Vermont Association of Hospitals and Health Systems

VAHHS Positions on 2025 Senate Health & Welfare Health Care Reform Committee Bill

Part 1. Statewide Health Care Delivery Plan

Statewide Health Care Delivery Plan: Support following emergency management process and utilize ongoing Act 167 process

- Vermont needs immediate action on health care access and affordability and should engage the emergency management model as suggested by Dr. Elliot Fisher.
    - Hot Wash: perform a facilitated quick after-action analysis of the All-Payer Model to inform future action
    - Policy Tabletop Exercise: assemble health care stakeholders under a facilitator to clarify roles and responsibilities, do a root cause analysis, and stress test policy proposals
        - For instance, does community rating have an impact? Maine, which is age-rated, charges an additional $300-$400/month for bronze coverage for a 64 year-old
- How does the Act 167 planning process inform and fit into this work?
- How much will this increase the bill back to hospitals? Hospitals pay for GMCB activities through bill back under 18 V.S.A. § 9374. For fiscal year 2024, hospitals paid over $2 million to support the Green Mountain Care Board.

Green Mountain Care Board review of hospital strategic plans: Not supported

Requiring Green Mountain Care Board approval of each hospital's strategic plan is an unprecedented extension of government authority that will have a chilling effect on recruiting volunteer board members and pursuing innovative solutions.

It will also increase administrative costs—hospitals already spend 6-8 months out of the year on the hospital budget process. Many hospitals do not have the capacity or staffing for another regulatory process.

How will this be funded? Will hospitals be billed directly for this process or would it be funded through bill back?

How will it be enforced? The Green Mountain Care Board has stated it does not have the authority to eliminate services. Oversight of each hospital's strategic plan is a reversal of that stance.

Part 2. Health system evaluation to support improvement and development of Statewide Health Care Delivery Plan

Establish advisory committee: If moving forward with a statewide health care delivery plan, include stakeholder members.

Health care reform efforts in Pennsylvania include impacted stakeholders. Maryland's rate setting authority includes individuals with hospital administrator experience. To ensure access to quality care, a VAHHS nominee with current hospital financial literacy should be included on the advisory committee in addition to other stakeholders.

Part 3. Integration of clinical and cost data for clinical improvement, regulation, health system evaluation, and policy development

VITL to develop a system of clinical and claims data: Support

- Hospitals will be pursuing interoperability between the four major EHR systems in Vermont.
- Other areas of opportunity:
    - Improve connections and interfaces at VITL
    - Improve connections with community providers
    - Increase the availability of bi-directional data.
    - Add radiology/PACs images.
    - FHIR/API needs.
    - Explore more opportunities to standardize data fields.

Part 4. Hospital budgets and payment reform

Reference-based pricing: Support exploring reference-based pricing with hospital and payer input and certain guidelines, including:

- Consider factors such as payer mix when developing the proposal
- Give hospitals the opportunity to measure impact of proposal
- 30-day payment of claims to ensure sustainable cash flow
- Medicaid growth rate at half the rate of inflation to ensure predictability
- Triggers and guardrails to ensure access to care

Total cost of care: Support if eliminating net patient services revenue

Net patient services revenue limits access to care and creates inequitable conditions in rural areas. Because net patient services revenue includes Medicare revenue, capping net patient services revenue also leaves federal dollars on the table.

Global Hospital Budgets: Support in the context of the AHEAD model

The Green Mountain Care Board cannot change the way Medicare pays hospitals without an agreement with the federal government. If there is no agreement from the federal government, hospitals will have to pursue global budgets only for Medicaid and commercial insurance while staying on fee-for-service for a large portion of patients, which will not drive change and add to administrative costs.

Substantial resources are also needed to maintain access and quality during implementation of global hospital budgets. Without additional federal dollars, it would be impossible for hospitals to implement global budgets while maintaining access to care.

GMCB Regulatory Duties

Revised timelines: Support with financial assistance to hospitals to cover administrative costs.

To implement a new calendar year, hospitals will have to change their fiscal year with the IRS. Hospitals will also have to redo audits for their current year with multiple year restatements. Durin the re-audit, hospitals will have to run their old fiscal year and the new fiscal year at the same time. All hospitals will also have to re-do their Medicare cost reports. This change should be state-funded to avoid additional undue administrative costs.

Example costs for a Critical Access Hospital:

- Audit: $70,000
- 990 changes: $11,000
- Uniform guidance for federal grants: $15,000
- Cost report filing: $25,000
- Total for Critical Access hospital: $121,000

Implement budget orders in a manner that is consistent with approved strategic plans: Again, the Green Mountain Care Board has consistently stated it does not have the authority or desire to eliminate hospital services. Tying hospital budgets to approved strategic plans is a reversal.

GMCB & DFR ensure that closure of a hospital service results in reduced premiums: Support.

It is unclear how this will be implemented, but we support showing the impact of hospital affordability efforts on premiums.

Reverse CON: Not supported without determination of reimbursement model.

Global hospital budgets allows hospitals to provide care that is underfunded in a fee for service model. The AHEAD model also includes service line oversight by both the GMCB and the federal government. Setting up an additional regulatory process when Vermont is doing global budgets creates additional administrative burden and cost.

Additionally, Rhode Island had adverse outcomes with hospital closure despite having a reverse certificate of need process.

Ratios of executive and other administrative salaries to clinical and other staff salaries: Not supported.

For executive salaries, current law at 18 V.S.A. § 9456(b)(13) has the GMCB consider the salaries for the hospital's executive and clinical leadership and the hospital's salary spread, including a comparison of median salaries to the medians of northern New England states.

A separate reporting requirement will add to administrative burden—hospitals will have to determine who is considered administrative when many individuals do both clinical and administrative work.

Uniform system of accounts: Not supported.

Dr. Nancy Kane pointed out that all relevant financial data is already available in Vermont. The Green Mountain Care Board has Adaptive, which has the ability to standardize hospital financial data and reporting. The Green Mountain Care Board has used this approach in the past. A uniform system of accounts serving the same function would lead to unnecessary administrative costs.

Single auditor: Not supported.

Dr. Nancy Kane pointed out that all relevant financial data is available. An additional audit would create more administrative costs for hospitals when Vermont is trying to decrease administrative costs.

Payments for clinical services: Not supported.

Vermont is already pursuing all available payment models. Pursuing additional payment models will create unpredictability and confusion.

Hospital improvement plans would add to administrative costs.

Part 5. Resources

Additional 15 GMCB staff: Not supported.

With the winding down of OneCare Vermont, the Green Mountain Care Board has approximately $1 million in resources to re-allocate towards pursuing a different payment model. Furthermore, Act 167 already allotted $4.1 million to the Green Mountain Care Board to pursue global budgets and hospital transformation. Additional resources when a payment model has not been determined would be premature, especially when those resources could be going towards supporting primary care in 2026.