

**Northwestern Medical Center (NMC)**  
**Fiscal Year 2019 (FY2019) Budget Narrative**

**1. Executive Summary:**

Northwestern Medical Center (NMC) continues to be devoted to our long-standing mission of providing exceptional care to our community. Over the last several years we have received many confirmations to our commitment to this important endeavor in 2017 we were gratified to be honored as one of the nation's "Top 100 Rural & Community Hospitals" in recognition of our excellence in: costs, charges, quality, outcomes, patient perspectives, market share, and financial stability. The breadth and depth of this recognition is a strong testament to the prudent approach NMC takes to the tremendous responsibility of caring for our community. We have been recognized for two consecutive years as being a "Most Wired" organization as we have worked to provide our staff and medical staff with the critical tools to provide exceptional care to our community. At the same time, NMC is devoted to being a leader in the reform of our healthcare delivery system for both our local community and for the state of Vermont through RiseVT and taking on risk in the ever expanding all payor model transformation.

NMC continues to lead the way – locally and at the state level – in integrating primary prevention into healthcare reform through the innovative, exciting RiseVT movement to embrace healthier lifestyles, as we believe the best way to pull costs from the healthcare system and bend the cost curve long-term is to improve the health of the population and prevent the need and demand for costly treatments and services. At the local level, in alignment with our Community Health Needs Assessment (CHNA) and in partnership with entities throughout our region, RiseVT continues to strengthen its engagement of families and its penetration into our schools, businesses, and municipalities. This collaborative, proactive, positive approach and its promising initial progress, which has been lauded and encouraged by the Green Mountain Care Board (GMCB), has garnered attention across the state from hospitals, the Vermont Department of Health, Blue Cross/Blue Shield, OneCareVT, the Vermont Business Roundtable, and others. NMC's efforts have inspired the creation of a formal RiseVT corporation with a high-powered Board of Directors at the State level on a mission to bring this positive primary prevention force throughout the state for the benefit of all Vermonters.

NMC has also continued to be a vested participant in OneCareVT, leading in the all payor model payment transformation initiative. In 2018 NMC expanded its participation from a Medicaid only system in 2017 to a program that includes Medicaid, Medicare and BC/BS of Vermont. We are currently covering nearly 6,500 lives in 2018 and expect that to increase to nearly 12,000 lives in 2019. With this expansion in covered lives our risk exposure has increased from \$182,000 in 2017 to \$1,500,000 in 2018 and \$3,500,000 in 2019. NMC is one of nine Vermont hospitals currently participating in this initiative and we expect that number will increase in 2019. We continue to be the lead participant in our region's Unified Community Collaborative which brings together leaders from many sectors – health care and social determinant areas – to work together for a healthier future for all as we pursue shared savings and improved population health. An increasing focus of this collaborative is both care coordination and prevention and wellness. We are 100% committed to helping Vermont make a successful transition from old style 'fee for service' medicine to the value-based approach of an integrated population health system.

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In the midst of this incredible work, NMC's FY2019 budget was arguably the most difficult budget we have had to prepare. The challenging part is this is the second year in a row that we have made this comment. All budgets are built on assumptions, but in healthcare at this time there are so many more moving parts and outside influences affecting this budget compared to recent years. Amidst that uncertainty, NMC continues to have a very flat operating margin. In 2017, we operated at a loss for the first time in many years. Through the first 8 months of 2018 we are experiencing a dangerously slim operating margin of 0.7%. There are many factors that have caused this change in our operating conditions. Many of our volumes are flat compared to previous years. This is a catch 22 as you would hope that a focus of wellness and prevention would result in those changes. However, our continued commitment to the importance of access to services and prevention and wellness, which we see as the cornerstones to health reform, has contributed to our current operating status. In 2019 we face increasing challenges. Soon we will have an Ambulatory Surgery Center adjacent to our service area that likely will siphon off many of the profitable services (and as we grow into a capitated environment our community attributed patients receiving care outside of the area when care is offered locally with close community care navigation) from our organization. Nevertheless, we must continue to provide a full range of services for our community. We will also face increasing risk with a significant increase in lives that will be covered by our capitated agreements with Medicare, Medicaid and BC/BS of Vermont. In preparing NMC's FY2019 budget, our management staff, medical directors, leadership team, and community Board of Directors have worked diligently to carefully balance the needs of our patients, the demands of healthcare reform, and financial prudence while working within the budgetary guidance and requirements of the Green Mountain Care Board (GMCB). NMC has had the lowest overall average annual rate increase among all Vermont hospitals since 2012 at 2.125% and yet this year's budget demands a requested rate that is lower than our average, yet still maintains an operating margin that will allow us to take on additional risk and continue investing in prevention and wellness and provide increase access to local healthcare services. Our community Board of Directors endorses this budget as the right thing for our community and Vermont in order to allow NMC to continue to provide exceptional care and be an effective leader in the expansion of prevention, the improvement of health, and the advancement of system reform.

Within the budget, the significant programmatic, staffing, and operational changes include:

- Improved access to local service to our community. This includes the return of Ear, Nose, & Throat (ENT) services to our community which have not been available for several years despite active recruitment to replace a retirement and the change of resources being offered by UVM Medical Center
- Partnering with UVMHC to provide rotating clinic service for Neurology services. This is another service that has been unavailable to the residents of Franklin County.
- Consolidation of both Urgent Care and Occupational Health Services from a subsidiary entity within NMC to reduce administrative burden and streamline operations
- Expansion of risk based payment arrangements with the growth in covered lives from 6,500 in 2018 to nearly 12,000 in 2019.
- With the impending retirement of a successful independent General Surgery practice NMC was able to continue to provide valuable services through the recruitment of a new General Surgeon who will join the Northwestern Associates of Surgery practice.

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- After having several part-time Pulmonologists (including higher cost locum physicians to ensure access to a top community need) serving the Franklin County community NMC has finally been successful in recruiting a fulltime Pulmonologists who will provide this critical service to our community.
- NMC continues to run with one less Orthopedic Surgeon than is necessary to support our community. This budget has additional costs built in to continue to provide necessary coverage of this service during this extended vacancy.

Northwestern Medical Center is committed to and leading in the healthcare transformation balancing the pace of change with evolving levels of capitation while ensuring the needs of the community are met with innovation surrounding the electronic medical record integration, telemedicine, partnerships around addiction services and mental health, a community vision for total wellbeing, consolidation of locations and services for efficiency management and even more importantly leading in learnings and actions around social determinants, trauma informed service sensitivity and ACE's. We are a catalyst to collaboration around these efforts and have a strategic plan that creates an umbrella organization, to build relations and innovation across our community organizations (accountable communities for health), focusing on efficiencies and system improvements to wrap around our population for seamless flow of care. We are excited about the early work on this with our Federally Qualified Health Center (NOTCH), Franklin County Home Health Agency, and Northwestern Counselling and Support Services. In addition, the work of the Unified Community Collaborative Governance Board is focused at this time on Food Insecurity as vital to total wellbeing. We are proud to be amplifying this work bringing the community together for one vision, one strategy. This cultural transformation takes time and investment. We believe this budget provides the framework for success balancing the hands on work today and the future that requires long term investment in keeping healthy people healthy and reducing or even reversing chronic conditions. We have an NMC team and a community ready to deliver.

We are paving the way and leading the future with accountability to regulation and to the needs of our community we are proud to serve.

**2. Payment and Delivery Reform:**

Investing in the All-Payer Model:

NMC continues to be a leader in the advancement of payment reform initiatives in the State of Vermont. As mentioned in the executive summary we will be participating in the Medicare, Medicaid and BC/BS of Vermont payment reform initiatives. As OneCareVT continues to negotiate with other payers including CIGNA and others NMC has every intention of participating in the expansion of this reform initiative. With this expansion comes a significant increase in risk for the institution. This risk will continue to require a strong balance sheet and profitability in order to weather any potential risk that may be experienced. In 2019 the risk is estimated to be nearly \$3.5 million.

- A. NMC has signed a letter of intent to participate Medicare, Medicaid and BC/BS of Vermont the three programs that are currently available.

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- B. We expect our fixed payments to be approximately \$31.2 Million. This number is contingent upon many factors and may change as OneCareVT continues to work on solidifying attributed lives and payor agreements.
- C. The current budget assumes a maximum upside and downside risk of nearly \$3.5 Million.
- D. The FY2019 budget includes our best estimate of the expected value of the upside and downside risk. This means that we assume the fixed prospective payments match the historic fee for service payments resulting in no upside or downside payments occurring. This also means that no dollars have been budgeted to be placed in reserve.
- E. At this point in time we have received no payments from OneCareVT associated with the Value-Based Incentive Program initiative. It is much too early in the process to predict what might be received and the 2019 budget does not contemplate a payment from this fund.

### **3. Community Health Needs Assessment**

Our region's current Community Health Needs Assessment, adopted by the NMC Board of Directors in Fiscal Year 2017, identified six top priorities: Mental Health & Substance Abuse; Obesity; Smoking; Cancer; Suicide; and Domestic & Sexual Abuse. Action plans have been created to help address each of these priorities and the awareness of these priorities is part of the thought process in all of our planning.

NMC has taken a leading role in improving access to care and services relating to Mental Health & Substance Abuse, including:

- Service by CEO Jill Bowen on the Vermont Opioid Coordination Council;
- the Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative in the Emergency Department (ED);
- integration within Primary Care;
- exploration of collaborative opportunities with Northwestern Counseling & Support Services (NCSS);
- work with the Howard Center to help facilitate expansion of their services;
- advocacy for improvements to access to inpatient mental health services at the state level;
- temporary hosting of the new BARRT Hub to provide more timely start of strongly needed services;
- continued care to patients through our Comprehensive Pain & Addiction practice;
- establishment of a pilot "Mental Health Tech" training program to create a new level of specially-trained support for key clinical environments;
- financial support of a community collaborative housing initiative to supplement the promise community grant in partnership with Champlain Housing Trust, United Way, Northwestern Counselling & Support Service, Samaritan House, Voices Against Violence, and Champlain Valley Office of Equal Opportunity; and
- securing funding for 'Trauma Informed' training for Primary Care and Pediatric embedded care managers, RiseVT field staff, and Vermont Department of Health Field staff in advance of a Blueprint Learning Lab collaborative focused on the topic as part of our work to build resiliency in our community.

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NMC has taken a leading role in the significant expansion and re-energization of primary prevention efforts within northwestern Vermont through the exciting and innovative RiseVT movement to embrace healthy lifestyles. This directly addresses the priorities of obesity, smoking, and cancer – and can contribute to a healthier overall perspective on life which may help reduce prevalence of the largely preventable chronic conditions which appear as other priority issues in our Community Health Needs Assessment. RiseVT continues to strengthen its engagement of families and its penetration into our schools, businesses, and municipalities. This collaborative, proactive, positive approach continues to demonstrate promising initial progress on our short-term measures as we pursue mid-term behavior change measures and long term outcome measures, including a reduction in obesity. Our measurement study with the schools of Franklin and Grand Isle counties showed that 41% of 1<sup>st</sup>, 3<sup>rd</sup>, and 5<sup>th</sup> graders are overweight or obese – significantly higher than the self-reported data available through the Youth Risk Behavior Study – further reinforcing the need for RiseVT and primary prevention and setting the baseline data targets for our improvement work. RiseVT has been lauded and encouraged by the GMCB, has garnered attention across the state from hospitals, the Vermont Department of Health, Blue Cross/Blue Shield, OneCareVT, the Vermont Business Roundtable, and others. NMC's efforts have inspired the creation of a formal RiseVT corporation with a high-powered Board of Directors at the State level on a mission to bring this positive primary prevention force throughout the state for the benefit of all Vermonters. That statewide organization is now staffed, led by Executive Director Marissa Parisi and RiseVT is now beginning to rollout in multiple hospital service areas across the state.

The primary prevention work of RiseVT is supplemented by strong and aligned secondary prevention work (treatment, education, cessation, support, etc.) relating to obesity, smoking, cancer through NMC's Lifestyle Medicine, Blueprint & Primary Care, and the NMC Cancer Program. Elisabeth Fontaine, M.D., NMC's Medical Director of Lifestyle Medicine and RiseVT, is now Board Certified in Lifestyle Medicine, becoming one of the first physicians in the world to achieve that status and she is working with the Lifestyle Medicine team of clinical experts to expand their impact on the health of our community as a complement and extension of primary care. NMC continues to have a strong Sexual Assault Nurse Examiners program in our Emergency Department, close working relationships with law enforcement, and serves as a resource to individuals who have been victims of sexual or domestic assault. We are a collaborative partner with organizations in our community working to address sexual assault and domestic abuse, such as Laurie's House / Voices Against Violence.

#### **4. Quality Measure Results**

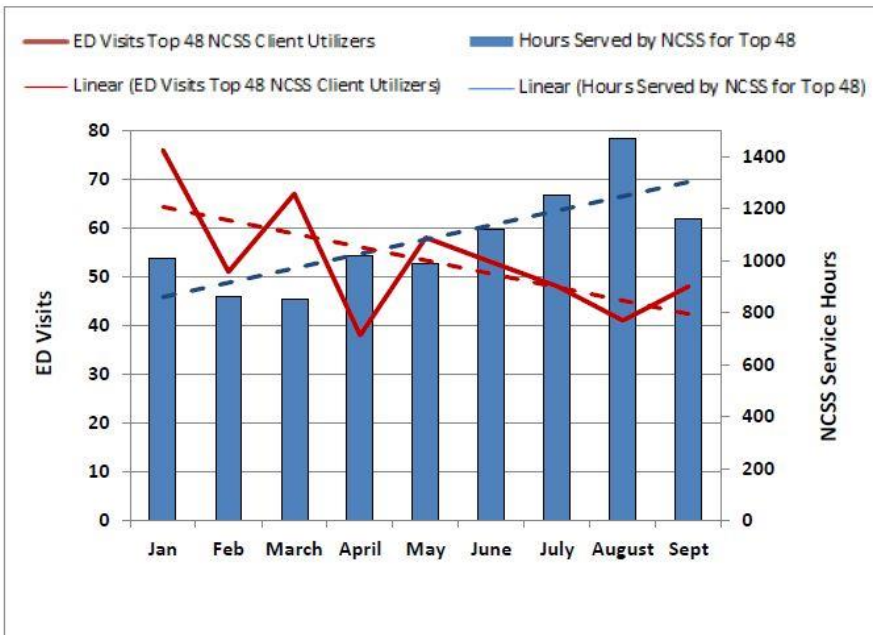
One of the most notable areas within the Vermont All Payer Quality Measures comparison, for the St Albans Health Service Area (HSA), is our 2016 growth of 14% in ED visits related to mental health and substance abuse. Associated measures include Initiation of alcohol and other drug dependence treatment (2016 baseline 36%), 30 day Follow Up after discharge for Mental Health (2016 baseline 67%), and 30 Day Follow Up after discharge for alcohol and other drug dependence (2016 baseline 38%) . In response to these historical performance rates, NMC has intentionally focused since early 2016 on its SBIRT (Screening, Brief Intervention, and Referral to Treatment) model in the ED. This program has shown remarkable results over time in the areas of screening, treatment initiation, and actual reductions in substance usage. Much of this is

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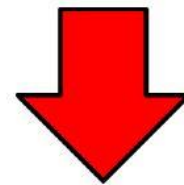
directly related to a dedicated certified drug and alcohol counselors within the ED. Over 12,000 patients have been screened for substance abuse and over 1,850 have received higher level services as a result. To date, 82 clients have enrolled in Brief Treatment, the intervention recommended for those at highest risk. 95% of those that attended 7-12 sessions reported abstinence in the last 30 days. These and other measureable results helped to assist in a 69% statewide decrease in the number of people reporting past month Opiate use.

The entire St Albans HSA is wrapping around this issue. Mental behavioral health social work is now embedded within all Patient Centered Medical Home clinics in the health service area in addition to NMC's Interventional Pain Clinic. This allows for timely warm handoff between provider and social work when concerns are identified, while the patient is still in the clinic. As well, case management of all mental behavioral health and substance abuse related discharges and ED visits occurs, assuring that patients have made contact with recommended clinic or community services following ED visit or inpatient stay.

NMC and its community partners including NCSS are engaged in an ongoing workgroup aimed at reducing ED visits related to mental health and substance abuse. They plan to continue to work closely with patients at risk to eliminate stigma, provide essential support, and foster attendance at treatment sessions, which as the aforementioned statistics show, reduces overall usage and ultimately reduce poor outcomes related to mental health and substance abuse disorders. A pilot study of a collaborative approach between NCSS and NMC involving 48 NCSS clients who had been identified as high ED utilizers resulted in a 37% reduction in ED visits between January 2017 and September of 2017. What is equally interesting is this cohort of patients had an increased prevalence of chronic medical conditions that are often overlooked with the acute care need of the mental health presentation. Chronic medical conditions are likely escalating the mental acute situation. We need to learn more about this correlation.



**37 % Reduction in ED  
Visits by NCSS Active  
Clients  
Jan to Sep 2017**



NCSS High ED Summary 11/22/17 \*ED visit data provided by NMC October 16, 2017, based on High ED Utilizer definition of three or more visits in three months

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We are currently working with NCSS on a second cohort and anticipate similar results. The services that achieved that result were funded through NCSS using Department of Mental Health (DMH) dollars. This is a promising model that State investment in would contribute to the ‘quadruple aim’ of reducing costs, improving outcomes, enhancing the patient experience, and enhancing the provider experience.

Other area of highlight:

Percentage of Medicaid adolescents with well child visits:

Knowing that NMC had an opportunity to improve performance in regard to adolescent well child checks, primary care and pediatric clinical teams have convened to assess current barriers and potential solutions. They implemented a plan that embedded well child check alerts into the Electronic Medical Record (EMR) and changed workflow such that distinct time was scheduled for well child visits as opposed to the prior practice of incorporating them into acute visits. As well, pediatricians began performing well child checks when sports physical were requested. This blended approach allowed NMC within 2017 to increase compliance rates from 66% to 77%. Our next steps are focused on panel management to reach out to those who are not coming into the clinics.

Diabetes HbA1C Poor Control: NMC has both leveraged its EMR and enhanced clinical workflows to improve performance in this measure. Clinical Decision Support rules have been built to flag patients with an A1C of greater than 9 and provide quick access to educational material and a referral to Diabetes Educator. These actions have assisted in improving our performance rates from a 2016 baseline of 11% to a preliminary 2017 rate of 51% (OneCareVT Preliminary 2017 Medicare results).

Controlling High Blood Pressure: NMC and community partners including St Albans Primary Care and specialty practices, banded together to attain regional improvement in this area. EMRs were again leveraged with clinical decision support to identify and respond to patients with defined high blood pressure. Primary Care sites addressed high blood pressure when identified, while specialty sites initiated timely referral to primary care for follow up. Focus on these workflows has allowed us as an HSA, to improve performance from a 2016 baseline of 67% to a 2017 preliminary rate of 77% (OneCareVT Preliminary 2017 Medicare results).

Prevalence of chronic disease – Chronic Obstructive Pulmonary Disease (COPD): In 2018, NMC engaged its medical directors in leading quality initiatives via the creation of the Quality Improvement Committee (QIC). This committee, comprised of inpatient, outpatient, primary care, specialty, and ancillary medical directors, evaluates current quality performance and prioritizes upcoming areas of focus. This is proving to be a powerful mechanism as NMC realizes that in order to have a strong and effective Quality Program, providers must be leading.

NMC’s QIC selected COPD as one of two clinical priorities for 2018. Our Chief Medical and Quality Officer, Lowrey Sullivan, M.D., and Director of Quality, Jodi Frei, are facilitating the development of an organizational COPD protocol, driven by evidence and supported by common practices across settings including uniform staging, use of patient educational materials, and patient messaging. This will create a highly reliable process aligned with Gold Standards, aimed at improving care and reducing readmissions related to COPD.

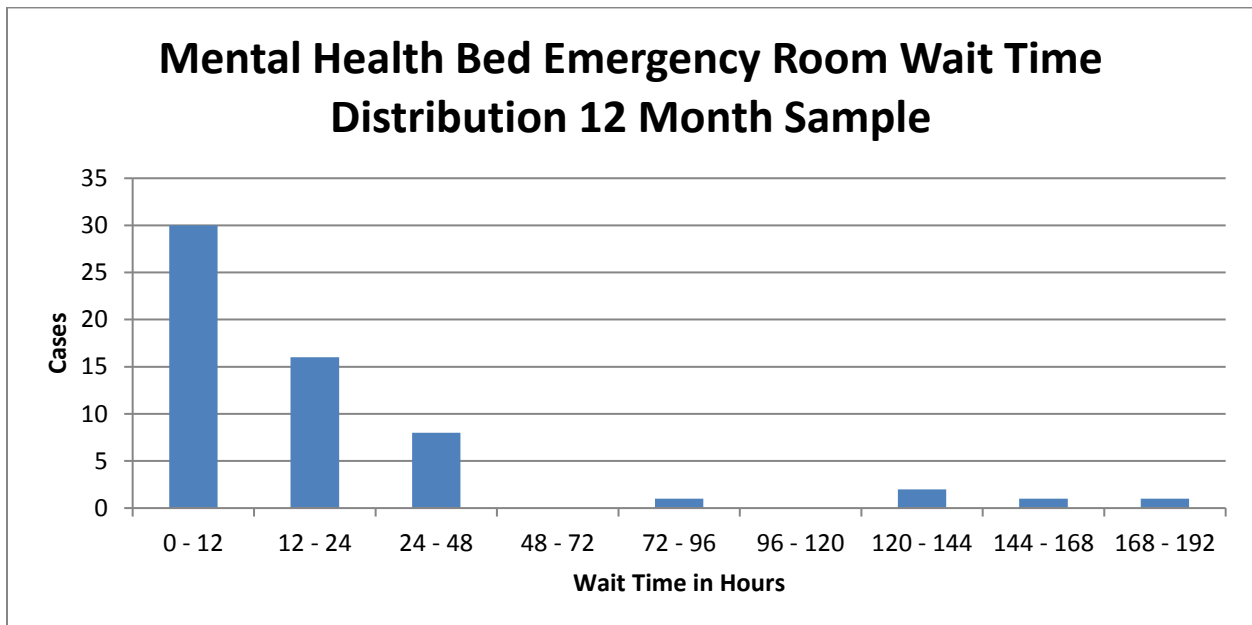
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**5. Mental Health – (sub questions A, B, C, D):**

We do not currently have any dedicated mental health beds. Patient beds in the emergency department are used as necessary or patients are admitted to inpatient rooms if there is a medical need.

Between June 2017 and May 2018, there were 58 patients with mental health concerns that waited in our emergency department after being medically cleared and were then either admitted to NMC or transferred to another facility. There was one additional patient that was held for 7.5 days after being medically cleared who left against medical advice.

The average wait time within the emergency department after being medically cleared was approximately 23 hours with the median being approximately 11 hours. The average is considerably higher than the median due to the extremely long lengths of stay that occur from time to time. Below is a chart showing the distribution of wait times for the 59 cases mentioned.



The average total cost per day is \$1,110 and the average variable cost per day is \$713. The 59 cases mentioned account for \$62,000 in total costs and \$39,900 in variable costs.

**5e. Mental Health Initiatives**

NMC’s goal is to provide quality, timely and appropriate mental health services for our community. In order to achieve this we have partnered locally with our designated agency; Northwestern Counseling and Support Services (NCSS) to provide our community with contracted mental health services such as crisis interventions and support as well as psychiatric services within our Emergency Department and Inpatient areas. In addition, we are about to embark on updating our contract for coverage within our physician/outpatient areas to expand those services to support primary care.



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We have also partnered with NCSS to develop a new Certified Mental Health Technician Program which was launched as a pilot educational program at NMC in May – June 29, 2018. The program was piloted with 6 ancillary staff members from the Inpatient, Emergency Department and Outpatient arenas. A nurse educator audited the course to evaluate it for content and the ability to ‘spread’ to other health professionals. This involved the development of curriculum focused on the support of mental health/substance abuse patients over the course of 6 educational modules. At the end of the course the staff is expected to sit for a national certification examination by September 30, 2018. The program also included MANDT training as part of the requirements. The MANDT system is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others. Our goal is to finalize the evaluation, make updates to the course as necessary and offer it year round- to ensure we have highly qualified support staff at the bedside to provide specialty support to our mental health population of patients.

In addition, we are actively engaged at the State level through the Vermont Association of Hospitals and Health Systems (VAHHS) to engage our physician and clinical leaders with the regulatory bodies/agencies to address these issues ongoing. We are doing this at NMC through community collaboration around Mental Health and Substance Abuse, to develop better care planning strategies using data and process improvement initiatives. At NMC we have a goal to reduce the number of patients in our ED requiring crisis interventions by 3% overall. As of the first quarter of FY18, we exceeded that goal at 7%; through active and engaging partnerships with NCSS, and with a focus on care coordination and transitions of care.

Lastly, we have made the renovations of our Emergency Department (ED) a top strategic priority as we develop the next phases of our Master Campus Plan. We have completed a design phase which incorporates two Behavioral Health patient rooms into our ED schematic design. This will support the safe care of these patients who have to be held in the Emergency Department for periods of time while awaiting transfer to more appropriate facilities. This will come before the GMCB within the year as a part of a CON application.

We are very fortunate in our HSA to have 90% of all primary care practices recognized by NCQA as patient centered medical homes. Our Blueprint funding is supporting continuous quality improvement through annual learning collaborative(s) whereby teams come together to develop new models of care and share learning. Our practices have made significant investments in making mental health services available in the primary care setting. In partnership with our designated agency, NCSS, we have built a brief treatment model based on the SBIRT screening (brief intervention and referral for treatment). This has made the warm handoff from primary care to mental health services safe and seamless. In 2015 the St. Albans HSA Primary Care Practices made a commitment to use Blueprint funds to subsidize one full time nurse care manager and one full time integrated mental health provider in each clinic. We kicked off a yearlong Learning Collaborative focused on integrating mental health in primary care. We had full participation from hospital employed, Federally Qualified Health Center (FQHC) and private practices.

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**6. Patient Access**

NMC primary care practices have made great gains over the last year with the addition of 4 primary care providers. We are able to offer same day access for any problem; however, using the IHI definition of 3<sup>rd</sup> next available appointment same day access is not included. Therefore, Northwestern Primary Care is currently at 7.5 days and Georgia Health Center is at 1.5 days. Our St. Albans practice continues to feel the pressure of access to primary care given the demand in the area. Our FQHC has recently added primary care resources, so we feel confident access continues to be a priority.

Here are the days until the “3<sup>rd</sup> Next Available Appointment” for each of our practices:

**Days (as of 6/20/18): Practice/Service:**

1	OB/GYN for a PA
1	Pediatrics – St. Albans
1	Pediatrics – Swanton
1	Rehabilitation – Cobblestone
2	Orthopaedics – for a NP/PA
2	Primary Care – Georgia
2	Pediatrics – Enosburg
5	Orthopaedics – for an MD
6	Ophthalmology
6	Rehabilitation – Enosburg
6	Rehabilitation – Pool
7	OB/GYN – for an MD
7	Urology
8	Primary Care – St. Albans
9	Addiction/Pain – for a PA
12	Rehabilitation – Georgia
13	Associates in Surgery
19	Addiction/Pain – For an MD
27	Pulmonology
47	Cardiology
76	Dermatology

**7. Substance Use Disorder Treatment Programs**

The Comprehensive Pain Clinic has developed into a model clinic serving Franklin and Grand Isle counties providing prevention, screening, intervention and treatment related to substance use and opioid use disorders. This program provides a team-based approach to treating substance misuse behaviors as well as risk reduction within the community. The Clinic is the centerpiece of a collaborative model involving a number of key community partners including: Northwestern Counseling and Support Services, The Howard Center, the Vermont Department of Health, Turning Point, BAART, as well as primary care offices. These health care partners jointly follow these complex patients to ensure a strong continuum of care. As part of our multi-

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disciplinary model we offer psychiatry services provided by our Board Certified Psychiatrist. Services include group session such as: Mind/Body, Recovering from Trauma, Making Recovery Easier, Open Recovery, Stimulant Support Group and Intensive Outpatient Program. BAART has also established a fully operational Hub in Franklin County located in St. Albans. NMC partners closely with BAART to support care transitions for individuals requiring varying levels of substance use treatment.

NMC also employs 9 providers that offer Medically Assisted Treatment (MAT) services within the clinic setting. 6 of these are primary care providers. In this setting, stable patients are able to co-manage their substance use treatment along with all other conditions. We are fortunate in our community to have such a receptive primary care providers engaging in this important work.

Over 1,850 community members have received higher level services since SBIRT began in the Emergency Department. We believe the continuation of the SBIRT program in our ED and potentially expanding through Primary Care is a critical clinical treatment component.

Health Homes build linkages to community supports and resources as well as enhanced coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses, including mental health and substance use. Health Home care coordinators enjoy close relationships with local substance abuse treatment provider, using a ‘warm hand off’ protocol for patients who need targeted treatment. The next phase is to join SBIRT counselors in the ED with care coordinators located in the St. Albans HSA Hub and Spokes. The SBIRT counselors in the ED identify clients who would benefit from longer-term treatment, and create a warm hand off to MAT care coordinators. The spoke practices tend to be primary care practices with providers who already have a relationship with the ED users. The investment in the SBIRT counselors will not only have a preventive and supportive outcome, but also further reduce unnecessary emergency department use. The SBIRT providers will identify patients without a primary care provider for referral to a Health Home. NMC has also submitted a letter of interest to participate in the Youth SBIRT grant. Should the State and Spectrum Youth and Family Services secure the grant, NMC’s St. Albans Pediatric Practice is an identified site to pilot Youth SBIRT.

Key specific statistics requested:

- Numbers of MAT patients serviced at Comprehensive Pain = 245
- Number of MAT providers employed by NMC = 9
- Total number of patients enrolled in MAT at NMC = 347

**8. Health Reform Investments -- Approved Health Reform Activities FY2016-FY2018**

Our FY16-FY18 healthcare reforms focused on our ACO participation and expansion of our prevention efforts through Lifestyle Medicine and RiseVT.

Please see Appendix 5 for our response in the format provided.

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**9. Reconciliation:**

**Projected 2018 Summary Income Statement**

	Budget 2018	Projected 2018	Variance	% Variance
Gross Revenue	203,187,845	197,023,419	(6,164,426)	-3.03%
Contractual Allowances & DSH	(90,178,364)	(82,274,986)	7,903,378	-8.76%
Bad Debt & Free Care	(6,881,258)	(8,646,911)	(1,765,653)	25.66%
Total Deductions	(97,059,622)	(90,921,897)	6,137,725	-6.32%
Net Patient Revenue	106,128,223	106,101,522	(26,701)	-0.03%
Other Operating Revenue	5,841,987	6,383,934	541,947	9.28%
Total Operating Revenue	111,970,210	112,485,456	515,246	0.46%
Salaries, Fringe & Phys Contracts	67,182,101	68,803,174	1,621,073	2.41%
Interest	1,157,186	661,544	(495,642)	-42.83%
Other Expense	42,818,589	42,535,373	(283,216)	-0.66%
Total Expense	111,157,876	112,000,091	842,215	0.76%
Net Operating Income	812,334	485,365	(326,969)	-40.25%
Non-Operating Revenue	752,188	2,850,704	2,098,516	278.99%
Excess of Revenue Over Expense	1,564,522	3,336,069	1,771,547	113.23%

In total, we are projecting to end the year very close to budget but there are a handful of income statement lines with variances worth noting.

- *Gross Revenue* – We are projecting to miss our gross revenue target by \$6 million or 3%. More than half of this variance is related to three physician practices. We have experienced vacancies in the pulmonology, chronic pain and orthopedic practices during FY2018. In addition to this, one of our orthopedic surgeons was injured and not able to perform their normal volume of surgeries for a period of months. Within small physician practices, vacancies can have a significant impact on overall volumes.
- *Contractual Allowances* – We have experienced a favorable variance in write-off rates in FY2018. Please refer to section 10 for a more detailed discussion by payer.
- *Bad Debt & Free Care* – A switch to a new collection agency resulted in a one-time Bad Debt write-off transaction that inflates this number in the current year. The model that is used to estimate the allowance on outstanding accounts will smooth the timing impact of this transaction but it takes roughly one year for accounts to work their way through the model so we expect the amount to remain high at the close of FY2018 and return to normal levels going forward.
- *Other Operating Revenue* – We are projecting higher than expected grant reimbursement related to the operation of our Community Health Team which is fully grant funded. This variance is over \$500,000. There are corresponding expenses which account for some of

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the variance in the Salaries line. Because these are offsetting variances, there is no impact Net Operating Income

- *Salaries, Fringe & Physician Contracts* – As noted, \$500,000 of this is related to the grant funded Community Health Team. In addition to this, some physician vacancies have been filled with temporary traveler physicians (Locum Tenens) that come at a considerable premium. This has affected our hospitalist group and the orthopedic practice in particular. Physician contracts in total are projecting to be approximately \$500,000 over budget when netted with the salary expense that they are replacing.
- *Interest* – The FY2018 budget used conservative interest rate numbers when calculating the expected financing costs related to new bonds issued to finance the master facility plan CON project. The actual rates have been more favorable and have resulted in a considerable savings. The FY2019 budget assumes that rates will increase from current levels but is still lower than the amount budgeted in FY2018.
- *Non-Operating Income* – The variance in this section is related to returns on investment which are unpredictable and prone to significant and sudden change.

**10. Budget to Budget Growth:**

**A. i. Net Patient Revenue:**

We are requesting approximately \$3.5 million in qualified physician transfers, the allowable 2.8% growth factor and a .4% increase related to investments in healthcare reform initiatives in accordance with the FY2019 budget guidance provided. The requested increases, which all fall within the guidelines provided, will result in a very modest 2% operating margin. We continue to believe that, based on national industry benchmarks, a 3% operating margin is necessary to adequately fund routine equipment replacement and infrastructure maintenance but also recognize that a strong balance sheet will allow us to operate at a lower margin for a period of time.

In calculating the budgeted net patient revenue for FY2019, we are including the net patient revenue related to four physician transfers:

- 1) The replacement of an independent general surgeon in St. Albans, who will be retiring, with a general surgeon that will be employed by NMC (\$526,591).
- 2) The reestablishment of ENT services in St. Albans that have been available sporadically over the past 10 years through independent physicians and contracts with UVM Medical Center. We will be hiring an employed physician to operate this program beginning in July of 2018 (\$719,544).
- 3) With the completion of the clinic space as part of the Master Facility Plan, we are seeking partners to offer clinic services on a rotating basis. We have partnered with UVM Medical Center to provide access to Neurology services in St. Albans on a part-time basis and will continue to explore additional options. Only the Neurology practice is included in the budget as no other clinics have been identified at this time (\$276,346).
- 4) The full year impact of the transfer of Northwestern Occupational Health (NOH) from a subsidiary to a department of the hospital as approved by the GMCB mid-way through FY2018 (\$1,727,173).

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We are also seeking to utilize the full amount allowed for healthcare reform investments. We continue to focus on primary prevention and wellness through a number of initiatives, including RiseVT in our community, a lifestyle medicine clinic available to our employees and our continued partnership with other hospitals throughout Vermont under the OneCareVT payment reform model. To further support these efforts, we are adding two wellness coaches to our primary care offices. It is our hope that in addition to these two positions, we will also be able to solidify additional funds from the Blueprint to support two more positions. This will allow us to provide consistent coverage in both primary care and pediatric offices. We also hope to provide wellcoaching to our comprehensive addiction services once we pilot the initial four locations. Coordinated case management is very important in achieving the goals of the ACO model. As such, we are eliminating our current physician practice electronic health record and moving all of the practices onto the same platform that is used throughout the rest of the hospital to create a single streamlined health record for all of our patients. The cost of this projected goes beyond the .4% allowed with the remainder to be funded from existing assets and operations.

We have calculated the total net revenue to be included in the FY2019 budget as follows:

**FY2019 Net Patient Revenue (NPR) Budget Calculation**

FY2018 Budgeted NPR	\$106,128,223	
2.8% Growth	2,971,590	
Total with Inflation		109,099,813
<i>Healthcare Reform</i>		
Wellness Coaches	107,000	
EHR Consolidation	317,513	
Total Healthcare Reform		424,513
<i>Physician Practice Transfers</i>		
General Surgery	526,591	
ENT	719,544	
Neurology	276,346	
NOH	1,727,173	
Total Physician Practice Transfers		3,249,654
<b>FY2019 Budgeted NPR</b>		<b>\$112,773,980</b>

**10. A. ii. Significant Changes:**

The only significant change made to the FY2018 budget was the transfer of Northwestern Occupational Health as noted previously. This was done through the standard process and an amended budget order that includes the 6 month impact of this change was issued on May 10<sup>th</sup>. The 6 month impact is built into the base used in calculating the FY2019 budget and the

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remaining 6 months is included in the list of physician transfers to be effective beginning in FY2019.

**10. A. iii. Cost Savings Initiatives:**

As noted in the FY2018 budget narrative, we are always looking critically at staffing levels through the use of third party benchmarking tools and looking for opportunities to utilize positions more efficiently to contain costs. In addition to this ongoing effort, there are a few other notable cost saving initiatives that have occurred or are currently in progress.

During FY2018, we undertook a complete review of all vendor contracts with the intent of eliminating or consolidating services where possible. This resulted in an annualized reduction in total costs of \$325,000 which has been incorporated into the FY2019 budget.

We have included \$90,000 in the FY2019 budget to fund cost savings innovations. We have identified the need to streamline workflows and improve supply utilization within the surgical services departments and have already begun a project to make those areas more efficient and to reduce costs.

We are actively working with Optum Consulting (previously The Advisory Board) to transition our surgical services to an Ambulatory Surgery like setup. This will include changing many of our operating processes, staffing levels and physical layout to accommodate a more streamlined and cost effective surgical program. We have already implemented certain aspects of this initiative during 2018 which allowed us to contract with BC/BS of Vermont for a case based payment rate for Colonoscopy services. During 2019 our intention is to expand to other types of cases.

We are working to establish a centralized patient access call center to improve efficiencies and reduce the salary expense required to support both our outpatient services as well as our physician practices.

The total impact of the work in surgical services and the centralize access center concept are not yet known. In addition to these initiatives, we will be continuing to identify further opportunities. To account for these efforts, the FY2019 budget includes a cost reduction of \$500,000.

**10. A. iv. Payer Specific NPR Changes:**

The most significant payer specific changes are related to growth in the OneCareVT capitated payment model. Anticipating the impact of these changes is very challenging and introduces a considerable amount of uncertainty into the net patient revenue budget.

**10. A. iv. a. Medicare**

The current proposed Medicare rules include a total increase of 1.25% for inpatient payment rates effective October 1<sup>st</sup> and a net increase of 1.35% for outpatient payment rates effective January 1<sup>st</sup>.

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In calendar year 2018, approximately 23.3% of our Medicare inpatient and 23.6% of Medicare outpatient revenue has been associated with patients that are a part of the OneCareVT model. We are anticipating a significant increase in this rate in 2019 due to the inclusion of attributed lives from two area primary care practices:

- 1) Northern Tier Center for Health (NOTCH) - NOTCH was not a part of the OneCareVT program in 2018 but is expected to be a part of it in 2019.
- 2) Cold Hollow Family Practice - Medicaid patients are part of the OneCareVT program in 2018 and Cold Hollow will attribute their Medicare population in addition to their Medicaid population in 2019.

We expect the addition of these two practices to increase the number of Medicare attributed lives in the St. Albans Health Service Area from 2,554 in 2018 to 4,787 in 2019. We expect this to increase the share of revenue that falls under the capitated payment model from 23.6% to approximately 44% for both inpatient and outpatient Medicare patients in 2019. The portion that falls under the capitated payment model will be subject to the annual per member per month increase that we expect to be between 3.7% and 3.8%, the remainder will receive increases in accordance with the proposed Medicare rules noted in the first paragraph of this section.

**10. A. iv. b. Medicaid**

Our budget assumes no increase in Medicaid reimbursement rates for FY2019 for fee for service patients yet a number of changes related to the OneCareVT model are included.

In calendar year 2018 to date, approximately 25% of all Medicaid revenue was associated with patients covered by the OneCareVT fixed payments. As with Medicare, we expect this to increase in 2019 due to the addition of one practice:

- 1) Northwestern Pediatrics – Due to technical issues at OneCareVT, the pediatric patients attributed to Northwestern Pediatrics were not included as part of the fixed payment model in 2018 but we expect them to be included in 2019.

We expect the addition of these two practices to increase the number of Medicaid attributed lives in the St. Albans Health Service Area from 2,743 in 2018 to 5,159 in 2019 which we expect will increase the percentage of revenue covered by fixed prospective payments to increase from 25% to 34%.

In calculating the net patient revenue associated with these patients, we included a general 1.5% increase in per member per month payment rates and also attempted to anticipate the impact of adding a significant number of low risk pediatric patients to the list of attributed patients. The current per member per month rates paid to UVM Medical Center and North Country Hospital were used as benchmarks in estimating the monthly payments that would result. This is an area carrying a particularly high level of uncertainty in our modelling.

We have experienced favorable reimbursement in FY2018 on a percent of charge basis. It is hard to quantify each source of this variance but we believe that there are two primary factors, both of which will be expected to continue in FY2019. The first as the fixed prospective payments are paid on a monthly basis which shortens days in accounts receivable and can even be thought of



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as unearned income where payments are received for visits that have not yet occurred. The second is that we have thus far experienced favorable results through the ACO model. It is conceptually challenging to determine whether this should be classified under changes in utilization or changes in reimbursement rate as the definition of both categories is based in the fee for service model. We've chosen to classify it as a change in reimbursement rate since placing it in the Utilization category as a positive number would give the impression that it was related to higher volumes when in fact the inverse is true.

**10. A. iv. c. Commercial/self-pay/other**

Net patient revenue from commercial payers is impacted by the proposed rate increase included in this budget. We estimate that the small rate increase requested for FY2019 will result in just under \$1.1 million of additional net patient revenue. The growth in the capitated model and higher than average increases from Medicare associated with these patients is taking considerable pressure off of commercial rates going in to FY2019.

**10. B. i. Operating Expenses**

The physician transfers that were previously noted carry with them operating expenses that total approximately \$4.0 million. All other expenses are expected to increase by a total of 3.0% which is exceptionally low given some of the other major challenges that we are facing going into FY2019. The table below summarizes the impact of the physician practice transfers on the total expenses of the organization.

Total operating expenses are expected to increase by \$7.25 million or 6.6% compared to budget 2018. The most significant increases are related to the physician practice transfers discussed in the net patient revenue section. The table below shows the impact of the physician practice transfers separately from the change in expenses related to existing programs and services.

Expense Type	2018 Budget	Physician Transfers	2019 Budget	Other Changes	Percent Change
Total Wages	51,560,433	3,113,605	56,382,075	1,708,037	3.31%
Other Expenses	57,727,898	826,728	60,159,637	1,605,011	2.78%
Total Expenses	109,288,331	3,940,333	116,541,712	3,313,048	3.03%

**10. B. ii. Significant Changes**

Total expenses excluding physician practice transfers are expected to increase by 3%. The main components of the changes are as follows:

*Salaries and Wages:* The revenue growth limitations instituted by the Vermont Legislature and implemented by the Green Mountain Care Board create the need to prevent job growth and eliminate existing jobs when possible. In successfully meeting the goals of these groups, we are able to present a budget that shows a reduction in well-paying, benefited jobs available to Vermonters located in Franklin County and the surrounding communities. Total FTEs are increasing due to the transfer of 38.66 FTEs of existing jobs as a result of the physician transfers. This is offset by a reduction of 16.44 FTEs related to cost savings initiatives compared to

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FY2018 year to date actual. Nearly all of the increase in this expense line is associated with annual wage rate adjustments.

*Medicaid Provider Tax:* The provider tax is calculated as 6% of net patient revenue and increases each year as net patient revenue grows through either normal growth or physician transfers. The calculation for FY2019 results in an expected increase of \$600,000.

*Physician Contracts:* We currently have a vacant orthopedic surgeon position in Northwestern Orthopedics. We are in the process of recruiting a new physician to fill this position and we are utilizing a temporary Locum Tenens surgeon to fill the position in the meantime. Surgeon positions are difficult to fill and can take a considerable amount of time. We are budgeting to continue to use a Locum Tenens through May of 2019 resulting in an incremental expense of approximately \$500,000.

*Supplies:* There are two significant factors driving the increase in supply cost from FY2018 to FY2019. The first is cost of drugs which have been impacted by a correction to the way a particular high volume item had been purchased in the past. This item had been purchased exclusively through the 340(b) program but upon auditing the process, we have adjusted which supplies qualify for the significantly reduced 340b pricing. As a result, we made a retroactive payment to correct for the historical purchases and we are budgeting to purchase these at full price in FY2019. We are in the process of developing a system that will allow us to capture the 340(b) benefit when available but are not far enough along in the process to include any impact in the budget.

The second item is the result of a change in the way that we purchase licenses for Microsoft Office. We are transitioning away from the outright purchase of the licenses and to a subscription model which will help us to maintain compliance with the terms of the licensing agreement. These were previously purchased as capital expenditures but will now be recorded as an operating expense within the supply category.

A general supply inflation rate of 2% was used for all patient and office supplies and a 5% increase was applied to the cost of raw food as we continue to increase our offering of fresh locally sourced foods for our patients and staff.

### **10. B. iii. Cost Savings Initiatives**

Please see section 10. A. iii. where this has been addressed.

### **11. Bad Debt**

The allowance models that we utilize to calculate bad debt expense assumes that 100% of all self-pay accounts that are 365 days or older are 100% uncollectible. Due to this assumption, accounts are effectively written-off entirely within the first year meaning that no bad debt recorded in FY2017 is associated with cases prior to FY2016.

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During 2018, the collection agency that we have used for many years decided to no longer focus on bad debt collection services and notified us they were discontinuing that service. In the second quarter of 2018 we switched our collection services to ElectroMedical Associates. This changeover did result in an increase in bad debt and Charity Care in the current fiscal year but we expect those results to return to historical trends.

Over the course of 2018, we have made changes to our billing practices to increase emphasis on our patient friendly billing practices. We continue to work on an initiative to build pricing transparency to our charge methodology and hope that we will implement that during the last quarter of 2018.

## **12. Rate Request**

To comply with the net patient revenue growth guidelines, we will be requesting an overall rate increase of 2.0%. Hospital based charges will be increased 2.67% and physician practice professional fees will receive an increase of 0%. The 2.67% increase on hospital based charges will be done across the board with no differences by insurance, meaning that there is no difference between the overall rate increase and the commercial ask. The commercial ask will be 2.67% on hospital based charges and 0% on physician professional fees resulting in an average commercial ask of 2.0%.

The assumptions related to payer specific changes to net patient revenue were discussed in section 10. The remaining components of net patient revenue that are significant are:

- 1) Bad Debt and Free Care
- 2) Disproportionate Share Payments

Bad debt and charity care continue to fluctuate from year to year but remain within a fairly narrow range as a percent of gross revenue when viewed in total. The exception is FY2018 YTD where the transition to a new collection agency for past due accounts has resulted in a significant number of accounts to be written off as bad debt in the current period. We view this as a one-time anomaly that will likely resolve itself in the current year as the allowance model adjusts over time to the transaction. With that in mind, the budget for FY2019 is consistent with the long term trends.

The table below shows the write off rates by year excluding physician practices. Physician practices differ from each other but generally have lower bad debt and free care write-off rates than hospital revenue. As total gross revenue from physician practices has grown as a share of total gross revenue, the impact is a decrease in the overall write-off rates for the organization so it is most useful to view the rates for hospital revenue only, as shown below.

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<b>Fiscal Year</b>	<b>Bad Debt %</b>	<b>Free Care %</b>	<b>Total %</b>
FY2012	2.42%	1.30%	3.72%
FY2013	2.64%	1.07%	3.71%
FY2014	3.15%	0.66%	3.81%
FY2015	2.27%	0.67%	2.94%
FY2016	1.48%	0.77%	2.25%
FY2017	2.50%	0.60%	3.10%
FY2018 YTD	4.26%	0.58%	4.84%
FY2019 Requested	3.00%	0.60%	3.60%

We received a notice that the DSH payments to be received in 2019 will be reduced by \$333,507 based on Medicaid utilization at NMC and the relative utilization at other Vermont hospitals. This decrease is offset by .59% of the requested 2.0% rate increase.

**13. FY2017 Overages**

NMC did not have an overage in FY2017.

**14. Capital Budget Investments**

The FY2019 capital budget consists of routine replacement of medical equipment, information systems equipment and facilities repairs and improvements. In addition to these routine items, we are planning for a handful of larger items, most notably:

*Emergency Department Renovation:* Like many other hospitals in Vermont, we have been dealing with a high number of patients in our emergency department who require mental health services along with medical services. The current configuration of the department is not ideal for this patient population as we do not currently have any beds set up in private rooms where safety precautions can be implemented. This requires us to use extra staff or security personnel to monitor these patients and/or to modify other rooms in or around the emergency department to hold these patients. This renovation would eliminate curtains between beds and instead place beds in private rooms with added safety features that could be used when appropriate. This project is in the very early design phase so the budget includes a very preliminary estimate for design and the initial construction phase. This project will meet the CON threshold so we are in the process of developing a Certificate of Need application for this important project.

*Meditech Ambulatory Module:* This project is to move all employed physician practices into the same electronic health record system that is used by the hospital. Physician professional fee billing along with all clinical documentation associated with a visit to one of our employed physician practices is done using a system called Medent which does not easily interface with the Meditech system. A single medical record enhances case management and care coordination as mentioned previously. In addition to these benefits, we have an increasing demand for data from internal and external customers that are very difficult to satisfy with two distinct systems. Patients currently receive two bills for their visits when they receive professional services from the providers as well as technical services provided by NMC staff such as an x-ray in the physician office. Receiving two bills for the same visit can be confusing to our patients and is not

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ideal. Having two systems is also a burden to our staff as many patients need to be registered in both systems during a single visit and nurses and providers must know which system to look in when trying to find information related to a visit or patient. Taken together, these issues present a clear need to transition all billing to the same platform.

### **15. Technical Concerns**

There is an inherent challenge in categorizing net revenue associated with fixed prospective payments as either hospital revenue or physician revenue. The idea of this categorization is based on the fee for service process where payments are made on specific claims, those claims having their origin as either hospital or physician charges and tied to a particular visit. Fixed prospective payments are not tied to particular visits or particular charges; they are tied to particular people. These people may have a changing mix of hospital and physician visits from year to year and some may have no visits at all. This problem is not unique, contractual allowance write-offs for governmental payers are set up in a similar fashion where a fixed case rate payment (DRG or APC) may be paid on an account regardless of the particular charges, meaning the payment is not linked to charges. Reporting in Adaptive Planning is set up for contractual allowance totals to be entered by payer and not divided into Inpatient vs Outpatient which simplifies the process. I would ask and recommend that fixed prospective payments be treated the same way with regard to physician vs hospital and require only a single total by payer.

There was a schedule produced for the board during the FY2018 budget review process that showed total increase in Net Patient Revenue as a percentage. This report did not build physician practice transfers into the base before calculating the percentage. The concern with this is that it results in the potential for physician transfer requests made during the budget process to be reviewed differently than if they had been requested as a mid-year adjustment. We observed that the higher NPR growth rate was a factor in the rate increase decision making process where it may not have had an impact if the physician transfers had been considered first and built into a base. We would respectfully request that physician transfer requests be reviewed and either approved or denied and having a new base set prior to calculating the NPR growth rate to provide for a consistent and equitable treatment of physician transfers.

The list of questions required to be submitted as part of the narrative has grown exponentially over the last ten years. An excerpt from the FY2012 budget instructions, when referring to the narrative, reads: *“The summary should be a concise document (3-5 pages).”* The narrative that we submitted for the FY2018 budget review was 13 pages and this year’s narrative requires 29 pages to satisfy the requirements. In small organizations there is no staff dedicated to preparing budget documents and submissions, it falls to a very small number of people and requires them to complete these requirements while balancing their day to day tasks. Many of the additional questions are not related to the budget but rather to hospital policy and practice. There is surely a better forum for reviews of that type so that main focus of the budget review process can be the budget.

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**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.**

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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

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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 an early adopter in the payment reform initiatives. We believe we have the foundations in place with our Rise VT program in addition to 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.



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**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.

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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;**

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- 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.

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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.**

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**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).