Rutland Regional Medical Center
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June 4, 2024

Mr. Owen Foster, Chair
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Dear Chair Foster,

In response to the draft Vermont Medicare Hospital Global Payment Design Methods Paper, Rutland Regional Medical Center would like to express the following feedback:

Governance
The approach outlined in the draft methods paper centralizes the governance structure within a single body. While this approach may have a positive impact of greater efficiency, in this instance, efficiency does not lead to the greatest likelihood of achieving equity, inclusiveness in the process, diversity of voices, and comprehensiveness of the oversight process.

Global Payment Cycle Timeline
Incorporating the proposed IPPS rules into the current budget timeline is impractical since it would be based upon only 90 days of runout data. This timeline provides, approximately, one month to formulate a revenue budget and identify potential expense reductions to achieve an acceptable margin, all before presenting the budget to hospital boards in June for submission to the state by July 1st. Additionally, integrating the final IPPS rule into a post-submitted budget process undermines the principle of predictability. It does not provide hospitals with adequate time to adjust their expenses or to seek board approval for necessary adjustments prior to the commencement of the next fiscal year. Such an approach compromises the financial planning process, making it challenging for hospitals to maintain fiscal responsibility and strategic foresight.

Pass Through Payments
Allocating Medicare shared savings to finance the Blueprint CHT program is not an optimal approach. Instead, the funding for this program should be sourced from the substantial savings accrued due to Vermont's status as a low-cost Medicare state. The millions of dollars saved through efficient Medicare spending in our state should be redirected to support the Blueprint CHT program. Redirecting these funds would ensure they are utilized in a manner that aligns with the intended purpose of cost-efficiency and healthcare improvement.

Exception Based Factors
It is crucial to recognize that adjustments need to be timely and contemporaneous with the budget cycle to ensure fiscal responsibility and operational consistency. Delaying the implementation of adjustments until PY2 does not account for the immediate financial realities faced by providers in PY1. This delay could result in significant budgetary discrepancies and challenges, causing potential detriment to hospital sustainability. Therefore, it is imperative that any adjustments be considered and incorporated within the same performance year. We would also appreciate

clarification as to the requirement for CMS approval regarding service line changes. The timeline for approval is critical for hospitals to better understand in order to ensure thoughtful planning and implementation.

Transformation Incentive

The transformative changes being implemented require a more substantial incentive to properly reflect and support these efforts. Moreover, the transformation incentive should be greater than 1%, because this minimal amount (approximately $500,000 annually over a two-year period for RRMC), does not adequately account for the significant resources and efforts that will be invested throughout this initiative. A higher percentage is warranted to ensure the program's success and long-term sustainability.

Vermont Health Care Delivery Reform Investment

While we agree that it is essential that Vermont seek additional funding to support healthcare delivery reform initiatives, we believe that the criteria used to evaluate the effectiveness of each initiative should be broadened to include impacts on access to care, including current wait time reporting. Access to care impacts would strengthen the criteria already listed that includes, community partnerships, Act 167 and affordability impacts. We also believe that if a healthcare delivery reform project requiring funding for building, infrastructure, or equipment is approved, the Certificate of Need process should be waived for the respective project.

In addition to investments in health care delivery, rates negotiated within the AHEAD Model should address the lack of sustainability in the hospital healthcare system. A portion of Vermont hospitals annually lose significant money on our Medicare population and this funding is critical so ensure long-term hospital viability across the State. Additional Medicare funding would also support the affordability concerns with commercial insurers, in that commercial insurers would not be positioned to subsidize Medicare losses to the extent they do today. This is important to keep Vermonters in the State receiving care.

Total Cost of Care

We believe that the current framework, which ties payment adjustments exclusively to the relative increase in primary care and preventive services, may overlook the broader impact of hospital-led initiatives on overall cost efficiency. Focusing solely on this proportion, especially in situations where hospitals do not control primary care, risks undervaluing the substantial gains achieved through improved hospital and specialty care efficiencies. While we support the state's goal of enhancing primary and preventive care, we recommend broadening the assessment and payment adjustment criteria to account for the multifaceted efforts of hospitals in reducing the total cost of care. By doing so, we can better align incentives with the diverse strategies hospitals employ to achieve cost efficiency and improve patient outcomes. This inclusive approach would ensure a more accurate and comprehensive reflection of a hospital's contribution to cost containment and quality care.

Effectiveness & Efficiency

Implementing such reductions without considering the broader context of hospital operations, quality patient care, and the unique challenges faced by healthcare providers will likely have detrimental effects on patient outcomes and access to care.

One of the greatest issues and drivers of potentially avoidable utilization, and therefore lack of effectiveness and efficiency, is the lack of resources, especially as it relates to bed availability. Tertiary care facilities, long-term care facilities, and residential treatment centers, collectively, have limits on access and bed availability that result in delays and boarding of patients in acute care hospitals and well as increased demand for emergency room services. This prevents patients from receiving the timely, accessible care they deserve.

Payment reductions must be justified by a thorough evaluation that accounts for the complexities of healthcare delivery. This evaluation must ensure that any changes implemented do not compromise patient safety or hinder hospitals from fulfilling their essential role and obligations in the community. Merely reducing payments based upon arbitrary risks in organizational metrics undermines the integrity of the healthcare system and has a high likelihood of undermining effective and quality care for Vermonters.

Service Line Adjustments

Increase Access – Critical aspects of healthcare delivery and patient care have a high risk of being overlooked if decision-making is only reliant upon the input of a single consultant or by prioritizing social needs over healthcare needs in community health needs assessments. It is essential to consider a comprehensive range of factors, including clinical expertise, evidence-based practices, and the specific healthcare needs of a specific community when determining which service lines should be established by hospitals. Furthermore, mandating preapproved service lines without sufficient consideration for the unique circumstances and capabilities of individual hospitals could undermine their ability to provide high-quality, individualized care to their communities.

Closures – While we recognize the state's legitimate interest in evaluating essential service lines for communities, we are concerned that granting the state authority to dictate which service lines a hospital may close not only undermines the principle of local control and the free market but imposes an undue burden and restrictions on healthcare providers' ability to adapt their services to meet the evolving needs of their communities. We believe it is essential to not understate the importance of delineating between governance, which focuses on strategic oversight and policy development, and operational management, which involves day-to-day decision-making and resource allocation within the organization. We can ensure hospitals retain the flexibility and autonomy necessary to effectively respond to the dynamic healthcare landscape by respecting this important boundary, while also maintaining accountability and transparency in governance processes.

Market Shifts – Conducting periodic market shift assessments to evaluate payment adjustments for hospitals every three years is too infrequent and insufficient to ensure ongoing alignment with evolving market dynamics and healthcare trends. We recommend conducting such assessments, at minimum, on an annual basis. Conducting these assessments too infrequently will have a detrimental impact on hospital finances, as hospitals may find themselves financially responsible for caring for patients without the necessary revenue to support the infrastructure to account for their needs. This imbalance will strain hospital resources and compromise the delivery of high-quality patient care. Therefore, regular, timely assessments are essential to ensuring hospitals receive fair, equitable, and adequate compensation for services rendered; further resulting in the safeguarding of financial stability and ability to meet the healthcare needs of everchanging communities.

Unplanned Volume Change Review – The proposed process to adjust payments for hospitals with volume changes exceeding 5%, allowing only 50% of the adjustment beyond the threshold, is impractical. This calculation, while intending to provide a mechanism for adjusting payments in response to significant volume fluctuations, presents several challenges that render it unrealizable and potentially inequitable.

First, the 5% threshold for volume changes is excessively high, which further highlights the inequity. Many hospitals may not meet this threshold, resulting in their ineligibility for payment adjustments despite significant shifts in patient demand. RRMC, for example, would require a change exceeding $4 Million in Medicare net revenue ($15 Million in Gross) to initiate an adjustment.

Second, the provision to grant hospitals only 50% of payment adjustments above the 5% threshold is absent any efforts to mitigate the financial impact of sudden volume changes. This approach risks significant and overwhelming financial strain on these hospitals who are experiencing increased volume, making it difficult to cover costs, to maintain high-quality patient care, and to have sustainable operations.

Finally, this approach does not account for the unique circumstances and challenges faced by individual hospitals, particularly those serving vulnerable or underserved populations. Hospitals serving communities with fluctuating healthcare needs may be disproportionately affected by this payment adjustment mechanism, exacerbating existing disparities in healthcare access and quality.

In light of these concerns, it is imperative to reconsider this proposed process and explore alternative approaches that provide a more effective balance for payment stability with the necessity of responsiveness to shifts in patient demand.

Data Sharing – While not specifically mentioned in the Methods document, data sharing is important to identify opportunities to improve care delivery and to ensure that the right care is provided in the right setting at the right time. Currently, participating hospitals are covered in the All-Payor Model with data sharing protections to permit sharing of health service area data that allows for partnering with designated agencies and primary care networks to address the critical needs of patients. This should continue in the AHEAD Model.

Without data sharing, hospitals like Rutland, who do not own primary care would be left with trying to improve care delivery without any data to support and suggest opportunities that relate to improving access and reducing costs.

Thank you for considering our feedback; we always welcome the opportunity to work collaboratively with Green Mountain Care Board Members and Staff.

Respectfully,

J. Bertrand

Jennifer Bertrand
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Rutland Regional Medical Center

Cc Judi Fox