

**Northwestern Medical Center (NMC)**  
**Fiscal Year 2020 (FY2020) Budget Narrative**

**1. Executive Summary:**

The FY2020 budget represents an opportunity for NMC to return to generating a positive margin from operations after three consecutive fiscal years (including our current year) of negative financial performance. This budget was created by the Leadership Team with the active involvement of our Management Staff and input from Medical Staff leaders and ultimate scrutiny and endorsement by our Board. It calls for NMC to have a bottom line from operations of 1% margin based on the projected approval by the Green Mountain Care Board (GMCB) of our requested rate increase of 5.9%.

This budget was crafted around NMC's long term strategic priorities to allow NMC to continue to deliver on our mission of providing exceptional care for our community. In order for NMC to continue to be a successful, relevant provider as Vermont's healthcare system transforms from fee-for-service to population health:

- We must continue to invest in Primary Care, Community Care Management, and Primary and Secondary Prevention.
- We must maintain and improve our levels of quality and access. To preserve access and advance Primary Care, we are planning for the employment of the Cold Hollow Family Practice in Enosburg.
- We must modernize our Emergency Department to increase safety and privacy.
- We need to invest in innovation to 'grow our own' nurses to reduce our reliance on travelers and so are partnering with Vermont Tech and Community College of Vermont to expand a nursing program into downtown St. Albans.
- We have also invested in a programmatic redesign of our outpatient surgery department to optimize workflows, efficiency and the patient experience, to take a significant step toward becoming the "hospital of the future".
- We are engaging our staff in Shared Governance to further enhance how NMC functions as one team with a singular focus on our mission and vision. This budget provides the necessary resources to achieve those goals.
- We must lead in the integration of systems and protocols for the care of the patient with addiction disorders collaborating with community partners.

Given that continued physician practice acquisition and medical inflation are driving growth in our expenses beyond allowable revenue growth, this budget includes significant expense reductions to produce a positive operating margin while investing in strategic priorities. We have found new efficiencies within existing contracts and pressed for creative approaches to reducing supply expenses. We continue our process of aligning staffing with volumes and ensuring proper levels of productivity across the organization. While we continue to invest strongly in prevention, due to financial constraints we have made significant reductions in the funding of Lifestyle Medicine, RiseVT and Healthy Roots. It is a balancing act of living in a 70% fee for service environment while appropriately investing in the future of population health with

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anticipated 70% capitation. Year 2022 is arriving more quickly than the plan for the evolution of the all payer model.

Growth at NMC in recent years has been driven by the revenue of acquired physician practices. The majority of these practices were pre-existing in the community prior to their employment at NMC and therefore this expense and the growth within it are traditional parts of the overall healthcare system costs, though in this format they can be confused for hospital-driven growth. These physician practices were likely to leave our community if NMC had not acquired them. In FY2010, physician practice gross charges represented 5.3% (\$6.8 million) of NMC's total gross charges and in the FY2020 budget, will represent 23.7% (\$53.1 million) of gross charges. In many cases, these investments in access come with a negative operating margin. **In an environment where total net patient revenue is capped, allocating an increased share of total net patient revenue to services that generate a negative operating margin makes it increasingly difficult to maintain a profitable organization.** Investments in primary prevention and surgical optimization are vital in an environment where the vast majority of reimbursement is made through a capitated payment system. The FY2020 budget assumes that approximately 30% of our net revenue will come through the capitated system administered by OneCare Vermont. The goal of OneCare Vermont is to increase the share of revenue being paid through capitation to 70% by 2022. The long-term financial success of the strategy of investing heavily in preventative services that lose money in a fee-for-service reimbursement model is tied to OneCare Vermont's success in growing the capitated population in Vermont. The guidance that we received from OneCare Vermont is that we should assume no growth in the program from 2019 to 2020 as they have met challenges in bringing on hospital employees and other self-funded plans. This is a cause for concern as 2022 quickly approaches.

The proposed FY2020 budget will be challenging to implement and represents a steppingstone in our transition back to a sustainable operating margin. Revenue targets and expense reductions must be achieved, and further expense reductions will need to be identified as we move to FY2021 and beyond. It is a difficult path; however, we believe that it represents the right path forward for the organization as we take our next steps in the journey of healthcare reform.

## **2. Payment and Delivery Reform:**

Investing in the All-Payer Model:

- A. NMC has signed a contract with OneCare Vermont to participate with Medicare, Medicaid and BC/BS of Vermont, the three programs that are currently available. Appendix V has been completed and is attached as requested.
- B. The upside and downside risk amounts are reported in Appendix V.
  - i. The assumption in the FY2020 budget is that we will break even on these risk components, so the risk has no impact on the income statement. A risk reserve has already been established and since the budget assumes the same levels of risk in

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FY2020 compared to FY2019, no change to this risk reserve has been budgeted. A change to the risk reserve amount would be reflected in the income statement.

The best method for managing the financial risk in this program is to ensure that patients have access to the necessary services at NMC. This begins with access to primary care services which is an area in which we continue to disproportionately invest. We are actively recruiting for providers to fill existing vacancies and will use temporary Locum providers as necessary to ensure that our patients have access to primary care services. We are also investing in additional health coaches within our primary care practices to encourage wellness and healthy lifestyles to reduce the need for visits with a primary care physician or nurse practitioner or more concerning the use of higher cost care such as the emergency department and specialists to manage chronic conditions. This is an investment in reducing utilization and is critical in a capitated environment but is financially challenging in a predominantly fee-for-services structure. It is an increased expense that has a goal of reducing revenue. This is a clear example of why moving to a very high rate of capitation as quickly as possible is critical for all hospitals engaged in this work and for the sustainability of the payment reform program.

- ii. Physicians are compensated based on volumes and quality benchmarks. The relative weight of the quality component has increased over time but remains at 20% of total compensation, meaning that volumes account for 80%. Based on data provided to us by a third-party consulting firm, placing a weight of 20% on quality is high relative to national norms but is not high enough in a capitated environment. We will continue to monitor quality scores for each individual physician and for the organization to ensure quality standards are being met. We will continue work with our provider compensation council to align incentives with a value-based system.

C. We do not have enough information to plan for additional value-based or quality performance incentive payments by the end of calendar year 2020.

D. Hospital employees who are part of the NMC self-funded insurance plan are not currently attributed to OneCare. This is a process that had begun but was placed on hold by OneCare. We are strongly in favor of attributing our employees to OneCare to increase the share of revenue associated with attributed lives and we hope that we will be able to move forward with this in the future.

E. Total expenses related to departments that work directly to improved population health has increased from 8.7% (\$10.1 million) of budgeted expenses in FY2019 to just over 9.4% (\$11.4 million) of total expenses in the FY2020 budget. They represented just under 9.4% of total expenses in the FY2018 budget. This includes Lifestyle Medicine and RiseVT as mentioned in the Executive Summary, and the majority of these costs are related to operating Primary Care, Pediatric and Addiction Medicine practices and providing health coaching and outpatient care management. **Given that these department generate a negative margin and success for them is measured by lower volumes in other ancillary departments, further reducing total margin, allocating nearly 10% of total expenses to this effort is significant and increasing this further**

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**while still operating in a predominantly fee-for-service environment is not sustainable.**

**3. Reconciliation**

**Projected 2019 Summary Income Statement**

	Budget 2019	Projected 2019	Variance	% Variance
Gross Revenue	210,649,546	214,938,804	4,289,258	2.0%
Contractual Allowances & DSH	(90,993,571)	(96,599,703)	(5,606,132)	6.2%
Bad Debt & Free Care	(6,881,995)	(7,900,649)	(1,018,654)	14.8%
<b>Total Deductions</b>	<b>(97,875,566)</b>	<b>(104,500,352)</b>	<b>(6,624,786)</b>	<b>6.8%</b>
<b>Net Patient Revenue</b>	<b>112,773,980</b>	<b>110,438,452</b>	<b>(2,335,528)</b>	<b>-2.1%</b>
Other Operating Revenue	6,166,078	5,182,889	(983,189)	-15.9%
<b>Total Operating Revenue</b>	<b>118,940,058</b>	<b>115,621,341</b>	<b>(3,318,717)</b>	<b>-2.8%</b>
Salaries, Fringe & Phys Contract	71,862,185	74,677,745	2,815,560	3.9%
Contracted Services	11,654,764	12,471,508	816,744	7.0%
Travelers	150,774	664,892	514,118	341.0%
Other Expense	32,575,624	32,538,080	(37,544)	-0.1%
<b>Total Expense</b>	<b>116,243,347</b>	<b>120,352,225</b>	<b>4,108,878</b>	<b>3.5%</b>
<b>Net Operating Income</b>	<b>2,696,711</b>	<b>(4,730,884)</b>	<b>(7,427,595)</b>	<b>-275.4%</b>
Non-Operating Revenue	1,151,419	1,151,420	1	0.0%
<b>Excess of Revenue Over Expens</b>	<b>3,848,130</b>	<b>(3,579,464)</b>	<b>(7,427,594)</b>	<b>-193.0%</b>

FY2019 has been a challenging year financially with net patient revenue projected to end the year below budget and expenses projected to exceed budget.

- *Gross Revenue* – The 2.0% favorable variance in gross charges is driven by outpatient surgery, urgent care and CT Scan. Through April, gross charges in these departments combined to be \$4.6 million ahead of budget. The increased volumes in these areas are partially offset by decreases in inpatient surgery, emergency department and inpatient admissions. Successfully transitioning from inpatient to outpatient surgical procedures and from emergency department visits to urgent care visits are key goals of healthcare reform. We are focused on this transition and it is working.
- *Contractual Allowances* – Write-off rates have been higher than anticipated in FY2019. There is always variation based on the mix of payers and services provided and calculations for the FY2019 budget were further complicated by significant changes to the number and risk level of attributed lives covered under the OneCare Vermont program and errors in the payment process from Medicare during calendar years 2018

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and 2019 related to attributed visits. Even small variances in the allowance write-off rate can result in a significant dollar impact. The difference between the budgeted and actual write-off rate is only 1.8% which equates to an approximately \$3.75 million

- *Bad Debt & Free Care* – See question 5 which addresses the current year variance and budget assumptions for FY2020.
- *Other Operating Revenue* – Other operating revenue is falling short of budget, most notably in Grant Reimbursement and 340(b) revenue. The timing of releasing grant funds based upon completion of the grant agreement is difficult to predict. Therefore, variances due to timing is not unusual. We challenged ourselves to increase utilization of the 340(b) program and to expand our partnerships with local retail pharmacies. We have not yet achieved the level of utilization that we had anticipated, and the efforts are ongoing. A dedicated 340(b) analyst has been hired to increase our ability to capture all opportunities related to this program and the early results have been very promising.
- *Salaries, Fringe & Physician Contracts* – We are projected to end the year 14 FTEs over budget. At the end of 2018, our nurses held a union vote and elected not to unionize and instead chose to continue to work directly with NMC leadership to address their concerns. Accordingly, the actions taken by leadership included an increase to environmental services staffing to support the inpatient unit, a reduction in the frequency of low-census and adjustment to the patient-to-staff ratios used on the inpatient unit. These two items account for approximately 12 FTEs and \$850,000. The other areas that have required more staffing than expected are Health Information Management (Medical Records and Coding) and Patient Access. These areas have been heavily impacted by the implementation of the Meditech Ambulatory system, during both the pre and post go-live phases. These departments are projected to end the year approximately \$660,000 over budget. We have had an unexpected vacancy in our hospitalist group which has been filled by a Locum Tenens physician for much of the year. The projected annual cost is approximately \$450,000.
- *Contracted Services* – FY2019 includes some significant unanticipated costs that have resulted in an unfavorable variance in contracted services expense. Examples include: A consulting firm was hired in the fall to help guide NMC leadership and management through the nurses’ union voting process; we have hired a consulting firm to assist with improving the efficiency and patient experience in our outpatient surgical department to become “Ambulatory Surgery Center Like”, and we currently have an interim CFO who is with us for a 6 month engagement. These items combined account for approximately \$700,000 in unanticipated expenses.
- *Travelers*– Nursing recruitment and retention remains a challenge. We have actively engaged our nursing staff to ensure that the right resources are available, as mentioned above. Part of this is ensuring that appropriate staffing levels are maintained even when vacancies exist. In order to maintain those staffing levels, we have used temporary staffing.

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**4. Budget to Budget Growth:**

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

We are including the allowable 3.5% growth factor and have included two physician transfers. One is a negative transfer as reported during FY2019 to account for the transition of a dermatologist from an employed position at NMC to private practice in St. Albans. The second is the anticipated acquisition of an existing primary care practice located in Franklin County. The requested increases fully comply with the benchmarks established under Green Mountain Care Board rule 3.202 and published in the document titled “FY2020 Hospital Budget Guidance and Reporting Requirements” and result in a very modest 1% 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 while we work to increase efficiencies to improve our overall margin.

We have calculated the total net revenue to be included in the FY2020 budget as follows:

**FY 2020 Net Patient Revenue Budget Calculation**

FY2019 Budgeted NPR	\$112,773,980
Negative Physician Transfer	(711,015)
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Total FY2019 Base Budget	112,062,965
3.5% Allowable Growth	3,922,204
Physician Transfer - Primary Care	941,346
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<b>FY2020 Budgeted NPR</b>	<b>\$116,926,515</b>

**4. A. ii. Significant Changes:**

No significant changes to the FY2019 budget have occurred.

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

Cost reductions and revenue enhancements have been a major focus for the organization to bring the operating margin up to a sustainable level. We target a 3% operating margin to ensure that routine capital replacement can be made and that we are able to save money to be able to make larger strategic investments without incurring additional debt and financing costs. FY2020 is expected to be a transitional year in which we make a meaningful step forward regarding our

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operating margin with an eye on returning to a sustainable margin in future years. The budgeted operating margin for FY2020 is 1%.

The budget includes a wide variety of items which total an estimated \$6.3 million in reduced costs and increased revenue. Items totaling \$4.6 million have been implemented in FY2019 and the remainder has been added to the list through the budget process and will be phased in as appropriate. It is important to mention that uncertainty exists within this plan. As noted, items with an annualized value of \$4.6 million had been previously identified and implemented. The remaining \$1.7 million is a combination of a) items that have been identified and can be implemented (\$613,000), b) items that have been generally identified and need additional work to fully specify and implement (\$403,000), and c) have not been specifically identified (\$641,000).

The attached list provides a summary of the items identified, listed by category.

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

**4. A. iv. a. Medicare**

The current proposed Medicare rules include a total increase of 2.7% for inpatient payment rates effective October 1<sup>st</sup> and a net increase of 2.70% for outpatient payment rates effective January 1<sup>st</sup>.

In calendar year 2019, approximately 60% of our Medicare inpatient and 54% of Medicare outpatient revenue has been associated with patients that are a part of the OneCareVT model. We are not anticipating any changes to the proportion of revenue associated with the attributed population. 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 3.9% in calendar year 2020, the remainder will receive increases in accordance with the proposed Medicare rules noted in the first paragraph of this section.

**4. A. iv. b. Medicaid**

Our budget assumes no increase in Medicaid reimbursement rates for FY2020 for fee for service patients and a 0.5% increase in the per member per month payments from OneCare Vermont related to the patients attributed through the Medicaid program. Like Medicare, we do not anticipate a change in the proportion of revenue associated with Medicaid covered lives.

**4. 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 rate increase requested for FY2020 will result in \$3.4 million of additional net patient revenue.

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**4. A. v. Bridges Table**

See Appendix VI, Table 1.

**4. B. i. Operating Expenses**

Operating expenses are the primary focus of our organization as we move into FY2020. As noted in section 4. A. iii., we are actively engaged in an operational improvement plan with the goal of reducing expenses and realizing revenue opportunities. The impact of this plan on the FY2020 expense budget is estimated to be \$6 million. Attached is a summary of initiatives that are underway, including approximately \$3.6 million in savings from staffing changes which include such things as reduced overtime, flexing staffing to match volumes and not filling vacant positions. A minimal amount of restructuring has and will occur in an effort to achieve the identified savings.

We have also been successful in renegotiating implant pricing and have begun utilizing a more cost-effective reference lab to conduct tests that we do not perform in-house. The two items have resulted in \$624,000 of annual savings.

The remaining \$1.7 million in savings include an expansion of our 340b program to reduce the cost of drugs sold and increase other operating revenue by a total of \$500,000, a redesign of how we fund and manage our investment in RiseVT and Lifestyle Medicine resulting in a reduction of \$250,000, a list of smaller items totaling \$444,000 and an additional savings target of \$500,000.

It is never desirable to eliminate positions, vacant or otherwise, and yet, it is the necessary result of cost containment efforts. 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.

It is important to explicitly note the trade-off that we make through cost containment within the hospital industry in Vermont. In exchange for reduced operating expenses that may or a may not translate into lower insurance premiums, we accept fewer job opportunities for working aged individuals that are currently in Vermont and those who may be willing to move to Vermont. Hospitals are unique employers in Vermont as they offer numerous jobs for individuals of all skill and educational levels, nearly all paying a livable wage with benefits, and are often the largest employer in our rural communities. When we are unstable the local economy is impacted.

We find ourselves in a challenging place in redefining who we are as a hospital. We will continue to seek cost reduction opportunities and to work within the current regulatory framework and we will continue to work with the Green Mountain Care Board to understand the larger role that they, and those they regulate, play in the overall economic health of Vermont. It is time the stakeholders executing on their own visions come together and align priorities, incentives, outcome metrics, payment, and overall regulation. We have a big job to do to transform the healthcare delivery system – our population is depending on us to get it right.

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**4. 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:* Net of physician transfers, the FY2020 budget includes a reduction in FTEs of 6.6 compared to current year which is 7.4 FTEs higher than the FY2019 budget, for reasons explained in section 3 we anticipate that further reductions may occur as we identify opportunities to work toward the additional savings target of \$500,000 that was previously discussed. There are also reductions related to decreased use of overtime and shift-incentive as well as a reduction to the hourly call-pay in a few specific situations. These reductions have the effect of reducing the overall average hourly rate of those who were previously receiving these differential payments. The remaining increase is related to annual wage increases, budgeted to be an average of 3%. It is imperative that we continue to be competitive in salary and wages in order to retain the talent we need to lead and provide care and services.

*Employee Benefits:* Employee benefits include several expenses of which the most significant are FICA tax, employee health, dental, and vision costs, stop-loss insurance coverage on health claims, contributions to retirement plans, workers' compensation costs, Healthy Û program costs, and the cost of various activities for employees throughout the year.

The FY2020 budget includes a substantial increase in health insurance claims compared to the actual expense in FY2018 (\$500,000) and the budget for FY2019 (\$400,000), however, this represents a decrease of \$800,000 compared to projected FY2019. We have experienced two of the highest claim months in history this spring which is driving up the cost in the current year. We have now experienced consecutive years of high claims which warrants the increase compared to prior year actual and budget, yet we do not want to overreact to the results of only a few months in the current year. The high level of variability in this expense is to be expected in a self-funded plan and we do have stop-loss coverage that pays all claims in excess of \$150,000 for any individual in a calendar year. The high costs in the current year are driven by a few individuals that will surpass the stop-loss limit, so we anticipate that the actual cost in FY2020 will be lower than the projection shown in the attached income statement.

Our health plan will continue to place accountability on employees for preventive health. If identified required preventive health is not obtained by an employee, they will pay a higher health plan premium than an employee that completes their required preventive health.

High risk employees are encouraged to utilize the services offered through the Lifestyle Medicine Clinic, including health coaching, which BlueCross BlueShield has identified as a successful strategy to reduce the cost per employee of medical care, in an effort to improve their overall health.

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*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 FY2020 results in an expected increase of \$870,000.

*Physician Contracts:* We currently have two vacant orthopedic surgeon positions in Northwestern Orthopedics and a vacant primary care physician position. We have two orthopedic physicians that will be joining NMC, one in May of 2020 and the other in September of 2019. We are budgeting to continue to pay for a temporary Locum Tenens surgeon until May of 2020 when the second full-time surgeon joins us. We have also budgeted for a Locum Tenens physician in primary care for the full year as we continue to recruit. The FY2019 budget included a full year of Locum Tenens expense in Orthopedics. Including a partial year in Orthopedics and a full year in Primary Care results in a reduction of \$100,000 compared to the FY2019 budget.

The cost of our anesthesiology contract will be increasing in FY2020 by \$275,000 compared to the FY2019 budget. The increase has been requested by the anesthesiology group to cover pay increases as they are having difficulty filling positions due to below-market pay rates, and to increase hours of coverage by CRNAs. The increase in pay requested has been validated by our national physician compensation consultants. Vacancies are currently filled using Locum Tenens, the cost of whom is passed on to the hospital.

*Supplies:* There are two major items identified in the operational improvement plan that impact supplies, both of which were discussed in section 4. B. i. Operating Expenses. This includes the renegotiation of surgical implant costs and the expansion of the 340(b) program. The total expense reduction related to these items is \$850,000 compared to the FY2019 budget.

A general supply inflation rate of 2% was used for most patient and office supplies, 3% was used for surgical supplies and the cost of drugs, and a 4% 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.

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

Please see section 4. A. iii. where this has been addressed.

#### **5. Bad Debt**

Bad debt increased in FY2018 and continues at this higher level in FY2019. This had originally been attributed to write-offs done as part of a transition to a new collection agency for past due accounts. We had expected the write-off rate to return to historical levels but that has not been the case. Increased patient responsibility as a result of high deductible insurance plans has contributed to this sustained rate of bad debt write-offs. Free Care write-off rates have remained steady over the last three years and is budgeted to continue at that same rate.

The table below shows the write off rates by year excluding physician practices. Physician practices differ from each other and generally have lower bad debt and free care write-off rates

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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 (3.2% in FY2020 budget) so it is most useful to view the rates for hospital revenue only, as shown below.

<b>FISCAL YEAR</b>	<b>BAD DEBT %</b>	<b>FREE CARE %</b>	<b>TOTAL %</b>
<b>FY2013</b>	2.67%	1.08%	3.75%
<b>FY2014</b>	3.22%	0.68%	3.90%
<b>FY2015</b>	2.39%	0.71%	3.10%
<b>FY2016</b>	1.75%	0.77%	2.52%
<b>FY2017</b>	2.68%	0.65%	3.32%
<b>FY2018</b>	3.74%	0.59%	4.33%
<b>FY2019 YTD</b>	4.04%	0.55%	4.59%
<b>FY2020 REQUESTED</b>	3.75%	0.60%	4.35%

**5. A. Appendix VII**

See Attached.

**5. B. Collection Agency**

We use a collection agency called ElectroMedical Associates.

**5. C. Patient Friendly Billing**

The agency does adhere to “patient friendly billing” guidelines.

**6. Operating Margin and Total Margin**

The operating margin presenting in this budget is 1% and the total margin is 2.4%. 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. FY2019 has been a challenge financially and we are currently projecting an operating margin of -4.1%. As discussed, cost reduction is a major focus for us in FY2019 and FY2020 and we view FY2020 as a transitional year where we take a step toward a 3% operating margin. The budgeted operating margin in the FY2019 was 2% but we have fallen short of that and now we are focused on getting from the projected operating margin back up to a positive margin in FY2020 and a sustainable operating margin in FY2021.

**7. Rate Request**

To comply with the net patient revenue growth guidelines, we will be requesting an overall rate increase of 5.9%. Hospital based charges will be increased by 7.63% and physician practice professional fees will receive an increase of 0%. The 7.63% increase on hospital-based charges will be applied 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

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7.63% on hospital-based charges and 0% on physician professional fees resulting in an average commercial ask of 5.9%.

The assumptions related to payer specific changes to net patient revenue were discussed in section 4. The remaining components of net patient revenue that are significant are:

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

We received a notice that the DSH payments to be received in FY2020 will be reduced by \$10,000 based on Medicaid utilization at NMC and the relative utilization at other Vermont hospitals.

### **8. FY2018 Variances**

NMC did not receive a letter regarding FY2018 variances.

### **9. Capital Budget Investments**

The FY2020 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 focused few larger projects, 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 outdated 30-year-old design of the department does not provide a safe or appropriate treatment environment for caring for patients suffering from severe mental health issues or suicidal ideations. As an interim step towards a full and necessary renovation, we now have one safe holding room within the Emergency Department, but this does not adequately meet the need. 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. The modernization of the Emergency Department will create a secure pod of 2 dedicated safe holding rooms and 2 flexible safe holding rooms. It will create 2 flexible airborne isolation rooms. It also transitions the outdated curtained treatment bays into private treatment rooms that are now the standard of care. It will also improve workflows and create appropriate space for embedded care managers and screening personnel addressing substance abuse issues. The need for this project was made abundantly clear during the 2018 Centers for Medicare and Medicaid (CMS) survey process at NMC. This crucial project meets the Certificate of Need (CON) threshold, so we have applied for a Certificate of Need and formally requested expedited review. We anticipate that a portion of the construction will occur during FY2020. As requested by the board, no impacts related to this project have been included in the FY2020 budget and will be address through the CON process.

*Building Renovation for Addiction Medicine Partnership:* Last summer, we acquired a multi-unit commercial office building (Valley Crossroads) located on the corner of VT routes 104 and 36 which is directly adjacent to the NMC campus. For several years, we have been in discussions

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with Northwestern Counselling and Support Services and the Howard Center about collocating services to establish a multi-agency center to support individuals struggling with addiction. Identifying a suitable location had been a challenge and the acquisition of Valley Crossroads has provided a logical solution. A portion of the building will be fit-up to accommodate this service.

*Nurse Training Partnership, Simulation Lab and Wellness Center:* In April, NMC, Vermont Tech, Community College of Vermont, Nedde Real Estate, and St. Albans City held a press event to celebrate our partnership on a nursing program for Franklin County in a new building at the corner of Congress and Main. This new building will include an expanded nursing program as well as a high-tech simulation lab for our multiple clinical specialties, as well as space for Lifestyle Medicine and RiseVT to infuse a focus on wellbeing, such as health coaching and a demonstration kitchen, into our downtown. This is an exciting investment in workforce development, economic vitality, and coaching a community to wellbeing. It is an important long-term strategy to addressing the nursing shortage and making healthy living the norm in our community.

## **10. 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. We 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.

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**Questions from the Health Care Advocate**

1. Please provide by payer (Medicare, Medicaid, BCBSVT, TVHP, MVP, and Cigna):
  - a. Your budgeted net patient revenue (NPR) and proposed NPR change from FY2019.
  - b. The formula(s) you used to calculate your budgeted NPR, the definition of each variable in the formula(s), and the budgeted value of each variable for FY2020.
  - c. The average ratio of the payer’s reimbursement rate to Medicare’s reimbursement rate.

Payer	Budgeted NPR			Ratio to Medicare
	FY2019	FY2020	Change	
Medicare	37,357,535	37,415,916	58,381	1.00
Medicaid	19,894,380	20,500,370	605,990	0.94
BCBSVT	34,648,578	33,846,104	(802,474)	1.44
MVP	3,418,154	5,561,936	2,143,782	1.46
CIGNA	6,152,461	7,084,578	932,117	1.31
Other*	11,302,872	12,517,675	1,214,803	0.91
<b>Total</b>	<b>112,773,980</b>	<b>116,926,579</b>	<b>4,152,599</b>	<b>1.11</b>

\*Includes all minor commercial payers, Disproportionate Share Payments, Bad Debt and Free Care

The process for calculating net patient revenue is a matrix algebra problem that accounts for volume assumptions by service line, average department charge per unit by service line, service line payer mix, proportion of capitated vs. fee-for-service revenue by service line, mix of inpatient vs outpatient by service line, reimbursement rate by payer and patient type for fee-for-service revenue, changes in number of attributed lives and changes in per-member-per-month payment rates for attributed lives by payer. Computer models are used to make the calculations due to the complexity and it would not be feasible or beneficial to report the value of each of the hundreds of variables in a document such as this. We would be happy to work with the Health Care Advocate to fully explain the model that is used, and it is important to note that some components of the model are proprietary.

2. 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).

Calendar year 2018 is the most recent full year for which financial performance related to the capitated payment model can be assessed. During FY2018, we generated a small profit (\$500,000) related to patients that are attributed to the St. Albans Health Service Area while the margin on all fee-for-service revenue was negative (\$4.8 million). St. Albans attributed cases accounted for approximately 18% of total gross charges and 20% of payments. We cannot yet evaluate financial performance in FY2019 but we can say that approximately 30% of gross

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charges are coming from St. Albans attributed cases and we expect a similar proportion in 2020. NMC is a member of OneCare Vermont and participates with Medicare, Medicaid and Blue Cross programs.

**3. 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?**

NMC's goal is to provide quality, timely and appropriate mental health services for our community. This topic was addressed in our response last year and the programs mentioned a year ago are continuing. In addition to those, at the end of 2018, we identified that we were not meeting CMS expectations around how to care for patients in a mental health crisis or with suicidal ideation. Therefore;

- NMC stood up a ligature free safe room with anteroom where a 1 to 1 observer can safely observe the patient free from distraction but within arm's reach.
- We trained all acute clinical staff and providers in the emergency department and inpatient unit in de-escalation training called MANDT to help safely negotiate and manage a patient who is escalating as a result of a mental health crisis.
- We increased security staff and created a code green response team to respond immediately to an emergent situation;
- We created a joint consultation/care plan process between our designated mental health agency and NMC's clinical teams to ensure that the patient is receiving the appropriate care, observation and access and it is clearly communicated to the care team.

We have submitted a Certificate of Need application to the Green Mountain Care Board for a significant modernization of the emergency department to provide additional safe rooms to partner with all of the above initiatives to ensure safe and appropriate care for all patients requiring treatment for a mental health crisis or suicidal ideation. The ligature free rooms decrease risk, increase comfort and safety for any patient at risk for harming themselves or others so that they can receive exceptional treatment with dignity and respect.

As discussed in the Capital Investments portion of the Green Mountain Care Board budget narrative, we are investing in space to create a multi-agency approach to assist with substance abuse and addiction. This population often overlaps with those needing mental health treatment and serving this population in an outpatient setting in an effort to avoid the need to visit the emergency room in a time of crisis, is the ultimate goal and the right thing to do for our patients and community.

**4. 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, and**
- c. Other avenues that you are pursuing to address this crisis in a sustainable way.**

There are currently 413 patients enrolled in medication-assisted treatment at NMC and we employ 9 MAT providers.

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Northwestern Partners in Hope & Recovery 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-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 10 providers that offer Medically Assisted Treatment (MAT) services within the clinic setting. Four 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 very receptive primary care providers engaging in this important work. The St. Albans Health Service Area (HSA) partners with 413 individuals in Medication Assisted Treatment.

Over 2,085 community members have received a brief intervention at the point of care, scheduled brief treatment or a referral to treatment since SBIRT began in the Emergency Department. In 2019, we continue to offer SBIRT services in our emergency department, and have expanded the program into Primary Care and have added youth screening for the population aged 12 to 21, which 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 emergency department with care coordinators located in the St. Albans HSA Hub and Spokes. The SBIRT counselors in the emergency department 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 emergency department 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

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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.

Over the last year NMC has worked in collaboration with our Chief Medical Quality Officer (CMQO), Director of Primary Care and Director of Comprehensive Pain to implement the CDC Guidelines on Management of Chronic Pain. The guidelines provide guidance on safe prescribing levels of opioids in managing chronic pain used by all providers at NMC. This guide was shared with our community partners to foster a reliable system of care for our patients. The guide defines safe doses, medication utilization monitoring and a patient-centered taper. Patients and providers can partner around clear expectations to increase opportunities for success. We have tracked our progress using the Vermont Prescription Monitoring System (VPMS) Quarterly metrics. In the past year, Franklin County has reduced the Daily Morphine Milligram Equivalent (MME) for Opioids Analgesics from 70 to 58 (CDC guidelines recommend less than 50 MMEs per day). The number of prescriptions for opioid analgesics decreased from 9,671 in the first quarter of 2018 to 7,411 prescriptions in the first quarter of 2019 – a 23% decrease.

**5. Please provide the number of patient bed days attributable to patients awaiting placement in an appropriate Skilled Nursing Facility bed, and average bed days per patient, for:**

- a. FY2018, and
- b. FY2019 to date.

FY2018 – 770

FY2019 – 587 (through May)

**6. Please provide the hospital's per unit profit margin on each 340B drug dispensed and the number of units of each drug dispensed.**

We continue to place an emphasis on maximizing the benefits available to us through the 340B program. It is a challenge to operate within the constraints of a net patient revenue cap, generate a sustainable operating margin and minimize annual price increases and programs such as this that offer relief on expenses and generate Other Operating Revenue are critical to our success. In FY2020, we have budgeted for an increase in utilization of this program which includes an additional \$500,000 of benefits, split between an increase in other operating revenue and a decrease in the total cost of drugs sold. The level of detail that has been requested is not available.

**7. Please describe any changes to the hospital's shared-decision making programs.**

- a. For any new initiatives, please describe the initiative(s), which departments participate, how you chose which departments participate, and how you plan to identify cost savings and quality improvement.

We do not have specific changes to report since last year's budget submission. NMC is focused on choosing care and treatment that is supported by evidence, not duplicative of other tests or

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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.

**8. Please provide copies of your financial assistance policy, application, and plain language summary (noting any changes from your last submission).**

- a. Please provide detailed information about the ways in which these three items can be obtained by patients, including links if they are available online.**
- b. Please provide the following data by year, 2014 to 2019 (to date):**
  - i. Number of people who were screened for financial assistance eligibility,**
  - ii. Number of people who applied for financial assistance,**
  - iii. Number of people who were granted financial assistance by level of financial assistance received,**
  - iv. Number of people who were denied financial assistance by reason for denial.**
  - v. Percentage of your patient population who received financial assistance.**
- c. Please provide the statistics and analyses you relied on to determine the qualification criteria, including any geographic restrictions, and the amount of assistance provided under your current financial assistance program. For example, analysis of financial need in the community and analysis of how much people can afford to pay.**

Attached is a copy of the financial assistance policy, application, and plain language summary. 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

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- The VT Department of Health St. Albans District office

Below is a link to our website where our financial assistance policy, plain language summary, and application can be found:

<https://www.northwesternmedicalcenter.org/patients-visitors/pay-an-nmc-bill/free-care-discount-policy/>

We are not able to provide all of the data requested for 2014 – 2019. 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	1,108	\$1,302,980
2015	1,252	\$1,270,121
2016	1,244	\$1,292,667
2017	1,123	\$1,112,947
2018	1,119	\$1,056,665
2019 (Projected)	1,240	\$1,196,174

We estimate that 2.36% of our patient population received financial assistance in 2018.

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.

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9. For the hospital's inpatient services, please provide your total discharges, case mix adjusted discharges, all payer case mix index, and average cost per case mix adjusted discharge for 2014 (actual) through the present (2019 budget and projected) and 2020 (budget).

Fiscal Year	Discharges	Case Mix Index	Cost per Discharge
FY2014	2,383	1.2286	\$9,603
FY2015	2,476	1.2572	\$9,712
FY2016	2,581	1.3128	\$9,794
FY2017	2,553	1.3081	\$9,618
FY2018	2,395	1.3364	\$9,931
FY2019 (Budget)	2,522		
FY2019 (Projected)	2,370	1.2849	\$10,287
FY2020 (Budget)	2,374		

10. Last year the Board's hospital budget orders instructed hospitals to negotiate with insurers rather than seeing the Board's approval as a specific set rate. Please describe how you implemented this directive.

- a. What average commercial rate increase did you implement for FY2019?
- b. What commercial rate increase did you get from each commercial payer (BCBSVT, TVHP, MVP, Cigna)?

The budget order received by NMC did not contain this directive. It was, however, understood that the Green Mountain Care Board did not intend for the approved price increase to limit or restrict the ability of hospitals to negotiate more advantageous payment rates with payers when possible. This is not the same as the rate increase which is restricted by the Green Mountain Care Board budget order. We implemented an overall 2.0% rate increase, as ordered, and this applied to all commercial and government payers.