Building a Bridge to Better Care, Improved Health and Lower Costs

Vermont Association of Hospitals and Health Systems
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EXECUTIVE SUMMARY

Vermont’s hospitals and policy makers have a shared vision for better care, improved health and lower costs . . .

The Institute for Healthcare Improvement has laid out a framework for health care reform known as the “triple aim”: better care for individuals, improved health for populations, and lower per-capita health care costs. Vermont’s health care reform efforts to date have been true to that framework, and Vermont hospitals have been strong supporters of efforts to achieve these goals.

. . . but also face many challenges as we try to realize that vision.

Overall health spending will continue to increase no matter what reform path is taken. Demographics and other factors will continue to drive health care costs, the promise of solutions such as the Vermont Blueprint for Health will take years to mature, and Vermont’s strong commitment to expanding health insurance coverage has predictably come at a cost. Potential system redesign opportunities created by the federal Affordable Care Act will also take years to plan and execute.

Hospitals have been an important part of the solution. Hospitals have taken a leadership role in many short and long-term efforts to bend the cost curve and advance needed reforms. Hospitals are increasingly employing physicians, at significant financial risk, in order to preserve access to primary care and some specialty services in light of a failing physician reimbursement system. Most hospitals are focusing on the core services that patients need close to home, leaving the most complex services to Fletcher Allen Health Care and other specialized services to regional centers. At the same time, Vermont hospitals have reduced costs by $83 million over the last two years while providing 13,800 jobs and driving significant economic activity in their communities.

The recession threatens access and health care reform. Vermonters have excellent access to a high-value system, with hospitals as the health care safety net, providing services to everyone regardless of their ability to pay. Quality and access are high, and Vermont is seen as a national leader on health care reform. All of this is at risk.

The Association has a recommended approach and hospitals will continue to do their part. Looking ahead on reform, more must be done. Hospitals are willing to continue to work with the State and other stakeholders to take bold, thoughtful steps to redesign the system. In order for this to be possible, the State must balance cost-cutting efforts and identify new revenue sources to draw down more federal Medicaid matching funds to sustain current and future efforts.
Vermont’s hospitals and policy makers have a shared vision for better care, better health and lower costs . . .

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Just last year, the Commonwealth Fund ranked Vermont as #1 in the nation based on five dimensions of care: access to health care, prevention and treatment, avoidable hospital use and costs, equity, and healthy living. The one area where Vermont ranked nearly last? Insurance premiums. Our success has come at a price.

Health care spending will increase, no matter what reform path we take. BISHCA predicts there will be between 6.5-7% in overall health care spending growth over each of the next three years.1 Much of that growth is related to factors we cannot or should not change.

A recent study on rising health care costs in Vermont determined that about half of the per-capita growth in costs in recent years was due to three factors outside the control of the health care system: an aging population, increased incomes, and coverage expansions.2

- Nationally, baby boomers are entering the 65+ age cohort. Health care spending for the 65+ age cohort in 2004 was 5.6 times higher than spending

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1 2008 Vermont Health Care Expenditure Analysis & 3-Year Forecast (Released March 2010), State of Vermont Department of Banking, Insurance, Securities & Health Care Administration, p. 5.
2 “Health Care Costs and Cost Growth in Vermont: An Analysis of Recent Trends and Explanatory Factors” (Sept. 2010), Anya Rader Wallack, PhD, Steven Kappel, MPA, and Stanley Wallack, PhD, pp. 11 – 18.
per child and 3.3 times spending per working-age person. Vermont’s population is an average of 4.2 years older than the national average, so we are feeling this demographic wave early.  

- **Health care expenditures are directly tied to per-capita income**, and in Vermont, the per-capita income grew faster than the national average.  

- **Vermont’s insurance coverage for residents increased, while most other states experienced a decrease in the number of insured.** State policymakers have designed a system of access that we can all be proud of, but expanding access through programs such as Dr. Dynasaur, VHAP and Catamount Health has predictably increased health care expenditures.  

There are other variables that could affect the demand for health care services in Vermont. These include population health and provider supply. The good news is that Vermont has consistently ranked as the healthiest state in the nation. Vermont’s growth rate does not appear to be related to excessive utilization – Vermont remains, on average, a low utilizer of health care services for both Medicare and commercial payers.  

**Figure 3: Discharges per 1,000 Medicare Enrollees, Vermont vs. US, 2000**

<table>
<thead>
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<th>U.S.</th>
<th>Vermont</th>
<th>Ratio, Vermont to U.S.</th>
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<tbody>
<tr>
<td>All Hospital Discharges</td>
<td>348.73</td>
<td>291.58</td>
<td>0.84</td>
</tr>
<tr>
<td>All Surgical Discharges</td>
<td>217.88</td>
<td>180.13</td>
<td>0.83</td>
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<tr>
<td>Discharges per Ambulatory Care Sensitive Conditions</td>
<td>80.68</td>
<td>66.9</td>
<td>0.83</td>
</tr>
<tr>
<td>High Variation Medical Discharges</td>
<td>217.88</td>
<td>180.13</td>
<td>0.83</td>
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**Hospitals have been an important part of the solution.**

Vermont is a consistently high performer when compared with others states, in part because of the work of our not-for-profit hospitals. In 2009, Vermont was ranked #1 by the Commonwealth Fund on five dimensions of care: access, prevention and treatment, avoidable hospital use and costs, equity, and healthy living. The same study ranked Vermont second in 2007. Vermont has also been ranked the “Healthiest States in the Nation” by the United Health Foundation for the past four years in a row.  

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4 “U.S. Health Spending by Age, Selected Years Through 2004,” *Health Affairs*, doi: 10.1377/hlthaff.27.1.w1 (published online November 6, 2007), M. Hartman et al.  
9 “Aiming Higher: Results from A State Scorecard on Health System Performance” (October 2009), Douglas McCarthy et al., p.9.
Most hospitals are focusing on services that patients need to have close to home, like emergency rooms. Vermont’s hospitals range from Fletcher Allen Health Care, a 562-bed (licensed) Level I Trauma Center and teaching hospital to the eight critical access hospitals that provide the basic services patients need close to home. Specialized services, like cardiac surgery and inpatient psychiatric care, are offered regionally. Even with this distribution of service, a lack of transportation options, compounded by Vermont’s geography and winter weather, can markedly influence treatment patterns and access. Depending on where you live, drive times to hospital emergency rooms may exceed 45 minutes.\cite{11}

Figure 4: Selected Hospital Services\cite{12}

Vermont hospitals are shoring up a failing physician reimbursement system that seriously threatens patient access, at significant financial risk. If doctors can’t make a living in Vermont, they will move, close their practices or ask their local hospital to employ them. Even if it is at a financial loss, hospitals have hired community physicians in order to ensure a local network of primary care providers and key specialty providers.

\footnote{\textit{America's Health Rankings™}, A Call to Action for People and Their Communities: 2009 Edition, United Health Foundation , p. 8.}
\footnote{The Health Disparities of Vermonters (June 2010), Vermont Department of Health, p. 44.}
\footnote{Health Resource Allocation Plan (July 2009), State of Vermont Department of Banking, Insurance, Securities & Health Care Administration, p. 62.}
From FY 2010 to FY 2011 hospital budgets increased by $22 million directly related to the acquisition of physician practices. Next to government underpayments, physician employment by hospitals is the largest reason for hospital rate increases.

The hospital provider tax generates enough federal dollars to fund all hospital Medicaid expenses, plus an additional $48.7 million. The provider tax is essentially a sales tax on Vermont hospitals. With the provider tax dollars, Vermont essentially “buys” federal dollars. For every provider tax dollar hospitals send to Washington, Vermont receives an estimated $1.50 back.

### Figure 5: Provider Tax Net to State SFY 2012

<table>
<thead>
<tr>
<th>Provider tax paid by hospitals</th>
<th>$111.5 million</th>
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<tbody>
<tr>
<td>Federal matching dollars</td>
<td>$167.3 million</td>
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<tr>
<td><strong>Total revenues</strong></td>
<td><strong>$278 million</strong></td>
</tr>
<tr>
<td>Less payments to hospitals related to care</td>
<td>($192.7) million</td>
</tr>
<tr>
<td>Less Medicaid DSH payments to hospitals</td>
<td>($37.4) million</td>
</tr>
<tr>
<td><strong>NET revenue to State</strong></td>
<td><strong>$48.7 million</strong></td>
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Vermont hospitals have embraced state initiatives aimed at keeping patients out of the hospital, despite the impact on their bottom lines. As just one example, Vermont hospitals are the cornerstone of the Blueprint for Health, the state’s “patient-centered medical home” integrated pilot initiative, providing support for physician practices and the community health teams that are essential for their success.

Vermont hospitals are the cornerstone of economic stimulus for the communities that they serve. Approximately one in every $23 in the total Vermont economy is attributable to VAHHS members. Connected to many local businesses, Vermont hospitals purchase many goods and services, both within their communities and statewide. This in-state purchasing power creates $780 million in state revenue and generates an additional $1 billion due to the economic “ripple effect,” when hospital spending causes down-stream spending and investment. Every industry in Vermont, even the tourism industry, depends on our community-based hospitals.

A total of 13,800 jobs – excluding employed physicians – are provided by Vermont’s hospitals. Additionally, for every job created in a hospital, it supports another job in the community, like accountants and food vendors. When these indirect jobs are included, hospital activity creates almost 23,000 jobs. At a time when jobs are a continuing concern for Americans and Vermonters, Vermont hospitals provide a full range of jobs – professional, technical and support roles – most with competitive wages and essential benefits like health insurance. As an industry, hospitals in Vermont employ more FTEs than Vermont’s ski areas combined. Hospital employees contribute more than $34 million to the State in tax revenues.

Vermont hospitals have cut $83 million in expenses over the last two years. Vermont hospitals continue to cut expenses. They have reduced their margins and restrained rate increases. Many have initiated targeted lay-offs, wage freezes and benefit reductions such as changing their retirement programs. Some hospitals have also reduced the number of beds they staff and changed vendor contracts, including taking advantage of group purchasing of health insurance. According to VAHHS estimates, by reducing hospital operating expense growth by 2.8%, overall spending for 2009-2011 was $83 million less than predicted.
All hospitals in Vermont have a free or reduced-cost care policies. This year, they will provide almost $25 million in free or reduced-cost care. As mission-driven, community-based non-profit institutions, hospitals in Vermont care for everyone who comes through their doors, regardless of their insurance status or ability to pay. Although Vermont enjoys one of the lowest uninsured rates in the country, more and more Vermonters find themselves unable to pay their hospital bills. Eligibility for free or reduced-cost care varies from hospital to hospital, but at a minimum they all offer some relief to anyone under 200% of the Federal Poverty Level. A few offer free or reduced-cost care to those under 300% FPL and some even up to 400% FPL.

Vermont hospitals are health information technology leaders and are making significant financial and human resource investments in electronic health records. Vermont Information Technology Leaders (VITL) was originally created by VAHHS, and hospitals continue to proudly support its efforts. But VITL’s efforts are focused primarily on expanding access to EHRs by physician offices, not hospitals. Hospitals are investing their own limited capital dollars toward this effort, often to the exclusion of other capital improvements.

The recession threatens access and health care reform.

The State’s projected $176 million deficit is the biggest threat to ongoing health care reform in Vermont. Medicaid’s deficit alone is estimated to be at least $50 million. The choices that will be made to close the Medicaid budget gap will have a direct impact on patients, providers and employers and could also stop or undo many of Vermont’s health care reform efforts.

Cutting the State’s expenses is possible, but those actions will generally lead to higher expenses overall. Here’s just one example: hospitals by law are required to provide 24/7 access to all patients needing care. As more patients without coverage receive hospital care, hospitals both absorb the losses from the unreimbursed care and try to increase their prices to all other patients to help cover those losses. This increase in prices, or rates, effectively means that Vermont’s businesses and workers pick up the tab when the state reduces provider payments. This pressure on hospitals increases when patients have reduced access to other community-based health care services.

Hospitals are financially challenged at exactly the same moment they are being asked to lead the way on health care reform. The disconnect between the immediate need to close the state’s budget deficit and the cost and time needed to implement the many reform efforts has received virtually no time and attention from policy makers. With razor thin margins at an average of 1.9% for budget year 2011 (average margin was 0.7% based on 2009 audited financials), hospitals won’t be able to invest in their organizations at a time when transformation of how they deliver care is necessary.

- **It costs nearly twice as much for hospitals to borrow money than it should.** That cost is passed on to Vermonters. Today the estimated risk-free borrowing rate is 3.72%. Community hospitals’ average borrowing rate is approximately 6.5%. Hospitals are capital-intensive – they have to maintain their buildings, their equipment and their computer systems. Borrowing to do so is the right financial practice, since items that last a long time should be paid for over time. But as any homeowner knows, a higher interest rate costs a lot more over time.13

- **The result is that credit agencies (like Moody’s and Standard and Poors) tell us that Vermont hospitals are on average financially weaker than their counterparts nationally.** In FY 2009, only

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two VAHHS member hospitals met the 3% total operating margin benchmark for an A-rated hospital. Only one VAHHS member hospital the 181 days cash on hand benchmark for an A-rated hospital. Only four VAHHS member hospitals met the 3.3% debt-to-cash-flow benchmark for an A-rated hospital.¹⁴

**Net state payments to hospitals for Medicaid are declining and unsustainable.** VAHHS estimates that the impact of “routine” underpayments for patient care, exacerbated by the state’s failure to direct sufficient payments to cover the provider tax hospitals pay to draw down federal dollars, means that **hospitals in Vermont will get somewhere between 36c and 58c per dollar of actual costs incurred** in serving Vermont Medicaid patients in SFY 2011.

- **The State pays hospitals less than it costs to care for Medicaid patients.** This shortfall, known as the Medicaid cost shift, was $111 million in 2009. Hospitals absorb what they can of this shortfall, and pass the rest on to the privately-insured in the form of higher rates.¹⁵ Vermont’s hospitals are becoming less able to shift this cost as the overall cost burden on insurers increases. The Legislature has studied this problem extensively but the cost shift continues to increase.

- **Vermont hospitals are paying more INTO the provider tax than they receive back and that problem is growing.** Since 2008, the state has failed to increase hospital payments enough to collectively cover the increase in taxes hospitals paid in the same budget year. The dollar amount of the tax grows each year because the tax base is hospital net revenues. If left uncorrected, the gap between the tax paid by all hospitals and the tax-related payments returned to hospitals will be an estimated $23.7 million in FY 2012. This gap adds to the underlying cost-shift created by Medicaid underpayments for care provided to beneficiaries.

- **This loss is obscured when viewing the state budget.** Looking only at the budget, it appears as though hospitals are getting Medicaid increases when other providers are being cut. That’s because hospitals are being partially reimbursed through Medicaid payments for the provider tax they pay. Their contribution to the state budget is less visible. Without fundamental restructuring of how the state generates Medicaid revenue (and thus federal Medicaid matching funds) the state will not be able to afford – or reform – Vermont’s health care infrastructure.

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The Association has a recommended approach. . .

Cost-cutting alone will not solve the structural Medicaid deficit and the challenge of rising health care costs. Instead, this requires a major transformation in the way that care is delivered, which will take time, leadership and investment.

We need the State to build a financial bridge. Short-term budget fixes will break the system before longer-term investments can provide relief. The State has maxed out its ability to generate federal Medicaid dollars by increasing the taxes collected from hospitals. Hospitals now need the State to balance cost-cutting efforts and identify new revenue sources in order to enhance receipt of federal Medicaid matching funds to sustain current and future reform efforts.

State reforms must remain wholly aligned with the federal Affordable Care Act. We cannot hope to advance sustainable health reforms without federal support. In addition, the federal framework that creates many new responsibilities for states is still evolving. As in previous Vermont reform efforts, a public/private collaborative approach is Vermont’s best hope to maximize the opportunities in the ACA while minimizing the risks.

. . .and hospitals will continue to do their part.

Hospitals are committed to better clinical integration with other providers and making sure patients get the support they need to keep them out of hospitals to the extent possible. In 2010, a group including hospitals, physicians, community health centers, long-term care facilities, home health agencies, and their associations formed a working group to better understand the impact of new federal and state policies. That group has turned its attention to improving “transitions of care” – the moments when a patient moves from one provider to another. When transitions of care don’t go well, patients may wind up back in the hospital unnecessarily. Almost any payment reform model under consideration will rely on improved transitions of care for success.

Hospitals are working to reduce the unnecessary duplication of diagnostic testing and imaging. Two initiatives are currently coming together. Fletcher Allen Health Care’s Radiology Department is leading an effort to research why and when duplicate imaging occurs, and to collaboratively develop guidelines for both referring and receiving hospitals to use to ensure that unnecessary tests are avoided. At the same time, the Act 49 committee has selected imaging as one of three areas of focus, bringing additional quality improvement resources to the investigation Fletcher Allen Health Care has begun.

Hospitals are working to reduce unnecessary variation and reduce readmissions. Under the leadership of Fletcher Allen’s Jeffords Institute for Quality and Operational Effectiveness, a number of Vermont hospitals are working together to reduce readmissions for congestive heart failure. Under the auspices of Act 49, Southwestern Vermont Medical Center and Northwestern Medical Center are also examining the inpatient admission rates and the higher use of the emergency department in their communities, respectively. This learning will be shared with other hospitals.

Hospitals are ready to pilot new payment models that move away from the traditional fee-for-service system. The federal Affordable Care Act includes grants to help accelerate successful payment and delivery reform strategies, which Vermont hospitals are very interested in applying for. As part of this effort, hospitals will continue to foster hospital/physician integration. Under the current reimbursement system, hospitals assume a significant risk when they take this step. They will continue to do so because it is the right thing to do.