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GREEN MOUNTAIN CARE BOARD

Hospital Budget Review: Overview & Goals for FY25 Guidance

February 21st, 2024

Agenda

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1. Background
2. FY25 HBR
    1. Goals
    2. Budget Guidance Structure
    3. Proposed Benchmarks for FY2025/Questions to the Board
    4. Timeline & Next Steps

Health Care Affordability is a Challenge Nationally and in Vermont

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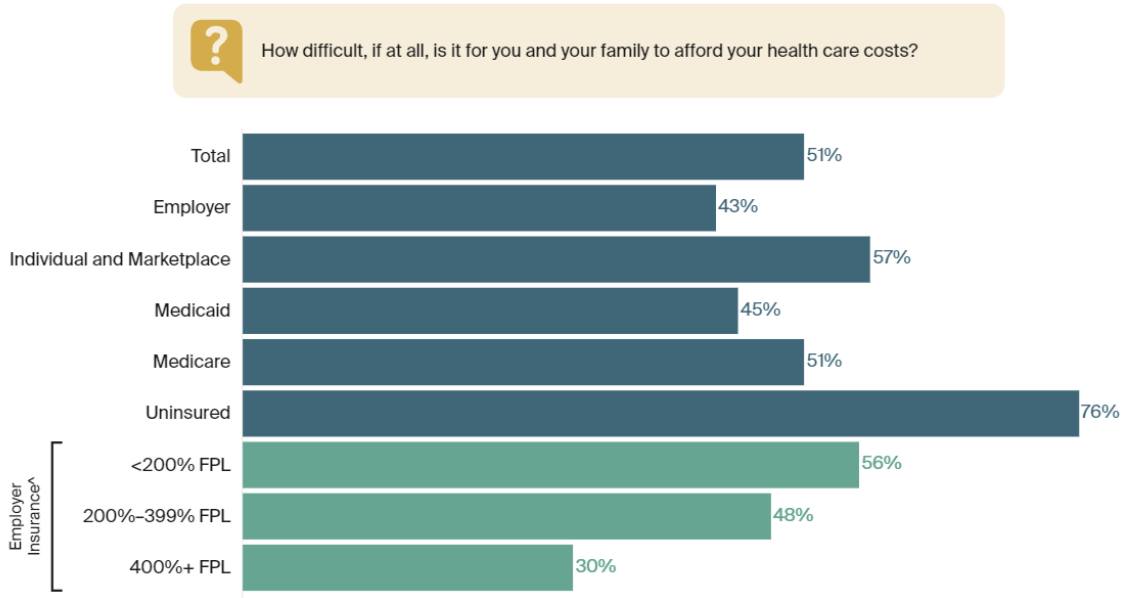
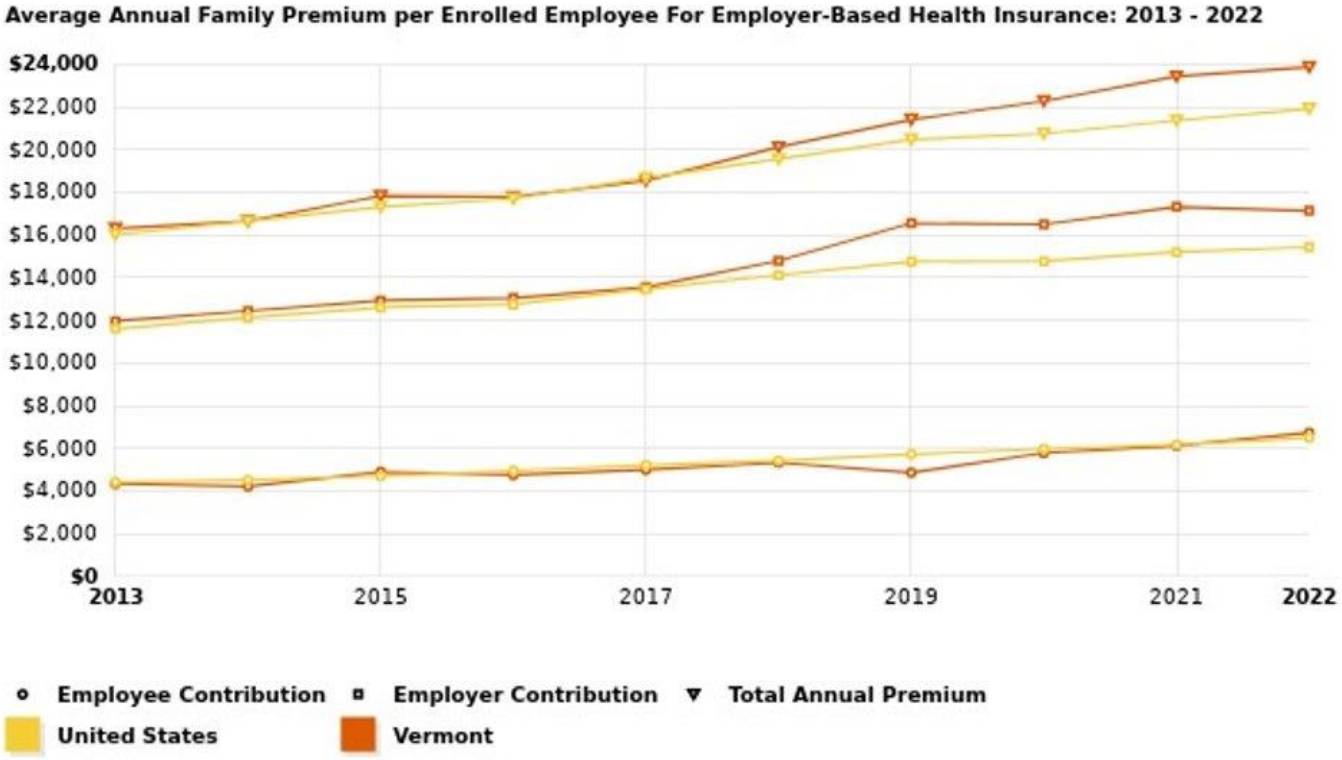
EXHIBIT 1

Half of working-age adults said it was very or somewhat difficult to afford their health care costs.

Percentage of adults ages 19–64 who reported difficulty affording health care costs, by insurance type and poverty level





Sources:
https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey
https://www.kff.org/health-costs/state-indicator/

Vermont Health Care Spending per Capita

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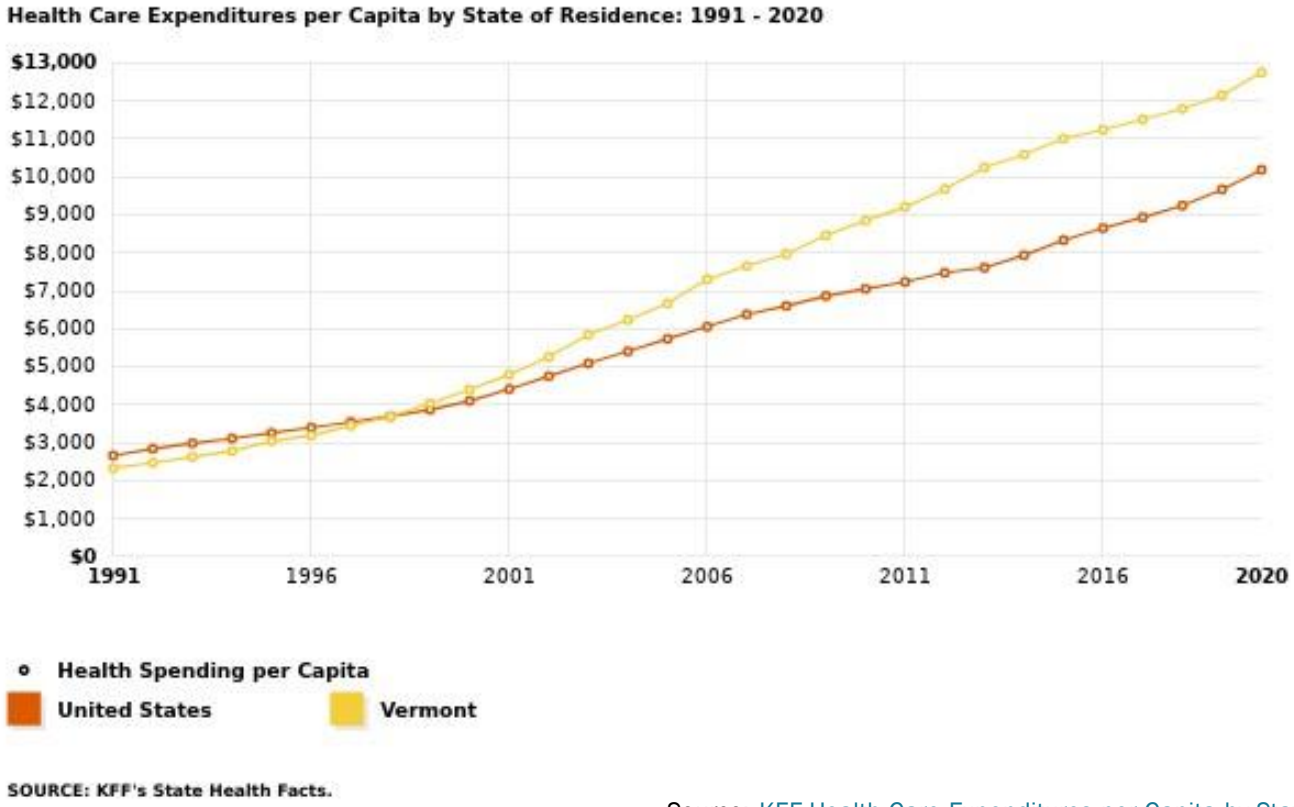

Source: KFF Health Care Expenditures per Capita by State of Residence

Notes

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary produces Health Expenditures by State of Residence and Health Expenditures by State of Provider every five years. The State Health Expenditure Accounts are a subcomponent of the National Health Expenditure Accounts (NHEA), the official government estimates of health spending in the United States. Additional information on data and methods is available here.

Hospitals Make Up Almost Half of Health Care Dollars Spent in Vermont

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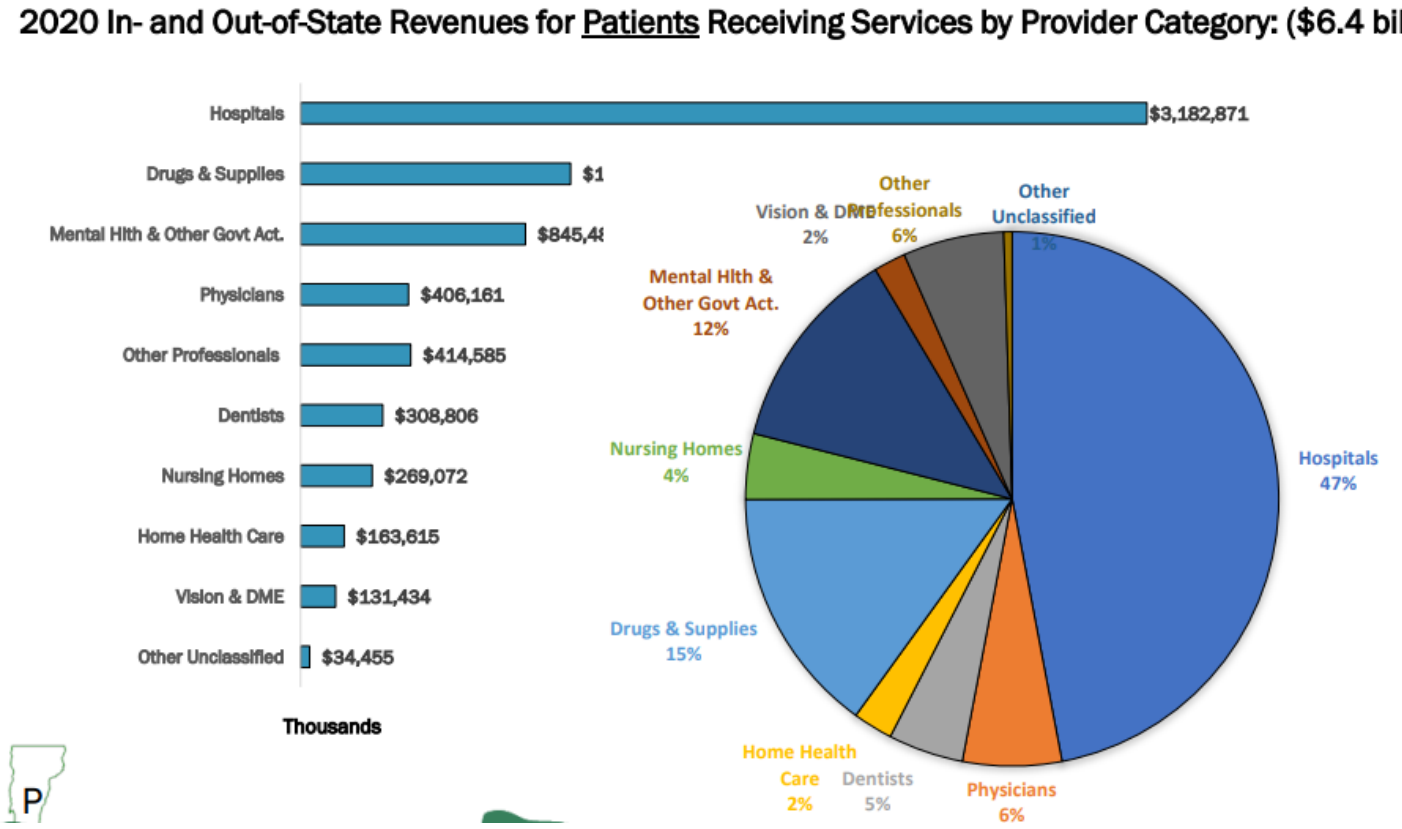

47%

of health care dollars spend in Vermont go to hospitals

Source: 2020 Vermont Health Care Expenditure Analysis
https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020_VT_Health_Care_Expenditure_Analysis_Final_May_9_2022.pdf

Note: *categorical definitions here are not equivalent to those on the previous slide and cannot currently be directly compared*

Vermont: 2nd Highest Growth in Hospital Spending per Capita since 1991

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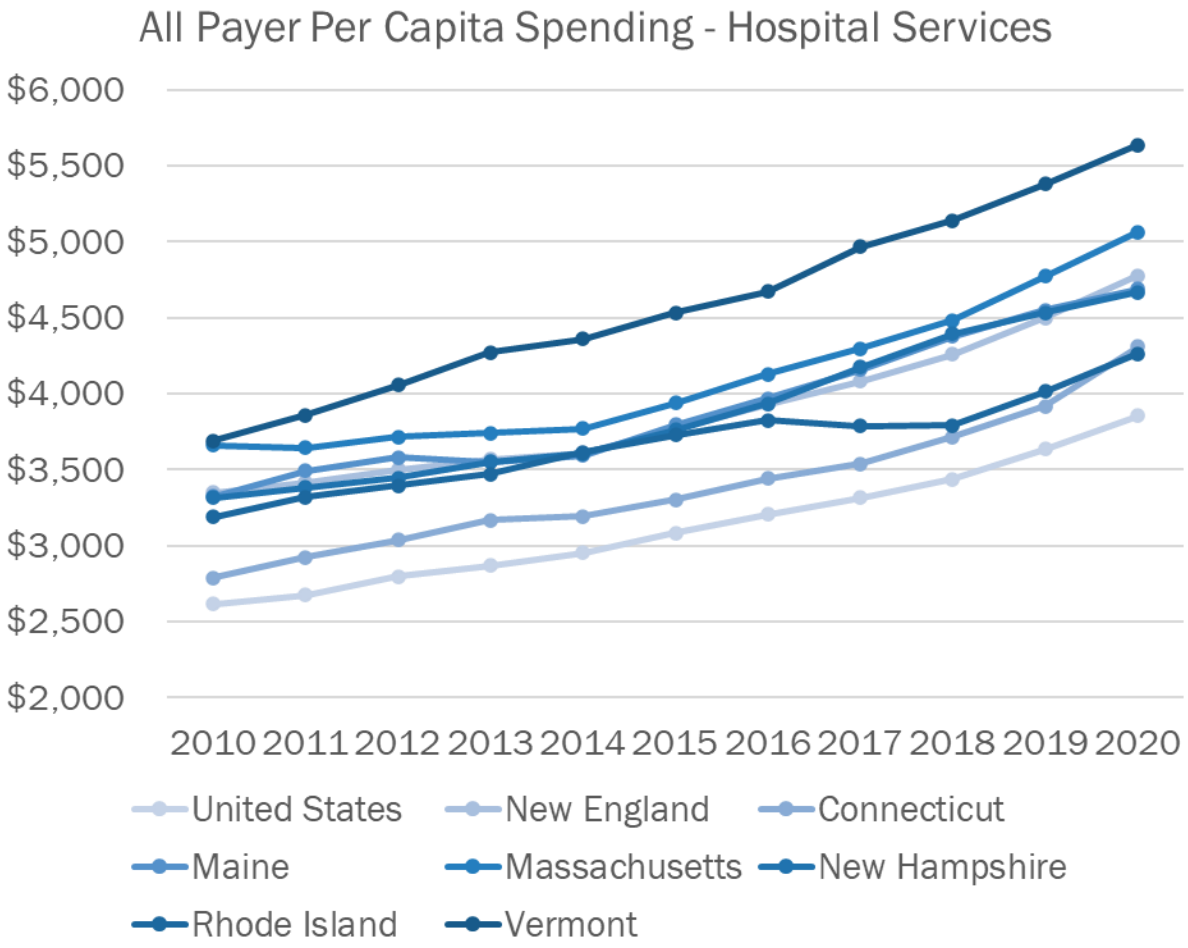

Region/state of residence	Average Annual % Growth (1991-2020)
United States	4.5%
New England	4.8%
Connecticut	4.6%
Maine	5.5%
Massachusetts	4.6%
New Hampshire	5.6%
Rhode Island	4.6%
Vermont	**6.4%**
Mideast	4.5%
Great Lakes	4.5%
Plains	4.9%
Southeast	4.2%
Southwest	4.2%
Rocky Mountains	4.6%
Far West	4.8%

Source: National Health Expenditures

Vermont: 4th Highest Hospital Spending per Capita

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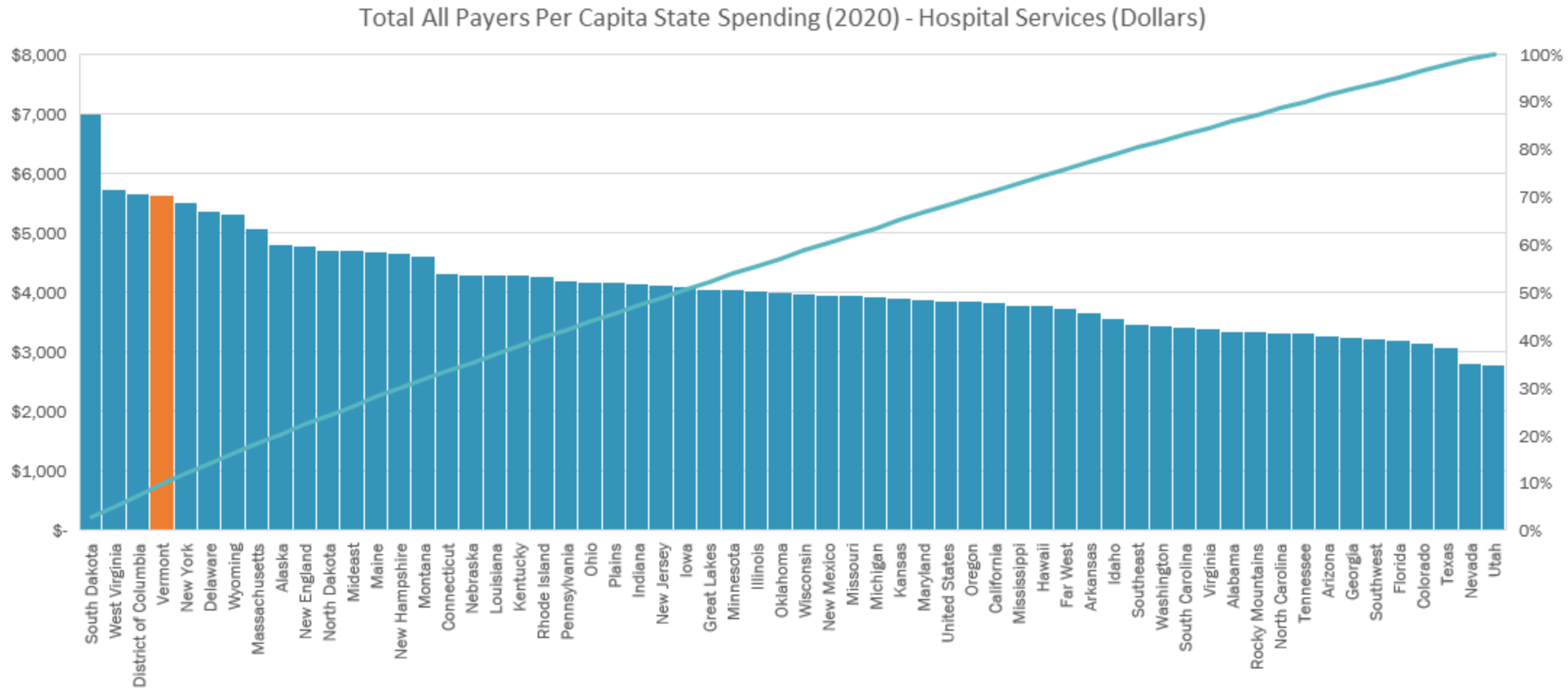

Brief History of Hospital Budget Regulation

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1983

Vermont establishes Hospital Budget Review

18. V.S.A. § 9456

1992

Vermont Health Care Authority Established

Merges Health Policy Council, Health Data Council and Certificate of Need Review Board

1995

Banking, Insurance, Securities, and Health Care Administration (BISHCA)

Established authority to limit hospital budgets

2011

Green Mountain Care Board

Transfers some authorities previously at BISHCA to GMCB renaming BISHCA to Dept. of Financial Regulation (DFR)

Why Regulate Hospitals?

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Higher hospital spending is a major contributor to **unaffordable health insurance premiums** and **out-of-pocket costs.**

Higher spending in one sector (e.g. Hospital Spending) **limits resources** that could otherwise be **allocated to other parts of the delivery system** (e.g. primary care, mental health, preventative services, social determinants of health etc.) or to other parts of the economy.

Vermont's health care system is highly concentrated. Regulation is essential to contain costs in **monopoly markets.** This is particularly salient in **rural settings** where there is less opportunity for efficient competition.

Evolving the Hospital Budget Review: Board Goals for Continuous Improvement

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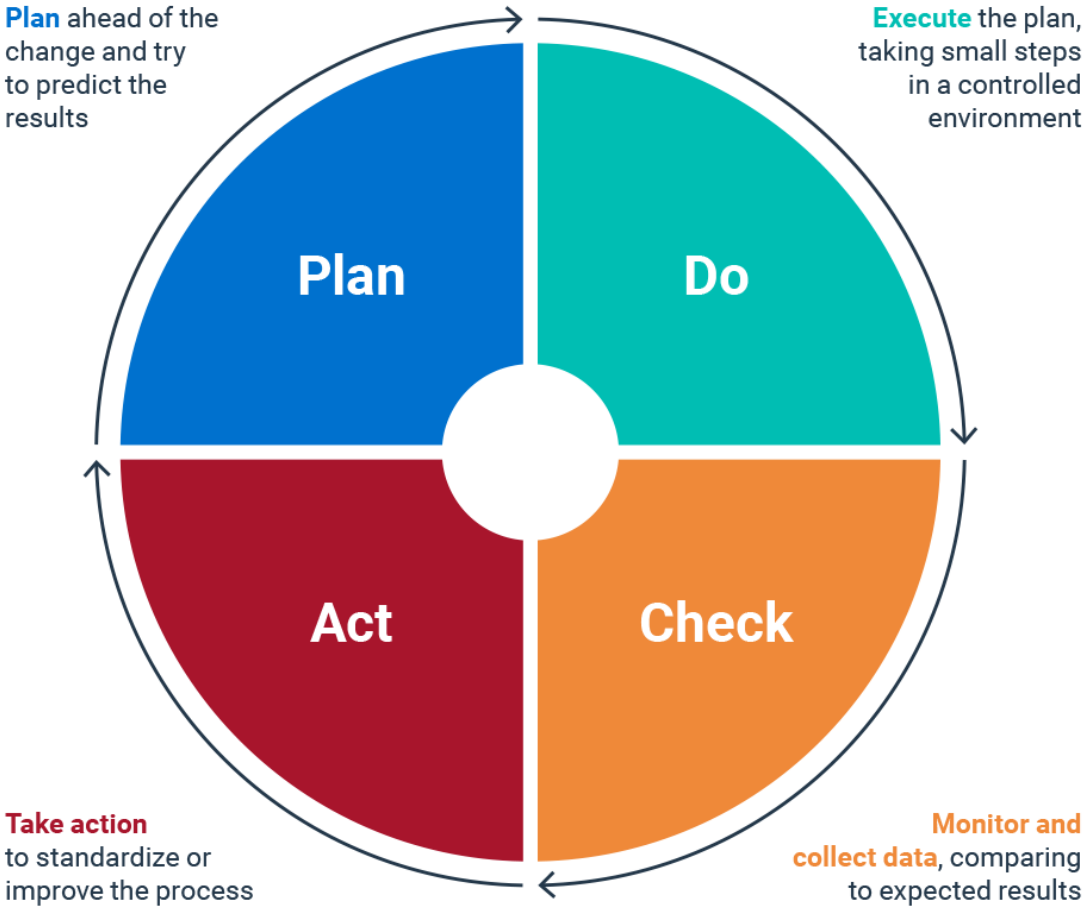

1. Establish objective metrics for evaluating hospitals' financial health and performance
2. Alignment of GMCB regulatory processes to improve affordability
   (particularly hospital budget and rate review)
3. Continue to look for opportunities to improve transparency, consistency, and predictability of the regulatory process
4. Minimize administrative burden as appropriate

Evolving the Hospital Budget Review: Progress Last Year (FY24)

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Decisions made through two key lenses: **hospital sustainability** and **health care affordability**

1. Established a two-year **Net Patient Revenue** target of **8.6%**, based on APM growth target, which aims to bring VT health care spending in line with economic growth
2. Capped hospital **commercial rate increases by payer**, creating a more direct link between hospital budget review and insurance rate review (as opposed to capping change in commercial charges)

Increased **evidenced-based regulation** through greater reliance on data and comparisons to peers and national trends; see Budget Review Tool.

Evolving the Hospital Budget Review: Implications of Act 167

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This work will be ongoing…

1. State's potential participation in AHEAD & Hospital Global Payments
2. Act 167 Community Engagement & Sustainability of the Vermont Hospital System

Evolving the Hospital Budget Review: Goals for FY25

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1. Establish **Benchmarks** that if met, give the Board confidence that the hospital's budget considers both health care affordability and financial sustainability*.
2. Continue to refine regulatory **decision-tree** and intended use of **comparative data**.
3. Continue evolution of a more **person-centered** monitoring framework, incorporating a more robust understanding of a community's access, quality, and affordability of care.
4. Continue to **improve data collection** and **analytic processes**, standardizing and automating where appropriate.
5. Solicit initial thoughts from hospitals on transformation and lessons learned from **Act 167 community engagement** discussions and recommendations.

*The Board recognizes that these objectives are not mutually exclusive and can work in tandem.

Statute

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- 18 V.S.A. § 9456(d)(1): annually, the Board shall establish a budget for each hospital by September 15, with a written decision by October 1.
- 18 V.S.A. § 9456(c): hospital budgets established by the Board shall meet the requirements of this section, including that the established budgets "…(2) take into consideration national, regional, or in-state peer group norms, according to indicators, ratios, and statistics established by the Board; (3) promote efficient and economic operation of the hospital; (4) reflect budget performances for prior years;…"

Statute (cont'd)

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- 18 V.S.A. § 9375(b)(7): the Board shall review and establish hospital budgets consistent with the principles for health care reform set out in 18 V.S.A. § 9371.
- 18 V.S.A. § 9372: the Board's review process will promote the general good of the state:
  - Improving the health of the population;
  - Reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
  - Enhancing the patient and health care professional experience of care;
  - Supporting the recruitment and retention of high-quality health care professionals; and
  - Achieving administrative simplification in health care financing and delivery.

GMCB Rule 3.000

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- Rule 3.202(a): GMCB will establish **benchmarks** for any indicators for **hospital use in developing** and preparing the upcoming fiscal year's budgets.
  - Meet with VAHHS & HCA to **obtain input** on the benchmarks.
  - Benchmarks established and provided to hospitals by March 31.
- Rule 3.202(b): the benchmarks will allow the Board to determine whether to adjust a hospital's proposed budget.
- Rule 3.202(c): thirteen categories of indicators for which the Board can set benchmarks, including "growth indicators," "cost and price indicators," and "other financial measures recognized or used in evaluating budgets and/or financial plans"

GMCB Rule 3.000 (cont'd)

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- Rule 3.306(a): The hospitals shall bear the burden of persuasion in justifying their proposed budgets.
- Rule 3.306(b): Sets out factors the Board shall take into consideration in reviewing a hospitals budget, including benchmarks established by the Board, utilization information, actual past performance of the hospital, public comment, and any other information the Board deems relevant or appropriate.

Hospital Budget Review: Work to Date

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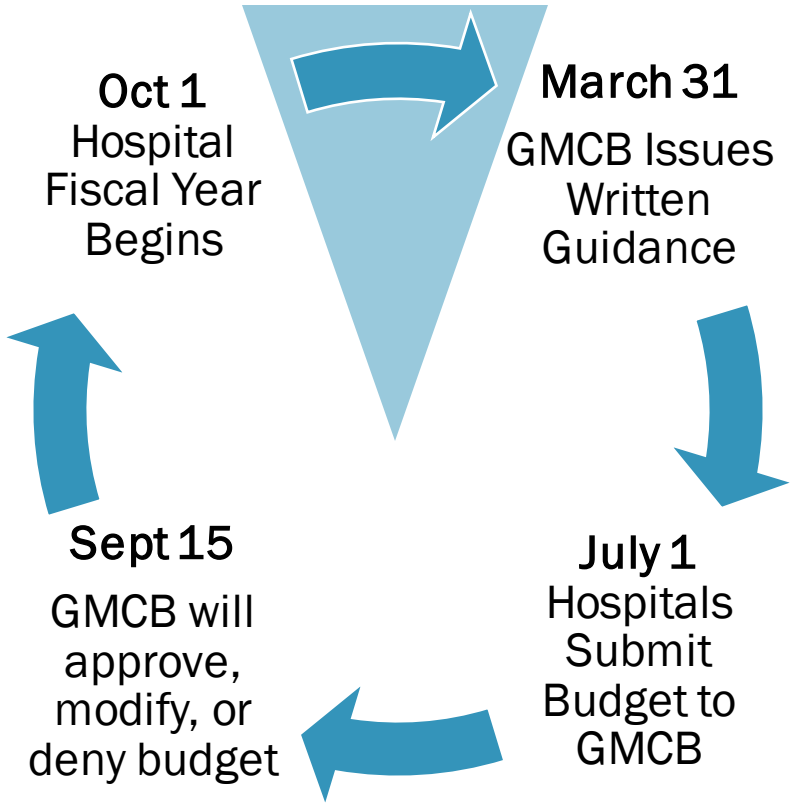
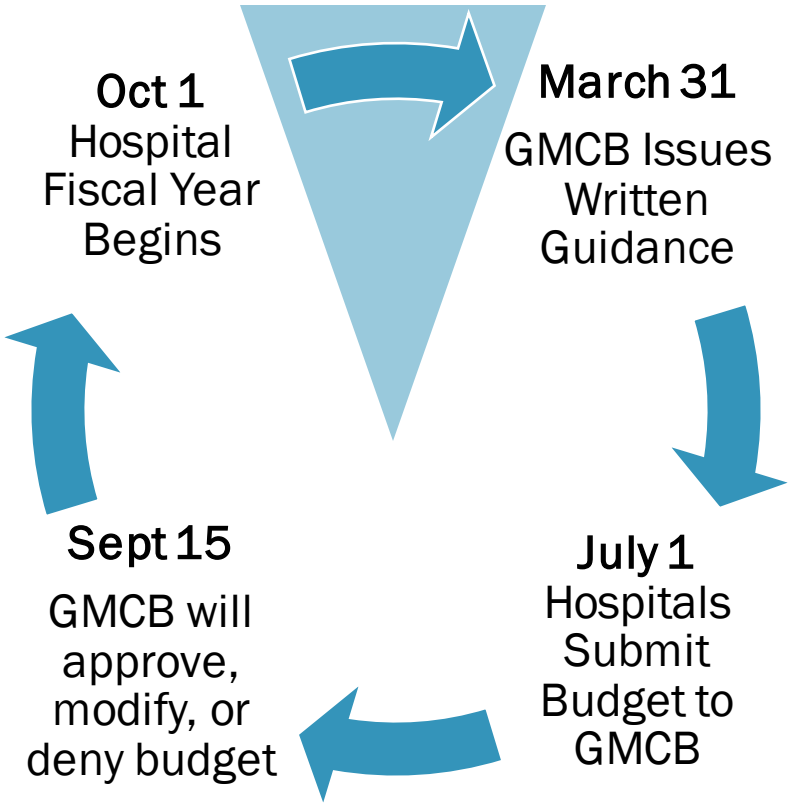


- ✓ **November:** staff meet with hospital CFOs to debrief FY24.
- ✓ **January-March:** staff meet with VAHHS and HCA to solicit input on benchmarks and other aspects of the process.
- ✓ **February:** open special public comment (Today).
- ❑ **February/March:** Staff continue collecting input on guidance from interested parties.
- ❑ **March:** Board issues hospitals written guidance for FY25.
- ❑ **April-July:** Hospital continue to develop FY25 budgets.
- ❑ **July:** GMCB receives budgets (due 7/1), staff begins review.
- ❑ **August:** Hospital Budget hearings (scheduling in progress).
- ❑ **September:** Board publicly deliberates to approve, modify, or deny budgets by 9/15.
- ❑ **October:** Budget orders delivered to hospitals by 10/1 (start of hospital fiscal year).

Hospital Budget Review: Upcoming



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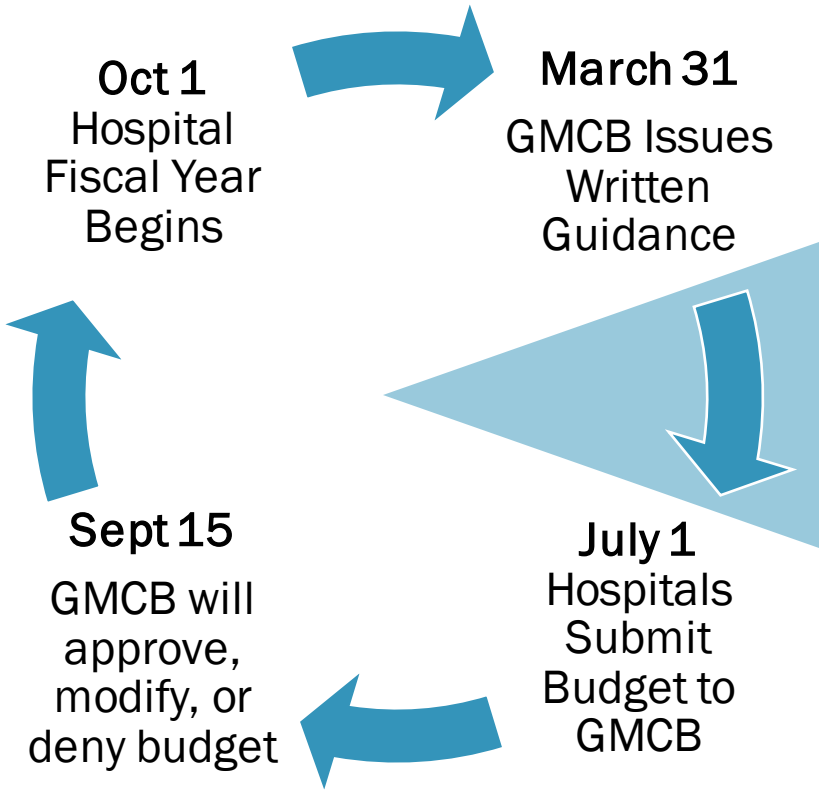

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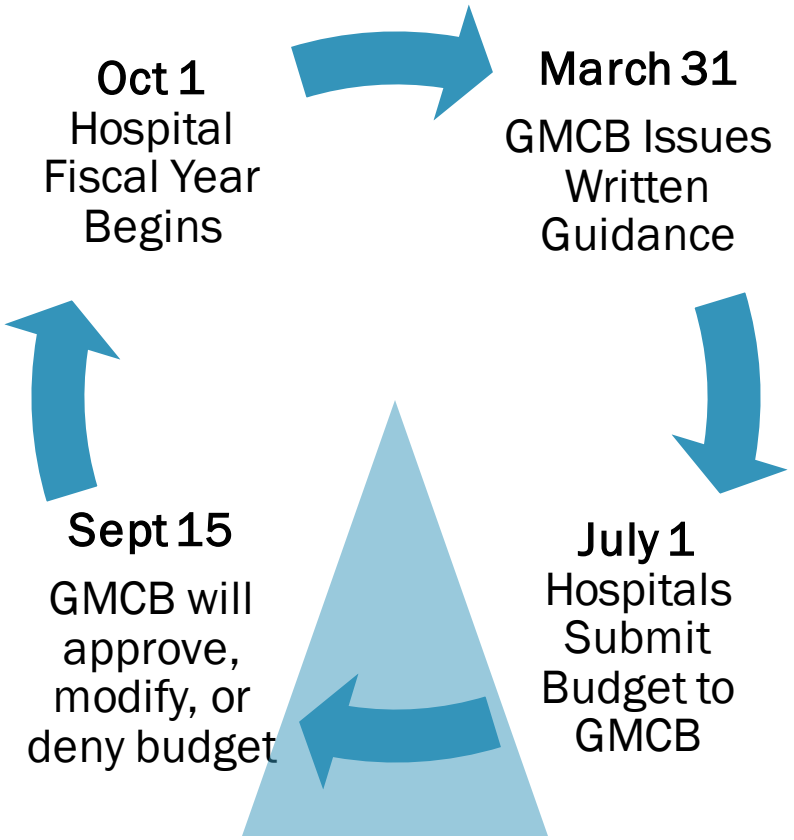

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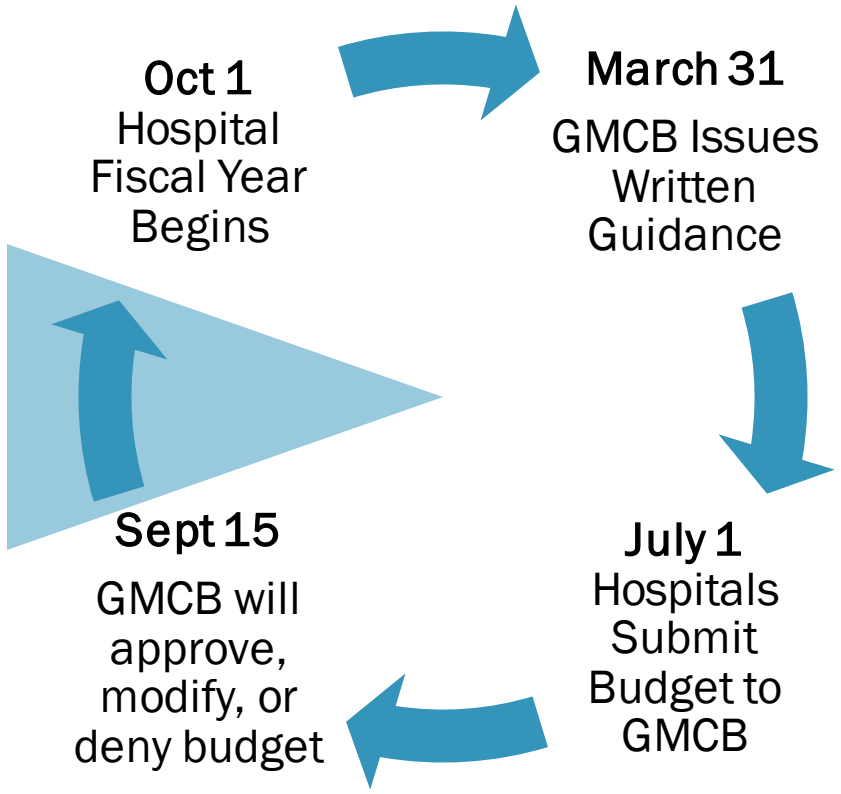

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Guidance Structure

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Guidance Section	Purpose
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 will use to evaluate hospital budgets in greater detail.
III – Budget Assumptions	Information on assumptions, measures, and data sources that hospitals rely upon in their budget submissions.
IV – Community Context	Contextual data for better understanding the needs of the community, may also including outside-hospital local delivery system pressures.
V – Monitoring	Measures of hospital performance for monitoring purposes but are not expected to be directly tied to establishing a hospital's budget.
VI – Narrative	Additional qualitative justifications for the proposed budget.

Hospital Budget Review Decision Tree

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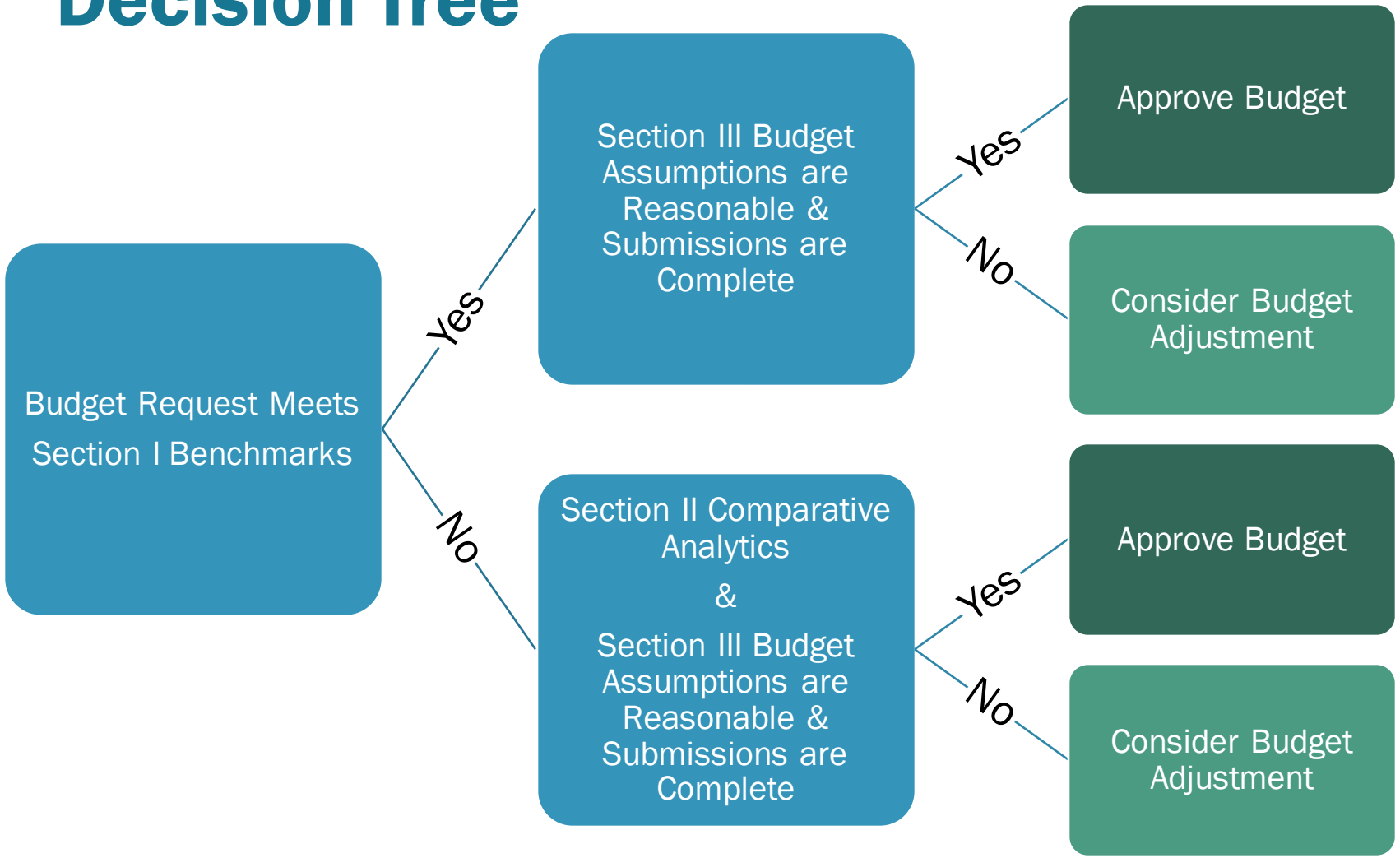

Regardless of budget approval or adjustment, insights gained from data in any of the sections of this guidance may be used to facilitate conversations around improvement opportunities and may lead to general or hospital-specific budget order conditions.

Hospital Budget Review Decision Tree

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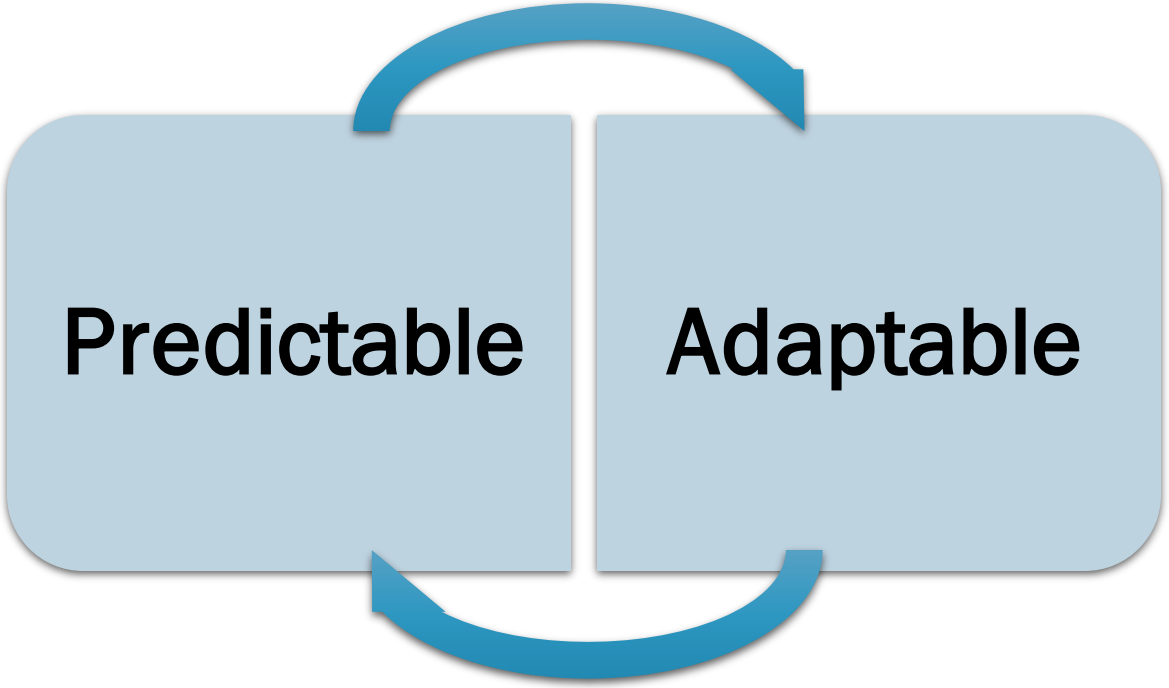

The revised Budget Guidance structure seeks to optimize two objectives (1) **predictability** of benchmarks, with (2) **adaptability** for **hospital-specific challenges** and a **dynamic** industry and economic **environment**.

Section I – Proposed Benchmarks

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Benchmarks aim to improve the hospital system through *two lenses*…

1. Health Care Affordability
2. Hospital Financial Sustainability

The Board recognizes that…

…**hospitals** provide essential care services and economic opportunity to communities. They **are vital**.

…**unaffordable hospital prices** will **not** create a **sustainable system**. The loss of a hospital because it is unaffordable devastates communities.

…the **relationship** between health care affordability and hospital financial sustainability is **complex**, affected by a variety of factors (e.g. hospital transformation, hospital efficiency, local market factors etc.).

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%** in line with the Vermont All Payer Model Agreement.*

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 Charges** and **Commercial Rates (Charges less negotiated discounts)** at no more than **X%…**

Section I – Proposed Benchmarks: Affordability

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How should we set cap on growth in hospital commercial charges and commercial rates?

(1) To which index should we tie expectations for growth?

(2) At what level of analysis? By payer? By care setting (i.e. inpatient, outpatient, professional services)?

Price Inflation Index	Timeliness	Hospital-Specific	Vermont-Specific
Implicit Regional Price Deflator	Annually (2022)	No	Yes – Metro vs. non-Metro
Producer Price Indices (PPI) for Hospitals	Monthly (Jan 2024)	Yes	No
Consumer Price Indices (CPI-U or CPI for Medical Care Services)	Monthly (Jan 2024)	No	No
Vermont Wage Growth	Monthly (Dec 2023)	No	Yes
Medicare Market Basket	Quarterly Forecast	Yes, but inpat only	No
Median Household Income	Annual (2022)	No	Yes
State TCOC (per VT APM)	Historical	No	Yes

Section I – Proposed Benchmarks: Affordability

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What are other states doing?

Through its affordability standards in insurance rate review, Rhode Island caps hospital rates at **CPI-U less food & energy +1%** (most recent 12-month % change for subsequent year); Prior to 2015, RI capped average annual price growth at **Medicare Market Basket** for hospital inpatient, outpatient, and professional services.

In statute, through its Department of Insurance, Delaware (beginning in 2022) caps insurers' average contracted prices, ensuring they are no more than the **greater of** 3% or Core CPI +1% (2022); 2.5% or Core CPI + 1% (2023); **2% or Core CPI + 1%** (2024-2026).

Maryland establishes all payer rate increases tied to the prior year first quarter **Medicare Market Basket** plus a "capital growth estimate".

Next steps: Modeling…

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 I – Proposed Benchmarks

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Meeting all three Sec. I Benchmarks

Budget Request Meets Section I Benchmarks

Yes

Section III Budget Assumptions are Reasonable & Submissions are Complete

No

Section III Budget Assumptions are Reasonable & Submissions are Complete

&

Section II Comparative Analytics

Narrative & Sec. II data will help explore hospital-specific dynamics

Sec. III Budget Assumptions are key to understanding hospital's budget submissions regardless of whether they meet Sec. I Benchmarks

Section II – Comparative Analytics

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Purpose: analyze and evaluate 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 many of these measures cannot stand in isolation but must be **considered collectively**.*

Section II – Comparative Analytics

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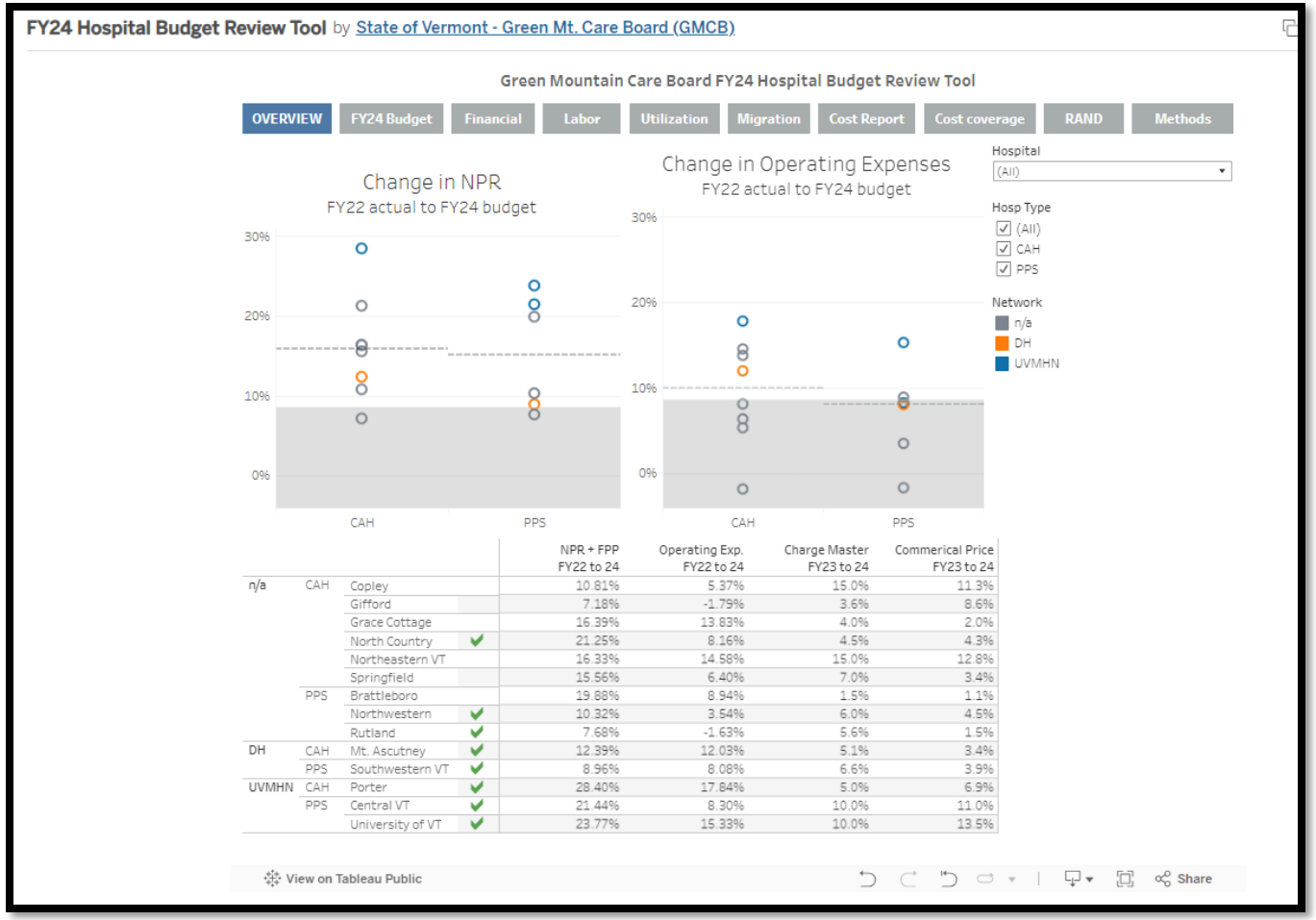
Types of measures include:

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



Section II – Comparative Analytics

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Work in Progress:

- Reviewing FY24 tool and metrics
- Focal measures to be included in a measure specification document
- Concurrently working on data visualization design

Specification document will:

- Include Section II metrics and to the extent time and resources allow, measures included in other Guidance Sections
- Outline methods, intended inferences, companion measures, limitations etc. with the goal that the measures and analyses used in the hospital budget process are **replicable** and **transparent.**

Section II – Comparative Analytics Establishing Peer Groups

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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

Guidance will include the peer group methodology that will be used for comparative analytics.

There will be a variety of factors considered when establishing this methodology. Staff asked VAHHS CFO sub-group to provide feedback on factors to be considered. More to come…

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 – Community Context

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- Health outcomes
- Population demographics and trends
- Economic and social needs
- Access to non-hospital services (e.g. Long-term care)
- Community Health Needs Assessment
- Drive time to services (e.g. VT Medicaid tracks this)
- And more…

Section V – Monitoring

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- Utilization
- Hospital Quality
- Quality Improvement Activities
- History of Regulatory Compliance
- Payment & Delivery System Reform Participation
- Uncompensated Care
- And more…

Section VI – 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
  - Patient Experience
  - Performance Improvement Strategies
  - Update on Performance Improvement Plans Ordered by the Board
  - Act 167 Community Engagement Experience
  - Health Equity Work
  - …

Timeline for FY25 Guidance

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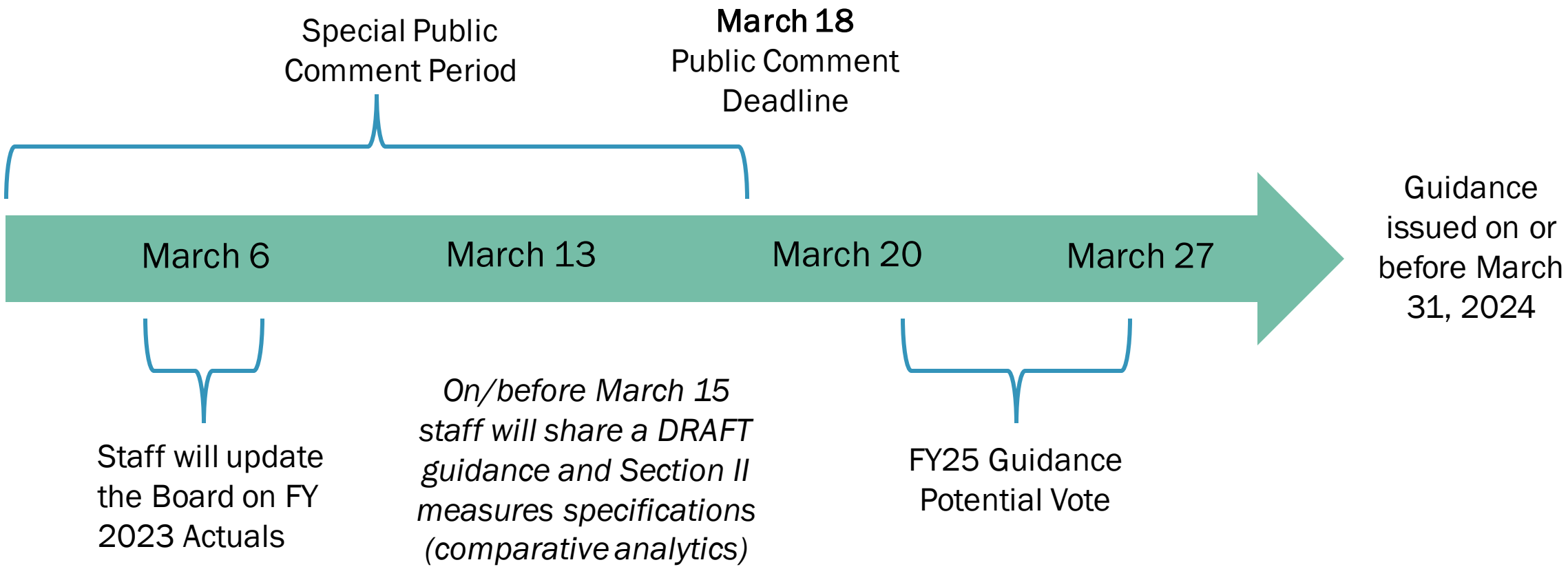

Questions

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