MT. ASCUTNEY HOSPITAL
AND HEALTH CENTER

A Dartmouth-Hitchcock Affiliate

August 18, 2017

Vermont Legal Aid, Inc.
Office of the Health Care Advocate
264 North Winooski Ave
Burlington VT 05401

Re: HCA Pre-Hearing Questions – Fiscal Year 2018 Hospital Budget Review

To whom it may concern,

We have provided answers below to the questions posed by your office.

1. What are the hospital's goals for participation in payment reform initiatives in 2018 and in the next five years?
    a. What steps will the hospital take to meet these goals?
    b. Please describe the reasons why the hospital has chosen not to participate in the risk-based Accountable Care Organization payment models offered to date. If the decision was informed by financial modelling, please provide the model specification, model inputs and results.
    c. Does the hospital participate in any capitated payment agreements directly with insurers? If yes, please describe:
        i. Whether the capitated payments save the insurer money compared to fee for service payments;
        ii. Whether the hospital and/or its providers earn more profit under capitated payments or fee for service, on average; and
        iii. How the hospital ensures that patients continue to receive appropriate services under capitated payments.

Answer:

For 2018 we are likely to engage with Vermont Medicaid Next Gen ACO. We are awaiting more details about the program AND will review the experience of Porter Hospital, a similar-sized critical access hospital. We continue to have questions regarding risk contracting and the interface with cost-based reimbursement as a CAH. We have not received satisfactory answers from either CMS or OCV regarding financial implication to our cost report in the case of down-side risk contracts. We suspect that we will likely move to a full risk model with OCV in 2019 if those questions can be answered. We have asked a health care consulting firm to help us with the financial modeling of cost-based reimbursement and capitated payment programs with down side risk. Virtually all of the tertiary care

that is required by patients attributed to MAHHC is provided by DHMC. This means that our highest spend patients (our highest utilizers) receive their care at DHMC, which is currently not in a risk bearing contract with VT. This puts MAHHC in a challenging position as we work diligently to keep our patients local, maintain our strong hospitalist program, and work with DH to provide specialty care in Windsor to control costs in the system. We also work with DH to ensure that our patients quickly move to MAHHC once their tertiary needs are met at DHMC.

The hospital currently does not participate in capitated payment agreements directly with insurers

2. Please describe the financial incentives that the hospital currently includes in provider, coder, and other personnel salaries and/or contracts.
    a. How has the use of incentives by the hospital changed over time?

Answer:

Our current standard practice is NOT to offer financial incentives for our staff, managers, and providers. That said, we do have a few providers whose contract terms are "grandfathered". Historically, only providers have received incentives and those incentives were based on productivity, quality, and customer satisfaction. Three providers still have an incentive based on those items and we have five providers who are paid based on average daily census targets in addition to their base pay.

3. Does the hospital or any of its departments or personnel receive financial or other benefits for using specific pharmaceuticals?
    a. Please list all pharmaceuticals for which the hospital or provider receives payment when the drug is prescribe, administered, and/or when the prescription is filled.

Answer:

The hospital does not receive direct or indirect benefit, financially or otherwise, for administering any specific pharmaceutical. We do have group purchasing arrangements that offer discounts to the hospital for purchases from certain distributors. Most distributors offer access to nearly all pharmaceuticals. No specific products have any such incentive.

4. With the various payment reform initiatives underway, shared decision-making is becoming increasingly important as an antidote to the potentially perverse incentives of risk-based payment models.
    a. Do you commit to implementing shared decision-making throughout your hospital system in 2018?
    b. Please describe your plan for doing so and how you will measure the plan's implementation progress.

Answer:

As a hospital that focuses on primary care, acute/urgent general surgery and post-acute/acute rehabilitative services, we engage in routine shared decision making for our interventions. These interventions typically include radiologic and lab services, for which we employ the advance beneficiary notice as proscribed by CMS. On our inpatient units we perform IN-ROOM rounding for patients, a multidisciplinary approach with patients and their families to outline the plan of care, upcoming interventions, and discharge planning. We measure our success by our patient experience surveys (HCAHPS).

We do not perform major surgeries, i.e. joint replacements, cardiovascular procedures and prostate/breast cancer surgeries which have established shared decision making protocols.

5. What is the extent of your Choosing Wisely initiative(s), if any? Please describe the initiative(s), how you have chosen which departments participate, and which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement.

Answer:

Choosing Wisely is an initiative of the ABIM to promote providers and patients choosing care that is supported by evidence, not duplicative, free from harm, and truly necessary. The VMS foundation rolled out a choosing wisely campaign around reducing unnecessary labs. By expanding our hospitalist service and providing education/outreach (not connected with Choosing Wisely) MAHHC ALREADY reduced lab and radiology procedures by 10-15% over the last 3 years.

We currently have educational forums in the outpatient and inpatient settings where we are addressing the following Choosing Wisely Initiatives:

- ***Reduction of indwelling urinary catheters- we have not had a catheter related urinary infection in 12 months***
- ***We do not treat asymptomatic bacteriuria in older adults without specific UTI symptoms***
- ***We do not place feeding tubes in patients with advanced dementia for our medical inpatients, we instead perform assisted oral feedings***
- ***We have implemented an antibiotic stewardship program to limit the use of unnecessary antibiotic prescriptions in both inpatient and outpatient settings***
- ***We have reduced the use of flouroquinolones and have lowered our rate of c. diff infection to near zero***
- ***We have lowered our transfusion threshold to 7.0 g/dl, significantly lowering our blood product usage***
- ***We developed strategies for our pediatricians and ER PAs to limit radiation exposure in patients with suspected appendicitis***

This is just a small sampling of current efforts that overlap with Choosing Wisely.

6. Please provide copies of your financial assistance policy, application , and plain language summary as well as detailed information about the ways in which these three items can be obtained by patients.
    a. Please provide the following data by year, 2014 to 2017 (to date):
        i. Number of people who were screened for financial assistance eligibility;
        ii. Number of people who applied for financial assistance;
        iii. Number of people who were granted financial assistance by level of financial assistance received;
        iv. Number of people who were denied by reason for denial.

Answer:

We have attached a copy of the policy, the plain language summary, and our application. The plain language document outlines the methods of initiating an application for assistance. Below is the summary data requested in i., ii., iii., and iv. above. Note that we do not file or track denials by year and that we have annualized FY17 based on data through June 30, 2017.

Financial Assistance Approval Statistics

Year	25%	50%	75%	100%	Total #	Denied	Total Screened
2014	8	10	16	372	406		
2015	7	7	18	270	302		
2016	5	19	13	221	258		
2017 Projected	7	9	9	177	202		
Total:					1,168	207	1,375

Financial Assistance Denial Statistics (FY14 - 3rd Qtr FY17)

Reason	Total #	% of Denials
Incomplete Application	111	54%
Over Income	78	38%
Assets	8	4%
Insurance Available	7	3%
Not Resident of Service Area	3	1%
Total:	207	
% Denied of Total Screened	15%	

7. As a nonprofit with a duty to benefit the community, how does the hospital ensure that its commercial rates are in the best interest of consumers? Please provide specific metric(s) that the hospital uses to determine this. For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

Answer: See answer to # 8

8. We often hear from hospitals that they charge extra for a wide variety of services in order to fund core hospital services. In light of this business model, how does the hospital ensure that the prices of its services are set appropriately?
    a. What factors are considered in setting prices?

b. What financial or quantitative metrics does the hospital use to ensure that its service pricing is appropriate? For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

Answer:

It is difficult to adequately explain the methodology in this mode of communication.

Our budgeting process drives our rate request each year. Our process and decision-making begin with determining what our volumes will be for each department. History, current results, and known changes drive the new volume budget. Once we determine how busy we will be in each department, we determine the necessary staffing levels to effectively and efficiently manage that volume. The volume also drives the changes in our variable expense (pharmacy, medical supplies, contracted services, etc.). Inflation factors, wage increases, and other considerations are added to the expense base. Changes in payer mix, payer contracts, governmental reimbursement, and the impact on our CAH cost report are determined. These factors are entered into our budget model to calculate revenues at current pricing with the projected volume. Our gain or loss on operations is determined and we increase our prices until we reach the desired margin.

Relative to how price increases are applied across the departments and services, the first general concept is that provider services are generally paid on a fee schedule with a less-than-market inflator. Therefore, provider charge increases greater than 3 or 4% create "unreimbursed" revenue. We generally try to keep increases to pricing in that service below those levels. That said, the rest of the revenue needed to make the necessary margin will come from the hospital services.

Old/existing charges are inherited and are baked into the revenue base. They may have has a logical basis at one point, but the effects of the cost shift and Fee For Service methodologies have erased their logical origin. It is hard to adjust them without creating risk or unnecessary reward. Typically, existing charges in the hospital departments receive a percent increase for the new year. If we are growing in an area that our prices are high, we can reduce the percent increase due to the increased volume and high percentage of fixed expense. If we do not have volume growth, it is near impossible to cut pricing without reducing your bottom line. MAHHC has seldom had growing utilization so this has not been an option for us.

New charges are set with some logic. Generally, we base pricing for new services, codes, etc. using the Medicare provider or hospital (APC) fee schedules. We take that schedule and mark it up based on expected reimbursement levels and our reasonable costs. We will compare this draft pricing to a software product's (Med Assets) 50th percentile. As types of services materially change (new methods of delivering the service, improvements in technology, etc.) the cost of performing the service, we will often revisit the charges and reset them if possible.

We review Act 53 data annually and do what we can to maintain or improve our position. We are happy to discuss this further at the hearing.

9. For the hospital's inpatient services, please provide your all-payer case mix index, number of discharges, and cost per discharge for 2014 (actual) through the present (2017 budget and projected) and 2018 (budget).

	FY14	FY15	FY16	BUDGET FY17	PROJECTED FY17	BUDGET FY18
ALL PAYER CASE MIX INDEX	1.2370	1.1533	1.0638	1.1200	1.1074	1.1100
DISCHARGES	916	1,073	977	943	1,003	996
COST PER (ADJUSTED) DISCHARGE	$ 10,027	$ 10,107	$ 13,036	$ 13,094	$ 12,440	$ 12,883

We look forward to seeing you next week. Please let us know if you have additional questions or concerns. Thank you.

Sincerely,

David C. Sanville
C.F.O./V.P. Finance

Cc: J. Perras, M.D.; C.E.O.
Budget File FY2108