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Update on Evolution of GMCB's Hospital Budget Review Process

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Overview

- Brief History of Hospital Budget Regulation in Vermont
- Enriching the historical approach with evidence-based techniques
- Demonstrating a new expense-based approach

Brief History of Hospital Budget Oversight

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1992

Vermont Health Care Authority

Merged 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

BISHCA renamed to Dept of Financial Regulation

Why regulate hospital budgets?

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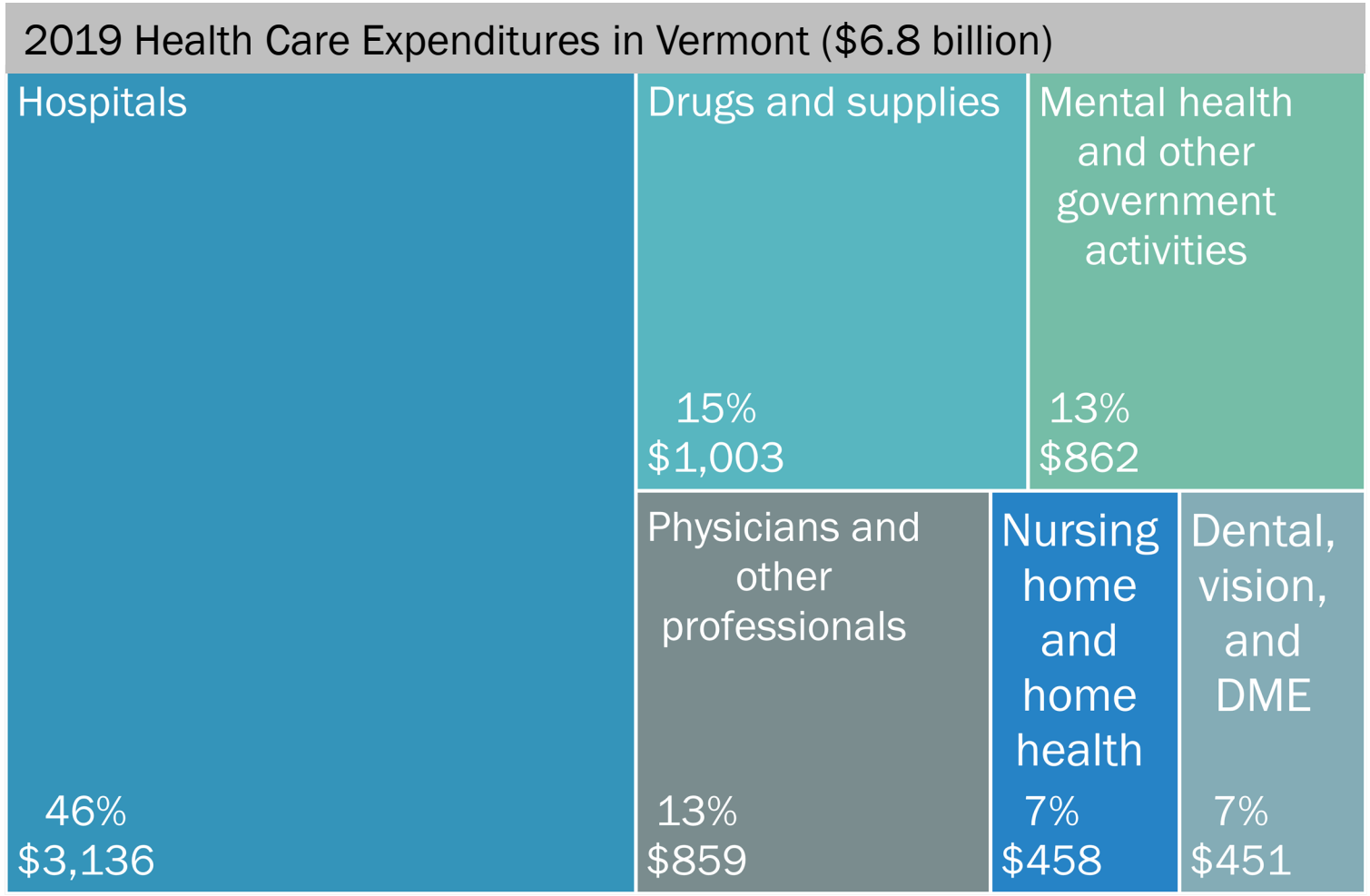

Millions of dollars. Excludes $44 million in other/uncategorized expenditures (<1% of total).

- Hospital expenditures make up nearly half of all Vermont health care expenditures.
- Vermont's health care system is highly concentrated. Regulation is essential to contain costs in noncompetitive/monopoly markets.

Approach to Date: Revenue Regulation

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- The GMCB's regulatory approach to date has centered on managing growth in **net patient service revenue (NPSR or NPR).**
- However, focusing on revenue may have unintended consequences. NPR changes for many reasons, such as:
  - Volume
  - Payer mix
  - Service mix
  - Price
  - Acquisition or transfer of practices

Evolving Approach: Expense Regulation

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- Since the GMCB was established, Vermont's health system has changed dramatically:
  - Passage of the Affordable Care Act (ACA)
  - Growth in multi-state networks
  - Establishment of 3 Vermont-based Accountable Care Organizations, of which only 1 remains
  - COVID-19 global pandemic
- Revenue-based regulation was designed for a different time and a radically different set of circumstances.
- Today, there is expanded ability to harness data to enrich our understanding of expenses in support of a more sustainable health care system.

Role of Tom Rees as team member

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Pertinent Health Care Experience

- Educated at University of Delaware with MBA from University of Florida
- 21 yrs. of hospital executive leadership starting at MCHV and ending at Geisinger
- 26 yrs. consulting with academic medical centers (21), Ascension Health hospitals (17), community medical centers (46).
- 20 yrs. perfecting hospital clinical analytics
  - 16 discrete hospital performance improvement team consultations.
  - 25 discrete deep-dive clinical expense analyses.

Gold Standard Metrics

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Based on deep experience working with hospitals, the following gold standard metrics are recommended to determine how Vermont hospitals compare with peers regionally and nationally:

1. Patient severity
2. Adjusted Medicare Cost per Case
3. Ratio of administrative and general salaries to clinical salaries
4. Earnings before interest, taxes, depreciation, amortization, and rental fees (EBITAR) per discharge
5. Cash available for operations
6. Percentage of Medicare patient deaths

1) Patient Severity

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By limiting our view to revenue only we miss the opportunity to weigh the **value** of patient care being delivered.

A GOLD STANDARD measurement of foundational importance is the hospitals Case Mix Index (CMI). It is a discrete measurement of the average **clinical severity** of patients admitted to each. CMI is the total institutional averaging of inpatient Medicare Case Weights assigned for each MSDRG grouping.

However, at present CMI has only been quantified for the **inpatient population**. Our staff plan is to extend this measure to include a similar metric for outpatient services.

2) Adjusted Cost per Case

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A universally accepted measurement factor reflects actual case cost adjusted for patient severity of all Medicare patients admitted to each hospital. It is the GOLD STANDARD for measuring the **cost efficiency** of hospitals. Many hospitals and hospital systems "manage to Medicare". By way of example, Ascension Health leadership utilize this standard to monitor the performance of their 121 hospitals.

3) Ratio of administrative and general salaries to clinical salaries

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This is a measurement created specifically for our expense-based approach and may be the most compelling of our Gold Standard parameters. It reflects the comparative level of gross staff salary investment in administrative and general functions (executive and support staff not including Nursing leadership) versus clinical service (All direct care including Nursing, laboratory, imaging, etc.) functions. It truly defines executive leadership **discretionary spending.**

4) EBITDAR per discharge

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- EBITDAR or earning without adjustments for amortization, depreciation, and rental expenses is a tool used to measure hospital **financial operating performance**. Computationally it removes extraneous variation and thus establishes a foundation for comparison across and among hospitals.

- Scaling these earnings by the number of discharges or adjusted discharges helps contextualize relative profitability across hospitals or systems of hospitals.

5) Cash for operations

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Cash available to operations is a critical measurement of **hospital sustainability**. It not only reflects liquidity based on past operating results, but it has great bearing on the potential of investment in future results. It has been a long-standing GOLD STANDARD reflection of financial health.

6) % Medicare deaths per discharge

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Patients come to hospitals to be healed and discharged. Thus the bedrock measure of hospital performance is what percentage of patients achieve or do not achieve that result. In-hospital deaths are a measure of performance **quality**. There are dozens of measures of hospital processes indicative of quality enhancing hospital behavior, but for our purposes we are utilizing this as our GOLD STANDARD measurement.

Example: A Tale of 2 Hospitals

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Two very similar hospitals with different expense structures.

	HOSPITAL I	HOSPITAL II
STAFFED BEDS	458	467
DISCHARGES	19,751	20,040
PATIENT DAYS	127,451	130,603
AVERAGE LENGTH OF STAY	6.45	6.50
PERCENT OCCUPANCY	76%	77%
INPATIENT REVENUE	$1,059,327,000	$1,308,237,942
OUTPATIENT REVENUE	$1,519,933,165	$1,250,022,214
TOTAL PATIENT REVENUE	$2,579,260,165	$2,558,260,156
TOTAL EXPENSE	$1,572,224,000	$1,022,757,516
AGE OF PLANT	13.6	14.1

Example: A Tale of 2 Hospitals

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Hospital I's bottom line is negative, driven by a higher operating loss.

Hospital I also has an alarmingly low amount of cash available.

The differences in days in receivables may indicate some inefficiencies in collections.

	HOSPITAL I	HOSPITAL II
OPERATING INCOME	($438,646,041)	($327,526,653)
TOTAL NON-PATIENT REVENUE	$366,234,239	$392,970,818
NET INCOME	($72,411,802)	$65,444,165
EBITDAR	($2,565,519)	$142,192,375
CASH ON HAND	$81,608,859	$151,812,246
DAYS CASH ON HAND	8.8	48.4
ACCOUNTS RECEIVABLE	$188,037,000	$179,160,741
DAYS IN RECEIVABLES	60.5	38.4

Example: A Tale of 2 Hospitals

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- Imagine both hospitals are requesting a 5% rate increase for their upcoming budget.
- Hospital I has very little cash, negative net income and EBITAR, and high expenses contrasted with Hospital II's lower expenses and stronger financial position (positive net income and EBITDAR coupled with moderate cash reserves).
- Would you give
  - both hospitals 5% or
  - more to one of the hospitals?

Example: A Tale of 2 Hospitals

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Gold Standard measures add context for the hospitals showing that Hospital II is providing more cost-effective care despite a more clinically complex patient population. Hospital I demonstrates higher relative expenditures in salaries associated with clinical vs A & G as well as high adjusted cost per case.

	HOSPITAL I	HOSPITAL II
CMI	1.9918	2.0261
ADJSUTED COST PER MEDICARE CASE	$12,914	$6,890
ADMIN & GENRAL COST : CLINICAL COST	23%	5%
EBITDAR PER DISCHARGE	($5,602)	$304,480
CASH ON HAND	$81,608,859	$151,812,246
% MEDICARE DEATHS PER DISCHARGE	3.39%	2.35%

Example: A Tale of 2 Hospitals

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- How does a granular evidence-base expense analysis and resulting gold standard metrics change the way you think about the 5% rate requests for each hospital?

How will the new metrics be used?

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The GMCB will incorporate these metrics in its FY24 hospital budget process. This bridge year will be an opportunity to learn more and determine how to most effectively and efficiently incorporate them into standard, predictable, evidence-based regulatory practice.