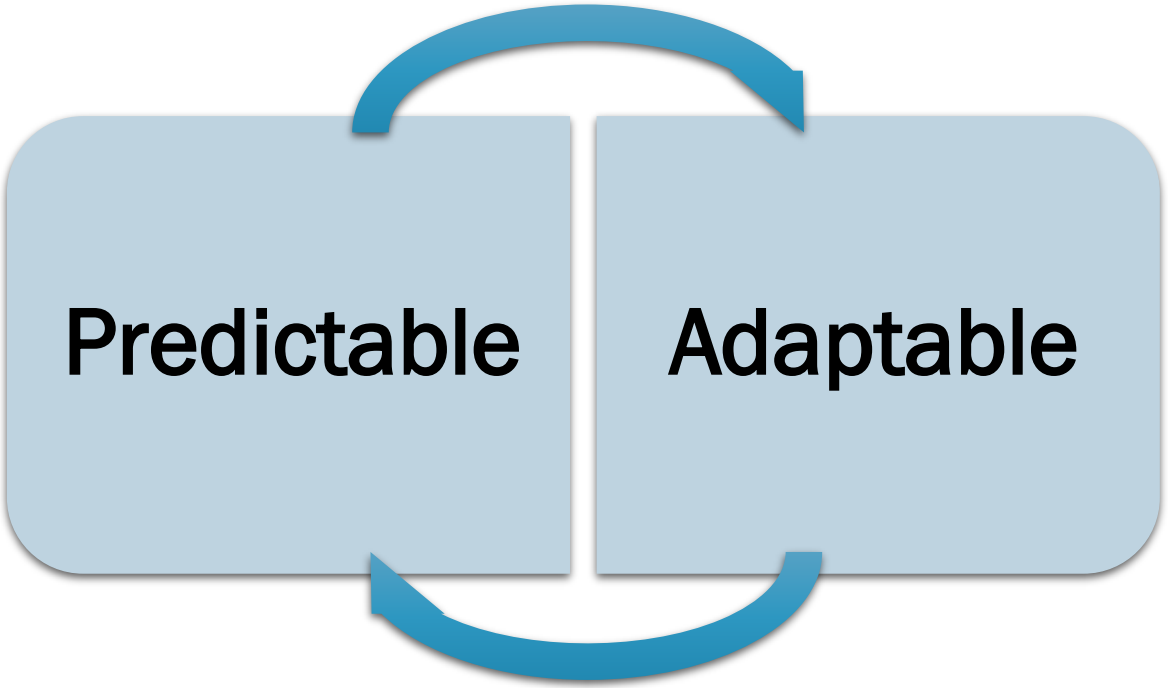

The revised Budget Guidance structure seeks to optimize two objectives (1) **predictability** of benchmarks, with (2) **adaptability** for **hospital-specific challenges** and a **dynamic** industry and economic **environment**.

Guidance Structure (Updated)

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Guidance Section	Purpose
Introduction	Includes details on hospital budget organizing framework, the review process, and other submission requirements.
I – Benchmarks	Establishes benchmarks against which hospital budget requests will be reviewed and evaluated.
II – Comparative Analytics	Comparative metrics and data sources that the GMCB may use to evaluate hospital budgets in greater detail.
III – Budget Assumptions	Information on assumptions, measures, and data sources that hospitals use in constructing their budget submissions.
IV – Contextual Information	Contextual data for better understanding the needs of the community, may also include delivery system pressures from outside the hospital.
V – Narrative	Additional qualitative justifications for the proposed budget.
VI – Hospital Reporting Requirements	Details of hospital reporting requirements.

REMINDER: Hospital Budget Review Decision Tree

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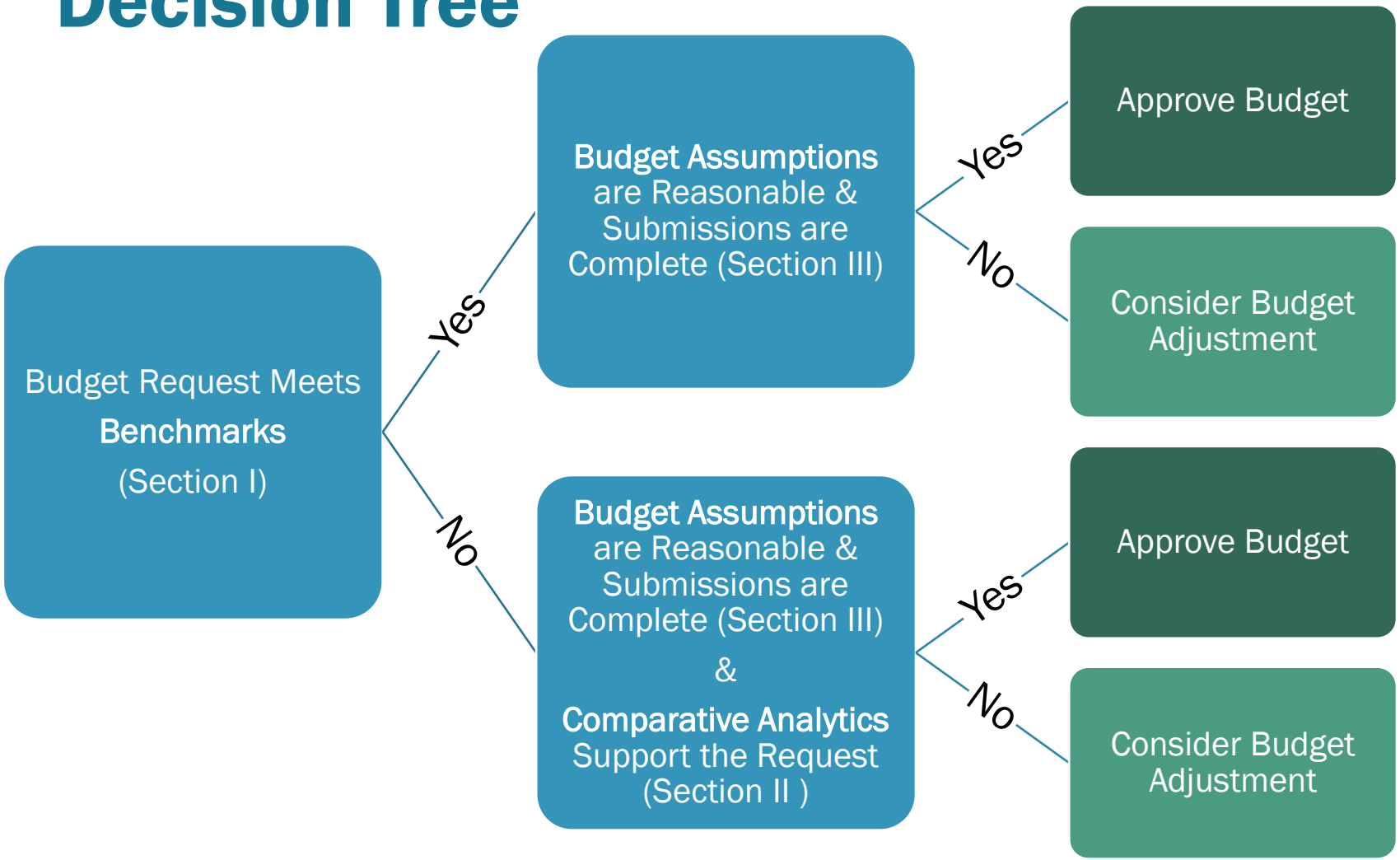

Regardless of budget approval or adjustment, insights gained from data in any of the sections of this guidance may be used to facilitate conversations around improvement opportunities and may lead to general or hospital-specific budget order conditions.

Section I – Proposed Benchmarks: Affordability

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(1) More **aggregate health care spending** (i.e. price x utilization) translates into higher costs of health insurance, which means higher premiums and out-of-pocket costs; thus, we propose…

*…a **cap** on system-wide hospital **Net Patient Revenue (NPR)** that is no more than **3.5 – 4.3%** above prior year budget, in line with the Vermont All Payer Model Agreement.*

Hospitals exceeding this benchmark will be required to justify with evidence.

NPR Growth vs. National & Regional Trends

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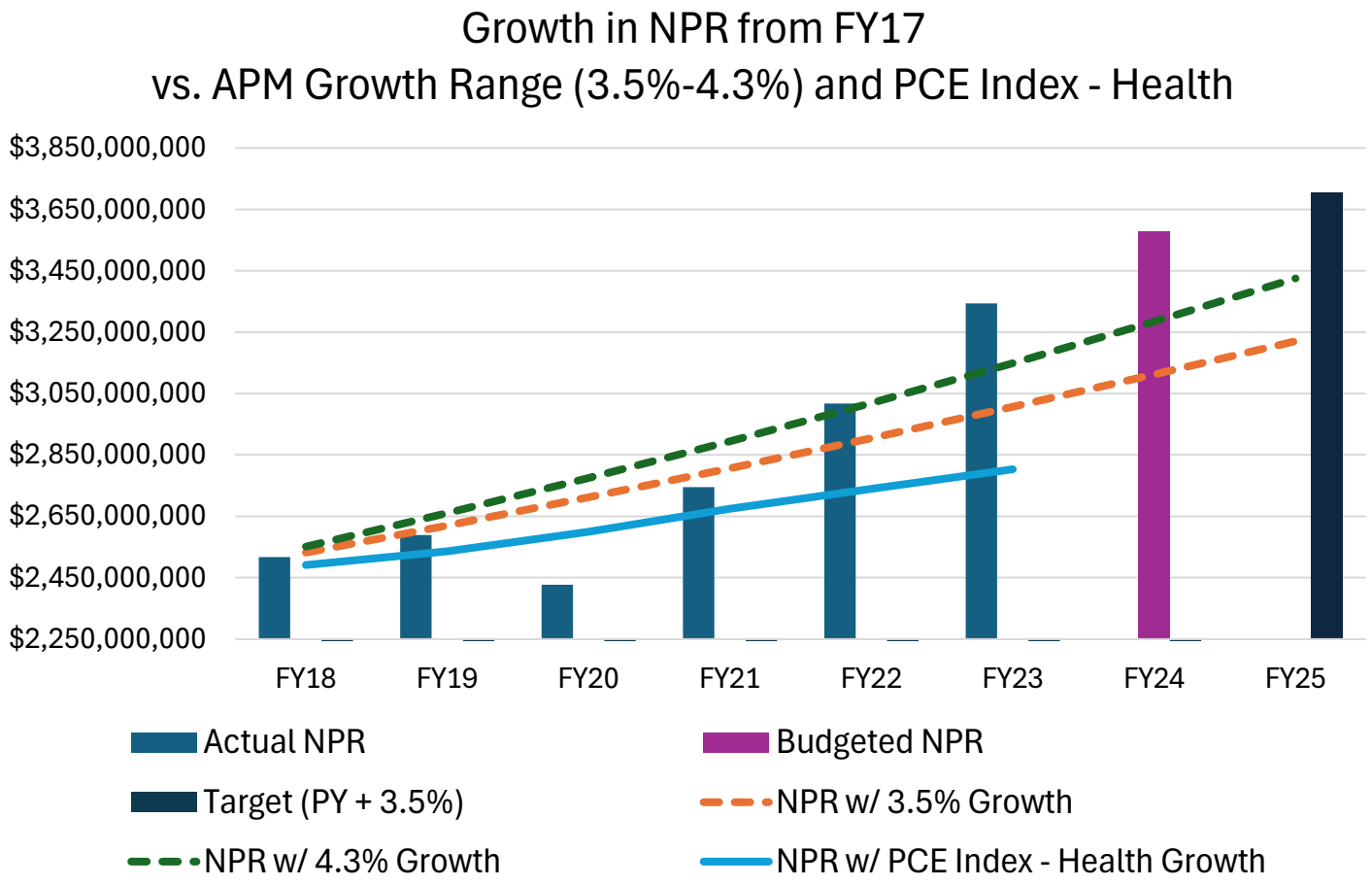

Compound NPR growth since 2017 has been just over 6%.

If we stayed at 4.3% growth since 2017, FY25 would be **$3.43 B**; at 3.5% growth, FY25 would be **$3.22 B**

millions	FY25 NPR Benchmark	FY25 vs. FY24 B	FY25 vs. FY17 Trended
FY24 @ 3.5%	$3,704	$125	$483
FY24 @ 4.3%	$3,732	$154	$278

Vermont Hospital System Volume Trends (VHUDDS)

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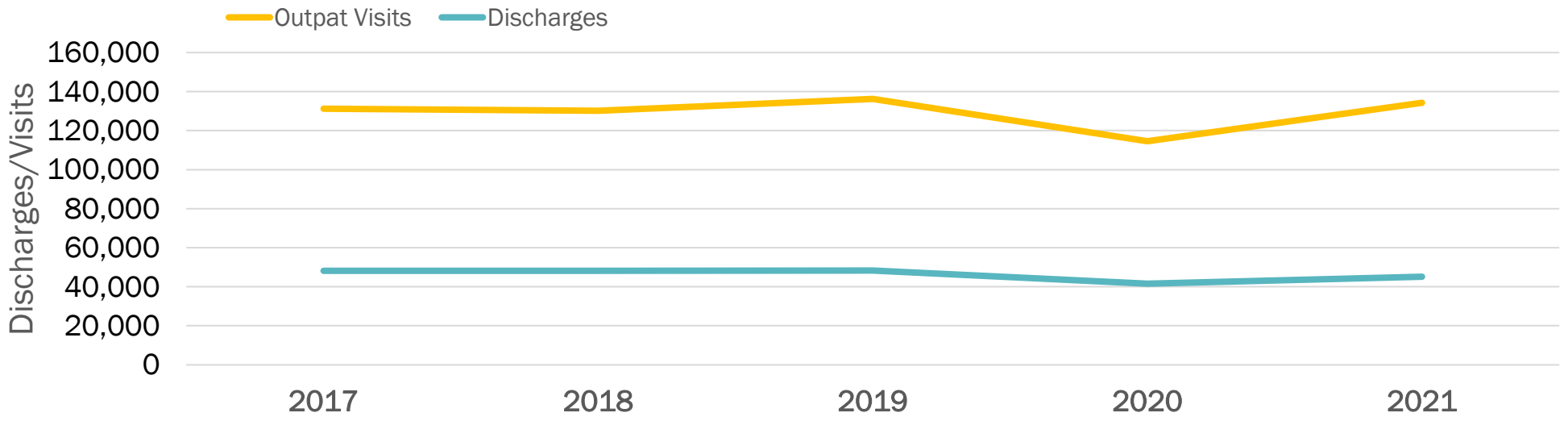

Year-Over-Year Δ	2017-18	2018-19	2019-20	2020-21
Outpatient Visits	-0.8%	4.6%	-15.9%	17.2%
Discharges	0.2%	0.1%	-13.9%	8.6%
Patient Days	2.1%	2.7%	-9.8%	10.0%
Ave LOS	2.0%	2.0%	3.9%	1.9%

*With the exception of COVID, inpatient & outpatient utilization is relatively stable, but these data are only currently available through **2021**.*

NPR Growth vs. National & Regional Trends

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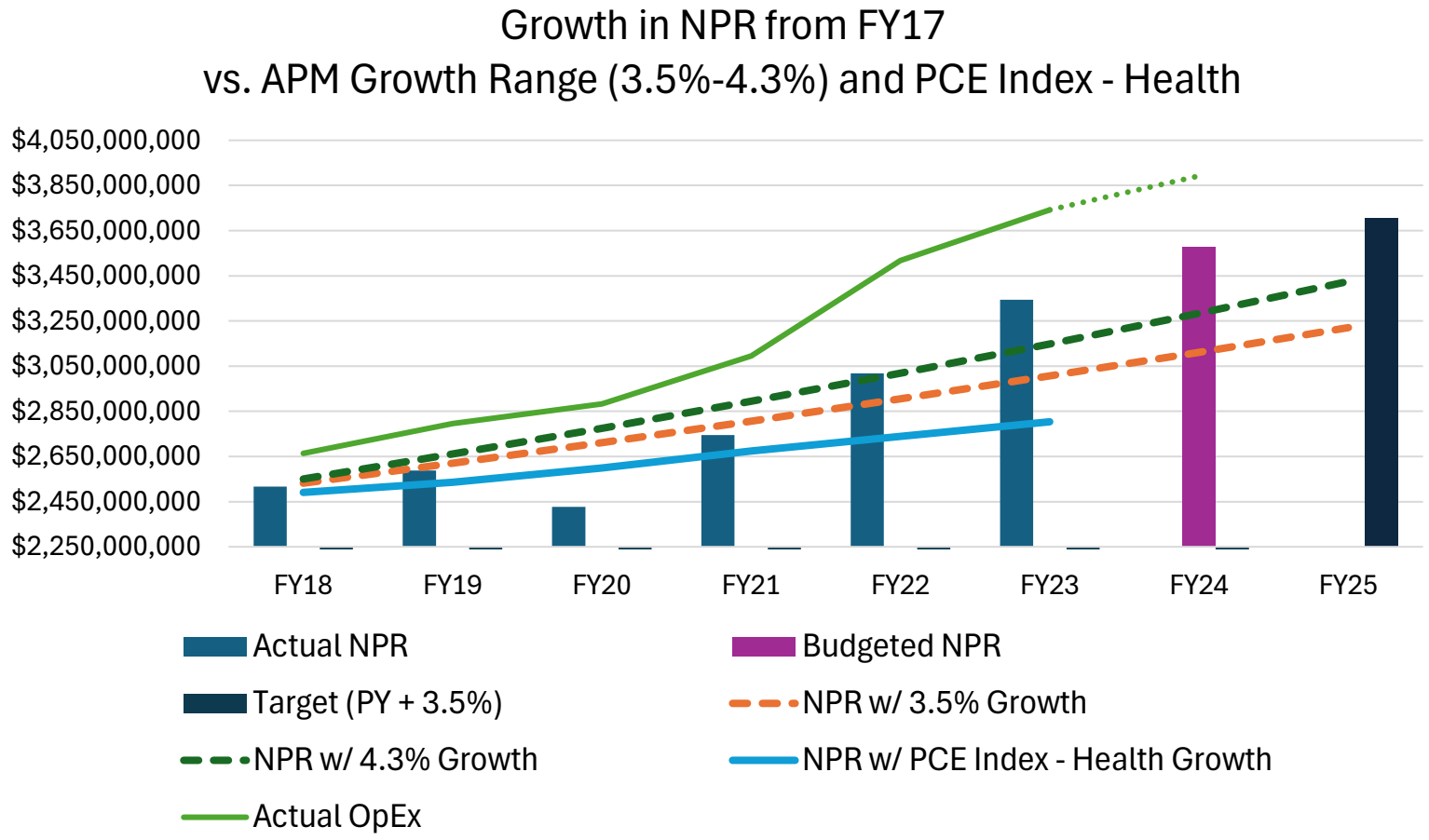

Vermont vs. New England States: OpEx Growth per Adj Discharge

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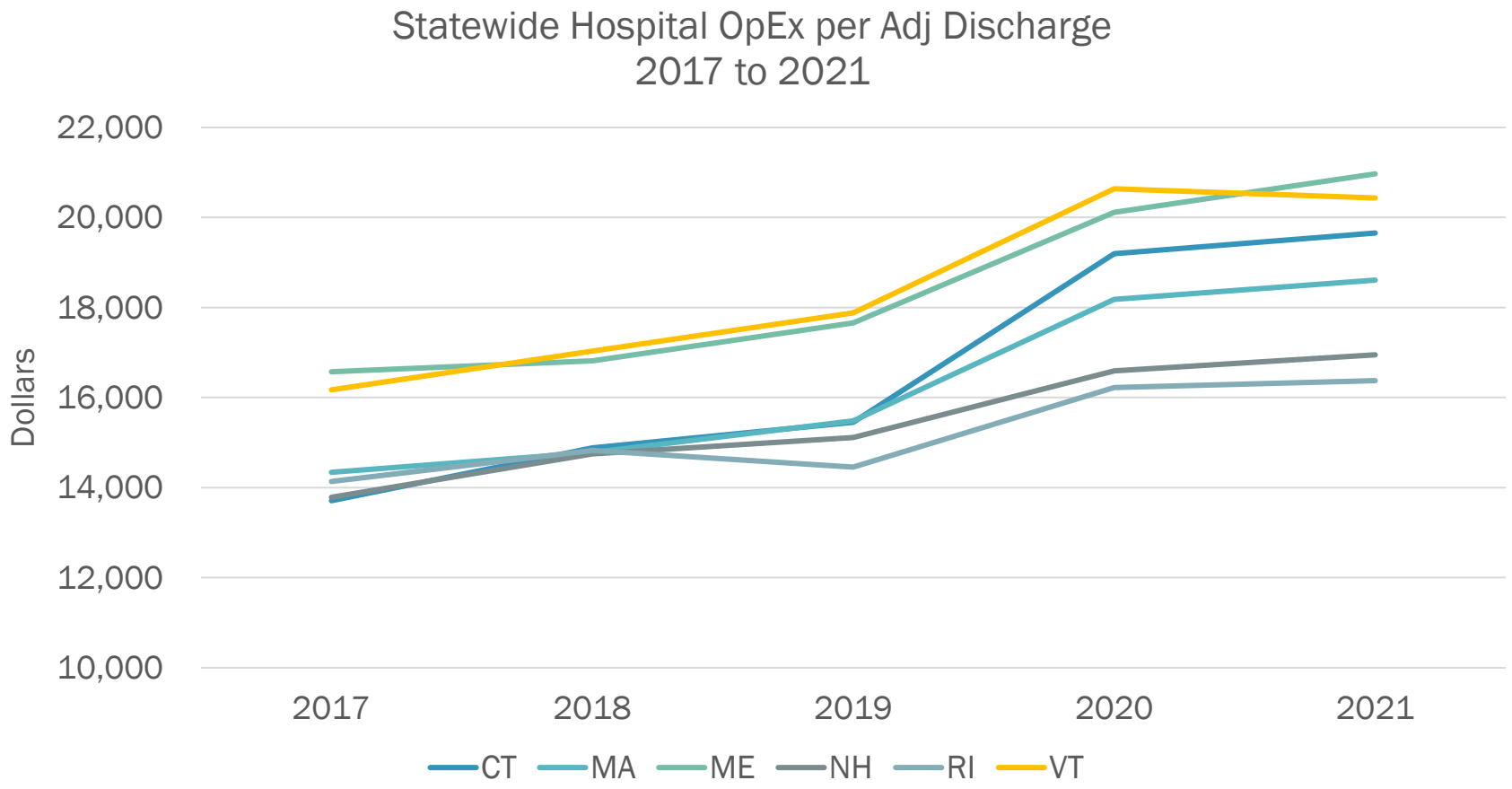

Charge Growth over time

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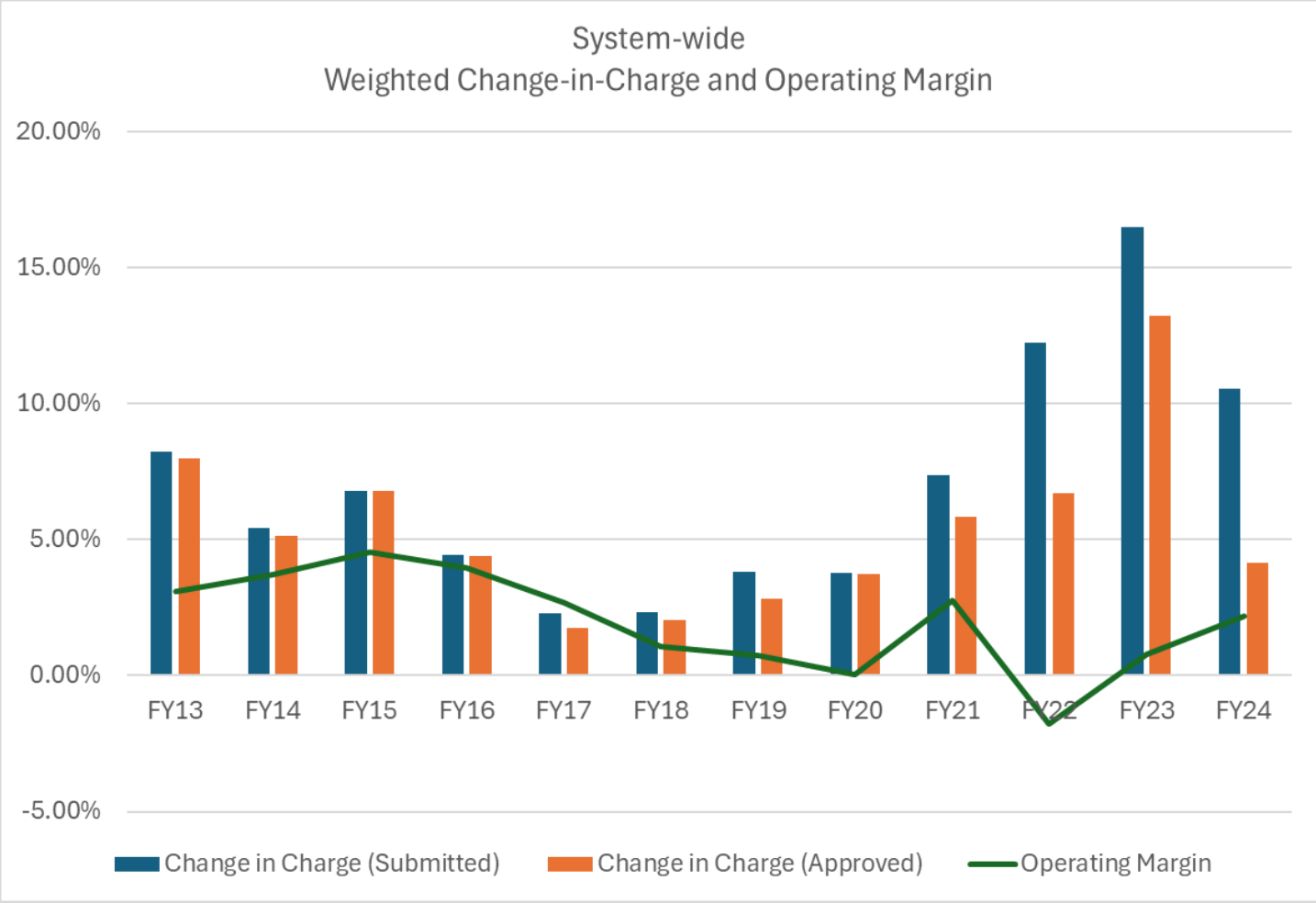

Section I – Proposed Benchmarks: Affordability

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Section I – Proposed Benchmarks: Affordability

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(2) The **price of health care services**, which affects patient cost sharing. Because government payers set prices directly, discretionary price growth is observed in the **commercial market**; and hospitals have some control over what price they negotiate and how much they need to cover their expenses; therefore, we propose…

… a cap on hospital growth in **Commercial Rates (Charges less negotiated discounts)** at no more than **X%**, overall and for each major commercial payer

Section I – Proposed Benchmarks: Affordability

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Price Inflation Index	Recommended Comparison	Inflation (Annual or 12 month)
GDP Implicit Price Deflators	Price changes in the overall economy.	2.6% (Oct 2023)
Price Indices – Consumer, Urban	Prices changes for consumers' out-of-pocket spending for specific goods and services.	3.2% (Feb 2024)
Price Indices – PCE Price Index	**Price changes in personal consumption expenditures by the household sector (not firms); available for Vermont, but lagged data.**	2.4% (Jan 2024)
Price Indices – Personal Health Care Deflator; NHE	Projected price changes for total health care expenditures and household out-of-pocket and third-party health care expenditures.	3.1% (2025)
Price Indices - Producer	Price changes for specific commodities or services (e.g. Hospitals)	3.6% (Feb 2024)
Employment Cost Indices (ECI)	Changes in business costs for worker compensation in selected industry categories.	4.1% (Dec 2023)
Medicare Market Basket (IPPS Hospital)	Inflationary factor used by Medicare as growth factor in payment methodologies, representing the relative cost of providing services in various settings (i.e. hospital).	3.1% (Q4 2025 Forecast)

Which index? Staff recommending **PCE Price Index + 1%**

- **PCE Price Index**: Included in state economist's recommended inflationary metrics for benchmarking price growth in the hospital budget process (published August 2022)
- **+1%**: Proposing the addition of 1% since this is the first year we are establishing a price growth benchmark and using Jan FY2024 inflation from FY2023 for FY2025, so providing some flexibility with additional 1%

Year over Year Comparison of Selected Inflationary Metrics

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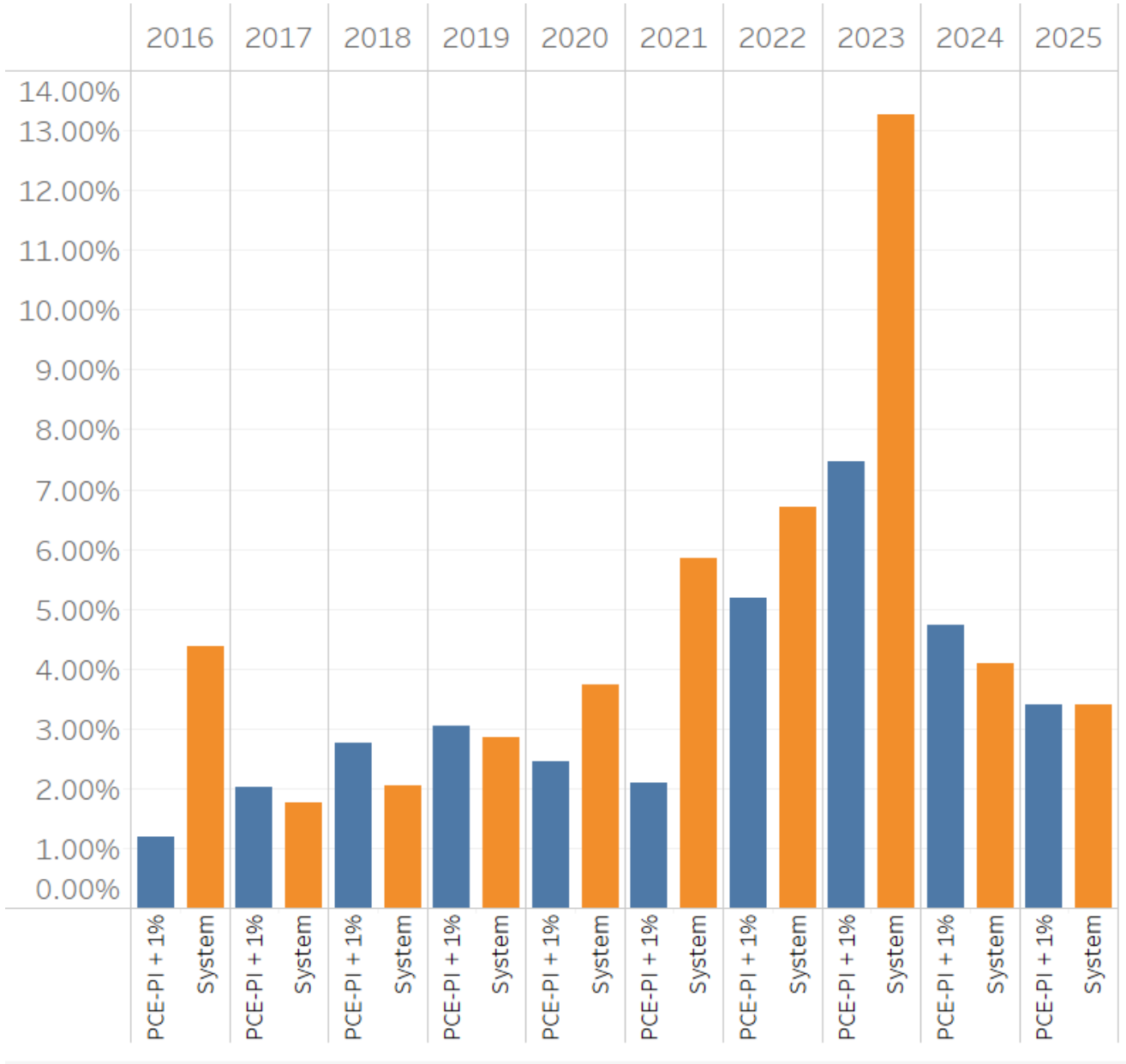
Delta from PCE-PI + 1%	2016	2017	2018	2019	2020	2021	2022	2023
PCE-PI+1%	1.60%	2.38%	2.90%	2.74%	2.26%	3.64%	6.34%	6.06%
CPI-U	0.33%	0.25%	0.46%	0.93%	1.01%	-1.04%	-1.65%	1.94%
Market Basket	0.00%	0.18%	0.50%	0.24%	0.16%	1.44%	1.94%	0.26%
PHC Deflator (NHE)	0.40%	1.08%	1.40%	1.24%	0.26%	1.44%	4.04%	3.26%



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Charge Growth vs. PCE Price Index + 1%

Note: Assumes that the lagged index is used to establish the commercial rate growth benchmark, e.g. the January 2024 PCE-PI growth + 1% would be used for the FY25 budget process.

Staff Recommendation

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Commercial Rate Growth: Commercial rate growth overall and for each payer shall be no more than the PCE price index +1% (January 2024 release), over FY24 approved budget, which amounts to **3.4%** for FY25. The GMCB anticipates establishing a cap on commercial rate increases for each hospital above its currently approved levels, which will also apply as a cap on the price increase that the hospital may receive on average from each individual commercial payer (i.e. net of changes in utilization). The GMCB approved rate increases will be caps that are subject to negotiation between a hospital and commercial insurers and are not amounts set or guaranteed by the GMCB.

Hospitals proposing budgets that exceed this growth rate will be required to justify this request, and report on productivity by department.

Section I – Proposed Benchmarks: Hospital Financial Sustainability

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Hospital financial sustainability is imperative to ensuring that ***Vermonters can maintain access to essential services where and when they need them***. While there are many indicators that are important for evaluating financial health, a key metric for private entities is **operating margin**, as it expresses the ongoing ability of an organization to cover its operating costs with its expected revenues from operations.

Operating Margin > 0% (i.e. Revenues > Expenses)

The Board recognizes that achieving a positive operating margin is not just about sufficient revenue but also about a hospital's ability to manage its costs.

Section II – Comparative Analytics

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Purpose: analyze budget submissions using key metrics and data sources to understand:

- **Operating factors** that might play a role in a hospital's ability to meet the benchmarks established in Section I.
- How Vermont hospitals compare to national and regional trends and within **peer groups,** where appropriate.

*There are **NO specific performance benchmarks** set for measures in this section as these measures must be **considered collectively.***

Section II – Comparative Analytics

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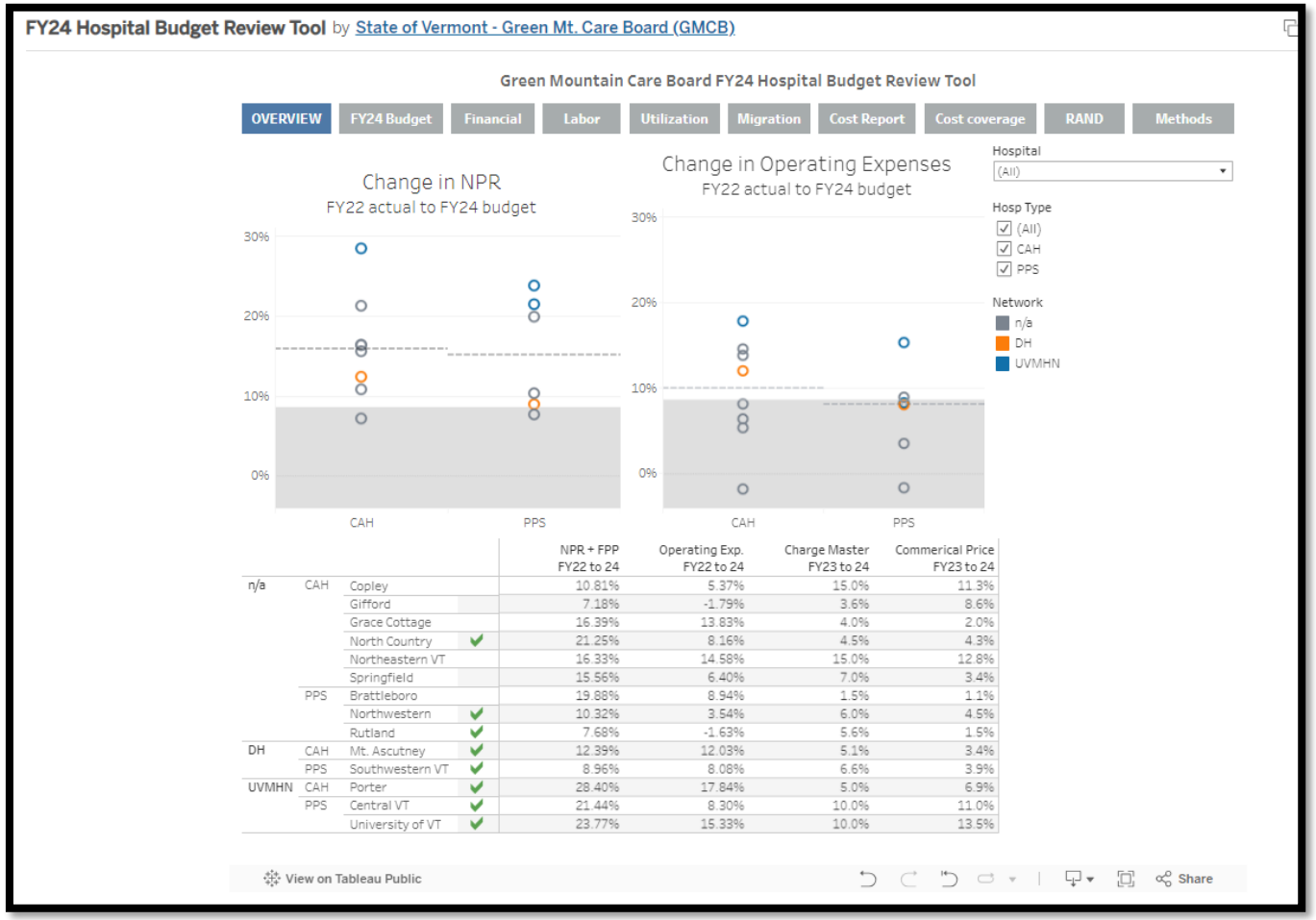
Types of measures include:

- Revenue trends (e.g. NPR per adjusted discharge)
- Operating efficiency (e.g. productivity, throughput),
- Financial health
- and more…

Measure specifications are labelled "Section 2" in the **Hospital Budget Review Measures Inventory**



Section III – Budget Assumptions

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- Government reimbursement changes
  - Vermont Medicaid
  - Out of State Medicaid (state-specific NY, MA, NH)
  - Medicare
- Payer mix
- Service Mix
- Patient Acuity (i.e. case mix index by payer)
- Utilization/Market Share
- Anticipated future capital investments
- And more…

Section IV –Contextual Information

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Measures and other qualitative information in this section will be used to provide insights about the broader context of healthcare needs in the community, the hospital's role and ability to meet those needs, as well as external pressures on hospital care delivery.

Section IV – Contextual Information

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Question for PCAG: *We pulled out some measures on the subsequent slides, do you have thoughts on these or other measures that are important for understanding (warranted) hospital utilization?*

Section IV – Contextual Information

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Metric	Why it matters
Long ED Stays	This measure captures the average length of stay in the ER per CCSR diagnosis group. It also captures the percentage mental health stays over 24 hours and the percentage of other types of stays over 12 hours. It's designed to illuminate issues with transferring patients to post-acute care settings, either due to inefficiencies in the transfer process or to a shortage of post-acute care providers.
Preventable Hospital Stays	This measure uses the CMS definition of ambulatory-sensitive condition to estimate the number of hospital stays that could have been prevented with adequate ambulatory care. It reports the number of preventable hospital stays per 100,000 Medicare enrollees. It's designed to shed light on the shortage and / or insufficiency of ambulatory care providers. Measurement unit: county.
Primary Care Providers Rate	This measure lists the rates of primary care physicians (FTE) and primary care physician assistants (FTE) per HSA per 100,000 population. It illuminates potential shortages in primary care. Measurement unit: HSA
Mental Health Counselors Rate	The measure lists the rate of mental health counselors in a county per 100,000 population. It's designed to illuminate potential shortages in mental health care. According to County Health Rankings and Roadmpas, nearly 30% of the population lives in a county designated as a Mental Health Professional Shortage Area. Measurement unit: county.
Skilled Nursing Facility Beds Rate	This measure lists the number of beds in skilled nursing facilities (nursing homes) in a county per 100,000 population. It's designed to illuminate potential shortages in nursing home care. Measurement unit: county.
Adults with a Routine Doctor Visit in the Past Year	This survey measure captures the percent of a county adults that reported a routine medical visit in the past year. Its useful for understanding how general preventative care relates to spending on hospital care. Measurement unit: county.

Section V – Narrative

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- Executive Summary
- Background
  - Corporate structure (ownership, affiliations etc.)
  - Service-line changes
- Budget Questions
  - Current year budget vs. Projected
  - Year over year variance analysis (from projected or PY budget?)
  - Budget risks
  - …
- Hospital & Health System Improvement
  - Investments in improving access to Mental Health, SUD, LT care, Primary Care etc.
  - Performance Improvement Strategies
  - Update on Performance Improvement Plans Ordered by the Board
  - Act 167 Community Engagement Experience
  - …
- Other

Section V - Narrative

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One question we plan to ask in the narrative is "*Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate*."

Question for PCAG: *What should we hope to hear from hospitals in response? Can we strengthen this question in any way?*

Section VI – Reporting

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Exhibit Name	Due Date	Purpose	Location
1. FY2023 Medicare Cost Report	4/1/2024	Financial Monitoring	Upload
2. Verification under Oath	7/1/2024	Attestation to truth of filing	Upload
3. Budget Narrative		Detailed explanation of budget and justification for budgets not meeting Section I benchmarks (see Guidance Section V)	Upload
4. FY2025 Budget Request		Details of budget request and underlying assumptions: Income statement, Balance Sheet, Other Operating Revenue, Payer Revenue, Case Mix, Utilization and Rate Assumptions, Staffing etc.	Adaptive
5. Hospital Operations		Complements budget request data highlighting internal and external budget pressures	Adaptive
6. Community Health Needs Assessment & Implementation Plan		Community Benefit	Upload
7. Financial Assistance Policy & Reporting		Act 119 of 2022	Upload
8. Affiliations & Third-party Contracts		Financial & Legal Relationships	Upload
9. Corporate Structure		Financial & Legal Relationships	Upload
10. Salary Information		Statutory Requirement 18 V.S.A. § 9456(b)(12)	Upload
11. Net Revenue & Public Payer Reimbursement		Statutory Requirement	Upload
12. Capital expenditures	8/1/2024	Compliance with CON program	Upload
13. IRS Form 990 for CY2022 (incl. Schedule H)	9/30/2024	Financial Monitoring	Upload

This section details requirements for hospital reporting for consideration of their FY25 budget request.

Uniform Reporting Manual

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This year… limited updates (limited staff capacity and resources)

- Defined Bad Debt and Free Care in accordance with the IRS definition
- Clinical vs. non-Clinical FTEs
- Payers: separately report Medicare Advantage, defined "major" commercial payers as BCBS, MVP, United Healthcare, Cigna, and any other payers that make up more than 10% of a hospital's commercial revenue.

Future opportunity to improve apples-to-apples reporting between hospitals

- Standardize definitions in the Uniform Reporting Manual (this would not solve the problem because of accounting differences)
- Hospitals could consider leveraging a single statewide auditor
- Hospitals could adopt a uniform chart of accounts

Hospital Budget Review Measures Inventory

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A library of measures that have either been referenced or used previously in the hospital budget review process, or similar.

Data will come from a combination of adaptive, Medicare cost reports, and other publicly available data sources.

Certain measures may be more/less relevant for hospitals of a certain designation.

Guidance	Bucket	Measure Count
Section 1	Target	3
Section 2	Financial health	16
	Operating efficiency	16
	Other	2
	Revenue trends	26
Section 4	Access	5
	Community Data	16
	Quality	12
Total		96

Timeline for FY25 Guidance

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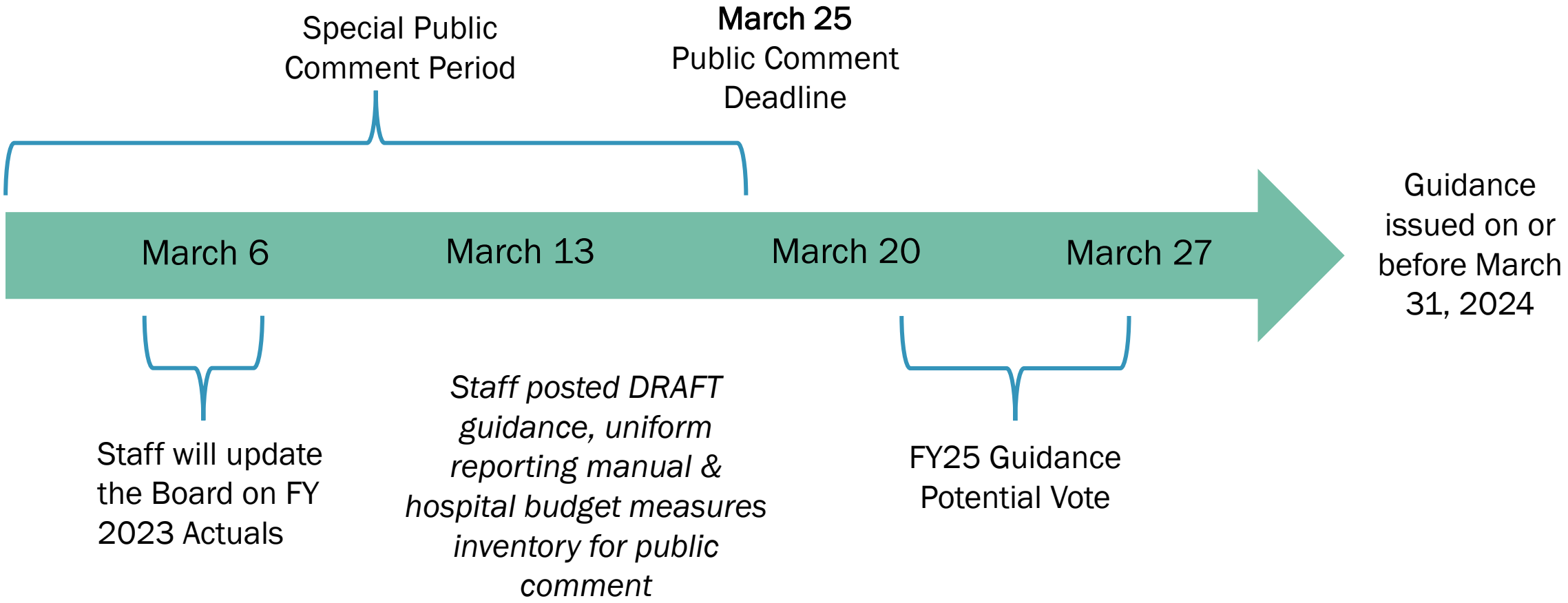

Going Forward: HBR & Increasing Primary Care Investment & Access

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Questions for PCAG:

How should we think about primary care investment in the hospital budget review process?

How do we track dollars flowing to primary care through hospitals?

How should we think about equitable reimbursement between hospital-owned and non-hospital owned primary care?

What else, if anything, can the Board do to support increasing Primary Care access through the Hospital Budget Review process?