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Public Oversight Commission — Gregory B. Peters, Chair

September 8, 2009

SEP - 9 2009

Commissioner Paulette Thabault
Vermont Dept. of Banking, Insurance, Securities and
Health Care Administration
89 Main Street, Drawer 20
Montpelier, VT 05620-3101

Ref: 2009 Hospital Budget Hearings

Dear Commissioner Thabault:

The purpose of this report is to provide observations and recommendations resulting from the late August and early September budget hearings. In most cases, the major observations and recommendations of last year's report dated September 9, 2008, a copy of which is attached, still apply. The observations and recommendations highlighted below are incremental to last year's report.

Major Observations:

- In general, requested budget increases from the hospitals are more reasonable this year (system wide average of 6.5%) compared to last year (9.5%), perhaps as a result of the Commissioner's guidelines on expectations for medical inflation and overall rate increases;
- Medicaid underfunding appears to have driven approximately 1/3rd (or 2%) of the respective hospital rate increase requests and is indicative of the ongoing problem of the cost shift onto commercial rate payers;
- Low primary care reimbursement is threatening independent physician practices, forcing some hospitals to acquire those practices in order to retain them in their respective service areas, effectively shifting losses from their operations to the hospitals acquiring them;
- Capital annual and 4-year budgets have become more focused on renovation, Electronic Health Record (EHR) implementation, and outpatient facilities as opposed to new inpatient bricks and mortar projects;
- Hospital balance sheets have been adversely affected in the past year by the downturn in the stock market, negatively impacting debt to capitalization ratios resulting in a slowdown in, or, in some cases, termination of, capital expenditure projects;

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- Smaller hospitals are beginning to turn toward Federally Qualified Health Centers (FQHC's) as a vehicle for delivering primary care, enhancing reimbursement from the federal government and limiting malpractice liability;
- There still is not a concerted focus among hospitals on cost containment and increased productivity; however, when faced with a crisis such as Central Vermont in 2007 and Southwestern Medical Center in 2009, they have demonstrated an ability to significantly reduce operating costs without affecting the quality of care or patient satisfaction, suggesting that there may well be additional excess cost within the system;
- A number of hospitals are projecting declining adjusted admissions/discharges but increasing utilization, suggesting that each patient is receiving an increasing amount of health care services per stay, serving as a key driver to escalating cost of care;
- Fletcher Allen Health Care (FAHC) as a tertiary care center is taking an increasingly constructive leadership role in collaboration with both intermediate and smaller sized (critical access) hospitals, providing backup support of specialty clinics and services;
- The revised HRAP issued July 1, 2009 appears to be more user friendly and more helpful to hospitals in their strategic planning; some of the task force work recommended by the HRAP, such as the Utilization Review and Variance Analysis work group, should be helpful in establishing benchmarks for capacity requirements and guidelines for CON decision making;
- There is an ongoing challenge of aligning incentives within the system between Medicare, Medicaid, commercial payers, providers (hospital, physician and other), employer and consumer/patient;
- The Blueprint (Medical Home) appears to be gaining traction with hospitals as an approach toward reforming delivery of primary care and aligning incentives of payers with providers and patients;
- Vermont, with its 14 independent hospitals in a relatively small geographic area, has needless duplication and waste of personnel, resources and services in its delivery system; the system could potentially be realigned in a configuration that could eliminate a significant portion of that duplication.

In response to the above observations, The POC offers the following specific recommendations, <u>in order of priority</u>:

1. Continue efforts to reform the rate setting process; provide clear cut rate guidance to the hospitals prior to budget preparation; base guidance on a 1.5% -2.5% cost shift factor (depending upon hospital's payer mix) plus current medical inflation rate (current rate is 3.1%); therefore this year's rates should range from 4.6%-5.6%; strongly limit and discourage exceptions to the guidance;
2. Establish a Blue Ribbon Commission (as recommended on page 100, recommendation 3.2, implement option 3.2.2 of the HRAP) to evaluate and make recommendations regarding delivery system capacity, to include system configuration and range of services required to cost effectively deliver quality care in the state; recommendations might include incentives through BISHCA for

hospitals to merge into one or more regional enterprises configured with a range of services aimed at improved delivery system efficiency;

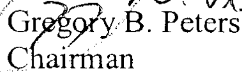
3. If can't fully-fund Medicaid programs, cut existing programs to fit what we as a state can afford; the current cost shift of Medicaid underpayment is penalizing hospitals with high Medicaid payer mix and is driving unsustainable, escalating commercial insurance premiums;
4. Tie incentives of cost, quality and productivity metric performance with the CON approval process; i.e. reward performance; utilize the results of the Utilization Review work group when complete as guidance in assessing system capacity and need when reviewing CON applications;
5. Keep working to clarify the HRAP vision of what the healthcare delivery system should look like in the year 2020 and set goals for achieving/measuring progress toward achieving that vision; utilize the results of recommendation 2) above as input to that vision.

Hopefully the above observations and recommendations may be of value to you as you make your rate setting decisions this year and contribute toward goal setting for both HCA and legislative/policy action during the year ahead.

The Public Oversight Commission would, once again, like to recognize the hard work and dedication of the BISHCA staff in preparation for the budget hearings. Should you wish to discuss the above observations and recommendations further, we would be pleased to do so with you.

Sincerely,

FOR THE PUBLIC OVERSIGHT COMMISSION



Gregory B. Peters
Chairman

Cc: Honorable James H. Douglas, Governor
Douglas Racine, Chairman, Senate Health and Welfare Committee
Steven Maier, Chairman, House Health Care Committee
Ann Pugh, Chairman, House Human Services Committee