Senate Health and Welfare – S.285
Green Mountain Care Board Testimony – February 25, 2022

<u>Hospital Sustainability Overview</u>
Jessica Holmes

As we know, our hospitals are struggling financially, and the headwinds are strong.

Our hospitals are seeing expenses rise faster than revenues. Margins are shrinking. Public payers are not keeping pace with inflation and increased reliance on commercial rates to cover these rising costs is no longer a viable long term strategy—even if the GMCB approved higher and higher commercial rates for hospitals, there are not enough Vermonters to afford those rate increases.

Some areas of the state are seeing population declines and technological innovation is moving care out of hospitals to outpatient settings and even into the home. A Fee for service system relies on volumes to keep hospital lights on… but those lights are starting to dim as populations decline, patients bypass their small local hospitals to seek care at larger centers, and new delivery models like hospital at home, telemonitoring and telemedicine gain more traction.

And we can't ignore that Dartmouth Hitchcock is building a new bed tower on the SE border of the state—this expansion will likely attract both work force and patients, which will exacerbate workforce shortages in VT and decrease occupancy rates for hospitals already struggling to cover their fixed costs.

If we don't change course and soon, rising commercial rates will lead to more uninsured and underinsured, more bad debt and charity care, and employers reducing health benefits. And hospitals in financial distress will close, go bankrupt or request $millions in emergency relief from the State as Springfield did. Others will divest essential services—and it will likely be the <u>least</u> profitable services like primary care and mental health that will be shed first. It is already happening in some areas of the state.

So, we are not on a sustainable path and if we don't act now, market forces will prevail. And we may not like the outcome. So, what the Board is requesting is funds to engage experts in *intentional* hospital payment and delivery system redesign so that our health care system is prepared for the headwinds coming our way.

<u>Section 1 – Payment Reform Appropriation and Support for Federal Agreement Development and Negotiations</u>
Robin Lunge

The $1.4 million appropriation request supports the technical analysis needed to further explore moving from fee-for-service payments to fixed, prospective payments (also known as global payments) as recommended by the legislature's consultant, Donna Kinzer. The dollars

would support consulting resources, such as actuaries and other payment reform experts, to continue to evolve payment methodologies for hospitals to align with the fixed payments currently provided by Medicaid through the accountable care organization. In other states, global payments have either focused on curbing cost growth (Maryland) or ensuring access/solvency for rural hospitals (Pennsylvania) – in Vermont, we need to do both. This funding would allow us to explore and design payment model(s), aligned across major payers, that would meet Vermont's unique needs. Some hospitals have expressed to the Board interest in looking at evolving the Medicare and commercial payment methods to align with Medicaid's payment method. In particular, small critical access hospitals have not participated in Medicare's current payment method through the ACO program due to concerns about impacts to that critical access status, among other stated reasons. Existing law sets forth a process that the Board is required to follow to exercise this type of authority, which include working with stakeholders, formulating an administrative rule, and reports back to the committees of jurisdiction. The House Health Care committee included this process language in their recommendations to the House Appropriations committee and it makes sense to include something similar in your language.

The appropriation also supports redesign of the existing regulatory processes to align with these payment models, including looking at the hospital budget process and accountable care organization oversight.

The $600,000 appropriation would support the development and negotiation of the state's next model with the Centers for Medicare and Medicaid Innovation (CMMI). For the last negotiation, both state parties to the agreement, the Agency of Human Services and the Board, brought resources to the table to support the agreement development. Earlier in testimony, AHS Director of Health Care Reform Backus indicated there was concern about duplication of resources. That is not our intent and we look forward to working with AHS collaboratively. We'd be fine adding additional language to clarify that these resources should supplement those AHS is bringing to the table.

<u>Section 2 - Community Engagement in Delivery System Transformation</u>

Jessica Holmes

It is critical that payment reform efforts be done in parallel with a patient-centered, community and provider-inclusive redesign of our health care delivery system. You want the payment system to support an efficient system designed to improve Vermonters' health at the lowest cost and highest quality.

So, $3m of the $5m request is to support the design and planning for a series of data informed discussions, specific to each community with a focus on how to best meet the needs of *patients* in each community.

We envision three parts to the community conversations—likely occurring at both the HSA and regional level:

1) An understanding of the Current State.
2) An 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?
3) An understanding of the Opportunities---What is possible? This is where we would all benefit from the knowledge from health systems experts who have successfully facilitated system redesign and found innovative solutions to meet community needs.

The $3m appropriation will support careful design of the community engagement process – ensure all stakeholders are included. We need to identify the best approach to facilitate meaningful conversation. The GMCB doesn't take this step lightly. We would benefit from expertise in this area to ensure the process is inclusive and informative.

That community engagement process will require:
1) Packaging complex data specific to each community so that it is easily understood by community members
2) Preparing for and facilitating many conversations with community leaders and stakeholders
3) We will also need to contract with experts to help us assess what is possible.

<u>Secs. 1 & 2: Data Provisions of S.285</u>
Sarah Lindberg

The proposed bill includes work recommended by Donna Kinzer related to analyses of low value care and benchmarking. While foundational to the work proposed, this work is currently included, and funded, in the current Budget Adjustment Act. We recommend striking Section 1(a)(3) and Section 2(a)(2)(C).

Section 2(a)(2)(B) of the bill suggests collaboration with the Agency of Human Services and the Blueprint for Health to further their work and the Board's price transparency tool, however, this is already codified in 18 V.S.A. 9410 and the Board believes this section could be struck. If the committee prefers, an explicit reference to the Blueprint for Health could be added to 9410(3)(A). See below for relevant text from 18 V.S.A. 9410:

(a)(1) The Board shall establish and maintain a unified health care database to enable the Board to carry out its duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

Lastly, the GMCB wholeheartedly supports the development of an EPMI and the larger goal of bringing data together to enhance care delivery. However, due to the Board's limitations on the way data is received and for whom it receives data, we believe it would be better placed elsewhere and would suggest working with AHS to determine an appropriate home. We'd recommend striking Section 2(a)(2) provisions and adding a new Section of the bill to address the development of the EPMI.

<u>Section 6. GMCB Summaries</u>

Robin Lunge

The Board has embraced Donna Kinzer's recommendation to provider simpler summaries of key findings and recommendations for our reports. We've submitted two examples to the committee today – a summary of the hospital sustainability report and a summary of the Act 17 primary care spend report. We're happy to have individual committee members contact us with feedback.

We do not believe statutory change is necessary, but if the committee prefers to keep the change, we'd ask that the Board be provided additional flexibility in choosing relevant reports to summarize by striking the word "all" from the provision. There are some reports that are not amendable to summarization (for example, reporting the price growth of the top 25 drugs) or may not be generally of interest to the public. In addition, not all reports contain key findings or recommendations.

Thank you for your consideration of our request.