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VERMONT
GREEN MOUNTAIN CARE BOARD

VERMONT
AGENCY OF
HUMAN SERVICES

Act 167 (2022) Community Engagement to Support hospital transformation

GMCB Board Presentation

08 July 2024

PROJECT CONTEXT

Act 167 objectives

Section 2 of Act 167 (2022) requires that the GMCB, in collaboration with the Director of Health Care Reform in the Agency of Human Services, "develop and conduct a data-informed, patient-focused, community-inclusive engagement process for Vermont's hospitals to:

- **Reduce inefficiencies**
- **Lower costs**
- **Improve population health outcomes**
- **Reduce health inequities**
- **Increase access to essential services**

All while maintaining sufficient capacity for emergency management

Oliver Wyman's work

Broad community and provider engagement in and across all Hospital Service Areas (HSAs) in Vermont.

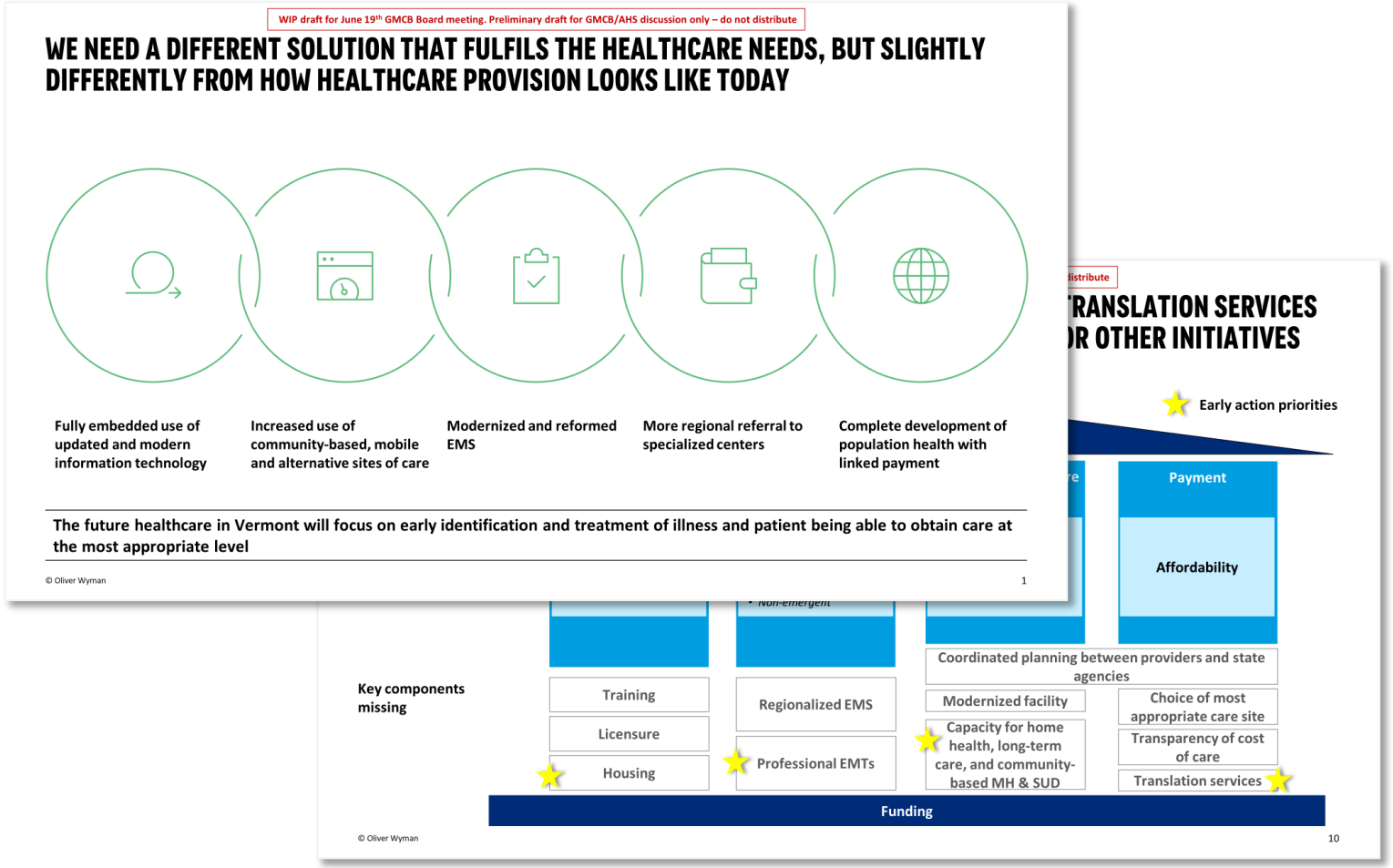
– a data-informed, patient-focused, community-inclusive engagement relative to the second stream of work for Act 167

Goals: engage diverse stakeholders and ascertain their interactions with the health system and perceived needs to overcome any barriers to equitable access and outcomes

Current plan: *conduct interviews and working sessions in 2 phases and codify qualitative and quantitative inputs to inform a recommendation.*

– *Phase 1 - August through mid-November 2023*
– *Phase 2 - March through Sep 2024*
– *Timing of the phases are subject to change by mutual agreement*

ON 19 JUNE, WE DISCUSSED THE RECOMMENDATIONS. TODAY WE WILL FOCUS ON RECOMMENDATIONS FOR THE HEALTH SYSTEM



WIP draft for June 19th GMCB Board meeting. Preliminary draft for GMCB/AHS discussion only – do not distribute

WE NEED A DIFFERENT SOLUTION THAT FULFILS THE HEALTHCARE NEEDS, BUT SLIGHTLY DIFFERENTLY FROM HOW HEALTHCARE PROVISION LOOKS LIKE TODAY

Fully embedded use of updated and modern information technology

Increased use of community-based, mobile and alternative sites of care

Modernized and reformed EMS

More regional referral to specialized centers

Complete development of population health with linked payment

The future healthcare in Vermont will focus on early identification and treatment of illness and patient being able to obtain care at the most appropriate level

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TRANSLATION SERVICES OR OTHER INITIATIVES

Early action priorities

Payment

Affordability

Coordinated planning between providers and state agencies

Key components missing

Training

Licensure

Housing

Regionalized EMS

Professional EMTs

Modernized facility

Capacity for home health, long-term care, and community-based MH & SUD

Choice of most appropriate care site

Transparency of cost of care

Translation services

Funding

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Today's focus

- Project approach
- Challenges faced by Vermont's health system
- Impact of traditional operational levers
- Recommendations on future transformation

Updated on 2 July 2024

WE WORKED WITH STATE AGENCIES, HOSPITALS, COMMUNITY PARTNERS AND OTHERS INSIDE AND OUTSIDE OF THE HEALTH SYSTEM TO BETTER UNDERSTAND CURRENT AND FUTURE NEEDS

1800+ participants — **Across all stakeholder types and meetings[1]**

~52 Participants — **On average per Ph1 community meeting, including state-wide meetings**

100+ Organizations — **Contacted**

93+ Public comments — **Received in Ph1**

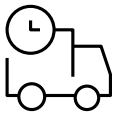
Meeting Type	# of Meetings	Estimated # of Attendees[1]
Stakeholder meetings on engagement plan	16	91[2]
Hospital Leadership and Boards	63	235
Diverse Populations	13	96
State Partners	36	67
Community Leaders	4	6
Community Meetings *(public HSA level)*	18	931
Provider Meetings *(public HSA level)*	14	460
Provider interviews and sessions	15	128

1. The number of attendees provided is an estimate as there are pending meetings, and technical errors/malfunctions in producing some attendance reports;
2. The 91 participants are excluded from the 1.8K total as they are accounted for in the other meeting types

SIMILAR COMMENTS WERE MADE IN OTHER COMMUNITIES ACROSS THE STATE

The lack of housing is a problem making it hard to attract providers, and impossible for patients who have nowhere to be discharged

Keeping staff is a function of addressing the cost of living, inflation, and ability to find affordable housing, and these have all been difficult



There isn't enough transportation to other hospitals if the community needs a major surgery or other locally inaccessible service

Getting patients home has been a challenge because the hospitals sending the patients back are also experiencing challenges arranging transportation

When I go to the urgent care clinic, I may not see a provider because of the workforce shortages

It's difficult to find primary care providers, and difficult to communicate between physicians in the community and in other hospitals

Many individuals don't go to care because the premiums and OOP are too high

I can no longer afford the procedures or medications – only option is not to take my medications

No one tells patients about financial services or campaigns available to support their broader health and social needs

Gender-affirming and reproductive health access is an issue and there needs to be greater availability

Individual quotes from HSA-level community calls held Aug-Nov 2023

WE REVIEWED EXISTING REPORTS AND CONDUCTED OUR OWN ANALYSES USING THE MOST RECENT DATA AVAILABLE

Input reviewed and used

1	Population projected through 2040 at a county level, from base year of 2019, by Mathematica
2	Homeless population count and concentration of dual eligibles by zip code
3	Projection of future needs for primary care physician/advanced practitioner access, capacity for chronic care
4	Future needs for preventative services, cancer, cardiovascular diseases projected
5	Projection of obstetrical services needed based on changes in the age-distribution of women
6	Review of surgical procedures with demonstrated relationship between volume and outcome

Financial Analyses conducted by Oliver Wyman

1	Projections of anticipated operating and total margin for each hospital through 2028 a) Straight-line projection of past performance b) Projection using 3.5% annual increase in revenue (GMCB target) and 5% annual increase in expense c) Projection using 3.5% annual increase in revenue (GMCB target) and 7-8% annual increase in expense
2	Examined impacts of avoiding potentially avoidable ED and IP use
3	Examined impacts of reducing the number of boarders and boarding stays
4	Evaluated patient numbers currently leaving the service area to seek community-level services elsewhere
5	Evaluated hospital capacity (staffed beds, operating room and procedure rooms) for capacity to absorb patients returning
6	Estimated financial impacts on hospital of returning patients

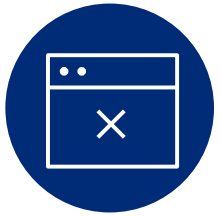
WE FOLLOWED A TRANSPARENT AND ITERATIVE PROCESS

1. Conducted multiple meetings with communities/agencies/groups
2. Conducted meetings with hospital leadership board in (Oct-Nov 2023)
3. Personal visit to each hospital (Feb-Apr 2024)
4. Multiple requests to hospital leadership to verify information regarding hospital capacity, staffing, patient volumes, medical staff and other issues
5. With Vermont Association of Hospitals and Health Systems (VAHHS), conducted survey of 2022 number of “boarders” and calculated potentially avoidable ED visits
6. Met hospital leadership and hospital board to present result of population projections, projections of future services needed, discuss financial implications to the hospital and explore potential options to address community needs (June 2024)
7. Revised analysis of capacity and potential sustainability with hospital feedback and **amended options based on hospital board input**

WE ENCOUNTERED SOME DATA LIMITATIONS

Limitations:

- HSAs were defined by Vermont Department of Health (version 4) and some hospitals felt these did not reflect their catchment area
- Outdated data on physician (2020) and APRN census (2019)
- Outdated data on chronic care facilities (2020)
- Outdated data on mental health workforce (including both community-based and institution-based)
- Service volume data used for analysis were from 2022



Note:

- **We used 2023 financials as the basis for financial projections**
- **We took into account the payments received by Critical Access Hospitals and sole community hospitals in the calculations**

What’s the problem we are solving for hospitals?

VERMONT HOSPITALS ARE EXPERIENCING A SIGNIFICANT DECLINE IN F

	FY19	FY20	FY21	FY22	FY23
Brattleboro Memorial Hospital	0.8%	0.6%	-1.7%	-3.8%	-1.7%
Central Vermont Medical Center	-2.1%	-0.6%	-1.0%	-6.5%	-6.5%
Copley Hospital	-3.2%	-3.9%	5.1%	-0.7%	-1.8%
Gifford Medical Center	-0.8%	2.5%	8.8%	7.0%	-8.3%
Grace Cottage Hospital	-6.7%	1.1%	8.0%	-6.8%	-8.9%
Mt. Ascutney Hospital & Health Center	0.2%	0.7%	9.1%	1.7%	2.0%
North Country Hospital	1.9%	3.7%	4.6%	-10.3%	-8.9%
Northeastern VT Regional Hospital	1.8%	1.3%	2.9%	0.2%	0.5%
Northwestern Medical Center	-8.0%	-0.9%	4.7%	-4.3%	-6.6%
Porter Medical Center	5.1%	4.0%	7.7%	3.1%	7.6%
Rutland Regional Medical Center	0.4%	0.2%	2.2%	-3.8%	2.1%
Southwestern VT Medical Center	3.3%	2.8%	4.5%	-0.2%	-3.8%
Springfield Hospital	-18.4%	-11.2%	1.2%	5.4%	-0.9%
The University of Vermont Medical Center	2.2%	-0.3%	2.3%	-1.2%	3.1%
All Vermont Community Hospitals	**0.7%**	**0.1%**	**2.8%**	**-3.3%**	**0.3%**

Source: https://gmcboard.vermont.gov/sites/gmcb/files/documents/167%20-%20brief%20history%20and%20motivation%206.19.pdf

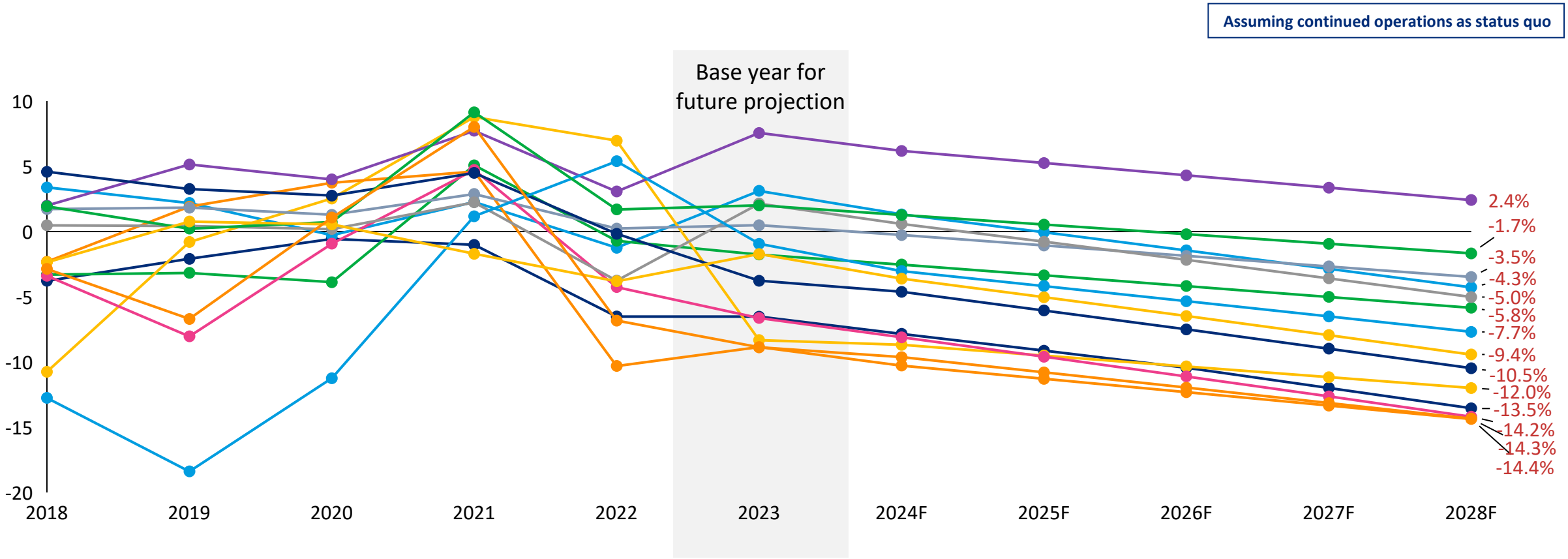
Outlier year due to federal COVID relief

9 out of 14

Hospitals ended with negative operating margins in FY2023

ALL HOSPITALS BUT ONE ARE FORECASTED TO HAVE NEGATIVE OPERATING MARGINS BY 2028 IF EXPENSES WERE TO GROW AT 5% AND REVENUE WERE TO GROW AT 3.5%

Vermont hospital operating margin forecasts, assuming 3.5% non-340B revenue growth and 5% expense growth annually
(%, 2018-2028F)



EVERY VERMONT HOSPITAL IS FACING SIGNIFICANT OPERATIONAL AND FINANCIAL CHALLENGES. MANY ARE OUT OF THEIR CONTROL

Operational challenges

Physician shortages and difficulty in recruiting staff since COVID

Low volume of procedures to sustain operational excellence

Old infrastructure needing repair/ replacement

Capacity consumed by caring for people with unmet social needs

Financial challenges

Increased labor and supply cost due to inflation

Depleting capital reserves unable to cover expenses and future investments

Increasing complications with reimbursement

Source: 1. GMCB Financial Records

WE EXAMINED THE IMPACT OF TRADITIONAL OPERATIONAL CHALLENGES

Operational challenges

- Physician shortages and difficulty in recruiting staff since COVID
- Low volume of procedures to sustain operational excellence
- Old infrastructure needing repair/ replacement
- Capacity consumed by caring for people with unmet social needs

Financial challenges

- Increased labor and supply cost due to inflation
- Depleting capital reserves unable to cover expenses and future investments
- Increasing complications with reimbursement

Analyses conducted

1. **Projections of anticipated operating and total margin for each hospital through 2028:**
   a) Straight-line projection of past performance
   b) Projection using 3.5% annual increase in revenue (GMCB target) and 5% annual increase in expense
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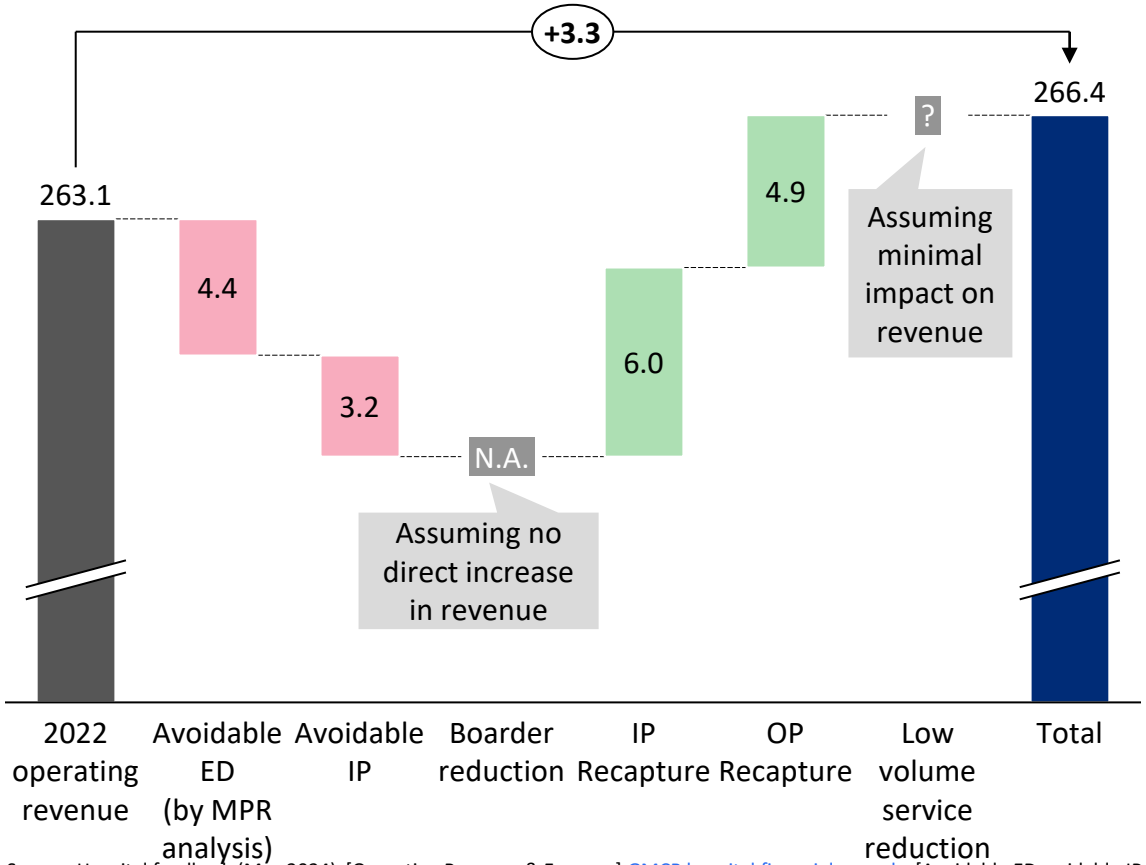
6. **Estimated financial impacts on hospital of returning patients**

OVERALL FINANCIAL IMPACT IS MOST INFLUENCED BY OUTPATIENT SERVICES FOR BOTH OPERATING REVENUE AND EXPENSES

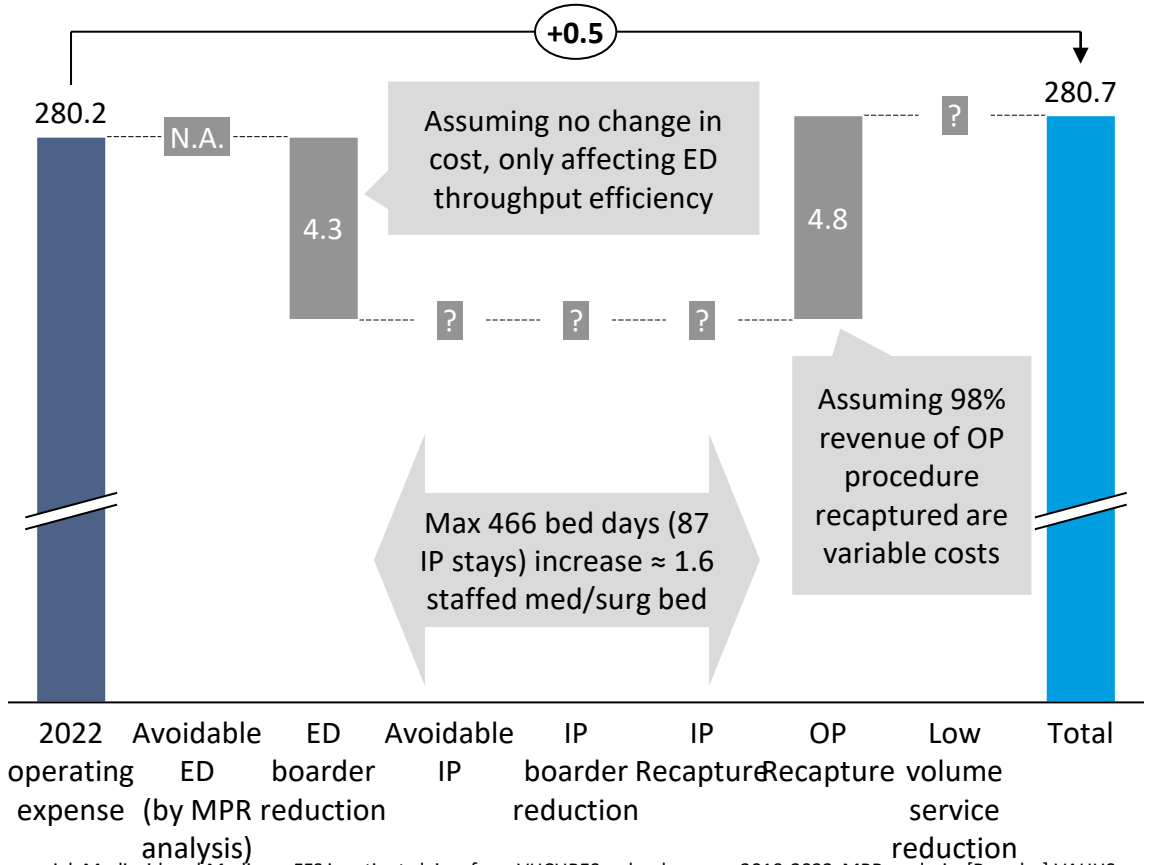
Illustrative financial impact on 2022 operating revenue

$USD MN



Illustrative financial impact on 2022 operating expense

$USD MN

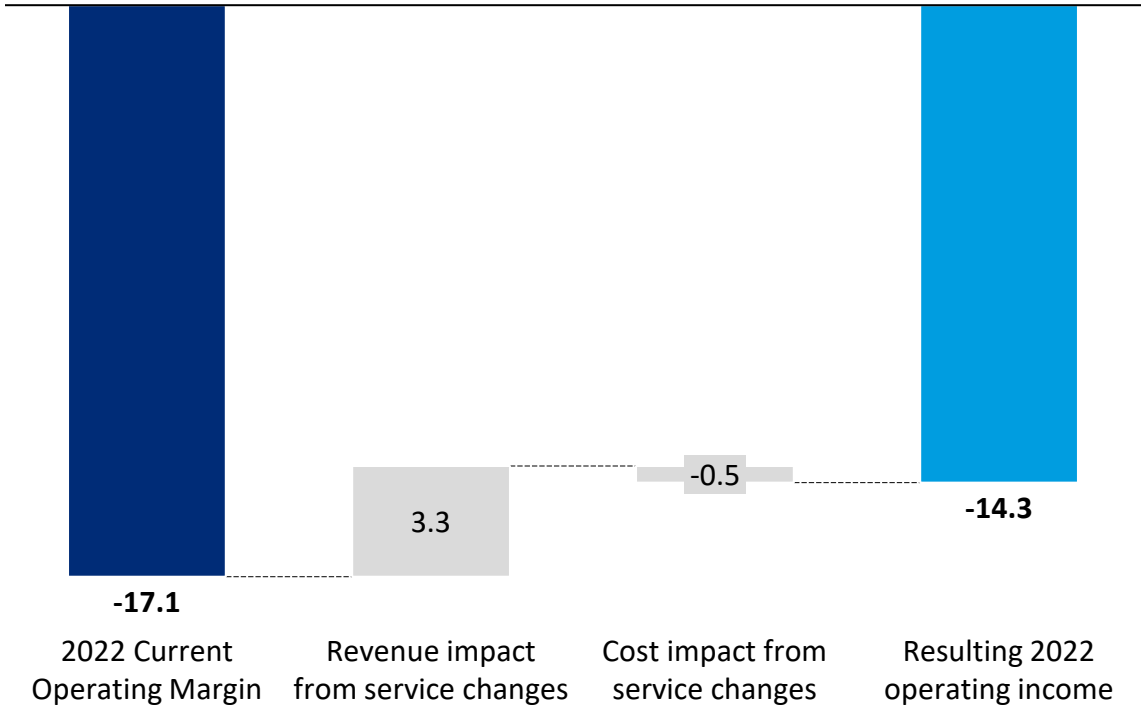


Source: Hospital feedback (May 2024), [Operating Revenue & Expense] GMCB hospital financial records, [Avoidable ED, voidable IP days] Commercial, Medicaid and Medicare FFS inpatient claims from VHCURES, calendar years 2019-2022, MPR analysis, [Boarder] VAHHS analysis using 2022 hospital discharge data (OW Survey CY 2022), [Transferred IP] MPR Final Inpatient Return to HSA Discharges Analysis based on patient flow analysis for 2022 using VHCURES data, [Transferred OP] MPR Final Outpatient Return to HSA Discharges Analysis based on patient flow analysis for 2022 using VHCURES data, [Low Volume] MPR Low Volume Service Analysis using VUHDDS data, 2020 & 2021 Vermont State Vital Statistics (Table B-16 in link and link), OW assumptions on low volume thresholds (see appendix) Hospital Feedback (June 2024) (current utilization affecting IP recapture), OW Analysis

DESPITE POTENTIAL ADJUSTMENTS, OPERATING INCOMES ARE PROJECTED BELOW ZERO, DEMONSTRATING MINIMAL OVERALL IMPACT AND NEED FOR STRUCTURAL CHANGE

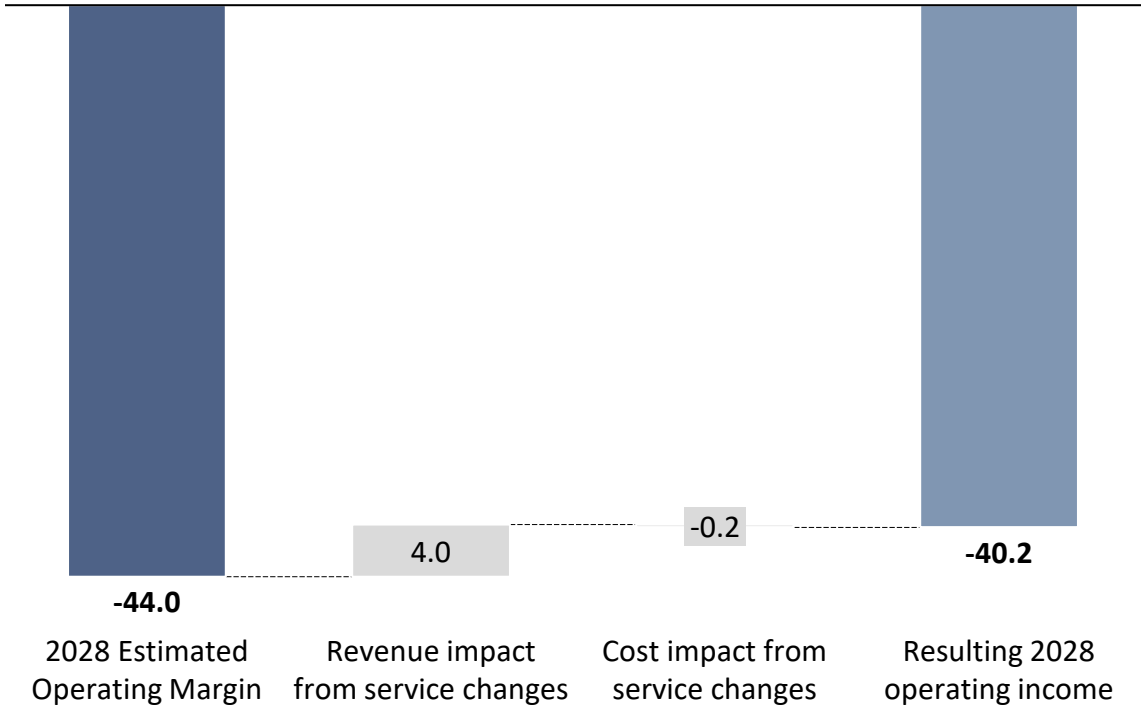
Illustrative financial impact on 2022 margin

$USD, MN



Illustrative financial impact on 2028 margin[1]

$USD, MN



1. Assuming 3.5% non-340B revenue growth and 5% expense growth annually

Source: GMCB hospital financial records, Oliver Wyman analysis

FURTHER POLICY HEADWINDS WILL LIKELY WORSEN THE FINANCIAL AN CHALLENGES FACED BY PROVIDERS

CMS estimates that Medicare payments to HHAs in CY 2025 would decrease in the aggregate by **1.7%**, or $280 million, compared to CY 2024, based on the proposed policies. 6 days ago

Centers for Medicare & Medicaid Services | CMS (.gov)
https://www.cms.gov › newsroom › fact-sheets › calenda...

Fact Sheets Calendar Year (CY) 2025 Home Health ... - CMS

AJMC

MedPAC Recommends Congress Approve Site-Neutral Medicare Reimbursement

Officials note it could slow acquisition of physicians' offices, but hospitals bristle at prospect.

21 Jun 2023

MedPage Today

Medicare Finalizes 3.4% Payment Cut for Physician Fees in 2024

Physicians would receive a 3.4% cut in their Medicare reimbursement under a final ruleopens in a new tab or window released Thursday by the...

3 Nov 2023

US raises tariffs on medical supplies from China

Paige Twenter - Tuesday, May 14th, 2024

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To incentivize domestic medical supply manufacturing, the U.S. is raising tariff rates on syringes, needles, personal protective equipment, and medical and surgical gloves, the White House said May 14.

The tariff rate increases are designed to combat China-made, low-cost products, the federal government said in a news release.

In 2024, tariff rates on syringes and needles will increase from 0% to 50%. Rates for some personal protective equipment, including certain respirators and face masks, will grow from 0%-7.5% to 25% this year. In 2026, tariffs for rubber medical and surgical gloves will increase from 7.5% to 25%.

Nursing Times

US to implement minimum nurse staffing levels in care homes

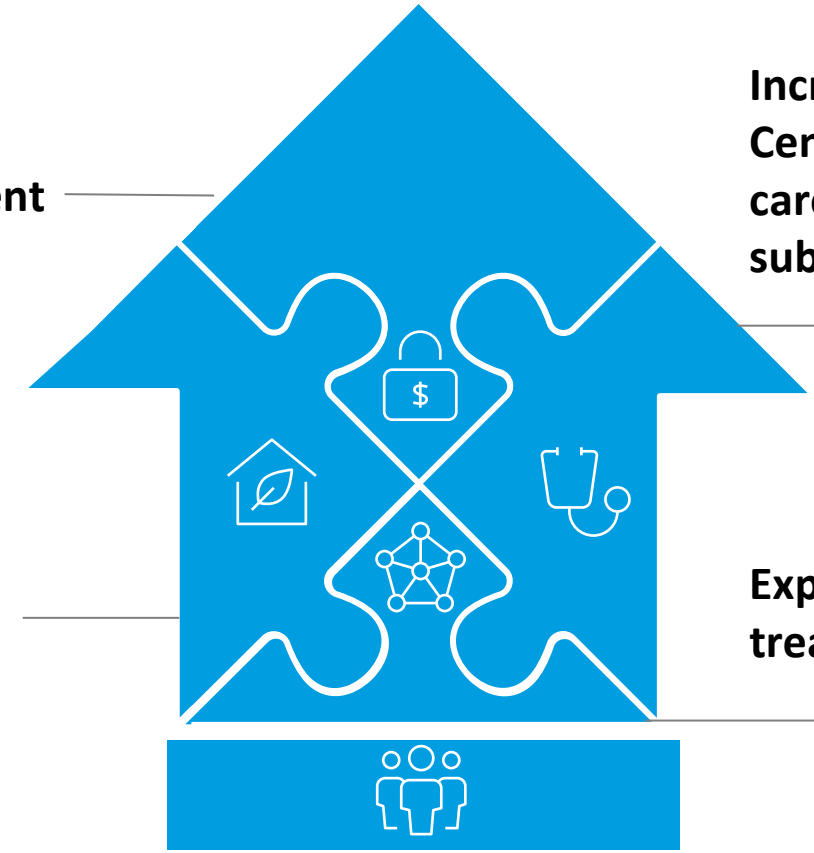
Read about a new law unveiled by USA president Joe Biden and vice president Kamala Harris aimed at regulating care home staffing levels.

24 Apr 2024

THE UNSUSTAINABLE TRENDS IN PATIENT NEEDS, FINANCIAL AND POLICY LANDSCAPE REQUIRE A REIMAGINATION OF HOW CARE IS DELIVERED

Continued cost reduction efforts in hospital care and movement of inpatient care to outpatient

Develop capacity for home-based care



Increased support for FQHC, Patient Centered Medical Home, other primary care providers, and mental health and substance abuse services

Expand non-hospital-based access and treatment options

Address population health conditions

The end-game for population health is movement of care out of the hospital and shift of hospitals to more intensive care

CONTINUED COST REDUCTION EFFORTS IN HOSPITAL CARE AN[illegible]OVE[illegible] INPATIENT CARE TO OUTPATIENT

Recommended action	Sub-category	Descriptions/detailed options	Rationale/impact
Seek operational synergy	Improve EMR functionality	Speed up adoption of VITL and embed into hospital workflow	✓ Improve efficiency of patient care ✓ Reduce duplication of testing
		Increase connectivity between hospital systems	
	Expand tele-health	Use of tele-pharmacy to support pharmacy technicians and nurses in outlying hospital/delivery sites	
		Support tele-rounding for specialists	
Seek cost synergy	Pursue group purchase	Pursue group purchasing (supplies, drug purchasing, insurance and group employee benefits) - *Ongoing*	✓ Reduce hospital operating expense
		Consider group purchase of equipment, services on equipment and common IT system	
	Centralize services	Centralize interpretative and linguistic services across all agencies with one phone number and single website	*Cost-benefit analyses should be conducted to ascertain whether centralization creates savings in the long-run when all direct and indirect costs are considered*
		Centralize laundry services and/or kitchen to prepare flash frozen meals for delivery to hospitals, SNFs, adult day care	
		Centralize central sterile supply for operating rooms	
		[Northwestern, Southwestern and Rutland only] Consider sub-contracting dietary and house-keeping services	
		Build a regional ambulatory surgery centers with 4-6 operating/procedure rooms and a recovery area to replace aged small inpatient ORs	
	Share staffing	Develop mobile health services with resources and cooperation between several HSAs	✓ Maintain patient access to essential yet low-volume services whilst allowing for potential specialization
		Allow smaller hospitals to form a corporation to jointly employ a "regional physician group" (esp. medical specialists) which could rotate MDs among the locations and provide internal telehealth support to the EDs	
		Centralize laboratory services, telepathology for surgical services	
		Centralize radiology interpretation	✓ Reduce staff cost
		Central monitoring for critically ill patients (e.g. sitters)	
		Central monitoring for patients at home	
		Share executive staff, operational staff (e.g. HR, quality, Infection Control, etc) and IT security staff between small hospitals	✓ Reduce staff cost

INCREASED SUPPORT FOR ALL PRIMARY CARE PROVIDERS (MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

1. Train and provide adequate support staff
2. Improve electronic health record performance and interoperability or replace systems
3. Improve performance of VITL to provide timely and accurate clinical information – *in progress*
4. Add nurse case managers to manage patients with complex medical problems - *in progress?*
5. Provide capability for IV infusions and inhalation therapy
6. ? Add capacity for X-rays and mammograms
7. Add pharmacists/Pharm D. In larger clinics
8. Provide telehealth consultative capacity to primary care site
9. Hire staff from minorities with language and social capabilities

DEVELOP CAPACITY FOR HOME CARE

1. Provide **primary care diagnostic options** using **telehealth**
2. Facilitate home-based **renal dialysis** and **ventilator support**
3. Support **home-based cancer care** and other services (e.g. Huntsman Cancer Center at Salt Lake City)
4. Consider **"Hospital at Home"** (e.g. MGH, multiple others)
5. Develop **"ED at Home"** (e.g. Atrius Health, Boston)

Requires:

1. Broadband internet
2. Stable electrical supply
3. Clean water and available sewage
4. Central monitoring capability
5. Adequate support in the home (family, home services etc.)
6. Clinician visit daily (Medicare requires two visits per day)
7. Availability of transportation to and from care
8. Appropriate payment for services

EXPAND NON-HOSPITAL-BASED ACCESS AND TREATMENTS

Facilities

- Free-standing diagnostic facility (radiology/ultrasound)
- Free-standing ambulatory surgery center
- Kiosks for telehealth access in community sites (e.g. in grocery stores)
- Mobile unit for migrant workers and others without transportation (medical/dental services)
- Dispensing machines in hospital ED for commonly prescribed non-scheduled drugs
- Use of community pharmacies for vaccines, venipuncture, routine refill of chronic medications (non-scheduled drugs), treatment of common illness under protocol (? use of rapid diagnostic tests)

People

- Pharmacists used in new roles
- Professional EMT/paramedics used to deliver home-based care
- Nurse case managers / navigators to help patients with complex medical problems
- Additional community health workers trained in preventative measures
- Immigrants with professional training allowed to practice in Vermont
- Permit nurses to function at top of license
- Provide training in culture sensitivity, gender identity, and mental health sensitivity to all patient-facing clinical staff

POPULATION HEALTH REQUIRES CONDITIONS NECESSARY FOR SUCCEEDING WITH POPULATION-BASED CARE MANAGEMENT AND PAYMENT

Conditions necessary for succeeding with population-based payments

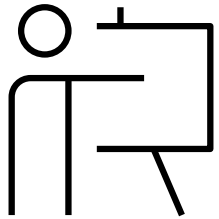
- Tight **alignment of financial incentives** among all participants.
- **Sharing of accurate and timely clinical information and financial performance** with all participants
- **Adequate resources for primary care, mental health and preventive services** in the community
- **Availability of referrals to specialists and needed diagnostic tests**
- **Availability of appropriate levels of care other than acute inpatient beds** (inpatient and outpatient mental health services, extended care facilities)
- Ability of **tertiary and other referral facilities to accept patient transfers** for needed care
- Availability of **appropriate transportation** for patients to and between facilities

The end-game for population health is movement of care out of the hospital and shift of hospitals to more intensive care

CONTINUED MAINTENANCE OF STATUS QUO IS UNSUSTAINABLE

- Pulling the **same operational levers** will have **no favorable** impact going forward
- **Current efforts appear insufficient** to support adequate access to healthcare services in communities
- **Dramatic re-design** of all aspects of healthcare delivery and financing are **needed**
- Given the potentially devastating financial projections for hospitals, the **window of opportunity to effect change is short**
- Prioritization of efforts to favorably affect **medical care for high needs/high expense populations** may provide the financial resources to assist in care re-design

NEXT STEP: COMMUNITY MEETINGS IN JULY AND AUG, AHS/HOSPITAL MEETINGS STARTING 10 JULY



14 in-person community meetings

9 July 2024 – 1 Aug 2024

See GMCB website for details[1]

AHS/hospital transformation planning meetings

Starting 10 July 2024

Virtual community meeting (state-wide)

5 Aug 2024
6:00pm - 7:30pm[1]

1. https://gmcboard.vermont.gov/Act-167-Community-Meetings


THANK YOU