VERMONT LEGAL AID

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June 3rd, 2024

Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Office of the Health Care Advocate Comments on Methods for Vermont Hospital Global Payment Program (v1)

Dear Chair Foster and Members of the Green Mountain Care Board,

The Office of the Health Care Advocate (HCA) provides the following high level and technical comments on the Methods for Vermont Hospital Global Payment Program (v1) draft. We thank the Board and its contractor – Mathematica, Inc. – for their work on this draft.

The HCA has several foundational concerns with the current version of the draft. It is notable and disappointing that the objectives and goals of the model establish no theory of change for how the model will address "needs regarding hospital transformation and health care affordability and quality." A prerequisite for any meaningful theory of change would require first defining terms such as affordability and access and how to measure them, which does not appear to be attempted in the current draft. As with the last All-Payer Model, delivering any measurable benefit to Vermonters is not stated as a goal let alone identified as a metric for success. The HCA strongly advocates for clearly outlining a theory of change for how the model will attempt to improve affordability and access for Vermonters, a timeline for how this will be achieved, and a method for evaluating what constitutes success with corresponding metrics. It is unacceptable to ask Vermonters to support yet another complex federal "reform" model that does not consider or speak to the now well-documented challenges they have been facing to get the right care at the right time. Additionally, any model that does not consider the negative impact of the fact that the state's only tertiary care academic medical center is now among the most expensive in the nation is certain to fail to meaningfully address the worsening affordability and access crisis in Vermont.

If an assumption of the model is that global payments will provide greater financial stability for hospitals to invest in population health, the program must require clear mechanisms for accountability and evaluation to ensure funds are allocated as intended. The current model does not have the enforcement and accountability mechanisms necessary to achieve this goal.

Though not specifically called out in the paper, the HCA also continues to question the decision to codify total cost of care (TCOC) targets by executive order as identified in the state's AHEAD application. Executive orders follow a process that is structurally non-transparent and unresponsive

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to Vermonters. As has been argued previously, Vermont's AHEAD application process should be conducted in public view as much as possible. Additionally, while the HCA supports approaches that maximize drawing down federal dollars for Medicare for the state, it is vital that the state does not consider an approach for commercial payers and Medicaid. Increased drawdowns from those "payers" will have disproportionate negative impacts to the state budget and Vermont consumers.

The HCA provides the following technical comments and recommendations on the draft below:

- It is misleading to state that the GMCB has set a cap on net patient revenue (NPR) and fixed prospective payment (FPP) growth, as it has historically only adopted guidance on these metrics and hospitals routinely exceed them without enforcement. It is also misleading to state that the Board has "required" hospitals to reduce their expenses - this has never been clearly delineated in any budget order (Page 5).
- Calculating prospective global payments for the first performance year (PY) using revenue from the historical baselines without considering evaluating hospital prices in excess of Medicare breakeven for commercial or establishing any metric of hospital efficiency guarantees baking in excess system costs that will be borne largely by Vermonters (Page 7).
- In their totality, it is hard to understand how a model with at least fifteen adjustment types (of which the vast majority are upward, and none are as exclusively downward) attempts to slow health care cost growth and/or improve affordability (Page 9-10, Table 3).
- Regarding "exception-based factors" having an adjustment on a "case by case basis," it remains unclear what year the adjustment would apply to and/or how this would impact future base calculations. Regarding "Vermont health care delivery reform investment," it is imperative that these investments for "improving access to care and delivery reform" are tracked and it is clearly established what qualifies as being "access to care" or "delivery reform." Such specificity is critical because there is a major distinction between money flowing to, for example, stand-up mobile outreach clinics for migrant farmworkers versus staffing a vice president of revenue cycle management position at a billing office (Page 9-10, Table 3).
- Clarify what qualifies as an "exogenous factor" and what does not (Page 15, 5.2.1).
- Establish a method to track whether investments map to intended purpose (Page 16, 5.3.1).
- Recommend adding compliance with Act 119 to scoring criteria for transformation (Page 16-17, 5.3.2).
- Adjustments to social determinants of health (SDOH) factors should align with time of implementation rather than past observed variation (Page 19, 5.4.3).
- Clarify whether core-based statistical areas (CBSAs) cover all Vermont counties (Page 20).

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- Given that this SDOH measure is of actual patients it would be prudent that this measure be slightly different, as it relates not to who is served by the hospital but rather a comparison of who is served relative to the underlying population. The HCA also recommends incorporating free care normalized by gross patient care revenue into table 11 as it provides a rough measure of economic equity (Page 22, Table 11).
- Clarify what is meant by distance and travel as Vermont's specific geography and relative lack of public transportation impact any definition of "access" (Page 25, 5.4.2.1.1).
- Clarify what qualifies for "adjustments" in the "Other" category. Does this mean payment rate changes, and if so, is it payments for a given service or average payment of all services at the hospital? If payments were to increase, would the state initiate a downward adjustment (Page 27, 5.4.4)?

Thank you for your consideration.

Sincerely,

s\ Sam Peisch
Health Policy Analyst, Office of the Health Care Advocate

s\ Eric Schultheis
Staff Attorney, Office of the Health Care Advocate

s\ Emma Zavez
Consumer Research & Health Policy Analyst, Office of the Health Care Advocate

s\ Mike Fisher
Chief Health Care Advocate, Office of the Health Care Advocate