



July 31, 2016

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Re: BMH Response to Pre-Hearing Questions FY2017 Hospital Budget Review

Please see our responses below.

General

1. If you included a rebasing in your proposed budget, why do you believe the Green Mountain Care Board should agree to rebase your budget? How do you plan to contain your growth going forward?

- We have not asked for a re-basing.

2. What is your expected All-Payer and/or Medicare case mix index for FY17?

a. Please also provide your case mix index for FY14 (actual), FY15 (actual) and FY16 (budget and projected) along with any drivers (e.g. demographic shifts, product line additions, payer mix changes, etc.) that explain increases or decreases over time.

Medicare Case Mix Index has been stable over time

○ FY2014 Actual	1.41
○ FY2015 Actual	1.38
○ FY2016 Budgeted	1.38
○ FY2016 YTD Actual	1.40
○ FY2017 Budgeted	1.40

- b. Please explain the basis for anticipated changes to your case mix index going forward from FY16, if any.

The CMI changes each year for many different reasons including CMS adjusting the relative weights of the DRG. Because case mix changes are generally beyond our control in the short term, for budgeting purposes we usually assume a static CMI.

3. Please explain the basis of any anticipated changes in your payer mix for FY17. What are the changes you expect to see going forward?

	Budget 2017		Budget 2016		change from prior budget	
Gross patient service revenue						
Medicare	66,907,656	42%	67,733,967	44%	(826,311)	-1%
Medicaid	33,034,042	21%	29,405,467	19%	3,628,575	12%
Other	57,531,857	37%	57,278,434	37%	253,423	0%
	157,473,555	100%	154,417,868	100%	3,055,687	2%

Because Payor mix changes are generally beyond our control, we usually assume payor mix will remain the same as the YTD period we are making the projection on. For years, Medicaid has been an increasing % of our volume.

4. As a nonprofit with a duty to benefit your community, please explain any policies your hospital has, if any, to put a reasonable cap on executive pay and on the percentage of your overall budget that is made up of administrative costs

On an annual basis, the Executive Committee of the Board of Directors reviews executive pay and periodically utilizes independent surveys and external consultants to assess competitiveness and equity.

5. If you have varied your commercial rate increases by program or service, how do you determine these increases? Are they based on projected cost increases by program or service or based on something else?

Our commercial charge rates and our Medicare charge rates and our Medicaid charge rates are the same thing. We use different pricing strategies for different reasons in many areas. Sometimes we try to maintain a relationship to a fee schedule established by Medicare. Other times we target a specific charge that a survey or complaint has shown out of range.

6. What is your margin target, and how was it determined?

- a. Is this a long-range target for your hospital?

	FY 2017	FY 2016	FY 2015	FY 2014	FY 2013	5 year
	Budget	Projected	Actual	Actual	Actual	cumulative total
Net Revenue	80,281,708	75,615,756	78,669,021	75,309,785	69,463,138	379,339,408
Operating gain	157,952	(1,266,933)	2,196,008	2,697,579	2,348,409	6,133,015
Operating margin	0.2%	-1.7%	2.8%	3.6%	3.4%	1.6%

We need to see operating margins between 3.0% and 5.0% over a 5 year period. We feel it is a low range target that should work if the underlying financial foundation is stable. We are currently significantly lower the 3% lower limit.

7. Please describe how your budget process would differ if a 3- or 5- year net patient revenue cap were used rather than a yearly cap.

There are many variables which impact our budget-volumes, service mix, physician complement, Medicare/Medicaid reimbursement, Commercial payor rates, payor mix, etc- we need to be able to respond at least annually to changes in these services and market challenges. Consequently, any 3-5% NPR cap must be subject to annual review.

8. What is your budgeted amount for Medicaid underpayment for FY17?

If you mean how far below cost are Medicaid Reimbursements – About \$7.7 million.

9. What is the extent of your Choosing Wisely initiative(s), if any?

- a. Please describe the initiative(s) and how you have chosen which departments participate. BMH has advocated that this initiative along with other evidenced-based initiatives be adopted by the OneCare Quality Committee to achieve consistency throughout the network. This initiative has embraced by the Medical Staff and link to the CW web site are located on the Hospital's intranet for easy and rapid access.
- b. Which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement? Many such as Emergency Department Committee review of pediatric care with feedback for appropriate imaging and antibiotic use, Hospitalist involvement on the statewide initiative to reduce unnecessary inpatient lab work, Radiology review of imaging orders for appropriateness, Post Acute Care Team working with patients and families to decrease unwanted hospitalizations from Long-Term Care Facilities, Increased adherence to appropriate C.Diff testing, Initiation of Antibiotic Stewardship. Others include COPD, CHF, Narcotics Task Force, Hospice, PCMH Chronic Disease Management, Obesity and Mental Health focused programs, SBIRT, and continued commitment to Care Coordination.

Community Benefit

10. Please explain how the federal regulations on nonprofit hospital financial assistance policies and billing practices that go into effect on October 1, 2016 affect your budget proposal for FY17 as compared to FY16.
 - a. Include how you anticipate the regulations affecting your bad debt and charity care.

No significant change expected.

b. b. Which charges did you base your financial assistance discounts upon in FY16?
Total gross charges

11. *For all community benefits that you listed on your Form 990 Schedule H, what is the dollar amount you are budgeting for each benefit by year (FY14 Actual, FY15 Actual, FY16 Budget, FY16 Projection, and FY17 Budget)?

Actual 990's are available for FY14 -15. FY16 – 17 are estimates.

	FY2014 Actual		FY2015 Actual		FY2016 budget		FY2016 Projected		FY2017 Budget	
Financial Assistance at cost	1,180,751	1.62%	1,565,555	2.05%	1,371,500	1.79%	2,403,865	3.12%	1,407,285	1.75%
Medicaid Shortfall	6,296,865	8.66%	9,242,483	12.08%	7,453,494	9.74%	6,638,805	8.62%	6,790,008	8.47%
Community Health Subsidy	407,746	0.56%	169,389	0.22%	583,541	0.76%	619,163	0.80%	1,649,168	2.06%
Subsidized Health services	98,037	0.13%		0.00%		0.00%		0.00%		0.00%
Community benefits donations	46,707	0.06%	35,475	0.05%	45,045	0.06%	83,075	0.11%	45,075	0.06%
Total	8,030,106	11.04%	11,012,902	14.39%	9,453,580	12.35%	9,744,908	12.65%	9,891,536	12.34%

12. *What is your current level of community benefit as a percentage of revenues?

a. *What percentage level are you willing to commit to on an ongoing basis? **10% or greater**

b. *Please provide a detailed breakdown of the programs and other components you include in your community benefit calculation.

For FY2017 budget:

- Financial assistance at cost is free care.
- Medicaid Shortfall is the cost of services provided to Medicaid patients plus the provider tax less the VT. DSH payments.
- Community Health Subsidy is the Community health team,
- Community benefits donations are various donations made to other community nonprofit organizations

13. How does the money you plan to spend on community benefit align with the top five issues identified in your most recent Community Health Needs Assessment (CHNA)? If your assessment of your top five issues has changed since your last Community Health Needs Assessment, please explain the change as part of your answer.

a. Are there needs identified in your CHNA that you would like to address, but feel that additional cooperation by outside entities is required for an effective solution? **Top five areas identified are: Mental Health, Obesity, Substance Abuse, Aging and Dental Health. As per our previously submitted CHNA Work Plan, all areas involve collaboration and coordination with multiple agencies and community organizations.**

Health Information Technology

14. Do you anticipate needing to replace your electronic health records system in the next five years?

We are in the process of replacing our EHR during FY2017 with Cerner Community Works. We have no plans for a subsequent replacement at this time.

15. Do you use any of the services offered by VITL (Vermont Information Technology Leaders)? Yes

a. If so, which services?

Lab, radiology, transcribed report results routing; lab orders from BMH Medical Group to BMH lab; VITL Access for patient clinical information; use of eHealth Consultant for assistance with BMH Medical Group Meaningful Use and Quality

b. To what extent are VITL's services integrated into the hospital's care delivery?

Results and orders are critical for communication between BMH Hospital, BMH Medical Group and local independent providers

c. Has the hospital experienced any cost savings or quality improvement from VITL's services?

Received Meaningful Use incentives for Medical Group with assistance of VITL eHealth Consultants; VITL HIE saves BMH from building result interfaces to each local provider that orders lab, radiology or pathology services from BMH.

d. Do VITL's services compliment your other health information technology initiatives? If so, how?

VITL helps us meet our need to submit outpatient results to the ordering providers in a timely manner. It also helps with quality of care in departments like our ED and Surgery to access patient information from other points of care outside of BMH. We anticipate that VITL will be valuable to us as we move forward with population health initiatives as the State develops the path forward.

16. *What percent of your employed primary care providers are participating in the Hub and Spoke program? Putney Family Medicine will start in program Fall, 2016 and Ob/Gyn is considering.

a. *What is the average number of substance abuse patients that those providers treat?

0-not started yet

b. *How many additional providers would be required to fully meet your community's needs in a reasonable amount of time? Please take into consideration any waitlists for treatment.

Acceptable number based on Retreat providers and other practitioners

c. *If your hospital is involved in any medication assisted treatment programs, do you have any information on your costs for these programs versus savings to your hospital?
[Program to start Fall 2016](#)

17. *Please explain to what extent mental health patients presenting at your Emergency Department impacts your budget?

[Mental Health patients clearly impact our operating budget for the Emergency Department. Annually they account for an average of ~6-8% of our patient volume with peaks closer to 9%. The average time in \[July 2016\]\(#\) for patients to be boarded in our Emergency Department was 12 hours and 15 minutes. The costs break out as follows:](#)

- a. [Patient watch time contracted security services and staff hours. Staff hours are extremely conservative due to gaps in data collection.](#)
 - i. [Contracted hours](#)
\$59,148 (Since January of 2016 for watches alone @\$28.13/hour). This figure does not take into account when a scheduled duty officer is used for a watch.
 - ii. [Staff hours](#) (703.5 hours from July 2015 to June 2015 with an average salary of \$36.00) **\$25,326**
- b. [Nursing Hours per Patient](#)
 - i. [In July 2016 there was roughly 733 hours of time in the ED that can be attributed to Mental Health patients.](#)
 - ii. [Mental Health patients on average spent 12.15 hours in the department versus the LOS for other patients at 3.8 hours.](#)
 - iii. [Call in of additional staff \(as needed\)](#)
 - iv. [Mental health patients require more staff hours than other patients. This includes administrative time to handle specific paperwork.](#)
 - v. [Full time Licensed Care Manager deployed in the ED.](#)
- c. [Mental Health Audits](#)
 - i. [Mandatory Mental Health Audits \(required by L&P secondary to findings\)](#)
 - ii. [\\$4500.00 in administrative time for audits \(excludes Quality Resources/RCAs/Meetings\)](#)

a. *Please explain how mental health patients are handled when they present to your Emergency Department or other triage location, including a description of any holding or isolation areas that you use, and how often you expect to use this type of area in FY17.

[Process for Mental Health Patients and projections FY 2017](#)

- ✓ [In room triage \(unless high volume and then triage room\)\[same as all patients\]](#)
- ✓ [Roomed in conversion/safe room](#)
- ✓ [Scored for Suicidal/Homicidal./Delusional Behavior at Triage](#)
- ✓ [5 rooms used for Mental Health Patients \(mild to seclusion\)](#)
- ✓ [Rooms evaluated for safety](#)
- ✓ [~1,050 times/year \(roughly 7% of patient volume\)](#)

b. *How do you train your security staff, contracted or in-house, on handling situations involving people experiencing mental health crisis? If some security staff members have been trained but not all, please explain which ones and why.

- ✓ Security staff to this point had not been on-boarded in CPI
- ✓ Security staff had used MOAB training
- ✓ It was decided for better alignment we would train in the same program and with our staff (CPI) this will start in September 2016.
- ✓ Trained security staff are also trained to work in concert with all clinical and administrative staff who are or will be trained in the utilization of de-escalation techniques and other strategies for violence management.

A risk analysis of all employees in the facility was done to identify staff members in high risk areas. All staff contracted or otherwise performing “sitter” operations with patients will need to have at least 8 hours of CPI annually which includes competency assessment. Staff that may have to seclude or restrain patients require a 16 hour course with 8 hours of refresher time regularly. In the Emergency Department we have 25 staff members that fall into the latter section. New changes to CPI require all staff to attend the 16 hour training.

- ✓ 400 hours of initial instruction
- ✓ 200 hours at the refresher training

Sincerely,

Steven R. Gordon
President and CEO

cc. Michael Rogers, CFO
Mike Davis, GMCB