COPLEY HOSPITAL, INC.
FY2019 PROPOSED BUDGET
RESPONSE TO QUESTIONS FROM THE OFFICE OF 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?**
b. **Are hospital senior management paid by hospital-related entities other than the hospital?**
c. **Are the revenues of these entities included in your budget submission?**

Copley Health Systems, Inc.

Copley Health Systems, Inc. (CHSI), which began operations in 1987, is a tax-exempt organization which is the parent company of and controls, through sole corporate membership, a number of entities as discussed herein. CHSI also coordinates and implements fundraising and other resource development activities for the various CHSI entities and holds, as agent for Copley Hospital, Inc. (the Hospital), an endowment for the benefit of the Hospital.

Copley Hospital, Inc.

The Hospital is a not-for-profit corporation organized under the laws of the State of Vermont for the purpose of establishing and maintaining a public, voluntary, short-term, critical access hospital (CAH). Hospital senior management are not paid by any other entities under the umbrella of CHSI. There are no revenues in the Hospital's budget submission related to any other entities under the umbrella of CHSI.

Health Center Building, Inc.

Health Center Building, Inc. (HCB) is a for-profit corporation that owns and manages one office building that is leased to the Hospital and area physicians.

Lamoille Area Housing Corporation d/b/a Copley Terrace

Lamoille Area Housing Corporation d/b/a Copley Terrace is a 38-unit apartment project located in Morrisville, Vermont, organized under the provisions of Section 202 and Section 8 of the National Housing Act for the purpose of providing subsidized housing for the elderly. Such projects are regulated by the U.S. Department of Housing and Urban Development (HUD) as to rent charges and operating methods. Copley Terrace is also subject to a Section 8 Housing Assistance Payments contract with HUD, and a significant portion of Copley Terrace's rental income is received from HUD. Copley Terrace's major programs are its Section 202 direct loan and its Section 8 rental subsidies.

Copley Woodlands, Inc.

Copley Woodlands, Inc. (CWI) is a not-for-profit corporation which operates an independent living retirement facility located in Stowe, Vermont. CWI is owned 50% by CHSI and 50% by University of Vermont Medical Center (UVMC) (formerly known as Fletcher Allen Health Care).

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

Copley has various agreements with providers that include incentive compensation based on overall productivity and performance evaluations. They do not incentivize any particular subset of procedures or patient categories over another. Staff compensation includes various incentives for working extra shifts, coming in on short notice, and other such financial incentives related to staff scheduling. Copley developed a bonus program specifically for service areas that have significant vacancies to make it more attractive for our own staff to cover shifts and help minimize the need for travelers. While there are no formal incentive programs available for staff based on performance or outcomes at this time, occasional bonuses may be granted at the discretion of management to reward excellence.

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)).

Copley Hospital does not currently have any agreements with insurers or ACOs that reimburse based on capitation or any other alternative payment methodologies. We are cost-based reimbursed by Medicare, paid under the Prospective Payment System by Medicaid and Tricare, and have commercial insurance agreements that reimburse on percent-of-charge or a fixed fee schedule.

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 refer to section 5 of the FY19 Proposed Budget Narrative to the GMCB.

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 refer to the FY19 Proposed Budget Narrative to the GMCB, sections 5 and 8 related to investments in social work in the emergency room.

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 refer to section 7 of the FY19 Proposed Budget Narrative to the GMCB.

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?**
b. **How much money will the hospital be at risk for in FY19?**
    i. **What will happen if a hospital loses that money?**

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

Please refer to section 2 of the FY19 Proposed Budget Narrative to the GMCB.

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?**

At this time, we have not committed to implementing shared decision-making throughout the hospital system in 2019. However, Copley Hospital's orthopaedic practice, Mansfield Orthopaedics, has been practicing Shared Decision Making for several years and the Cardiology practice completed a shared decision-making study regarding treatment strategies for atrial fibrillation this year.

With the support of Healthwise, we developed decision aids for patients describing their diagnosis of atrial fibrillation, and helpful information for them to use in determining whether they should take an anticoagulant (blood thinner). We had two sets of study groups, a baseline group of patients who did not receive the decision aids, and the intervention group of patients who did receive the decision aids. Both study groups were provided with surveys asking questions assessing their knowledge of their disease, the risk factors associated with it, and their treatment options. Patients in the intervention group had additional questions on their surveys relating to their opinion on the usefulness of the education provided in the decision aids.

This study had multiple goals. The primary goal was to develop a practical workflow for implementation of an anticoagulant therapy decision aid at a Cardiology practice in rural Vermont. The secondary goal was to assess whether the implementation of the decision aid resulted in positive improvements in decision quality – specifically knowledge about anticoagulant therapy, patients' certainty about the medication decision, and the patient's view of the process for decision making. The tertiary goal was to collect feedback on the decision aid booklet to improve the product.

All patients in the study were scored with the CHA2DS2-VASc system (pronounced Chad-Vasc) by Dr. Kunin. This score helped him and the patient understand their risk level for stroke secondary to atrial fibrillation, which also helped patients decide what treatment option was best for them.

We mailed surveys to our baseline group of 70; 46 were returned for a 64% response rate. Sixty-nine (69) surveys were sent out to the intervention group and 50 were returned for a 72% response rate. Some of the information they assessed includes demographics (age, highest level of education, overall self-reported health), outcomes (decision conflict, knowledge score), and decision-aid feedback. The final report from Healthwise includes the open-ended booklet comments as well as a logistic regression for the two outcomes: Decision Conflict and Knowledge Score.

At this time, we do not have plans for extending this program in Cardiology. The study did not reflect any identifiable cost savings or significant quality improvement.

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.**

Copley's financial assistance policy, application, and plan language summary are made widely available to patients and easily accessible at all hospital and clinic registration locations and on Copley's website at https://www.copleyvt.org/for-patients-and-visitors/billing-and-insurance/assistance-programs/. Additionally, a short version of the financial assistance application is on the back of every patient statement.

Copley does not conduct upfront screening for presumptive eligibility for financial assistance as this time. Following is a summary of financial assistance application data from 2014 to 2018 (thru May 31, 2018):

	FY14	FY15	FY16	FY17	YTD18 May
Applications Completed	657	696	694	761	326
Households Granted Aid	645	681	676	739	317
100% Free Care	568	628	632	699	293
75% Discount	25	25	29	23	18
50% Discount	15	9	15	17	6
25% Discount	37	19	n/a	n/a	n/a
Applications Rejected	12	15	18	22	9
Acceptance Rate	98%	98%	97%	97%	97%

Copley does not track the detailed reasons for rejection of a financial assistance application, so we cannot provide that requested data. Anecdotally, we can share that the majority of rejected applications are for households that are over the income threshold. Occasionally an applicant is over the asset threshold (ie. balance of cash, investments, etc.).

The amount of financial assistance granted to eligible patients is determined on a sliding scale based on the household income. Free care is granted to eligible patients whose household income is at or below 300% of the Federal Poverty Level Guidelines (FPLG). Discounted care is granted to eligible patients whose household income is between 300% and 400% of the FPLG. Following is a table summarizing the amount of the discount granted to eligible patients based on the FPLG:

FPLG	Up to 300%	301%-350%	351%-400%
Discount	100%	75%	50%

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).

	ACT14	ACT15	ACT16	ACT17	BUD18	PROJ18	BUD19
All-payer Case Mix Index	1.06	1.15	1.19	1.22	1.19	1.26	1.26
Total Discharges	1,795	1,980	1,994	2,025	2,107	2,056	2,137
Gross Price per Discharge	$15,654	$17,283	$17,870	$18,582	$19,485	$17,811	$20,482

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.

Without meaningful payment reform that adequately finances the shortfall in government reimbursement, hospitals will continue to be forced to shift the unreimbursed costs of serving public program beneficiaries and uninsured patients to private sector payers. We must do this in order to remain financially viable under the existing reimbursement system and continue to preserve high quality access to vital health care services for all of our patients.

As part of its charge to reduce the rate of the health care cost growth while ensuring that we maintain a high quality, accessible health care system in Vermont, the GMCB performs an independent review and analysis of hospital budgets and health insurance rates, as well as other major factors influencing the cost of health care. Based on their findings, which includes an analysis of the cost shift, the GMCB approves or modifies hospital budgets, including proposed rate changes and net patient revenue targets, and has the been granted the authority under state law to enforce the approved budget.

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 how you have accounted for this change in past or current budgets.**

Please refer to section 8 of the FY19 Proposed Budget Narrative to the GMCB.