Proposed Vermont Hospital Sustainability Framework
February 26, 2020

Introduction

The topic of sustainability has been a growing concern in Vermont, including policy makers, the GMCB, and all healthcare providers, especially those in a hospital setting. April 3, 2019, the Board held a panel discussion, including a national expert, to start the conversation on rural health care issues, specifically those facing Vermont's hospitals. The legislature then passed Act 26 (2019), which established the Rural Health Services Task Force, charged with providing recommendations to address rural health issues across the provider spectrum in Vermont, which were submitted in January 2020.

Demographic issues, payer mix shifts, opaque nature of pricing, lagging public reimbursement, a move towards value/fixed payment-based reimbursement, workforce shortages, and growing supply costs are a few of the reasons hospitals find themselves more financially vulnerable.[1] According to the UNC Sheps Center for Health Services Research, 166 rural hospitals in the US have closed since 2005 and the proportion of rural hospitals predicted to be at mid-high or high risk of financial distress is high (over 25%) and growing.[2] In VT, one hospital has declared bankruptcy and 6/14 have consistently reported negative operating margins for at least 3 of the past 5 years. Closures of rural hospitals have significant, negative impacts on their communities.[3] In Northern New England, health care workers are 10% of each state's workforce.[4] When a community's sole hospital closes, it is estimated to reduce per capita income by 4% and increase unemployment by 1.6% in that community.[5] In addition, every $1.00 spent by a hospital supports approximately $2.30 of additional business activity in that community, which in Vermont is estimated to have a $2.2 billion impact.[6] Hospital closures also impact the physician supply, including primary care, and reduces services available to that community.[7]

The Rural Health Services Task Force recommended four areas of focus in addressing the issues common across Vermont's health care providers, including addressing health care workforce shortages, expanding telemedicine, and continuing with payment and delivery system reform.[8] The legislature is currently looking at several of these recommendations with action looking possible on some. In addition, the Bipartisan Policy Center's report on Reinventing Rural Health Care's recommendations are consistent with the Task Force's, but also recommends "rightsizing health care services to fit community needs" and includes Medicare policy changes on the federal level to provide more flexibility for hospitals, in particular, to right-size.[9]

---

[1] Rural Health Services Report, See slides 7-8, 10-11 & Workforce White Paper, pages 1-5.
[2] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/; https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2019/04/FDI-Trends-1.pdf

[3] Rural Health Services Report, Slides 44-47
[4] Id.
[5] Id.
[6] Id.
[77] Id.
[8] Id, Slides 28-30, 58-29, and 66.
[9] Reinventing Health Care, Bipartisan Policy Center, page 4.

The GMCB has a statutory obligation to ensure that hospital budgets "promote efficient and economic operation of the hospital" and "reflect budget performances for prior years". 18 VSA 9456 (3) & (4). -In its 2020 hospital budget review, the Board ordered 6 of the 14 hospitals to complete sustainability plans to address concerns about sustained operating losses. The initial stage of sustainability planning will include both a plan to achieve financial health and an assessment of current services. The goal is to identify pathways to ensure that hospitals remain strong enough to maintain access to high quality and financially sustainable services in their communities.

Below, we provide the framework for those sustainability plans. It is hoped that each hospital leverages this opportunity to think deeply about their sustainability and ensuring their community's access to essential services, and works with their leadership team Board members, and communities to incorporate this analysis into their strategic plans over time. The Board requires these plans to be completed by X/XX/20. Each submission must include the signatures of the CEO, CFO and Board Chair.

Section 1: Financial Health

Please review Table 1 which contains a summary of your hospital's Overall Financial Performance, Liquidity and Financial Flexibility, and Debt along with national benchmarks provided by S&P[10].

For **each** financial metric highlighted as "vulnerable" or "highly vulnerable" relative to the benchmark, provide 1) specific *action steps* taken or to be taken to bring under-performing metrics into the "adequate" zone, 2) the *time* needed to achieve that milestone and 3) potential *obstacles* to success as well as *strategies* to overcome those obstacles.

Section 2: Ensuring Provision of Essential Services

Given the current confluence of forces facing hospitals, it is important that Vermont as a state begin to discuss right sizing health care in its communities in order to ensure access to essential services and avoid the hospital closures happening around the country. This is a challenging process, which must take into consideration community needs, financial viability, and other factors. This section asks hospitals to comment on their ability to provide, or support the provision of, Essential Services in its community. We rely on the American Hospital Association's definition of Essential Services as outlined in its 2016 report "Task Force on Ensuring Access in Vulnerable Communities".[11] These Essential Services include: **Primary Care** (which includes Pediatrics, Palliative Care, Rehabilitation), **Prenatal Care**, **Home Care**, **Dentistry, Psychiatric and Substance Abuse Services** (which includes Behavioral Health, Psychotherapy, Social Work Services, Individual and Family Counseling), **Emergency and Observation Services**, **Diagnostic Services** (which includes laboratory and imaging services), **Transportation** (which includes Ambulance Services as well as bus/car transportation for patients to travel to provider appointments), and a **Robust Referral System/Transfer**

[10] https://www.standardandpoors.com/en_US/web/guest/article/-/view/type/HTML/id/2232376

[11] https://www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf; AHA Resources for hospitals are available here

Agreements for specialty services (to avoid low-volume service and reduce unnecessary duplication).

Please review Table 2 which lists each of the AHA Essential Service areas delineated above. For each Essential Service, 1) tell us whether community needs for that service are *not met*, *partially met*, or *fully met*, and 2) which *entities* deliver these Essential Services (e.g., Hospital, FQHC, Designated Agency, Independent providers, Home Health Agency, etc.).

For any Essential Service *delivered by the Hospital*, please report whether the *contribution margin* (revenue net variable costs) and *total margin* (revenue net fixed and variable costs) are positive or negative. Also, please **estimate** the average *"Commercial to Medicare reimbursement ratio", "Medicaid to Medicare reimbursement ratio", payer mix* and *% contribution to NPR* for each Essential Service line.

Please answer the following additional questions:

1) What percentage do the above-defined Essential Services contribute to total NPR?
2) For each Essential service, please describe any current and future obstacles to sustainably and fully delivering the service to your community. (By sustainably, we mean for each Essential Service, revenue exceeds cost, without cross-subsidization from other services).
3) Please offer possible solutions to those obstacles that can be undertaken by the Hospital, and if any, solutions that could be addressed by other stakeholders, regulatory or policy bodies (e.g., GMCB, State legislature, Agency of Human Services, VAHHS, etc.)

Section 3: Sustainability of Other Services

This section focuses on other services delivered by hospitals in each service area. As we transition to a value-based environment, hospitals will become more accountable for both cost and quality. Sustainability will require that hospitals evaluate their ability to deliver low cost, high quality care for each service line. Volume must be considered in that context given the evidence that for some procedures, there is a relationship between volume and quality.[12] Notably, Johns Hopkins, Dartmouth-Hitchcock and the University of Michigan recently pledged that they will require their surgeons and affiliated hospitals to meet minimum annual thresholds for several procedures; for example, for knee or hip replacements, the Volume Pledge requirement is 25 per surgeon and 50 per hospital. To the extent that many VT hospitals are facing declining populations, and growing fixed and variable costs, low volumes may impact both cost and quality. As we move to a value-based payment world, hospitals may need to reoptimize their service lines by investing in services that can be delivered at low cost and high quality and

[12] See for example: Bauer H, Honselmann KC. 2017. "Minimum Volume Standards in Surgery - Are We There Yet?" *Visceral Medicine*. 33(2):106-116.; Kozhimannil et al. 2016. "Association between Hospital Birth Volume and Maternal Morbidity among Low-Risk Pregnancies in Rural, Urban, and Teaching Hospitals in the United States." *Am J Perinatol*. 33(6):590-9; https://newsatjama.jama.com/2015/06/10/jama-forum-back-to-the-future-volume-as-a-quality-metric/; https://khn.org/news/three-hospitals-hope-to-spark-a-reduction-in-surgeries-by-inexperienced-doctors/

divesting of services that are more cost-effectively delivered elsewhere. In such cases, hospitals will need to explore innovative ways to ensure that its community has alternative access to those services.

Please review Table 3 which lists hospital services. For each service delivered by the hospital, please report whether the *contribution margin* (revenue net variable costs) and *total margin* (revenue net fixed and variable costs) are positive or negative; the average *"Commercial to Medicare reimbursement ratio"* and *"Medicaid to Medicare reimbursement ratio"; payer mix; % contribution to NPR; distance to nearest alternative provider*; *growth potential*; *whether this service line supports an Essential Service (and how)*; and *whether this service line would be included in an optimal service line mix in a Value-Based environment.*

Please complete Table 4 which focuses on hospital capacity and procedural volume for surgical procedures.

Please answer the following additional questions:

1) How will your institution balance the need to deliver care to rural patients who, on average may be older, poorer, and less mobile than other patients, with the need to ensure that services delivered in your community are delivered efficiently at the lowest cost and highest quality?
2) For services whose Commercial to Medicare reimbursement rates are greater than 150%, please describe strategies to bring down the cost of delivering that service to your commercial patients, while maintaining access to services for all.
3) For procedures identified in Table 4 where hospital volumes lie below 50 and surgeon volumes lie below 25, please assess whether these surgical volumes are sufficient to maintain low cost and high-quality outcomes for your patients.
4) In 3-5 years, assuming a scaled-up, value-based payment model focused on primary prevention and population health where hospitals are held accountable for cost and quality, discuss what an optimized service line would look like for your hospital. Specifically, evaluate whether the hospital can sustainably deliver each of the services listed in Table 3, cost effectively and at high quality. If not, what action steps might the hospital take to move toward more cost effective, high quality delivery of an optimized service line? What steps will the hospital take to ensure that patients have access to divested services through referral and transportation options; establishment of regional collaboratives, management agreements; clinical affiliations; telemedicine, etc.?
5) Given the existing financial and economic pressures faced by hospitals and the goal of delivering high-quality low-cost care, which assumes lean operations, how do we simultaneously plan for an impending public health crisis (e.g. coronavirus); what is the right level of slack in the system?
6) Please describe any current and future obstacles to sustainably and fully delivering cost effective, high quality care in your community for your envisioned optimized service line.
7) Please offer possible solutions to those obstacles that can be undertaken by the Hospital. Also suggest solutions that could be addressed by other stakeholders, regulatory or policy bodies if you have suggestions (e.g., GMCB, State legislature, Agency of Human Services, VAHHS, etc.)