Questions from the Health Care Advocate

1. **Please describe all entities related financially to the hospital, the purpose of each entity, and the financial relationships between the entities (e.g., parent organization(s), subsidiary organization(s), membership organization(s), etc.). In particular:**

    a. What non-profit and/or for-profit entities does the hospital or its parent organization own in part or in full and/or is the hospital owned by in part or in full?

Northwestern Medical Center (NMC) currently operates all of its services out of one corporate entity, Northwestern Medical Center, Inc. There are three additional companies that the hospital has operated over the last several years.

NMC is the sole–owning member of Northwestern Occupational Health, LLC which until mid-2018 operated both our Occupational Health and Urgent Care programs. In April of 2018 we consolidated these programs to be departments organized within NMC. Although the corporate entity remains in existence it is not being used at this time.

NMC's consolidated financial statements also include the activity of the Northwestern Medical Center Auxiliary, Inc. which is organized specifically for the promotion and support of the Hospital.

NMC is the sole-owning member of Rise VT, Inc. This is a new corporate entity that was established in 2017 to expand the Rise VT program to other communities within the state. This entity is operated by its own independent board of Directors and its activity is managed through OneCareVT.

    b. Are hospital senior management paid by hospital-related entities other than the hospital?

Yes, The Hospital has a management agreement with Quorum Health Resources which employees the Hospitals' Chief Executive Officer.

    c. Are the revenues of these entities included in your budget submission?

No the activities of these entities are generally not included as part of this budget submission. However, the hospital does have contractual agreements with Rise VT to provide medical director and clerical support.

2. **Please describe any financial incentives/bonuses that your executives, providers, coders, and other personnel are eligible to receive that are tied to services that have the potential to increase your hospital's revenue. Please include both staff and subcontractors.**

    a. As a part of your answer, please disclose for which procedures the hospital pays providers volume-based incentives.

As part of our compensation systems NMC provides a modest bonus program for its Senior Leadership Team. These programs are based on accomplishment of predefined goals none of which have a direct relationship to volumes.

The hospital employs many physicians and has different compensation models for different physician groups. Our Emergency Department Physicians have an Incentive Program as part of their contract but none of the criteria of that program have any relationship to volume.

Our employed physician practice groups have a Physician Incentive Compensation program that is based on volume. The volume is primarily used to measure productivity in order to target physicians compensation based on market data for recruitment and retention purposes. The program also has Quality, Citizen and Patient Satisfaction criteria that must be met to earn the compensation. Below is a list of service that are included:

- OB/GYN
- Orthopedics
- Ophthalmology
- Comprehensive Pain
- Primary Care
- General Surgery
- Dermatology
- ENT new in 2018
- Pediatrics

b. Are these incentives the same for OneCareVT attributed patients as for non-attributed patients?

There is no differentiation in any of the arrangements we have regarding payment methodology.

3**. Please delineate the hospital's financial performance and patient distribution by capitated business, fee for service business, and any other payment methodologies. (If you only have one type of business please state which type.) a. Please indicate which entities the hospital has capitated or other alternative payment agreements with (e.g., insurer(s), ACO(s)).**

In 2017 NMC participated in a Pilot program with OneCareVT for the Vermont Medicaid Next Gen (VMNG) program. This was the hospitals first participation in a capitated agreement. The total revenue generated from this agreement equated out to $8.7 Million and represented 8.5% of NMC's net patient revenue. The average # of lives covered in this program for our HSA was 3,279. As we are early into this payment reform initiative we do not currently track financial performance at that level of detail. The remaining 91.5% of our net patient revenue is based on fee for service methodology in some way.

In 2018 NMC is again participating with OneCareVT in an expanded capitated agreement which includes Medicaid, Medicare and BC/BS of Vermont. The total revenue generated from this agreement is estimated to be $16.3 Million and represents approximately 15% of NMC's net patient revenue. The average # of lives covered in this program for our HAS was approximately 6,500. As

we are early into this payment reform initiative we do not currently track financial performance at that level of detail. The remaining 85% of our net patient revenue is based on fee for service methodology in some way.

4. Please provide data on the experience of mental health patients at your hospital, including:

a. The total number of mental health beds at your hospital;

b. The range and average wait time for placement of mental health patients who report to your hospital in need of inpatient admission;

c. The range and average time patients have spent in your emergency department awaiting an appropriate mental health placement;

d. The total number of patients who waited in your emergency department for an available mental health bed at your hospital or at another facility.

Please see the answer to this question in Section 5 of the budget narrative above.

5. Please describe any initiatives that you have implemented to address the inadequate access to mental health treatment experienced by Vermonters.

a. What other avenues are you pursuing to address this crisis in a sustainable way?

Please see the answer to this question in Sections 5 and 3 of the budget narrative above.

6. Please provide data on substance use treatment at your hospital, including:

a. The number of patients currently enrolled in medication-assisted treatment at your hospital;

b. The number of MAT providers employed by your hospital;

Please see the answer to this question in Section 7 of the budget narrative above.

7. Please describe the hospital's plans for participation in payment reform initiatives in this fiscal year and over the next five years.

a. How do you plan to manage financial risk, if applicable, while maintaining access to care, high quality care, and appropriate levels of utilization?

In question 3 above in addition to question 2 of the main narrative we have explained our participation in payment reform initiatives. NMC has prided itself as being and early adopter in the payment reform initiatives. We believe we have the foundations in place with our Rise VT program in additional other programs like Health U and Lifestyle Medicine to be able to focus on wellness and prevention while still providing equal or greater access to patients for needed services. Capitated agreements are not always about less service but about the right service at the right time in a highly reliable way. NMC is a financially strong institution we have a strong balance sheet which will be a critical asset to our ability to weather the risk that the organization will be subject to as payment reform expands.

b. How much money will the hospital be at risk for in FY19?

Although attributed lives nor specific payor contracts are solidified at this point in time preliminary estimates would suggest that our risk could be as high as $3.5 Million in 2019.

i. What will happen if a hospital loses that money?

The hospital understands the potential risk and reward of this program. OneCareVT and the participating hospitals are researching opportunities to purchase reinsurance that will cover some of the losses should they occur and hospitals are prepared to access the assets on our balance sheet to supplement those losses that are not covered by insurance.

ii. How will the hospital fill in this gap, if necessary, without increasing rates?

Although the impact of operating losses that would be caused by the potential risk would be challenging for our hospital we do not believe that rate increases would be necessary to bridge that difference. This is a long term investment and short term steps will not make the program successful.

iii. How does the hospital track access to care, utilization, and quality of care to ensure that provider financial incentives do not have a negative impact on patient care?

We do not currently identify patients that are covered under a capitation system in any way that would highlight providers to treat them differently. We believe that the steps taken for our capitated patients should be taken for our entire population.

8. Please describe the hospital's shared-decision making programs, if any, and any plans for expanding those programs.

a. Please describe the initiative(s), which departments have participated, how you have chosen which departments participate, which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement, and the number of patients served by these programs.

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

c. What are you doing to ensure/increase provider buy-in in these programs?

In addition to accessing best practice protocols, NMC is implementing standardized order sets across all departments and some using a platform called “Provation” which updates clinical orders routinely against evidence based practice standards. The physicians and providers have access to a myriad of orders that are cross checked with the latest medical information to ensure high quality and low cost. We also use Up To Date, which is NMC’s evidence based clinical decision support resource. All clinical staff has access; hospitalists, therapists, and clinic based providers use it regularly to guide their treatment choices and protocols. At the bedside, patients and families are engaged in the plan of care through these clinical decision support tools. Lastly, NMC is developing a Patient Advisory Group that will help us to inform our practices as we develop a highly reliable system of care for our community.

Our Diagnostic Imaging (DI) department has implemented a new software program that supports algorithms and protocols for low dose radiation in CAT Scans. This supports the goal to reduce radiation exposure in our patients for certain types of diagnostic imaging testing which is a best practice.

Our Emergency Department has implemented quality dashboards as provider scorecards on pertinent metrics such as utilization of services and treatments (e.g. Diagnostic imaging studies and Laboratory testing) to compare practices and costs of those services used by each provider. Cost savings have been realized by standardizing our protocols to reduce clinical variation by provider.

NMC is focused on choosing care and treatment that is supported by evidence, not duplicative of other tests or procedures, and free from harm – the fundamental spirits of "Choosing Wisely." These are central to our mission of 'exceptional care.' NMC uses the "Up To Date" system for evidence-based clinical decision support. Our providers use it regularly to guide their treatment choices and protocols. "Up To Date" is written into the Quality Assurance Plan of every newly hired Nurse Practitioner and our commitment to it is part of our NCQA certification. In addition, we use the Lippincott Nursing Advisor system which provides a similar level of professional support and guidance for our nurses. Our provider practices each also have the Lexicomp system as well as additional patient educational materials varying in source by specialty, to use with patients in advance of treatment to help ensure informed decision making. While NMC has not adopted "Choosing Wisely" itself as a singular standard across every one of our services, we are using many of the initiatives and recommendations highlighted within "Choosing Wisely" campaign as they are the best practices coming from professional associations. For example: NMC providers do not routinely drain non-painful fluid-filled breast cysts. This is an established clinical protocol within our imaging services, as recommended by the American Society of Breast Surgeons. Another example is our approach to pharmaceutical management where we do not use expensive medications when an equally effective and lower-cost medication is available as recommended by the American College of Preventive Medicine. Additionally, our clinical patient care committees are continually assessing lower cost drugs to place on our hospital formulary versus more expensive brand names.

Our medical directors are engaged in and lead many of our clinical quality and process improvement initiatives. Our newly redesigned Quality Improvement Committee is focusing on high reliability systems of care which include many of the aforementioned protocols and evidence based practices. Buy-in results from a strong focus on clinical quality improvements for our patients and having physician leaders at the helm of these advancements. As we focus clinical systems improvements, efficiency and process optimization, we are adopting clinical practices that better serve the patients while achieving the triple aim of high quality, cost and access to service.

9. Please provide copies of your financial assistance policy, application, and plain language summary (noting any changes from your last submission) 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 2018 (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 financial assistance by reason for denial.
v. What percentage of your patient population received financial assistance?

b. Please provide the statistics and analyses you relied on to determine the qualification criteria and the amount of assistance provided under your current financial assistance program.

Attached is a copy of the financial assistance policy, application, and plain language summary. We have made minor changes to these documents since our last submission to increase our compliance with Section 501(r) of the Affordable Care Act. We recently successfully completed a compliance check with the Internal Revenue Service as well related to our compliance with Section 501(r). As outlined in our policy, patients can obtain information related to our financial assistance policy in a variety of ways that include:

- At each registration/admission area
- Every admission packet
- Our hospital website
- Our billing statements
- Periodic notices in the St. Albans Messenger and other free publications in the greater Franklin and Grand Isle counties
- The Franklin Grand Isle United Way office
- The VT Department of Health St. Albans District office

We are not able to provide all of the data requested for 2014 – 2018. We have provided the number of people who were granted financial assistance and the total amount of financial assistance awarded as shown below:

Fiscal Year	Number of People Granted Financial Assistance	Total Amount of Financial Assistance Granted
2014	1108	$1,302,980
2015	1252	$1,270,121
2016	1244	$1,292,667
2017	1123	$1,112,947
2018 Projected	1300	$1,059,257

We estimate that 2.27% of our patient population received financial assistance in 2017.

We consult with various outside entities such as Quorum Health Resources, the Healthcare Financial Management Association, and our auditors, all of whom have access to industry wide data when developing our policies and procedures to ensure that they are adequate and appropriate.

10. 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 (2018 budget and projected) and 2019 (budget).

	FY2014	FY2015	FY2016	FY2017	FY2018 YTD	Budget 2019
Discharges	2,383	2,476	2,581	2,553	2,518	2,522
Case Mix Index	1.2286	1.2572	1.3128	1.3081	1.2849	
Cost per Discharge	$9,603	$9,712	$9,794	$9,618	$9,755	

Note: All payer case mix index and average cost per discharge are not metrics used directly in the budget preparation process and as such, cannot be reported for Budget 2019.

11. As part of the GMCB's rate review process during the summer of 2017, Blue Cross Blue Shield of Vermont (BCBSVT) was asked to "explain how the cost shift factors into your approach when negotiating with providers." BCBSVT responded: "Since the creation of the GMCB hospital budget and the greater transparency that it has created, providers insist that it is the responsibility of BCBSVT's members to fund the cost shift. Providers acknowledge that they manage to a revenue target, insist that commercial members must fund the cost shift in order for providers to meet their revenue targets, and remind BCBSVT that the GMCB has approved the revenue target." (GMCB 08-17rr, SERFF Filing, July 5, 2017 Response Letter). Do you agree with this statement? Please explain why or why not. If you disagree, please point to any data available that supports your position.

Hospital budget preparation is not solely focused on meeting revenue targets. The key component of our budget preparation is to produce an operating margin that allows NMC to meet is vision of "Providing Exceptional Healthcare For Our Community". In order to be able to do that and invest for the future the hospital must remain profitable. It is public news that 8 of the 14 hospitals in the state lost money in 2017 including NMC. At the same time insurance carriers continue to reap profits or increase reserves to fund the future. It is also common knowledge that Government funded programs often reimburse for services at far less than the cost to provide those services. BC/BS of Vermont is not singled out in this equation. Somewhere in the system the shortfall created by critical services that are poorly reimbursed must be funded elsewhere.

12. Please provide updates on all health reform activities that you have submitted under the GMCB's extended NPR cap during previous budget reviews including
- **a. The goals of the program;**
- **b. Any evidence you have collected on the efficacy of the program in meeting these goals;**
- **c. Any other outcomes from the program, positive or negative;**
- **d. Whether you have continued the program and why.**

e. If you have discontinued one or more of these programs, please describe you have accounted for this change in past or current budgets.

Please see the answer to this question in Section 8 of the budget narrative above (appendix 5).