Gifford Medical Center

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To: Kevin Mullin, Chair, Green Mountain Care Board

From: Daniel Bennett, Chief Executive Officer
Jennifer Bertrand, Chief Financial Officer

Date: July 1, 2021

Subject: Gifford Medical Center Budget Narrative, Fiscal Year 2022

A. Executive Summary

Gifford Medical Center's FY 2022 Budget focuses on ensuring financial sustainability in addition to allowing continued support of our population health initiatives and meeting the needs of our community. The budget was developed to align with future strategic planning goals and initiatives that will allow us to adequately invest in capital needs and infrastructure improvements, ensuring attentiveness to age of plant. The FY 2022 budget GMC is proposing is responsible and remains within GMCBs guidelines; consequently, we are requesting presumptive approval of our FY 2022 budget.

As of June 2021, all COVID-19 related services such as drive through testing and vaccine clinics have been asimilated into routine operations. The vaccines and testing are now available through our FQHC clinics and the hospital continues to be prepared to address any patient who presents with COVID-19 related symptoms.

B. Year-Over-Year Changes

i. Net Patient Revenue/Fixed Prospective Payment Overview

a. *FY 2022 Budget vs. FY 2021 Budget:*
Gifford Medical Center is requesting a 3.5% increase in Net Patient Revenue as it compares to the FY 2021 approved budget, after the allowable adjustment for COVID-19 testing revenue. This increase is mostly comprised of revenues generated by inpatient and burgeoning outpatient services. These service lines include, pharmacy, lab, and imaging.
FY 2022 Budget vs. FY 2021 Projection:
The FY 2022 budget as it compares to the FY 2021 projection is consistent with the aforementioned trend in volume.

1. Medicare revenues are budgeted in accordance with our Critical Access

Cost-based settlement process. GMC's estimates for the FY 2022 Budget have taken into account an increase in inpatient activity and have adjusted net revenue assumptions accordingly.

Fee-For-Service Medicaid revenues do not reflect a change in rate for the FY 2022 budget. Additionally, Medicaid FPP has been budgeted in accordance with the attribution attrition trend rate. GMC does anticipate a slight decline in disproportionate share receipts in FY 2022.

Fee-for-service commercial revenue assumptions are reflective of a 3.5% rate increase.

2. As of the time of our FY 2022 budget submission, we have not identified any significant changes in reimbursement policies, settlement adjustments, other accounting adjustments, etc. that have an adverse impact on our projected FY 2021 or FY 2022 budget. It is important to note; however, that our Medicare interim rate settlement did reflect a considerable increase (19%) in Inpatient reimbursement and a slight increase of 1% for outpatient reimbursement.
    a. We formulate our budgeted bad debt and free care based on a historical trend rate calculated as a percentage of gross revenue. Furthermore, we do not budget revenue based on the number of insured individuals. The FY 2022 budget reflects a reduction in bad debt as it compares to the FY 2021 budget as FY 2022 is more aligned with historical trends.
3.
    a. The impact of the COVID-19 vaccine clinics and testing as it pertains to net revenue for the FY 2021 projection equates to $410K and $318K for the FY 2022 budget. Respectively, the impact of the COVID-19 vaccine and testing expense is $508K for the FY 2021 Projection and $394K for the FY 2022 budget.

ii. Utilization

a. The FY 2022 budget as it compares to the FY 2021 budget and projection reflects notable variances in medical surgical, operating room, pharmacy, emergency department, and sport medicine services.
b. The analysis in appendix 3 assists in identifying the service lines with notable directional shifts from an aggregate perspective; however, it does not provide a complete portrayal of utilization drivers.
    - The decrease in Medical Surgical volume is related to shifts in status between inpatient and observation stays based on more appropriate clinical documentation.
    - The reduction operating room revenue is primarily driven by shifts in case mix.
    - Pharmacy volume is a result of favorability in utilization as well as an increase in the use of higher cost and higher revenue generating drugs.

- The increase in emergency room volume is related to in acuity of the patient seen in the ED.
- The decline in volume related to Sports Medicine is a result of provider vacancies.

iii. Charge Request

a. Gifford's FY 2022 budget proposes a 3.5% increase in the areas of inpatient, outpatient, and professional fees. Subsequently, Gifford is proposing a commercial rate increase of 3.5%.

b. The methodology used to allocate the gross patient revenue by payer is based on actual activity, year-to-date through March, to develop a baseline, which is then compared to historical trend, identifying and understanding drivers and relevant changes in rate, mix, and volume to determine if the year-to-date experience contains any anomalies that may need to be taken into consideration. Net revenue assumptions were based on a historical lookback for adjudicated claim activity.
   - Medicare reflects the shift in interim rate referenced above.
   - Medicaid is reflective of the change in mix as well as the slight reduction in fixed payments.
   - Commercial reflects a reduction in outpatient revenue, which is related to a trending decline in volume, which is slightly offset by the rate request.

c. The FY 2022 budgeted value of a 1% change in rate is $309,192.

iv. Adjustments

a. The FY 2022 budget includes two accounting adjustments:
   1. Historically, a Community Grant expense has been recognized in Other Non-salary expenses. This expense has existed as a line item to recognize the subsidy provided to the two other corporations under Gifford Health Care: Gifford Health Care, Inc. (FQHC) and Gifford Retirement Community. The FY 2022 budget removes this as an expense and in the future will be treated as a transfer among affiliates. This however does not negate that a subsidy still exists to support the other two corporations, it simply appropriately recognizes the transaction in accordance with accounting principles.
   2. Previously, in prior year reporting, Gifford Medical Center's depreciation expense was reduced and allocated to the other two corporations in lieu of an assessed rental fee expense. The assets are owned by GMC; therefore, the depreciation of the asset should be recognized on GMC books. Subsequently, a rental fee expense should be charged to the other two corporations and recognized as other revenue for GMC. The FY 2022 budget reflects an increase in the depreciation expense to appropriately reflect this change and is offset in other revenue to recognize the rental income received.

v. Other Operating & Non-Operating Revenue

a. *FY 2022 Budget vs. FY 2021 Budget:*

The FY 2022 Other Operating Revenue budget assumes an increase as it compares to the FY 2021 Budget, which is the result of the aforementioned change in accounting methodology pertaining to the rental income received from the other two corporations under Gifford Health Care, which is now being recognized in other revenue. Budget-to-budget non-operating revenue assumptions remain flat to one another.

FY 2022 Budget vs. FY 2021 Projection:

The FY 2022 Other Operating Revenue budget assumes a decrease as it compares to the FY 2021 Projection, which is primarily driven by a reduction in grant income. FY 2022 Budget as it compares to FY 2021 Projected non-operating revenue assumes a decrease in investment income as the predictability of the market activity is uncertain and a conservative approach to budgeting this line item is apropos. Additionally, in FY 2021, GMC was able to terminate a swap arrangement with favorable gains as compared to expectation.

b. Please refer to Appendix 7 for a summary of the treatment of COVID-19 funding.
c. At the time of our FY 2022 Budget submission, GMC does not anticipate any further COVID-19 funding or advances.
d. Although the majority of 340B funding is recognized under Gifford Health Care, our FQHC and parent corporation, any unfavorable impacts to 340B funding will circuitously impact the hospital as GMC is the primary guarantor of any losses incurred by the other corporations under the GHC umbrella. Therefore, the unpredictable reductions in 340B funding poses uncertainty for the hospital in that more of its margin gain would need to support the operating deficits of the other two entities.

   Another area of unpredictability is the of uncertainty of market returns, which would have an impact on GMCs total margin.

vi. Operating Expenses

a. *FY 2022 Budget vs. FY 2021 Budget:*

   The FY 2022 budget as it compares to the FY 2021 budget equates to an increase of $589K. Noteworthy variances exist within salaries, depreciation, other non-salary expense, purchased services, and pharmaceuticals.

   - Salary Expense – the overall increase in salary expense equates to $266K. The increase in non-MD salary expense is related to a compounding wage issue whereby the base wages that were used to inform the FY 2021 budget did not include the inflationary wage increase that was implemented late in the FY 2020 fiscal year. Additionally, the increase in expense is related to an increase in FTEs. We have begun the implementation of a staffing control mechanism that will manage and monitor all FTE activity within the organization. The reduction in physician salaries is related to shifts in provider compliment, prolonged provider openings, and we have elected not to replace a provider opening through attrition.

- Depreciation – the increase in depreciation expense is primarily related to the aforementioned change in accounting methodology referenced in B.iv.2.
- Other Non-Salary Expense – the decrease in expense is primarily related to the change in accounting methodology referenced in B.iv.1.
- Purchased Services – the decrease in expense is related to the reduction in service contracts in addition to the reduction of one-time expenses.
- Pharmaceutical Expense – the increase in expense is directly correlative with the increase in volume. Additionally, the FY 2022 budget assumes an inflationary increase of 5% on drug costs.

b. *FY 2022 Budget versus FY 2021 Projection:*
The FY 2022 Budget as it compares to the FY 2021 Projection equates to a decrease of $2.4M. Noteworthy variances exist within salaries, employee benefit expense, and purchased services.
    - Salary Expense – the overall decrease in salary expense equates to $317K. The increase in non-MD salary expense is related to the compounding wage issue applicable to the FY 2021 fiscal year outlined in "a." above. Additionally, the physician salary expense reduction is related to the variance referenced in "a." above.
    - Employee Benefit Expense – the decrease in expense is related to the anticipated plan structure changes considered in the FY 2022 budget as well as the restructuring of stop loss and administrative premiums planned for CY 2022.
    - Purchased Services – the reduction in expense is related to the aforementioned service contracts and one-time expense reductions.
c. Inflationary assumptions incorporated into the FY 2022 budget include an increase in salaries of 2%, a pharmaceutical increase of 5%, supply increases of 3%, and other expenses increases of 2%.
d. Gifford's ongoing commitment to reduce costs has enabled us to recognize expense savings and incorporate cost avoidance strategies without compromising our commitment to delivering high quality care to the patients we serve.
    - Staffing Control Mechanism – As stated previously, we are in the process of operationalizing a staffing control mechanism to control salary expenses and FTE growth.
    - Salary Expense – in the FY 2022 budget we did reduce the intended cost of living/merit increase to 2% as opposed to the desired and customary 3% that has been applied for the last two years.
    - Employee Benefit Expense – as indicated prior, we are anticipating a reduction in employee benefit expense as a result of changes to the plan structure and fees.

- Service Contract Assessment – we have performed a cursory analysis of the current service contract arrangements and have been able to incorporate anticipated savings into the FY 2022 Budget.

e. The reduction in expenses incorporated into the FY 2022 Budget has allowed us to achieve a positive operating margin to continue to serve the needs of our community while remaining compliant with GMCB guidelines for NPR/FPP.

vii. Operating Margin & Total Margin

a. As the foundation for establishing the FY 2022 budgeted operating margin for GMC, we utilized a financial sustainability model that aligns our budget with our strategic planning process and initiatives. The model allows for the effective balance necessary when correlating margin targets with appropriate and affordable investment in capital. The model contains three classifications of financial sustainability: survive, sustain, and thrive. In consideration of our financial performance over the last few years, we built our FY 2022 budget based on the ability to survive, which caps our capital spending to a level that is affordable based on the margin that our consolidated organization can produce. From a strategic planning standpoint, for this budget cycle, we did have to make some concessions based on the margin we were able to generate. We are in the process of developing a five-year financial framework that aligns with our emerging strategic plan to ensure we can achieve future initiatives that in particular address GMC's age of plant.

   As it compares to the FY 2021 Projection, the FY 2022 budgeted operating margin assumes an increase of $2.2M, which is primarily related to a reduction in expenses.

b. When evaluating Gifford Medical Center's operating margin, it is important to consider it is the primary revenue source for the entire organization and therefore subsidizes any losses incurred by the other corporations under Gifford Health Care.

C. Risks & Opportunities

i. Risks:

Financial Sustainability – America's rural hospitals are, in general, at risk as illustrated by many of the factors listed below. Gifford Medical Center has a relatively strong balance sheet but faces the challenges of costs growing faster than revenue, workforce vulnerability, the need for investments in technology, and the data infrastructure necessary to be successful in a value-based care/population health environment.

Workforce challenges – challenges that existed prior to the pandemic's onset have only worsened in the intervening months. In addition to lack of candidates to fill existing positions throughout the organization and in all job classifications, employees face additional pressures from lack of child care options; uncertainty brought on by remote schooling, and the many stressors brought on by the pandemic. Wage pressures continue to challenge our organization as competition for workforce heightens.

Provider Recruitment – provider recruitment is challenging in small, rural settings such as ours. We continue to require the use of locum physicians to fill vacancies as they arise, which result in additional expenses that are not covered by the revenue they generate. Call coverage also represents a significant challenge for providers, particularly in small groups and specialties.
Electronic Health Record – Gifford is at the beginning phase of exploring a new integrated electronic health record system. While we expect the outcome of this project to result in clinical and operational efficiencies, the project will require significant organizational resources. Our focus, while implementing these tools will be to continue to provide excellent clinical care and efficient business practices.
Age of Plant – Gifford Medical Center's age of plant exceeds industry benchmarks. We continue to make significant investments in our facilities and equipment, but will require sufficient future operating margins to ensure adequate funding for capital investments.
Inflation and Supply Chain Disruptions – the global supply chain has experienced significant disruption during the pandemic resulting in various medical supply scarcities and cost increases.

Opportunities:
Strategic Planning Process – Gifford is currently engaged in a strategic planning process that began last fall and includes a Board education series that focuses on topics such as: FQHCs, financial analysis of Gifford operations, national healthcare environment/value-based care, Vermont's value-based care programs, and Gifford's Community Health Needs Assessment. Gifford's Board and staff will evaluate numerous forms of qualitative and quantitative data to craft a plan that ensures we address community needs in a sustainable manner.
Population Health Initiatives – Gifford Medical Center, along with its parent Gifford Health Care (a federally qualified health center), is actively engaged in growing our capacity to deliver population health services. We have submitted a proposal to HRSA to utilize ARPA funding to invest in our population health infrastructure, including expanded care coordination services and enhanced data management and analytical capabilities.
Future Efficiencies - New EHR – Gifford's leadership team has identified clinical and revenue cycle opportunities that can be earned by reinstalling or replacing our existing EHR/ERP systems. New or improved systems will also support our efforts to expand population health activities with improved data management and analytical capabilities.
Telemedicine – Gifford gained valuable experience through expanded telemedicine usage during the pandemic. Providers utilized this means of patient communication at a significantly higher rate than in the past, and many incorporated this technology into their practice for the first time. We were able to recognize the value of telemedicine to patients and providers and will continue to incorporate it to reach vulnerable populations and expand access to care.

ii. During the shutdown of elective care (spring 2020) Gifford was able to provide access for in-person urgent/emergent care, while providing routine care via video and

telephonic encounters. Some of our practices provided approximately 40% of their total appointments via video and phone during spring 2020. Overall, volumes declined significantly during that period and then again at the end of calendar year 2020 but have since recovered to normal levels. Access to care and wait-times are at normal levels as we begin summer 2021. We continue to offer telemedicine services as an option for patients and providers, and this has proven beneficial particularly with improving no-show rates for behavioral health services. We continue to require heightened infection control protocols including masking, eye protections, limitations on visitors, and physical distancing and we will continue to evaluate them on an on-going basis.

iii. During the COVID-19 pandemic we have certainly learned valuable lessons to ensure our readiness for future crises; such as the effectiveness of expanded telehealth services in improving access to care, implementing pandemic-related infection control protocols on a permanent basis, and the ability to expand utilization of technology for remote work, community and employee communication. Most of all, we have learned, once again, that our team is talented, resilient, and cares for their community and one another.

D. Value-Based Care Participation

i. Gifford continues to be an active participant in the value-based payment and delivery reform programs offered through OneCare Vermont. Gifford's FY 2022 budget includes participation in Medicaid, MVP, and tentatively, Blue Cross Blue Shield of Vermont.

ii. The projected FY 2021 ACO dues equate to $76K and $137K for the FY 2022 Budget.

iii. Currently GMC is using the information provided by OneCare to target specific chronic conditions for outreach and intervention through care coordination efforts. These efforts focus primarily on diabetic care and high utilizers in the ED in the effort to reduce ED utilization through preventative measures. In FY 2022 we will be working with our FQHC to expand care coordination and explore team-based care opportunities.

iv. Gifford is uniquely situated in a remote rural area where patients are far more reticent to receive care. Therefore, our outreach efforts are focused on trying to provide easily accessible care to medically underserved and vulnerable populations, which can be challenging.

v. One of the most substantial encumbrances to expanding our further participation in value-based care is the current state of our EMR. An EMR must have the ability to appropriately track, analyze, and report data that will enable us to create actionable strategies.

    a. Before a "tipping point" or threshold of FPP versus fee-for-service can be identified, programmatic changes to the current structure of the all payer model would need to be addressed:

        1. It would be ideal if the Medicare program would transition to an unreconciled model similar to Medicaid.
        2. For the next iteration of the model, ensure critical access hospitals can continue with cost settlement methodology as CAHs will be able to utilize this as a bridge as the revenue shifts over time to a more capitated payment. Additionally, it will ensure financial sustainability

as fixed costs comprise 80 – 85% of total CAH expenses. This is one of the many reasons CAHs are reimbursed differently.
    a. Issued guidance is needed from CMS to ensure CAHs can claim attributed beneficiaries on the cost report.
3. Participating providers should be granted the full allowable rate increase outlined in the all payer model. Thus, reducing the cost shift to commercial payers.
4. Migrate away from the fee-for-service lookback benchmarking methodology and develop a preset basis for spending targets, ensuring inflationary factors in healthcare spending is taken into consideration.
5. Medicare blueprint funding methodology needs to be addressed.
6. As it pertains to quality accountability, the model needs to be additive rather than penalizing.
7. In order to attract more participants, the risk model should begin at a modest level and gradually transition to accepting a higher level of material risk.
8. Ability to develop adequate risk reserves.

b. The answer to this question would be contingent on the above.
c. Medicare and commercial fixed payment programs would need to ensure a true capitated payment methodology and eliminate any reconciliation to fee-for-service claims. All the while ensuring CAH cost-based reimbursement.

vi. The estimated value of maximum risk by payer is $350K for Medicaid, $0K for MVP (shared savings only program), and $50K for BCBS.

E. Capital Investment Cycle

i. Gifford's capital investment cycle is based on several varying factors dependent on the type of investment: 1). Routine equipment replacement is based on current end of useful life schedules that are tracked and monitored by item. 2). Routine plant improvements are incorporated into the budget process based on an as needed basis as determined by Plant Operations 3). IT equipment replacement is based on a staggered 5-year replacement cycle. 4). Major plant improvements/additions and major equipment investments are based on strategic planning initiatives.

Moreover, annual capital expenditures are based on actual financial performance and periodic adjustments will be made to the capital allocation based on that performance. Additionally, once the annual capital budget has been determined, in an effort to sensibly distribute the impact capital expenditures have on cash flow, a quarterly allocation methodology is applied, taking into account critical item needs that must occur within the first quarter of the fiscal year.

ii. The current list of capital investments planned for FY 2022 are routine and critical replacement items. They are not improvements required by a regulatory or governing agency.