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August 26, 2022

Jessica Holmes, Chair
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Office of the Health Care Advocate FY2023 Hospital Budget Review Comments

Dear Chair Holmes and Members of the Green Mountain Care Board:

The Office of the Health Care Advocate (HCA) would first like to communicate our gratitude to Vermont's front-line workers for their courageous work on behalf of Vermonters during the ongoing COVID-19 pandemic and amidst a disturbing uptick in workplace violence. We also wish to express our appreciation for the important and difficult work of the Green Mountain Care Board (GMCB or Board) to regulate Vermont's health care system during a period of historically high inflation and acute workforce pressures.

As the Board is aware, the state remains at a critical tipping point as we struggle to ensure both affordability and access to care for Vermonters and hospital sustainability. Our comments provide recommendations on multiple focus areas we believe are critically important to achieving this important balance. We also provide recommendations to the Board thinking ahead to the implementation of Act 167. Our comments focus on the following: 1) defining and prioritizing health equity; 2) determining the role of OneCare Vermont (OCV) in future health reform efforts; and 3) standardizing and improving the quality of data used in the hospital budget process.

1) Health Equity

Affordability and Access

It is a widely documented truism of public health that lack of affordability leads to reduced access to care. [1] In other words, without affordability, access becomes limited, even nonexistent. Health care affordability is an acute problem in Vermont. As documented in the most recent Vermont Household Health Insurance Survey (VHHIS), 44% of commercially insured Vermonters are underinsured.[2] This data point aligns with conclusions drawn from the Community Health Needs Assessments (CHNAs) undertaken by Vermont's non-profit hospitals, which consistently document that Vermonters struggle to afford the right care at the right time. Multiple factors contribute to this affordability crisis—from high insurance premium costs, surprise medical bills, medical debt (or fear of incurring medical debt), high deductible and high-cost sharing plans, to the lack of insurance. Affordability challenges are not exclusive to individuals with commercial insurance. Vermont hospitals across the board report that substantial portions of free care and bad debt go to individuals and families with Medicare or Medicaid in addition to commercial and self-pay patients. This quantitative data aligns with qualitative data collected by our office from Vermonters who contact our Helpline as well as through our Medical Debt Storytelling Project.[3]

To their credit, Vermont hospitals are prioritizing health equity efforts. At the same time, however, hospitals often present affordability and access as either a secondary priority or a perceived threat to financial solvency -sometimes both. This inaccurate framing of affordability and access is unfortunate. It risks confining the Board to considering hospital health equity efforts broadly as being *contingent* on the Board approving hospital budgets as submitted. This would be both problematic and counterproductive from equity, reform, and regulatory authority standpoints. We encourage the Board to reinforce that affordability and access are cornerstones of health equity. The upcoming Act 167 community engagement process represents a unique opportunity for the Board and its partners to establish a theory of change that seeks to improve access and affordability. Such

[1] Lowry E., et.al. "States Hold Keys to Health Care Affordability, But Are They Using Them?" *Health Affairs*. 22 February 2022. <https://www.healthaffairs.org/do/10.1377/forefront.20220204.765285/>
[2] Vermont Department of Health. "2021 Vermont Household Health Insurance Survey." March 2022. <https://www.healthvermont.gov/stats/surveys/household-health-insurance-survey>
[3] Vermont Office of the Health Care Advocate (HCA). "Vermont Medical Debt Stories." 2022. <https://vtmedicaldebt.org/>.

efforts must include clear metrics for evaluating progress, for example by using causal models such as difference-in-difference (DID) analysis.

Free Care and Bad Debt

The HCA maintains that the ratio of free care to bad debt is a helpful metric for evaluating the overall functioning of hospital free care and patient financial assistance efforts. Through discussion in this year's hospital budget hearings, it is notable that this perspective is shared by at least several hospital leaders across the state. The passage of Act 119–An act relating to patient financial assistance policies and medical debt protection, represented productive collaboration between the HCA and the Vermont Association of Hospitals and Health Systems (VAHHS) that resulted in the creation of a tangible requirement for hospitals to standardize and improve their hospital patient financial assistance (PFA) policies.

It is our view that Act 119 complements the planned work of Act 167, and with this in mind, we recommend that the ratio of free care to bad debt be utilized as a metric for evaluating the overall functioning of financial systems in Vermont hospitals. This ratio also provides a concrete metric that could be used to evaluate efforts to improve affordability over time. Targets should be developed to incentivize reducing the ratio of bad debt to free care over time. For example, the Board could establish a benchmark to hold hospitals to meeting a 1:1 ratio of free care to bad debt in three years, 1:0.75 in 5 years, and 1:0.50 in seven years. We are aware that uncompensated care is a small percentage of overall hospital budgets and little bad debt is recovered. However, moving to shift a larger proportion of bad debt to patient financial assistance would have a tangible and substantial net impact on consumer affordability and access to care. A recent Peterson-Kaiser Family Foundation (KFF) study of census data showed that 51% of persons with medical debt have bills that were less than $2,000. In other words, even minor shifts from bad debt to free care can have substantial impacts on debt relief, an effect which directly improves affordability and access.[4]

[4] Rae M., et.al. "The Burden of Medical Debt in the United States." Peterson-Kaiser Family Foundation. 2022. 10 March 2022. <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#Percent%20of%20adults%20with%20over%20$250%20in%20medical%20debt,%20by%20health%20status%20and%20household%20income%20relative%20to%20the%20federal%20poverty%20level%20(FPL),%202019>.

2) OneCare Vermont

The University of Vermont Health Network's (UVMHN) decision to fold OneCare Vermont into a new $3 million dollar Population Health Services Organization (PHSO) raises fundamental questions about OCV's role in health reform under Vermont's All-Payer Model.[5] Hospitals consistently demonstrated during this year's budget hearings that they appear both compelled to and capable of investing in effective, community-informed population health and care coordination programs in their Health Service Areas (HSAs) without OCV. This dynamic calls into question the effectiveness and return on investment to the state of major elements of OCVs Strategic Plan which states that "OneCare and its health care provider partners will work together to continuously improve health outcomes" and that "OneCare and its health care provider partners will work together to move toward a system that pays for value."[6] Both of these stated "Strategies, Goals, and Anticipated Outcomes" were also conspicuously absent in UVMHN's hospital budget presentation. OCV and the newly established PHSO were not mentioned once in UVMHN's slides.[7] Both were discussed only after Board and HCA questioning, and UVMHN's responses focused on the new PHSO being a data and analytics product.

The fact that OCV seems to now be redefining itself within the new PHSO also calls into question whether it is compliant with anti-trust regulations. By design, OCV has data from participating hospitals statewide. Will a firewall exist between hospital-wide data and UVMHN data? If so, how will it be structured and enforced, and by whom? Does UVMHN hope to profit financially from the formation of this PHSO, which includes OCV? If so, how will this revenue be utilized to improve population health? What benefit, if any, will there be to the state and to Vermonters? We look forward to working with the Board to rigorously examine these questions during the OneCare Vermont budget process.

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[5] Green Mountain Care Board (GMCB). Vermont's All Payer Model. 2022. <https://gmcboard.vermont.gov/payment-reform/APM#:~:text=Vermont's%20All%2DPayer%20Accountable%20Care,pay%20differently%20for%20health%20care.>

[6] OneCare Vermont. "Strategic Plan Summary: 2021-2023. <https://www.onecarevt.org/strategic-plan/>.

[7] University of Vermont Health Network. "UVMHN FY23 Budget Presentation." 10 Aug 2022. <https://gmcboard.vermont.gov/document/uvmhn-fy23-hospital-budget-presentation>.

3) Support for Improved Data Quality and Standardization

The HCA continues to advocate for the importance of collecting qualitative and quantitative data to allow for system-wide, cross-hospital comparisons to effectively evaluate and regulate the Vermont hospital system. We applaud and fully support the efforts underway by the Board's Hospital Budget Team to develop standard metrics for defining inflation, affordability, and allowable cost growth. We strongly encourage the Board to address both the lack of standardization in hospital budget development as well as the substantial unexplained data variance between what is reported to the Board and to the federal government—particularly as it pertains to free care and bad debt. We look forward to working with the GMCB on this issue in November of 2022.

Conclusion

The current paradigm of spiraling costs — and corresponding blame shifting between providers and carriers — only hurts Vermont families and small businesses. Therefore, we urge the Board to consider this year's hospital budget decisions in the context of future work related to Act 167. With this in mind, and to mitigate the worst potential impacts on affordability and access, we recommend that the Board (at minimum) not approve any hospital budget above its previously established allowable rate of growth target of 8.6%.[8] This decision would support hospital sustainability and help prevent global budget negotiations from commencing at an even more unaffordable starting point. We offer our support to the Board as it begins considering reforms to Vermont's hospital system. Please do not hesitate to contact us at hcapolicyteam@vtlegalaid.org with any questions, concerns, or requests to collaborate on any of the important efforts discussed above.

Sincerely,

s\ Mike Fisher, Chief Health Care Advocate
s\ Sam Peisch, Health Policy Analyst
s\ Eric Schultheis, Staff Attorney
s\ Charles Becker, Staff Attorney

[8] Green Mountain Care Board. "Preliminary Review of FY2023 Hospital Budget Submissions." 27 July 2022. <https://gmcboard.vermont.gov/sites/gmcb/files/documents/Preliminary%20Review%20FY2023%20Hospital%20Budgets%20%281%29.pdf>