Hospital Budget Review

VERMONT
GREEN MOUNTAIN CARE BOARD

Summary

Annually by October 1, the Green Mountain Care Board (GMCB) has the responsibility to review and establish budgets for Vermont's 14 community hospitals. In its review, the Board considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public.

18 V.S.A. § 9375(b)(7); 18 V.S.A. § 9456

Background Information

Vermont's hospital budget review process is intended to help slow health care spending growth. Because community hospitals account for around 40% of the total amount of money spent on health care in Vermont, hospital budgets have a big impact on the cost of health care for Vermonters and for out-of-state patients who seek care at Vermont hospitals.

Vermont's Legislature assigned the GMCB the responsibility to see that Vermont's health system improves the health of Vermonters while slowing health care cost growth, including -- in Act 171 of 2012 -- responsibility for hospital budget oversight. The Board performs its hospital budget regulatory duties by:

- *Establishing Budgets*. The Board establishes revenue growth rates for Vermont's 14 community hospitals:
    - Under oath, hospitals submit budget requests by July 1 and discuss these budget requests at hospital budget hearings in August.
    - The Board deliberates publicly at scheduled Board meetings and writes budget orders by October 1.
    - The Board regulates hospitals' ***net patient revenue (NPR)*** and ***fixed prospective payment (FPP)*** growth. The Board also regulates NPR/FPP by limiting ***change in gross charges***, which can impact consumers' insurance costs.
- *Enforcing Budgets*. The Board may review the financial performance of hospitals that exceed the growth limits ordered in their budgets, and may take enforcement action if performance differs substantially.
- *Monitoring Performance*. Hospitals submit monthly performance information to the Board. Hospitals facing financial challenges may be required to meet periodically with the GMCB Chair and staff.

Green Mountain Care Board

The purpose of the Green Mountain Care Board is to promote the general good of the State by:

1. Improving the health of the population;
2. 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;
3. Enhancing the patient and health care professional experience of care;
4. Recruiting and retaining high-quality health care professionals; and
5. Achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

March-April	April-July	July-August	September-October
• The Board provides hospitals with written guidelines for the upcoming budget, including a limit for the growth of patient revenue • Enforcement review of previous year's budget order	• Hospitals develop their proposed budgets according to guidelines, including details on proposed growth of patient revenues and changes in charges • Hospital budgets are submitted July 1	• The Board reviews hospitals' budget submissions • Hospitals present their proposed budgets to the Board at public hearings	• Board publicly deliberates to approve, modify, or deny budgets by September 15 • Budget orders are delivered to hospitals by October 1 • Hospital fiscal year begins October 1

Hospital Budget History

In 1983, Title 18 established the hospital budget review process as a way to slow the rising costs of health care and ensure hospital budgets were reasonable and fair.

In 2011, Act 48 gave Vermont new tools to apply to the hospital budget review process designed to manage costs, including the creation of the Green Mountain Care Board.

In 2012, Act 171 assigned the Green Mountain Care Board responsibility for hospital budget oversight.

Understanding Hospital Revenues

Most hospital revenues are ***patient revenues*** – revenues generated by providing health care services to patients. Hospitals also generate some ***non-patient revenues*** through grants, donations, parking fees, cafeteria purchases, pharmaceuticals, investment revenue and other sources. GMCB's regulation focuses on patient revenues. Vermont hospitals receive payment for patient revenues in two major ways:

1. **Fee-for-service (FFS):** Hospitals get paid for each service they provide. This is the most common way of paying for health care. In FY2022, FFS makes up about 86% of Vermont hospitals' budgeted net revenues. To develop budgets for their FFS business, hospitals need to estimate ***price*** (how much they expect to get paid – this can vary by insurer) and ***volume*** (how much of each service they expect to provide).

2. **Fixed prospective payments (FPP):** Hospitals that choose to participate in the Accountable Care Organization (ACO) can receive a type of value-based payment known as fixed prospective payments for some patients. These payments are made in advance for a set group of patients for the cost of the care those patients will receive for a specific set of services during a defined time period. Providers who meet quality and performance targets can receive incentive payments. Right now, FPP accounts for a minority of Vermont hospitals' budgets, but this amount is growing as Vermont's payment reform efforts advance under the All-Payer Model.

How GMCB Regulates Hospitals

GMCB regulates hospitals' **NPR/FPP growth**, as well as **change in charges**.

In setting NPR/FPP growth and change in charges, the Board takes several factors into consideration, including the needs of the hospital's local community and the hospital's financial health. The 14 community hospitals in Vermont serve communities with varied geography, demographics, needs, and resources. The Board considers individual hospitals' issues and opportunities resulting from these factors, as well as each hospital's cost structure, capital investments, utilization patterns, and overall financial health.

Net Patient Revenue

Gross patient revenue is the total charges at the hospital's established rates (sometimes referred to as "sticker price") for providing patient care services. This includes FFS claims at the charged amount, and represents services paid for under FPP arrangements. However, most patients do not pay the sticker price and hospitals do not receive the total amount of gross revenues. The actual monies received by the hospital are referred to as ***net patient revenue (NPR)*** – a key metric in GMCB's hospital budget process.

Net Patient Revenue = Gross Revenues – Deductions

To calculate NPR, hospitals subtract deductions from gross revenues. Common deductions include:

- Contractual Allowances: Reductions to the hospital's "sticker price" (established rates) negotiated between commercial insurers, government payers and the hospital.
- Reserves: Profits that have been set aside for a particular purpose.
- Uncompensated Care: Care provided to patients who can't or don't pay.

Net Patient Revenue (NPR) is the net revenue a hospital receives for patient services rendered. Patient services include but are not limited to tests, procedures, prescription medication, and time spent in the hospital or with a doctor or nurse. If everyone paid the sticker price for these services, then it would be easy to figure out how much hospitals make: just multiply the volume—the number of times a particular service is used—by the sticker prices. In practice, different payers negotiate different prices.

Payers are often categorized by type: Medicare, Medicaid, or commercial (private insurance). Medicare and Medicaid have a set fee schedule for providers who choose to accept their patients, while commercial insurance companies negotiate with hospitals for deductions from the sticker price. If a hospital's sticker price for an arm x-ray is $100, Medicare might pay the hospital only 80%, or $80, for this procedure. A private insurance company might pay 90%, or $90, for the same x-ray.

To estimate net patient revenue, hospitals must consider their **payer mix** – how many of their patients are covered by each payer type and the negotiated prices those payers will pay compared to the sticker price.

Change in Charges

The **change in charges** is the increase (or decrease) in the ***average gross charge*** – the FFS sticker price – for all services, for all payers. Instead of regulating charges for particular hospital services, the Board sets a maximum average gross charge increase per hospital for all services for all payers; however, Medicare and Medicaid do not negotiate their prices, so change in charges impact hospitals' negotiations with commercial insurers. The Board regulates the increase in ***gross charges*** (sticker price) instead of ***net charges*** (which are gross charges minus the negotiated deductions by payers and hospitals) because negotiated prices are considered confidential, and this information is not available to the GMCB.

Impact of COVID-19

The COVID-19 public health emergency significantly impacted Vermont hospital volume and finances in FYs 2020-21. Hospitals have received over $300 million in federal relief funds to balance this unpredictability. At the same time, GMCB has sought to minimize hospitals' regulatory burden.

Transparency and Public Engagement

During the hospital budget review process, the Board gives public notice of board meetings and invites the public to comment and attend these public meetings. The Board deliberates in a public setting and posts budget information to its website. The GMCB is subject to Vermont's Open Meeting Law (1 V.S.A. § 310-314), which means that all meetings and deliberations about the hospital budget process are open to the public, with meeting information and an agenda shared in advance on its website.

GLOSSARY

Payer: The person, company, or government agency that pays the hospital bill.

Provider: An individual or organization that performs medical care. This can refer to hospitals, clinics, doctors, nurse practitioners, etc.

Utilization: How much a particular service is used. In many cases, the cost for a service decreases when utilization goes up because more payers split fixed costs. Also referred to as "volume."

Price: Also referred to as "charge" or "rate."

Uncompensated Care: Care provided by the hospital to patients who can't or won't pay, including bad debt and free care. Bad debt is bills that are considered uncollectible; free care is bills that are waived, usually based on a patient's inability to pay.

By statute, the Office of Health Care Advocate, a division of Vermont Legal Aid, receives hospital budget materials and other pertinent information, and participates in the budget process and hearings.

Additional Resources

- Map of Vermont Hospitals
- Vermont Department of Health: Hospital Report Cards and Community Health Needs Assessments

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