Northwestern Medical Center – Fiscal Year 2022 Budget Narrative

A. Executive Summary

Northwestern Medical Center (NMC) is requesting a 3.0% average charge increase and a 3.5% growth in net patient revenue compared with the approved FY2021 budget and results in a 2.0% operating margin.

No physician transfers or major structural changes are included in the FY2022 budget. Cost saving efforts are discussed throughout section B and are critical in reaching our budgeted operating margin.

As of July, all Covid-19 specific services have been incorporated into existing departments as part of normal operations. This means the closing of the dedicated Covid-19 inpatient unit, curbside testing location, outpatient acute respiratory center and off-site vaccination clinic. Testing, treatment and vaccinations remain readily available through Northwestern Urgent Care, two primary care locations (St. Albans and Georgia) and all pediatric locations. Inpatients can be cared for in negative pressure rooms within our inpatient unit.

B. Appendices and Financial Comments

B.i.a.i. and B.i.a.ii. Medicare reimbursement is expected to increase by 2.3%, based upon proposed rules, which equates to $429,565 annually. This equates to the avoidance of an additional 0.64% overall change in charge request that would have affected commercial payers (this analysis is intended to satisfy 18 V.S.A. § 9456(b)(9))

Net patient revenue was calculated utilizing the **base period of July 2020 through January 2021.** Appendix 1 includes two significant items affecting the net patient revenue budget when comparing the approved FY2021 budget with the requested FY2022 budget:

1. Increase in Fixed Prospective Payments (FPP) – We are not budgeting a change in the risk reserve in FY2022 which increases total FPP by $1.6 million compared with the FY2021 budget. Additionally, actual monthly payments have exceeded budget in FY2021 and the budget for FY2022 has been increased accordingly.
2. Payer mix shift between Medicaid and Commercial – The FY2021 budget had assumed a shift toward Medicaid and away from Commercial based on the idea that the Covid-19 pandemic would cause a spike in the unemployment rate and increase Medicaid enrollment. Thankfully, this did not transpire, in fact, we saw an increase in the share of Commercial revenue and a decrease in the share of Medicaid revenue. The FY2022 budget reflects the payer mix as observed during the base period.

B.i.a.iii. As shown in Appendix 5, Covid-19 testing was a significant source of net patient revenue during FY2021. The FY2022 budget assumes that outpatient test volumes will drop to 25% of those seen during

the base period. As of June 2021, volumes have come down 50% from the base period. The remaining lab volume does generate a positive margin as these tests are being processed without additional staffing. Payments from the Cares Act were recognized as Other Operating Revenue during calendar year 2020 which includes the first three months of FY2021. We do not anticipate any additional stimulus payments in FY2022.

We had expenses related to a dedicated Covid-19 inpatient unit, screeners at all entrances, a curbside collection center and fees for sending lab specimens to outside labs early in the pandemic before the testing capabilities were brought in-house. These expenses are reflected in the amount shown in Appendix 5.

B.ii.a. Please see B.i.a.i, B.i.a.ii for discussion of Fixed Prospective Payments and payer mix.

B.ii.b. Appendix 3 attempts to quantify utilization changes with gross revenue as the primary measure. While inexact, this accurately identifies areas with changing utilization and estimates a relative magnitude.

The FY2021 budget was prepared as a "Covid Free" budget and the FY2022 budget uses a base period intended to reflect a "new normal". These conflicting assumptions produce some utilization differences that can be partially explained through traditional means, leaving the remaining difference to be understood as the interaction between changes in consumer behavior and care delivery methods (tele-health).

Utilization has been strong in surgical services. Two orthopedic surgeons that started with NMC within the last two years have ramped up and are seeing strong demand for their services. This increase in complex cases has been paired with a focus on block time utilization to ensure that the surgical services facilities and staff are being used as efficiently as possible.

Laboratory utilization has increased as a result of Covid-19 testing as discussed in B.i.a.iii.

Emergency department volumes continue to move lower and the Covid-19 pandemic appears to have created a short-term acceleration in this long-term trend.

Physician Office revenue is primarily driven by physician vacancies or other changes in our provider roster, including the impact of ramp-up periods for new providers and lower volumes from temporary (Locum Tenen) providers. Physician revenue has lagged since FY2019. The FY2022 budget includes increases in a few selected practices based on identified opportunities to optimize scheduling practices or to expand visit type availability. The net revenue impact of any physician practice utilization is very small relative to gross charges because a high percentage of these visits are covered by fixed prospective payments.

Other areas experiencing decreased utilization are ancillary areas closely tied to emergency department volumes.

B.iii.a Table 1 of Appendix 2 shows how the change in charge request will be applied. Because all payers utilize a fee schedule for outpatient physician practices, no increase is applied to those services as it would only impact the uninsured population and those with high deductible plans. The overall change in charge request is 3.0% with an increase of 3.59% to be applied to all hospital based services and 0% applied to all outpatient physician services.

B.iii.b. Revenue by patient class (inpatient/outpatient/physician office) and by payer from the base period was annualized to serve as a basis for calculating the impact of the change in charge request. Capitation rates by patient class and payer where incorporated into the model since changes in gross charges associated with capitated revenue does not result in additional net revenue. Changes in charge have a negligible impact on net revenue associated with Medicare and Medicaid patients, only impacting those who may have a secondary insurance. Nearly all net revenue generate from a change in charge comes from commercial payers who pay based on a percent of gross charge. Appendix 1, Tables 1 and 3 show the net revenue impact of the change in charge by payer group.

Payment rates by payer as of January 31, 2021 were utilized in calculating net patient revenue. An increase in reimbursement for Medicare was incorporated as noted in B.i.a.i. and B.i.a.ii.

Appendix 2, Table 4 shows the net patient revenue value of 1% as $671,268.

B.iv.a. No adjustments or physician transfers are included in the FY2022 requested budget.

B.v.a. and B.v.b.Covid-19 relief funds as shown in Appendix 7 represent the most significant variation between the FY2022 requested budget and both the FY2021 budget and FY2021 projection.

Non-operating revenue is projected to exceed budget in FY2021 due to market returns on our investments. We budget $0 for realized and unrealized returns on investments due to the unpredictable nature of these results. FY2022 budget uses this same methodology.

B.v.c. We do not anticipate any additional relief funds or advances related to Covid-19.

B.v.d. Market returns are the only unstable source of income in the other operating and non-operating revenue sections of the income statement.

B.vi.a. Appendix 1, Table 2 shows the major changes in operating expenses between the approved FY2021 and requested FY2022 budgets. Total operating expenses are budgeted to decrease by 0.2% compared with the FY2021 budget. Inflation is expected to be higher than in previous years for supplies, but most notably, the price of traveler RNs which has spiked since the beginning of the Covid-19 pandemic. Appendix 4 provides a breakdown of the inflation costs included in the FY2022 budget.

The budget for XIX provider tax has increased compared with the FY2021 budget. This is a function of under budgeting the FY2021 value based on the projected net revenue impact of Covid-19 when the FY2021 budget was prepared. That projection proved to be too conservative and the FY2022 budget reflects current projections of FY2021 net patient revenue.

We continue to be focused on cost containment. We have employed the principles of high reliability to work toward more efficient systems that allow us to reduce staffing demands. As positions become vacant through attrition, we take the opportunity to reevaluate how the work is being done to look for more efficient methods. We have restructured the way that we deliver occupational health by embedding key processes into primary care and urgent care when we serve outside employers, and utilizing a dedicated employee wellness team within human resources for our own employees. This has reduced paid hours and total cost while maintaining the same services. We have also placed an increased emphasis on flexing staffing levels to meet volumes across the organization and not only on inpatient units. Based on third party benchmarking data, we recognize that we have opportunities to become more efficient in clinical and non-clinical departments. Improvements in some of these areas have been incorporated into the FY2022 budget. We are also transitioning the Hospitalist service from an employed model to a contracted model which results in decreased salary expense with an offsetting increase in contracted services. Since physician contracts are reported to the GMCB with physician salaries, dollars will not change dramatically but physician FTEs will be reduced. In total, FY2022 budgeted FTEs are 29.1 or 4.4% below the FY2021 budget (excluding Travelers). This reduction results in a corresponding reduction in employee benefits as also shown in Appendix 1, Table 2.

B.vi.b. Appendix 1, Table 4 shows a reconciliation between projected FY2021 operating expenses and FY2022 budgeted operating expenses. The nature of the variances is the same as in B.vi.a. The magnitude of the salary change is greater when comparing the FY2022 budget to the FY2021 projection because of the dedicated Covid-19 positions that are impacting actual FY2021 expenses. These temporary positions have now been eliminated.

Traveler expense has exceeded budget in FY2021 and as we work to flex staffing to volumes and continue recruitment and orientation efforts, we expect the need for traveler RNs to decrease compared with current levels.

The FY2022 budget includes Locum Tenen expense to cover one military deployment and one known vacancy. The deployment is scheduled for later this summer and the vacancy will occur October 1 so very few expenses will fall into FY2021.

Health Care Provider tax will increase as the FY2021 tax is based on FY2020 net patient revenue that was depressed as a result of the Covid-19 pandemic.

B.vi.c. Appendix 4 shows inflation assumptions incorporated into the FY2022 budget.

The cost of Traveler RNs has risen by more than 50% since the beginning of the pandemic, further emphasizing the need to reduce utilization of temporary staffing.

Ordinary wage increases are included with scheduled raising going into effect during the first pay period in calendar year 2022. The timing of the implementation means that 75% of the full annual effect is included in the FY2022 expense budget. Wages represent 42.8% of total operating expenses so even modest inflation results in a significant increase in total expenditures.

Supply inflation is expected to range between 3%-6% depending on the category but it is important to note that the resources we utilize predict a wide potential range of outcomes, underlining the fact that there is more uncertainty around inflation this year compared with recent years.

B.vi.d. Cost savings efforts related to staffing were described in B.vi.a.

B.vi.e. The requested budget-to-budget reduction in operating expenses has allowed us to submit a budget request that fully complies with GMCB guidance for change in charge increase and net patient revenue growth while also achieving a positive operating margin. Continued cost containment with modest allowable growth in net patient revenue will allow us to return to a sustainable operating margin over the next few years.

B.vii.a. We aspire to achieve 3% operating margin to ensure long-term sustainability. As a not-for-profit organization, all operating income is utilized within the organization to routine capital replacements, facility refreshes and to make investments in services that our community needs. We have fallen below this target for a number of years and it has made it difficult to maintain an adequate replacement cycle for equipment and facilities. We recognize that containment of operating expenses will be key to achieving this within the current regulatory environment.

B.vii.b. The FY2022 budget does not include support or a need to support any other entity outside of the physical hospital.

C. Risks and Opportunities

C.i. There are two key areas of risk and opportunity that we continue to monitor: 1) volumes in outpatient clinics, and 2) recruitment and retention of inpatient nursing staff.

Many of our outpatient physician practices are seeing fewer patients per day than national benchmarks suggest. We also know that demand is high enough to support those higher volumes and internal systems and workflows need to be streamlined to increase efficiency. This has been an ongoing challenge and is one where we have made slow but steady progress. The FY2022 budget includes an overall 5% increase in wRVU production across all outpatient physician practices.

The use of Traveler RNs has increased in FY2021 along with the market price for these services which has had a significantly negative impact on FY2021 financial results. The FY2022 budget assumes a significant reduction in the need for Traveler RNs compared to FY2021, though the budgeted cost remains quite high.

These are both high leverage areas where unanticipated success or challenges could result in a material variance from budget, favorable or unfavorable.

C.ii. Covid-19 significantly impacted access to care on a variety of fronts. The first, being fear on the part of the patient for their personal safety. This was most evident in our older patient population but also extended to the other end of our most vulnerable patient population with our pediatric patients and their care decision makers.

Overcoming fear through education and communication of our safety precautions to our community was a constant focus across the hospital and all care settings.

However, the most significant impact to access was the reduced throughput volumes we could accommodate simply due to the size of our footprint. Reducing waiting room furniture, social distancing, and increased PPE requirements for positive screening (symptoms, not actual diagnosis) significantly limited our ability to see patients at a rate prior to Covid.

NMC was very agile in its response to Covid and immediately expanded our telehealth capability. It was widely used across most outpatient departments, including physician therapy where we could lead patients through exercises in the comfort and safety of their homes.

Unfortunately, not all visits are conducive to telehealth. This was challenging for our pediatric clinic to keep children on their recommended vaccine timelines, well child and milestone visits, and cognitive/hearing/sight evaluations due to a need for a physician visit to administer vaccines and physically observe.

Ophthalmology was significantly impacted and our in person visits were limited to urgent injury related issues.

We saw significant decline in our aerosol generating procedures and associated clinic such as cardiology and pulmonology. A combination of necessary precautions and patient fear significantly reduced our volumes.

C.iii. Covid highlighted the already urgent need of a modernized emergency department. Our curtained bays were not sufficient for patient isolation and prevention of spread. This required moving services around in order to create the appropriate number of negative pressure care settings in close proximity to our ED. This was inefficient and required more staffing across a larger area of care significantly impacting our cost.

Telehealth should be here to stay and should be reimbursed appropriately after the waiver is lifted. For rural communities already challenged with transportation and other socio-economic hurdles, telehealth provides a cost effective way of providing care.

D. Value-Based Care Participation

D.i. Please see Appendix 6 for details about our participation in OneCare Vermont.

D.ii. We have budgeted ACO dues of $969,000 in FY2022.

D.iii. The placement of community health team members and care coordinators within primary care practices is the most visible and impactful effort. These position are funded by the dues that we pay and through the Blue Print for Health grant program. The goal of these programs is to ensure seamless transitions of care between primary care and specialty providers to ensure patients are receiving the care they need when they need it.

D.iv. Participation in the all-payer model remains the largest barrier and opportunity. Approximately 32% of our total gross revenue falls under the all-payer model which is not high enough to align the goals of the all payer model with the financial stability of the hospital. To reach this alignment, approximately 52% of gross revenue would need to be part of the all-payer model.

Opportunities to increase the overall rate of participation include:

Blue Cross fully participating in the ACO – We continue to receive fee for service payments from Blue Cross and no fixed payment reconciliation is performed at the end of the year, so while patients may be listed as attributed to the ACO through Blue Cross, revenue from these visits cannot be counted toward the goal of 52%.

Increased membership – Participation by the largest unions in the Vermont (Vermont State Employees and National Education Association) and enrollment of self-insured plans are necessary to achieve this goal.

D.v.a. See D. iv.

D.v.b. Medicare outpatient, CIGNA, MVP and Blue Cross account for approximately 55.5% of total gross revenue. With Medicaid included, this moves to 75.2% of total gross revenue and would shift financial incentives away from volume driven models and toward volume reduction models.

D.v.c. Key attributes of a successful fixed payment model:

1. Consistent payment and risk/shared savings reconciliation methodologies across all payers
   -To reduce administrative burden and allow for consistent cash flows.
2. There must be no reconciliation of fixed payments to fee for service reimbursement
   -Once a fixed payment is set, it should not be adjusted based on patient volumes, only by the targeted annual inflation. Any reconciliation to actual volumes immediately moves the financial incentive back to a fee for service model.
3. There must be a way to adjust fixed payments when services are added or discontinued
   -Fixed payments create a disincentive to add services even when they are necessary in a health service area, because no additional revenue is received when treating patients that are part of the all-payer model. Fixed payments also create an incentive to discontinue services and shed expenses with the knowledge that revenue will not be reduced. A successful all-payer model needs a prescribed process to ensure that necessary services can be financially viable by increasing fixed payments, and requires a mechanism to reduce fixed payments when a service is discontinued to ensure that the program returns value to the payers, the State of Vermont and to Vermonters.
4. Need method to account for price differences between hospitals when calculating risk penalties.
   -Price discrepancies between hospitals in neighboring HSAs creating differing levels of susceptibility to outmigration of services in the risk based model.

D.vi. Our maximum risk liability for CY2022 is expected to be $3.5 million.

E. Capital Investment Cycle

E.i. As a not-for-profit institution, the sole purpose of an annual operating income is to fund future capital investments, including the replacement of obsolete equipment, refurbishment of aged facilities or the purchase of new items to support programs that meet community needs.

Capital purchases were paused at the onset of the Covid-19 pandemic. This created a backlog of requests with items planned for FY2020 competing with items planned for FY2021 for FY2021 capital funds. We currently have a list of approximately $1.2 million that are on hold and not currently part of the FY2022 capital budget. Two items below have been deferred and included in the FY2022 capital budget.

Item Description	Original Fiscal Year	Status	Estimated Amount
Self Pre-Registration Kiosk	2021	Hold	130,200
Cooling Tower Replacement	2021	Hold	144,695
Roof Renovation - Conference Center	2021	Hold	62,400
Roof Renovation - Cobblestone	2020	Hold	95,920
Door Replacement - Surg Svcs	2020	Hold	125,000
Lighting Retrofit - Surg Svcs	2020	Hold	73,320
Bulk Oxygen Tank Relocation	2020	Hold	666,915
Pharmacy Renovation	2020	FY22 Budget	75,000
Omnicell Dispensing Cabinets	2020	FY22 Budget	171,260

We routinely reevaluate capital expenditure priorities and our ability to spend on capital items based on cash flow and operating margin. We have communicated with our board of directors that we may be coming to them with unbudgeted capital requests during FY2022 if our operating margin supports additional purchases to work down this list of items.

E.ii. No planned capital items are required by regulator or accreditation agencies.