Responses to HCA Pre-Hearing Questions – Fiscal Year 2018 Hospital Budget Review
BRATTLEBORO MEMORIAL HOSPITAL

1. What are the hospital's goals for participation in payment reform initiatives in 2018 and in the next five years?

BMH intends to enter into a risk bearing agreement with One Care Vermont (OCV) in 2018 for Medicare, Medicaid and Commercial. Our goals focus around improving the health of our community and addressing the needs as identified in our CHNA.

a. What steps will the hospital take to meet these goals?

Please refer to Slides 4 and 5 for specific programs and initiatives.

2. As the hospital takes on financial risk, how is it planning to manage that risk while maintaining access to care, high quality care, and appropriate levels of utilization?

We believe the key to managing this financial risk is by continuing to provide quality medical care in concert with the Population Health efforts that we have been investing in for the past several years. (see Slide 4 and 5). In addition, we continue to use the metrics provided through One Care to monitor progress in achieving our goals.

a. How much money will the hospital be at risk for in FY18?

The hospital's total risk for Medicare is $980,415, the total for Medicaid is $286,828, and the total for Commercial is $202,805. This creates a total risk of $1,470,048 (see Slide 15)

b. What will happen if the hospital loses that money?

BMH has built a hedge factor of 50% of this total risk figure into our FY18 Budget, thus the total risk impact would only be half that. It is out of concern for shouldering unexpected risk that we decided to build this hedge factor into the budget.

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

- While it is unlikely that we would have to absorb full risk in each of these three different payer categories, we have made plans to avoid this. Our many programs already in place have helped BMH to achieve excellent quality and utilization rates in our current work with the ACO. We expect this intensive work to continue and have budgeted for it again in FY18, and expect it will continue to yield outcomes that are in support of a reduction in total spend combined with excellent quality of care.

c. What will happen to the savings, if the hospital saves money?

BMH has been funding many of the intensive services needed to get to these savings for several years. We continue to examine all of the opportunities available for creating innovative ways of providing services to our patients. In this current year these have newly included programs such

as tele-health for emergency neurology services and tele-psychiatry, a BMH respite bed at Ground Works, (a local long term homeless shelter), Centering Pregnancy Program, and a Vulnerable Population RN Care Coordinator. We expect that we will continue to seek ways to fund such initiatives through outside resources or via our own budgeting process.

- **Will it go towards increased provider or executive salaries, lower commercial rates, community investments, or something else?**
  Any savings or additional funds will be reinvested in operations to fund our existing program in support of our community's health.

d. Beyond the ACO-level quality measures, how will the hospital track access to care, utilization, and quality of care to ensure that new provider incentives do not have a negative impact on patient care?

We are developing clinician report cards in collaboration with the BMH Medical Group leadership which will address these and other performance metrics.

- **Please list the specific metrics the hospital will use.**

  In development

For any metric(s) currently in use for this purpose, please provide results by year for 2014 to 2017 (to date).

NA

3. Does the hospital participate in any capitated payment agreements directly with insurers? If yes, please describe:

BMH does not currently participate in any capitated payment agreements.

4. Please describe the financial incentives that the hospital currently includes in provider, coder, and other personnel salaries and/or contracts.

BMH does not offer financial incentives to personnel. However, BMH employed physicians participate in an RVU-based productivity program based in part on MGMA regional data. It should be noted that fewer than 10% of these physicians have qualified for this incentive program.

a. How has the use of incentives by the hospital changed over time?
The Medical Group Leadership is evaluating the use of quality metrics to be included in the incentive program.

5. Does the hospital or any of its departments or personnel receive financial or other benefits for using specific pharmaceuticals?

No

a. Please list all pharmaceuticals for which the hospital or provider receives payment when the drug is prescribed, administered, and/or when the prescription is filled.

NA

6. 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? *:*

Shared decision making amongst patients and clinicians, when it comes to setting forth a plan for care, is something that is very important at BMH. The commitment to shared decision-making is already in place at BMH and will continue in 2018. Shared decision making is recognized at BMH through receiving input and partnership with patients, as well as joint decision making by BMH's Medical Staff and BMH Administration.

b. Please describe your plan for doing so and how you will measure the plan's implementation progress.

BMH has many examples of how they currently implement shared decision making initiatives and plans to continue this work in 2018 and beyond. BMH is committed to the use of 'motivational interviewing', as seen in their involvement with the SBIRT (Screening, Brief Intervention and Referral to Treatment) model of care. Motivational interviewing draws on current motivating factors for the patient to make a change in a potentially unhealthy behavior. The outcome of motivational interviewing is to set forth a plan of care, based on where the patient's motivation lies in their desire and willingness to make a change.

BMH also works to create shared care plans within their Emergency Room, Primary Care Practices and with community partners. Patients are at the center of these care plans and clinicians work to facilitate the health care goals which are created by the patient. These care plans are created by the group who has the most contact with the patient. Sometimes the care plan is created in the ER, sometimes it is created in the office of the patient's primary care clinician and sometimes, it is a community resource that facilitates the creation of a care plan, such as SASH or HCRS. The care plan belongs to the patient and follows them to whoever is caring for them in that instance. As a result, the healthcare team is working with the patient to achieve the goals for which the patient and the entity of care have worked to create.

Two of BMH's primary care practices also participate in a 'Vermont Child Health Improvement Program' (VCHIP) initiative that involves a patient partner. Just So Pediatrics and Maplewood Family Practice sent an open invitation to parents/guardians of their pediatric patients asking for them to get involved with the operations of both Medical Group Practices. The response was

wonderful and both practices engaged separate patient partners. VCHIP funded the initiative and provided guidance regarding the process. Patient partners were compensated for their time and childcare was provided as necessary. Patient partners participated in bi-monthly operation meetings and their time and energy was spent on a specific quality improvement activities. Decisions were made in partnership on issues, such as marketing, approach with patients, follow-up and metrics used to determine success of the program.

Administration and Clinicians at BMH also work very closely to make joint decisions regarding operations and how resources are utilized. In 2015, BMH embarked on a new model of shared decision making amongst clinicians and administrators, known as dyad leadership. This involves a clinician lead in every Medical Group Practice, who is paired with the Manager of that practice. Those teams make applicable decisions regarding the creation of proposed budgets for a new fiscal year, hiring staff, how best to increase access to care, making proposals on policies and procedures, etc. The clinician lead then represents their department on the clinician leadership committee. This committee meets once a month and on an ad hoc basis and works with BMH's Medical Group Medical Director and Medical Director Administration to make final decisions on the above mentioned items, as well as other important operation issues to the Medical Group. This model of leadership ensures that clinicians have the time and the opportunity to make decisions in a shared manner with members of Administration.

Success of the implementation of this shared-decision making model with be realized through high patient satisfaction scores, as determined by tools used by BMH (National Research Center Patient Satisfaction Surveys) when compared to scores from previous years and national counterparts; High quality of care metrics as determined by OCV's clinical reports cards, when compared to BMH's scores from previous years and other applicable Hospitals in Vermont; and the retention of Clinicians within BMH's Medical Staff.

7. 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.

BMH Medical Staff embraces the concepts of the Choosing Wisely Campaign and are committed to decreasing the instances of unnecessary testing or treatment. This work takes on a variety of approaches. A few examples of this are:

- Our Emergency Physicians routinely discuss the Evidence Based Practices with the goals of avoiding unnecessary testing and treatments.
- Our Pediatrics Department routinely reviews the pediatric care of our Emergency Department to ensure these best practices are followed for minimal pediatric radiologic and antibiotic exposure.
- We have instituted protocols that adhere to these best practices in many of our departments, such as requiring appropriate rationale for blood transfusions or certain radiologic studies.
- Our Hospitalist team was a participant in the Vermont SIM grant project through the Vermont Medical Society Foundation which focused on eliminating unnecessary testing in the inpatient setting.
- Our Clinical Collaboration Committee, which includes physicians from DH Keene and BMH, has identified the need to improve our ability to share lab results on our mutual patients to alleviate duplicative testing.

8. 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.

See attached financial assistance policy, application, and plain language summary.

Individuals may initiate the Financial Assistance application process by contacting the BMH Community Resource Liaison in one of the following methods:

- By telephone: Please call the Community Resource Liaison at (802) 257-8814 (fax: (802) 251-8465).
- In person: Stop at the front desk of the hospital or any one of the medical group practices and inquire with the receptionist regarding applying for financial assistance. A list of addresses for the hospital and medical practices are attached to this policy.
- By mail: Please send a request to apply for Financial Assistance to the Community Resource Liaison at the following address:

  Community Resource Liaison
  Brattleboro Memorial Hospital
  17 Belmont Avenue
  Brattleboro, Vermont 05301

- Patients may also obtain an application from our webpage. Simply search for Financial Assistance and the financial assistance policy, application, and plain language summary will all pop up to be selected.

	FY2014	FY2015	FY2016	FY2017
Applied	361	208	269	158
Granted 100%	305	162	205	138
Granted sliding scale	41	32	63	20
Denied	15	14	1	0

9. 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).

- We will utilize any benchmarks we can find including Medicare and Medicare fee schedules and Act 53 Price Surveys.

10. 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?

- See answer to #9 above

a. What factors are considered in setting prices?
  - Direct and indirect cost of procedure or supply
  - Payor mix and third party payor methods

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).

- See Act 53 price surveys

11. 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).

	FY2018 Budget	FY2017 Budget	FY2016 Actual	FY2015 Actual	FY2014 Actual
Inpatient Charges	37,476,642	29,795,555	29,309,983	28,331,883	27,716,232
Total Discharges	2,006	1,924	1,930	1,920	1,884
Case mix	1.23	1.14	1.23	1.14	1.14
case mix adjusted discharges	2,467	2,193	2,366	2,189	2,148
avg charge per discharge - (case mix adjusted)	15,189	13,584	12,387	12,944	12,905