Northwestern Medical Center
2018 Budget
Healthcare Advocate Questions

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

Northwestern Medical Center has been a leader in participation in payment reform over the last year. We are currently one of four hospitals participating in the Vermont Medicaid Next Gen pilot agreement with the State of Vermont through One Care to cover approximately 30,000 Medicaid lives through a capitated agreement. In 2018 we are one of seven hospitals who have agreed to participate in an expanded capitated model through One Care that will include Medicare, Medicaid and Blue Cross. This expanded model will increase the lives covered across the state in a capitated model to nearly 150,000 lives. The St. Albans HSA will have approximately 12,441 of these lives under the capitated model.

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

NMC has prepared well for this payment reform movement. Through our local Unified Community Collaborative (UCC) we have engaged all aspects of the healthcare system in the St. Albans HSA. In the VMNG initiative with One Care we have engaged in the development of a comprehensive Care Coordination model which is the foundation for coordinating the care of the lives covered in the capitated model.

b. If the hospital has chosen not to participate in the risk-based Accountable Care Organization payment models offered to date, explain the rationale. If the decision was informed by financial modelling, please provide the model specification, model inputs and results.

Not Applicable

c. Does the hospital participate in any capitated payment agreements directly with insurers? If so, please provide your analysis to illustrate the effect on costs.

The only capitated agreement that we are currently participating in is the 2017 VMNG agreement with the State of Vermont. Since we are only 7 months into this agreement it is too early to have any reliable data to evaluate its effectiveness.

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 are a strong proponent that capitation should not limit access to care but should enhance access to care. The critical aspect of the success of risk based contracting will be our ability to collaborate with our partners in developing and implementing a seamless care coordination model across all aspects of the healthcare system.

Northwestern Medical Center
2018 Budget
Healthcare Advocate Questions

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

As we are participating in the Medicare, Medicaid and Blue Cross capitation agreements led by One Care Vermont ACO our total at risk amount is approximately $2.9 Million.

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

If the hospital were to pay out the entire portion of the amount at risk it would clearly be a significant blow to the organization. However, our organization has been preparing for and leading health reform for many years. We have built a strong balance sheet and would rely on that if these risk items were to be realized. However, we believe effective care coordination and appropriate cost management would both be important factors to minimize the direct impact on our balance sheet.

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

The answer above addresses this part of the question as well.

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

As is the case with any money that the hospital makes it is reinvested into the healthcare delivery system to continue to grow and develop a system that is flexible as the healthcare system changes.

i. Will it go towards increased provider or executive salaries, lower commercial rates, community investments, or something else?

We believe the most appropriate use is to invest in our community. Unfortunately we are not confident that lowering commercial rates will actual make its way to our community members.

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?

Ultimately, possible "negative impact" that this question postulates would likely be visible with increases in readmission rates, within changes in visits to the Emergency Department, and within our overall patient satisfaction, all of which are monitored closely by hospital Leadership and Board Committees, tracked on NMC's strategic dashboard, and reported to our Board of Directors on a quarterly basis. Moving forward, we believe we will also be able to track any such "negative impact" through the monitoring of compliance to our evidence-based clinical protocols. While these tools are commonly thought of to help identify possible areas of over-utilization, they can also be used to help identify possible areas of under-utilization.

The important point in this discussion is that regardless of what system NMC must operate within, our approach will always focus on evidence-based protocols through the clinical expertise of our providers and best practice as we provide the right care to the right patient at the right time in the right setting.

Given that our population is aging and that we have a higher rate of high risk patients in the Medicaid Next Gen pilot, our focus on ensuring proper care to our population will be critical. Enhanced, care coordination, warm hand-offs, and effective transitions of care are crucial. The use of our Up To Date approach (see answer to question regarding Choosing Wisely) to foster even greater shared decision making is also crucial. By adhering to evidence-based protocols, educating and involving our patients, and coordinating care, we will be able to avoid any negative impacts. Our ongoing monitoring of readmissions, emergency visits, patients satisfaction, and clinical protocol adherence will allow us to ensure we are on track.

i. Please list the specific metrics the hospital will use.

See answer above.

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

NMC tracks a wide variety of readmission indicators, emergency department volume statistics, patient satisfaction levels, and other quality/compliance metrics – but not specifically for the purpose discussed in this question at this time.

3. Does the hospital participate in any capitated payment agreements directly with insurers?

Yes, in 2017 we are participating in the Vermont Medicaid Next Gen Pilot Capitated model.

If yes, please describe:

a. Whether the capitated payments save the insurer money compared to fee for service payments.

This program has only been in place since January of this year and therefore it is too early to make any conclusions on its impact on the organization.

b. Whether the hospital and/or its providers earn more profit under capitated payments or fee for service, on average.

This program has only been in place since January of this year and therefore it is too early to make any conclusions on its impact on the organization.

c. How the hospital ensures that patients continue to receive appropriate services under capitated payments.

Our capitated model is to makes sure that all patients have access to care. We continue to develop a Care Coordination model with our partners to ensure patients are receiving the care that is appropriate for their individual situation.

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

Many of our physician contracts have incentive based aspects that have various criteria including Patient Satisfaction, Peer Review, Quality Metrics, Committee Participation and wRVU production. In addition certain members of our Senior Leadership team have specific goal accomplishment that can result in incentive payments.

a. How has the use of incentives by the hospital changed over time?

The physician incentive programs have changed over the years to include a larger component of the incentive be based on Quality.

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.

None

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.

We believe the most important piece of our move to a capitated environment is the Care Coordination model and how you engage the individuals in there care.

a. Do you commit to implementing shared decision-making throughout your hospital system in 2018?

We are totally committed to the successful implementation of our Care Coordination model through One Care.

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

We will do this through the continued implementation of the Care Coordination that has been developed in collaboration with One Care Vermont.

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.

Up To Date is NMC's evidence based clinical decision support resource. All clinical staff have access; hospitalists, therapists, and clinic based providers use it regularly to guide their treatment choices and protocols. Use of Up To Date is written into the Quality Assurance Plan of every newly hired Nurse Practitioner. NMC as well commits to its use as part of our NCQA certification.

Of late, one of our primary care providers changed her clinical decision in regard to a medically complex, recently discharged patient that presented to Northwestern Georgia Health Center. The provider's course of action would have been to readmit this patient, but based on her Up To Date query, prescribed instead an oral regimen that resolved the patient's symptoms and prevented the need for readmission. Such medical admissions have a direct variable cost to NMC of approximately $3,000/case.

Choosing Wisely is under review and may supplement our existing clinical decision support approaches.

8. Please provide copies of your financial assistance policy.

Attached is a copy of our financial assistance program. The Hospital uses a variety of methods of communication to inform and educate patients about its financial assistance program. For example, information related to financial assistance and charity care is available on the Hospital's website and patient portal, included on the back of patient statements, posted on signs at registration areas, and patients may speak on the phone with a collection specialist. The Hospital's financial assistance program is also wide publicized within the community, including published information regularly placed in the local newspaper and information brochures displayed at local United Way and Department of Health offices.

a. Please provide the following data by year, 2014 to 2017 (to date):

i. Number of people who applied for financial assistance;

Because the financial assistance process is largely paper based, we can't run any reports to tell us the number of people who were screened, the number of people who applied, or the number of people who were denied and for what reason but we can share that anecdotally we don't have many denials.

ii. Number of people who were granted financial assistance by level of financial assistance received;

Number of accounts receiving financial assistance by discharge fiscal year:

FY2014 – 3,168
FY2015 – 2,831
FY2016 – 2,658
FY2017 Projected – 2,700

Breaking this down into particular levels is difficult given the data that we have but we are able to look at free care write-offs as a percentage of gross charges on these accounts to evaluate whether assistance levels are changing in aggregate and over this time period, we see a steady increase in free care write-offs as a percentage of gross charges over this time period.

iii. Number of people who were denied, by reason for denial.

See answer above.

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).

For certain common services, we are able to evaluate our pricing against other hospitals in Vermont by utilizing the Act 53 pricing data made available through the Vermont Department of Health. Our rates compare very favorably with other Vermont hospitals as we are among the three lowest costs hospitals for 65% of the tests listed.

Since not all charges are reported under Act 53, we use annual price increases implemented through the budget process as a way of benchmarking ourselves against our peers. The data table below was included in the narrative submitted to the Green Mountain Care Board as part of the FY2018 budget submission and shows that we have the lowest average annual price increase since FY2011. For some context, if a test cost $1 in 2010, the median price for that test in 2017 would be $1.43 and the price at NMC would be $1.13 putting NMC 20% below the median price.

Hospital Rate Increases	2011	2012	2013	2014	2015	2016	2017	Total Since 2011	Average Annual Increase
Grace Cottage Hospital	5.5%	10.6%	6.5%	6.0%	5.00%	5.00%	5.00%	52.49%	6.21%
Porter Medical Center	6.5%	10.3%	5.0%	6.0%	5.00%	5.30%	5.30%	52.22%	6.19%
Gifford Medical Center	5.8%	7.0%	6.1%	7.6%	5.60%	5.80%	3.90%	50.02%	5.97%
UVM Medical Center	5.7%	5.9%	9.4%	4.4%	7.80%	6.00%	2.45%	49.67%	5.93%

North Country Hospital	4.4%	5.1%	4.6%	8.0%	8.30%	4.80%	3.50%	45.61%	5.51%
Southwestern VT Medical Center	6.0%	5.5%	6.8%	7.2%	4.50%	3.80%	3.40%	43.60%	5.31%
Rutland Regional Medical Center	5.5%	9.8%	10.3%	4.8%	8.40%	3.70%	-5.10%	42.85%	5.23%
Northeastern VT Regional Hospital	4.8%	7.5%	6.5%	5.6%	5.00%	3.20%	3.80%	42.51%	5.19%
Central Vermont Medical Center	5.2%	6.0%	5.0%	6.9%	5.90%	4.70%	2.45%	42.18%	5.16%
Mount Ascutney Hospital	6.5%	3.5%	7.0%	5.0%	3.22%	5.70%	4.90%	41.74%	5.11%
Brattleboro Memorial Hospital	6.0%	7.4%	5.2%	5.8%	2.70%	-1.40%	3.50%	32.80%	4.14%
Springfield Hospital	3.8%	5.8%	6.0%	4.6%	5.45%	2.80%	0.00%	32.00%	4.05%
Copley Hospital	5.5%	6.0%	3.0%	6.0%	0.00%	-4.00%	0.00%	17.21%	2.29%
Northwestern Medical Center	1.8%	6.3%	2.9%	3.9%	6.40%	-8.00%	0.00%	13.25%	1.79%
Health Connect – Blue Cross					7.70%	5.90%	7.30%		
Health Connect – MVP					15.30%	3.00%	8.80%		

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?

Clearly some services provided at the hospital are profitable and allow the organization to provide other core hospital services that are not profitable. However, our hospital does not charge "extra" for services. The hospital includes several factors in determining what it charges for various services including cost to provide the service. The most important factor is being market competitive for the services that we provide.

a. What factors are considered in setting prices?

Market Competitiveness, Cost, Reimbursement Levels.

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).

Service specific price comparisons can be made in some cases by reviewing Act 53 data as mentioned previously. We are concerned that the approval of the private ambulatory surgery center in Colchester sets a precedent of allowing private organizations to siphon market share from the historically profitable service lines within a hospital which exposes hospitals to considerable risk. Because of this, we are now reevaluating this business model to try to understand the impact of pricing all services in a way to minimize losses in all services. It is too early to know what this would look like but it is clear that labor and delivery and outpatient women's health are the service lines that would be most adversely affected by implementing this alternative pricing strategy.

Northwestern Medical Center
2018 Budget
Healthcare Advocate Questions

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).

Fiscal Year	Case Mix Index	Acute Discharges
2014	1.2286	2,386
2015	1.2572	2,467
2016	1.3128	2,581
2017 Bud		2,630
2017 Proj	1.3156	2,578
2018		2,603

Since only Medicare reimburses us based on Case Mix Index, we do not explicitly budget an all-payer case mix index. Likewise, department costs are budgeted in total and not allocated between inpatient and outpatient since the staff and supplies are utilized to treat all patients within each department. The GMCB reports cost per adjusted discharge which is an adequate approximation.