



# *Vermont . . .*

Public Oversight Commission

John O'Kane, Chair

September 12, 2006

Commissioner John Crowley  
Vermont Dept. of Banking, Insurance, Securities and  
Health Care Administration  
89 Main St., Drawer 20  
Montpelier, VT 05620-3101

Ref: 2006 Hospital Budget Hearings

Dear Commissioner Crowley,

The members of the Public Oversight Commission attended the August 22-24 Hospital Budget hearings and offer the following observations and recommendations as you and the Department implement the 2007 Hospital Budget Orders.

## Overall status of the Vermont Hospital System:

While there are substantial differences between individual institutions, the overall hospital system appears to be in stronger financial and operational condition than in prior years. Factors reflecting this are:

1. Budgets more consistent in rate increases and operating margins
2. Evidence that hospitals are beginning to adopt the HRAP recommendations with a focus on the Institute of Medicine's STEEEP priorities. Quality reporting and price transparency are positive indicators.
3. Most hospitals have decreased their dependence on "travelers" for nurse staffing providing more predictability in labor costs
4. Several hospitals are implementing detailed financial and operating management practices to provide objective measurements of improvement in efficiency and productivity
5. As one hospital administrator pointed out, the Vermont Unified Health Care budget is heading past four billion dollars in 2007. There seems to be adequate money in the system.

While there is some good news in the budgets, the overall hospital system is under stress from a number of factors:

1. Of all the challenges facing the health care system, the most immediate seems to be the increasing shortage of physicians willing to work in Vermont, not only in primary care, but also in specialties which are critical to the financial viability of hospitals and access to comprehensive health care. The hospitals, with few exceptions, are embarked on a path of expanded hospital employment of physicians with the accompanying need to subsidize salaries. The root causes of this situation are limitations on income for physicians stemming from underpayment by government payers and limited volume for some specialties due to the small population service areas of many Vermont hospitals. This physician shortage may lead to further discrepancies in health care access between Chittenden County and other sectors of Vermont. It represents significant financial risk to the hospitals.
2. Vermont's demographics of an aging population, large numbers of citizens on government sponsored health programs which do not fully pay health care costs, continued increases in health care utilization, and resistance to higher rates by commercial payers all create an increasingly challenging outlook.
3. Federal reimbursement policies seem to be the major factor driving hospital decisions on capacity and types of services. This may not be in the best interest of the system as a whole. Vermont has limited options to change federal policy, but changes in hospital behavior in collaboration and sharing of resources and specialties could make for a more rational result.
4. Compensation increases, particularly for nurses, may have gone beyond correcting for historically low pay to becoming a major driver of health care costs. Several of the hospitals described salary planning systems which took average market pay as a starting point to which seniority and performance increases were added, bringing total pay to above market rates. Some of these increases stem from collective bargaining agreements which seem very generous given the overall system concern with hospital rate inflation.
5. Virtually all hospitals acknowledge the need and value of better information management for safety, efficiency, and effectiveness of care. The Vermont Information Technology Leaders initiative intends to support these needs, but the IT plans of individual hospitals appear to be moving ahead of, and at a faster pace, than VITL can achieve. Hospital IT plans should maintain the communication protocols and interoperability standards set forth by VITL over time.
6. Some hospitals, such as Rutland and Central Vermont, have implemented management systems focused on productivity improvement and cost control. The extent of such systems and their effectiveness in all hospitals is an area for further review. Some hospitals appeared to be strategic

planners, while others were reacting to problems which could have been foreseen.

Recommendations:

1. Hospital rate requests are too high. Cost shift, particularly from Medicaid, justify some of the increases above inflation rates, but the question must be asked of hospitals why they cannot do more to control costs and utilization. Enabling hospitals to achieve financial measures consistent with BBB bond ratings should be an objective in granting increases, but the hospitals must demonstrate accountability in improved results for the increases they receive. Adequate margins are necessary, but improved productivity and cost reduction are an alternative to increasing rates to provide necessary operating margins.
2. Cost control and strategic planning need more focus. Each hospital should be able to demonstrate plans to achieve and maintain fiscal stability while satisfying the HRAP objectives. Progress in implementing sound planning, productivity improvement, and financial improvement should be expected results. As an example, Fletcher Allen Health Care should have their strategic plan more clearly defined prior to review of CON's for the food court and the Vermont State Hospital so that the POC can have the context within which to properly assess these proposals. Salaries are escalating at double the rate in the overall labor force, so productivity improvement and/or changes in the skill and cost mix of medical staff should be implemented.
3. Hospital IT investments must be coordinated to achieve Vermont's objectives of a safer and more effective integrated health care system. Perhaps VITL's role in implementing a state-wide health care IT system requires more resources and an accelerated schedule. Promoting standards for interoperability of separate hospital systems is certainly a good start, but there probably needs to be a more coordinated state strategy on how to implement IT beyond hospitals into providers' offices.
4. The challenge of physician recruitment and retention needs a new focus. An institution by institution approach may not be appropriate. Shared staffing models or some other approach to deal with changing physician expectations is needed. Hospitals should encourage the use of telemedicine and other forms of communication and information technology to leverage available assets and compensate for the maldistribution and/or scarcity of, current and projected MD and other service capacity resources. Individual hospitals could create "centers of excellence" providing high quality and efficient services to wider service regions. This would provide the volume of patients and the employment climate needed to successfully recruit and retain good physicians. The hospitals, as a group, should be challenged to propose such system wide solutions which go beyond the current focus on retaining each community hospital in its current form.

5. Vermont's community hospitals have modified their number of beds and services in response to changes in reimbursement guidelines (CAH, Medicare Dependent), but continue with their historic community hospital roles and service areas. The system is under enough stress that it may be time for a revamping of services and providers into a more regionalized model for greater efficiency while maintaining reasonable access and high quality.
6. While hospitals are utilizing HRAP and IOM objectives in reporting, this should be more closely tied to budget and CON requests. Report cards showing substantive and measurable progress in these standards should be included in all reviews of hospital performance. Objective quality results should be primary in all considerations of hospital requests for budget increases or capital projects.
7. The financial outlook for the Vermont health care system is not good. Legislative initiatives such as the HRAP which may place more emphasis on access and choice than on sustainable affordability need continual reassessment.

The Public Oversight Commission members appreciate the cooperation of the BISHCA staff and the Vermont hospitals in providing valuable insight into the financial plans and operating issues affecting the health care system.  
Sincerely yours,

John O'Kane  
Chair  
Public Oversight Commission