Vermont Association of Hospitals and Health Systems

# VAHHS Positions on Senate Health and Welfare Health Care Reform Committee Bill

## General Recommendations: Keep it Simple, Representation, Process

### KEEP IT SIMPLE: STATE PLAN AND REFERENCE-BASED PRICING PILOT

This bill has both immediate (reference-based pricing) and future (global budgets) recommendations. Given the uncertainty at the federal level and limited resources at the state level, Vermont should work on a state plan and a reference-based pricing pilot.

### STAKEHOLDER REPRESENTATION

Many of the experts testifying health care economics and policy emphasized the importance of stakeholder engagement. For any health care reimbursement model to succeed, providers and payers need to be at the table to provide their experience and technical expertise.

### ADMINISTRATIVE PROCESS

The reference-based pricing component of this bill does not provide a lot of detail. Build in guardrails and appropriate process to ensure continued access to health care. For instance, the Green Mountain Care Board does not have an internal appeals process.

## Detailed Recommendations:

## Sec. 1 Green Mountain Care Board Duties

**Reference-based pricing timing:** **Supported for FY 2027**

- Timing should be FY 2027 budgets: Hospitals have received draft budget guidance and have been building their budgets since January. They will not be able to change their budgets in time for FY 2026, which is due July 1, 2025.

**Hospital global budgets:** **Not supported without Medicare participation**

- Hospitals cannot participate in global budgets without federal Medicare participation.

## Sec. 2: Payment Amounts; Methods

**Reference-based pricing pilot:** **Supported with more information and VAHHS proposal**

- The current language states “all payers.” Does reference-based pricing apply to self-insured plans?
- How will the state subsidize facility costs if moving towards site neutrality?
- What is the process around reference-based pricing pilot? Why is the Green Mountain Care Board consulting with payers but not providers?

**VAHHS proposal for reference-based pricing pilot:**

- Give hospitals the opportunity to measure the impact of the proposal.
    - Suggested language:
- Consider risk factors when developing the reference-based pricing proposal:

  - **Suggested language:** *The Green Mountain Care Board shall base its reference-based pricing pilot on an actuarial analysis that takes into account payer mix, acuity, and social risk adjustments.*
- Medicaid growth rate at half the rate of inflation to ensure predictability
- Specific guardrails backed by data to ensure access to care, including from 33 V.S.A. § 1882(a)(5) of Act 48 of 2011:
  - **Suggested language:**
    - *Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending*
    - *Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care profiressionals*
- Specific triggers determined prior to implementation to determine failure of the pilot—include measurements from committee bill for hospital global budgets
  - **Suggested language:**
    - *The Board shall establish outcome measurements to ensure that hospital costs are appropriate, that quality and access are maintained or improved, **hospitals have appropriate reserves, and affordability is being met.***
    - *The Board shall measure reference-based pricing against the above standards annually and at the request of a hospital. If the standards are not met, the Board shall terminate the reference-based pricing pilot.*

## Sec. 3 Hospital Duties

**Administrative vs. direct care reporting: 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 and costs—hospitals will have to determine who is considered administrative when many individuals do both clinical and administrative work.

**Uniform system of accounts: Language change.**

Dr. Nancy Kane pointed out that all relevant financial data is already available in Vermont. The Green Mountain Care Board already spent over $260,000 on Adaptive, which has the ability to standardize hospital financial data and reporting. The Green Mountain Care Board has used this approach in the past and should continue to use this tool. A uniform system of accounts serving the same function is an unnecessary cost to taxpayers.

- **Suggested language:** *The Green Mountain Care Board shall build off its current capabilities for hospital budget data standardization.*

## Sec. 4 Budget Review

**Consider statewide health care delivery plan, including total cost of care targets: VAHHS supports.**

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**Consult with AHS to ensure compliance with federal requirements regarding Medicare and Medicaid: VAHHS needs more information.**

- What does Green Mountain Care Board oversight of AHS mean and what problem is it trying to solve?

**Incentives for hospitals to support community-based, independent, and nonhospital providers: VAHHS supports/neutral.**

**Compare base salaries and total compensation for hospitals executive and clinical leadership with those of the hospital's lowest-paid employees who are delivering health care services. Not supported.**

- Reporting will add additional administrative burden when executive compensation is already reported.
    - Which definition of health care services is being used?
    - Is a medical assistant serving the physician providing direct services? Is a mental health tech providing health care services?

**Number of employees who are administrative versus number who are direct care and national staffing ratios. Not supported.**

- Reporting will add additional administrative burden when executive compensation is already reported. Many hospital employees are administrative and direct care.

**Budgets shall be consistent with the statewide health care delivery plan, including total cost of care targets: VAHHS supports with removal of net patient services revenue target.**

**Beginning in FY 2028, establish global hospital budgets for 5 hospitals, not CAHs, all hospitals by 2030: VAHHS supports with inclusion of Medicare through the AHEAD model.**

- For delivery system transformation, all payers must participate in global budgets. Vermont does not have the legal capability to compel Medicare to participate.
- Significant federal resources are also needed to implement global budgets.

**Outcome measurements to ensure that hospital costs are appropriate and quality and access are maintained or improved and that hospitals implement their budget orders in a manner that is consistent with the health care delivery plan: VAHHS supports with consistent measurements year to year.**

- VAHHS has submitted a dashboard with proposed finance, quality, operational effectiveness and access measurements to the Green Mountain Care Board.

**Hospital reduction or elimination of services requires a notice of intent to the Board, AHS, HCA, and the General Assembly and Board needs to approve: VAHHS supports notice of intent, but not approval without state financial support of services during process.**

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

**Board shall monitor the decrease and connect it to health insurance premiums. VAHHS supports.**

## Sec. 5 Hospital Network Financial Operations

**Allows the GMCB to "take appropriate action as necessary to correct a hospital network's operations that are inconsistent with the principles of health care reform": Not supported.**

- This would allow the Green Mountain Care Board to take over a health care network under vague circumstances, with no concrete criteria and with no process or avenue for appeal.

## Sec. 6 & 7 Statewide Health Care Delivery Plan

**GMCB, AHS, DFR, VPQHC, and the health care delivery advisory committee shall develop a statewide health care delivery plan: VAHHS supports with VAHHS nominee to represent hospitals and definition of affordability.**

- Plan should define affordability, so hospitals and payers understand what they are working towards.
- Without representation from all sectors of health care, advisory committee could end up with all the same provider representatives (e.g. all payers or all primary care providers). The committee and plan oversight will be strongest with representation from all aspects of the health care system.

## Sec. 8 Integrated system of clinical and claims data

**VAHHS supports.**

## Sec. 9 GMCB and Blueprint for Health will explore opportunities to retain capabilities of OneCare

**VAHHS supports.**

## Sec. 10 Additional GMCB Positions

**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 and beyond.

See below for the GMCB's comparison chart—the GMCB combines the VT Public Utility Commission and Department of Public Service, which is like combining the GMCB with the Health Care Advocate and parts of AHS and VITL. For pure regulatory functions, the GMCB is compatible to other sectors and states.

GMCB Chart

| | VT Health Care (GMCB) | VT Energy (PUC+PSD)* | Mass Health Policy Commission (HPC) + Center for Health Information & Analysis (CHIA)** | Maryland Health Service Cost Review Commission (HSCRC) |
|---|---|---|---|---|
| Budget | $8.8M | $18M | $45M | $145M |
| Staff Size | 37 | 83 | 174 | 60 |

Disclaimer! For reference, but not apples to apples...

Notes:
* Excludes Vermont Community Broadband Board (VCBB) budget and staff.
** Mass & Maryland budget details based on publicly available materials for fiscal year 2024. PUC & GMCB based on FY25 As Passed.

Regulatory and Policy Comparison Chart

| | VT Health Care (GMCB) | VT Energy (Just PUC) | Mass Health Policy Commission w/out center for information and analysis | Maryland Service Cost Review Commission |
|---|---|---|---|---|
| **Budget** | $8.8M | $5.7M | $12.0M | |
| **Staff Size** | 37 | 30 | | 7 volunteer commissioners and 48 staff |
| Population | 650,000 | 650,000 | 7.1M | 6.3M |
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