CFO Discussion Group

Board Room
Green Mountain Care Board
89 Main St, Montpelier
December 6, 2017

GMCB Attendance: Tom Pelham, Maureen Usifer, Susan Barrett, Andy Pallito, Tom Crompton, Lori Perry, Kelly Theroux, Michelle Lawrence, Ena Backus, Sarah Lindberg, Agatha Kessler, Janeen Morrison

Hospital Attendance: Mike DelTrecco, Andre Bissonnette, Stephen Majetich
Scott Whittemore (phone), Rick Vincent (phone), Chris Hickey

The meeting began at 9:00 am. After introductions, Andy briefed the group on the meeting objectives and agenda. At its November 16, 2017 GMCB meeting, the Board asked the hospital budget team to work with VAHHS and the CFO group on budget guidance for fiscal year 2019 and various details of the hospital budget process. The Board has asked the Hospital Budget Team to report back to them at the December 14, 2017 meeting.

Mike has talked to his CFO group and briefed them on the agenda items. He would like this meeting to identify the areas to focus on and VAHHS will come back to the next meeting with recommendations.

Andy asked Janeen to send out the meeting minutes by the close of business Thursday.

Maureen said the overall objective is to inform the decision making of the Board and that begins with getting feedback from the CFOs who are on the front line.

Stephen said that Vermont's three groups of hospitals, Critical Access Hospitals (CAH), Prospective Payment System (PPS) hospitals, and Teaching hospitals, each have different revenue structures and that therefore we need standardized ways of doing things for each of these groups while also remembering the uniqueness.

Mike had three recommendations to begin with. He suggested standardized presentations for the hospital budget hearings. For example, how many slides should focus on CHNA, budget information, etc. He also recommended moving to a broader view – possibly a 2 or 3-year look – especially for the CAHs. Lastly, he said that the "dashboard" look which the GMCB began using last year was a good start and that maybe a few more statistics would be helpful. He mentioned depreciation coverage as being a useful statistic.

Susan mentioned that for the most part, we have a brand new Board (with the exception of Jess) and that this is an opportunity to take this process and line it up with the APM. Mike said that maybe one of the slides in the hospital presentations could focus on that. Consistency was

mentioned. Susan said that every year we add without taking things away and so that is another thing to look at. Stephen agreed and said that if we're not using something, shut it off. Stephen said that the dashboard was a good start but doesn't think it was used much in the process. Andy said the dashboard is an attempt to provide a custom tool to help the Board make their decisions.

Andre asked how the Board prepares for the budget hearings? Andy explained the basic process: we get the data in, run the edits and reports, send a report package to the HCA, do the analysis, send the questions to the hospitals, we receive responses back from the hospitals, we send the analyses to both the Board members and the HCA a week prior to the first hearing. Maureen said that it is very difficult to process and digest all this information given the tight timeframe. In the past, the Legislature has not been open to changing the legislation which says we cannot meet with Board members on the side – everything must be a public meeting. Also, Maureen mentioned that even at the budget hearings, the hospitals aren't spending too much time talking about the budget piece.

Mike said that the timing of everything is a challenge. Timing on federal level, the unknowns. Right now, the CAHs are looking at payment changes to fund low volume.

Tom Pelham said that we have time before March 1 to make guidance changes. He was glad to see Sarah and Ena here. He is looking forward to building a more collaborative process

Ena said that her group has long desired to establish a "basic information" set about the hospital system, recognizing the differences, drawing upon the vast set of data at the GMCB and other sources of data, discharge data set and VHCURES. To Mike she mentioned that her group completed some payer analyses about a year ago and sent them to VAHHS. She sees GMCB issuing these types of reports in a standard way, year after year. The development of a statewide hospital profile.

Rick Vincent would like to get away from looking at just one year in the budget process. He also mentioned the lack of connection with the Capital budgets or long-term projects. He recommended looking at historical information. He said the hospitals can standardize and simplify the data they are providing. He said the hospitals would like a presentation structure to follow.

Scott agreed that we rarely talk about the numbers and said that it's because the hospitals give them to the GMCB in 6 different ways, so we tell the story that isn't in the spreadsheets. He also likes the idea of the 3 peer groups.

Chris said that waiting until March to set the calendar is too late. Chris agreed with more consistency while at the same time identifying unique elements.

Andy agreed that shifting to the three peer groupings (CAH, PPS and Teaching) made sense.

Susan asked if could we identify items that we feel can be consistent? There are some hospitals heavily involved in ACO and taking on risk, moving forward. Others are not – and moving forward there needs to be flexibility and this is how we want the state to move forward. Mike said there's an umbrella for the APM rules out there and if you are a risk-taking hospital what does your attribution and revenue stream look like, for a payer. The GMCB will need to report on scale targets. At one point do the NPR and Fixed Prospective Payments (FPP) become one? Mike's recommendation is to add an element to look at attribution and payment for services. Packaged within NPR or patient related dollars.

Maureen said that maybe the 3 year or long-range strategy would be good but not at budget time but perhaps at actual time? To Stephen's comment – we must go through the numbers – it's important to see that and go through it – the Board is getting 14 hospitals at one time and so even if its repetitive, it is necessary. She also mentioned opportunities, and what's coming. Andre agrees with a standardized set - plus a set of unique elements for each hospital.

Andy asked Mike what it would look like if we issue instructions on Feb 28? Mike said this would be difficult because all calendars have been set for this year. As it is, hospital budgets have already been done or are in process. Andre starts beginning of February and Stephen begins the budget process on January 2. Andy asked Mike to give us 4 points on this by December 20. Stephen's biggest gripe is that he gets Questions at the end of July and submits answers and gets more Questions on the 10th of Aug. There's such a tight window to respond in.

Andy envisioned giving question to the hospitals and the HCA at the end of June. Susan said if it can't work for this year, lets look at it for next year. Andy asked the CFOs what they could do internally to shift the timeframe. Chris said he can make any date given enough time, but the question will be, "How good is the information"? Mike said that the reaction of the CEOs is that it can't happen.

Stephen said that looking at Budget to Actual may be better than Budget to Budget and Andre suggested even Actual to Actual. Maureen discussed the pros and cons of using these different scenarios. Maybe come up with some type of efficiency metrics. Mike mentioned cost per adj admission. Mike said we should come up with an expense metric. Maureen talked about a "top line increase" (revenue) vs. "expense increase" Talking about the hospitals whose expenses have increased but not their revenue. Maureen would like to see the "bridges" where the hospitals clearly explain the reasons for the increases. She would also like to look at efficiencies.

With regards to NPR, Andy suggested switching from the current budget to budget calculations and starting with 16 actual, then apply 17 budget (percentage) as ordered, then to that, apply the 18 guidance. He also said that the NPR must be all the patient related revenue – including the FPP. Stephen thinks this is a good start. Maureen would like to see this for a hospital who fell short as well as for one who ran hot. Mike asked staff to run a schedule showing this calculation for all 14 hospitals for the December 20th meeting. GMCB's "Report 7" was mentioned as a good source for comparing hospitals within peer groupings.

Stephen said the Board needs to look at expenses somehow – if my FTEs per adj adm is lowest in state – I know I want the expense discussion in his presentation and most hospitals wouldn't mind this either. To keep the cost of health care down, Stephen is thinking - if my costs are lower and revenue coming in 3% all the time, my bottom line is a little bigger, so what – I'm being more efficient. Maureen – its almost like we're rewarding bad behavior in some way. Not saying its intentional. Chris said his hospital has done very well from cost perspective but feels like they're being penalized for things such as their level of *days cash on hand*. Good financial management isn't being rewarded – it's being penalized.

In Conclusion:

Andy said we will leave this meeting with 3 deliverables for December 20th:

1 Staff will get you the NPR chart using 16 Actual
2 CFO group will think about an expenditure metric, (CFOs want us to give the metric)
3 VAHHS will give us thoughts on the very unique cost structure of each hospital

Mike said it should be incumbent on each organization to say, "here are the drivers" or "bridges".

Stephen said we could create consistency by just placing in the Guidance, for example – this is where each hospital should report their 340B and like things. Maureen agreed and said so we can see apples to apples.

The group talked about the in-migration and out-migration. Mike asked Stephen to bring the information he prepared last summer. Andy said that he remembered Stephen's report showed the information by zip codes – blind to the payer. He asked if Stephen could further drill down to see if it's an out of state (OOS) payer. The question is should we be making decisions on that OOS revenue? Andy said when we look at your budget, we could break out the OOS revenue and write the budget order on just the instate revenue. Stephen will bring this on the 20th.

Andy said that on the 20th we can get into the specifics and the CFOs should let us know if there is information we request that the hospitals think is unnecessary.

Andre said the monthly reports should be seasonalized – just to divide by 12 is not useful.

Mike said all 14 hospitals want a chance to report and to be heard at the budget hearings. Tom Pelham said it would be good to review the hospitals within the three peer groups at the budget hearings. Mike likes the idea of looking at the hospitals 3-year trend line rather than one year at a time.

Mike and Andy will meet before the December 20th meeting.

The meeting adjourned at 10:53 am.