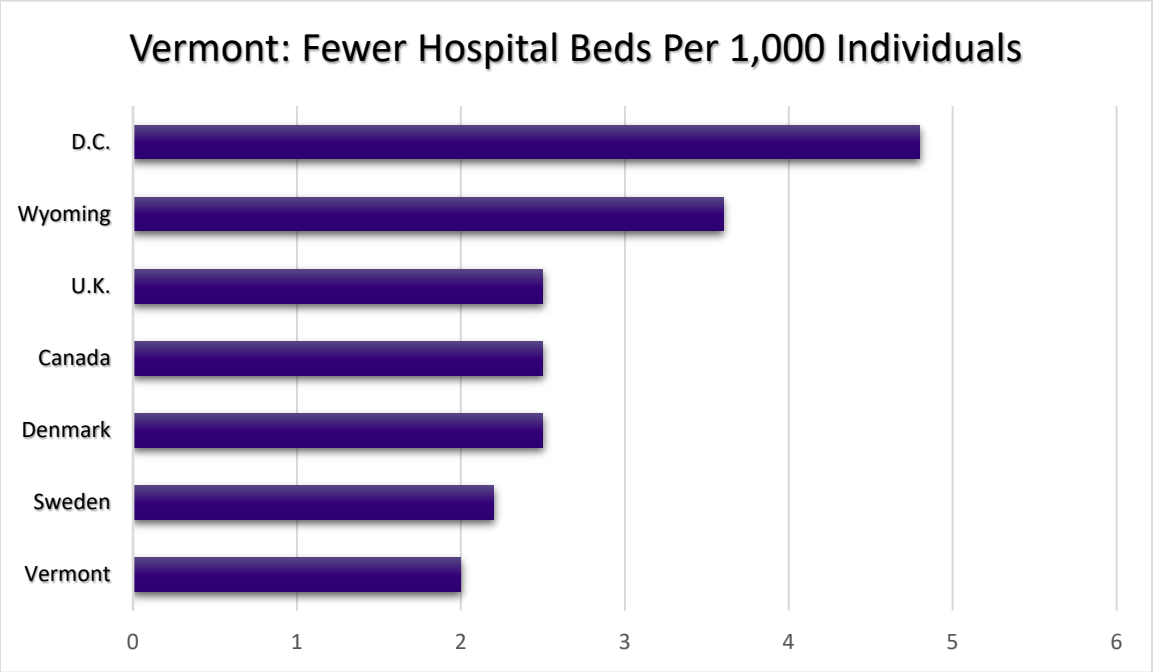
Vermont Association of Hospitals and Health Systems

Testimony: S.290, Implementation of Health Care Reform

Vermont's Hospital System: Doing More with Less

Vermont's hospitals provide access to high quality care in a challenging environment.

- Vermont is the second most rural state in the nation.[1] Providing health care to a population that is spread out, instead of concentrated in one area, is difficult.
- Vermont is 39th in the nation for hospital beds and low for beds internationally



Source: Kaiser Family Foundation, Hospital Beds per 1,000 Population by Ownership Type, 2017; OECD Data, Hospital beds, 2018.

- Vermont is consistently highly rated nationwide for good health
  - United Health Foundation ranks Vermont as number 1 for 2019[2]
  - Commonwealth ranks Vermont in the top 5 for 2019[3]

Vermont's Health Care Reform: Doing More with Less

Vermont's hospitals are fueling major health care reform in Vermont for much less than other states serving similar populations.

- California has $1.5 billion in federal funds to apply to care coordination and addressing social determinants of health through their Whole Person Care program.[4] They expect to enroll 300,000 individuals.

[1] Census Bureau Data, https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html
[2] America's Health Rankings, 2019 Annual Report, https://www.americashealthrankings.org/learn/reports/2019-annual-report
[3] The Commonwealth Fund, 2019 Scorecard on State Health System Performance, https://scorecard.commonwealthfund.org/rankings/
[4] https://harbageconsulting.com/wp-content/uploads/2019/03/Harbage_WPC_MidPointPaper.pdf

- Pennsylvania is doing a similar payment reform with 13 of its rural hospitals. The federal government has made $25 million available for funding startup costs to oversee the Model, aggregate and analyze data, compile and submit reports, propose and administer global budgets, approve Rural Hospital Transformation Plans, conduct quality assurance, and provide technical assistance to participant rural hospitals as they redesign the care they deliver.[5]
- Vermont had $9.5 million in federal funding for its startup costs. The federal government agreed to a total of $209 million in funds. To date, hospitals and community providers have seen only a fraction of that funding for the All-Payer Model.

Health Care Reform Oversight Today

Vermont passed health care reform oversight in 2016 with Act 113, which set out the standards for the All-Payer Model agreement, the All-Payer Model, Accountable Care Organization oversight, and ACO budgets.

All-Payer Model (APM) Agreement

The APM agreement with Medicare must meet the following:

- Is consistent with Vermont's health care reform principles set out in Act 48
- Preserves consumer protections under Medicare, including maintaining Medicare covered services, Medicare cost sharing, and Medicare appeals process
- Allows providers to choose to participate
- Gives patients provider choice
- Includes outcome measures for population health
- Medicare payments go directly from federal government to ACO or providers—NOT through the State of Vermont

The All-Payer Model

The All-Payer Model must meet the following:

- Is consistent with Vermont's health care reform principles set out in Act 48
- Medicare payments go directly from federal government to ACO or providers—NOT through the State of Vermont
- Maximize alignment between payers
- Strengthens and invests in primary care
- Incorporates social determinants of health
- Adheres to mental health parity and integrates mental health and substance abuse treatment into the health care system
- Includes a process for integration of existing community-based providers into a fully integrated care system that may include transportation and housing

[5] CMS.gov, Pennsylvania Rural Health Model, https://innovation.cms.gov/initiatives/pa-rural-health-model/

- Integrated approach to data collection, analysis, exchange, and reporting
- Evaluates access to care, quality of care, patient outcomes and social determinants of health
- Requires shared decision-making
- Supports coordination of care
- Works with HCA to ensure robust grievance and appeals process,

ACO Oversight

In order to receive Medicaid payments or commercial insurance payments, ACOs with 10,000 patients or more must be certified by GMCB and board must ensure following criteria met:

- ACO governing body: governance, leadership, and management is transparent and represents ACO participants and providers
- Care coordination, including Blueprint
- Mechanisms for receiving and distributing payments to providers
- No discrimination against providers
- Evidenced based health care, coordination of care, electronic health records, and other technologies
- Meaningful participation in health information exchanges
- Performance standards
- No restrictions on information in provider-patient relationship
- Shared decision-making
- Explanation of how ACOs work—outreach and hotline for complaints and grievances
- Sharing deidentified complaint information with the Office of the Health Care Advocate
- Collaborates with community providers
- Patient choice
- Public session of ACO meetings
- No decrease in access to health care
- Financial guarantee to cover losses

ACO Budgets

GMCB will oversee ACO budgets and HCA will have the right to intervene. Section also includes antitrust provision. GMCB will review and consider

- Information re: utilization of health care
- Goals of health resource allocation plan
- Expenditure analysis of previous year
- Soundness of the ACO and its principals
- Reports from professional review orgs
- Efforts to prevent duplication of services
- Incentives for health care investments to strengthen primary care
- Incentives to integrate community providers
- Incentives for system health care investments in social determinants of health

- Incentives for addressing adverse childhood experiences (ACEs)
- Public comment on all aspects of ACO cost and use on ACO proposed budget
- Information from meetings with ACO
- Information re: ACO admin costs
- Effect of Medicaid reimbursement rates
- Extent to which costs are transparent to make patients aware of costs of health care services
- Added with Act 52 in 2017: the extent to which the ACO provides resources to primary care practices to ensure care coordination and community services, including mental health and substance use disorder counseling that are provided y community health teams that are available to patients

Other additions with Act 52 in 2017:

- By December 1, 2019, the GMCB shall report on the manner and degree that social services are integrated into the ACO
- By January 15, 2020, AHS must provide an interim status report
- AHS and the GMCB must submit a plan to coordinate the financing and delivery of Medicaid mental health services and Medicaid home- and community-based services as well as future plans for integrating long-term care, due January 1, 2021

S.290 Implementation of Health Care Reform: Less is More

Act 113 and additional legislative reports already address the concerns that have been articulated during committee discussion, and S.309 addresses recent provider contract issues.

Instead of helping rural hospitals, this bill adds further burden and expense. Approving every contract between provider and insurer will expand and slow down oversight at a time when the regulatory process should be focused on health care reform. Furthermore, approval of contracts circumvents the local decision-making process by inserting the government in the middle of private contracts.

At previous hearings, the question has been asked: “Why are hospitals doing this?” Hospitals are participating in health care reform because it’s an opportunity for providers and patients to work together to determine how to provide the optimal health care through evidence-based initiatives and coordinated care. It’s also the future for rural hospitals. Prospective payments provide hospitals with the predictability they need to better serve their community instead of balancing their budgets on a bad flu season. The legislative process is breaking that promise of predictability by reopening and threatening the status of the ACO and health care reform year after year.

VAHHS does not support this bill. Instead of added administrative burden, we need focused, funded reform.