Vermont Association of Hospitals and Health Systems

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August 8, 2023

Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Sent via email

Dear Chair Foster and Members:

Thank you for the opportunity to comment on the FY 2024 hospital budgets. We appreciate the Green Mountain Care Board's willingness for input and further context as it undertakes the difficult task of balancing efficiency with quality and access in making its determinations. Vermont's hospitals have submitted economical and efficient budgets that propose a 2.6% margin statewide while stabilizing from the long-term effects of COVID-19, preparing for upcoming crises, and continuing to care for a rural and elderly population.

Vermont's non-profit hospital system efficiently provides quality health care and effective emergency response to a rapidly aging population in the most rural state in the nation.
In addition to being the third highest median age in the nation, Vermont is also the most rural state, with the greatest percentage of the state's population located in rural areas.[1] Individuals in rural areas typically face more health disparities than their urban counterparts and need additional resources to improve health.[2]

Over half of Vermont's hospitals are Critical Access Hospitals, which recognizes the inherently inefficient nature of serving rural populations with a federally specified payment model. Despite the challenging landscape, Vermont has fewer hospital beds per capita than the national average, ranking 38th in the nation at a little over 2 beds per 1,000 people.[3] Washington D.C., which has a similar number of people in a much more concentrated area, comes in at more than double Vermont's rate with almost 5 beds per 1,000 people. Vermont's hospital system efficiently delivers quality care with fewer beds, despite having a resource-intensive population.

Efficient and affordable hospitals include 24/7 care, emergency response, and investment in long-term health outcomes.
Hospital affordability and efficiency must always include consideration of quality, access, emergency response and management, as well as investment in long-term health outcomes. Hospitals need reserves of health care providers, resources, and funding to respond quickly

[1] United States Census Bureau, "An Aging U.S. Population With Fewer Children in 2020," May 25, 2023 and "Nation's Urban and Rural Populations Shift Following 2020 Census," Dec. 29, 2022.
[2] Centers for Disease Control and Prevention, "About Rural Health," Updated May 9, 2023.
[3] Kaiser Family Foundation, "Hospital Beds per 1,000 Population by Ownership Type," 2021.

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when long-term or short-term catastrophes strike. Vermont's intensive care capacity is lean, coming in last in the nation at 1.6 ICU beds per 10,000 compared to the national average of 2.7 ICU beds per 10,0000.[4] The FY 2024 hospital budgets as submitted continue to allow for reserves and emergency management capacity.

In addition to emergency management, hospitals serve several unique functions within their communities. Hospitals are the backup for complications in community settings and are the one resource that is open 24/7. In the current healthcare landscape, this often includes providing nonmedical services from respite care for stressed caregivers, to shelter during a flood, to serving as a residential setting due to lack of post-acute care. Until the community can meet these needs, hospitals will likely continue to serve as the catch-all resource in their communities.

Vermont's hospitals are looking to avoid being the provider of last resort by improving overall health and investing in long-term health initiatives. Hospitals have partnered on medical housing models, psychiatric alternatives to emergency departments, care management, and healthy food programs. Better long-term health outcomes require the ability to invest in new initiatives now, in addition to traditional medical services.

Hospital administrative costs reflect policy choices intended to increase access and improve health outcomes.

Administrative costs include necessary costs such as electronic health records, cybersecurity, financial assistance counseling, and quality improvement. A recent study found that simply reporting on quality metrics, without implementing quality interventions, cost Johns Hopkins over $5.6 million dollars and over 100,000 person hours.[5]

More importantly, many of Vermont's access and reform efforts are reflected in hospital administrative costs, including a 6% hospital provider tax used to draw down federal funding to support Vermont's Medicaid program. Only 5 other states have a hospital provider tax over 5.5%.[6] In addition to the provider tax, Vermont's hospitals support the All Payer Model with dues to OneCare Vermont and funding for the Blueprint for Health. In the spirit of health care reform, Vermont's hospitals are also investing in the social determinants of health directly through programs like partnering with a local housing organization and less directly through revitalizing downtown areas. These costs are reflected in general and administrative costs.

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[4] Kaiser Family Foundation, "State Health Facts: ICU Beds," 2018.

[5] Saraswathula A, Merck SJ, Bai G, et al. The Volume and Cost of Quality Metric Reporting. *JAMA.* 2023;329(21):1840–1847. doi:10.1001/jama.2023.7271

[6] Kaiser Family Foundation, "States and Medicaid Provider Taxes or Fees," Table 2, Jun 27, 2017. For years after 2016, National Conference of State Legislatures "State Actions Tax Database" using "Health Care Related" search term.

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Hospitals administrative costs also include regulatory costs, such as the direct costs of regulation by the Green Mountain Care Board for hospital budget review and certificate of need determinations as well as half of the nongovernmental share for all other expenses of the Green Mountain Care Board.[7] In addition to contributing to Vermont's unique regulatory structure, administrative costs also include complying with 629 discrete federal regulatory requirements across nine domains, including the Centers for Medicare and Medicaid Services, Office of Inspector General, Office of Civil Rights and the National Health IT Coordinator.

Vermont prioritizes access over cost in its health care coverage policies.
To reduce health disparities in its population, Vermont also has a long history of making health care coverage more equitable. We have near universal coverage, pure community rating so that older individuals do not pay more for coverage, and first dollar coverage for preventive services such as mammograms and colonoscopies. While these initiatives add cost to premiums, the tradeoff of access to necessary health care likely improves health outcomes.

Vermont and hospital investments in health care are paying off and strike the balance between cost, access, and quality.
Vermont's investments in access to health care coverage have paid off. Nationally, Vermont consistently ranks in the top 5 for health care systems.[8] For costs, the most recent Household Insurance Survey showed that insured Vermonters are less likely to have problems paying medical bills, are less likely to use savings to pay a health care bill, less likely to incur large credit card debt or a loan, or be unable to pay for basic necessities than in previous years.[9] Additionally, under the federal premium tax credit, no one should be paying more than 9.12% of their monthly income towards health insurance premiums.[10] If the lowest cost plan a business offers has health insurance premiums that are more than 9.12% of an employee's income, then the employee is eligible for subsidies that ensure coverage at no more than 8.5% of income until 2026.

The proposed budgets are not just relying on federal subsidies to create affordability. Hospitals are reducing costs by sharing providers and services to maximize efficiencies, participating in group purchasing. They are also working to reduce the use of contracted labor through retention programs, shared clinical faculty to train students, and developing nursing talent pipelines. Meanwhile, Vermont is first in the nation for slowest growing personal health care

[7] 18 V.S.A. § 9374(h)(2)(A).
[8] The Commonwealth Fund, "2023 Scorecard on State Health System Performance," June 22, 2023.
[9] Vermont Department of Health, Vermont Household Health Insurance Survey, March 2022. (Insured Vermonters are less likely to have problems paying medical bills in 2021 than in 2012 (13% in 2021 vs. 21% in 2012).Insured Vermonters are less likely in 2021 than in 2018 to have needed to use their savings to pay a bill (5% vs. 9%), incur large credit card debt or a loan (3% vs. 6%), or be unable to pay for basic necessities due to medical bills (1% vs. 3%). Insured Vermonters have a similar likelihood of paying a bill >$500 in 2021 as in 2012 (13% both years)).
[10] HealthCare.gov, Affordable Coverage 2023.

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spending, despite its rural and aging population.[11] Vermont's adjusted expenses per inpatient day are also lower than the national average.[12]

In terms of quality, Vermont state averages exceeds the national average 9 out of 10 questions on hospital quality in the latest Hospital Consumer Assessment of Healthcare Providers and Systems survey.[13]

The 340B Drug Pricing Program is crucial for hospitals to reduce costs and maintain access to care.

The 340B Drug Pricing Program was created in 1992 as part of the Public Health Services Act to "enable [covered] entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."14 The purpose of the program was to subsidize health care organizations serving vulnerable individuals. All of Vermont's hospitals qualify for the 340B Drug Pricing Program and use this funding for health assistance programs, programs to address substance use disorder, and to keep their doors open and maintain access for the community. The 340B Drug Pricing Program is under threat right now, with pharmacy benefit managers and prescription drug manufacturers adding onerous administrative requirements or refusing to pay. Vermont's hospitals are aware that their current reliance on 340B as a funding mechanism creates financial uncertainties and are open to alternative options as healthcare reform in the State evolves.

Hospitals have submitted budgets with responsible margins to stabilize and partner on quality health care and emergency response for our communities.

Vermont's hospitals continue to work with the Agency of Human Services and the Green Mountain Care Board on the next iteration of health care reform. We have also engaged with Pennsylvania's Rural Health Redesign Center on their hospital global budget model and are excited to incorporate what they learned into our next model. With global budget rates typically set based on past budgets, it is imperative that Vermont have a sustainable baseline to ensure rural health care access. Because the current federal reimbursement model expiring at the end of 2024 and there is no new model available until 2026, Vermont's hospitals are also working within a highly unpredictable environment. Amidst this uncertainty, Vermont's hospitals have submitted the budgets they need to meet the needs of their community while maintaining a responsible statewide net operating margin of 2.6%.

We look forward to further engaging with you in this process. We are concerned to see that in the MVP 2024 Decision and Order the GMCB anticipates reducing hospital requested rates by

[11] Centers for Medicare and Medicaid Services, "NHE Fact Sheet."
[12] Kaiser Family Foundation, Hospital Adjusted Expenses per Inpatient Day by Ownership, 2021 data.
[13] HCAHPS Report (Reporting Period 7/1/2021—6/30/22). "
[14] H.R. Rep. 102-384,102d Cong., pt. 2, at 12 (2d Sess. 1992).

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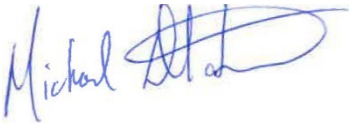
50% prior to having held the hospital budget hearings.[15] We appreciate the difficult work you have ahead of you and ask that you consider Vermont's achievements, our unique political, regulatory, and demographic landscape as well as the unwavering commitment that we have toward healthcare reform as compared to the rest of the nation. Please feel free to contact us at any time.

Sincerely,



Michael Del Trecco
President & CEO
Vermont Association of Hospitals and Health System

[15] In re: MVP Health Plan, Inc, 2024 Small Group Market Rate Filing, pg 18 ("Fourth, MVP must use the FY 2024 hospital rate requests calculated by Board staff and assume that the Board will reduce these requested rates by 50%.").