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S.285

Secs. 1-2; 10 - Hospital Sustainability Planning
Sec. 3 – AHS All Payer Model Planning

April 12, 2022

Kevin Mullin, Chair GMCB

Robin Lunge, Board Member GMCB

Agenda

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1. Sections 1-2; 10 – Hospital Sustainability Planning
   - Review of Hospital Sustainability Planning
   - Hospital Payment Reform & Community Engagement

2. Section 3 – AHS All-Payer Model Planning

Note of Section 9 - GMCB report summaries:

I've submitted two examples of one page report summaries. We welcome feedback at any time.

Sections 1-2; 10 Introduction

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Description	S.285	H.740 Sec. E.345
Hospital Value-Based Payment Design	Sec. 1.	(b)(1) – (3)
Community Engagement; Delivery System Reform	Sec. 2	(a)
Appropriations	Sec. 10	Each subsection

- Similar content outlining the hospital sustainability planning work proposed by the Board and included in the House budget
- Appropriations amounts & process
  - GMCB, in collaboration with Director of Health Care Reform, to submit a plan for spending over $1M
  - Health Reform Oversight Committee approval before spending

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Quick Review:
Hospital Sustainability Planning Background

Act 159 Section 4: Defining the work

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Hospital financial sustainability: How can we ensure that **hospital revenues** (provider reimbursement) are sufficient to **cover the costs** of operating a system that strikes the appropriate **balance between quality, efficiency,** and **access in rural Vermont**?

How can sustainable hospital reimbursement ensure:

1. Equitable access to essential services for all Vermont communities
2. Efficient and economic delivery of services (and affordability)
3. Improved health outcomes for Vermonters through high-quality care delivery

Rural Hospital Closures are Increasing across the U.S.

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- Since 2005, **181 rural hospitals have closed** nationally, and since 2010, the rate of closure has only been increasing, with 2020 the highest of any previous year[1,2].

- In a study published in Health Affairs in 2020, rural hospitals that closed during the study period had a **median overall profit margin of -3.2% in their final year before closure**[3].

- Hospital closures threaten patient **access** to services and materially impact the **local economy**[4].

- Vermont experienced its own hospital bankruptcy, alarming the Board, Legislators, and hospitals across the state.

1. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
2. https://onlinelibrary-wiley-com.dartmouth.idm.oclc.org/doi/full/10.1111/jrh.12187
3. Bai G, Yehia F, Chen W, Anderson GF. Varying Trends in the Financial Viability of US Rural Hospitals, 2011-17. Health Aff (Millwood). 2020;39(6).
4. Rural Health Services Report, Slides 44-47

Vermont Hospital Operating Margins Continue to Decline

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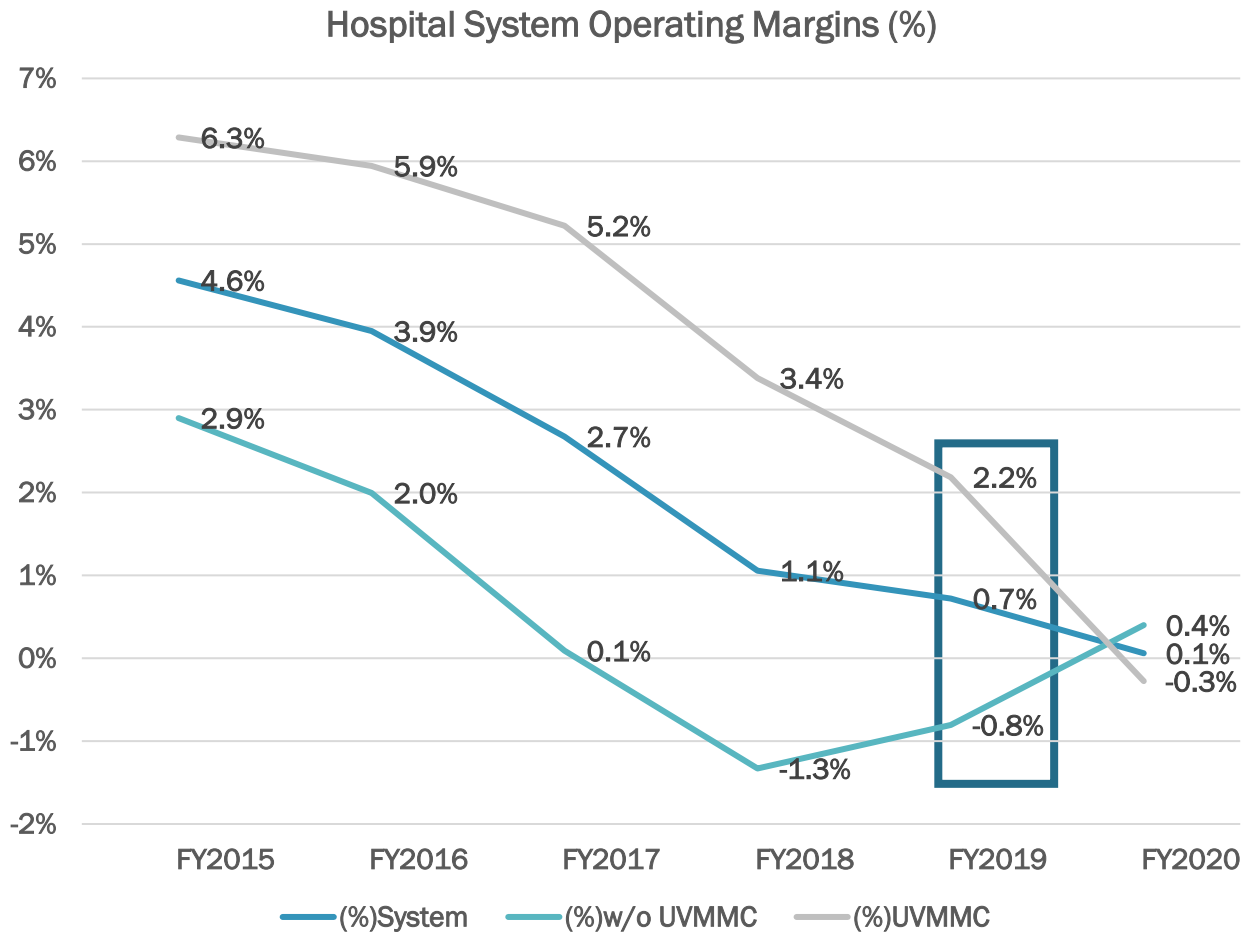

*Note FY2020 includes COVID Relief Funds and Expenses

Declining Operating Margin(%) is a System-Wide Issue

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Operating Margin (%) Hospital	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	5 Year Median	5 Year Average	3 Year Median	3 Year Average
Brattleboro Memorial Hospital	2.8%	-0.6%	-3.1%	-2.4%	0.8%	0.6%	-0.6%	-0.9%	0.6%	-0.3%
Central Vermont Medical Center	2.9%	1.0%	-0.9%	-3.8%	-2.1%	-0.6%	-0.9%	-1.3%	-2.1%	-2.1%
Copley Hospital	6.2%	-0.1%	-0.6%	-3.3%	-3.2%	-3.9%	-3.2%	-2.2%	-3.3%	-3.4%
Gifford Medical Center	2.7%	3.9%	-1.6%	-10.7%	-0.8%	2.5%	-0.8%	-1.3%	-0.8%	-3.0%
Grace Cottage Hospital	-9.8%	-8.0%	-6.9%	-2.9%	-6.7%	1.1%	-6.7%	-4.7%	-2.9%	-2.8%
Mount Ascutney Hospital and Health Center	-2.4%	0.3%	2.7%	1.9%	-0.1%	0.9%	0.9%	1.2%	0.9%	0.9%
North Country Hospital	3.5%	0.2%	-2.3%	-2.3%	1.9%	3.7%	0.2%	0.2%	1.9%	1.1%
Northeastern Vermont Regional Hospital	2.2%	2.0%	1.9%	1.7%	1.8%	1.3%	1.8%	1.7%	1.7%	1.6%
Northwestern Medical Center	9.7%	3.4%	-1.2%	-3.4%	-8.0%	-0.9%	-1.2%	-2.0%	-3.4%	-4.1%
Porter Medical Center	-2.4%	1.9%	2.7%	1.8%	5.2%	4.1%	2.7%	3.1%	4.1%	3.7%
Rutland Regional Medical Center	1.9%	4.2%	1.6%	0.5%	0.4%	0.2%	0.5%	1.4%	0.4%	0.4%
Southwestern Vermont Medical Center	3.6%	3.4%	3.7%	4.6%	3.3%	2.8%	3.4%	3.5%	3.3%	3.5%
Springfield Hospital	3.9%	0.3%	-7.1%	-12.8%	-18.4%	-11.2%	-11.2%	-9.8%	-12.8%	-14.1%
University of Vermont Medical Center	6.3%	5.9%	5.2%	3.4%	2.2%	-0.3%	3.4%	3.3%	2.2%	1.8%
Total	4.6%	3.9%	2.7%	1.1%	0.7%	0.1%	1.1%	1.7%	0.7%	0.6%
Median	2.8%	1.4%	-0.7%	-2.3%	0.2%	0.8%				
Flex Monitoring Team Northeast CAH					1.8%					
Flex Monitoring Team U.S. CAH					0.7%					
Fitch Ratings Solutions, Inc Northern New England					1.2%					
Fitch Ratings Solutions, Inc Northeast U.S.					0.8%					

*Note FY2020 includes COVID Relief Funds and Expenses

Summary of Key Findings

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1. Without tackling underlying inefficiencies, Vermont hospitals' financial health is likely to deteriorate after federal relief funds cease. This is problematic because it (1) exacerbates the health care affordability crisis and (2) increases the probability of hospital closure and divestment of essential services, most likely to threaten access to care for the most vulnerable Vermonters. The time to act is now.
2. Vermont has an opportunity to redesign care to ensure that Vermonters have access to the care they need, in an appropriate, high-quality setting, at an affordable cost.
3. Completing hospitals' transition to value-based payment models (e.g. global payments) will enable hospitals to make the changes they need to ensure the equitable delivery of high-quality affordable care to Vermonters.

Hospital Levers to Balance Revenues & Expenditures

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- ☒ Increase Commercial Prices
- ☒ Reduce Operational Costs
- ☒ Increase Volume of Profitable Services

Hospitals do not have any viable levers to improve their financial health and guarantee their sustainability.

Why does this matter to Vermonters?

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Affordability

In Vermont, hospitals' primary lever to increase operating margin is commercial price, which only exacerbates the existing affordability crisis through its impact on premiums, foregone wages, and out of pocket costs.*

Quality

Hospitals in financial distress "struggle to maintain quality and patient safety and have worse patient outcomes relative to well-resourced hospitals"[1].

Access

Financial distress is a key predictive factor in determining the likelihood of hospital closure, which left unaddressed compromises communities' access to essential services, such as primary care, mental health, and maternal health etc.[2]

**Employers must often choose to invest more for the similar coverage year over year or reduce benefits.*

1. Source: Akinleye DD, McNutt LA, Lazariu V, McLaughlin CC. Correlation between hospital finances and quality and safety of patient care. *PLoS One*. 2019;14(8):e0219124. Published 2019 Aug 16. doi:10.1371/journal.pone.0219124
2. Source: Holmes GM, Kaufaman BG, Pink GH. Predicting financial distress and closure in rural hospitals. *The Journal of Rural Health* 2017;33(3): 239-249.

Goals for Sustainability Planning Framework

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1. Engage in a robust **conversation** on maintaining **access to essential services in our communities,** preparing for a shift to **value-based care,** and understanding the threats to the **sustainability** of our rural health care system;
2. Encourage **hospital leadership, boards, and communities** to **work together** to address sustainability challenges and the shift to value-based care;
3. Identify **hospital-led strategies** for sustainability, including efforts to "right-size" hospital operations, particularly in the face of Vermont's demographic challenges and making the shift to value-based care;
4. Identify **"external" barriers** to sustainability and making a successful shift to value-based care that are more aptly addressed by other stakeholders, policy-makers, or regulatory bodies, and generate insights to inform the state's approach to planning for- and designing a proposal for a subsequent Federal agreement with The Center for Medicare & Medicaid Innovation.

Act 159 Report Recommendation #1: Accelerate Shift to Value-based Payment & Delivery

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Hospital Payment Reform

1. Preserves Vermonters' access to essential services by establishing a sustainable funding stream for hospitals, particularly for lower volume facilities.
2. Eliminates "two canoes" and shifts hospital focus from volume to value.
3. Allows hospitals greater flexibility to deliver cost-effective, high value care in more innovative ways.
4. Offers a glide path for transitioning to value-based payment and care delivery.

Community Engagement

1. Hospital delivery system transformation that is intentional, patient-focused, and based on a reformed payment system can ensure the efficient delivery of high-quality care (e.g. improve equitable access to high impact, essential services, promote delivery system organization around low-cost, high-quality centers of excellence).
2. Provides a real opportunity to improve health care affordability and quality, and expands Vermonters' equitable access to necessary care.

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S.285 Section 1

Hospital Value-Based Payment – Process for further reform

Support for Value-based Care

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"Pre-pandemic there was already a press for a more aggressive shift to risk payment models, and most Medicare spending was predicted to be tied to value by 2025. As COVID-19 has evolved, 49% of surveyed health care executives say they have a higher interest in participating in value-based care"

The AHA advocates for global budgets to ensure access in rural communities.

American Hospital Association™
Advancing Health in America
Section for Small or Rural Hospitals

"WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN'T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY."

CMMI Director Dr. Liz Fowler on "Strategic Refresh" (4/25/21)

Where are Vermont Hospitals in their transition to Value-based Care?

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CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A **Foundational Payments for Infrastructure & Operations** (e.g., care coordination fees and payments for HIT investments)	A **APMs with Shared Savings** (e.g., shared savings with upside risk only)	A **Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B **Pay for Reporting** (e.g., bonuses for reporting data or penalties for not reporting data)	B **APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B **Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C **Pay-for-Performance** (e.g., bonuses for quality performance)		C **Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Figure 6: Systemwide Proportion of Value-Based Hospital Revenue from Vermont Residents[9]

	2017 (PY0)	2018 (PY1)	2019 (PY2)	2020 (PY3)
Total Revenue	$2,378,721,942	$2,520,075,138	$2,597,288,054	$2,444,037,937
Estimated VT Resident Revenue	$2,234,000,656	$2,329,290,531	$2,401,820,237	$2,238,229,808
Prospective Payments + Other Reform Payments	$43,510,957	$231,893,481	$299,908,013	$351,471,909
Proportion of Revenue	**1.9%**	**10.0%**	**12.5%**	**15.7%**

Hospital Payment Reform

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- Collaboration with the Director of Health Care Reform to maintain consistency with AHS-led larger health reform efforts
- Meaningful engagement from providers, payers, ACOs, and other stakeholders
- Building on and consistent with successful health care reform efforts
- Consulting resources to do the technical payment design work and recommendations for regulatory changes to reflect new payment models

Hospital Payment Reform

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- Design a process for establishing and distributing value-based payments for hospitals, that will:
  A. help move the hospitals away from a fee-for-service model;
  B. provide hospitals with predictable, sustainable funding that is aligned across multiple payers and sufficient to enable the hospitals to deliver high-quality, affordable health care services to patients; and
  C. take into consideration the necessary costs and operating expenses, and not be based on historical charges.

Accountable Care Organizations

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- Hospital value-based payment models can be done with an ACO or directly between payers and providers

- Example:
  - Medicaid's ACO payment model includes fixed payments to hospitals

Regulatory Change

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- Regulatory processes will be reviewed to incorporate new payment models
  - Hospital budget process
  - Accountable Care Organization Budget Review
  - Rate review
- Look at metrics to measure appropriate hospital budget growth (examples in bill language)
- May require future statutory change

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S.285 Section 2

Community Engagement in Hospital Delivery System Reform

Community Engagement

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- Meaningful engagement with communities in collaboration with AHS
  - data-informed discussions
  - identify opportunities for hospital delivery system changes that will reduce inefficiencies, lower costs, increase access to essential services, and improve health outcomes

- Consulting resources for:
  - Design of community engagement, preferably with experience in rural communities
  - Hospital/health system design
    - Technical assistance for hospitals

Community Engagement

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Building a shared understanding of the **current state** in that community:

- Local Hospital---financial health (margins), relative prices, relative costs, quality, occupancy rates…trends over time.
- Health status of patients in the community
- Where are residents seeking care—home hospital or elsewhere and why?
- What does access to essential services look like? For example: are we seeing evidence of avoidable hospitalizations in the community that could be prevented?

Community Engagement

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Building a shared understanding of the **future state** –

- What trends are on the horizon and how well is the local health care delivery system prepared for those trends? What headwinds should each community be prepared for?
- Is the local population shrinking or growing? Aging? At rates faster or slower than the rest of the state?
- Is the hospital going to be impacted by other hospital plans? For example, Dartmouth Hitchcock expansion—how will DH's new bed tower impact local community hospital's occupancy rates? Will it create or exacerbate work force shortages as workers are drawn to higher wages at DH?
- The Federal govt is moving to payment models that hold hospitals more accountable for costs and quality—are hospitals ready? Where does the local hospital stand on measures of both cost and quality?

Community Engagement

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Creating Opportunities---

- What is possible?
  - Need the experience of health systems experts who have successfully facilitated hospital/health system redesign and found innovative solutions to meet community needs
  - Community thoughts as well

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Appendix

Resources & Related Board Presentations:

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- Conversations with Leaders in Health Care Reform: Panel Discussion: January 12, 2021
- Price and Cost Coverage Variation: HMA Burns, October 27, 2021
- Vermont Hospital Quality and Capacity Analysis: Berkeley Research Group, October 27, 2021
- Potentially Avoidable Utilization at Rural Hospitals: Mathematica, August 11, 2021
- The Future of Rural Healthcare: Stroudwater and Associates, June 23, 2021
- Act 159 of 2020 Section 5 Report: Options for Regulating Provider Reimbursement for Provider Sustainability and Equity: GMCB Report to the Legislature, April 7th, 2021
- All Payer ACO Model Implementation Improvement Plan: Ena Backus, Director of Health Care Reform, November 19, 2020
- Hospital Price Transparency Project: RAND, October 21, 2020
- A Look at Vermont Hospitals with NASHP Hospital Cost Tool: NASHP, October 21, 2020
- National Trends in State Affordability and Sustainability Strategies: Bailit Health, May 13, 2020
- Rural Health Services Task Force: January 15, 2020

Disclaimer!

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Though COVID-19 has shifted how we deliver and consume care, it is unclear how many of these changes are temporary or permanent. As such, the subsequent analyses rely predominantly on CY/FY 2019 and prior years, which is reasonable when assessing long-term trends. Going forward, it may be reasonable to update some of these analyses as we learn more about our post-COVID world and incorporate any learnings into future sustainability planning efforts.

Key Finding #1

Left alone, Vermont hospitals' financial health will continue to decline. This will make health care even less affordable, will erode quality of care over time, and threaten Vermonters' continued access to care in their community.

- The financial health of Vermont's hospitals, as assessed by operating margin, declined over six recent fiscal years (FY2015 to FY2020).
- The cost of delivering care is increasing faster than payments to hospitals for providing services to patients.
- Hospitals in poor financial health…
  - must often rely on commercial rate increases to maintain/increase margins;
  - are often forced to eliminate low margin essential services;
  - are not able to invest in quality improvement and often experience declines in quality as financial health worsens; and
  - are more likely to experience bankruptcy and closure.
- The impacts of hospital financial distress mentioned above disproportionately affect the most vulnerable Vermonters.
- Hospital closures compromise access to essential services, and have been a growing concern among rural hospitals across the U.S.
- While non-operating revenue sources offer some hospitals relief, this is not sustainable.

Cost coverage varies by hospital, payer, and setting

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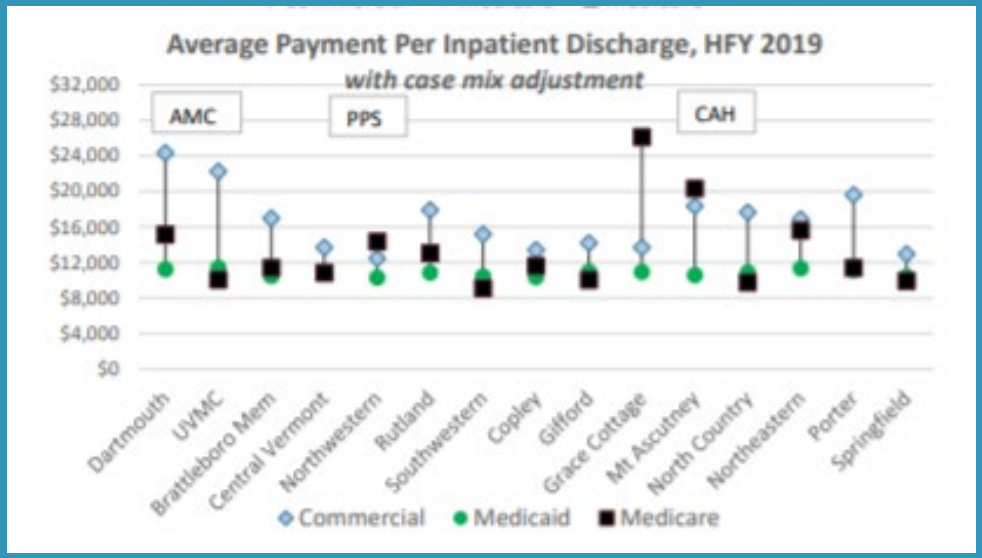
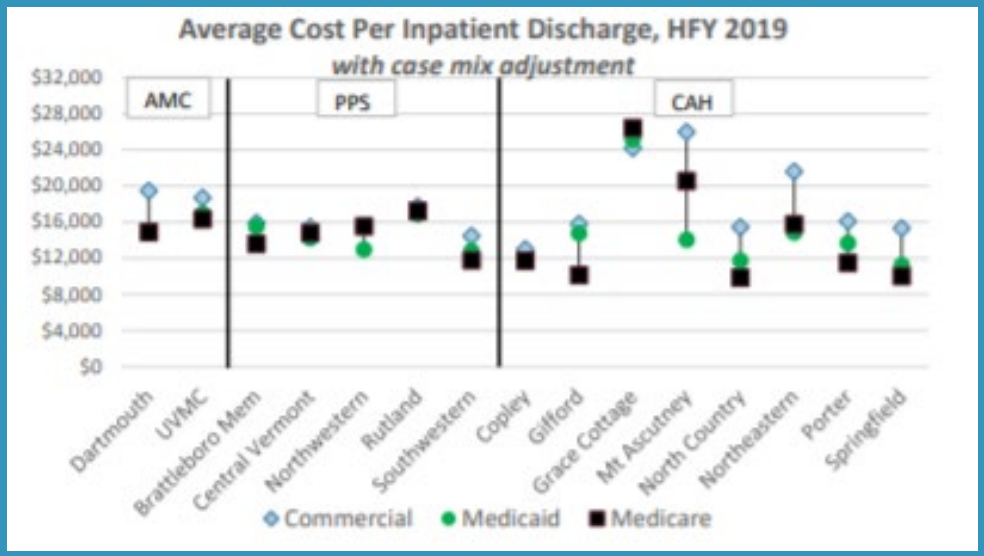
- Medicaid and in many cases, Medicare, do not cover the current costs of delivering care to their patients.
- This puts enormous pressure on hospitals to ensure that commercial payers cover both the cost of delivering care to commercial patients **and** the unpaid costs of delivering care to Medicare and Medicaid patients. This is unsustainable.

Prices



Costs



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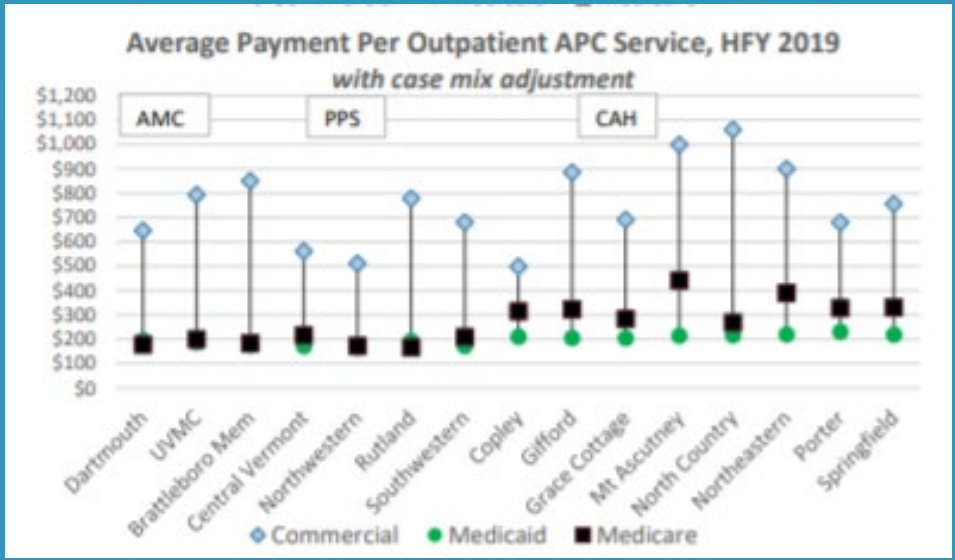
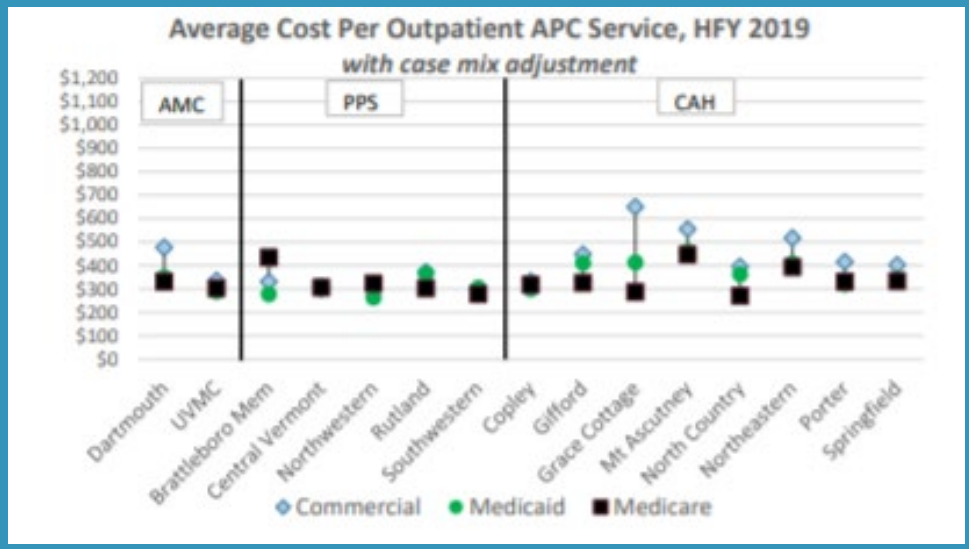
Inpatient: Drivers of poor cost coverage vary between hospitals…

Source: analysis from Burns/Health Management Associates

Prices



Costs



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Outpatient: Drivers of poor cost coverage vary between hospitals…

Source: analysis from Burns/Health Management Associates

Key Finding #2

There is significant variation across hospitals in the extent to which their reimbursements cover their costs of delivering a particular service, even after controlling for case-mix.

- Cost coverage also varies by payer and care settings (inpatient/outpatient).
- These variations could reflect high fixed costs, care delivery inefficiencies, and/or pricing strategies.
- Commercial payments are higher than governmental payments for similar services
- Often, governmental payments are insufficient to cover the current costs of delivering many services to patients.
- Hospitals relying more heavily on revenues from governmentally insured patients are often financially disadvantaged as compared to those with a greater share of their revenue coming from commercially insured patients.
- Governmentally insured patients often have greater social and physical health needs.

Key Finding #3

Hospital price regulation strategies in Vermont have room to evolve in order to more aptly address affordability.

- In Vermont, hospital prices are regulated through the Green Mountain Care Board's review and approval of a hospital's commercial change in charge in the Hospital Budget Review Process.
- There is an inconsistent and sometimes weak relationship between change in charge and negotiated payments by insurers.

Hospital Levers to Balance Revenues & Expenditures

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- ❑ Increase Commercial Prices
- ❑ Reduce Operational Costs
- ❑ Increase Volume of Profitable Services

Hospital Prices: The Tension…

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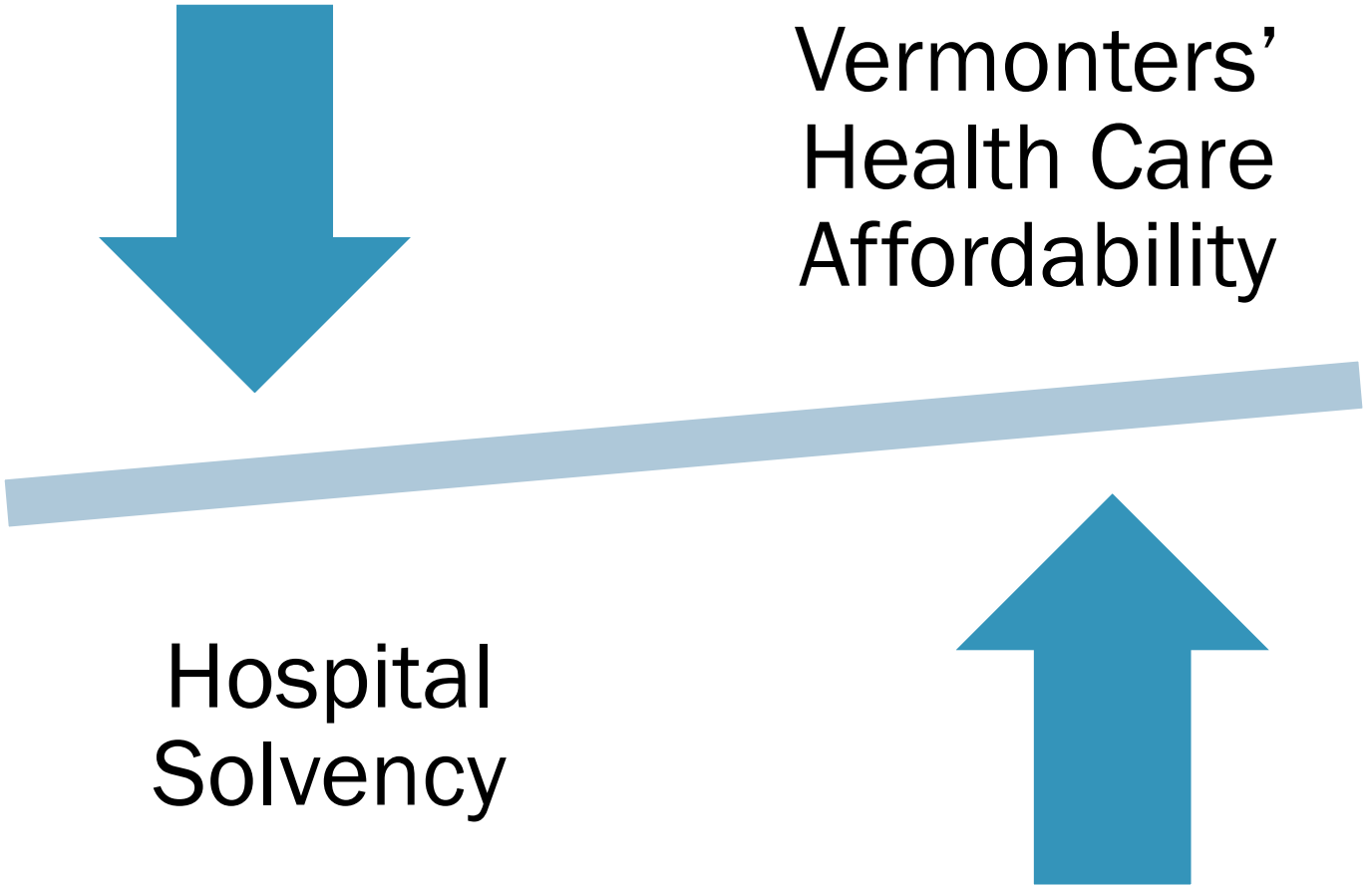

Hospital Commercial Charges

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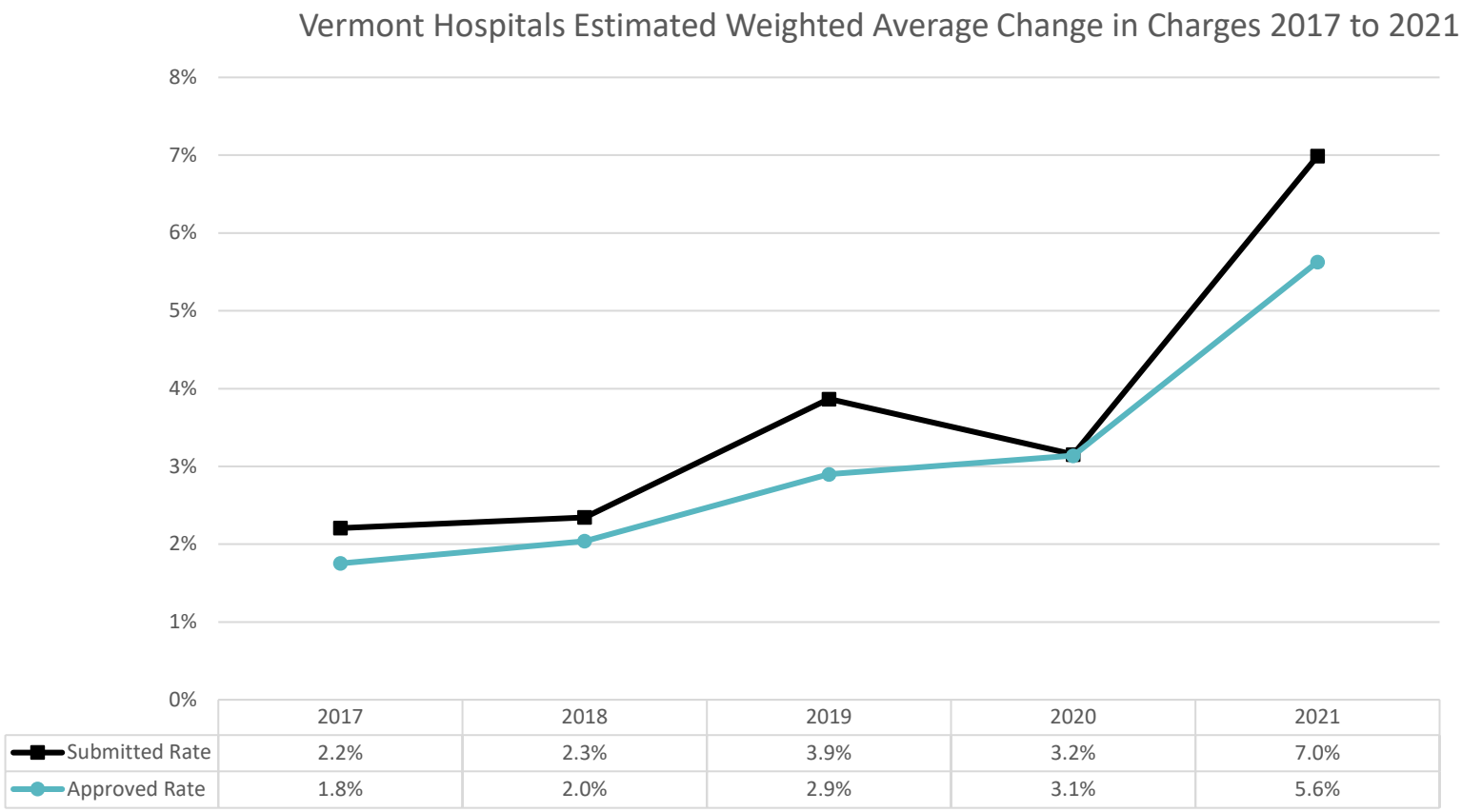

	2017	2018	2019	2020	2021
Submitted Rate	2.2%	2.3%	3.9%	3.2%	7.0%
Approved Rate	1.8%	2.0%	2.9%	3.1%	5.6%

Estimated Weighted Average for all hospitals is calculated by factoring in each hospital's proportion of gross revenue to the change in charges (rate).

Premium Rate Growth

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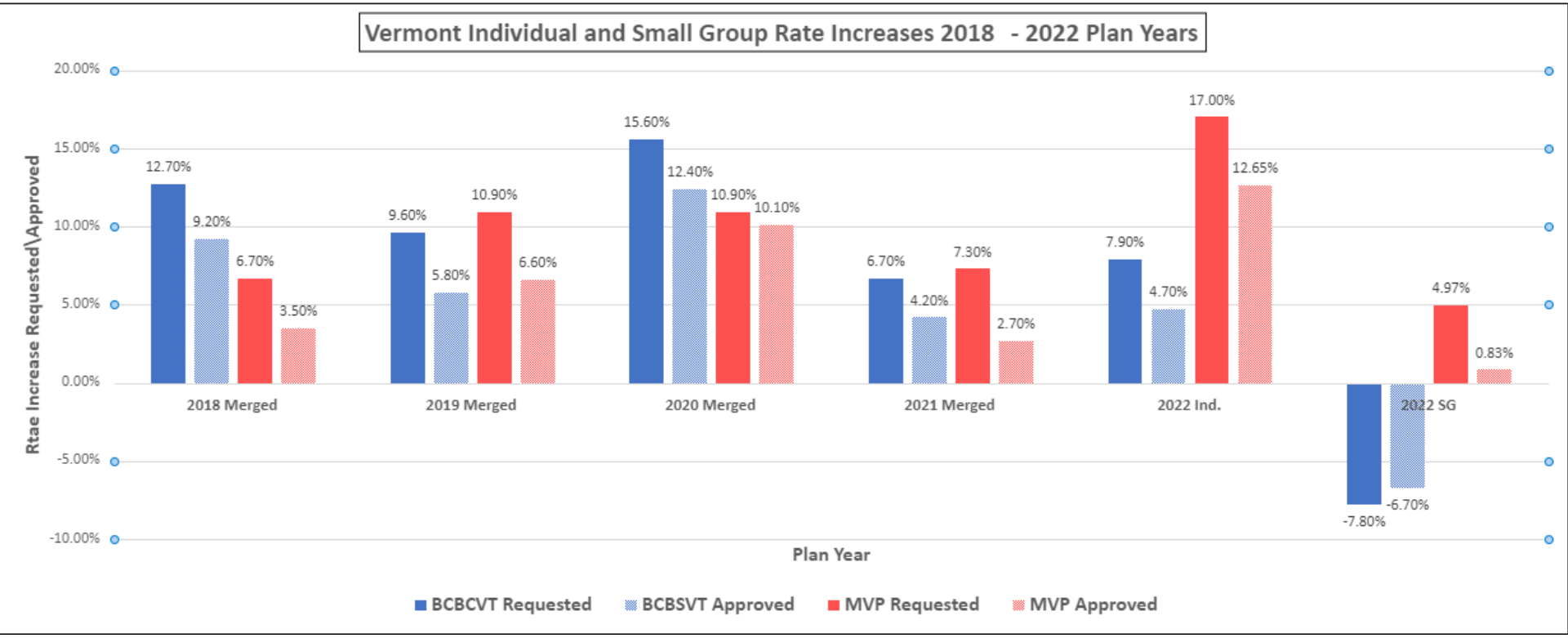

Commercial rate increases to maintain margins is not affordable or sustainable

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1. Commercial rate increases lead to higher premiums making private health insurance less and less affordable for Vermonters.
    - Over 50% of uninsured Vermonters cite cost as the primary obstacle
    - Between 2014-2018, the proportion of privately insured Vermonters who are underinsured rose from 27% to 40%.

2. There are fewer and fewer commercially insured patients available to cover growing costs, exacerbating the required magnitude of increases.
    - Between 2013-2019, while the Medicaid and Medicare populations *grew* by a combined 21%, the privately insured population *fell* by 10% in VT

Key Finding #4

If we do nothing, commercial prices will likely continue to outpace economic growth, making health care even more unaffordable and potentially compromising access to care.

- Commercial rate growth has created significant affordability problems for employers and for Vermont residents with employer-based coverage.
- Continuing to rely on commercial rates to maintain margin will only exacerbate the affordability crisis, potentially compromising access to care.
- Commercial rate increases are an unsustainable lever to address hospital financial health, due to a declining commercial population in Vermont. At some point, rate increases will be insufficient to keep hospitals open, another risk to Vermonters' continued access to essential services.

Hospital Levers to Balance Revenues & Expenditures

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- ☒ Increase Commercial Prices
- ☐ Reduce Operational Costs
- ☐ Increase Volume of Profitable Services

What about reducing operational costs?

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- We hear from hospitals about the challenges of cutting operational costs…
- A few reasons for these challenges include:
  - Small rural hospitals struggle to cover the fixed costs of running a hospital, particularly as they face declining populations and care is shifted to the outpatient settings[1]
  - Recruitment challenges lead to higher staffing costs (*note*, a majority of a hospital's budget is for staffing)
  - Low volumes threaten hospitals' ability to cover fixed costs
  - Inadequate mental health infrastructure and low reimbursements threaten hospital financial health and compromise patient health
- These challenges will only worsen as plants age and capital investment becomes more expensive, workforce shortages put higher pressure on wages, and volumes continue to shrink due to declining populations and a shift away from inpatient care settings.

1. Source: https://www.aha.org/system/files/2019-02/rural-report-2019.pdf

Pre-Covid, Several Vermont Hospitals Faced Low Occupancy Rates & Low Volumes

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- According to *Berkeley Research Group's* analysis:
  - Some small VT hospitals faced low occupancy rates pre-Covid
    - Some hospitals may face excess capacity in the future given Dartmouth's bed expansion and population decline (note, other hospitals may need expanded capacity due to population growth)
    - Low volumes in certain services may increase costs and compromise quality
    - *Centers of Excellence* may be a path forward to increase efficiency, financial sustainability and high-quality care
  - Other VT hospitals could expect capacity constraints, given projected bed need based on changing demographics

There appears to be a mis-match between Vermonters' health needs and how health care resources are distributed across the state.

Key Finding #5

Hospital and health system infrastructure has not kept pace with community health needs and the only way to address both hospital financial sustainability and ensure Vermonters' access to high quality, affordable care is to accelerate delivery system transformation.

- Improving operational efficiency is critical for minimizing wasteful spending, but hospitals will not be able to "cut" their way back to sustainability.
- Balancing hospital financial sustainability and health care affordability is a systemic issue that requires a systems-oriented solution.
- Preliminary analyses suggest that absent COVID, Vermont's care delivery system is over capacity in some areas and under capacity in others. Future projections based on demographic trends and the impact of DH expansion indicate that post-COVID, the mismatch between need and capacity will widen across the state.
    - Several Vermont hospitals are operating at low occupancy, some in close proximity to one another.
    - Some are operating high-cost service lines with low volumes (e.g., less than 5 ICU beds).
    - Vermont's health care system lacks sufficient capacity and reimbursement for mental health patients which challenges hospitals' financial sustainability and operational efficiency.
- Rethinking how care is organized across the state (e.g. regional collaborations and Centers of Excellence) is essential to preserving access and quality as well as efficiently allocating our already strained health care workforce.
- COVID has revealed the ability of our health system to rapidly respond to evolving patient needs (e.g. building a makeshift hospital in a week) and meet patients where they are (e.g. telemedicine).
- Maintaining costly excessive capacity is not necessary, but we must ensure that hospitals have the financial resources required to respond to changing environments.

Hospital Levers to Balance Revenues & Expenditures

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- ☒ Increase Commercial Prices
- ☒ Reduce Operational Costs
  (given current system-wide infrastructure)
- ☐ Increase Volume of Profitable Services

What about increasing volume at the hospital level?

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- Increasing **volume may be warranted**, particularly when there are **gaps in access** (e.g. primary care, mental health).
- …but it could also lead to unnecessary care or avoidable utilization (and higher health care spending).
- The organization and delivery of services should be based on **Vermonters' needs** and which services and care settings will yield the **best possible health outcomes**.
- Health care reform and the shift to value-based care has been precisely focused on this issue, ensuring that **Vermonters receive only the care that they need**, and ensuring that that care is **high-quality**.
- According to works by Mathematica & BRG, Vermont has a number of opportunities to **reduce avoidable utilization**.
- As we work to reduce unnecessary care and avoidable utilization, some **hospitals will see lower occupancy rates** and **greater excess capacity**, likely resulting in a **negative impact to their financial health**.

Under the current payment system (majority fee-for-service), doing the right thing for Vermonters may further harm Hospitals' financial health.

In many VT hospitals, 10% to 34% of inpatient revenue is potentially avoidable

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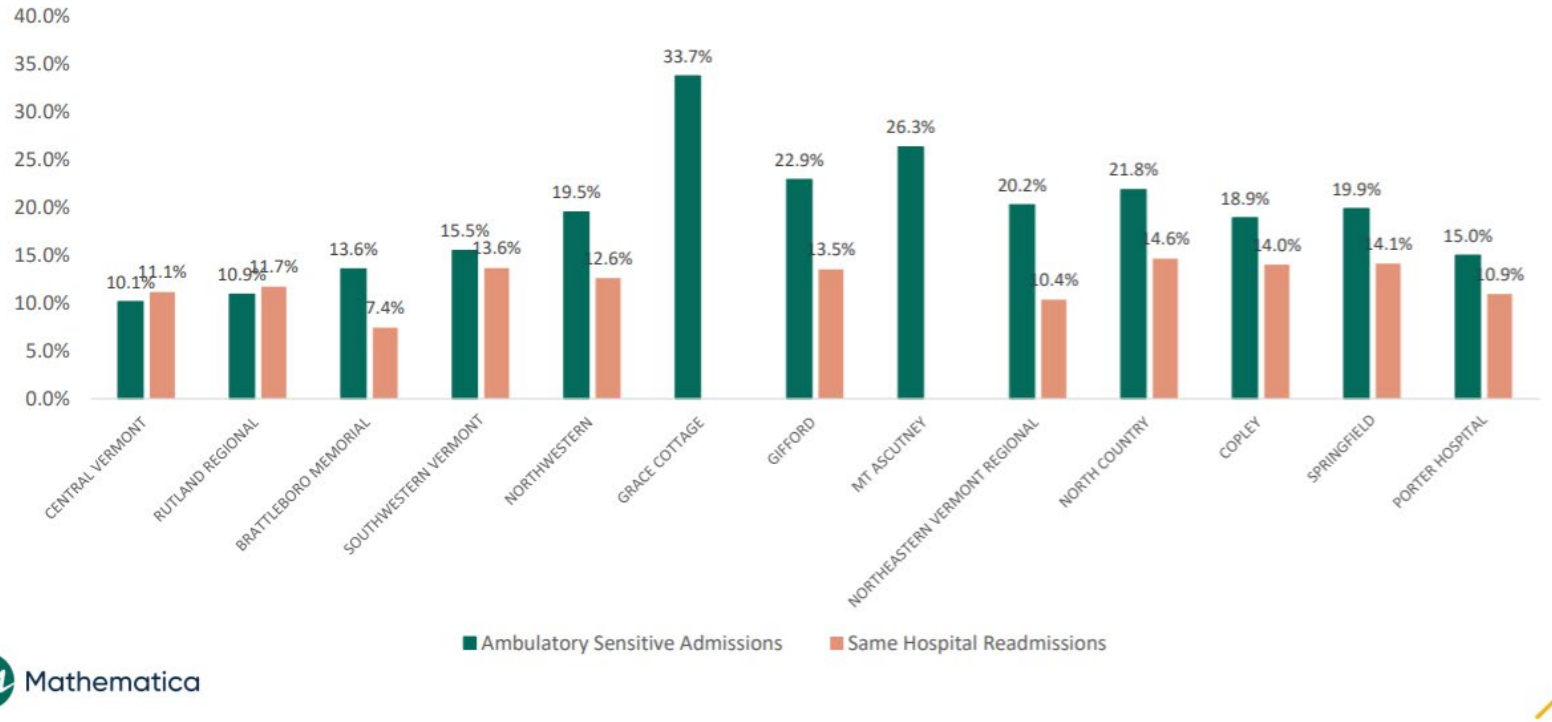
Proportion of Revenue in Avoidable Utilization- Inpatient



Mathematica

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Key Finding #6

Vermont must accelerate its transition from fee-for-service to value-based payments in order to address hospital financial sustainability and ensure Vermonters' access to high-quality affordable care.

- Despite being leaders in their commitment to value-based care, Vermont hospitals are still predominantly paid on a fee-for-service basis
- As long as the majority of Vermont hospitals' revenues come from fee-for-service, they will be constrained by high margin, volume-driven strategies to ensure their financial health.

Quality Improvement & Measurement

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While for the first time we have a collated baseline of hospital quality data (BRG analyses October 27, 2021), these data are not reported consistently across Vermont hospitals, nor is there consensus across hospitals as to the most appropriate hospital quality measures and for whom.

In partnership with VPQHC, we are now convening a stakeholder group to establish a hospital quality framework that can be considered within the hospital budget review process.

Key Finding #7

There are opportunities to improve and streamline hospital quality measurement, and some preliminary evidence suggests that in some areas the quality of care being delivered to Vermonters could also be improved.

- For some services, in some Vermont hospitals, volumes may not be sufficient to guarantee the delivery of high-quality care.
- Vermont hospitals' rate of potentially avoidable admissions is above optimal levels, suggesting better care for patients with common chronic conditions is warranted.
- While the baseline quality data aggregated for this report was helpful for highlighting general areas of opportunity, measures of hospital quality are not consistently reported across hospitals and make systematic review of hospital quality data difficult, if not impossible.

Key Finding #8/9

The stress that COVID-19 has put on our health system has highlighted not only the existing failures (e.g. fee-for-service) but also its strengths, particularly in its ability to quickly pivot to meet public health needs (e.g., build a makeshift hospital in a week, scale up ICU beds, accelerate widespread telemedicine access, etc.).

- Relying on volume for reimbursement threatens financial health of hospitals
- In order to sustain a diversity of health care during a public health crisis requires stable and predictable funding streams.

Analysis of long-term trends must focus on years prior to the pandemic, with a recognition that data and analyses may need to be updated as this pandemic becomes endemic.

- While it is evident that the pandemic has shifted how care is delivered and consumed, it is unclear how many of these trends are temporary or permanent.
- Care patterns from 2020, 2021, and potentially 2022 are skewed by disruption and pent-up demand from the pandemic.

Key Dates for Federal Agreement with CMMI

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	Current APM Agreement	Suggested in One-Year Extension Request
Deadline for Proposal for Subsequent Federal Agreement with CMMI	December 31, 2021	December 31, 2022
Vermont Engages with CMMI on Potential Subsequent Agreement	**Throughout 2022**	**Throughout 2023**
Current APM Agreement End Date	December 31, 2022	December 31, 2023
Subsequent Agreement Start Date	January 1, 2023	January 1, 2024