UMMHC Transfer of Ownership of Marlborough Hospital

APPLICANT RESPONSES #1
Please Respond by March 21, 2025
Responses should be sent to DoN staff at DPH.DON@State.MA.US

> While you may submit each answer as available, please
> - List question number and question for each answer you provide.
> - Submit responses as a separate word document, using the above application title and number as a running header and page numbers in the footer.
> - When providing the answer to the final question, submit all questions and answers in order in one final document.
> - Submit responses in editable WORD or EXCEL format.
> - Whenever possible, include a table with the response data.
> - **For HIPAA compliance Do not include numbers <11.**

Factor 1

1. **Provide the most recent utilization data FY(2024) for Marlborough Hospital vs for UMMMC in a manner that is compatible with CHIAA's Hospital Profiles FFY 2023 Appendices a-j**
   https://www.chiamass.gov/massachusetts-acute-hospital-profiles

   To be provided.

2. **Provide the data on the transfers including differentiating ED and ED boarders:**
   a. **Transfers from Marlborough to UMMMC by specialty and by acuity**

Please see Tables 1 and 2 below.

Table 1: Transfers MH to UMMMC	FY2023 Transfer #	FY2023 Transfer %	FY2024 Transfer #	FY2024 Transfer %
Higher Level of Care	605	69.5%	604	71.5%
Service Not Supported	238	27.4%	211	25.0%
Other	27	3.1%	30	3.6%
Total	**870**	**100.0%**	**845**	**100.0%**

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Table 2: Transfers MH to UMMMC by Specialty	FY2023 Transfer #	FY2023 Transfer %	FY2024 Transfer #	FY2024 Transfer %
Trauma Surgery	111	12.8%	153	18.1%
Pediatrics	148	17.0%	131	15.5%
Neuro/Neuro-Surg	86	9.9%	78	9.2%
Hospital Medicine	81	9.3%	74	8.8%
Obstetrics	61	7.0%	70	8.3%
Critical Care	77	8.9%	68	8.0%
Cardiology	67	7.7%	61	7.2%
General Gynecology	32	3.7%	36	4.3%
General Surgery	31	3.6%	34	4.0%
Orthopedics	35	4.0%	33	3.9%
Other Surgery	30	3.4%	32	3.8%
Urology	36	4.1%	28	3.3%
Vascular Surgery	20	2.3%	21	2.5%
Emergency Medicine	23	2.6%	13	1.5%
Other	32	3.7%	13	1.5%
Total	**870**	**100.0%**	**845**	**100.0%**

    b. Transfers from UMMMC to Marlborough by specialty and by acuity.

UMMMC transferred 7 patients in FY23 and 13 patients in FY24 to Marlborough Hospital. Due to HIPAA prohibitions, the hospital is unable to provide further breakdown of these patients by specialty and acuity.

3. **Provide more details of the specific annual cost savings associated with the items described on page 2 of Patient Panel Need:**

    a. Maintaining 2 licenses

Based on a preliminary analysis, the Applicant anticipates that the elimination of a separate license for MH will result in annual savings of approximately $20,000. This includes the elimination of duplicative licenses, registrations, accreditations and certifications that UMMMC already holds and would be extended to the Marlborough campus.

    b. Maintaining 2 administrative staffs

There are multiple synergies gained from eliminating the need for two administrative staffs. The President of UMMMC will assume oversight of the Marlborough Hospital campus which will become a satellite of UMMMC, reducing the current allocation of a 0.4 FTE for a president of Marlborough Hospital. Additional roles that will be reduced and folded into UMMMC's governance and management structure following the merger include the chief medical officer, the assistant vice president for clinical services, and other administrative functions.

This will save a total of 2.83 FTE's and 4 physician leadership stipends. For an annualized savings of approximately $890,000. In an effort, to preserve jobs and protect individual livelihood, individuals may be reassigned to other roles within the health system once their roles at Marlborough Hospitals transition to UMMMC.

    c. Maintaining 2 governing bodies

The Marlborough Hospital Board convenes ten times annually for a two-hour meeting. For each board meeting, the Applicant estimates that ten hours of preparation work are performed. Eliminating the Marlborough governing body through the proposed merger would save approximately 120 hours of

tracked management time annually to manage, prepare, and deliver for the board of trustees. As a licensed satellite of UMMMC, Marlborough governance and operations will fall under UMMMC, resulting in a minimal increase to the preparation and duration of each UMMMC board meeting.

d. Reduction in transports between the 2 entities

In the current state, patients requiring services not available at Marlborough Hospital must be transferred to another facility. Because of capacity issues, UMMMC is often unable to accept transfers. These transfers between hospitals occur by ambulance, the cost of which is the responsibility of the patient. It is not uncommon for a patient's insurance to decline payment for the ambulance transport or to pay only a small portion, leaving the patient with a significant cost burden that varies based on the patient's individual coverage. This has even led patients to refuse ambulance transfer because of fear of excessive bills.

As a licensed campus of UMMMC, when an admitted patient is transported between campuses of the same hospital, the hospital incurs the cost of the ambulance transport because it is for the movement of a patient from one location to another of the same licensed provider. As a result, with the merger, the cost impact to public and private payors and to patients will be eliminated.

With the merger there will always be patients that require transport from MH to UMMMC due to the need for a higher level of care or the lack of specific services being available at MH. However, as a campus of MH, it will be possible for more patients to receive teleconsults at MH and not need to be transported to UMMMC for specialty consultation as occurs today.

4. **Since both Hospitals are under the same health system, and since UMMHC uses the EPIC system, explain why the integration is not more seamless. Explain why there are impediments and how much more burdensome such processes as telecommunication and the rotations of the intern and resident program poses. Why are tele-consults not possible under the current structure?**

A. Regulatory Obligations

As a preliminary matter, MH and UMMMC are two separately licensed hospitals within the UMass Memorial Health ("UMass Memorial") system. Each hospital also holds its own Medicare Certification. As a result, each hospital must separately and independently comply with the regulatory requirements for licensure as well as the Medicare Conditions of Participation (CoPs).

Physician Staffing and Contracting

Each hospital must maintain its own medical staff as well as credentialing teams and workflows in compliance with the Medicare CoPs. This entails a significant and costly administrative effort to oversee and administer the medical staff, as well as contracted services when on-staff services are not available.

In practical terms, this means that a physician credentialed at Facility A cannot provide clinical services to Facility B's patients unless the physician is also a credentialed provider of Facility B. These clinical services include both in-person care and teleconsults. This means that UMMMC medical staff cannot provide care to MH patients unless the individual staff member is duly credentialed and holds privileges as a member of the MH medical staff.

Credentialling all providers at both UMMMC and MH is not a practical option because of the significant cost to providers (two medical staff dues) and it would impose significantly more administrative burden on the Medical Staff Office at Marlborough Hospital.

As a result of these medical staff limitations, Marlborough Hospital must purchase coverage models from physician groups to provide basic hospital services to its patients. In many cases, this coverage is purchased from private physicians or groups. In some cases, it is purchased from medical groups which are owned by the healthcare system. Unlike many community hospitals, Marlborough Hospital does not own and operate an employed physician group. National data shows a growing proportion of physicians prefer employment to private practice, shrinking the pool of available specialists to hospitals without employed medical groups.[1]

The Medicare CoPs require a separate review of contracted quality standards which entails a significant and costly administrative effort. Due to the high costs associated with contracted specialty coverage, is not financially sustainable for MH to obtain coverage for a number of services that would allow patients to remain in the community but are not utilized at a high enough rate to justify the cost of 24/7 coverage. Examples of services that have seen reductions in coverage or lost entirely over the past year alone include Anesthesia (weekend coverage now every other weekend), General Surgery (from 24/7/365 to 3 weeks out of 4), and a complete loss of Urology call coverage. As a result, MH is limited in providing these services to patients impacting access to care at MH.

Due to the limited availability of specialty services at MH because it is cost prohibitive to maintain clinical coverage, MH patients must be transferred to UMMMC to obtain necessary specialty consults and services. However, because of the capacity constraints within Central Massachusetts, UMMMC often cannot accept these patients, prompting a transfer to the closest tertiary care facility that has capacity. This is a hardship for the patient as they are left with no option but to seek care outside UMass Memorial from providers unfamiliar with their care, with less access to their existing health information and often at considerable distance from their home and family. The resulting transfer also delays the delivery of care.

Through the proposed merger, the consolidation of the medical staff at UMMMC and MH will provide expanded opportunities for tele-consultation at no additional cost to providers and without the need for separate contracting. Providers of the unified medical staff will be able to provide formal opinions to their colleagues when requested; and would, in fact, be required to do so by the Medical Staff bylaws.

Medical Records and Billing

As a separately licensed entity, MH is required to be set up as an independent entity in EPIC for billing purposes. Following the proposed merger, the Marlborough campus can set up in EPIC as a connected entity which will allow for the following capabilities:

- o Patients who move from MH to UMMMC will no longer need to be discharged from MH and registered at UMMMC. There will only be one registration and admission to UMMMC because the physical move from MH to UMMMC's Worcester campuses will be treated as internal transport. This administratively simpler process will result in patients being moved faster between the campuses.
- o Providers will be able to view all aspects of the patient encounter, such as key vitals trends, at both facilities seamlessly once integrated.
- o There will be increased transparency regarding capacity and access as the Marlborough departments will now be visible directly within UMMMC views in EPIC.
- o Administratively, coding and billing will be tied to one encounter instead of two based on the separate entities. Moreover, only one payer prior authorization for services will be needed.

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[1] Condon, Becker's Hospital Review April 11, 2024: "Nearly 80% of Physicians Now Employed by Hospitals, Corporations."

B. <u>Intern and Resident Rotations</u>

Per the guidelines from the Accreditation Council for Graduate Medical Education (ACGME), training programs must designate a specific, licensed facility for interns and residents to train at. As separately licensed facilities, numerous inefficiencies exist due to these guidelines:

- o In order for departments at UMMMC to have interns, residents or fellows provide clinical care at Marlborough Hospital, each training program must separately submit an application to add Marlborough Hospital as a participating site. Due to requirements by most training programs, MH also must maintain a separate educational infrastructure separate from UMMMC including roles like a designated program director.
- o Due to the above, under the current structure, interns, residents and fellows cannot freely float between the two hospitals. If there was an urgent provider staffing need at Marlborough Hospital that could be helped by deploying a trainee from UMMMC this would not be possible on an urgent basis as the process for adding a participating site takes time. The greater freedom to deploy trainees to Marlborough Hospital under the same license as UMMMC would greatly enhance potential services available at Marlborough Hospital and increase the trainees' educational exposure.
- o On-call structures that currently exist at UMMMC often depend on a resident working under the supervision of an attending physician. This model, even for teleconsultation, cannot be used to extend services to Marlborough Hospital under the current licensing structure.

5. **Compare the quality, patient safety, and regulatory oversight processes now, and how will they be different assuming project approval.**
   a. **Why are these programs not currently integrated in the long-term planning around quality, safety and outcomes. Explain why as part of the UMMHC system these functions are not currently possible.**

   As noted in the response to Question #4, the responsibility for quality and patient safety is with the licensed and certified hospital. From a regulatory compliance perspective, each hospital is solely responsible for its Governing Body, Administration and Medical Staff, as well as the associated costs. This important work of the licensed hospital is supported at the UMass Memorial system level for quality, patient safety, and regulatory oversight including centralized efforts at federal and state data reporting, quality reporting through standardized metrics, and overall system-wide legal, audit, compliance, and risk management activities. However, support cannot be provided or leveraged between separately licensed hospitals. Any programs of one hospital, such as UMMMC, could be duplicated at another hospital, but they cannot be fully integrated or otherwise act as a singular program. As a small community hospital, MH does not have the personnel resources to implement the same level of programming available at UMMMC which has significantly more resources to carry out this work.

   For example, UMMMC has a robust patient quality, safety and regulatory readiness program anchored by a Chief Quality Officer and an AVP of Patient Safety and Regulatory Affairs. Additionally, every UMMMC Medical Staff Department has Physician Quality Officers that are responsible for quality within the department from a provider perspective. This depth of expertise and quality control is simple not possible for a Medical Staff of an entity the size of Marlborough Hospital. With the merger, UMMMC will have the ability to absorb MH into the currently

established program with virtually no additional cost and improve the quantity and depth of quality and safety activities at MH.

UMMMC additionally has a robust patient grievance and patient experience office which will be able to further support MH with patient grievances and patient experience. MH will be fully incorporated into the Medical Center's patient grievance and patient experience governance process.

b. **Explain why "redesigning patient care" at Marlborough Hospital that achieves efficiencies and reduces operational costs is not possible as part of the UMMHC system currently.**

As discussed in these responses and in the DoN narrative, the major challenge that MH is facing is its ability to provide access to community hospital services because of the significant costs involved with obtaining specialty coverage to support the provision of inpatient community-hospital level care. As more fully described in the response to Question #4, regulatory barriers exist with the current two hospital model that do not permit MH to obtain clinical and administrative services from UMMMC without significant costs and administrative burden. Through the proposed merger, patients in the Marlborough region will have access to a wider array of specialists through the integration of UMMMC's and MH's medical staffs. For example, providing call coverage singularly to a 79 bed hospital is less efficient than providing coverage to both the 79-bed hospital campus and a large academic medical center. As a result, the needed expansion of specialty services can be achieved much more efficiently with MH operating as a licensed campus of UMMMC than any efforts to do so as a separately licensed campus.

c. **Public Health Value Equity focused**
   a. **Are the programs listed currently not available at to MH patients?**

The programs listed in the DoN narrative are primarily UMMMC programs. MH currently has the following programs described in more detail in the narrative: Interpreter Services; Culturally Competent Staff; MyChart in English and Spanish; UMass Memorial Health Equity Improvement Initiatives; MassHealth Health Equity Incentive Program; and CommunityHelp.net and GetWell. Marlborough Hospital does not have a doula program because it does not provide maternity services. With respect to Community Benefits Programs, those listed in the DoN are programs of UMMMC. Following the merger, the Marlborough Campus will be part of the UMMMC license and as a result some of the Community Benefits Programs may be extended to the Marlborough service area as appropriate.

   b. **If not will these all be available to MH patients?**

Please see response to question #6a.

   c. **SDOH screening- Is this screening available in languages other than English.**

The Inpatient SDoH screenings are done by the nurse as part of the admission process. For patients with limited English Proficiency, the nurse utilizes Interpreter Services which includes phone, video conference and in-person to facilitate the screening.