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# Green Mountain Care Board

Presentation to Health Reform Oversight Committee (HROC)

December 06, 2024

# Hospital Sustainability 2019-Present

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## 2019

**Trends of Rural Hospital Closures**

- GMCB convenes Rural Health Services Task Force (Act 26 of 2019)
- GMCB requires 6 of 14 hospitals to develop sustainability plans

## 2020

**Expanded focus on Sustainability Planning**

- GMCB requirement for sustainability planning expanded to all hospitals
- Legislature passes Act 159 requiring GMCB to provide recommendations to improve hospital sustainability

## 2021

**GMCB Develops Recommendations**

- GMCB's Act 159 Hospital Sustainability Report provides recommendations for hospital sustainability

## 2022

**Legislature Passes Act 167**

- Act 167 Sec 1 and 2 provide funding to implement the recommendations from the hospital sustainability report, including community engagement to support hospital transformation

## 2023

**Act 167 Work Underway**

- Act 167 outlined multiple work streams that support hospital sustainability
- This work is ongoing and will continue throughout 2024

## 2024

**Act 167 Work Continues**

- GMCB concludes Community Engagement to Support Hospital Transformation project and contractors publish final report outlining options and recommendations for sustainability
- GMCB will assess the recommended regulatory changes. (see slide 16 of this presentation)

## 2025

**Transformation**

- Per Act 51 of 2023, the Agency of Human Services will lead implementation of hospital transformation

# Rural Hospitals Have Been Struggling

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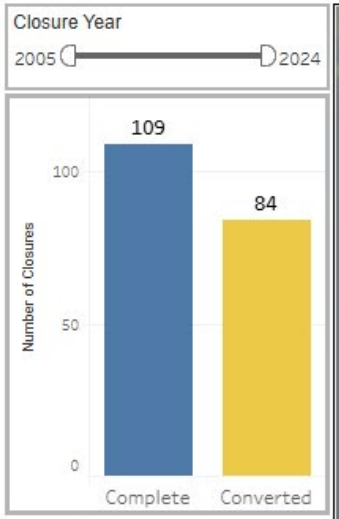


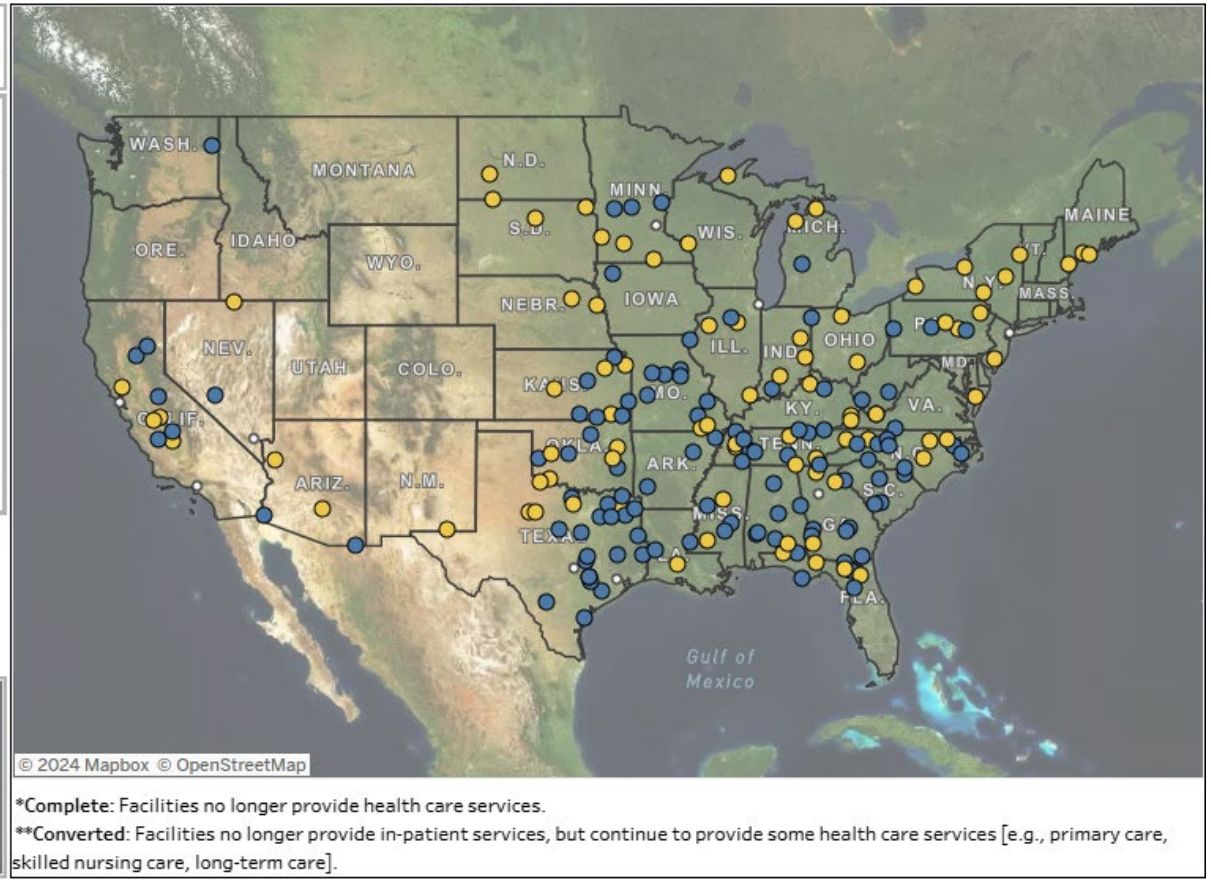


*Complete: Facilities no longer provide health care services.
**Converted: Facilities no longer provide in-patient services, but continue to provide some health care services [e.g., primary care, skilled nursing care, long-term care].

193 closures since 2005 (150 since 2010)

**Designation:** 38% PPS, 37% CAH

**Rurality:** 39% small rural, 33% large rural, 24% isolated

*Source: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/*

# NPR Growth vs. National & Regional Trends

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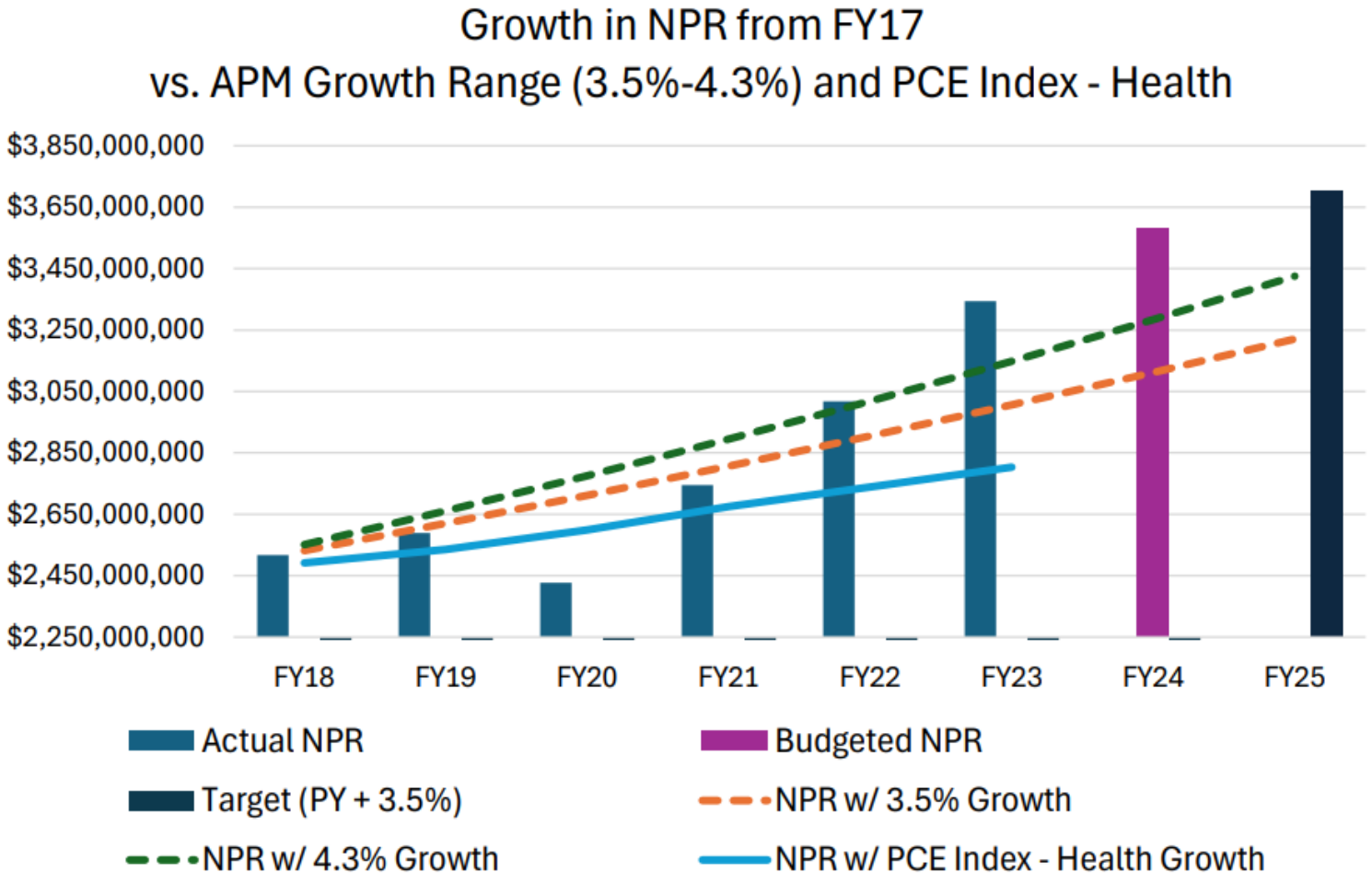


Compound NPR growth since 2017 has been just over **6%.**

If we stayed at 4.3% growth since 2017, FY25 would be **$3.43 B**; at 3.5% growth, FY25 would be **$3.22 B**

| *millions* | FY25 NPR Benchmark | FY25 vs. FY24 B | FY25 vs. FY17 Trended |
|---|---|---|---|
| FY24 @ **3.5%** | $3,704 | $125 | $483 |
| FY24 @ **4.3%** | $3,732 | $154 | $278 |

# Days Cash on Hand
# Vermont Community Hospitals

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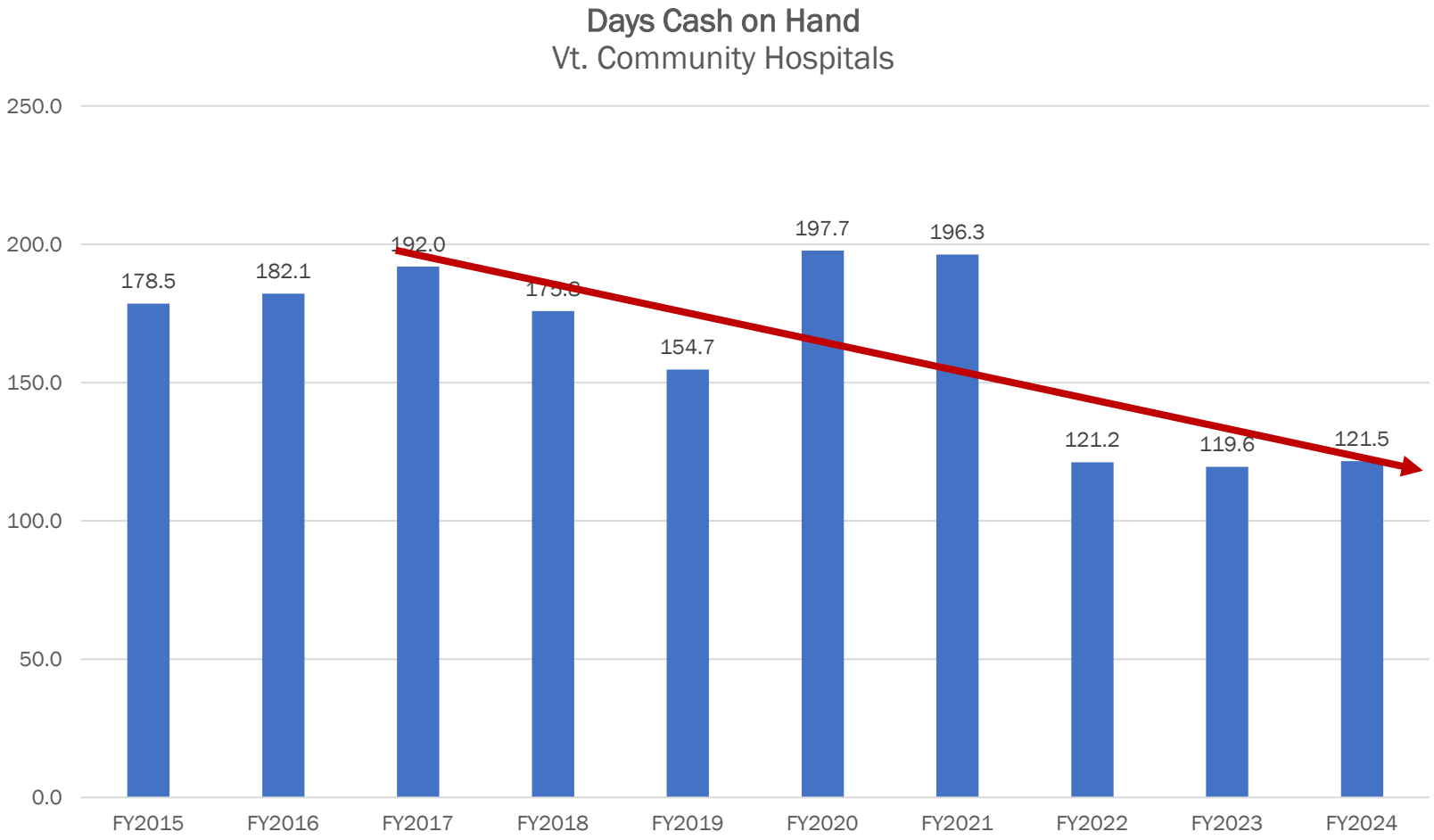

BECKER'S

# Hospital CFO Report

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## Financial Management

# 705 hospitals at risk of closure, state by state

Molly Gamble (Twitter) - Friday, November 22nd, 2024

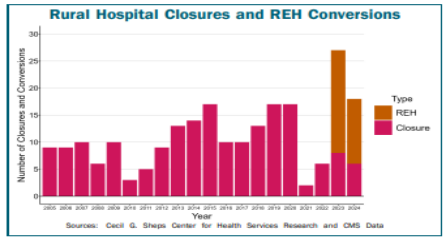
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

## RURAL HOSPITALS AT RISK OF CLOSING

### Millions of Americans No Longer Have Hospital Care in Their Community

Over the past two decades, nearly 200 rural hospitals have closed. As a result, the millions of Americans who live in those communities no longer have access to an emergency room, inpatient care, and many other hospital services that citizens in most of the rest of the country take for granted.

In addition, 31 hospitals eliminated inpatient services in 2023 and 2024 in order to qualify for federal grants that are only available for Rural Emergency Hospitals (REHs). Every year, more than 7,000 rural residents had received inpatient care in those hospitals, but now seriously ill individuals in their communities will have to be transferred to a hospital far from home in order to receive the services they need.

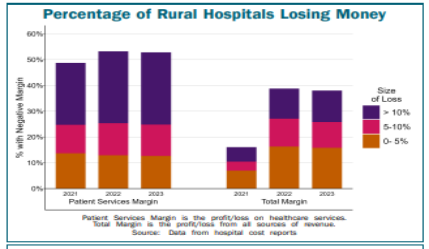


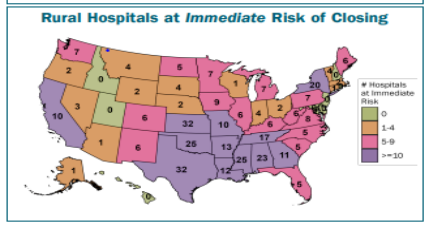

### Hundreds More Rural Hospitals Could Close in the Near Future

More than 700 rural hospitals – over 30% of all rural hospitals in the country – are at risk of closing because of the serious financial problems they are experiencing. Over half (364) of these rural hospitals are at *immediate* risk of closing because of the severity of their financial problems. (See RuralHospitals.org for the methodology used to estimate risk of closing.)

- **Losses on Patient Services:** The majority of rural hospitals in the country are losing money delivering patient services. It costs more to deliver health care in small rural communities than in urban areas, and many health insurance plans do not pay enough to cover these costs.
- **Insufficient Revenues From Other Sources to Offset Losses:** Many hospitals have managed to remain open despite
- **Low Financial Reserves:** The hospitals at greatest risk of closing have more debts than assets, or they do not have adequate net assets (i.e., assets other than buildings & equipment, minus debt) to offset their losses on patient services for more than a few years.

Rural hospitals are at risk of closing in almost every state. In the majority of states, over 25% of rural hospitals are at risk of closing, and in 10 states, over 50% are at risk.




### Rural Hospital Closures Harm Patients and the Nation's Economy

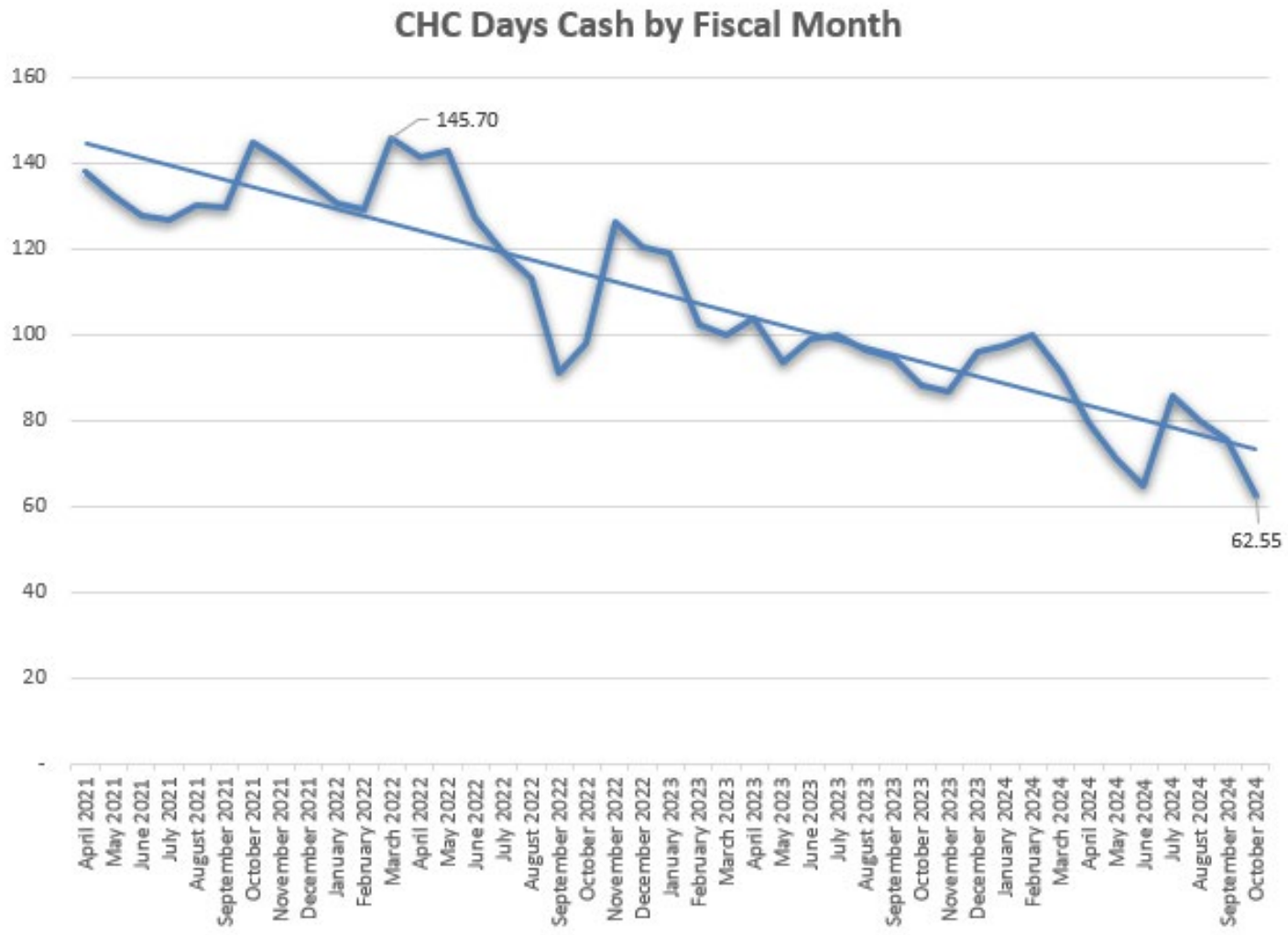
Most at-risk hospitals are in isolated rural communities, where closure of the hospital would force residents of the community to travel a long distance for emergency or inpatient care. Moreover, in many cases, the hospital is the only place where residents can get laboratory tests or imaging studies, and it may

**Vermont**

8 hospitals at risk of closing (62%)

4 at immediate risk of closing in next 2-3 years (31%)

# The need: Days in Cash



# CHC Gain (Loss) by Fiscal Year


| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 Projected |
|---|---|---|---|---|---|---|---|---|
| Change in Net Assets | $968,653 | $364,232 | $531,029 | $5,846,402 | $1,308,478 | $(401,187) | $(655,209) | $(2,328,249) |
| Trend | $968,653 | | | | | | | $(2,328,249) |

# Little Rivers Health Center

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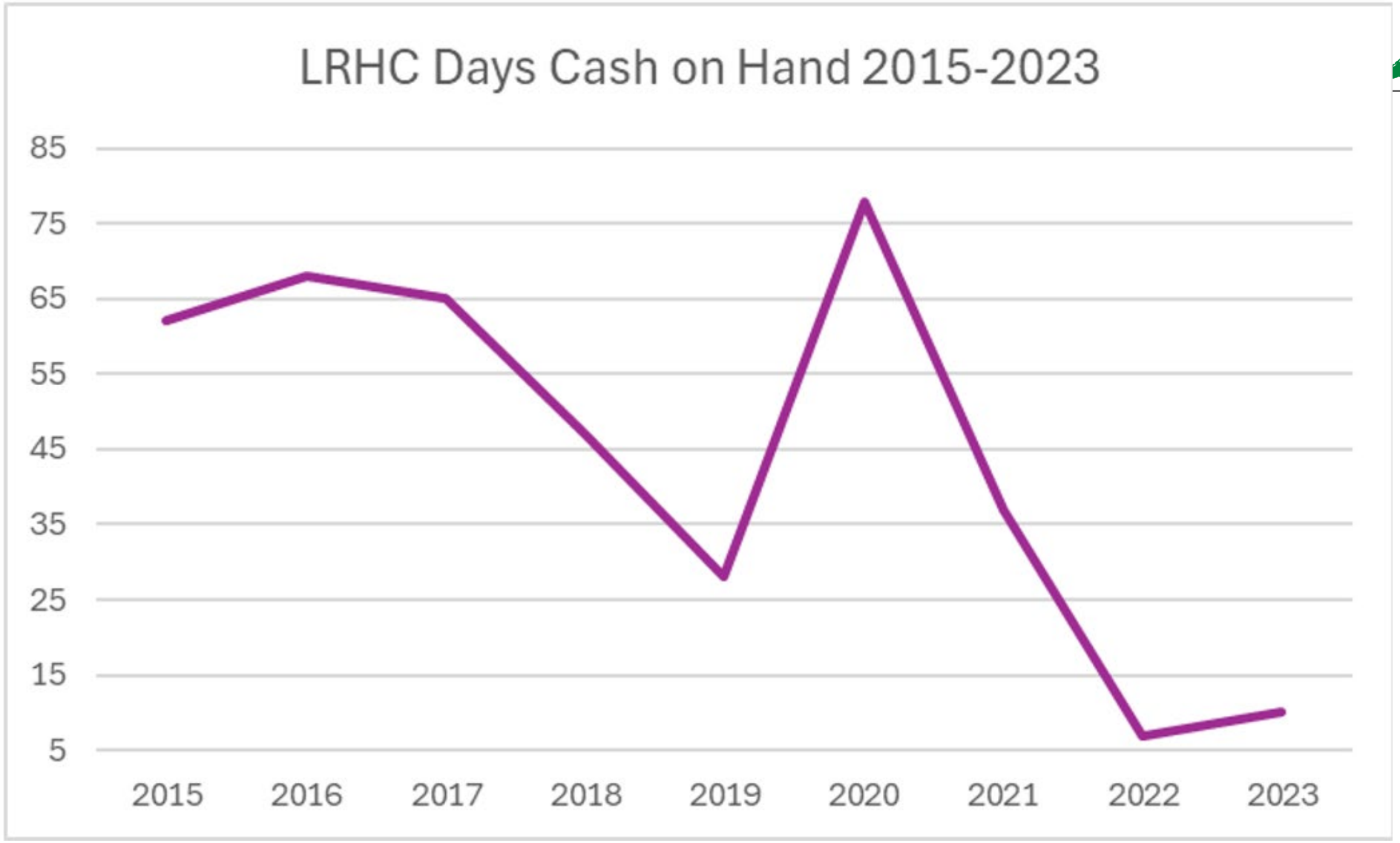


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# Health Care Landscape Trends

## Affordability

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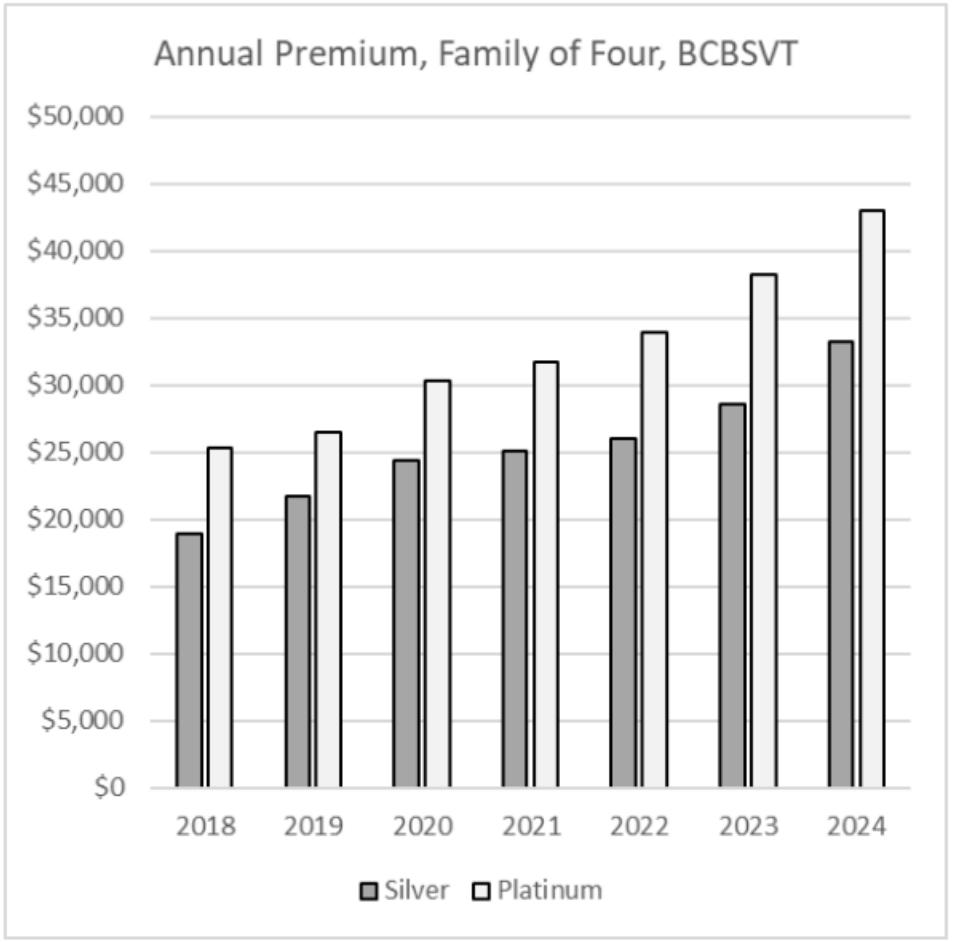


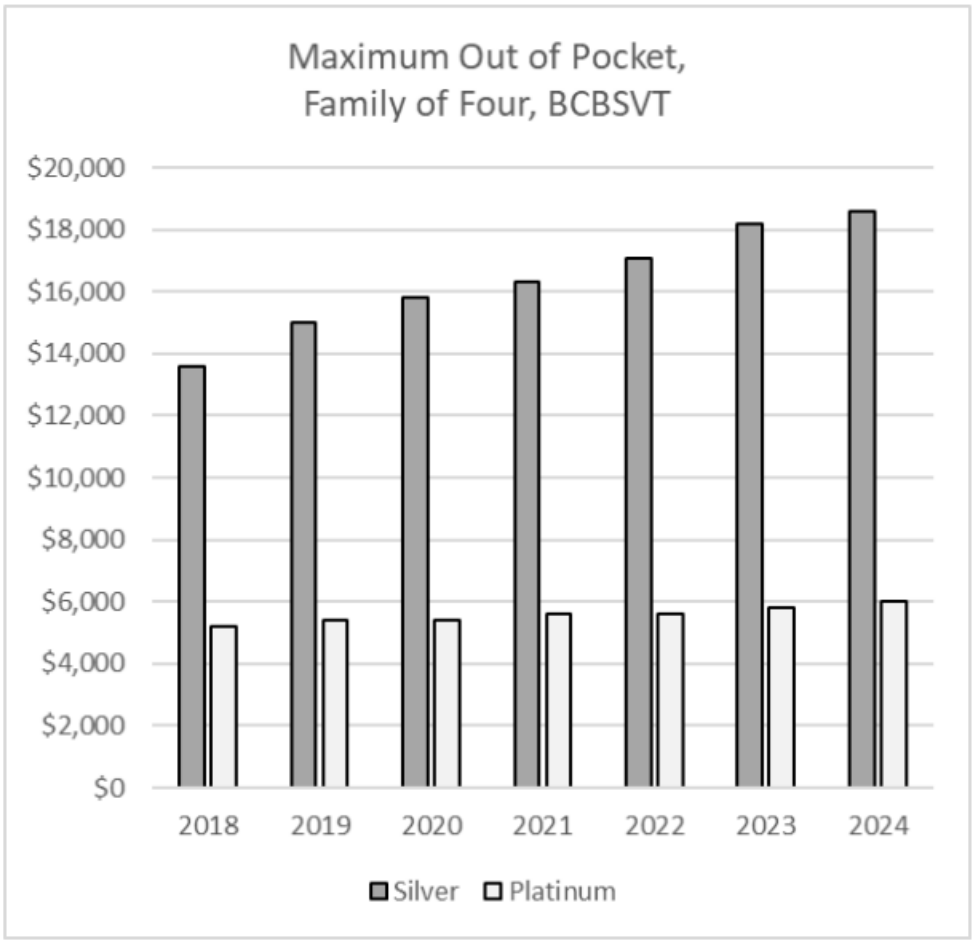


**Note.** Most VHC users are eligible for subsidies or tax credits. Most uninsured Vermonters are for VHC plan subsidies. Enhanced subsidies from APRA will continue through 2025.

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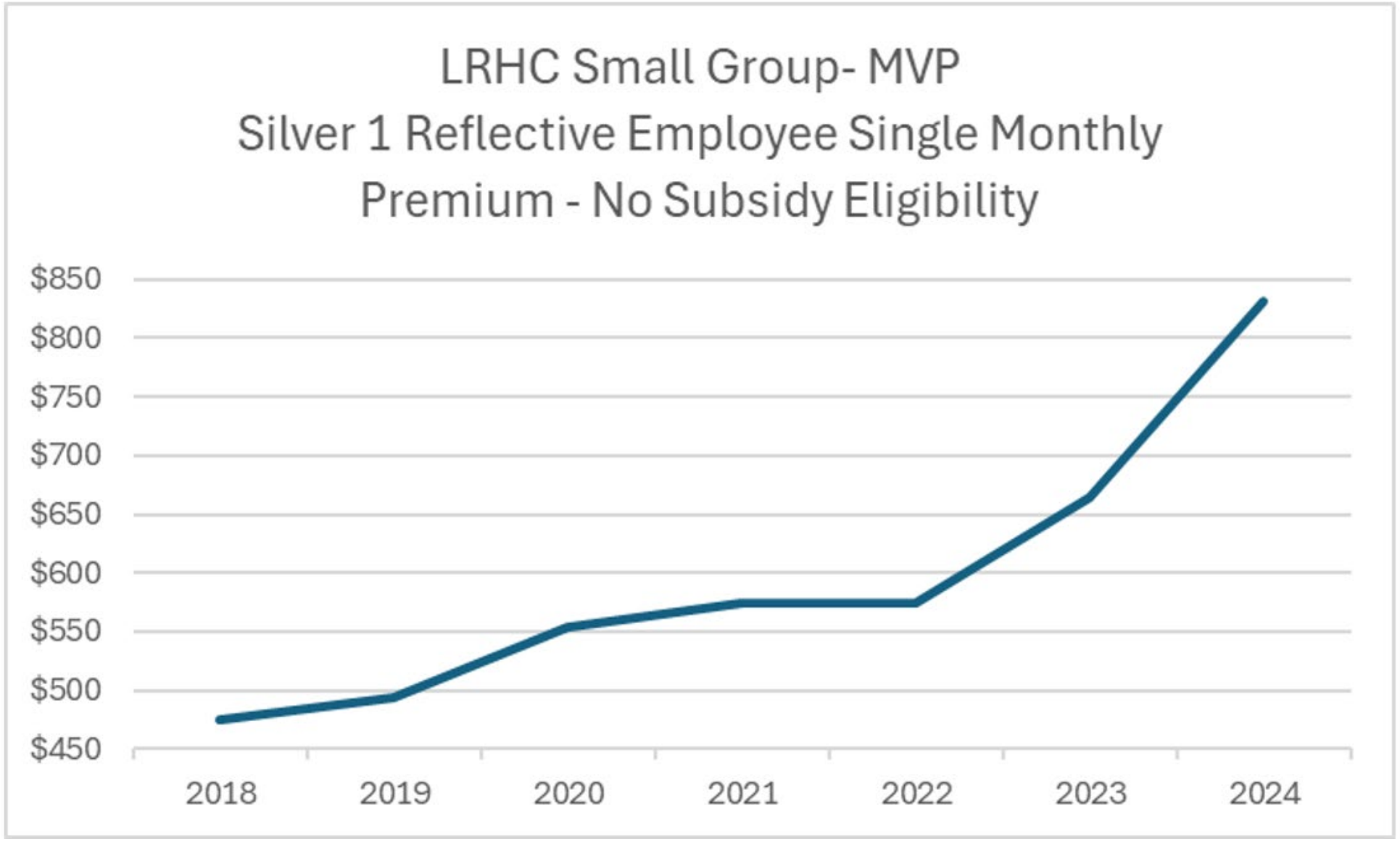
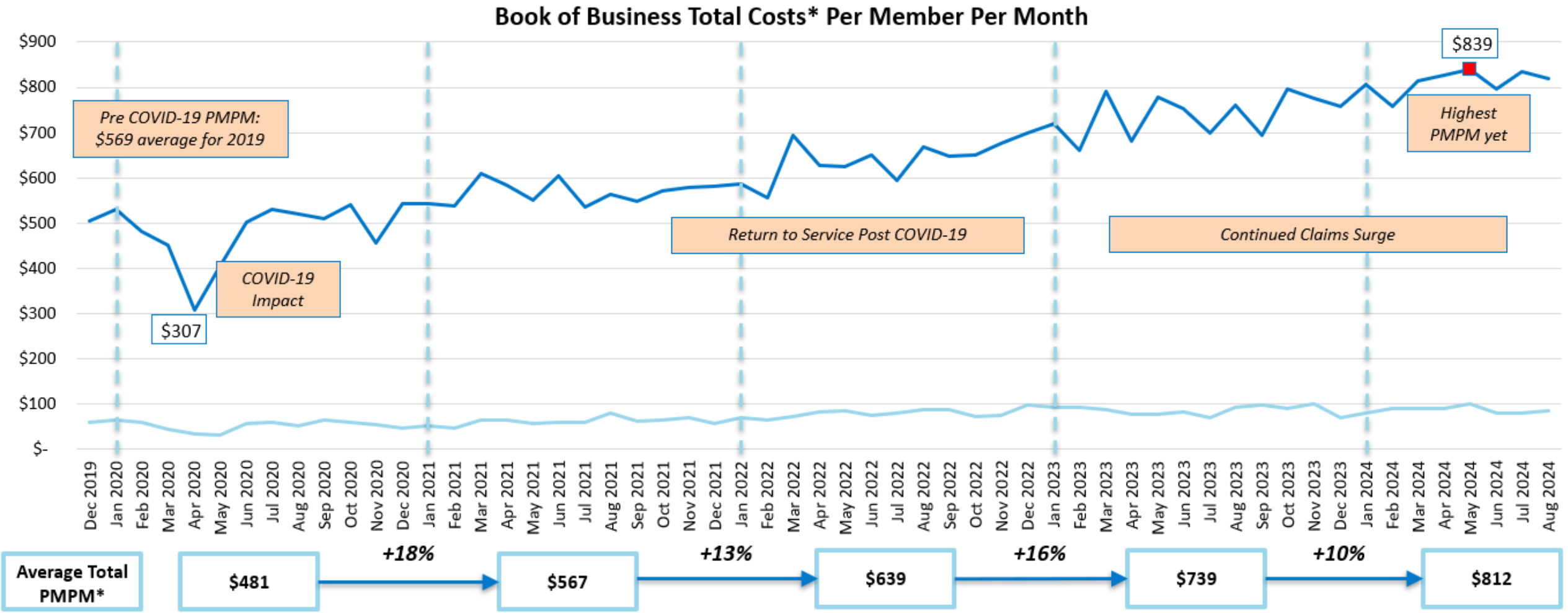


Average annual per member per month medical and pharmacy costs have increased from $481 to $812 since 2020 for local claims only, excluding Medicare primary and FEP. Blue Card claims trend does not exhibit the same escalation.




| Average Total PMPM* | $481 | +18% | $567 | +13% | $639 | +16% | $739 | +10% | $812 |
|---|---|---|---|---|---|---|---|---|---|

*Blue Card claims represent 12% of total medical claims in 2024 year to date.*

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

**EXCLUDES BLUE CARD, FEP, MEDICARE PRIMARY*
*INCURRED CLAIMS BASIS*
*CURRENT PERIOD = INCURRED CLAIMS JAN-AUG 2024, PAID THROUGH OCT 2024*

# BCBS Statement for Friday, Dec 6th

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Blue Cross VT's RBC level (risk based capital) began 2024 well below the range recommended by the Department of Financial Regulation, and over the course of this year has declined further, triggering regulatory oversight.

Medical and drug claims have surged since the end of the pandemic using up more than $100 million of Blue Cross VT reserves—that's nearly ¾ of the company's reserves. There is no evidence that these expenses are slowing. This is a serious situation that is concerning to the GMCB and DFR.

These extraordinary expenses can be attributed to multiple factors – the impact of high hospital price increases compounded over several years, increased utilization and intensity at hospitals including new cancer drugs and rising costs of medications, injections and infusions in the outpatient setting, and the evolving mix of specialty drugs like the rise of GLP-1s.

While the GMCB approved higher premiums to increase Blue Cross's reserve level this summer, those rates don't go into effect until 2025.

There is more than enough money being spent on health care by our citizens and employers. A few of our hospitals are collecting significantly more revenue than was approved in their budgets, while our payers – Blue Cross VT, the VEHI Trust Fund, and thousands of small employers and individuals are struggling financially to pay for health care. We need to correct this situation/even the decks to prevent further escalation and serious consequences.

# SCOPE AND APPROACH: TO IMPROVE THE VERMONT HEALTHCARE DELIVERY SYSTEM, WE SOUGHT OUT INPUT FROM COMMUNITY STAKEHOLDERS OVER 12 MONTHS

Act 167 (of 2022) requires GMCB, in collaboration with the Agency of Human Services, to develop and conduct a data-informed, patient-focused, community-inclusive engagement process for Vermont's hospitals to **reduce inefficiencies, lower costs, improve population health outcomes, reduce health inequities, and increase access to essential services**

**Green Mountain Care Board:** *Community and Provider Engagement*

**Agency of Human Services:** *System Transformation*

| ***Aug-Sept 2023*** | ***Sept-Nov 2023*** | ***March – July 2024*** | ***Aug – Sep 2024*** | ***Sept 2024 - ?*** |
|---|---|---|---|---|
| Step 1. Finalize engagement plan and interview scheduling | Step 2. Develop current state understanding in 1st round interviews | Step 3. Develop solution options, vet with community | **Step 4. Develop and deliver final report** | **Step 5. Transform healthcare delivery system** |
| Identify and schedule interviews with key stakeholders:<br>• Hospital leaders<br>• Provider organizations<br>• Community leaders and members<br>• Diverse populations<br>• State of Vermont partners and Legislators<br>• Health related organizations | Obtain community perspective on:<br>• Hospital Service Area (HSA) characteristics<br>• Hospital & healthcare delivery system performance<br>• Community needs<br>• Desired health system future state | • Develop solutions to address current needs and reach the desired future state while considering Act 167 goals<br>– *In conjunction with analytics contractor*<br>• Obtain stakeholder perspective on the impact of recommendations on hospital performance and healthcare delivery | • Document and socialize confirmed current state understanding, designed future state, and recommended steps to achieve future state (including pros and cons)<br>• Publish report | • Devise action plan and budget allocations<br>• Implement chosen healthcare delivery system transformations |
| ***Completed Phases*** | | | ***Focus of This Report*** | |

# VERMONT LEGISLATORS AND AGENCIES NEED TO START ON TRANSFORMATION PRIORITIES IN 2025 TO ALLOW FOR ORDERLY SYSTEM TRANSFORMATION TO COMPLETE BY 2028

## Priority policy changes for Vermont legislators to approve in 2025

1. Remove barriers to building affordable housing for VT residents and newcomers to the State
2. Approve funding for EMS transformation
3. Expand broadband coverage to rural areas (e.g. Star Link)
4. Review existing AHS agency structure and program list to identify overlaps and opportunities for efficiency
5. Develop state regulations and provision details for Rural Emergency Hospital and free-standing birthing centers
6. Expand professional licensure and practice scope for nurses, EMT and pharmacists

Form the critical **infrastructure and regulatory foundations** for implementation of health system transformation

## Priority transformation programs for AHS to initiate in 2025

1. Regionalize of specialty care services across hospitals
2. EMS professionalization and regionalization
3. Improved care coordination and management for heavy utilizers (e.g., elderly, mental health, and neuro-divergent and foster care)
4. Dual eligible targeting, care planning and coordination
5. State-wide electronic medical record coordination and optimization

Devise **realistic operational details and implementation plan** for transformation initiatives

## Priority regulatory changes for GMCB to apply starting 2025

1. Permit no further increases in commercial subsidization for hospital financial shortfalls
2. Refrain from licensing any further hospital-based outpatient department unit
3. Simplify and shorten CON process
4. Encourage free-standing diagnostic, ASC, birthing centers
5. Begin movement to reference-based pricing ideally at 200% of Medicare or less for PPS hospitals
6. Require all hospitals to use the same accounting agency and method to construct hospital financials and budget submissions

**Align system incentives and guardrails** to desired transformation goals

# TRANSFORMATION IS COMPLEX AND REQUIRES CLARITY IN GOVERNANCE ROLES

## Agency of Human Services

- Improve efficiency of AHS by consolidating efforts directed at same populations
- Reduce administrative complexity and paperwork for applicants and providers
- Accelerate construction of affordable housing/transportation
- Facilitate and fund EMS Regionalization
  - Fund broadband access for EMTs (e.g. Starlink)
- Expand workforce efforts
- Re-evaluate efforts at VITL and complete changes by FY 2026
- Convene community stakeholders to evaluate, choose and implement ways to move care out of the inpatient hospital and into the home and community (Act 167 Report)
- Convene community stakeholders from several communities to decide on regionalization of health services (Act 167 Report)
- **Support Needed:** Project Management Office and Facilitation Support

## Green Mountain Care Board

- Add Division of Planning and Effectiveness
  - Calculate impacts of changes in the sites of care on hospital budgets, prices to consumers and availability of long-term care
  - Monitor access to and affordability of community providers
  - Monitor progress of transformation / assist AHS in calculations
  - Monitor progress on Quality / Access/ Equity measures
    - Access to Services
    - Low volume procedures
    - Physician work effort
    - Measures of equity in access to health services and health
    - Move payment model for all providers to reference-based pricing over next 3-5 years
- Modify hospital budgets to account for movement of services to a regional model
- Require alignment of Quality / Access / Equity metrics across all payers and Agencies and link to payment for all healthcare providers
- Link payments to Primary Care providers to those of Hospitals
- **Support Needed**: Project Management Office and analytic support while additional staff are hired and automation is installed

# Act 167 of 2022 Section 1(b)

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Using a stakeholder process (Sec1(a)(3)), GMCB, in collaboration with AHS, shall develop **all-payer value-based payments** (could be global payments) 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, consistent with the principles set forth in 18 V.S.A. § 9371, and sufficient to enable the hospitals to deliver high-quality, affordable health care services to patients;

C. take into consideration the necessary costs and operating expenses of providing services and not be based solely on historical charges; and

D. take into consideration Vermont's rural nature, including that many areas of the State are remote and sparsely populated;

And determine how to incorporate such payments into the Board's regulatory processes…

# Work to Date Developing Global Budget & Payment Methodologies

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- GMCB engaged Mathematica, Inc. and Bailit Health to analyze and model options for a Medicare Global Budget and Payment methodology, beginning in January 2023
- Work groups included key stakeholders including but not limited to:
  - Vermont Hospital CEOs and CFOs, the Office of the Health Care Advocate, Blue Cross and Blue Shield of Vermont, MVP, Cigna, Agency of Human Services and it's Office of Health Care Reform, Vermont Association of Hospitals and Health Systems, Department of Financial Regulation
- Work groups created analytics on potential model inputs such as base years for calculations, data sources to use, population risk adjustment methods, service line adjustments, etc.
- A draft methodology was submitted to CMS Innovation on July 8, 2024
- Cooperative Agreement funding attached to the AHEAD model includes dollars earmarked for further developing a framework for global payments with GMCB's existing Hospital Budget Review process

TAG Meeting Materials

# (Some) Board Questions to Date: AHEAD Hospital Global Payments

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- Will AHEAD/HGP reduce Vermont's reliance on Commercial insurance to sustain hospital financial health?
- What are the mitigation strategies for the incentive under a fixed budget to ration care and avoid delivery of high-cost services, particularly in a state where we already have access challenges and low utilization?
- What are the implications of AHEAD/HGP on wait-times for hospital care?
- How does the AHEAD model incentivize hospital system transformation? What kind of transformation?
- What are the implications of this model for Primary Care & Mental Health/Substance Use Disorder access?
- What are the implications of this model for the challenges associated with hospital borders & other capacity pressures due to challenges outside the hospital?
- How do the risks and opportunities of AHEAD/HGP differ on a voluntary or mandatory basis? What does all-payer participation mean?
- What is our "Best Alternative to a Negotiated Agreement"? How does AHEAD/HGP compare?
- What are the lessons learned from our current reform models? Do we have a Vermont-centered evaluation?
- What does this model mean for the financial strain/fragility of our hospital system, given that 9/14 hospitals have negative operating margins?
- What are the mechanisms for identifying and removing inefficiencies under the AHEAD model?
- What will Medicaid and Commercial Hospital Global Payments look like and how will they all work together?
- What are the projected revenues under the AHEAD model vs. FFS?
- Has there been an assessment of system preparedness, especially given the financial sustainability challenges?
- Will adequate resources be allocated to the State/GMCB to operationalize this?