House Health Care and Senate Health and Welfare Joint Committee 2/10/2022
Testimony on Hospital Sustainability: Jessica Holmes, Board Member GMCB

I thought it might be helpful to share a few opening remarks. I speak as just one Board member but one who has been involved in these hospital sustainability efforts since the beginning and is passionate about making the health care system better for Vermonters.

Vermont is an amazing place—we have committed state leaders, compassionate hospital leaders and health care providers, and strong communities dedicated to improving our health care system. That's why we are all here. But we can't kid ourselves. If we really want to improve Vermonters' health and make health care more affordable, we need to completely change how we pay for health care and we need to update our delivery system to ensure it maximizes access and quality… and minimizes cost.

Significant payment and delivery reform will require resources, time and frankly, the leadership and courage to overcome the inevitable resistance to change. It is human nature to resist change. It is an emotional response – it has a name --status quo bias—a strong preference for the status quo. Any change from the status quo is perceived as a loss.

But Vermonters are not winning right now. Health care is not affordable for many families. Many Vermonters don't have access to primary care, dental care, and other essential services. Our mental health care system does not come anywhere close to meeting the needs of Vermonters and the stories we hear about people's struggles to find care are truly heartbreaking. And as populations decline and volumes shrink, average costs will rise, and quality of care may be compromised.

Our hospitals are struggling financially and in response, some are beginning to reduce essential services, like pediatrics. Both Brattleboro and Northwestern recently shed their pediatrics practices. This is devasting news; investing in our children's health is investing in our future. Public payers are not keeping pace with inflation and increased reliance on commercial rates to cover rising costs is no longer a viable strategy—even if the board approved higher and higher commercial rates for hospitals, there are not enough Vermonters to afford them.

If we don't change course and soon, we will see more uninsured and underinsured, more free debt and charity care, and employers reducing health benefits. We will see families facing hard choices between paying rent or buying medicine. And as access is compromised and essential services are dropped, population health will inevitably decline.

So, we are not on a sustainable path. And if we don't act now, with intentional payment and delivery redesign, market forces will take over. Some hospitals will go bankrupt, close, or come to the state for emergency relief as Springfield did, asking for and receiving millions of state dollars to keep its doors open. And it will be those hospitals serving our most vulnerable patients that will fall first. Other hospitals will divest of 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. So, we need to act swiftly and courageously. As you will see, the Board is asking for

$5m to support the hard work necessary to ensure a sustainable, high quality health care system. $5 million dollars may sound like a large investment but think of the cost of doing nothing.

The Board offers a path to sustainability: Global Payments and Delivery System Transformation.

Global payments will ensure that hospitals have predictable revenue streams that cover the cost of delivering high value services in their communities. Hospitals will no longer have to chase fee for service volume and offer low value care to stay afloat. Instead, they can redirect scarce resources to those services that have the greatest impact on Vermonter's health, like primary care and mental health. They can invest in the social determinants of health which often have a greater impact on health outcomes than medical care. And they will be incentivized to keep patients healthy and out of the hospital. Global payments are the path to both better health for Vermonters and greater hospital sustainability, particularly in rural areas facing declining populations and low volumes. But thinking about how to set and operationalize global payments, inclusive of Medicare, will take actuarial expertise, careful planning, and negotiation with the Federal Government—hence the $2m of the $5m ask.

It is critical that this payment reform be done in parallel with a patient-centered, community and provider-inclusive redesign of our health care delivery system. You want the global payments to support a system that is designed to improve Vermonters' health at the lowest cost and highest quality. So, $3m of the $5m request is to support the challenging work of delivery system reform. This effort will be time-consuming and data-driven and will require working collaboratively with health systems experts, hospitals and other health care providers, community leaders, and patients.

If we were to whiteboard the optimal health care delivery system, it is unlikely that we would arrive at our current system. As an example, Dr Bruce Hamory, former Chief Medical Officer at Geisinger (one of the most well-respected health care delivery systems in the country), shared some compelling insights with the Board. Geisinger serves roughly the same size population as VT over more than double the geographic area as VT, with about the same # hospital beds, but 3 fewer hospitals and 300 fewer providers. Service lines are optimized across the system to maintain minimum volume thresholds to reduce costs and ensure quality. And access is ensured through regional transport services and a helicopter.

Maintaining VTs current infrastructure means struggling to pay high fixed costs in the face of declining populations and spreading our already strained workforce too thinly. With our very real workforce shortage, we cannot afford to have an inefficient system. The stark reality of a fee for service system is that you cannot rely on volume to cover high infrastructure costs and growing labor costs if volumes are shrinking and care is moving out of hospitals.

So, we need to work with health systems design experts, hospitals, and communities to explore opportunities for shared services and regionalization of care, possibility creating centers of excellence that specialize in procedures where there is a known volume-quality relationship. For example, could some of our hospitals specialize in orthopedic procedures so that widely accepted minimum volume standards for joint replacement are met? Could some of our hospitals with excess capacity pivot to become centers of excellence in mental health care where we have acute

need? Could shared service agreements, satellite specialty clinics, and increased investment in regional transport ensure that patients in more remote regions of the state like the NEK have better access to high quality essential services?

We should explore new federal designations like “Rural Emergency Hospitals” and “Freestanding Emergency Depts” that might better meet the needs of communities who, post Covid, may face a return to high costs and excess capacity, especially those in close proximity to other full-service hospitals - like those near Dartmouth Hitchcock which is undertaking a $130m expansion that may add as many as 112 new beds. This will certainly be a draw for both patients and workforce and affect the sustainability of border hospitals.

We need to learn more about exciting new delivery models like Hospital at Home where acute patients can receive care at home but stay connected to a hospital care team through in-person and video visits and continuous biometric monitoring. For many patients, hospital at home is cheaper, safer, and more comfortable. A McKinsey report out this week projects that $265b of Medicare services will be delivered in the home by 2025. That is about 25% of the total cost of care. This transition to care at home threatens the financial solvency of hospitals reliant on fee for service inpatient volumes. We need to prepare now for this profound shift in care setting.

Finally, we must incorporate the learnings from the pandemic. We learned that fee for service does not work in a public health crisis. When volume shrinks, so do revenues but fixed costs remain. Global payments would have kept hospitals solvent when people stopped seeking hospital care. Technological innovation showed us that we can meet people where they are through care at home, telemedicine, and remote monitoring, and we can build a 400-bed makeshift hospital in a week. So, as we look to the future, we don’t need to maintain high cost, excess capacity but we do need to make sure that our hospitals have the financial resources they need to invest in technology and quickly pivot in times of crisis.

We have a lot of work to do, and we cannot afford to wait. In my mind, $5m is a small investment to ensure that our payment system aligns provider incentives with desired health outcomes, that the health care delivery system is prepared for the trends that are coming, and that it is optimally designed to meet the health care needs of all Vermonters, no matter where they live. This $5m might be the most important investment in health care we will ever make.

Thank you for your time.