



Vermont . . .

Public Oversight Commission

Gregory B. Peters, Chair

Attachment I

Public Oversight Commission
2007 Report to the Commissioner of
Banking, Securities, Insurance and Health Care Administration

Purpose:

The purpose of this report is to provide observations and recommendations resulting from the August 21-23 budget hearings attended by the members of the Public Oversight Commission.

Overall status of the Vermont Hospital System:

On the surface, the hospital portion of the health care delivery system appears to be in reasonable shape. Projected '07 net revenues are up 7.9 % year over year, yielding a net surplus of 5.2% across the system (including non-operating income). Hospital balance sheets and overall age of plant and equipment are also generally in reasonable condition.

However, the picture is not all rosy. Although the aggregate 7.3% rate increase request by the hospitals is within the range of requests in recent years, the breadth of the range of requests from 4% to 14% reflects the volatility of individual hospital performance and the fragility of the system overall. The remainder of this report will focus upon the major external challenges facing the system, observations on the system itself and how it is working, specific observations on individual hospitals, and, finally, recommendations for both budget order and health policy consideration.

Major External Challenges:

- 1) There continues to be a serious shortage of physicians, nurses and other allied health professionals within the system. This situation is unlikely to change in the near to medium term given the projected volume of graduates from medical, nursing and allied health education programs. Attracting and retaining MDs is particularly difficult in the more rural parts of the state, where the loss of a single subspecialty, such as orthopedic surgery, can have a significant impact on the financial well-being of a 25 bed Critical Access Hospital. The difficulty of attracting physicians is further

- exacerbated by the lack of challenging and well-paying jobs for mates in the relocation process.
- 2) Vermont's demographics create a challenging environment for hospitals. The State's aging population, increasing numbers of people on Medicare, Medicaid and other government funded programs, end-of-life care and prevalence of chronic diseases continue to increase demand for, and utilization of, health care services. The impact of the aging population is particularly significant in areas surrounding Rutland, Bennington and the Northeast Kingdom.
 - 3) Federal and state reimbursement policies drive the "cost shift" burden to third-party commercial and self-pay patients. The cost shift is a hidden tax on those not covered by government programs, causing higher health insurance premiums and higher prices for self-pay patients. The burden on employers and their employees, who are paying a disproportionate share of the cost of health care, is reaching the breaking point. More favorable reimbursement from federally funded programs is unlikely in the foreseeable future.
 - 4) Compensation increases for nurses in recent years have helped to reduce the need for "travelers" but have served to increase the underlying cost of delivering care. Health care delivery is labor intensive. Escalating salaries and fringe benefits have become a major driver in the increasing cost of health care relative to other sectors of the economy.

System/Process Observations:

- 1) The present regulatory, rate setting and budget system tends to reinforce ongoing behavior by the participants in the system. The system forces hospital CEO's to deal with the cost shift by encouraging demand and utilization of services where they can make money in order to cover increased operating costs. Rate increases are used to bridge the gap and guarantee a modest operating margin. The system is self-perpetuating and doesn't encourage efficiency or productivity improvements, or focus on core business programs and services.
- 2) The 1-year budget cycle is volatile and does not encourage much in the way of longer term planning. Hospitals that are in financial difficulty, or are attempting to strengthen their balance sheets in anticipation of an expansion program, make larger rate requests. Budgets traditionally are not zero-based and typically add programs and services. Rarely (if ever) are programs and services reduced or eliminated.
- 3) There is a lack of alignment between the goals of the system (i.e. increase quality, contain costs and improve the patient experience) and incentives to get there. Rate increases and CON approvals are not necessarily awarded to those who perform well, but rather to those in financial difficulty and/or requiring upgrade of equipment and facilities to stay competitive irrespective of their performance on CMS quality measures or other standards of excellence.

- 4) The Health Resource Allocation Plan (HRAP) is not well-understood by the hospitals and is not useful to them as a planning tool. The CON guidelines updated by HRAP serve more as a guide for the permitting process, which, if satisfied, result in the granting of a CON. At present, the guidelines are not a visionary tool by which to strategically allocate resources over time to yield the type of health care delivery system that delivers quality care in a patient-centered environment at a price which we can afford. The current CON guidelines, therefore, are not a particularly useful framework for CON decision making.
- 5) The Blueprint, with its focus on chronic diseases, multi-disciplinary approaches toward delivering care, electronic health record and pay-for-performance may be a model for how incentives can be aligned between hospitals, providers, community services and patients to improve quality, reduce cost and improve patient lives over time.
- 6) There is not a vision of what the Vermont health care system of 2020 should look like. Critical Access Hospitals are not significantly impacted by the budget process and rate requests in that their Medicare services are reimbursed on a cost plus basis, supporting them financially and potentially delaying the day of reckoning when they must transform into a different form of primary care institution.
- 7) The demand for the latest equipment technology to satisfy the desires of the medical staff can be a driver of increasing services, higher utilization and therefore higher costs. In contrast, the proper use of information technology can reduce duplicate testing, minimize medical errors, improve efficiency, encourage benchmarking and enhance the practice of evidenced-based medicine.

Specific Hospital Observations:

- 1) Aggregate system rate increases that have averaged over 7% in the past five years are too high. The system goal should be no more than the increase in the cost of living nationally, i.e. currently in the range of 3-4%.
- 2) Overall, the age of plant and equipment across the system is in an appropriate range. However, the physical plant of some hospitals is both aging and inefficient. Pressure is on a number of hospitals to update facilities and move toward private rooms for acute inpatient care.
- 3) At least two hospitals (Northwestern and Central Vermont) are under some financial stress from an operating standpoint, although their balance sheets are sufficiently strong to suggest they are not in financial jeopardy.
- 4) The two hospitals (Rutland and Southwest Regional) with the most challenging demographics/aging population have the two largest upcoming expansion/renovation projects.
- 5) Although some hospitals are focusing on improving efficiency and productivity, there seems to be a general lack of urgency in this area.

- 6) Collaboration seems to be becoming more evident among hospitals. The joint project between Central Vermont, Fletcher Allen and Dartmouth Hitchcock for a radiation oncology center is a good case in point.
- 7) FAHC rate requests are declining after several years of above average rate increases, reflecting a return to financial health. However, major capital investments loom in the form of IT, radiation oncology, and eventually an inpatient tower. Transparency in the support of education and research from clinical care revenues would be appropriate to share. FAHC is beginning to demonstrate a leadership role, in collaboration with smaller community hospitals, providing shared pharmacy and support of understaffed clinical services.
- 8) Rutland is saddled with high payroll/benefit costs and an aging facility. As an institution, it hasn't demonstrated a tough cost-cutting mentality to date. Management seems to be looking for improvement in Medicare and Medicaid reimbursement to bail them out. Balance sheet strength is okay for the short to medium term.
- 9) Northwestern Medical Center has been under financial duress, largely the result of losses in key members of its medical staff. Although attempting to bridge the gap, a permanent solution to the difficulty of attracting and maintaining medical staff is unclear.
- 10) Springfield Hospital's viability over longer term is unclear. However, management seems to be operating within their means and has a tough minded approach to cost, allowing them to survive in the interim. A more permanent role in the delivery system and associated strategy may be required.
- 11) North Country Medical Center (NCMC) and Southwestern Medical Center (SWMC) are attempting to deal with medical staff recruitment and retention by employing more MDs and/or guaranteeing income. In the case of NCMC, they are building a medical office building to solidify relationship with MDs. This strategy is not without risk, given the difficulty in managing MDs productivity, and it may end up being a potential burden on the financial health of the institution in the longer term.
- 12) In general, hospital strategic plans fail to clearly deal with the downside scenario of reimbursement pressure, i.e. clearly defining core services, cutting programs where appropriate, cutting costs where possible, improving quality and efficiency, and becoming "lean and mean".

Recommendations:

- 1) Focus on what we can control, not what we can't (such as changes in federal government reimbursement). Vermont's health care system must learn to live within the State's means;

- 2) Focus system goals on quality, cost and patient experience, and align incentives with those goals. Reward those who perform well with rate increases and CON approvals. Do not reward those who perform poorly.
- 3) Use performance tools such as utilization metrics, evidenced-based medicine and outcomes measurement to measure hospital performance, program and equipment additions, rate requests and CON approvals.
- 4) Continue to encourage collaboration, networking, shared thinking and shared services among institutions;
- 5) Continue to push price/quality transparency, consumer education, and consumer responsibility and accountability for their own health care;
- 6) Engage in the discussion of what we, a state of 630,000 people, can afford. Do we need 14 hospitals? If so, what should they look like in order to rationalize the system, recognizing the limitations and costs of medical staff, nursing and allied health professional shortages and capital;
- 7) Leverage existing resources through:
 - shared services, centers of excellence, collaboration;
 - information technology, telemedicine, electronic health record;
 - best practices, evidenced-based medicine;
 - available MDs and allied health professionals;
- 8) Update the HRAP. Develop a clear vision of what the delivery system should look like in 2020. Update the CON guidelines to reflect that vision with greater clarity. Link hospital performance on system goals to CON approval. Clearer guidelines should provide a better planning tool for hospitals, and increase predictability of the CON process.
- 9) Revamp the budget, rate increase process. It serves only to perpetuate an overregulated, ineffective process. Consider a flat rate increase to all hospitals that decreases from the 7% of today down to the national economy's rate of inflation over the next 3 years.

Summary:

In closing, the Public Oversight Commission would like to recognize the hard work and dedication of the BISHCA staff in preparation for the budget hearings, and for their support throughout the year. We recognize that the health care delivery system faces multiple challenges and that there are no quick or simple fixes to achieving the goals of improving quality, containing costs and improving the patient experience for all Vermonters. Hopefully the above observations and recommendations may help shed some light on how we might better move forward toward achieving those goals.