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Hospital Sustainability Planning: Key Findings and Paths Forward

January 21st, 2022

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Agenda

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1. Background on Hospital Sustainability Planning
2. Key Findings
3. Paths Forward
   1. Recommendations for Act 159 Report
   2. Evolving GMCB's Regulatory Levers
4. Appendices

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Background

Hospital Sustainability Planning

In 2019, GMCB required sustainability plans for 6 of 14 hospitals and then following COVID-19, expanded the effort to all hospitals.

Act 159 of 2020 - Sec 4: "The Green Mountain Care Board shall consider ways to increase the financial sustainability of Vermont hospitals in order to achieve population-based health improvements while maintaining community access to services."

Board Homework Due 01/19: Key Findings

Based on what has been observed through hospital budget reviews over the last 5+ years, as well as various analyses and insights from thought leaders on hospital sustainability, affordability, and health care reform, what key findings do you think I have missed (draft to be shared prior to January 19th presentation)?

Sample of relevant analyses/Presentations:

- Conversations with Leaders in Health Care Reform: Panel Discussion: January 12, 2021
- Price and Cost Coverage Variation: HMA Burns, October 27, 2021
- Vermont Hospital Quality and Capacity Analysis: Berkeley Research Group, October 27, 2021
- Potentially Avoidable Utilization at Rural Hospitals: Mathematica, August 11, 2021
- The Future of Rural Healthcare: Stroudwater and Associates, June 23, 2021
- Act 159 of 2020 Section 5 Report: Options for Regulating Provider Reimbursement for Provider Sustainability and Equity: GMCB Report to the Legislature, April 7th, 2021
- All Payer ACO Model Implementation Improvement Plan: Ena Backus, Director of Health Care Reform, November 19, 2020
- Hospital Price Transparency Project: RAND, October 21, 2020
- A Look at Vermont Hospitals with NASHP Hospital Cost Tool: NASHP, October 21, 2020
- National Trends in State Affordability and Sustainability Strategies: Bailit Health, May 13, 2020

Board Homework Due 01/19: Recommendations

Long-term recommendations are largely process oriented and focus on developing a shared vision for the design of an efficient delivery system that delivers the best possible, affordable care to Vermonters, and how it should be paid for. This will allow providers to continue partnering with the state and Vermonters in developing this shared vision, since providers have been overwhelmed by the pandemic and have not yet had an opportunity to engage on the level necessary to establish a tangible path forward. A process will also allow us to map out any connections to a potential next federal agreement, and any necessary legislative changes based on that shared vision.

What are your thoughts on this approach and what the Board can do through the evolution of its regulatory processes in the interim to ensure Vermonters continued access to essential services and addressing, to the extent possible, Vermont hospital sustainability as we transition from volume- to value-based care?

- Hospital Budgets
- ACO Budget Review and Certification
- Insurance Rate Review
- CON
- Potential Next Federal Agreement

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Key Findings

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Though COVID-19 has shifted how we deliver and consume care, it is unclear how many of these trends are temporary or permanent. As such, the subsequent analyses rely predominantly on CY/FY 2019 and prior years, which is reasonable when assessing long-term trends. Going forward, it may be reasonable to update some of these analyses as we learn more about our post-COVID world.

Rural Hospital Closures are Increasing across the U.S.

- Since 2005, **181 rural hospitals have closed** nationally, and since 2010, the rate of closure has only been increasing, with 2020 the highest of any previous year[1,2].

- In a study published in Health Affairs in 2020, rural hospitals that closed during the study period had a **median overall profit margin of -3.2% in their final year before closure**[3].

- Hospital closures threaten patient **access** to services and materially impact the **local economy**[4].

- Vermont experienced its own hospital bankruptcy, alarming the Board, Legislators, and hospitals across the state.

1. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
2. https://onlinelibrary-wiley-com.dartmouth.idm.oclc.org/doi/full/10.1111/jrh.12187
3. Bai G, Yehia F, Chen W, Anderson GF. Varying Trends in the Financial Viability of US Rural Hospitals, 2011-17. Health Aff (Millwood). 2020;39(6).
4. Rural Health Services Report, Slides 44-47

Growing Challenges Faced by Rural Hospitals

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- Declining populations
- Rising costs
- Workforce challenges
- Rural bypass for larger community hospitals or Academic Medical Centers
- Aging plant
- Needed investments in population health under value-based care models
- Technological and clinical innovation requirements
- Managing a public health crisis

Source: BRG Presentation October 2021

Vermont Hospital Operating Margins Continue to Decline

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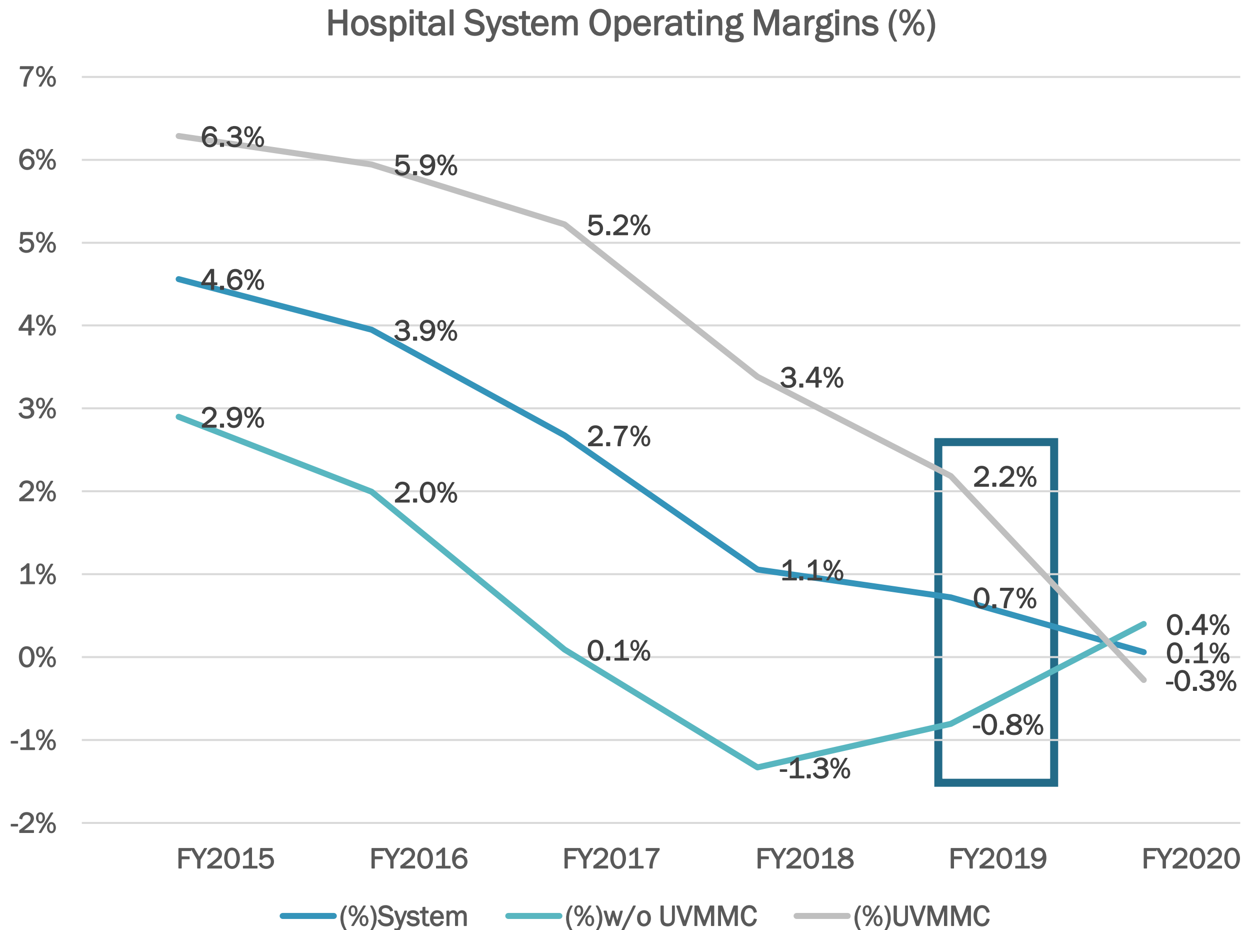

*Note FY2020 includes COVID Relief Funds and Expenses

Operating Expenses are Outpacing Operating Revenues

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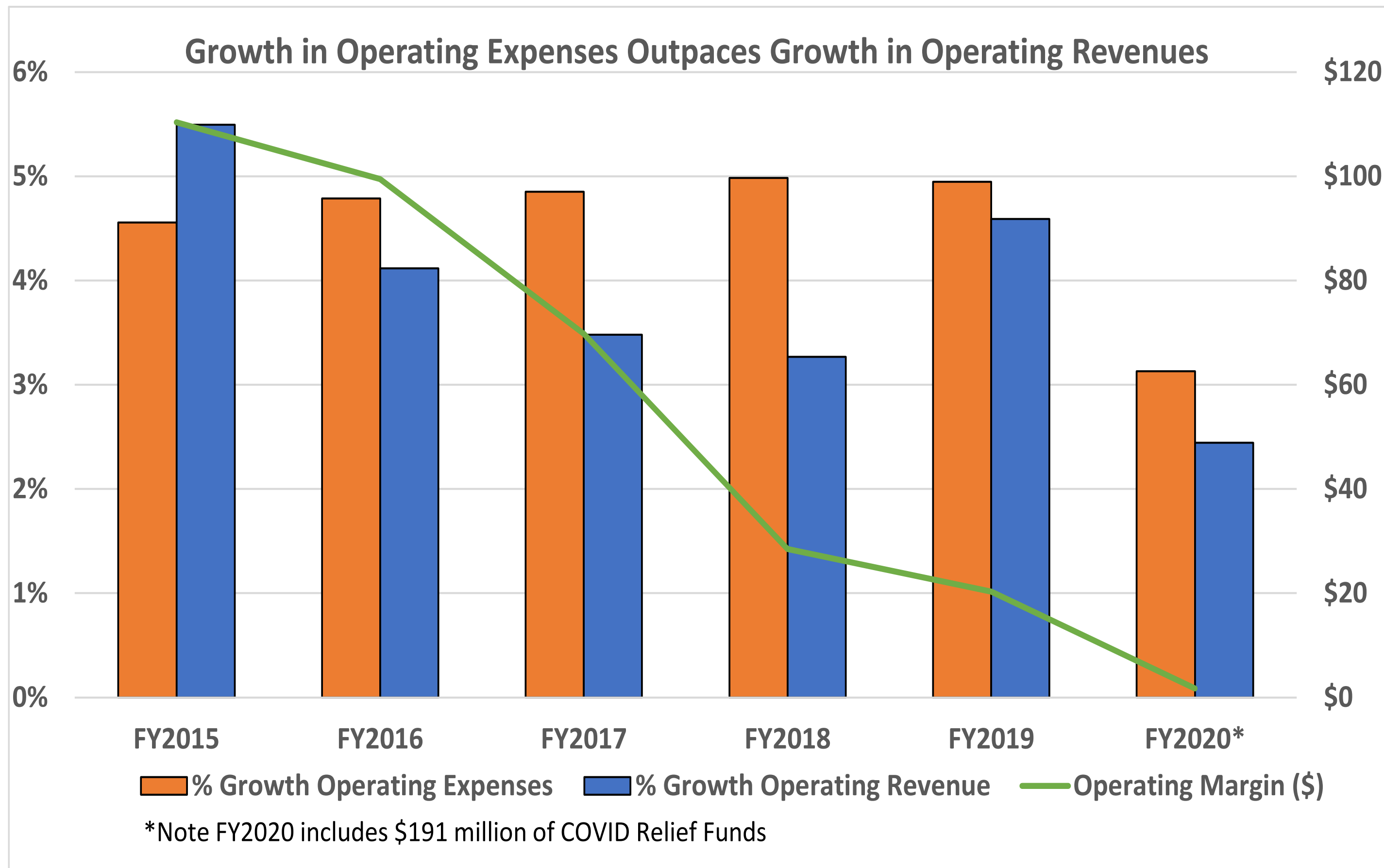

<u>Expense Growth Drivers in 2019</u>

- Cost of Labor & Benefits (including travelers)
- Cost of Supplies, including Pharmaceuticals
- Aging population

Source: Green Mountain Care Board

Declining Operating Margin(%) is a System-Wide Issue

Operating Margin (%) Hospital	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	5 Year Median	5 Year Average	3 Year Median	3 Year Average
Brattleboro Memorial Hospital	2.8%	-0.6%	-3.1%	-2.4%	0.8%	0.6%	-0.6%	-0.9%	0.6%	-0.3%
Central Vermont Medical Center	2.9%	1.0%	-0.9%	-3.8%	-2.1%	-0.6%	-0.9%	-1.3%	-2.1%	-2.1%
Copley Hospital	6.2%	-0.1%	-0.6%	-3.3%	-3.2%	-3.9%	-3.2%	-2.2%	-3.3%	-3.4%
Gifford Medical Center	2.7%	3.9%	-1.6%	-10.7%	-0.8%	2.5%	-0.8%	-1.3%	-0.8%	-3.0%
Grace Cottage Hospital	-9.8%	-8.0%	-6.9%	-2.9%	-6.7%	1.1%	-6.7%	-4.7%	-2.9%	-2.8%
Mount Ascutney Hospital and Health Center	-2.4%	0.3%	2.7%	1.9%	-0.1%	0.9%	0.9%	1.2%	0.9%	0.9%
North Country Hospital	3.5%	0.2%	-2.3%	-2.3%	1.9%	3.7%	0.2%	0.2%	1.9%	1.1%
Northeastern Vermont Regional Hospital	2.2%	2.0%	1.9%	1.7%	1.8%	1.3%	1.8%	1.7%	1.7%	1.6%
Northwestern Medical Center	9.7%	3.4%	-1.2%	-3.4%	-8.0%	-0.9%	-1.2%	-2.0%	-3.4%	-4.1%
Porter Medical Center	-2.4%	1.9%	2.7%	1.8%	5.2%	4.1%	2.7%	3.1%	4.1%	3.7%
Rutland Regional Medical Center	1.9%	4.2%	1.6%	0.5%	0.4%	0.2%	0.5%	1.4%	0.4%	0.4%
Southwestern Vermont Medical Center	3.6%	3.4%	3.7%	4.6%	3.3%	2.8%	3.4%	3.5%	3.3%	3.5%
Springfield Hospital	3.9%	0.3%	-7.1%	-12.8%	-18.4%	-11.2%	-11.2%	-9.8%	-12.8%	-14.1%
University of Vermont Medical Center	6.3%	5.9%	5.2%	3.4%	2.2%	-0.3%	3.4%	3.3%	2.2%	1.8%
Total	4.6%	3.9%	2.7%	1.1%	0.7%	0.1%	1.1%	1.7%	0.7%	0.6%
Median	2.8%	1.4%	-0.7%	-2.3%	0.2%	0.8%				
Flex Monitoring Team Northeast CAH					1.8%					
Flex Monitoring Team U.S. CAH					0.7%					
Fitch Ratings Solutions, Inc Northern New England					1.2%					
Fitch Ratings Solutions, Inc Northeast U.S.					0.8%					

*Note FY2020 includes COVID Relief Funds and Expenses

Hospital Total Margin Looks Better, but Not Sustainable

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Total Margin (%) Hospital	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	5 Year Median	5 Year Average	3 Year Median	3 Year Average
Brattleboro Memorial Hospital	4.0%	2.3%	0.9%	1.1%	1.6%	9.5%	1.6%	3.1%	1.6%	4.1%
Central Vermont Medical Center	3.5%	1.9%	6.7%	0.9%	-4.0%	4.5%	1.9%	2.0%	0.9%	0.5%
Copley Hospital	7.1%	0.3%	3.9%	-2.4%	-2.6%	-3.2%	-2.4%	-0.8%	-2.6%	-2.7%
Gifford Medical Center	7.9%	7.8%	0.3%	-6.2%	4.8%	5.8%	4.8%	2.5%	4.8%	1.5%
Grace Cottage Hospital	-4.0%	-2.1%	1.3%	3.7%	-0.3%	6.2%	1.3%	1.8%	3.7%	3.2%
Mount Ascutney Hospital and Health Center	-3.1%	2.6%	10.5%	5.3%	-4.0%	10.0%	5.3%	4.9%	5.3%	3.8%
North Country Hospital	1.8%	2.5%	2.3%	1.2%	3.0%	7.8%	2.5%	3.4%	3.0%	4.0%
Northeastern Vermont Regional Hospital	0.6%	3.2%	0.6%	2.3%	1.8%	3.8%	2.3%	2.3%	2.3%	2.6%
Northwestern Medical Center	8.1%	6.2%	6.8%	0.5%	-7.6%	-1.1%	0.5%	1.0%	-1.1%	-2.7%
Porter Medical Center	2.4%	5.9%	7.1%	6.1%	5.9%	4.3%	5.9%	5.9%	5.9%	5.4%
Rutland Regional Medical Center	1.7%	8.3%	7.5%	4.2%	2.1%	5.2%	5.2%	5.5%	4.2%	3.9%
Southwestern Vermont Medical Center	3.6%	3.8%	4.9%	5.8%	3.5%	4.6%	4.6%	4.5%	4.6%	4.6%
Springfield Hospital	-0.8%	0.7%	-3.2%	-12.0%	-38.9%	-11.7%	-11.7%	-13.0%	-12.0%	-20.9%
University of Vermont Medical Center	4.4%	6.8%	6.7%	5.1%	4.5%	-1.2%	5.1%	4.4%	4.5%	2.8%
Total	3.7%	5.5%	5.8%	3.5%	1.9%	1.5%	3.5%	3.6%	1.9%	2.3%
Median	3.0%	2.9%	4.4%	1.7%	1.7%	4.6%				
Flex Monitoring Team Northeast CAH					3.4%					
Flex Monitoring Team U.S. CAH					2.4%					
Fitch Ratings Solutions, Inc Northern New England					2.0%					
Fitch Ratings Solutions, Inc Northeast U.S.					3.5%					

*Note FY2020 includes COVID Relief Funds and Expenses

Increasing Reliance on Other Operating Revenue

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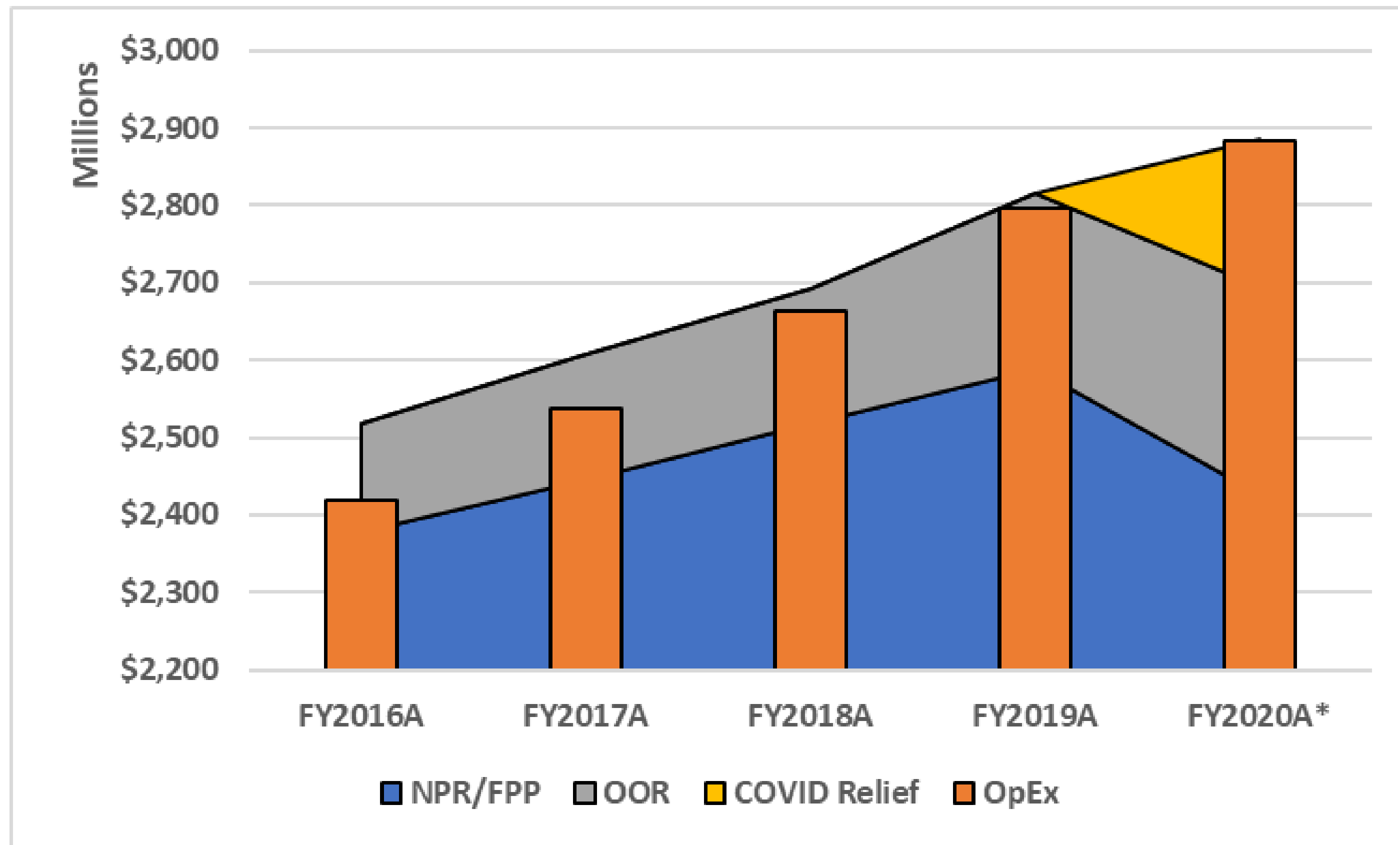

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Age of Plant: Growing Concern of VT Hospitals

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Age of Plant Hospital	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
Brattleboro Memorial Hospital	8.6	9.4	9.9	10.1	12.1	12.9
Central Vermont Medical Center	9.0	9.7	10.2	10.8	12.2	14.0
Copley Hospital	10.4	10.9	11.5	9.8	11.2	11.8
Gifford Medical Center	11.4	13.1	14.1	17.4	18.7	17.4
Grace Cottage Hospital	10.4	17.8	22.0	23.3	20.5	20.4
Mt. Ascutney Hospital & Health Ctr	8.6	12.6	11.8	12.8	11.7	11.4
North Country Hospital	9.1	9.3	10.9	12.7	14.0	14.0
Northeastern VT Regional Hospital	13.2	13.1	13.0	13.1	13.8	15.4
Northwestern Medical Center	9.9	10.6	11.1	11.3	11.0	11.8
Porter Medical Center	10.8	11.1	12.3	12.5	13.2	13.7
Rutland Regional Medical Center	11.5	11.8	13.3	13.5	13.9	14.4
Southwestern VT Medical Center	17.3	17.1	16.7	17.4	18.3	19.4
Springfield Hospital	12.5	14.5	15.6	17.5	17.2	19.0
The University of Vermont Medical Center	12.0	11.9	12.5	13.2	13.4	11.6
VT Hospitals' Median	10.6	11.9	12.4	12.9	13.6	14.0
Flex Monitoring Team Northeast CAH					14.6	
Flex Monitoring Team U.S. CAH					12.3	
Fitch Ratings Solutions, Inc Northern New England					12.5	
Fitch Ratings Solutions, Inc Northeast U.S.					12.6	

Why does this matter?

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Affordability

In Vermont hospitals' primary lever to increase operating margin is commercial price, which only exacerbates the existing affordability crisis

Quality

Hospitals in financial distress "struggle to maintain quality and patient safety and have worse patient outcomes relative to well-resourced hospitals"[1]

Access

Financial distress is a key predictive factor in determining the likelihood of hospital closure, which left unaddressed compromises communities' access to essential services[2]

1. Source: Akinleye DD, McNutt LA, Lazariu V, McLaughlin CC. Correlation between hospital finances and quality and safety of patient care. *PLoS One*. 2019;14(8):e0219124. Published 2019 Aug 16. doi:10.1371/journal.pone.0219124
2. Source: Holmes GM, Kaufaman BG, Pink GH. Predicting financial distress and closure in rural hospitals. *The Journal of Rural Health* 2017;33(3): 239-249.

Staff Key Finding #1

Hospital Financial Health: The financial health of Vermont's hospitals, as assessed by operating margin, declined over six recent fiscal years (FY2015 to FY2020). This means that the cost of delivering care is increasing faster than payments to hospitals for providing services to patients. Left alone, this trend could lead to the erosion of service quality, reduced affordability, and/or hospital closures. Hospital closures compromise access to essential services, and have been a growing concern among rural hospitals across the U.S. While non-operating revenue sources offer some hospitals relief, this is not sustainable.

Adjustments? Other Board takeaways?

Prices Vary by Hospital, Payer, & Setting

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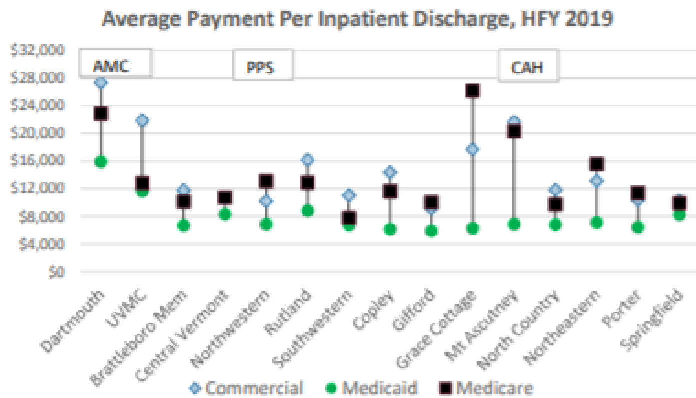

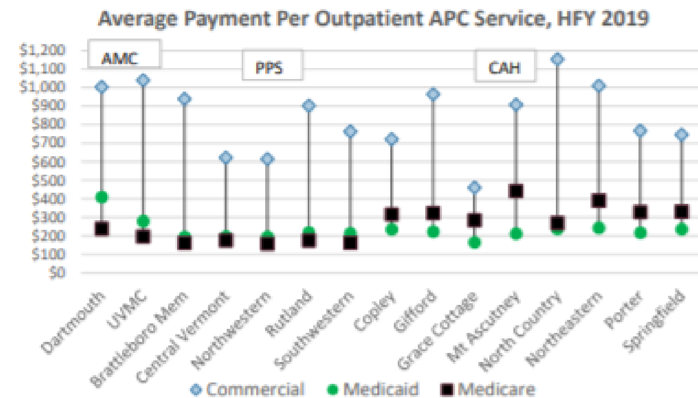

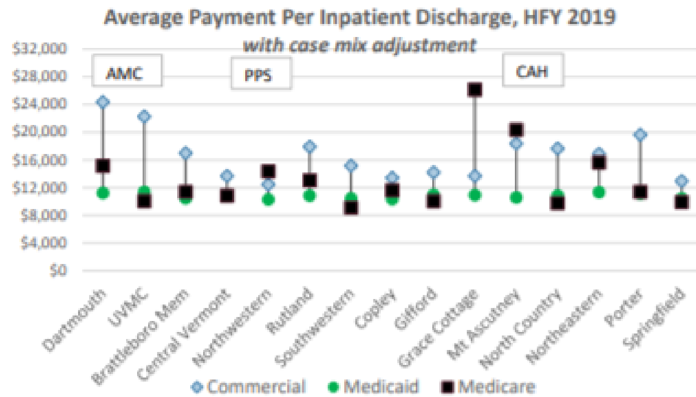

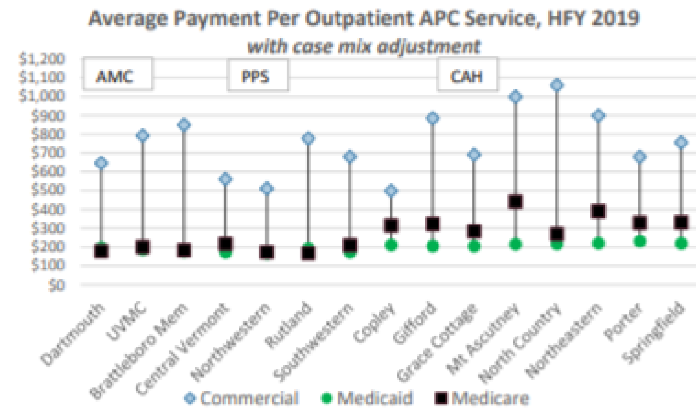

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Costs Vary by Hospital, Payer, & Setting

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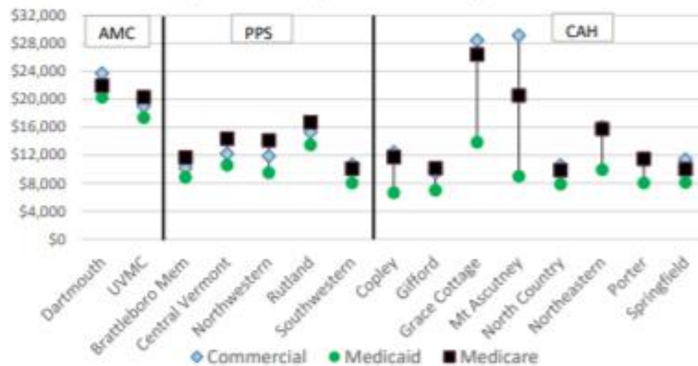

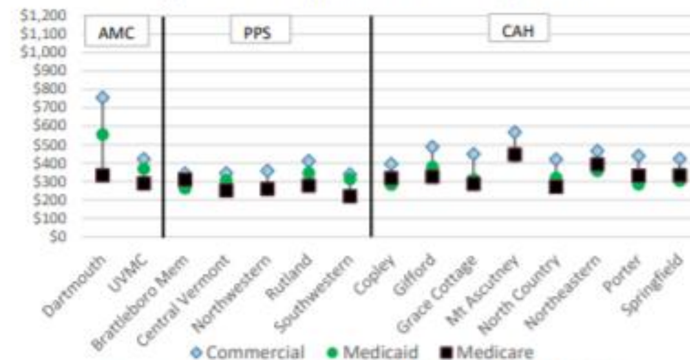

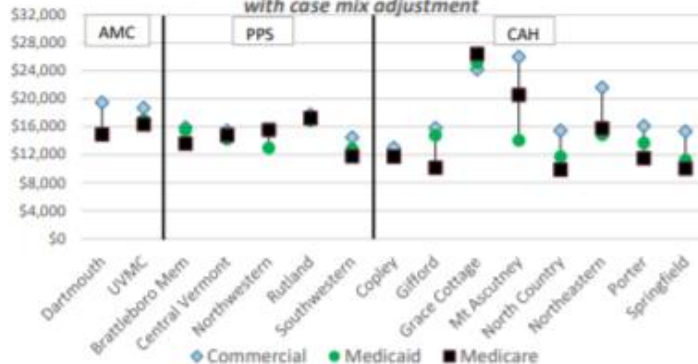

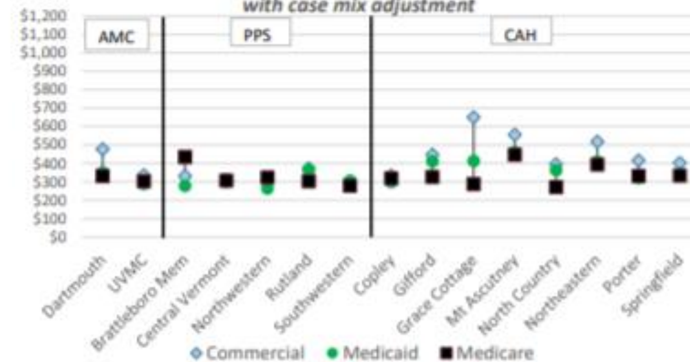

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Cost Coverage Varies by Hospital, Payer, & Setting

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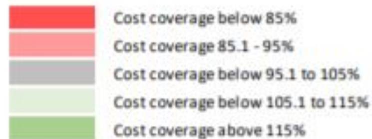

		Inpatient									Outpatient								
		Medicaid			Medicare			Commercial			Medicaid			Medicare			Commercial		
		HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19	HFY17	HFY18	HFY19
Weighted Average		73.1	73.1	72.6	95.4	89.4	81.8	114.5	109.7	109.1	76.0	72.6	71.2	68.7	73.8	75.1	255.6	254.6	204.0
Dartmouth	AMC																		
UVMC	AMC																		
Brattleboro Mem	PPS																		
Central Vermont	PPS																		
Northwestern	PPS																		
Rutland	PPS																		
Southwestern	PPS																		
Copley	CAH																		
Gifford	CAH																		
Grace Cottage	CAH																		
Mt Ascutney	CAH																		
North Country	CAH																		
Northeastern	CAH																		
Porter	CAH																		
Springfield	CAH																		

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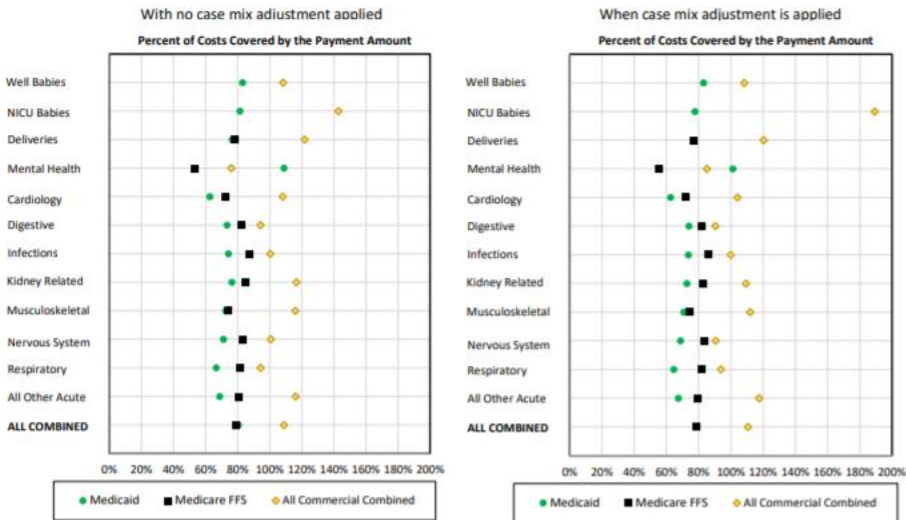
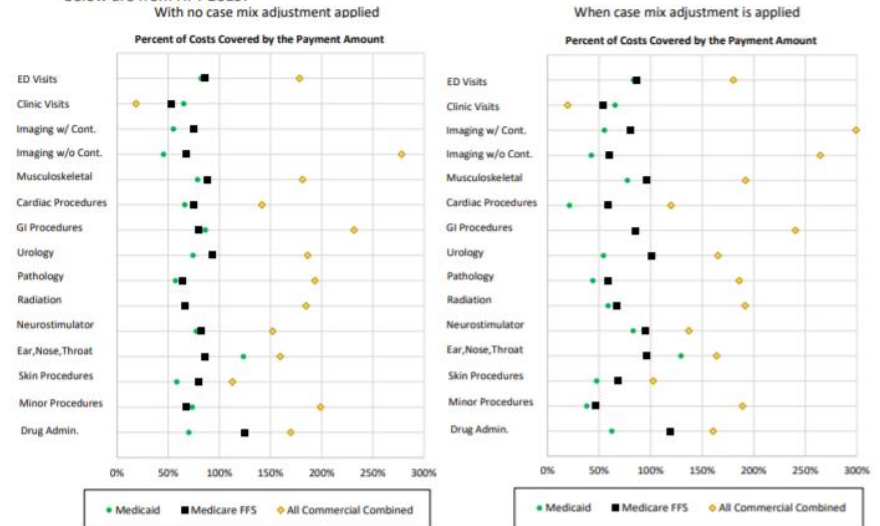
Cost Coverage Varies by Services Category





Staff Key Finding #2

Price and Cost Coverage: There is significant variation across hospitals in the extent to which reimbursements cover the costs of delivering a particular services, even after controlling for case-mix, and this varies by payer and care settings (inpatient/outpatient). These variations could be driven by relative efficiency, or pricing strategy, or likely both. Commercial payments are higher than governmental payments for similar services and often, governmental payments are insufficient to cover the current costs of delivering many services to patients. This disadvantages those hospitals and populations that serve a higher proportion of patients that are insured by government payers, which are often those patients with greater social and physical health needs.

Adjustments? Other Board takeaways?

Charges vs. Payments

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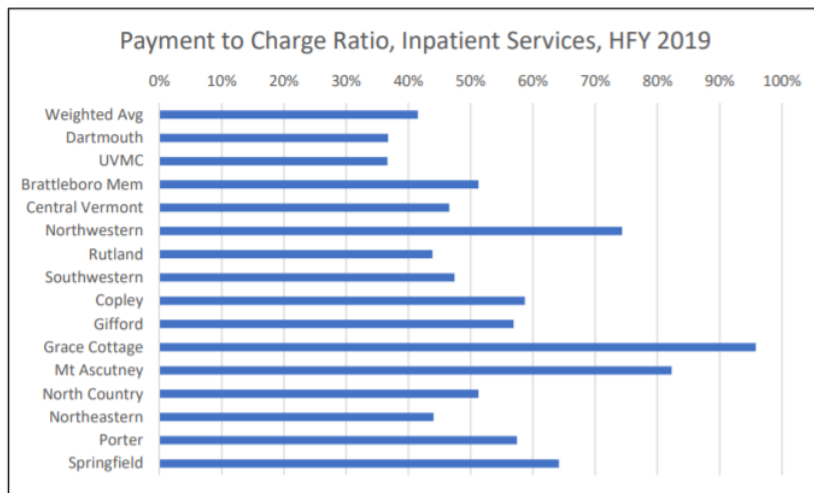

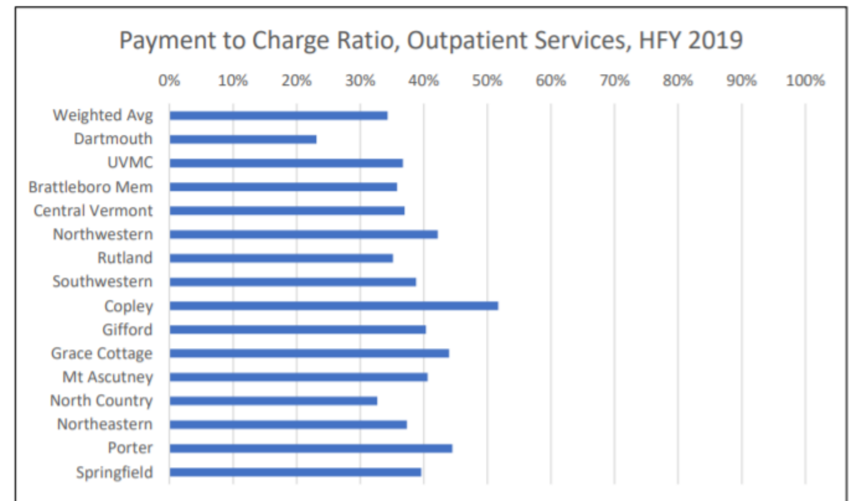

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Staff Key Finding #3

Hospital Price Regulation in Vermont:
In Vermont, hospital prices are regulated through the Green Mountain Care Board's review and approval of a hospital's commercial change in charge in the Hospital Budget Review Process. However, changes to a hospital's charge master is not the best way to influence the net payment received and address affordability.

Adjustments? Other Board takeaways?

Hospital Levers to Balance Revenues & Expenditures

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- ❑ Increase Commercial Prices
- ❑ Reduce Operational Costs
- ❑ Increase Volume of Profitable Services

Hospital Prices: The Tension…

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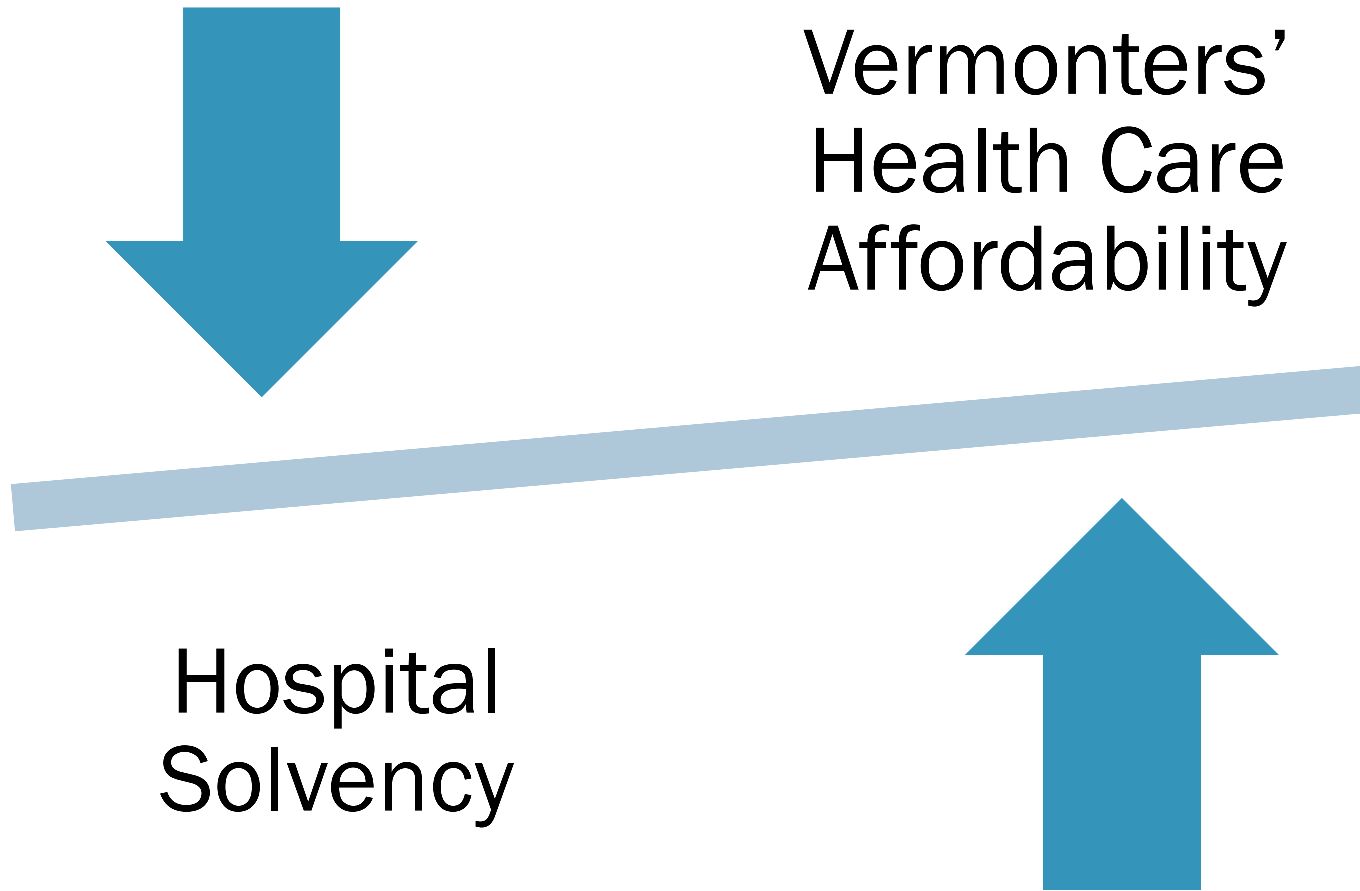

Affordability is a Problem for Vermonters

According to the 2018 Household Health Insurance Survey:

- More than a quarter (28%) of those who are uninsured work for an employer who offers health insurance
- A large proportion indicate cost is either the only reason (51%) or one of the main reasons (22%) they do not have health insurance
- Overall, more than a third of Vermonters under age 65 are underinsured (36%).
- Among those who have private health insurance, 40% can be considered underinsured.
- The proportion of Vermonters younger than 65 who have private health insurance and are underinsured has increased since 2014 when 27% were underinsured.

Premium Rate Growth

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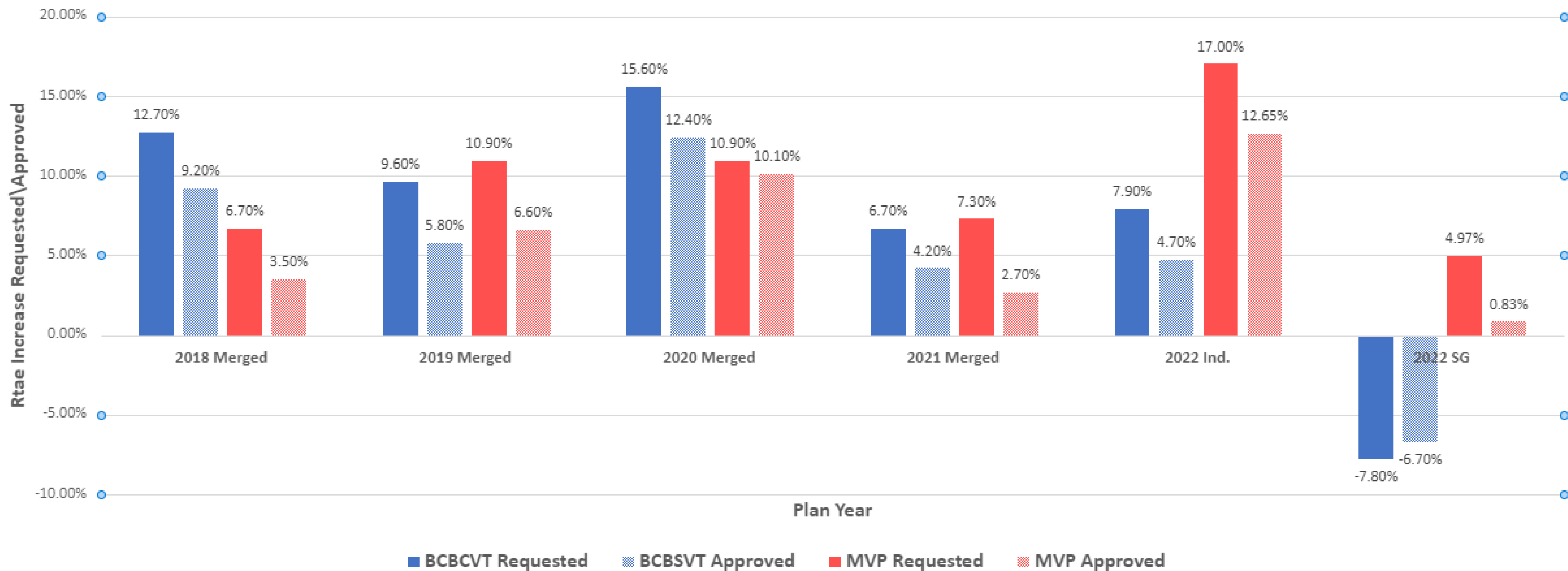

Hospital Commercial Charges

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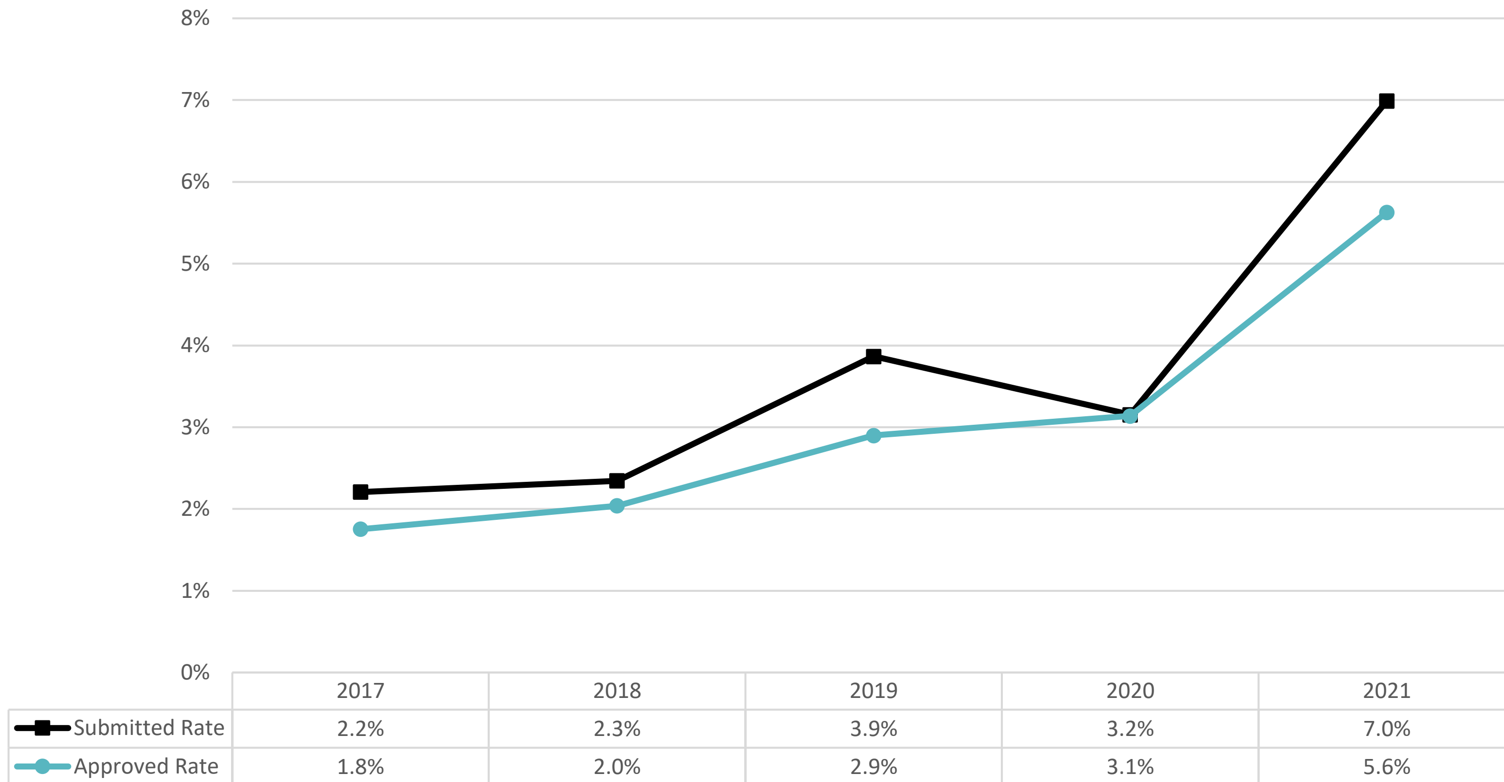

	2017	2018	2019	2020	2021
Submitted Rate	2.2%	2.3%	3.9%	3.2%	7.0%
Approved Rate	1.8%	2.0%	2.9%	3.1%	5.6%

Estimated Weighted Average for all hospitals is calculated by factoring in each hospital's proportion of gross revenue to the change in charges (rate).

The problem with relying on commercial rate increases to cover hospital costs and maintain margins?

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1. Commercial rate increases lead to higher premiums making private health insurance less and less affordable for Vermonters.

2. There are fewer and fewer commercially insured patients available to cover growing costs, exacerbating the required magnitude of increases.

   Between 2013-2019, while the Medicaid and Medicare populations *grew* by a combined 21%, the privately insured population *fell* by 10% in VT

Staff Key Finding #4

Price & Affordability: The magnitude and growth of commercial rates have created significant affordability problems for employers and for Vermont residents with employer-based coverage. Continuing to rely on this mechanism will only exacerbate the affordability crisis, potentially compromising access to care of the commercially insured as care becomes increasingly cost prohibitive. Further, commercial rate increases are unsustainable lever to address hospital financial health, due to a declining commercial population in Vermont, and at some point, may be insufficient to keep hospitals open, another risk to Vermonters' continued access to essential services.

Adjustments? Other Board takeaways?

Hospital Levers to Balance Revenues & Expenditures

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- ☒ Increase Commercial Prices
- ☐ Reduce Operational Costs
- ☐ Increase Volume of Profitable Services

What about reducing operational costs?

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- We hear from hospitals about the challenges of cutting operational costs…
- A few reasons for these challenges include:
  - Small rural hospitals struggle to cover the fixed costs of running a hospital[1]
  - Recruitment challenges lead to higher staffing costs (*n.b.*, a majority of a hospital's budget is for staffing)
  - Low volumes
- These challenges will only worsen as plants age and capital investment becomes more expensive, workforce shortages put higher pressure on wages, and volumes shrink due to declining populations and a shift away from inpatient care settings.

1. Source: https://www.aha.org/system/files/2019-02/rural-report-2019.pdf

Pre-Covid, Several Vermont Hospitals Faced Low Occupancy Rates & Volumes

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- According to *Berkeley Research Group's analysis*:
  - Some small VT hospitals faced low occupancy rates pre-Covid
  - Some hospitals may face excess capacity in the future given Dartmouth's bed expansion and population decline (other hospitals may need expanded capacity due to population growth)
  - Low volumes in certain services may increase costs and compromise quality
  - Centers of Excellence may be a path forward to efficiency, financial sustainability and high-quality care

Staff Key Finding #5

Operational Efficiency: While improving hospital operational efficiency is necessary and important for minimizing heath care spending waste, and improving quality, focusing within an individual hospital alone is unlikely to solve the issue of financial sustainability due to the small size of many hospitals and relatively high fixed costs. Thus, any significant opportunities to increase efficiency will require streamlining operations (e.g., Centers of Excellence) and eliminating duplicative services across the entire system of inpatient and outpatient care.

Adjustments? Other Board takeaways?

Staff Key Finding #6

Hospital Capacity: Preliminary analyses suggest that absent COVID demands, Vermont's care delivery system is overcapacity in some areas and under capacity in others. Several Vermont hospitals are operating at very low occupancy and some of these hospitals are located relatively close to one another. This suggests that despite demographic shifts over time, right-sizing of hospital infrastructure has not kept pace. Projections of Vermont population demographics indicate that post-COVID, the mismatch between need and the distribution of capacity across the state are expected to widen.

COVID has also revealed the need of health systems to pivot quickly to meet evolving patient needs, but also that maintaining costly excessive capacity is not necessary, as hospitals have the ability to innovate in response to changing environments.

Given these trends and lessons learned, there is an opportunity to strength Vermont's health system and rethink the structure of care delivery to ensure it is efficient, nimble and innovative, and prepared to serve Vermonters high quality affordable care.

Adjustments? Other Board takeaways?

Hospital Levers to Balance Revenues & Expenditures

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- ☒ Increase Commercial Prices
- ☒ Reduce Operational Costs
  (given current infrastructure)
- ☐ Increase Volume of Profitable Services

What about increasing volume at the hospital level?

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- Increasing volume may be warranted when there are gaps in access, but it could lead to unnecessary expenditures and possible worse health outcomes for Vermonters.
- The organization and delivery of services should be based on Vermonters' needs and which services and care settings will yield the best possible health outcomes.
- Health care reform and the shift to value-based care has been precisely focused on this issue.
- And according to work by Mathematica, there are opportunities to reduce avoidable utilization

Potentially Avoidable Utilization

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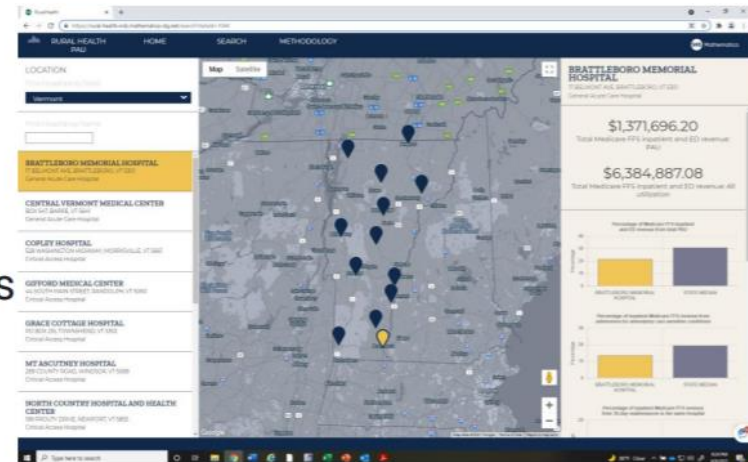
- PAU is defined as hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community-based care.
- Three claims-based measures
  - -Readmissions within 30-days
  - -Ambulatory care sensitive admissions
  - -Avoidable Emergency Department visits



Mathematica

6

There is room to reduce potentially avoidable utilization

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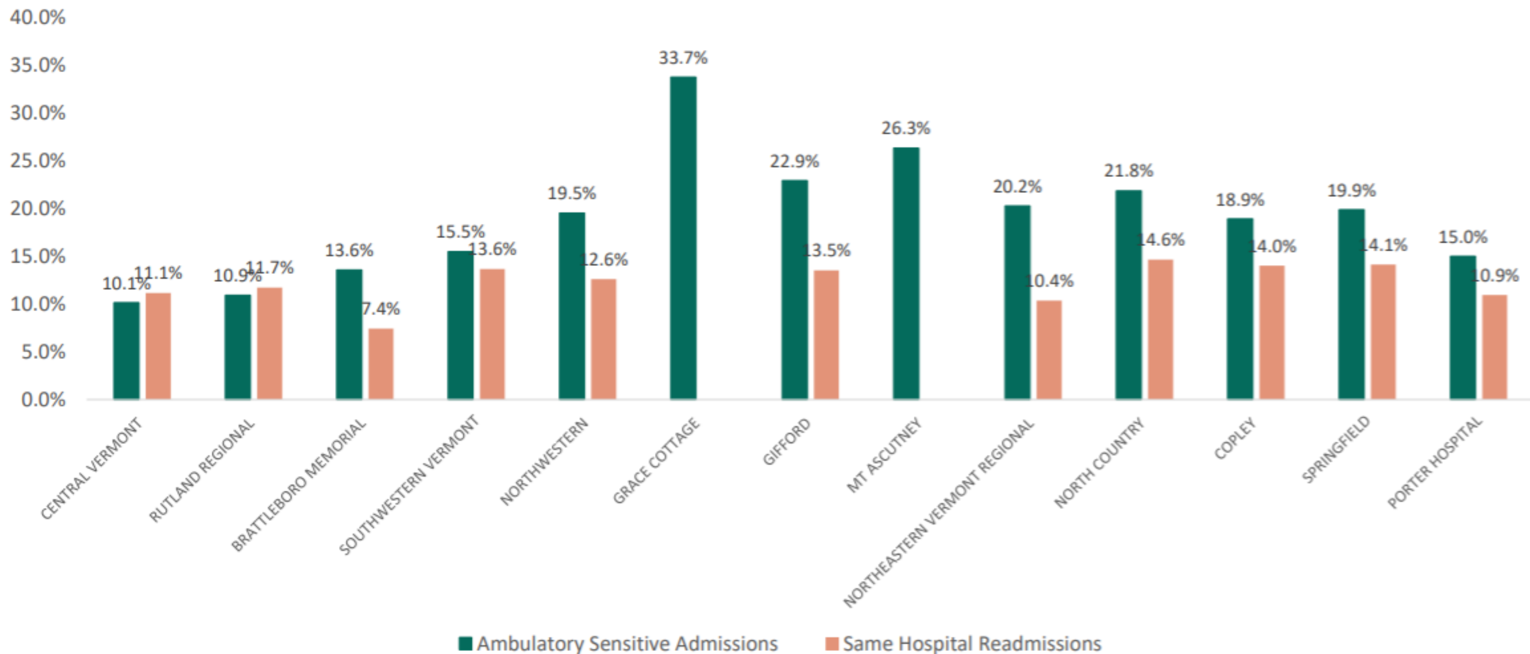
Proportion of Revenue in Avoidable Utilization- Inpatient



Mathematica

12

There is room to reduce potentially avoidable utilization

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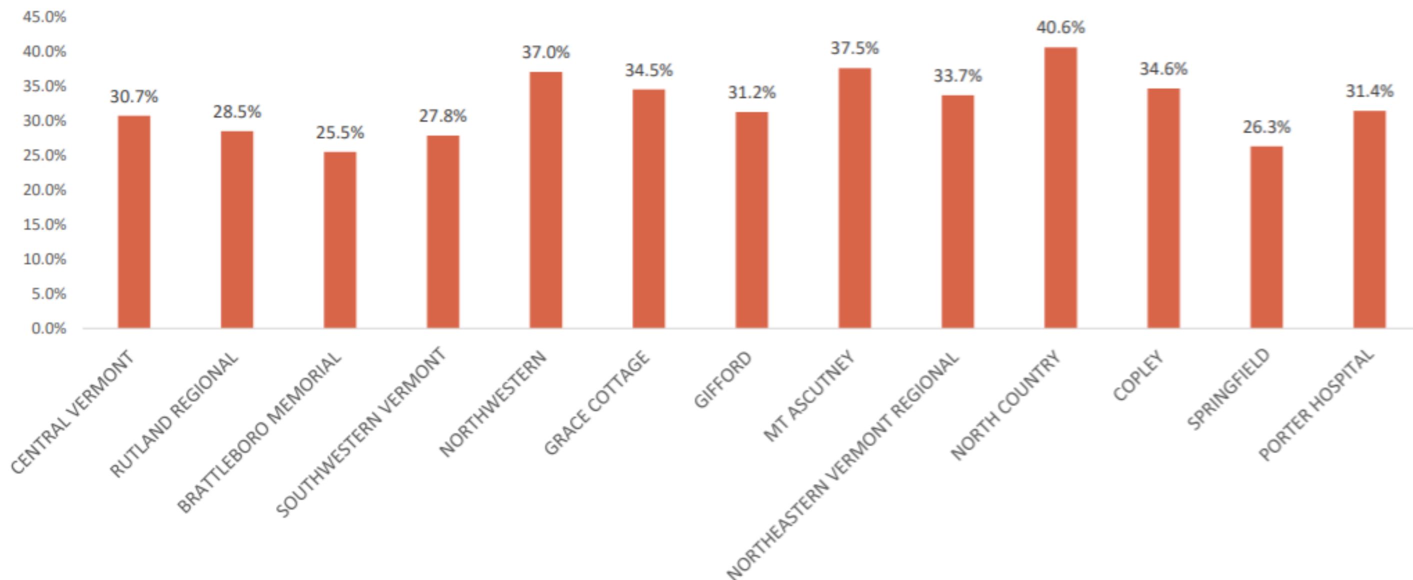
Proportion of Revenue in Avoidable Utilization- Emergency Department



Mathematica

We can improve outcomes and lower costs by reducing unnecessary utilization

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Category of Waste	Estimated Percent of US Spending
Failures of Care Delivery	3.8% – 4.8%
Failures of Care Coordination	0.9% –1.3%
Overtreatment	5.9% – 7.1%
Administrative Complexity	4.0% – 9.2%
Pricing Failures	3.1% – 4.9%
Fraud and Abuse	3.0% – 6.6%
Overall Percent of Spending, US Health Care	**21% – 34%**

Berwick and Hackbarth, JAMA 2012

Presentation slide from Dr. Elliott Fisher presentation to the Board January 12, 2022

Hospital Levers to Balance Revenues & Expenditures

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- ☒ Increase Commercial Prices
- ☒ Reduce Operational Costs
- ☒ Increase Volume of Profitable Services

Support for Value-based Care

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"Pre-pandemic there was already a press for a more aggressive shift to risk payment models, and most Medicare spending was predicted to be tied to value by 2025. As COVID-19 has evolved, 49% of surveyed health care executives say they have a higher interest in participating in value-based care"

The AHA advocates for global budgets to ensure access in rural communities.

American Hospital Association™
Advancing Health in America
Section for Small or Rural Hospitals

"WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN'T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY."

CMMI Director Dr. Liz Fowler on "Strategic Refresh" (4/25/21)

Where are Vermont Hospitals in their transition to Value-based Care?

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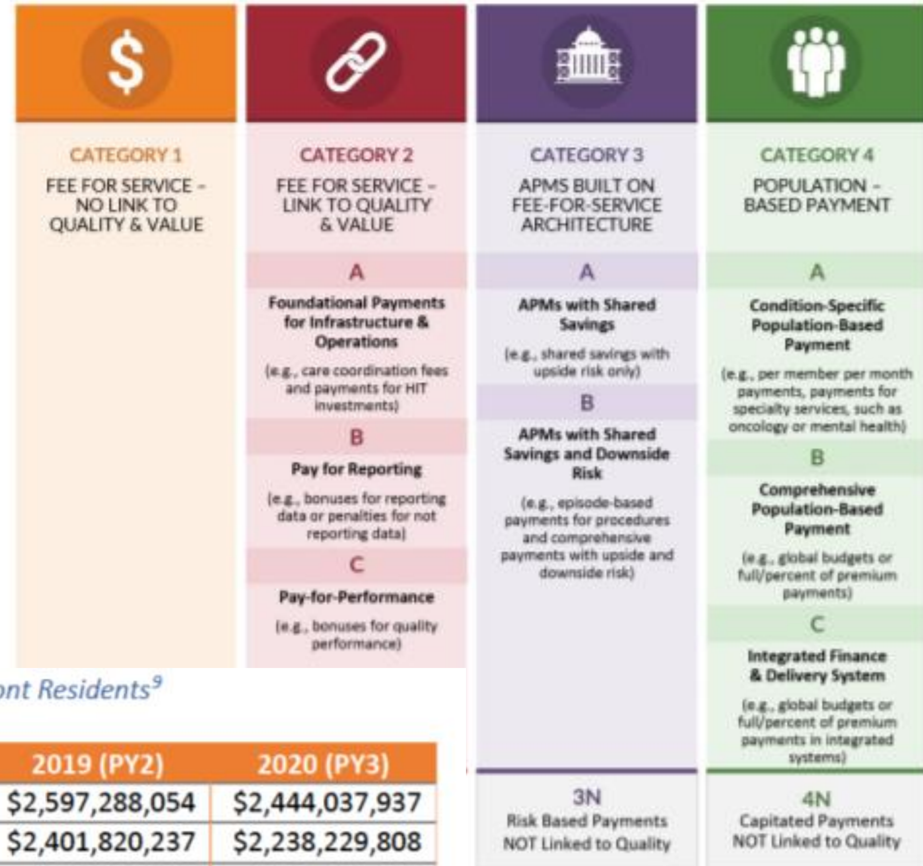

Figure 6: Systemwide Proportion of Value-Based Hospital Revenue from Vermont Residents[9]

	2017 (PY0)	2018 (PY1)	2019 (PY2)	2020 (PY3)
Total Revenue	$2,378,721,942	$2,520,075,138	$2,597,288,054	$2,444,037,937
Estimated VT Resident Revenue	$2,234,000,656	$2,329,290,531	$2,401,820,237	$2,238,229,808
Prospective Payments + Other Reform Payments	$43,510,957	$231,893,481	$299,908,013	$351,471,909
Proportion of Revenue	**1.9%**	**10.0%**	**12.5%**	**15.7%**

Staff Key Finding #8

Volume to Value: Despite being leaders in their commitment to value-based care, Vermont hospitals are still predominantly paid on a fee-for-service basis which continues hospitals' reliance on volume-driven strategies to ensure their financial health.

Adjustments? Other Board takeaways?

Quality Improvement & Measurement

While for the first time we have a collated baseline of hospital quality data (BRG analyses October 27, 2021), these data are not reported consistently across Vermont hospitals, nor is there consensus across hospitals as to the most appropriate hospital quality measures and for whom.

In partnership with VPQHC, we are now convening a stakeholder group to establish a hospital quality framework that can be considered within the hospital budget review process.

Staff Key Finding #9

Quality Improvement & Measurement: There are likely opportunities to improve the quality of care being delivered to Vermonters. For example, in some areas, volumes may not be sufficient to guarantee high-quality of care for some services. In addition, Vermont hospitals' rate of potentially avoidable admissions is below optimal levels, suggesting better care for patients with common chronic conditions is warranted.

While this baseline data is helpful for highlighting general areas of opportunity, measures of hospital quality are not consistently reported across hospitals and make systematic review of hospital quality data difficult if not impossible.

Adjustments? Other Board takeaways?

Other Key Findings?

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Are there key findings that I missed?

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Act 159 Report: Potential Paths Forward

Act 159: Defining the work

Hospital financial sustainability: How can we ensure that **hospital revenues** (provider reimbursement) are sufficient to **cover the costs** of operating a system that strikes the appropriate **balance between efficiency** and **access in rural Vermont**?

How can sustainable hospital reimbursement ensure:

1. Equitable access to essential services for all Vermont communities
2. Efficient and economic delivery of services (and affordability)
3. Improved health outcomes for Vermonters

Summary of Key Findings

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1. Left alone, hospital financial health is likely to deteriorate, potentially leading to hospital closure, and health care affordability is likely to worsen for the commercial population.
2. Vermont has numerous opportunities to redesign care – in order to improve quality, efficiency, affordability, and access to care for Vermonters.
3. Completing the transition to value-based payment models will enable the health care system to improve quality and control health care spending growth (allowing us to seriously address affordability) while maintaining access to needed services.

Recommendation #1

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Establish a shared vision for the transformation of Vermont's health care delivery system to improve access, affordability, quality, and health equity.

How?

- Appropriate funding for a contractor to lead state leaders, hospitals, and communities in a process to:
  - Assess the efficiency and quality of the current hospital delivery system and
  - Lead efforts to design a system that optimizes access, quality and costs in order to be sustainable in a value-based world.

Do you agree? Adjustments?

Recommendation #2

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Explore moving hospitals to all-payer prospective population-based payments (i.e. global budgets) that are flexible and sufficient to deliver high quality affordable care to Vermonters, equitably.

How?

- Appropriate funding for a contractor to assist with
  - The design of a facility-focused all-payer population-based payment
  - Its incorporation into a proposal for Vermont's subsequent federal agreement

Do you agree? Adjustments?

Recommendation #3

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Establish a hospital quality framework that can be incorporated into the hospital budget review process.

How?

- Continue partnership with VPQHC and stakeholders and ensure that the resulting hospital quality framework is ultimately incorporated into the hospital budget review process.

Do you agree? Adjustments?

Other Recommendations?

Are there recommendations that we should include in our Act 159 section 5 report to the legislature that I missed?

GMCB Next Steps

Evolution of Regulatory Levers

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- Hospital Budget Review
  - FY2023
    - Report revenues per LAN framework
    - Include price & cost coverage in NPR/Change in Charge decision
  - FY2024+
    - Track fixed vs. variable costs
- Insurance Rate Review
- CON
- ACO Budge Review Certification
- Potential Next Federal Agreement

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Appendix

Goals for Sustainability Planning Framework

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1. Engage in a robust **conversation** on maintaining **access to essential services in our communities,** preparing for a shift to **value-based care,** and understanding the threats to the **sustainability** of our rural health care system;
2. Encourage **hospital leadership, boards, and communities** to **work together** to address sustainability challenges and the shift to value-based care;
3. Identify **hospital-led strategies** for sustainability, including efforts to "right-size" hospital operations, particularly in the face of Vermont's demographic challenges and making the shift to value-based care;
4. Identify **"external" barriers** to sustainability and making a successful shift to value-based care that are more aptly addressed by other stakeholders, policy-makers, or regulatory bodies, and generate insights to inform the state's approach to planning for- and designing a proposal for a subsequent **All-Payer Model Agreement (APM 2.0).**