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Hospital Sustainability Planning

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Green Mountain Care Board
February 26, 2020

Background: National Hospital Closures

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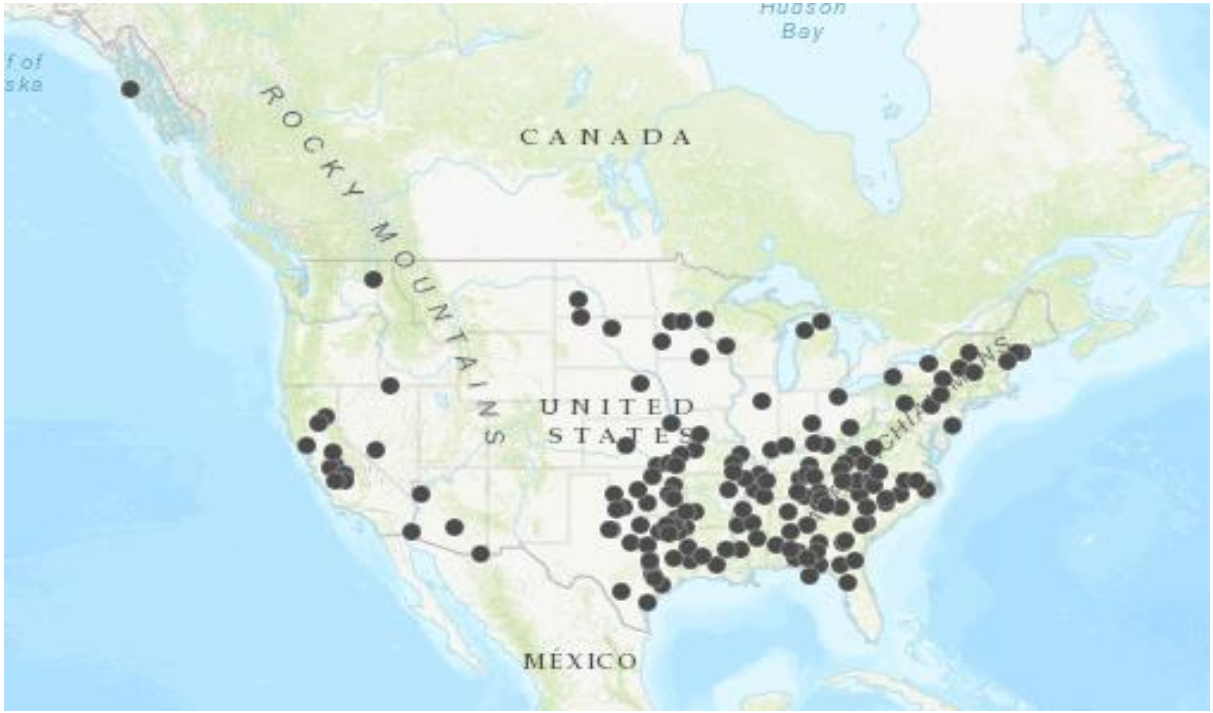

Source: University of North Carolina Rural Health Research Program;

Since 2005, 166 rural hospitals have closed nationally and **25%** of rural hospitals are predicted to be at mid-high or **high risk** of financial distress.

Background: Vermont Hospitals

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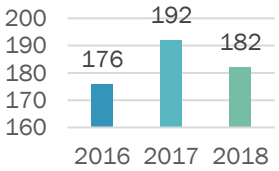
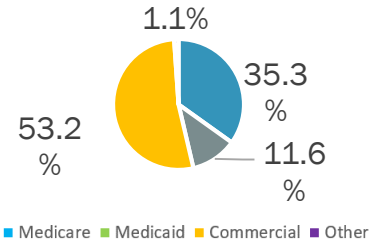
	Operating Margin (%)					
	Actuals FY2015	Actuals FY2016	Actuals FY2017	Actuals FY2018	Actuals FY2019	5-Year Average
Brattleboro Memorial Hospital	2.8%	-0.6%	-3.1%	-2.4%	0.8%	-0.5%
Central Vermont Medical Center	2.9%	1.0%	-0.9%	-3.8%	-2.1%	-0.6%
Copley Hospital	6.2%	-0.1%	-0.6%	-3.3%	-3.2%	-0.2%
Gifford Medical Center	2.7%	3.9%	-1.6%	-10.7%	-0.8%	-1.3%
Grace Cottage Hospital	-9.8%	-8.0%	-6.9%	-2.9%	-6.7%	-6.9%
Mt. Ascutney Hospital & Health Ctr	-2.4%	0.3%	2.7%	1.9%	-0.1%	0.5%
North Country Hospital	3.5%	0.2%	-2.3%	-2.3%	1.9%	0.2%
Northeastern VT Regional Hospital	2.2%	2.0%	1.9%	1.7%	1.8%	1.9%
Northwestern Medical Center	9.7%	3.4%	-1.2%	-3.4%	-8.0%	0.1%
Porter Medical Center	-2.4%	1.9%	2.7%	1.8%	5.2%	1.8%
Rutland Regional Medical Center	1.9%	4.2%	1.6%	0.5%	0.7%	1.8%
Southwestern VT Medical Center	3.6%	3.4%	3.7%	4.6%	3.3%	3.7%
Springfield Hospital	3.9%	0.3%	-7.1%	-12.8%	-18.4%	-6.8%
The University of Vermont Medical Center	6.3%	5.9%	5.2%	3.4%	2.2%	4.6%
SYSTEM TOTAL	4.6%	3.9%	2.7%	1.1%	0.7%	2.6%

Source: Green Mountain Care Board

Days Cash on Hand System Level



Payer Mix FY2018 System level



- 50% of hospitals are projecting negative operating margins in FY19
- 78% of hospitals are projecting to miss their FY19 budget targets (measured by "budget-to-actual" NPR/FPP variance)
- As operating margins decline, hospitals become more reliant on other revenue such as donations and the 340B pharmacy program

Vermont's hospital system is comprised of both large and small hospitals – critical access, Medicare dependent, and prospective payment hospitals. Benchmarking on a system level are not useful given the diversity in hospital types.

Background: GMCB Panel

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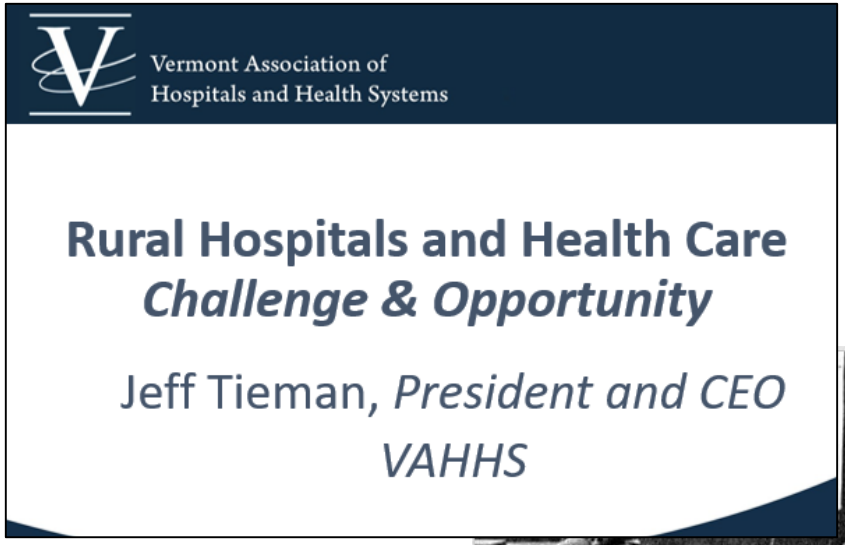

Background: Act 26

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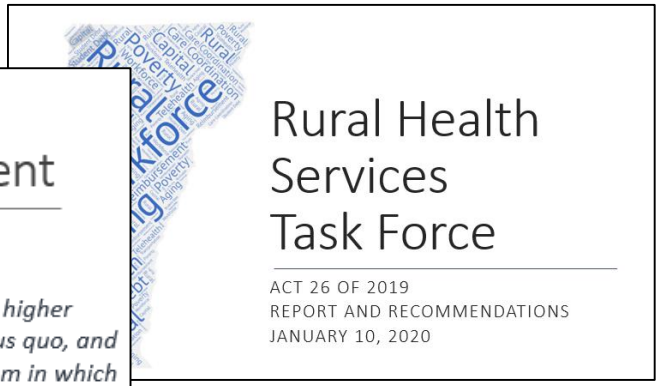


Introduction: National Context
CMMI Direction: Continuing with Value-Based Payment

STROUDWATER

- If there was any doubt about the Trump administration's desire to push healthcare towards a value-based system, Center for Medicare & Medicaid Innovation (CMMI) Director Adam Boehler makes things clear:

"I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to **blow up fee for service…** *That's one of our prime goals—is to get rid of fee for service."*

- However, getting rid of fee for service is easier said than done given the industry's current reliance on the existing infrastructure.

34%	10.5%	>50%
of healthcare payments tied to an APM in 2017	of Medicare payments in traditional legacy arrangements not linked to quality	of Medicare FFS payments with some level of pay-for-performance

Seema Verma, September 2019:

"And finally, in order to deliver lower cost higher quality care, we must move past the status quo, and past a fee-for-service payments to a system in which we're paying providers to keep people healthy, reduce costs and deliver better outcomes."

Source: https://www.cms.gov/newsroom/press-releases/remarks-administrator-seema-verma-american-hospital-association-regional-policy-board-meeting

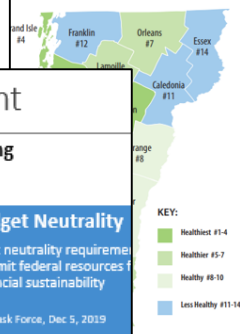
Source: The Ne… presentation to…

Introduction: National Trends & Pressures Impact Vermont

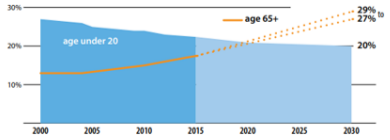
Vermont health care providers are not immune from national pressures focused on reducing reimbursements in fee-for-service and destabilizing the Affordable Care Act

High Deductible Health Plans & Increasing Cost Sharing	Medicare Policy Shifts	Medicaid Budget Neutrality
•Value (Cost x Quality) More Important to Patients •Uncompensated Care again on the rise •Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019	•Centers for Medicare & Medicaid Innovation programs (bundles; ACOs; medical home); •Reduced FFS payment (MACRA; Sequestration) and Value Incentives (MIPS) •New Payment Models (e.g. SNF, home health) •Source: The New Future of Rural Healthcare Strategies for Success, Stroudwater presentation to the Green Mountain Care Board 4/3/2019	•Federal Medicaid budget neutrality requirement… for 1115 waivers could limit federal resources f… addressing provider financial sustainability •Source: AHS Presentation to Task Force, Dec 5, 2019
Shifts in Care Delivery	**Market Profile**	**Workforce Shortages**

Introduction: Rural Vermont
Older and Less Healthy



- Vermont is one of the most rural states in the nation, based on size of cities and towns
- Vermont is the 3rd oldest state and is aging at a faster rate
- % of Vermonters age 65+ is growing while the % under age 20 is declining
- In Vermont, the least populated and most rural counties are the oldest and have the poorest health outcomes



Background: Priority Areas – National Perspective

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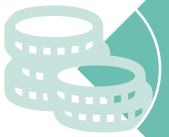
Build and retain the rural workforce

Expand telemedicine services



Create appropriate payment models and value-based care programs that account for low patient volumes, and a reliance on Medicare and Medicaid

Allow rural communities to adjust their own health care services to better fit the community's needs, including changes to Critical Access Hospitals, small rural clinics, and rural hospitals

BIPARTISAN POLICY CENTER

Source: Reinventing Rural Health Care, Bipartisan Policy Center

Rural Health Care: Lessons Learned
JANUARY 2018

Background

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The GMCB memorialized their concern for hospital sustainability in FY 2020 Hospital Budget Orders with the requirement for **6** of **14** hospitals to submit a sustainability plan.

Goals for Today

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1. Staff update on hospital sustainability framework
2. Board discussion and feedback on framework
3. Next steps

Goals of Sustainability Planning

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1. Engage in a robust conversation on community access to essential services and barriers to the sustainability of our rural health care system
2. Ensure that hospital leadership, boards, and communities are working together to address sustainability challenges and formalizing their approach in their strategic plans over time
3. Identify **hospital-led strategies** for sustainability, including efforts to "right-size" hospital operations, particularly in the face of Vermont's demographic challenges and payment reform efforts
4. Identify barriers to sustainability that are more aptly addressed by other stakeholders, policy-makers, or regulatory bodies
5. Insights gained through hospital sustainability plans may be leveraged as the state begins to think about its subsequent proposal to the All-Payer ACO Model (APM 2.0)

Building the Framework

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- **Financial Benchmarks and Indicators of Vulnerability**
  - S&P Global Ratings – U.S. Public Finance: U.S. And Canadian Not-For-Profit Acute Care Health Care Organizations
- **Comparing Prices across hospitals-methodology**
  - RAND Corporation – Relative Prices Paid to Hospitals, Medicare vs. Commercial Payers
- **Addressing Health Care Needs of Rural Communities**
  - Bipartisan Policy Center – Right-sizing Rural Health Care
  - American Hospital Association – Task Force on Ensuring Access in Vulnerable Communities
  - NC Rural Health Research Program – National Context of Rural Hospitals
  - National Organization of State Offices of Rural Health – Toolkit for Working with Vulnerable Hospitals & Communities

Building the Framework

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- **Exploring Volume-Quality Relationship**
  - Meyer et al. 2011 "Impact of department volume on surgical site infections following arthroscopy, knee replacement or hip replacement" *BMJ Quality Safety*. 2011. 20: 1069-1074
  - 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
  - JAMA Forum: Back to the Future: Volume as a Quality Metric June 6, 2010
  - Three Hospital Volume Pledge: https://khn.org/news/three-hospitals-hope-to-spark-a-reduction-in-surgeries-by-inexperienced-doctors/
  - Ohmann et al 2010 "Two short-term outcomes after instituting a national regulation regarding minimum procedural volumes for total knee replacement." *J Bone Joint Surg Am* 92(3):629-38.
- **VAHHS and input from Hospital C-suite and board chairs**

Framework

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1. Discussion of Hospital's Financial Health
2. Ensuring Provision of Essential Services
3. Sustainability of Other Services

Financial Health

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Financial Profile							
Hospital: Vermont Hospital		**Financial Performance - Stand-Alone Hospitals**					
		Extremely Strong	Very Strong	Strong	Adequate	Vulnerable	Highly Vulnerable
Category:	**Notes:**	1	2	3	4	5	6
Total Operating Revenue (Millions $)		>1,050	630-1,050	420-630	210-420	130-210	<130
EBIDA Margin (%)		>18	14.0-18.0	12.0-14.0	10.5-12.0	9.0-10.5	<9.0
Operating Margin (%)		>6.0	4.0-6.0	2.5-4.0	1.0-2.5	0-1.0	<0
Total (Excess) Margin (%)		>9.5	7.5-9.5	5.0-7.5	2.5-5.0	1.0-2.5	<1.0
Debt Service Coverage Ratio (:1)		>6.5	4.5-6.5	3.5-4.5	2.5-3.5	1.8-2.5	<1.8
		Liquidity and Financial Flexibility - Stand-Alone Hospitals					
		Extremely Strong	Very Strong	Strong	Adequate	Vulnerable	Highly Vulnerable
Category:	**Notes:**	1	2	3	4	5	6
Avg. Age of Plant (years)		<8.5	8.5-10	**10-11**	**11-12**	12-14	>14
Cap. Ex./Depr. Exp. (%)		>175	**140-175**	120-140	**100-120**	80-100	<80
DCOH		**>275**	**205-275**	160-205	110-160	80-110	<80
		Industry Median -Stand -Alone Hospitals					
A/R Days		**46.2-53.3**					
		Debt - Stand-Alone Hospitals					
		Extremely Strong	Very Strong	Strong	Adequate	Vulnerable	Highly Vulnerable
Category:	**Notes:**	1	2	3	4	5	6
LTD/Capitalization (%)		<25	25-35	35-42	42-50	50-60	>60

*Based on S&P Global Ratings for US and Canadian Not-for-Profit Acute Care Health Care Organizations

Financial Health

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Hospitals will be asked to respond to the following in regard to their financial profile:

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
3) Potential *obstacles* to success as well as *strategies* to overcome those obstacles.

Ensuring Provision of Essential Services

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As Medicare moves away from fee-for-service and the state begins developing a proposal for APM 2.0, how can hospitals c*apitalize on predictable payment streams and maintain access for their community to a baseline of high-quality, safe, and effective services?*

1. **Access to essential services**: a baseline of essential services must be prioritized for population health
2. **Cost-efficiency**: With fixed revenues, cost-accounting at the service-level becomes essential for understanding hospital efficiency and establishing financial stability

Ensuring Provision of Essential Services

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American Hospital Association's *Task Force on Ensuring Access in Vulnerable Communities* identifies the following categories of essential services:

- Primary Care
  - Including pediatrics, palliative care, and rehabilitation
- Prenatal Care
- Home Care
- Dentistry
- Psychiatric and Substance Abuse Services
  - Including mental health, psychotherapy, social work services, individual and family counseling
- Emergency and Observation Services
- Diagnostic Services
  - Including laboratory and imaging services
- Transportation
  - Including ambulance services as well as bus/car transportation for patients to travel to provider appointments
- Robust referral system/transfer agreements for specialty services

Ensuring Provision of Essential Services

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Sustainability Planning - AHA Defined Essential Service Line Assessment

Hospital Name: (select)
Type of Hospital : (select)

			If the service is delivered by the hospital please complete these columns					
Service Line - Essential Services	**Is Essential Service unmet, partially met, fully met in your community?**	**Please list the entities that deliver this service in the community.**	**Contribution Margin** (+, -, N/A)	**Total Margin** (+, -, N/A)	**Average Commercial to Medicare Reimbursement Ratio**	**Average Medicaid to Medicare Reimbursement Ratio**	**Payer Mix Concentration**	**% contribution to NPR**
Example: Service X	*Fully Met*	*Hospital, DA, Independents, FQHC*	*+*	*+*	*175%*	*75%*	*40% Comm.; 35% MCR; 25% MCD*	*5%*
Primary Care								
Pediatrics								
Palliative Care								
Rehabilitation - Cardiac								
Rehabilitation - Occupational Therapy								
Rehabilitation - Physical Therapy								
Rehabilitation - Speech Therapy								
Nutritional Services								
Gynecology								
Obstetrics/Prenatal Care/Midwifery								
Lifestyle Medicine								
Dental Services								
Home Care								
Psychiatric Services-Inpatient								
Psychiatric Services-Outpatient								
Behavioral Health								
Substance Use Disorder Inpatient Treatment								
Substance Use Disorder Outpatient Treatment								
Social Work Services								
Express/Urgent Care Center								
Emergency and Observation ED Services								

Ensuring Provision of Essential Services

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Hospitals will be asked to respond to the following as it relates to each of the "Essential Service areas":

1. Are community needs for that service *met*, *partially met*, or *fully met*
2. Which entities deliver these essential services (Hospital, FQHC, Designated Agency, Independent providers, Home Health Agency etc.)?
3. Financial metrics by Hospital-provided Essential Service
   - *Contribution margin, Total margin* → +/-
   - *Commercial to Medicare reimbursement ratio, Medicaid to Medicare reimbursement ratio, Payer mix, % contribution to NPR* → Estimated

Ensuring Provision of Essential Services

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4. What percentage do the above-defined Essential Services contribute to total NPR?
5. 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).
6. 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.)

Sustainability of Other Services

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In a value-based world where hospitals are accountable for both cost and quality, to successfully prioritize access to *essential services*, it becomes critical to assess the viability of "other services" which may otherwise detract from scarce resources:

- **Can the hospital deliver these services at high quality and low cost?**
- **Volume** has been correlated with **quality** for **surgical procedures**
- **Capacity** and **utilization** as a proxy for **efficiency** is a correlate of **cost**

Sustainability of Other Services

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Sustainability Planning
Other Service Line Assessment

Hospital Name: **(select)**
Type of Hospital : **(select)**

	If the service is delivered by the hospital please complete these columns									
Service Line - Other Services	**Contribution Margin** (+/- or N/A)	**Total Margin** (+/- or N/A)	**Average Commercial to Medicare Reimbursement Ratio**	**Average Medicaid to Medicare Reimbursement Ratio**	**Payer Mix Concentration**	**% contribution to NPR**	**Distance to Next Closest Provider**	**Growth Potential** (Strong, Neutral, Weak, N/A)	**Supports an Essential service(s)? If so, how?**	**Will be offered in a Value-Based Environment** (Yes, No, N/A)
Example: Service X	*+*	*+*	*175%*	*75%*	*40% Comm.; 35% MCR; 25% MCD*	*5%*	*50 miles*	*Weak*	*Complements and Enhances Primary Care*	*Yes*
Anesthesiology										
Allergy and Immunology										
Audiology										
Bariatric/Weight Control Services										
Burn Care										
Cardiac Catheterization (Diagnostic)										
Cardiac Catheterization (Interventional)										
Cardiac Intensive Care										
Cardiology Services										
Chemotherapy/Infusion										
Chiropractic										
Complementary and Alternative Medicine Services (please indicate types of services with additional rows)										
Computer Assisted Orthopedic Surgery (CAOS)										
Dermatology Inpatient										
Dermatology Outpatient										
Ear, Nose and Throat										
Endocrinology Inpatient										
Endocrinology Outpatient										

Sustainability of Other Services

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Hospitals will be asked to respond to the following as it relates to each of the "Other Services":

1. Financial metrics by Other Services
   - *Contribution margin, Total margin* → +/-
   - *Commercial to Medicare reimbursement ratio, Medicaid to Medicare reimbursement ratio, Payer mix, % contribution to NPR* → Estimated
2. Capacity (monthly min/max/average)
   - Staffed Bed Occupancy Rate
   - ED visits/day
   - Number of births (if birthing center present)
3. Procedural Volume
   - List any surgical procedure (CPT code) and its volume if the procedure is done fewer than 25 times/year per physician and/or fewer than 50 times/year by the Hospital

Sustainability of Other Services

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--- CAPACITY ---

	Monthly		
	Min	Max	Average
Staffed Bed Occupancy Rate			
ED visits/day			
Number of Births (if birthing center present)			

--- VOLUME ---

Please list any surgical procedure and its volume if the procedure is done fewer than **25 times/year** per physician and/or fewer than **50 times/year** by the Hospital

Department	Procedure Name	CPT Code	Location (in/outpatient)	Number of Providers	Total Hospital Volume

Other Important Questions

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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.

Other Important Questions (Continued)

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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 to streamline 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?

Other Important Questions (Continued)

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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.)

Next Steps

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1. Board discussion and feedback on framework
2. GMCB staff to identify resources for hospitals to use as they engage in sustainability planning
3. Special Public Comment Period: Today through March 11, 2020
4. Establish Date for Publication and Submission