

To: Lieutenant Governor Molly Gray
President Pro-Tempore Becca Balint
Speaker Jill Krowinski
Sen. Anne Cummings, Chair, Senate Committee on Finance
Sen. Ginny Lyons, Chair, Senate Committee on Health and Welfare
Sen. Jane Kitchel, Chair, Senate Committee on Appropriations
Rep. Mary S. Hooper, Chair, House Committee on Appropriations
Rep. William J. Lippert, Chair, House Committee on Health Care

From: Green Mountain Care Board
Date: February 1, 2022
Title: Green Mountain Care Board Position Letter on Equitable and Accessible Health Care and Hospital Sustainability

Dear Lt. Governor Gray, President Pro-Tempore Balint, Speaker Krowinski, Sen. Cummings, Sen. Lyons, Sen. Kitchel, Rep. Hooper, and Rep. Lippert:

The Green Mountain Care Board (GMCB) respectfully writes this letter to accompany the Hospital Sustainability report submitted to the Vermont Legislature per section 4 of Act 159 of 2020. Per Act 159 of 2020 Section 4, the Legislature tasked the Green Mountain Care Board to “*consider ways to increase the financial sustainability of Vermont hospitals in order to achieve population-based health improvements while maintaining community access to services.*”

This work has revealed several concerning trends that threaten hospital sustainability and compromise access to affordable high-quality care for Vermonters. Without intervention, Vermont hospital financial health will likely resume deteriorating, exacerbating the health care affordability crisis and increasing the probability that hospitals will shed essential services and/or potentially close. While COVID-relief funds have been instrumental in keeping hospitals afloat during the pandemic, once these one-time subsidies cease, underlying inefficiencies in the system will continue to challenge hospitals’ abilities to deliver the right care, at the right time, in the right setting, for an affordable price. The result will either be continued deterioration of hospital margins or unaffordable increases in commercial rates and health care premiums. These trends will be intensified by the workforce challenges facing Vermont and their resulting expense pressures. Inadequacy of our mental health infrastructure must also be addressed to ensure hospital sustainability and access to necessary care for vulnerable Vermonters.

The Green Mountain Care Board recognizes the pressures hospitals have been facing throughout the pandemic and appreciates their efforts to care for our communities. However, the time to act is now. Waiting until the pandemic ends only exacerbates the underlying issues and increases the risk of financial crisis and/or compromised access to care. Also, it is critical that we ensure that delivery system reform efforts are aligned and integrated into current state health reform planning for the next Federal agreement. Vermont has an important opportunity now, to redesign care delivery to ensure that Vermonters have access to the care they need, in an appropriate, high-quality setting, at an affordable cost.



We are recommending that the State invest \$2 to \$5 million in one-time funding to:

- 1) design and implement Hospital Global Payments that are predictable, flexible, and sufficient to equitably deliver high-quality, affordable care to Vermonters as recommended by legislative consultant Donna Kinzer;
- 2) support facilitation by health systems optimization experts in a community-engaged redesign of our health care system to reduce inefficiencies, lower costs and improve health outcomes; and
- 3) provide the resources necessary for hospitals and communities to transform Vermont's delivery system.

The success of these efforts will also require appropriate investments in primary care, mental health and Medicaid payments that are sufficient to cover the cost of delivering essential services. In this vein, the Board also recommends supporting DVHA's efforts to align Medicaid reimbursement rates with established rate methodologies that include adjustments for medical inflation. It is also essential that the Board receive timely estimates of Medicaid payments so that it may consider its impact on hospital finances in its review of hospital budgets.

We look forward to working with you, our communities, hospitals, health care providers, businesses, payers, and other key stakeholders to address the financial sustainability of Vermont hospitals and ensure that Vermonters' have equitable access to high-quality, affordable care.

Sincerely,

Kevin Mullin, Board Chair

Jessica Holmes, Ph.D., Board Member

Robin Lunge, J.D., MHCDS, Board Member

Tom Pelham, Board Member

Thom Walsh, Ph.D., MS, MSPT, Board Member



Act 159 Section 4 Report: Hospital Sustainability Planning

February 1st, 2022

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2. Key Findings
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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.”

Goals for Sustainability Planning Framework

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)**.

Project Approach



Part 1 – Analysis of Current State

GMCB hired contractors to analyze hospital prices, costs and cost coverage, as well as capacity, and quality. This paired with insights from regular reporting and analysis of hospital budgets offered a foundation for understanding the current state of hospital financial sustainability.

Part 2 – Hospital Engagement

Initially hospital sustainability required hospitals to provide data, analysis, and commentary on the state of their financial health and their plans for improving their financial sustainability, and preparedness for value-based payment. Due to COVID-19 and the limited capacity of hospitals to take on new work, much of the analysis was performed by GMCB staff and contracted support. Hospitals were engaged throughout the process to weigh in on the data and methodologies underlying key analyses.

Part 3 – Key findings and Potential Paths Forward

GMCB staff presented proposed key findings and paths forward to the Board and solicited feedback during a [public Board meeting on January 21st, 2022](#). A special public comment period was also open until January 28th, 2022. Final recommendations included here aim to improve hospital sustainability, equitable access to affordable high-quality care, preparedness for value-based care, and health care workforce challenges.

Key Findings

Disclaimer!

Though COVID-19 has shifted how we deliver and consume care, it is unclear how many of these changes 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 and incorporate any learnings into future sustainability planning efforts.

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).

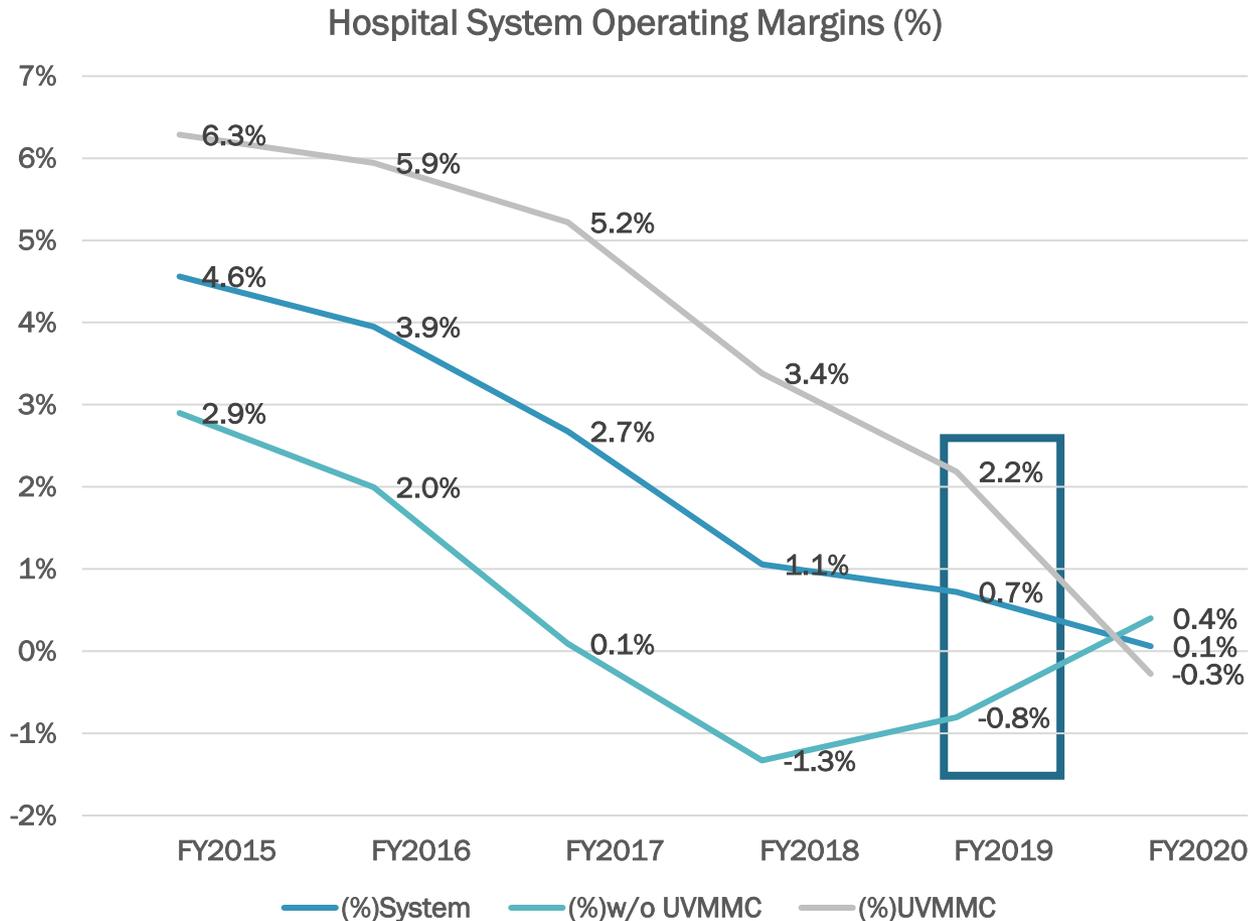
4. Rural Health Services Report, Slides 44-47

Growing Challenges Faced by Rural Hospitals

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

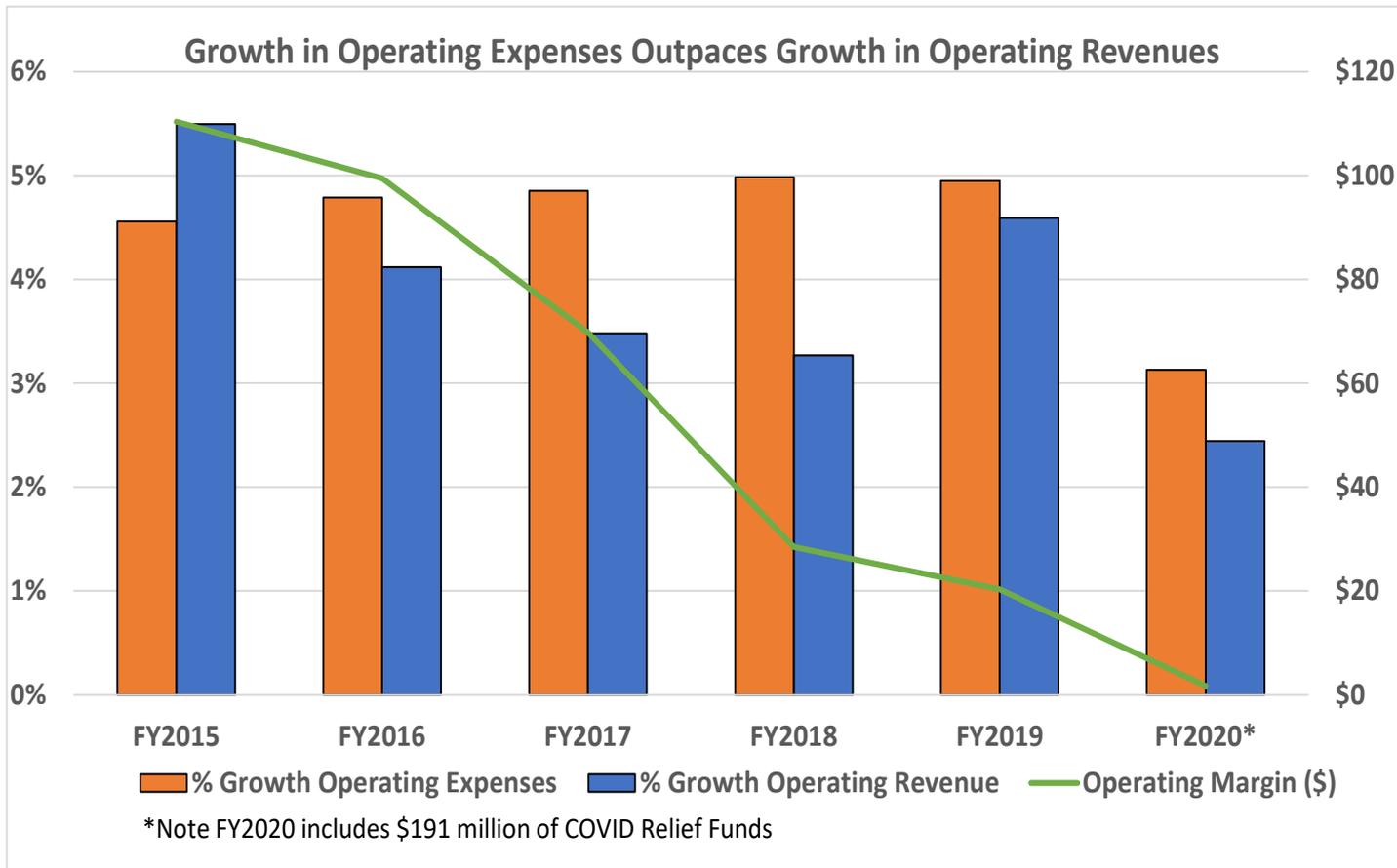
Source: [BRG Presentation October 2021](#)

Vermont Hospital Operating Margins Continue to Decline



*Note FY2020 includes COVID Relief Funds and Expenses

Operating Expenses are Outpacing Operating Revenues



Expense Growth Drivers in 2019

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

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%					

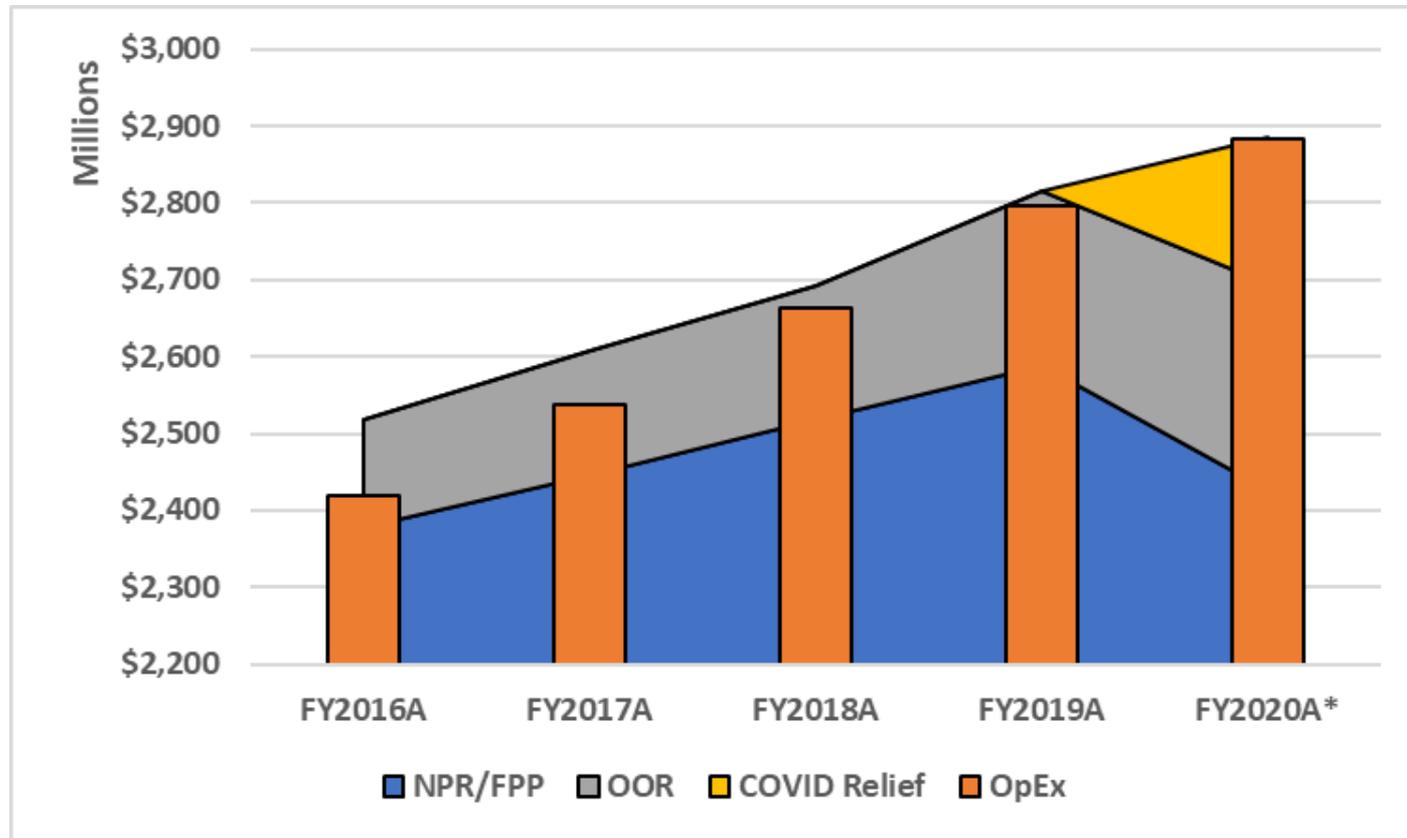
*Note FY2020 includes COVID Relief Funds and Expenses

Hospital Total Margin Looks Better, but Not Sustainable

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



*Note FY2020 includes COVID Relief Funds

Age of Plant: Growing Concern of VT Hospitals

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?

Affordability

In Vermont, hospitals' primary lever to increase operating margin is commercial price, which only exacerbates the existing affordability crisis through its impact on premiums, foregone wages, and out of pocket costs.*

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, such as primary care, mental health, and material health etc.²

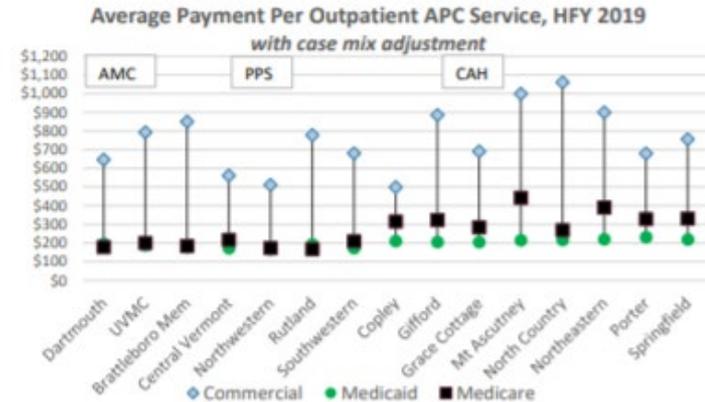
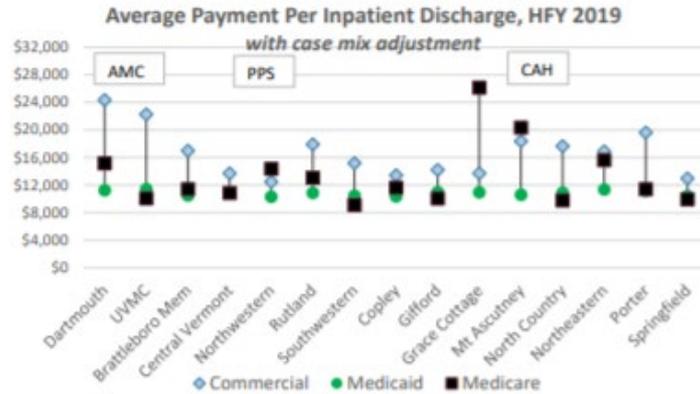
**Employers must often choose to invest more for the similar coverage year over year or reduce benefits.*

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.

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 services, reduced affordability, lower quality, and/or hospital closures, all of which will disproportionately affect the most vulnerable Vermonters. 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.

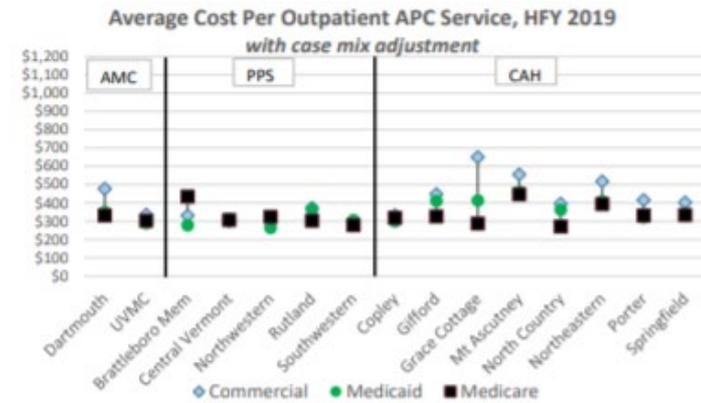
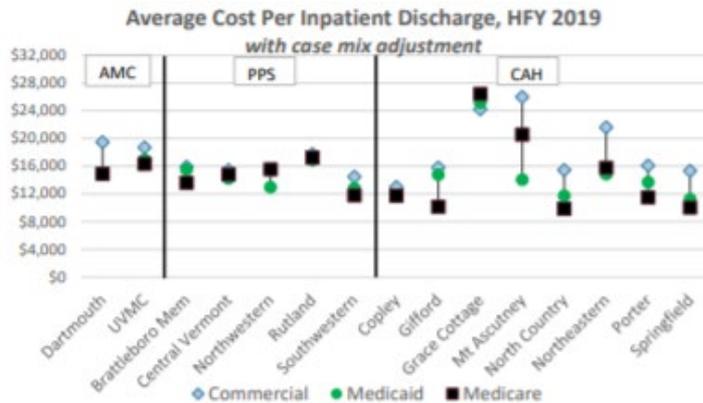
Prices Vary by Hospital, Payer, & Setting



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- For tertiary care centers, Dartmouth is reimbursed more by commercial payers for inpatient services than UVMC while the reverse is true for outpatient services
- Many small hospitals receive higher commercial reimbursements for outpatient services than either tertiary care center (e.g., Brattleboro, Gifford, Mt Ascutney, North Country and Northwestern)

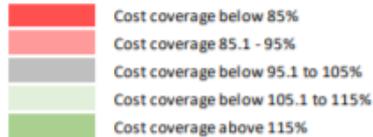
Costs Vary by Hospital, Payer, & Setting



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- There is less cost variation across hospitals for both inpatient and outpatient services
- Where there are cost differences, smaller hospitals tend to be higher than tertiary care facilities. For example, Mt Ascutney, Grace Cottage and Northeastern

Cost Coverage Varies by Hospital, Payer, & Setting



		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	Red	Red	Red	Grey	Light Green	Grey	Light Green	Light Green	Light Green	Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
UVMC	AMC	Red	Red	Red	Light Red	Red	Red	Light Green	Light Green	Light Green	Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
Brattleboro Mem	PPS	Red	Red	Red	Grey	Light Red	Red	Grey	Light Green	Light Green	Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
Central Vermont	PPS	Red	Light Red	Red	Light Green	Grey	Red	Grey	Light Green	Light Green	Light Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
Northwestern	PPS	Red	Red	Red	Light Green	Light Red	Red	Red	Light Red	Light Red	Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
Rutland	PPS	Red	Red	Red	Red	Red	Red	Grey	Light Green	Light Green	Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
Southwestern	PPS	Red	Light Red	Red	Light Red	Light Red	Red	Grey	Light Green	Light Green	Red	Red	Red	Red	Red	Red	Light Green	Light Green	Light Green
Copley	CAH	Grey	Grey	Light Red	Grey	Grey	Grey	Light Green	Light Green	Light Green	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
Gifford	CAH	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
Grace Cottage	CAH	Red	Light Red	Red	Grey	Grey	Grey	Red	Red	Red	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
Mt Ascutney	CAH	Red	Red	Red	Grey	Grey	Grey	Red	Red	Red	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
North Country	CAH	Light Red	Light Red	Light Red	Grey	Grey	Grey	Light Green	Light Green	Light Green	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
Northeastern	CAH	Red	Red	Red	Grey	Grey	Grey	Light Red	Grey	Red	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
Porter	CAH	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green
Springfield	CAH	Light Green	Grey	Grey	Grey	Grey	Grey	Grey	Light Red	Light Red	Red	Red	Red	Grey	Grey	Grey	Light Green	Light Green	Light Green

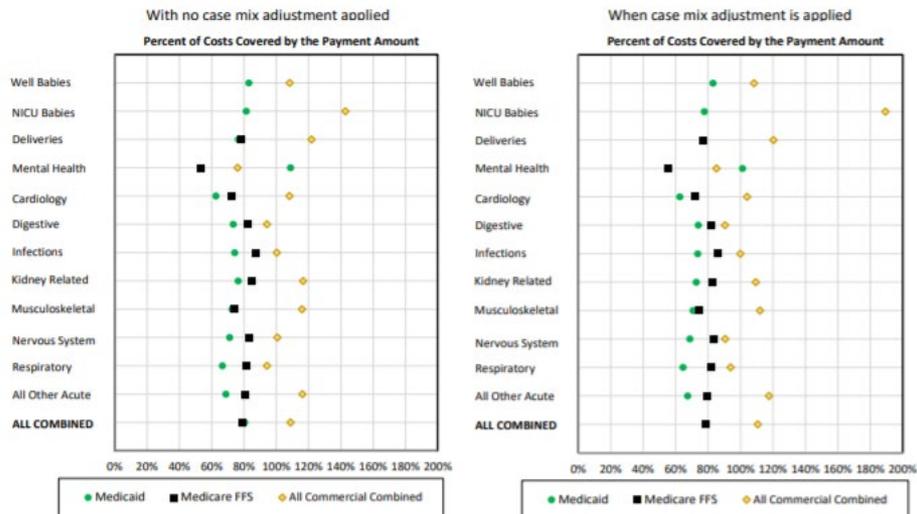
HEALTH MANAGEMENT ASSOCIATES

- Medicaid and in many cases, Medicare, do not cover the current costs of delivering care to their patients.
- Some hospitals like Grace and Mt Ascutney and Northeastern and Northwestern do not have inpatient costs covered by the commercial payers.

Cost Coverage Varies by Services Category

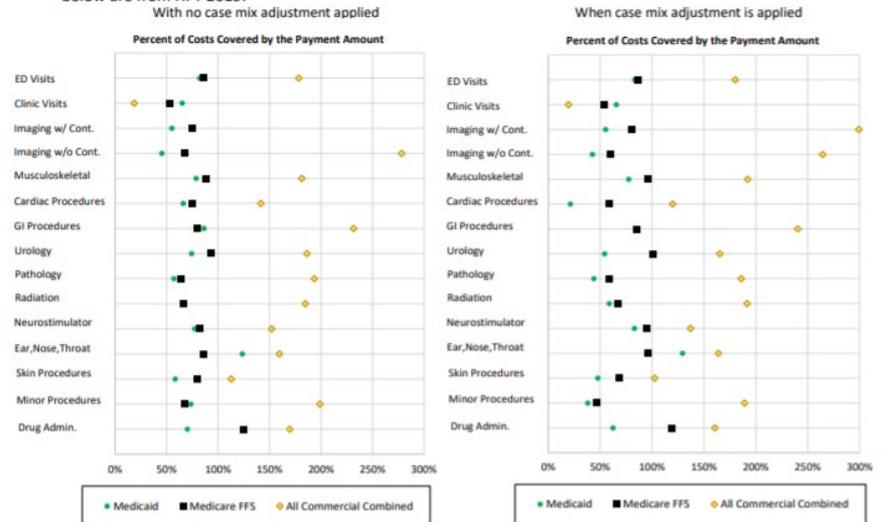
COST COVERAGE BY INPATIENT SERVICE CATEGORY VARIES BY PAYER

Although the variation in percent of costs covered does usually tighten when applying a case mix adjustment, there is still considerable variation in cost coverage at the major inpatient service category level. Results below are from HFY 2019.



COST COVERAGE BY OUTPATIENT SERVICE CATEGORY VARIES BY PAYER

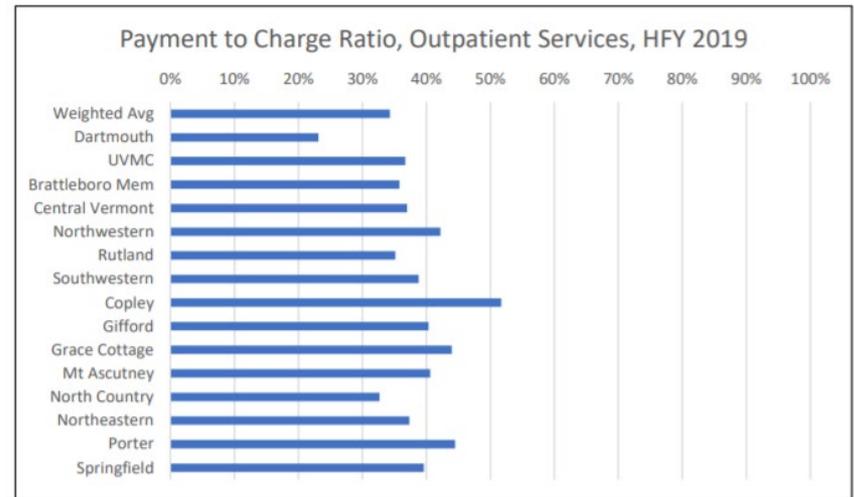
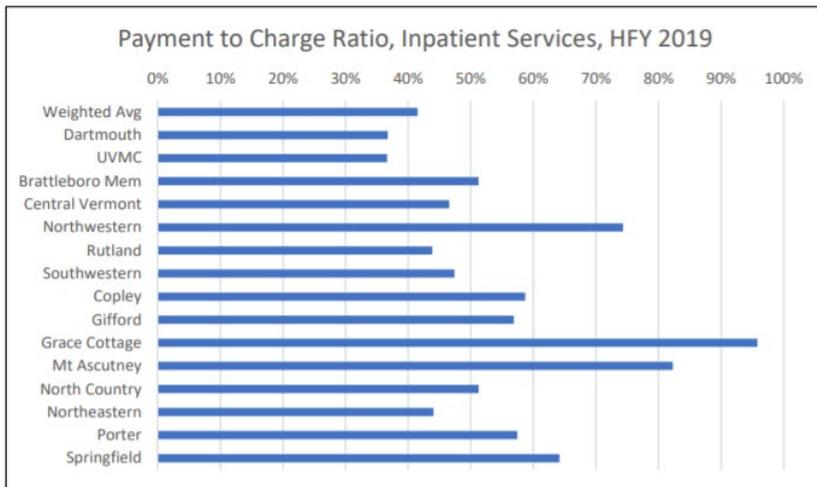
Similar to what was observed for inpatient service categories, there is wide variation in the percent of costs covered by outpatient service category. This is true even after applying a case mix adjustment factor. Results below are from HFY 2019.



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 service, even after controlling for case-mix, and this varies by payer and care settings (inpatient/outpatient). These variations could reflect high fixed costs, care delivery inefficiencies, and/or pricing strategies. 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.

Charges vs. Payments



Key Finding #3

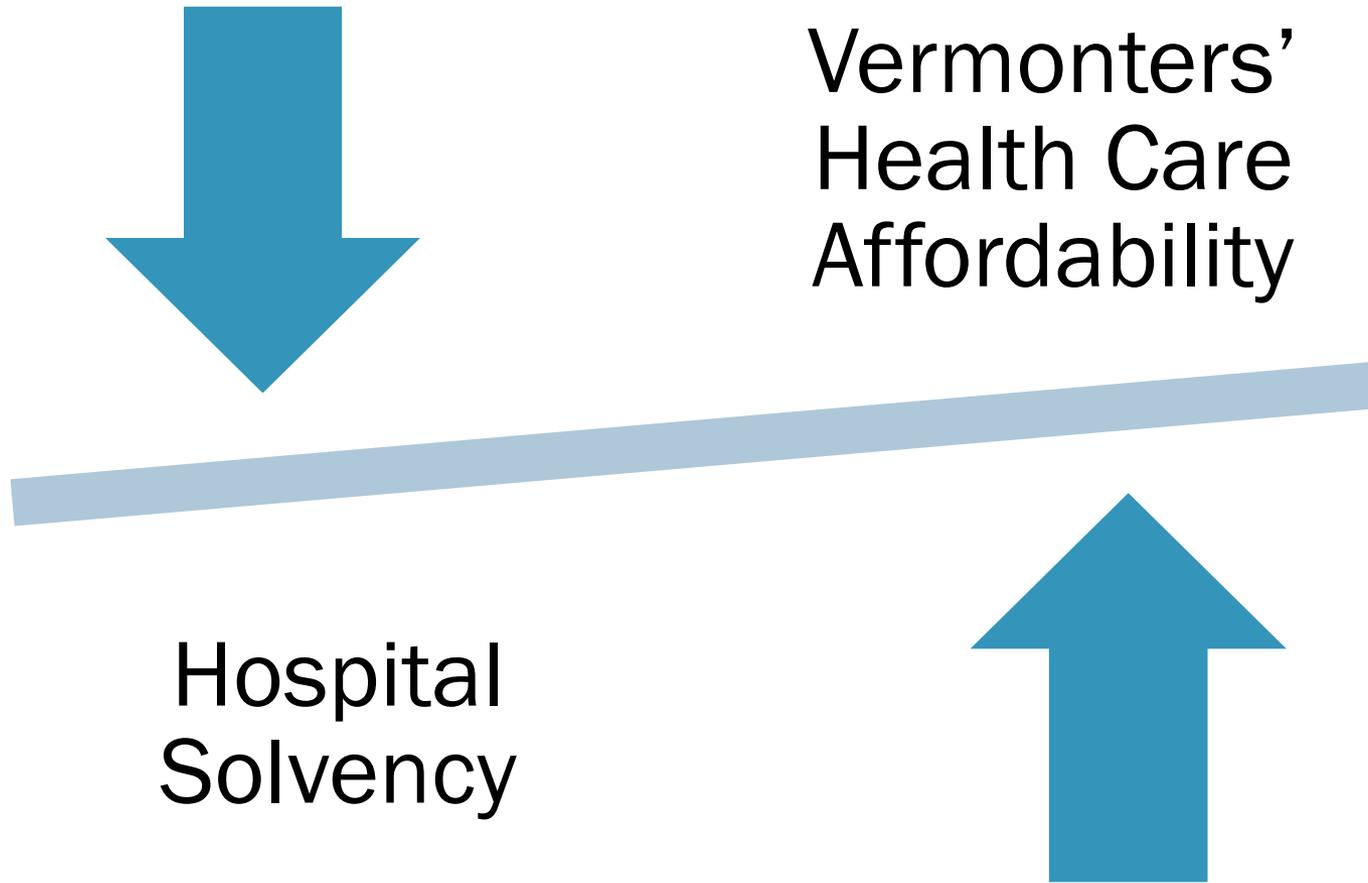
Hospital Price Regulation in Vermont:

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, given the inconsistent and sometimes weak relationship between change in charge and negotiated payments by insurers, regulation of change in charge is not the best way to address affordability.

Hospital Levers to Balance Revenues & Expenditures

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

Hospital Prices: The Tension...



Affordability is a Problem for Vermonters

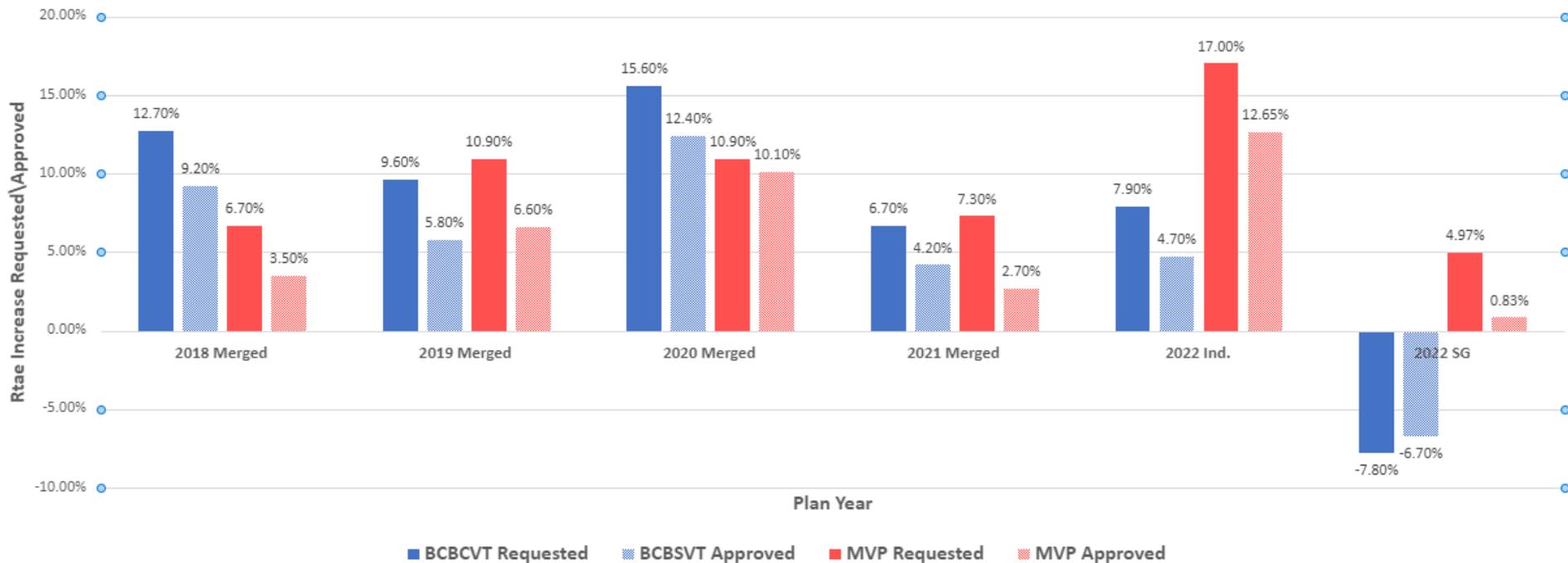


According to the 2018 Household Health Insurance Survey:

- 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.

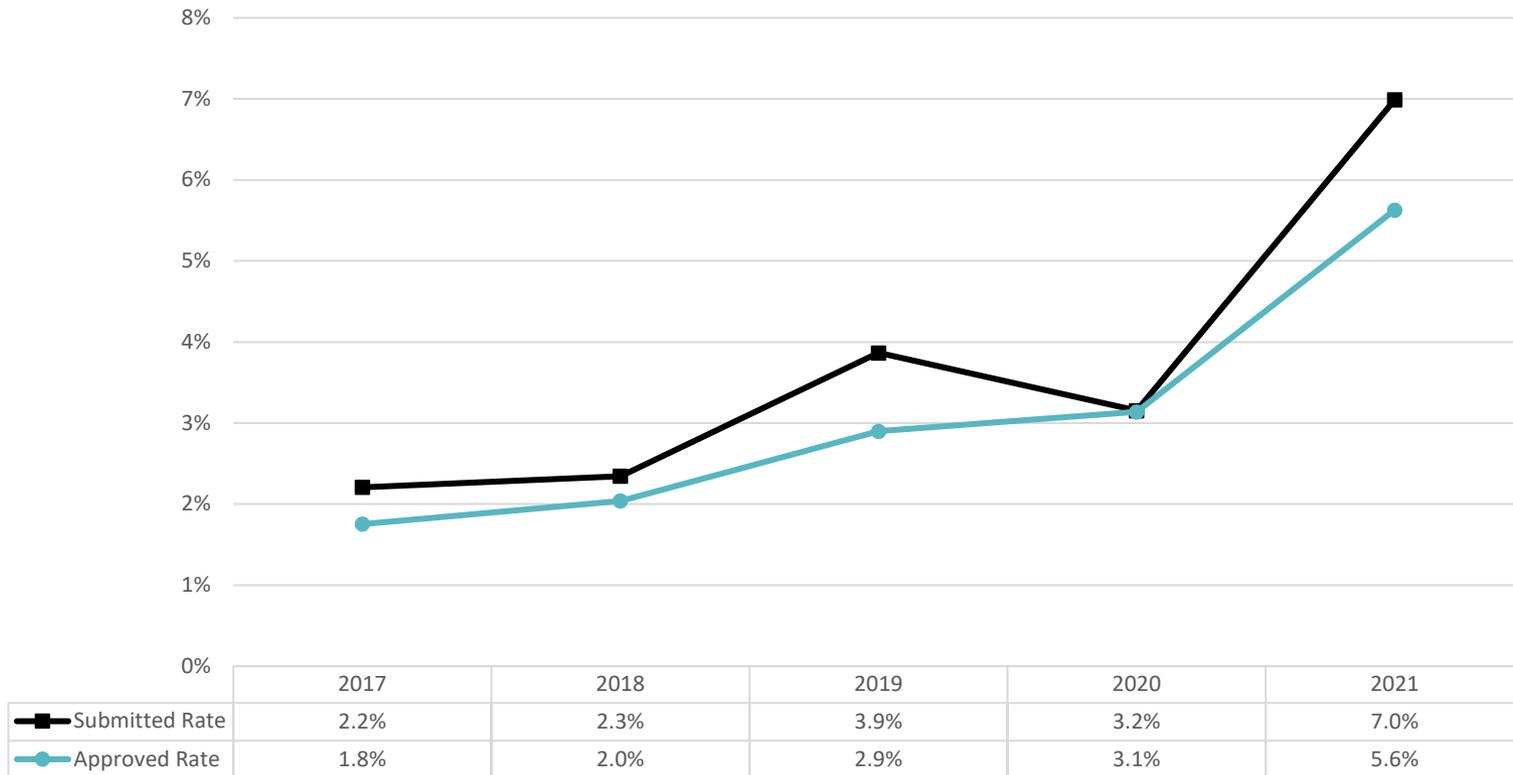
Premium Rate Growth

Vermont Individual and Small Group Rate Increases 2018 - 2022 Plan Years



Hospital Commercial Charges

Vermont Hospitals Estimated Weighted Average Change in Charges 2017 to 2021



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?

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

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 an 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.

Hospital Levers to Balance Revenues & Expenditures

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

What about reducing operational costs?

- 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, particularly as they face declining populations and care is shifted to the outpatient settings¹
 - Recruitment challenges lead to higher staffing costs (*note*, 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 continue to 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 & Low Volumes

- 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 (note, 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

Key Finding #5

Hospital and Systemwide Efficiency: Improving operational efficiency is critical for minimizing wasteful spending, but hospitals will not be able to “cut” their way back to sustainability. Balancing hospital financial sustainability and health care affordability is a systemic issue that requires a systems-oriented solution.

Preliminary analyses suggest that absent COVID demands, Vermont’s care delivery system is over capacity in some areas and under capacity in others. Several Vermont hospitals are operating at low occupancy, some in close proximity to one another. Some are operating high-cost service lines with low volumes (e.g., less than 5 ICU beds). Vermont’s health care system is also lacking sufficient capacity for mental health patients which challenges hospitals’ financial sustainability and operational efficiency.

Taken together, this suggests that hospital and health system infrastructure has not kept pace with community health needs. Projections of Vermont population trends indicate that post-COVID, the mismatch between need and capacity across the state will widen.

Vermont must seize the opportunity to optimize our system of inpatient and outpatient care, create Centers of Excellence, optimally allocate our strained workforce, and ensure adequate access to mental health beds.

COVID has revealed the ability of our health system to rapidly respond to evolving patient needs (e.g. building a makeshift hospital in a week) and meet patients where they are (e.g. telemedicine). Maintaining costly excessive capacity is not necessary, but we must ensure that hospitals have the financial resources required to respond to changing environments.

Hospital Levers to Balance Revenues & Expenditures

Increase Commercial Prices

Reduce Operational Costs
(given current infrastructure)

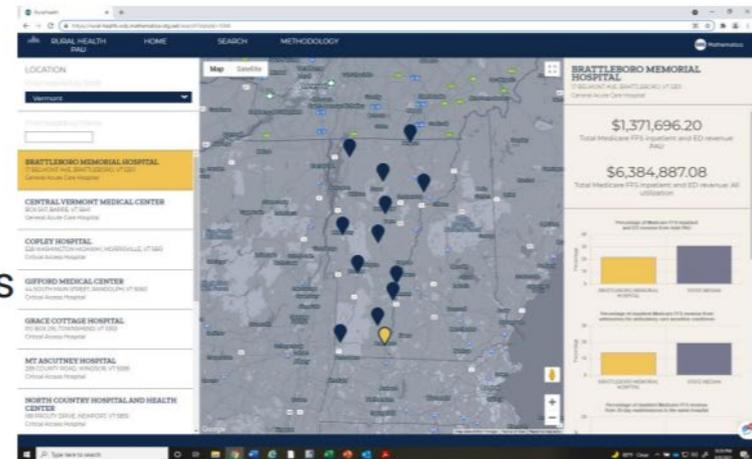
Increase Volume of Profitable Services

What about increasing volume at the hospital level?

- 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
- As avoidable utilization declines, some hospitals will see lower occupancy rates and greater excess capacity.

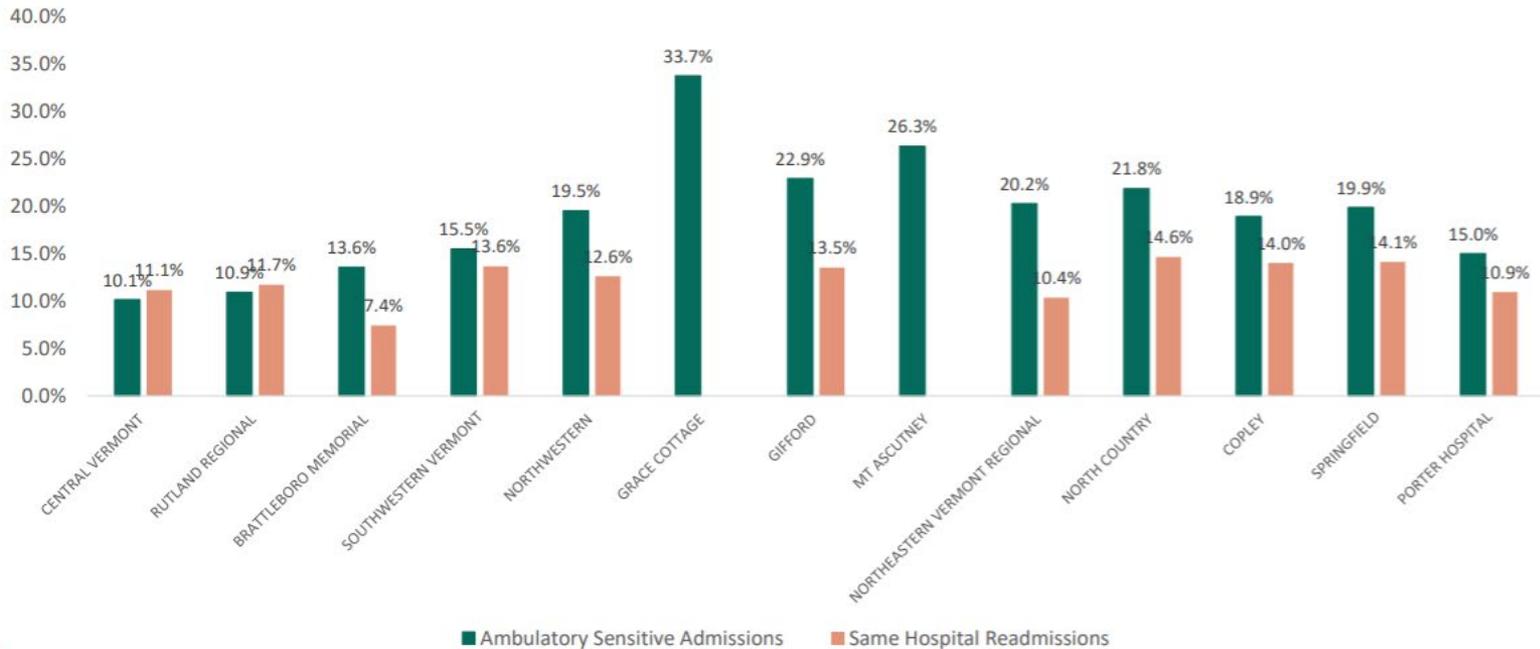
Potentially Avoidable Utilization

- / 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



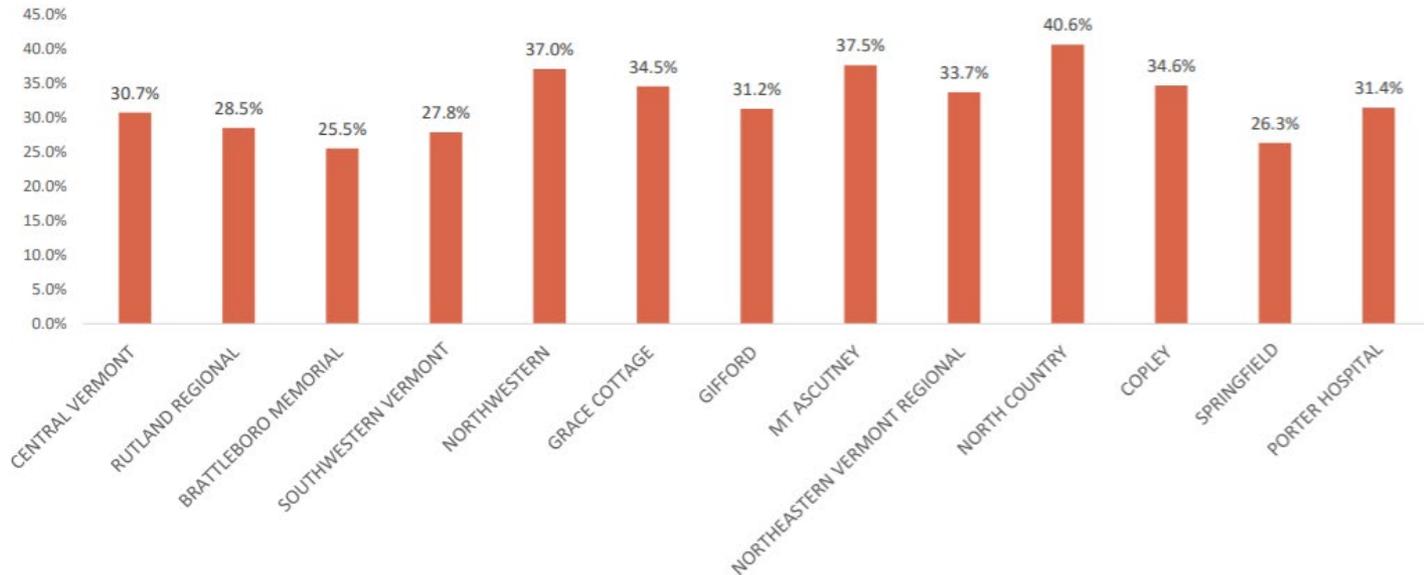
In many VT hospitals, 10% to 34% of inpatient revenue is potentially avoidable

Proportion of Revenue in Avoidable Utilization- Inpatient



In many VT hospitals, 25% to 40% of ED revenue is potentially avoidable

Proportion of Revenue in Avoidable Utilization- Emergency Department



We can improve outcomes and lower costs by reducing unnecessary utilization

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

Increase Commercial Prices

Reduce Operational Costs

Increase Volume of Profitable Services

Support for Value-based Care

“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.](#)



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?

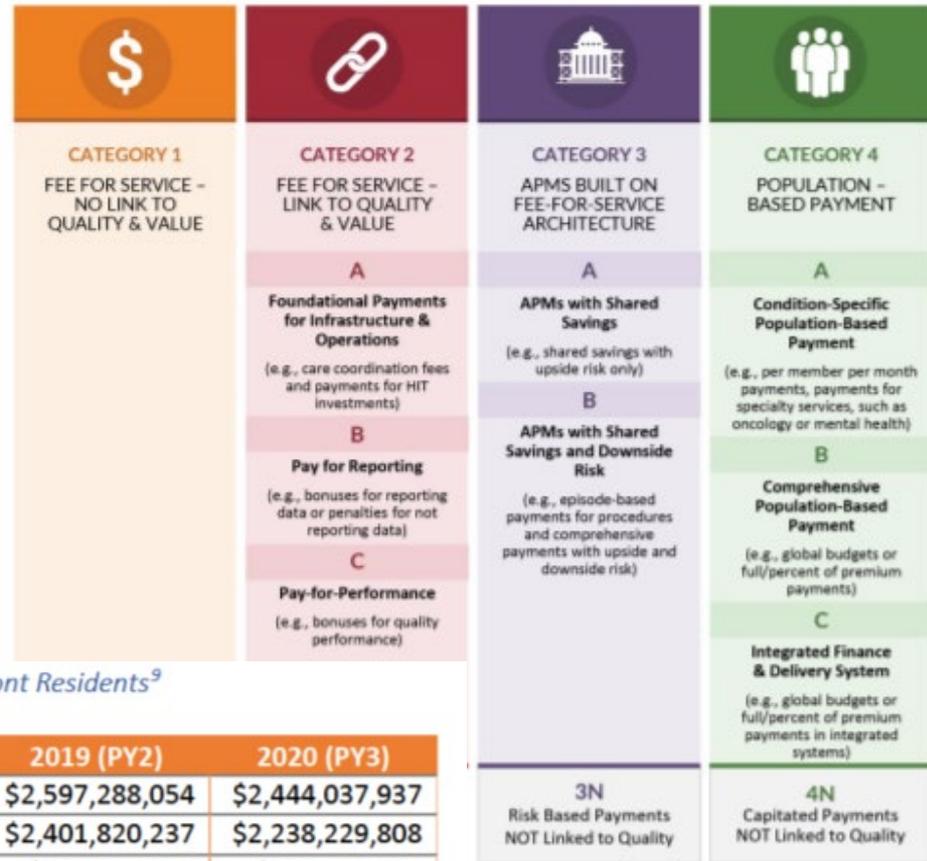


Figure 6: Systemwide Proportion of Value-Based Hospital Revenue from Vermont Residents⁹

	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%

Key Finding #6

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.

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.

Key Finding #7

Quality Improvement & Measurement: There are likely opportunities to improve the quality of care being delivered to Vermonters. For example, for some services, volumes may not be sufficient to guarantee the delivery of high-quality care. In addition, Vermont hospitals' rate of potentially avoidable admissions is above 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.

Key Finding #8

COVID-19: While it is evident that the pandemic has shifted how care is delivered and consumed, it is unclear how many of these trends are temporary or permanent. Care patterns from 2020, 2021, and potentially 2022 are skewed by disruption and pent-up demand from the pandemic. For this reason, analysis of long-term trends must focus on years prior to the pandemic, with a recognition that data and analyses may need to be updated as this pandemic becomes endemic. Despite these challenges of uncertainty, future sustainability efforts should reflect critical learnings from the pandemic:

1. Reliance on volume for reimbursement threatens financial health of hospitals during a public health crisis; stable and predictable funding streams sustain a diversity of health care providers
2. Health systems have demonstrated a remarkable ability to quickly pivot to meet public health needs (e.g., build a makeshift hospital in a week, scale up ICU beds, accelerate widespread telemedicine access, etc.).

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

1. Without tackling underlying inefficiencies, Vermont hospitals' financial health is likely to deteriorate after federal relief funds cease. This is problematic because it (1) exacerbates the health care affordability crisis and (2) increases the probability of hospital closure, most likely to threaten access to care for the most vulnerable Vermonters. The time to act is now.
2. Vermont has an opportunity to redesign care to ensure that Vermonters have access to the care they need, in an appropriate, high-quality setting, at an affordable cost.
3. Completing hospitals' transition to value-based payment models (e.g. global payments) will enable hospitals to make the changes they need to ensure the equitable delivery of high-quality affordable care to Vermonters.

Recommendation #1: Accelerate Shift to Value-based Payment & Delivery

Hospital Global Payment

1. Preserves Vermonters access to essential services by establishing a sustainable funding stream for hospitals, particularly for lower volume facilities
2. Eliminates “two canoes” and shifts hospital focus from volume to value
3. Allows hospitals greater flexibility to deliver care in more innovative ways
4. Offers a glide path for transitioning to value-based payment and care delivery

Community Transformation

1. Ensure hospital budgets reflect the efficient delivery of high-quality care (e.g. promote delivery system organization around centers of excellence)
2. Provides a real opportunity to improve health care affordability and quality, and expands Vermonters’ equitable access to such care

Recommendation #1: Accelerate Shift to Value-based Payment & Delivery



How?

Invest \$2 to \$5 million in one-time funding to design and implement...

1. Hospital Global Payments embedded within Hospital Budget and ACO Regulatory Processes
 - i. Design predictable, flexible, and sufficient global payments to hospitals, regardless of payer, to equitably deliver high-quality, affordable care to Vermonters.
 - ii. Negotiate with CMS to include Medicare in the global payment and Vermont care transformation initiatives.
2. Community Care Delivery Transformation
 - i. Facilitation – expert(s) in health systems optimization to facilitate community/regional redesign to ensure access, lower cost, improve quality and assist with workforce challenges and identifying opportunities for centers of excellence throughout the state.
 - ii. Technical Assistance - support hospitals/communities in change management following redesign.

Recommendation #2: Incorporate quality into the hospital budget process



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

How?

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

Recommendation #3: Ensure sustainable Medicaid payments

How?

1. Support DVHA's FY23 efforts to professionalize Medicaid reimbursement methodologies and appropriate necessary funding.
2. Analyze potential enhancements to budgeting process (e.g., 32 V.S.A. § 307(d)) to consider medical inflation and sustainability.
3. Ensure timely reporting from DVHA to GMCB of any Medicaid impacts on hospitals to ensure hospital budget process incorporates appropriate Medicaid assumptions.

Appendix

Resources & Related Board 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](#): GVCB 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
- [Rural Health Services Task Force](#): January 15, 2020



January 31, 2022

Ms. Susan Barrett
Executive Director
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

RE: Responses to Hospital Comments on Capacity and Quality Analyses

Dear Ms. Barrett,

Thank you for the opportunity to respond to the comments submitted by the Vermont hospitals and various stakeholder groups regarding Berkeley Research Group's (BRG) capacity and quality analyses. BRG found the comments to be thoughtful and demonstrated a strong interest in the work of the Green Mountain Care Board (GMCB) in these areas.

In order to adequately respond, BRG reviewed comments submitted by the following organizations:

- University of Vermont Health Network
- Vermont Association of Hospitals and Health Systems
- Mt. Ascutney Hospital and Health Center
- Brattleboro Memorial Hospital
- Copley Hospital
- North Country Hospital
- Springfield Hospital
- Northwestern Medical Center
- Southwestern Vermont Medical Center
- Gifford Medical Center
- Vermont Program for Quality in Health Care, Inc.

BRG would like to provide additional information in two key areas that may support GMCB's future work regarding hospital sustainability:

- Response to stakeholder comments
- Considerations for future policy development

Response to Stakeholder Comments

In addition to reviewing the specific comments from individual organizations, BRG would like to respond to some overarching themes contained within them:

- **Questions and comments regarding the cost analysis completed by Burns & Associates.** Several of the comments submitted by the hospitals related to the cost analysis completed by Burns & Associates. These comments were outside of the scope of

BRG's engagement. These comments may be separately addressed by Burns & Associates or GMCB staff at a future date.

- **The capacity analysis did not account for 2020 Census data.** BRG utilized Claritas data for the future capacity projections. Claritas' methodology supplements data from the Census Bureau with various other sources, including internal data, data from other government agencies, the United States Postal Service, and private organizations. The most recent American Community Survey data reflected in the Claritas data utilized for this analysis were from 2018. Claritas plans to include the updated Census information in its 2022 release but the exact date for the release has not been confirmed. BRG would recommend potentially refreshing the projections analysis utilizing the 2022 Claritas release once available.
- **Impact of Dartmouth-Hitchcock expansion.** BRG acknowledges the potential impact on the projections based on the proposed expansion of Dartmouth-Hitchcock and agrees that the expansion should factor into any future capacity planning discussion for Vermont's hospitals. Additional information and analysis are needed, however, regarding the current usage of Dartmouth-Hitchcock by Vermont's residents, the services planning to be offered as part of the expansion, and the potential for out-migration.
- **The analysis did not take into account other factors such as initiatives in value-based care, hospital-specific quality improvement strategies, etc.** BRG acknowledges that it did not have insight into each of the initiatives that the hospitals are undertaking, including plans for future expansion or service line changes. BRG is providing the capacity and quality analyses to GMCB as components of a broader discussion with the hospital industry regarding future facility disposition and needs across the state.
- **Use of the term "bypass" in discussing in vs out of Hospital Service Area (HSA) utilization.** BRG reviewed the utilization of inpatient services by Vermont residents within each of the HSAs. The goal of the analysis was to determine the extent to which patients utilized their local hospital vs travelling outside of their HSA, or potentially the state, to seek services. "Bypass" was used to refer to patients that chose not to utilize the hospital within their HSA and instead seek care elsewhere. A December 2020 report for the Centers for Medicare and Medicaid Services (CMS) entitled *Examining Rural Hospital Bypass for Inpatient Services* cited specific potential reasons for this occurrence:
 - Rural patients often cite limited services and lack of specialty care as reasons for bypassing their local rural hospital.
 - Across inpatient and outpatient admissions, patients are more likely to access care nearby for emergency and urgent care than for elective or scheduled care.
 - Smaller hospitals (i.e., hospitals with fewer beds), less profitable hospitals, and those closer to larger hospitals were associated with higher bypass.¹

¹ <https://www.cms.gov/files/document/ruralhospitalbypassfinalreport.pdf>

BRG believes that patient behavior, including the potential for rural bypass, should be considered by GMCB when making decisions regarding future hospital need.

- **Licensed vs staffed beds for the analysis.** BRG used publicly available data and data provided by GMCB staff to complete the capacity analysis. The data was limited to the licensed bed numbers included in Medicare cost reports. Although Vermont’s hospitals currently report staffed bed capacity, additional discussion between GMCB and the industry would be helpful to standardize definitions and reporting requirements. BRG would like to highlight a couple of points, however, regarding the analysis using licensed beds:
 - Significant differences between licensed beds and staffed beds, e.g. the number of staffed beds is dramatically lower than the licensed bed amount, can indicate unnecessary fixed costs that are remaining at the hospital. If a hospital is consistently staffing significantly below the licensed bed amount, this area should be explored further.
 - Hospitals typically staff to census to meet patient demand. BRG reviewed the Average Daily Census (ADC) at the facilities to inform its capacity analysis and to identify potential areas of opportunity. Low ADC raises concerns regarding the fixed cost structure at the facility and the clinical quality of care being provided.
- **Use of Prevention Quality Indicators (PQI) as an appropriate measure.** The Agency for Healthcare Research and Quality (AHRQ) uses PQIs to “identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge. More specifically, the PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality outpatient care.”² Given Vermont’s concerted efforts to move toward population health, including the implementation of OneCare Vermont as an Accountable Care Organization for the State, BRG believes that PQIs are a relevant measure to track and report. It is also important to note that the majority of HSAs are only served by one hospital, allowing for the tracking of PQIs at a population level.
- **CMS Star Ratings vs other quality methodologies.** Many of the comments BRG received concerned the use of CMS Star Ratings as an appropriate measure of quality for the hospitals. BRG supports the use of CMS Star Ratings as a directional view of hospital quality in the absence of more robust hospital quality data reporting. BRG believes, however, that additional hospital quality data reporting that supports Vermont’s healthcare delivery efforts should be explored. Hospital quality reporting should also be one piece of a comprehensive quality reporting program that supports population health initiatives across the care continuum.

² https://qualityindicators.ahrq.gov/modules/pqi_resources.aspx#techspecs



Considerations for Future Policy Development

Based on BRG's analysis and engagement with GMCB, BRG would also recommend that GMCB consider two additional areas that may assist with future policy development:

- Data collection and reporting
- Stakeholder engagement

Data Collection and Reporting

The goal of data collection and reporting is to develop a comprehensive understanding of the entire capacity and quality of the healthcare delivery system. This is especially important as Vermont's providers participate to a greater extent in value-based payment models that reward reduced cost and improved quality across the care continuum.

GMCB and the hospital industry should collaborate to standardize data definitions, establish a routine cadence for submitting data, and provide a robust feedback loop between the regulator and industry. Any data reporting requirements need to be weighed against the potential administrative burden placed on the providers. All efforts should be made to utilize claims and encounter data, supplement with clinical quality data as practicable, and automate reporting to the extent possible.

Examples of additional data collection and reporting that could support GMCB's policy efforts include:

- Additional hospital data, including staffed bed capacity.
- Clinical quality data (electronic medical records).
- Aggregation of data that is voluntarily submitted by providers to other agencies (for example the Critical Access Hospitals submit to the Medicare Beneficiary Quality Improvement Project).
- Detailed data on outpatient and ancillary services to provide a comprehensive picture of hospital utilization and how it changes over time with changes in technology and clinical capabilities.

Stakeholder Engagement

As evidenced by the extensive comments submitted by Vermont's hospitals and other stakeholders, there is great interest in the work of GMCB and the policy decisions that it will be making over the next several years. GMCB staff and leadership would benefit from ongoing and consistent engagement with the hospital industry and other key stakeholders going forward. Joint workgroups comprised of GMCB staff, other governmental stakeholders, and hospital leadership should be considered around specific topics. This will likely require additional resources for GMCB and a strong commitment from the hospital industry to participate as these workgroups, while beneficial, consume additional staff time and resources.



Examples of potential stakeholder workgroups include:

- **Care Delivery.** Creating an ongoing forum for clinical leadership to meet, share best practices, and make recommendations to GMCB leadership could be helpful to drive improvements in Vermont's healthcare delivery system. The group could be tasked with reviewing innovative clinical delivery models such as hospital at home and making recommendations to state policy makers regarding their potential application in Vermont.
- **Quality Improvement.** GMCB should consider creating a regular forum for quality executives to discuss federal and state quality initiatives, including reviewing data across hospitals, and to make recommendations regarding future programmatic changes. This group could consider how to appropriately use federal quality programs while supplementing with Vermont-specific initiatives.
- **Payment Methodologies.** With the move to greater participation by Vermont's providers in value-based care models, it will be critical to develop payment methodologies that align with and promote changes to care delivery. Consistently engaging with financial leadership from the hospital industry to develop payment models that support this transition will greatly aid this effort, creating additional transparency between GMCB and the providers and allowing GMCB to leverage the intellectual capital of the provider community.

Conclusion

BRG appreciates the feedback from the organizations within Vermont and believes that ongoing engagement between GMCB and the hospital industry will lead to successful longer-term planning for the future healthcare needs of the citizens of the state. If GMCB or other interested stakeholders have any questions or concerns, BRG is available to participate in additional discussions upon request.

Sincerely,

Patrick Dooley

Director, Clinical Economics