

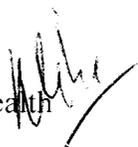


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MEMORANDUM

TO: Senator Douglas A. Racine, Chair, Senate Health & Welfare Committee
Representative Steven B. Maier, Chair, House Health Care Committee

FROM: Michael Davis, Director of Hospital Regulatory Operations, Division of Health
Care Administration (DHCA) of the Department of Banking, Insurance,
Securities and Health Care Administration (BISHCA) 

RE: FY 2010 Vermont Hospital Budget Report Addendum

DATE: May 21, 2009

CC: Paulette J. Thabault, Commissioner, BISHCA
Christine M. Oliver, Deputy Commissioner, DHCA
Heidi Tringe, Secretary of Civil and Military Affairs
Greg Peters, Chair, Public Oversight Commission
Public Oversight Commission members
James Hester, Director, Commission on Health Care Reform
Vermont Hospital Chief Executive Officers
Bea Grause, Executive Director, Vermont Association of Hospitals and Health
Systems

Attached is a copy of the *FY 2010 Vermont Hospital Budget Report Addendum*. This report was developed under 18 V.S.A. § 9456 that directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to annually prepare an analysis of the hospital budget submissions. The Commissioner established the FY 2010 budgets on October 1, 2009.

We have also included an update of the hospitals' *2010 Cost Shift Analysis* in response to the recommendations listed in the December 2006 Cost Shift Task Force Report to the Commission on Health Care Reform.

The report is available at BISHCA's website, <http://www.bishca.state.vt.us/health-care/research-data-reports/research-data-reports>. If you have difficulty accessing the file, let us know and we will get you a hard copy.

Please feel free to contact BISHCA if you have any questions regarding this publication.



STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION



LEGISLATIVE REPORT
DIVISION OF HEALTH CARE ADMINISTRATION

FY 2010 Vermont Hospital Budget Report Addendum

(includes 2009 Actual Results & Cost Shift Analysis)

May 2010

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Acknowledgements

This report would not have been possible without the support of the Vermont hospitals completing comprehensive budget reports. The budget information is used to inform the annual budget review process, provide data for uncompensated care analysis, cost shift analysis, CON applications, the disproportionate share program, and numerous other health care reform requirements. The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) would like to thank all participants who provided data and feedback in a timely manner.

Introduction

Purpose of the Report

This report is the follow-up to the January *FY 2010 Vermont Hospital Budget Report*. The purpose of the *FY 2010 Vermont Hospital Budget Addendum* is to present the results of the FY 2010 hospital budget filings, a review of the 2009 hospital Budget to Actual filings, and an update on the hospital system cost shift. The report includes updated 2009 actual data that will present key financial ratios and hospital industry indicators compared to various industry peers.

This Report will highlight some key financial information and much of this will focus on the entire Vermont community hospital system rather than individual hospitals. The individual hospital information is on file with the Department and is available upon request.

Data Sources

The Vermont hospital information has been taken from formal budget filings that hospitals complete annually. The data is summarized by BISHCA to evaluate the budget requests and rank, compare, and trend various ratios, statistics, and indicators. National and regional comparative data are typically obtained from the Sourcebook, Inc., Ingenix, Inc, KaufmanHall, Moody's, Fitch's, Standard & Poors, as well as other sources that provide comparative or illustrative facts.

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Executive Summary

The annual hospital budget review process, established in 1984, is a policy tool for Vermont. The process serves to develop an understanding of hospital operations, ensure fair hospital rate increases, and provide an information base to examine policy issues that emerge.

Since its inception, numerous policy issues have been addressed at the annual public budget hearings held by both the Hospital Data Council (now the Public Oversight Commission) and BISHCA. The list of issues is extensive and includes, at a minimum:

- The appropriate surplus for a non-profit hospital;
- The appropriate growth level of input costs;
- The need for future capital investments;
- The growth and change in patient utilization;
- The shift in care from the inpatient setting to the outpatient setting;
- The change in reimbursement policy;
- The scope of the cost shift;
- The need for subsidies to support hospital services that lose money;
- The need to subsidize non-hospital services;
- The scope and cost of bad debt and free care;
- The high cost to hire “travelers” or locum tenens to meet staffing shortages;
- The shift in the industry to employ physicians in hospitals who formerly were in private practices.

Section 50 of Act 61 passed in 2009 required that the Commissioner of BISHCA establish a goal “...to lower the average system-wide rate increase for all Vermont hospital budgets below the average system-wide rate increase for all hospitals during the previous three years.” The Act goes on to say that as part of this effort the Commissioner may take specific actions that might limit increases in the budgets.

The Commissioner responded to the weakening in the Vermont economy in FY 2010 by preparing the FY 2010 hospital budget instructions to establish tighter limits on hospital costs. Subsequent to that, upon request by the hospital CEOs and the Vermont Association of Hospitals and Health Systems, the Commissioner met with the hospitals to describe these changes and emphasize the need to be sensitive to economic pressures.

Upon final approval of the 14 community hospital budgets for FY 2010, the following key findings are noted in Vermont’s hospital system:

- 1) There was a reduction in the system-wide rate from 9.5% in 2009 to 5.9% for FY 2010. This was lower than the three-year weighted average rate of 7.4% for 2007-2009;
- 2) Rate increases across hospitals ranged from 4% to 7.1%;
- 3) The total system increase was \$90.3 million in net patient revenues over 2009 budgets;

- 4) The net revenue increase is estimated to be funded by rates of \$53.4 million and utilization \$52.9 million, offset by reductions (\$16 million) in disproportionate share;
- 5) Overall utilization is budgeted to increase over 2%;

In addition, the hospitals have filed their 2009 actual operating results. Key findings as a result of that review:

- 12 of 14 hospitals' **net patient revenues** met adjusted budget levels;
- 12 of 14 hospitals' **expenditure levels** met adjusted budget levels;

See Appendix A, Schedule A, Binding Budget Analysis of Net Patient Revenues
See Appendix A, Schedule B – Binding Budget Analysis of Expenses

- Total operating revenues of \$1.814 billion increased 7.4% over 2008;
- Six hospitals saw a larger operating surplus; 8 hospitals had lower profits than budget in 2009; operating profits totaled \$31.8 million;
- The overall cost shift experienced in 2009 was \$ 27.3 million lower than what had been budgeted.

Finally, BISHCA has included a series of charts in the Appendix that present the trends of key indicators across the Vermont hospital system. These charts compare Vermont to various peer groups that have been used to benchmark the hospitals as part of the annual budget reviews. The charts present information on costs, utilization, capital spending, operating surplus, and the cost shift. This information is used to evaluate new Certificate of Need applications, compare Vermont to U.S. and regional peers, and monitor ongoing changes in the health care system.

Our findings based upon that review include:

- The net revenue increase for hospitals has averaged about 8% for the period 2001-2010;
- Outpatient and physician service revenue now accounts for over 70% of the hospital system budget;
- Acute admissions and related ancillary care represent about 26% of the hospital system budget;
- Vermont hospital's median cost per adjusted admission is lower than their New England peers but higher than their U.S. rural, not for profit peers;
- Hospital capital spending is cyclical and it appears the Vermont hospital system will see higher increases in the near future;
- Vermont's hospitals' median age of plant are quite similar to their comparable peers,
- Vermont hospitals' median debt to capitalization is better than most peers but it is trending higher;
- Vermont hospitals' median cash on hand and operating surplus reflected a downturn in 2009 due to the overall economy. This is similar to what rating agencies saw in other states.

REVIEW OF THE FY 2010 HOSPITAL BUDGET SUBMISSIONS

FY 2010 Hospital Budget Approvals

The law requires that hospital budgets be reviewed and established on an annual basis. The law states the Commissioner must establish budgets that are consistent with the Health Resource Allocation Plan, must consider appropriate national, in-state, regional and peer group norms; must promote efficient and economic operation of the hospital; and must reflect budget performance in prior years.

In FY 2010, the Vermont hospitals requested an average 6.3% rate increase, with individual hospital rate requests ranging from 4.0% to 8.8%. The requests totaled an increase of over \$100 million in operating revenues, not including Southwestern Vt. Medical Center).¹

The Commissioner's review of the budgets included an evaluation of: whether each hospital budget complied with the Department's overall inflation and utilization targets, the changes occurring in government and insurance reimbursement, the overall economic pressures, hospital physician acquisitions, the challenges associated with recruiting medical professionals to Vermont, hospital investments in information technology, the need for operating margins, a hospital's budget performance in prior years, price, quality and patient satisfaction information, and the unique circumstances of each hospital. The Commissioner also considered the comments of the Public Oversight Commission prior to establishing each budget.

The Commissioner's final budget decisions resulted in a decrease from the requested 6.3% system average rate increase to 5.9%. The resulting net patient revenue increase totaled \$90.3 million.² The sources of the new revenues from all payers were generated from increased utilization, improved reimbursement, and increased rates. The chart below outlines the trends and increases in these areas over the last several years.³

Trends in Vermont Hospital Budgets (in millions)				
Budget to Budget change	Total Net Revenue Increase	Generated from Rates	Generated from Utilization	Generated from Other
Bud 03 - Bud 04	\$89.5	\$48.4	\$32.0	\$9.1
Bud 04 - Bud 05	\$89.0	\$46.0	\$34.0	\$9.0
Bud 05 - Bud 06	\$72.5	\$56.2	\$14.9	\$1.3
Bud 06 - Bud 07	\$135.4	\$58.2	\$45.5	\$31.7
Bud 07 - Bud 08	\$148.8	\$54.7	\$89.7	\$4.4
Bud 08 - Bud 09	\$163.9	\$86.8	\$79.0	(\$1.9)
Bud 09 - Bud 10	\$90.3	\$53.4	\$52.9	(\$16.0)

¹ The budget for Southwestern Vermont Medical Center was delayed so the new management team could prepare a financial recovery plan. As a result, the submitted budget numbers did not include SVMC. The budget was subsequently submitted at the end of August in a form and manner prescribed by the Commissioner of BISHCA.

² The final approved budgets did include the budget for Southwestern Vermont Medical Center so that information is included in the findings on page 5.

³ The "Other" category includes disproportionate share and other non-direct patient care revenue such as parking, cafeteria, etc.

REVIEW OF THE FY 2010 HOSPITAL BUDGET SUBMISSIONS

Final Hospital Rate Approvals

As noted previously, Section 50 of Act 61 in 2009 required the Commissioner to establish a goal “...to lower the average system-wide rate increase for all Vermont hospital budgets below the average system-wide rate increase for all hospitals during the previous three years.”

In addition, the Commissioner prepared instructions in the spring of 2009 that would limit the cost inputs the hospitals were allowed to add to their 2010 budgets. These factors, along with improvements in reimbursement resulted in rate increases that more than met the goal noted in Act 61. The effect of this was a reduction in the overall system-wide rate from 9.5% in 2009 to 5.9% for FY 2010. This was also lower than the three-year weighted average of 7.4% for the period 2007-2009.

Vermont Community Hospitals

Rate Increases	Approved	Approved	Submitted	Approved	Avg 08-10
	2008	2009	2010	2010	
Brattleboro Memorial Hospital	6.3%	7.5%	8.8%	7.1%	7.0%
Central Vermont Hospital	8.0%	9.6%	8.0%	6.8%	8.1%
Copley Hospital	4.5%	6.0%	6.0%	6.0%	5.5%
Fletcher Allen Health Care	5.5%	10.0%	6.5%	6.0%	7.2%
Gifford Memorial Hospital	6.4%	7.9%	5.8%	5.8%	6.7%
Grace Cottage Hospital	8.7%	5.0%	5.0%	5.0%	6.2%
Mount Ascutney Hospital	5.3%	10.5%	6.1%	6.1%	7.3%
North Country Hospital	6.5%	7.0%	4.0%	4.0%	5.8%
Northeastern VT Regional Hospital	6.5%	9.2%	6.0%	6.0%	7.2%
Northwestern Medical Center	10.5%	10.7%	6.5%	5.2%	8.8%
Porter Medical Center	7.4%	8.7%	7.0%	6.7%	7.6%
Rutland Regional Medical Center	8.5%	9.6%	6.5%	5.5%	7.9%
Southwestern Vermont Medical Center	7.0%	10.7%	5.0%	5.0%	7.6%
Springfield Hospital	4.3%	3.8%	6.7%	6.1%	4.7%
System average	6.3%	9.5%	6.3%	5.9%	7.2%
Median	6.5%	9.0%	6.4%	6.0%	7.2%

REVIEW OF THE FY 2010 HOSPITAL BUDGET SUBMISSIONS

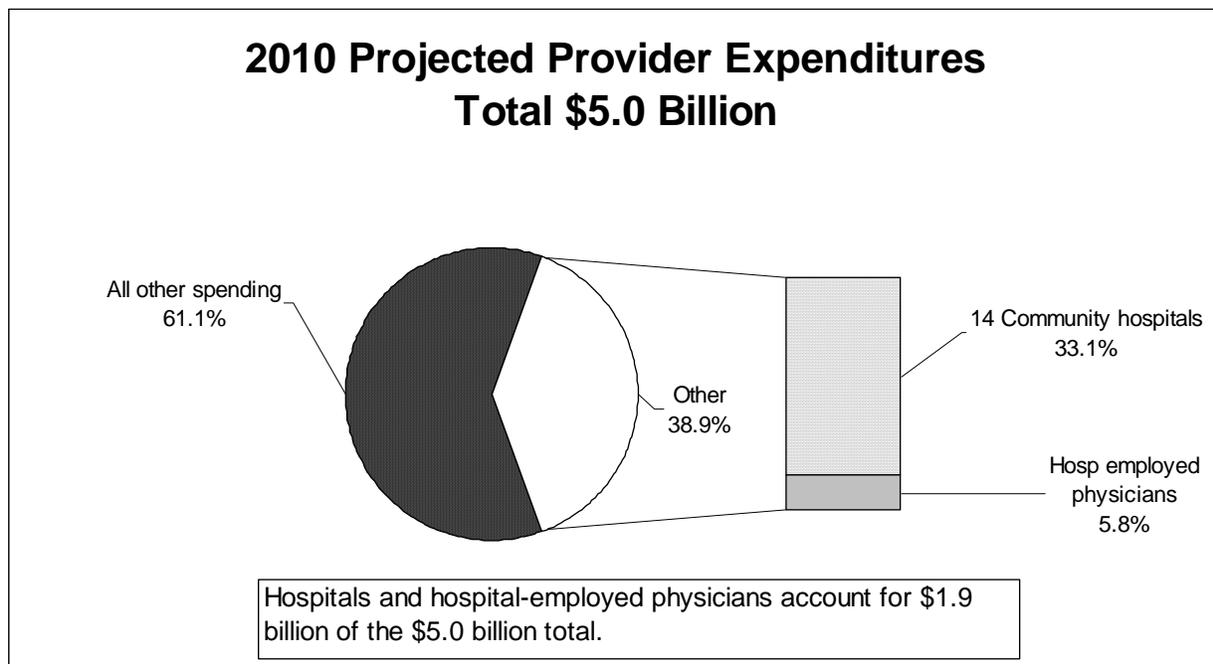
Vermont Hospital System Key Indicators (As approved Oct '10)

- Budgets reflect lower rate increases than FY 2009 – only two hospitals requested higher rates than the prior year;
- Overall net revenue increase is \$90.3 million; 4.9% increase;
 - Net patient revenues are increasing \$107 million. Medicare is up \$33 million, Medicaid, \$40 million, and commercial insurance \$33 million.
 - Disproportionate share and other revenue is lower by \$17 million
- Net revenues are budgeted to increase 4.9% in 2010. This compares to an average annual increase of 8.1% for the period 2005 – 2009;
- The operating surplus is budgeted at \$40.3 million across the system;
- The operating surplus is budgeted at 2.1% of net revenues in 2010. This compares to an average actual amount of 2.2% for the period 2005 – 2009;
- The expense per adjusted admission budget-to-budget increase is 5.4% in 2010. This compares to an average annual increase of 3.3% for the period 2006 – 2009;
- The average salary and benefits per full time equivalent (non-MD) is \$73,826, an increase of 3.0% over 2009. The average annual increase for the period 2006 – 2009 is 4.8%;
- Overall bad debt and free care is budgeted at 3.1% of net revenues, a little lower than recent levels experienced in 2008 and 2009;
- Vermont hospitals will employ 11,325 non-MD full time equivalents in FY 2010, an increase of 307. The number of physicians that will be employed will now total 1,117;
- New capital investment, not including Certificate of Need projects, is budgeted at \$102 million;
- In addition, hospitals have another \$28 million in projects that will require review under the Certificate of Need process;
- Hospital net assets total \$762.8 million of which \$437 million is Board Designated Assets (reserve funds specifically controlled by the hospital Board);

- Overall, the cost shift decreased in 2010 because of improved reporting and increased reimbursement for some payers. The estimated cost shift for 2010 is \$231.5 million. See the Cost shift discussion in Appendix B;
- Overall utilization continues to increase. Inpatient acute admissions show a small decrease of 731 (-1.5%). Acute average length of stay is at 4.5 days, essentially the same level it has been at since 2004;
- Outpatient services now dominate the hospital system, with over 2.4 million visits in 2009. This is reflected in increases for selected services such as radiology, MRI and CT scan imaging, laboratory tests, physician and clinic office visits, as well as a shift in care from the inpatient setting to outpatient care. Changing and new technologies have accelerated much of this change;
- Vermont hospitals report about 2.9 million physician visits in 2010, reflective of the large number of physicians employed by the hospitals;
- Certain Vermont hospitals also provide inpatient services to nursing home residents and patients needing rehabilitation services. There are 57 staffed Rehab beds serving 1,182 admissions and 208 staffed nursing home beds serving 342 admissions.

Vermont hospital spending

Vermont's 14 not-for-profit community hospitals will account for 38.5% (\$1.8 billion) of health care provider services spending in FY 2010. Included in the hospital budgets is a significant portion of revenues earned by hospital-employed physicians. Other Vermont hospital projected spending in 2010 that is not included in this report is the Veteran's Administration (\$142 million), the Brattleboro Retreat (\$38 million), and the Vermont State Hospital (\$24 million). Those three hospitals typically serve unique populations.



REVIEW OF THE FY 2010 HOSPITAL BUDGET SUBMISSIONS

Vermont Hospital System Key Indicators

	Act 06	Act 07	Act 08	Act 09	Bud 10
Total Net Revenues	\$1,446,242,297	\$1,578,080,037	\$1,689,174,453	\$1,814,285,571	\$1,924,251,178
Annual increase	9.9%	9.1%	7.0%	7.4%	6.1%
Cost per Adj Admission	\$9,353	\$9,706	\$9,927	\$10,297	\$10,760
Annual increase	7.3%	3.8%	2.3%	3.7%	4.5%
Adjusted Admissions	150,650	158,871	167,379	173,113	175,093
Acute Admissions	47,766	47,910	48,275	47,998	48,831
OP Visits	2,169,672	2,522,878	2,588,574	2,635,914	2,646,969
Physician Office Visits	2,034,843	2,250,202	2,390,924	2,829,445	2,938,147
Full Time Equivalents	9,761	10,270	10,671	11,143	11,325
Non MD FTEs per 100 adj disch	6.5	6.5	6.4	6.4	6.5
Physician FTEs	903	947	986	1,057	1,117
Operating Surplus	\$37,259,757	\$35,999,547	\$27,575,430	\$31,805,217	\$40,300,784
Operating Surplus %	2.6%	2.3%	1.6%	1.8%	2.1%
Cash on Hand	128	142	124	122	108
Bad debt % of Gr Rev	1.9%	2.1%	2.2%	1.9%	1.9%
Free care % of Gr Rev	1.2%	1.2%	1.3%	1.2%	1.2%
Age of Plant	10.0	10.3	10.1	8.8	9.9
Debt to Capitalization	42.7%	42.2%	43.5%	44.8%	44.3%
Capital Expenditures	\$107,506,685	\$77,114,736	\$92,430,767	\$104,934,442	\$102,329,544

Review of 2009 Binding Budget Analysis

HOSPITAL BUDGET SUBMISSIONS

Introduction

We have prepared this *Binding Budget Analysis* as part of our regulatory oversight responsibilities under 18 V.S.A., §9456, to ensure that each hospital operates within its established operating budget. It is one of the criteria the Commissioner will consider in establishing each new budget in the coming year.

This examination follows the Hospital Binding Budget Procedures that are provided to the hospitals' in each year's Uniform Reporting Manual Supplement. The analysis compares actual results against the budget that was approved by BISHCA. It evaluates whether or not a hospital met its budget within BISHCA's pre-determined variance levels. In addition, BISHCA reviews the financial health of the institution and prepares a report for each hospital.

As part of its evaluation, BISHCA examines both net patient revenues and expenditures to ascertain what explains any variances. Typically, this includes a review of utilization change, changes in law that may effect reimbursement levels, newly approved Certificate of Need programs, and mergers or program acquisitions not budgeted. Upon completion of the review, any variances not explained will deem a hospital as not meeting its approved budget level. This finding is used in establishing any future budget and/or rate requests.

Results for FY 2009 After Adjustments

The following summary describes the Actual 2009 operating results for the Vermont community hospital system. This analysis provides an overview for the system as a whole. For individual hospital analyses, contact the Department.

- 12 of 14 hospitals' **net patient revenues** met adjusted budget levels;
- 12 of 14 hospitals' **expenditure levels** met adjusted budget levels;

See Appendix A, Schedule A, Binding Budget Analysis of Net Patient Revenues
See Appendix A, Schedule B – Binding Budget Analysis of Expenses

- 6 hospitals had higher than budgeted operating profits; 8 had lower profits;
- Only four hospitals had higher than budgeted non-operating funds

Review of 2009 Binding Budget Analysis

HOSPITAL BUDGET SUBMISSIONS

Bud 09 to Actual 09 change

Vermont hospitals' actual net operating revenues for fiscal year 2009 totaled \$1.814 billion. Compared to budget, the overall system earned net operating revenues that were 1.1% lower (\$19.6 million) than the budget levels. This was the first time since at least 2003 that revenues were lower than budget. The fiscal years 2004, 2005, 2006, 2007, and 2008 were higher by 0.8%, 0.2%, 3.1%, 3.6%, and 1.0% respectively.

Analyses of the revenues find that, as a system, the hospitals were lower than budget because of higher utilization (\$17 million), higher reimbursement (\$2.7 million), offset by lower disproportionate share (\$3.3 million). The higher reimbursement was primarily due to Medicare and Medicaid paying more on the dollar than was budgeted.

Vermont hospitals' expenditures were lower than budget as well. Compared to budget, the overall system expenditures of \$1.782 billion were 0.3% lower (\$5.2 million) than the budget levels. The fiscal years 2004, 2005, 2006, 2007, and 2008 were higher by 1.5%, 1.2%, 4.1%, 3.8%, and 2.1% respectively. This year's variance is related to lower depreciation, interest, and bad debt than had been budgeted.

The hospital system had an operating surplus of \$31.8 million in 2009 but the weakness of the overall economy was reflected in the non-operating surpluses (investments, contributions). Overall, hospitals budgeted a \$25.2 million surplus but lost \$29.6 million in 2009. This followed 2008, when non-operating lost over \$59 million. Both of these years illustrate dramatic changes that reflect the instability in the economy as well as the vagaries of accounting for unrealized losses.

As a system, hospital actual indicators (as compared to Budget 2009) finds:

- Overall utilization, as measured by adjusted admissions, was lower than budget by 1.1%;
 - Adjusted admissions, while lower than budget, still showed an increase over actual 2008 levels;
- Acute admissions of 47,998 were 3.2% lower than budget; this was offset some by higher ancillary inpatient and outpatient services;
- Acute length of stay at 4.41 days was slightly higher than the budget of 4.39 days;
- There was a continued shift in services and dollars to outpatient services, now at 70.3% of the \$3.303 billion in billed revenues;
- There was a slight downturn in productivity measures;

Review of 2009 Binding Budget Analysis HOSPITAL BUDGET SUBMISSIONS

- Overall reimbursement (“pennies earned per dollar billed”) came in slightly lower than budget levels for Medicare and commercial payers;
 - Medicaid payers reimbursed at higher levels than budget;
- Bad debt of \$62.8 million in charges was lower than budget and lower than the \$65.5 million in 2008;
- Free care, \$41.3 million in 2009, was lower than budget;
- Despite being lower than had been budgeted, free care did show an 11% increase in actual growth – the fourth year in a row it saw a double digit increase;
- Total operating revenues of \$1.814 billion increased 7.4% over 2008 though they were slightly under 2009 budget;
- Overall operating surplus of \$31.8 million was lower than budget but higher than 2008 actuals of \$27.6 million;
- Cost per adjusted admission for FY 2009 was \$10,297; over budget by 0.9%;
- Capital spending of \$102.3 million was above budget by \$21.5 million – most of this was related to new Certificate of Need projects approved in 2009;
- Long term debt to assets decreased from 36.1% in 2008 to 34.9% in 2009;
- Liquidity remains good, but declined 2.7 days in 2009 to 121.6 days cash on hand.

Vermont Hospital System Budget	BUD 09	ACT 09	BUD 10
GROSS PATIENT CARE REVENUE	\$ 3,289,933,144	\$ 3,303,469,532	\$ 3,550,316,811
Deductions from revenue, dispro share	\$ (1,495,661,229)	\$ (1,533,661,513)	\$ (1,667,525,183)
NET PATIENT CARE REVENUE	\$ 1,794,271,915	\$ 1,769,808,019	\$ 1,882,791,628
Other Operating revenue	\$ 39,661,678	\$ 44,477,552	\$ 41,459,550
TOTAL OPERATING REVENUE	\$ 1,833,933,593	\$ 1,814,285,571	\$ 1,924,251,178
TOTAL OPERATING EXPENSE	1,787,715,446	1,782,480,353	1,883,950,394
NET OPERATING INCOME (LOSS)	\$ 46,218,147	\$ 31,805,217	\$ 40,300,784

Binding Budget Analysis of Hospital Net Patient Revenues

Schedule A

Hospital	Net Patient Care Revenues Bud 09	Net Patient Care Revenues Act 09	Over (under) Budget	% Over (under)	Volume Adjustment	Dispro Share	Reimbursement Over (under) Bud	Materiality Adjust	Adjusted Variance over Budget
Brattleboro Memorial Hosp	\$53,054,937	\$53,936,363	\$881,426	1.7%	\$ (507,319)	\$154,695	\$1,234,049	\$1,061,099	\$172,950
Central Vt Med Center	\$123,917,235	\$129,531,295	\$5,614,060	4.5%	\$ 3,830,826	\$201,975	\$1,581,259	\$2,478,345	BINDING BUDGET CRITERIA MET
Copley Hospital	\$45,453,776	\$43,291,900	(\$2,161,876)	-4.8%	\$ (743,825)	(\$35,715)	(\$1,382,336)	\$909,076	BINDING BUDGET CRITERIA MET
Fletcher Allen Health Care	\$847,515,372	\$847,343,547	(\$171,825)	0.0%	\$ 2,245,074	(\$16,488,430)	\$14,071,531	\$16,950,307	BINDING BUDGET CRITERIA MET
Gifford Medical Center	\$51,998,655	\$51,549,087	(\$449,568)	-0.9%	\$ 2,044,452	\$18,542	(\$2,512,562)	\$1,039,973	BINDING BUDGET CRITERIA MET
Grace Cottage Hospital	\$15,142,780	\$14,247,229	(\$895,551)	-5.9%	\$ 53,779	\$156,717	(\$1,106,047)	\$454,283	BINDING BUDGET CRITERIA MET
Mount Ascutney Hospital	\$47,107,897	\$45,538,372	(\$1,569,525)	-3.3%	\$ (251,920)	(\$52,869)	(\$1,264,736)	\$942,158	BINDING BUDGET CRITERIA MET
North Country Hospital	\$63,669,339	\$65,582,306	\$1,912,967	3.0%	\$ 2,449,578	(\$896,583)	\$359,972	\$1,273,387	BINDING BUDGET CRITERIA MET
Northeastern Vt Reg Hosp	\$53,490,072	\$51,996,793	(\$1,493,279)	-2.8%	\$ (718,460)	\$311,503	(\$1,086,322)	\$1,069,801	BINDING BUDGET CRITERIA MET
Northwestern Med Center	\$66,632,764	\$67,829,097	\$1,196,333	1.8%	\$ (215,972)	(\$70,606)	\$1,482,911	\$1,332,655	\$150,255
Porter Medical Center	\$55,482,981	\$55,917,780	\$434,799	0.8%	\$ 2,079,814	\$133,112	(\$1,778,127)	\$1,109,660	BINDING BUDGET CRITERIA MET
Rutland Regional Med Cent	\$176,838,016	\$170,935,583	(\$5,902,433)	-3.3%	\$ (595,842)	\$225,635	(\$5,532,226)	\$3,536,760	BINDING BUDGET CRITERIA MET
Southwestern Vt Med Cente	\$139,651,947	\$124,528,419	(\$15,123,528)	-10.8%	\$ 546,763	(\$2,623,311)	(\$13,046,980)	\$2,793,039	BINDING BUDGET CRITERIA MET
Springfield Hospital	\$54,242,143	\$47,577,951	(\$6,664,192)	-12.3%	\$ (3,706,197)	(\$17,516)	(\$2,940,479)	\$1,084,843	BINDING BUDGET CRITERIA MET
Total Net Patient Care Revs	\$1,794,197,915	\$1,769,805,722	(\$24,392,193)	-1.4%	\$6,510,750	(\$18,982,850)	(\$11,920,092)	\$36,035,386	

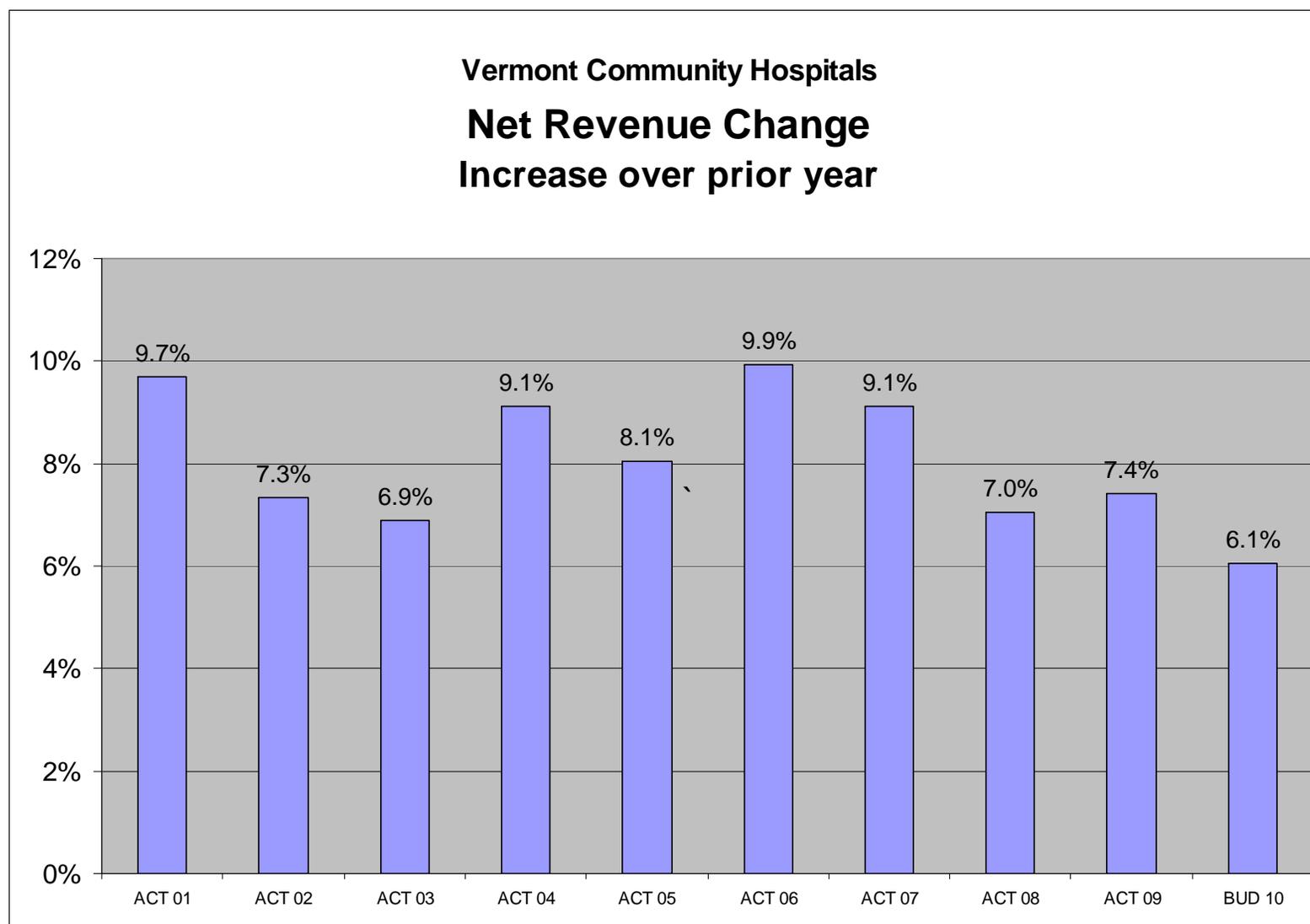
Binding Budget Analysis of Hospital Expenses

Schedule B

Hospital	Bud 09	Act 09	Over (under) Budget	Volume Adjustment	Provider Tax	Adjusted over (under) budget	Materiality Adjustment	Adjusted Variance over Budget
Brattleboro Memorial Hospital	\$ 53,138,577	\$ 54,451,727	\$1,313,150	(\$304,391)	(\$218,551)	\$1,836,092	\$1,062,772	\$773,320
Central Vermont Hospital	\$ 123,224,304	\$ 127,961,084	\$4,736,780	\$2,298,496	\$203,267	\$2,235,018	\$2,464,486	BINDING BUDGET CRITERIA MET
Copley Hospital	\$ 44,884,631	\$ 44,098,907	(\$785,724)	(\$446,295)	(\$87,683)	(\$251,747)	\$897,693	BINDING BUDGET CRITERIA MET
Fletcher Allen Hospital	\$ 850,367,375	\$ 850,264,585	(\$102,791)	\$1,347,045	\$691,709	(\$2,141,544)	\$17,007,348	BINDING BUDGET CRITERIA MET
Gifford Memorial Hospital	\$ 52,119,184	\$ 51,894,933	(\$224,251)	\$1,175,420	\$0	(\$1,399,670)	\$1,042,384	BINDING BUDGET CRITERIA MET
Grace Cottage Hospital	\$ 14,442,226	\$ 15,326,541	\$884,315	\$32,267	\$9,806	\$842,242	\$433,267	\$408,975
Mount Ascutney Hospital	\$ 47,599,970	\$ 46,771,256	(\$828,714)	(\$151,152)	\$82,572	(\$760,134)	\$951,999	BINDING BUDGET CRITERIA MET
North Country Hospital	\$ 63,897,250	\$ 65,403,368	\$1,506,118	\$1,411,639	\$269,154	(\$174,675)	\$1,277,945	BINDING BUDGET CRITERIA MET
Northeastern Vermont Reg H	\$ 52,753,516	\$ 50,839,325	(\$1,914,191)	(\$431,076)	\$48,281	(\$1,531,396)	\$1,055,070	BINDING BUDGET CRITERIA MET
Northwestern Medical Center	\$ 66,231,483	\$ 65,852,562	(\$378,921)	(\$129,583)	(\$4,989)	(\$244,349)	\$1,324,630	BINDING BUDGET CRITERIA MET
Porter Medical Center	\$ 55,304,467	\$ 56,331,309	\$1,026,842	\$1,208,989	\$34,092	(\$216,239)	\$1,106,089	BINDING BUDGET CRITERIA MET
Rutland Regional Medical Ce	\$ 172,873,327	\$ 169,377,891	(\$3,495,436)	(\$357,505)	\$1	(\$3,137,932)	\$3,457,467	BINDING BUDGET CRITERIA MET
Southwestern Vermont Med	\$ 137,447,796	\$ 134,247,082	(\$3,200,714)	\$328,058	\$70,025	(\$3,598,797)	\$2,748,956	BINDING BUDGET CRITERIA MET
Springfield Hospital	\$ 53,431,341	\$ 49,659,784	(\$3,771,557)	(\$1,846,552)	\$300,033	(\$2,225,038)	\$1,068,627	BINDING BUDGET CRITERIA MET
Total	\$1,787,715,448	\$1,782,480,353	(\$5,235,095)	\$4,135,358	\$1,397,717	(\$10,768,170)	\$35,898,731	

Vermont Hospital System Trends Hospital Net Revenue Growth

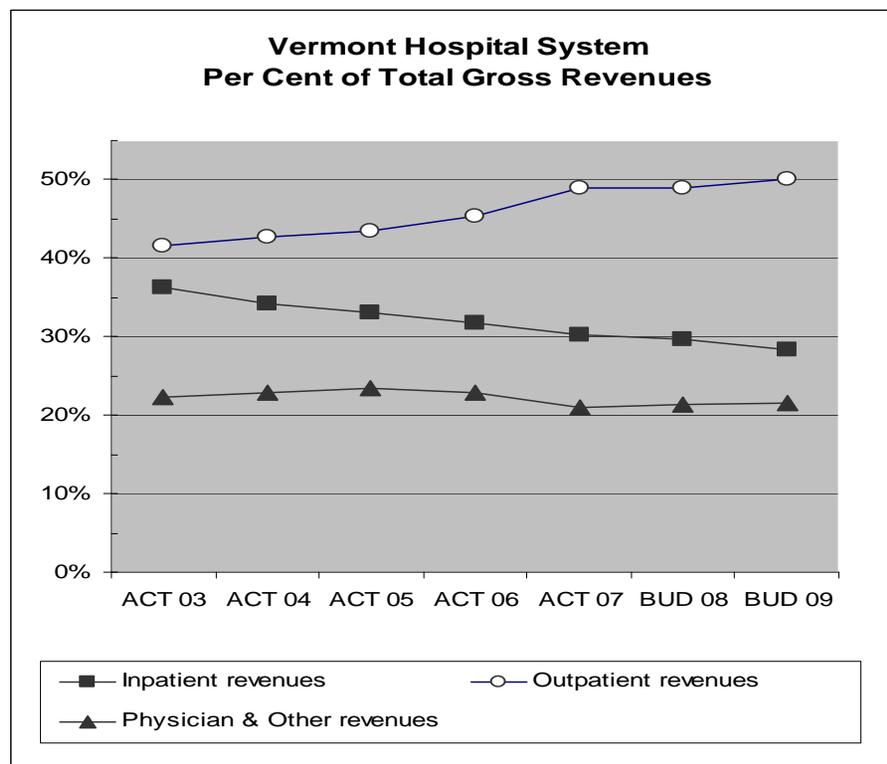
The Vermont community hospital system saw actual net revenues grow from \$830.1 million in the year 2000 to \$1.924 billion by FY 2010. This increase averages about 8.2% growth for the period 2000 – 2005 and then slows to an average of 7.7% for the period 2005 – 2010. The largest cost factors driving these increases were health care inflation and increases in utilization.



Vermont Hospital System Trends Utilization

There have been dramatic shifts in the delivery of hospital care since 1990. In acute inpatient care, both admissions (as measured by discharges) and length of stay have decreased while outpatient care has increased. Since 1990, the inpatient hospitalization rate has dropped 26.7%. Age-adjusted inpatient discharges in 2006 are at 84 per 1000 Vermonters. This is slightly lower than the United States rate of 85 per 1000 when the U.S. rate is adjusted for its more racially diverse population. The acute care length of stay has dropped 30.3% since '90, and at 3.5 is lower than rural U.S. hospitals' length of stay of 3.6.⁴ More information is in the 2006 Inpatient Hospital Utilization Report.⁵

Measuring change in outpatient services is more difficult due to the variety of services delivered. Using charges to measure growth, outpatient grew 13% per year since '01 and inpatient grew 6% per year. For complete detail of outpatient procedures in Vermont hospitals, refer to the 2006 Outpatient Hospital Utilization Report.⁶ The chart below reflects the changing trends based upon overall billed revenues.



⁴ The Comparative Performance of U.S. Hospitals; 2008 Sourcebook, Thomson Reuters

⁵ http://www.bishca.state.vt.us/HcaDiv/Data_Reports/hospdata/vthospital_utilization_reports/index_vthospital_utilization_reports.htm

⁶ http://www.bishca.state.vt.us/HcaDiv/Data_Reports/hospdata/vthospital_utilization_reports/index_vthospital_utilization_reports.htm

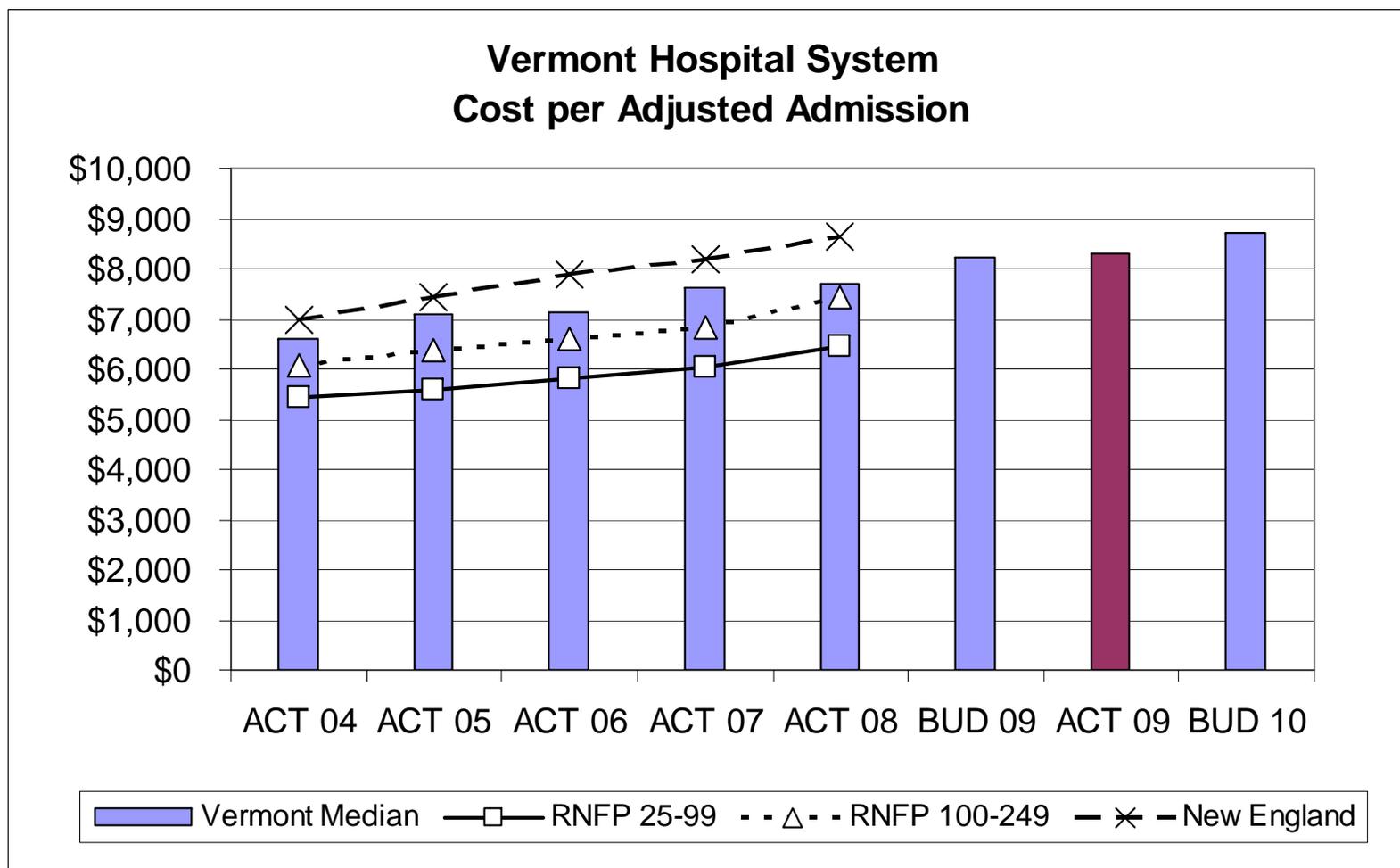
Vermont Hospital System Trends Utilization

Examining units of service in each cost center reflects utilization change in the budget. The table below illustrates this information for inpatient and outpatient high volume and high dollar services. These services reflect over 80% of all hospital budgeted services based upon an analysis of gross revenues.

<u>Service</u>	<u>'01 – '10 Ave Annual Change in Units</u>	<u>Bud '10 Gross Revenues</u>	<u>Per Cent of Budget</u>
All hospitals services	-	\$3,550.3 million	100%
Acute admissions	-0.6%	\$277.4 million	7.8
IP ancillary services	-	\$703.1 million	19.8%
Outpatient clinics	19.6%	\$96.9 million	2.7%
Physician office practices	8.3%	\$716.8 million	20.2%
Outpatient lab tests	5.2%	\$282.5 million	8.0%
OP Magnetic resonance imaging	7.8%	\$90.2 million	2.5%
OP Cat scans	7.9%	\$126.9 million	3.6%
OP Radiology	2.3%	\$203.4 million	5.8%
OP Operating room	2.0%	\$189.6 million	5.3%
Emergency room	2.0%	\$181.0 million	5.1%

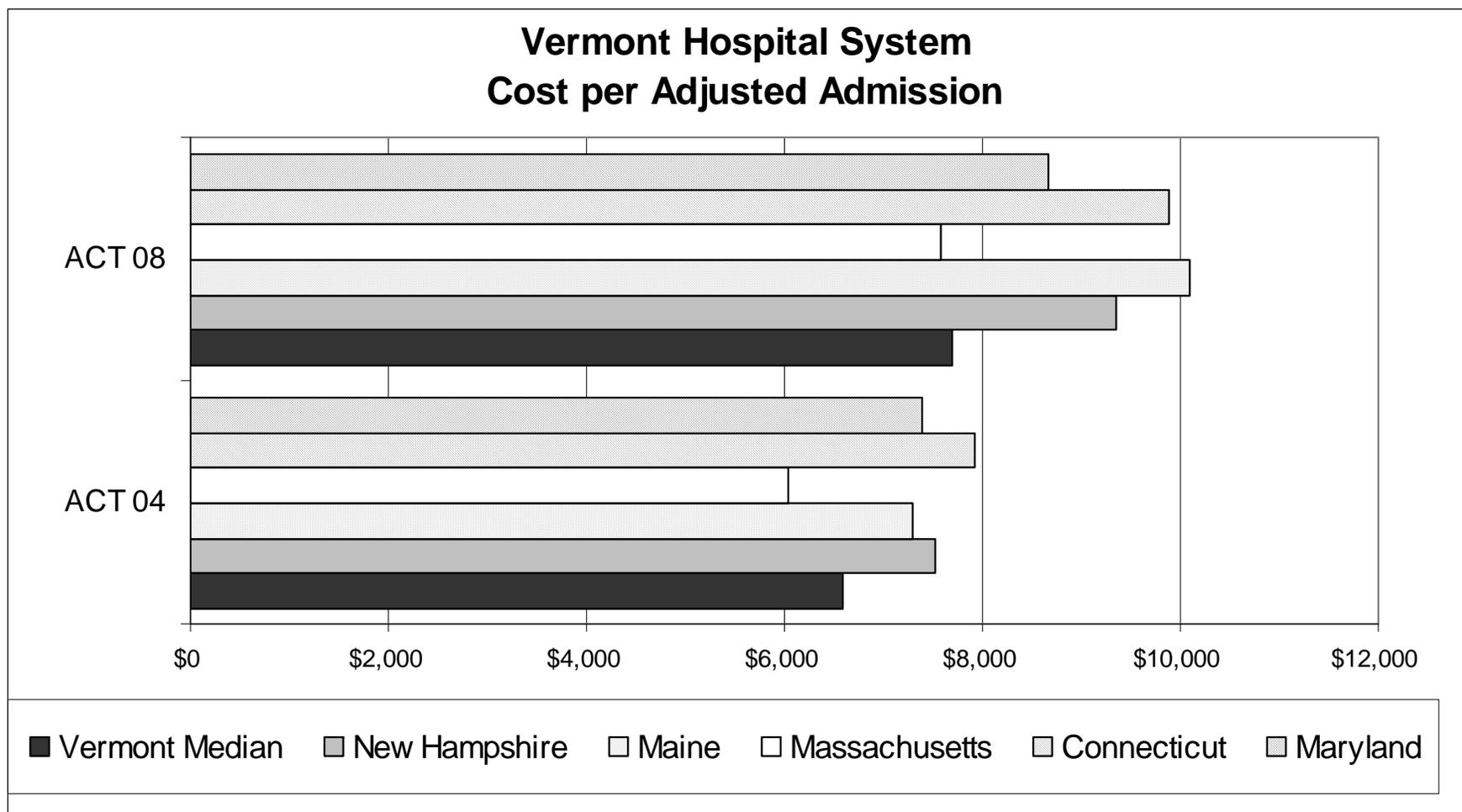
Vermont Hospital System Trends Cost Per Adjusted Admission

Vermont hospitals' median cost per adjusted admission reflects a steady increase of 4.3% per year for the period 2003 – 2009. Comparison data with United States rural not-for-profit hospitals finds Vermont at a higher median value through the year 2006 but less than the median when compared to New England hospitals.



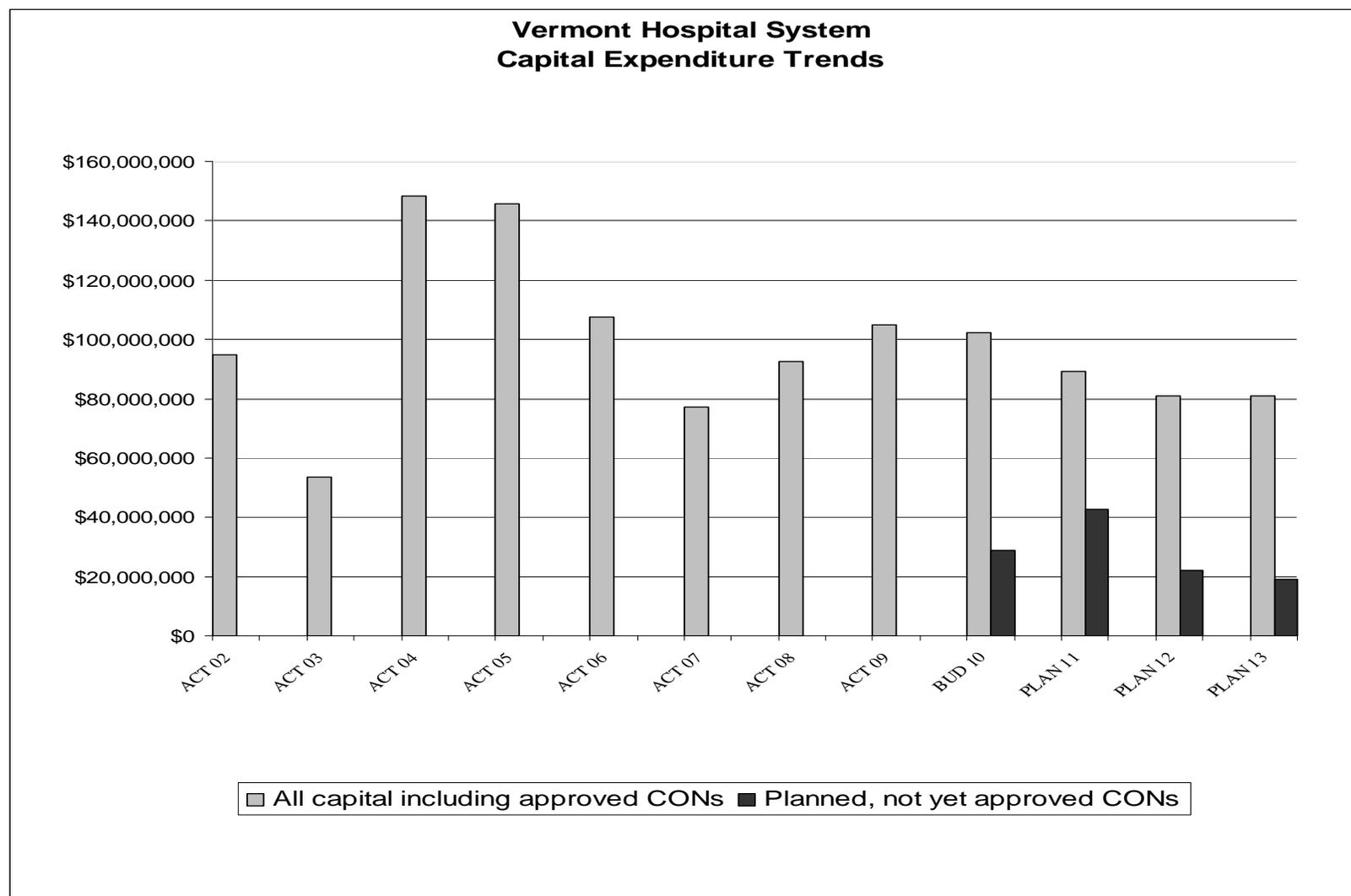
Vermont Hospital System Trends Cost Per Adjusted Admission

Another perspective is to examine the cost per adjusted admission in comparison to other states. We examined four New England states and Maryland (Maryland was selected because they have a statewide rate setting system for hospitals). A review of per unit costs in 2001 and 2006 finds that Vermont compares well, with Vermont lowest in '01 and the 2nd lowest in '06. However, during that same period, Vermont's per unit rate of growth is the 2nd highest, being only lower than Maryland.



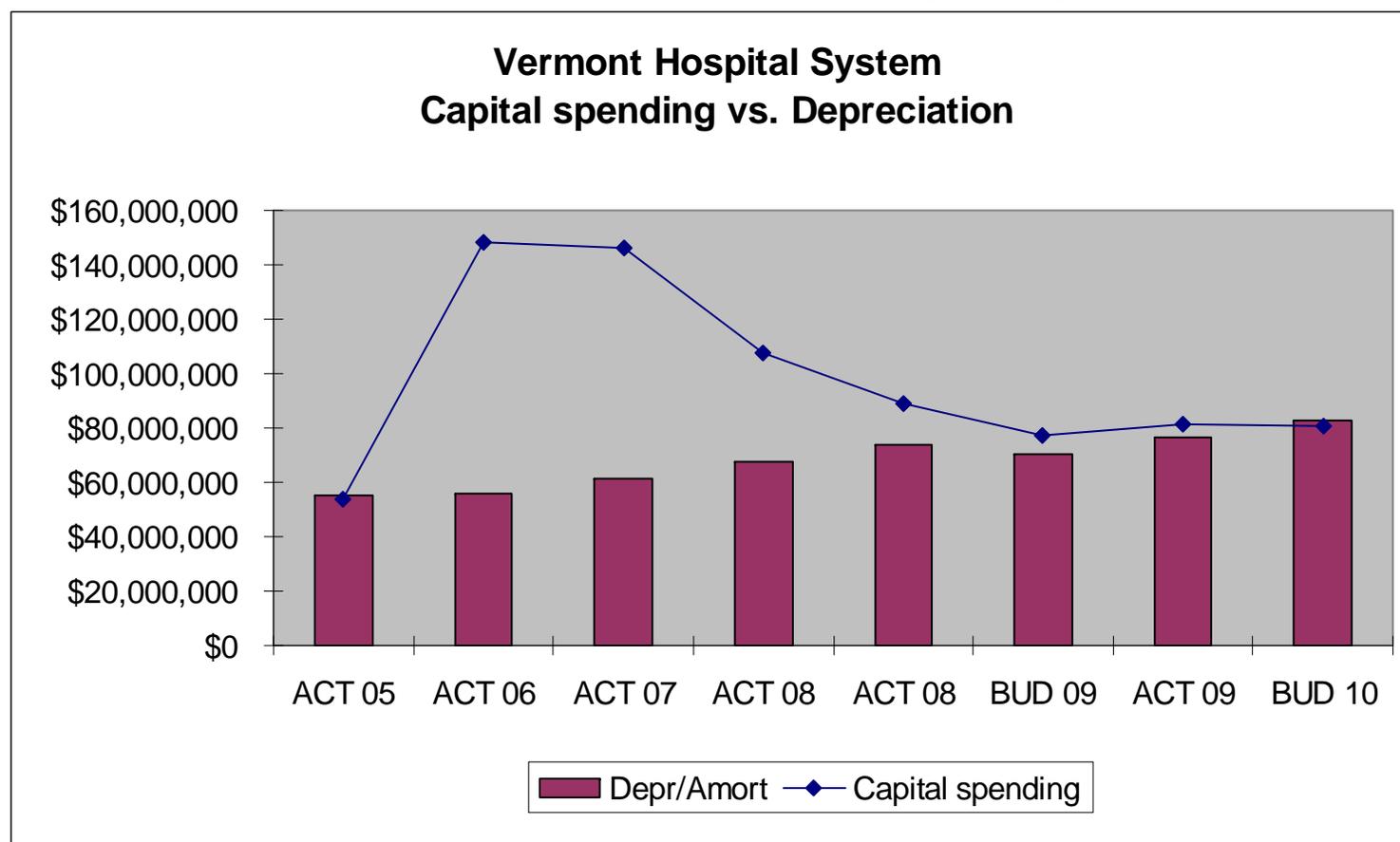
Vermont Hospital System Trends Capital Budgets

Hospital capital spending is cyclical and the last several years reflect this trend in Vermont. Less than \$60 million was spent in 2003 followed by three years of spending in excess of \$100 million.



Vermont Hospital System Trends Capital Investment

One analysis is to examine capital spending as it relates to the amount of depreciation. This measure has recently been incorporated by Moody's Investor Service for credit rating purposes. Ken Kaufman, managing partner of Kaufman Hall, said there is no "right number" to determine investment, but rather it is a tool to evaluate the capital spending as it relates to other hospital indicators.⁷ As the chart illustrates, Vermont hospitals' capital spending exceeded depreciation during the period of FAHC's Renaissance project, as the project was a new investment. The "one to one" spending in the other years suggests that Vermont hospitals are spending at a pace that replaces old capital.

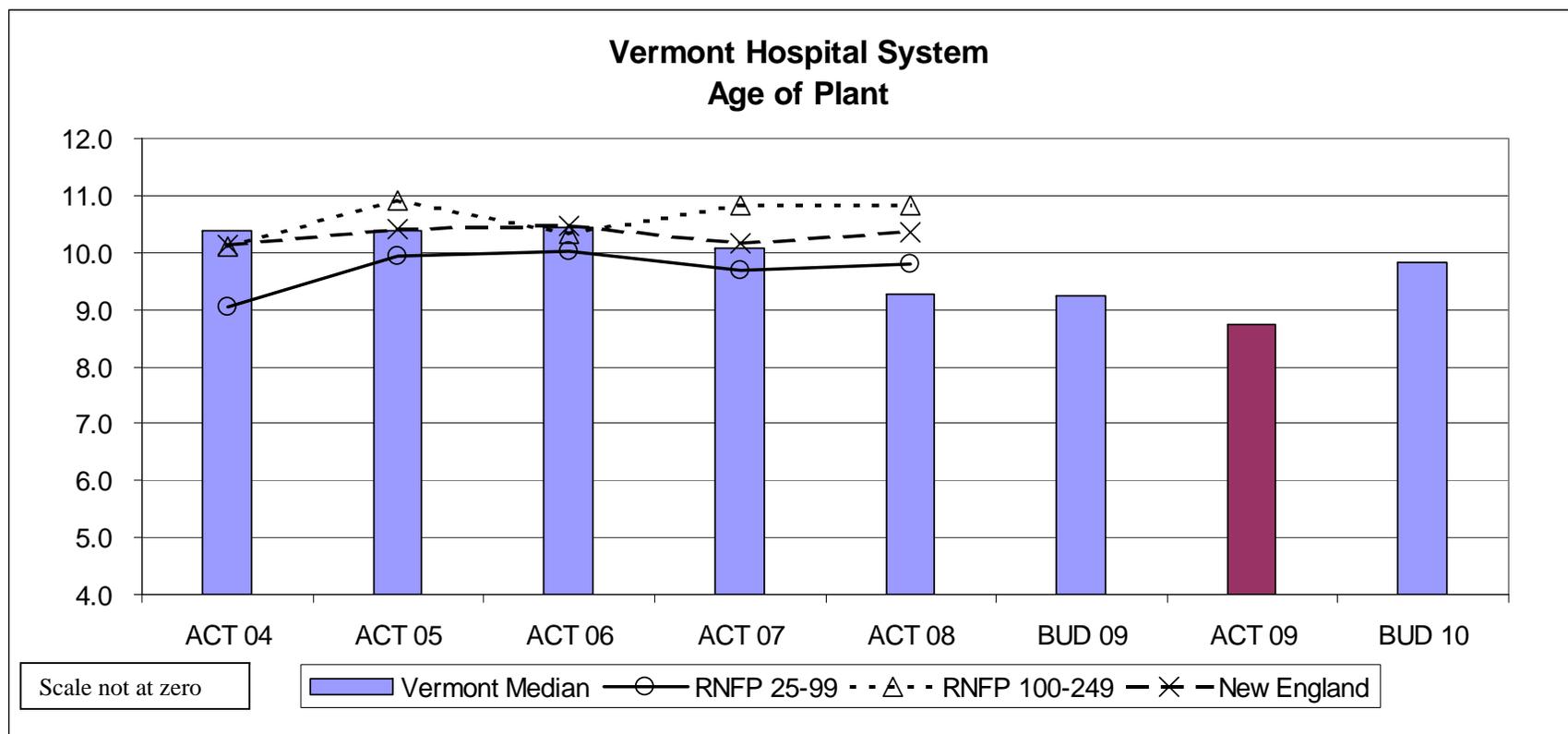


⁷ Hospital and Health Networks (H&HN), "Capital Catch-22" Alden Solovy, 12/23/2008

Vermont Hospital System Trends Capital Investment

Another way to evaluate hospital capital investment is to measure the age (in years) of a hospital’s capital assets. The age of plant statistic provides that proxy. An analysis of the age of the physical plant (and major medical equipment) indicates that Vermont’s capital has gotten “younger” as the age in years has moved from over 10 years to just over 9 years. When compared to peer statistics through 2006, Vermont hospitals have slightly “younger” overall capital (favorable).

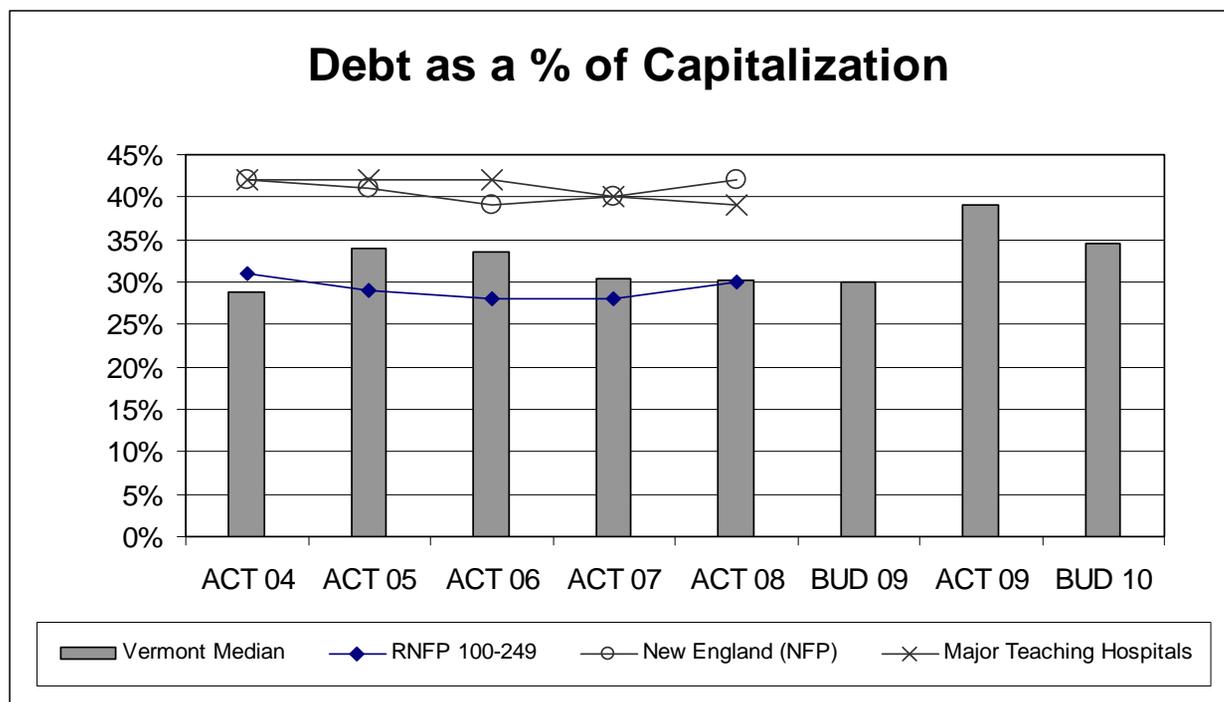
When examining an individual hospital, BISHCA distinguishes the age of buildings separately from the age of equipment. This allows an examination of whether the hospital has invested in one component of capital at the expense of the other. We have not been able to find peer information using these indicators with which to compare Vermont hospitals .



Vermont Hospital System Trends Capital Debt

Accessing capital for Vermont hospitals is expected to be difficult in this economy. The small size of most Vermont hospitals may make accessing capital difficult, particularly in the near future.⁸ An examination of key indicators used by prominent bond rating agencies to evaluate hospitals reflects mixed findings. Vermont's liquidity and age of plant compare well with "B" rated levels, while Vermont's level of debt and bad debt/free care are more favorable and meet "A" rated medians. It should be noted that hospitals are rated individually and many other factors are considered when determining a hospital's rating.

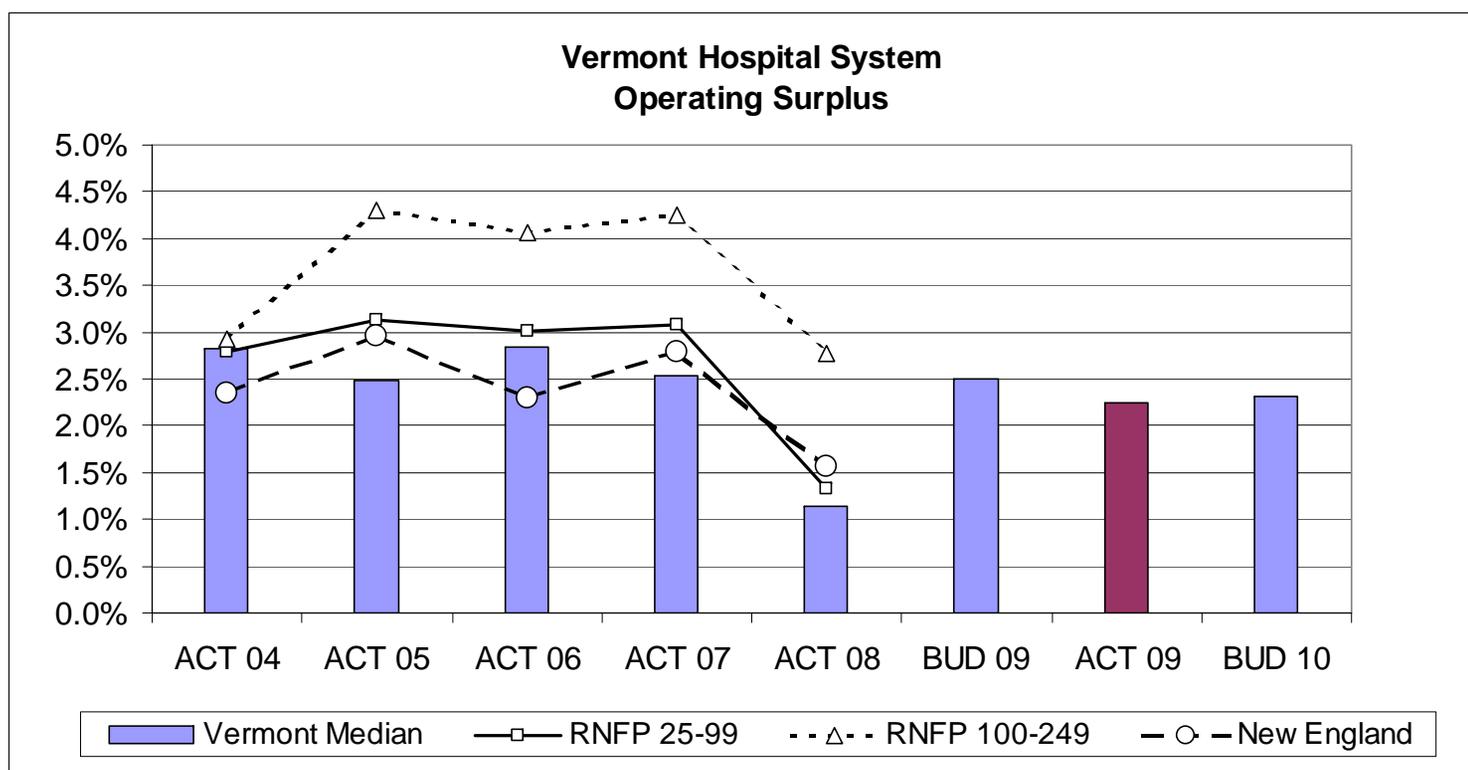
The debt needed to finance capital spending by Vermont hospitals has remained steady over the last several years. These values compare well with United States hospital peer groups through 2006.



⁸ "Economic Crisis: Impact on Vermont Community Hospitals", Anne Warren, KeyBanc; January 2009

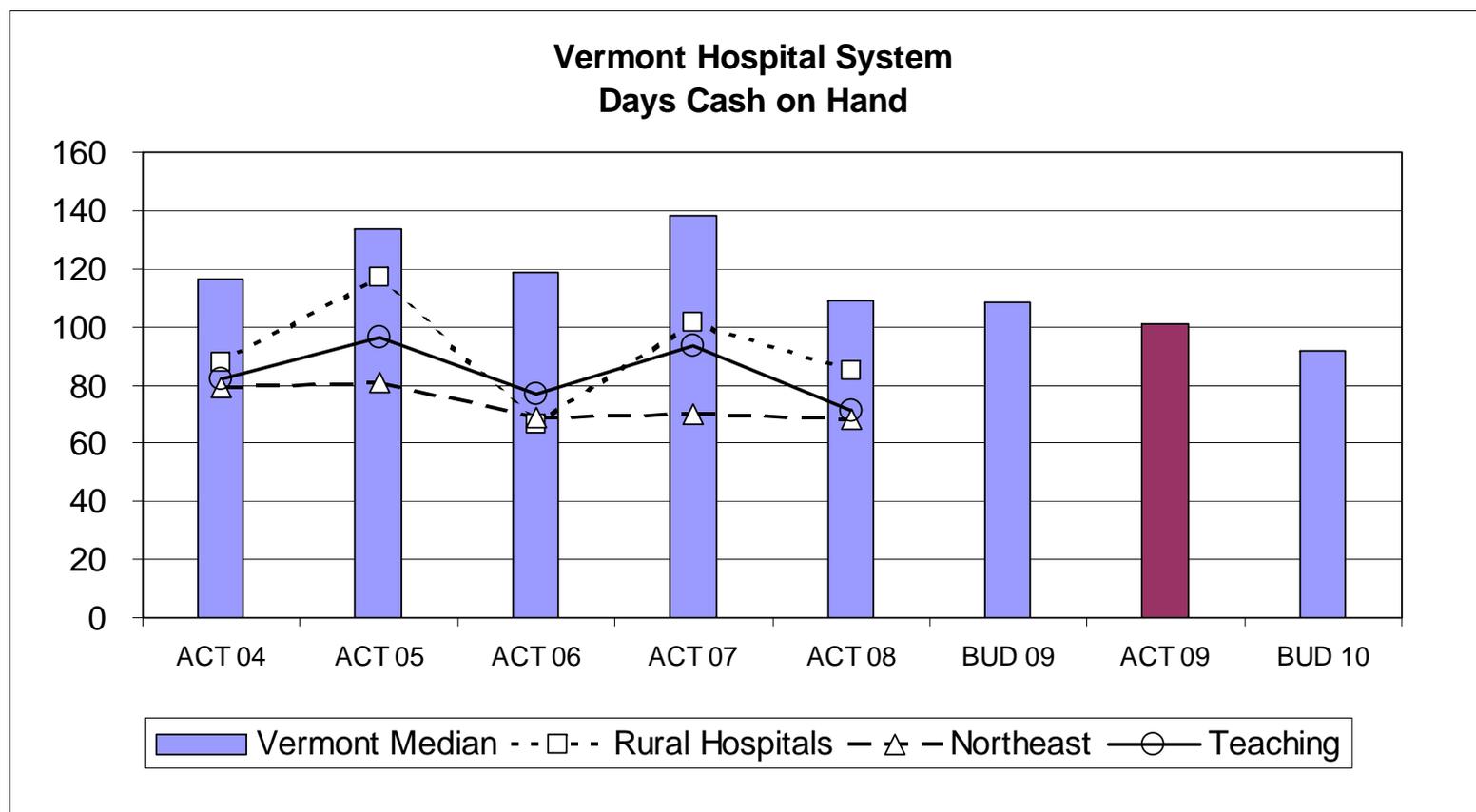
Vermont Hospital System Trends Operating Surplus

The operating surplus as a percent of net revenues has remained close to the 2.5% level since 2005. Median values reflect a similar finding. Comparison with United States rural not-for-profit hospitals shows Vermont at a lower average value through 2006. The 2010 budget level totals \$40.3 million compared to the budget level of \$46.2 million in 2009.



Vermont Hospital System Trends Cash on Hand

Examining Days Cash on Hand finds favorable comparisons for Vermont when compared to most peers. It is expected that Cash on Hand pressures will increase over the next several years due to economic problems. (Note: Peer groups are different for each graph because Sourcebook does not publish Cash on Hand. That data is from Ingenix.)⁹



⁹ Almanac of Hospital Financial and Operating Indicators, Ingenix, 2010

Vermont Hospital System Trends Cost Shift Analysis

Introduction

A Cost Shift Task Force was created by Act 191 to recommend changes needed to “ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums.” The Task Force met in 2006 and filed a report after completing its work. The report was delivered to the Commission on Health Care Reform in December 2006 and included a series of recommendations. This is the fourth report that BISHCA has prepared that provides updated information on the cost shift. To date, BISHCA has met many of the recommendations outlined by the Task Force, though additional work is required to complete the more sophisticated recommendations.

Defining the Cost Shift

BISHCA’s March 2008 Cost Shift Report states that, from the perspective of a payer of health care costs, the cost shift is defined as:

“The payment of higher prices (above cost) paid by one or more payer groups to offset lower prices (below cost) paid by other payers.”¹⁰ In layman’s terms, this is often referred to as “charging Peter to pay for Paul”. In Vermont, this means commercial insurers and the self-insured pay more as a result of Medicare, Medicaid, and the uninsured not providing full reimbursement for the services delivered.

From the perspective of a hospital, the cost shift is a pricing mechanism used to achieve revenues to support services provided to all patients when payments from some payers do not cover the costs incurred by those patients. In its simplest form, one can think of the cost shift as a subsidy.

¹⁰ Health Affairs, Jan/Feb 2006, Volume 25

Vermont Hospital System Trends Cost Shift Analysis

Current findings and trends

The cumulative hospital cost shift in FY 2010 is measured at \$255.7 million. While this is an increase over 2009 actual hospital results, it is \$3.1 million *smaller* than was budgeted in 2009. The table below shows a history of the hospital cost shift and reflects how it has changed over the last several years. The average annual increase is just over 12%.

Since 2001, Medicare and Medicaid have both increased in their relative share of the cost shift. Medicaid has increased from 29% to 39% of the cost shift while Medicare has increased from 35% to almost 39%. Bad debt and free care has actually decreased from 36% of the cost shift to 22%. Estimates of the Medicaid cost shift finds that about 6% -8% of the total Medicaid cost shift is related to out-of-state Medicaid patients.

Hospital Payers Shifting Costs (in millions)					
Hospital Fiscal Year	Medicare	Medicaid	Bad Debt & Free Care	→	Commercial & Other *
ACT 01	(\$32.2)	(\$26.4)	(\$32.7)	equals	\$91.4
ACT 02	(\$42.5)	(\$35.7)	(\$33.5)	equals	\$111.6
ACT 03	(\$52.1)	(\$34.7)	(\$34.9)	equals	\$121.7
ACT 04	(\$55.5)	(\$48.3)	(\$41.1)	equals	\$144.9
ACT 05	(\$55.8)	(\$57.7)	(\$40.8)	equals	\$154.3
ACT 06	(\$53.7)	(\$81.6)	(\$41.4)	equals	\$176.7
ACT 07	(\$59.8)	(\$88.3)	(\$48.2)	equals	\$196.3
ACT 08	(\$72.6)	(\$96.2)	(\$54.5)	equals	\$223.3
ACT 09	(\$85.9)	(\$91.8)	(\$53.8)	equals	\$231.5
BUD 10	(\$98.7)	(\$99.8)	(\$57.2)	----->	\$255.7
A09- B10 Diff.	(\$12.7)	(\$8.0)	(\$3.4)	equals	\$24.2

Numbers are the sums of the individual hospitals' cost shifts.

The payers values include all hospital and employed Physician services.

Numbers in () reflect the amount of services providers were not compensated for.

* The amount providers shifted to commercial insurance and self pays.

Vermont Hospital System Trends Cost Shift

How does this effect hospital rates?

The cost shift has the effect of increasing a hospital's rate increase higher than would be necessary if all payers were required to pay the rate increase. Currently, as hospital expenses increase, rates passed on to commercial and self-pay payers are larger when state and federal payer sources do not provide full payment for those cost increases. Bad debt and free care are also part of the cost shift. This requires the hospitals to price their services higher in order to generate more revenues from the commercial and self-pays.

Higher hospital rates, will ultimately impact commercial insurance premiums since the price of services, along with utilization of services, is passed along to the insurers. Accordingly, an increasing cost shift typically results in higher commercial insurance and self-insured insurance premiums.

Essentially, a smaller population (commercial and self-pays) is paying for a larger share of the health care "pie" because other payers "shift" their costs to them. Our most recent analysis finds that the cost shift, on average, explains about 18% of a given rate increase. Remarkably, this compares almost exactly with that found on the national level.¹¹ Of course, each hospital's circumstances are different and Critical Access Hospitals have much lower burdens from Medicare, thus lowering the cost shift burden on their respective rates.

The overall FY 2010 hospital budget rate increase of 5.9% did not include an increased share to pay for any cost shift increase. That is because the 2010 budgets actually showed a decrease in the cost shift when compared to 2009. That said, some individual hospitals had a cost shift increase and others actually saw a decrease. The table that follows shows the individual hospitals and what part of their rate was attributed to the cost shift.

¹¹ Hospital & Physician Cost Shift, Milliman, Fox and Pickering, December 2008

Vermont Hospital System Trends Cost Shift Analysis

Vermont Community Hospitals			
Bud 10 Cost Shift Impact on Hospital Rate Increases			
	Approved Overall Rate Increase	Rate Due to Cost Shift	Rate to Meet All Other Needs
Brattleboro Memorial Hospital	7.1%	2.8%	4.3%
Central Vermont Hospital	6.8%	2.1%	4.7%
Copley Hospital	6.0%	1.0%	5.0%
Fletcher Allen Health Care	6.0%	0.1%	5.9%
Gifford Medical Center	5.8%	1.0%	4.8%
Grace Cottage Hospital	5.0%	1.6%	3.4%
Mount Ascutney Hospital	6.1%	0.6%	5.5%
North Country Hospital	4.0%	0.1%	3.9%
Northeastern VT Regional Hospital	6.0%	4.6%	1.4%
Northwestern Medical Center	5.2%	0.0%	5.2%
Porter Medical Center	6.7%	2.4%	4.3%
Rutland Regional Medical Center	5.5%	0.0%	5.5%
Southwestern Vermont Medical Center	5.0%	0.0%	5.0%
Springfield Hospital	6.1%	0.0%	6.1%
System	5.9%	0.0%	5.9%

Notes: Analysis built on Budget to Budget change - final approved budgets.

System analysis completed separately from individual hospital analysis.

Other operating revenue, disproportionate share, and provider tax not considered.

Variations on rate impacts will change each year due to changes in utilization, reimbursement, costs, and payer mix.

Vermont Hospital System Trends Cost Shift Analysis

How do We Reduce the Cost Shift?

The cost shift is a change in whom will “pay the bill.” Eliminating the cost shift from the hospital budgets will NOT lower their overall budget. Rather, it will have the ultimate effect of lowering their rates to commercial insurance and self-pays. While a reduction in the cost shift will reduce hospital **rates**, the cost shift can only be reduced by an increase in other revenue sources or a reduction in services.

The cost shift can be reduced in two ways – increase overall revenues or decrease the cost of health care related to each payer. Both reflect either a consequence of reduced services or a need to raise revenues from other sources. For example, the hospital cost shift can be reduced if hospitals lower input costs for salaries, supplies, capital costs, etc. But for every dollar of reduced spending, a portion of the cost shift would be reduced if all other things (such as operating surplus) remained the same.

The option to increase revenues from other sources has its own difficulties. Federal and state taxes or other revenue sources would need to be increased in order to provide revenues that will allow government payers to provide higher reimbursement to providers. Of course, this would require raising taxes or other legislation to shift other revenues to pay for hospital services. A cost shift would still remain, however, to cover both bad debt and free care services that the hospitals provide.

**Vermont Hospital System Trends
Cost Shift Analysis**

Hospital Payers Shifting Costs - Budget 2010					
Total Cost Shift	<u>Medicare</u>	<u>Medicaid</u>	<u>Bad Debt & Free Care</u>		<u>Commercial & Other *</u>
Brattleboro	(\$7,088,011)	(\$2,896,480)	(\$2,713,247)	equals	\$12,697,738
Central Vermont	(\$10,869,947)	(\$6,322,955)	(\$4,479,262)	equals	\$21,672,164
Copley	(\$95,523)	(\$3,937,961)	(\$1,849,253)	equals	\$5,882,737
Fletcher Allen	(\$34,631,511)	(\$47,399,261)	(\$19,657,046)	equals	\$101,687,818
Gifford	(\$3,571,724)	(\$2,034,924)	(\$2,266,883)	equals	\$7,873,531
Grace Cottage	\$1,135,903	(\$561,896)	(\$496,031)	equals	(\$77,976)
Mount Ascutney	(\$30,919)	(\$1,766,141)	(\$1,311,104)	equals	\$3,108,164
North Country	(\$3,623,225)	(\$5,778,798)	(\$2,388,646)	equals	\$11,790,668
Northeastern	(\$3,722,068)	(\$5,000,126)	(\$2,434,828)	equals	\$11,157,022
Northwestern	(\$5,213,200)	(\$4,496,364)	(\$2,834,021)	equals	\$12,543,585
Porter	(\$435,836)	(\$3,168,779)	(\$2,402,136)	equals	\$6,006,751
Rutland	(\$22,244,031)	(\$9,811,273)	(\$6,690,251)	equals	\$38,745,554
Southwestern	(\$7,837,703)	(\$3,406,593)	(\$4,620,619)	equals	\$15,864,915
Springfield	(\$428,469)	(\$3,236,049)	(\$3,072,311)	equals	\$6,736,828
Sum	(\$98,656,263)	(\$99,817,598)	(\$57,215,638)	equals	\$255,689,500

The payers' values include all hospital and employed Physician services.

Numbers in () reflect the amount of services providers were not compensated for.

* The amount providers shifted to commercial insurance and self pays.

HOSPITAL BUDGET REVIEWS

Vermont Hospital Budget Review Law

18 V.S.A. § 9406 requires the Commissioner of Banking, Insurance, Securities and Health Care Administration to adopt an annual “Unified Health Care Budget.” The budget, which includes the binding hospital budgets established through the process set forth in 18 V.S.A. § 9451-9457, is to be used as “the basic framework within which health care costs are controlled, resources directed, and quality and access assured.” BISHCA is responsible for health care budgeting, including developing an annual “expenditure analysis” summarizing what is spent each year on health care in Vermont, and what Vermonters spend on health care whether inside or outside the state.

The hospital budgets established by the Commissioner comprise the formal portion of each year’s unified health care budget. The less formal unified budget is the expenditures of other providers and services of the health care system. Those costs are summarized in the annual expenditure analysis, but there is no active controlling regulatory body for most other providers.¹²

The hospital budget review process was established under Title 18 in 1983. From that point until 1996, the Hospital Data Council administered the hospital budget review and then assisted the Health Care Authority when it was created in 1992. In 1996-2004, the Public Oversight Commission (POC) replaced the Hospital Data Council and made recommendations to the Division of Health Care Administration in reviewing budgets. Act 53 changed the process to require the BISHCA Commissioner to establish the budgets and hold budget hearings. Further, Act 53 removed the POC from providing formal budget recommendations. Act 53 did require the Public Oversight Commission to review four-year capital information and “engage in a dialogue” with the hospitals.

Review of the hospital budgets are administered under Rule 7 of the Unified Health Care Budget. BISHCA prepares staff analyses, formulates questions, and has ongoing meetings with hospital budget executives. Each hospital’s budget is evaluated in categories such as financial health, utilization, reimbursement, prior performance to budget, etc., along with comparisons to various benchmarking and peer group information.

The hospitals are required to present their budgets and make themselves available for questioning by the Commissioner at a public hearing. Members of the public are also given an opportunity to comment on the proposals. After reviewing all of the hospital budgets, the Commissioner establishes the allowed rate increase for each hospital budget and may include special Orders for ongoing review and reporting.

¹² The Division of Rate Setting does set rates for Nursing Homes. It is contemplated that BISHCA could work with them to develop a cost shift for that sector, but at this time that task has not started.