Northwestern Medical Center Fiscal Year 2025 Budget Follow-Up Questions & Requests

On corporate structure

1. Please provide details of the corporate structure of the New England Collaborative Health Network. In addition, please provide any contract(s) you have with the New England Collaborative Health Network, including any contract(s) with the consulting firm Ovation.

The New England Collaborative Health Network, LLC (NECHN) is open to any independent hospital in the states of VT, NY, NH, ME, MA along with their Community Partners in Care, identified typically but not limited to home health agencies, medical groups, FQHC, long-term care facilities, mental health providers, substance abuse agencies, etc.

The Collaborative is governed by our member hospital CEO's who each have a seat as an independent Board of Directors, with an equal vote, and provide direction for the Collaborative's goals and initiatives.

An Executive Director will execute these initiatives and provide the project management leadership to achieving the Collaborative's goals. Supporting the Executive Director are various industry partner organizations who will provide the education, specialized expertise, and/or provide consultative or services on a collective basis for the Collaborative Hospitals, as agreed upon by the Board of Directors.

Collaborative leadership councils in Supply Chain, Human Resources, Information Technology/Cyber Security, Finance, Quality/Operations will focus on the execution of board plans and provide opportunities to network together.

To date, NECHN has identified almost $1.4 million in potential supply spend and $1.6 million in potential employee benefit cost savings for its current and interested members with added savings yet realized by aligning and group purchasing for business insurance, purchased services, and planned capital expenditures.

Longer-term, NECHN's goal is to be a tool, a tactic, a resource for our member hospitals and community partners with helping to keep care local, reducing costs, addressing workforce challenges, and external funding opportunities.

2. To the best of your ability, please estimate your expected return on investment for your participation in the New England Collaborative Health Network. What do you anticipate will be the main driver of your savings/improvements in quality etc.? Where do you anticipate potential risks associated with your ability to achieve the expected value?

Please see response to Question 1. above. NMC anticipates that the main drivers of our savings and improvements in the next 2 to 3 years will come from supply chain cost savings and employee benefit cost savings. Those savings will begin positively impacting NMC in FY2026 and beyond. Potential risks include future unexpected increases in inflation that offset savings achieved, and mergers, acquisitions, and closures that negatively impact membership.

On labor expenses

3. What is the likelihood of filling these traveler positions with permanent employees, especially with number of current vacancies? If not filled, how will your NPR be affected?

At the end of FY2022, NMC had over 50 travelers. We had great success in reducing that number throughout FY2023 and ended that year with just over 30 travelers. We counted on that trend to continue when we built our FY2024 budget. Unfortunately, that has not happened, and we have budgeted travelers in FY2025 at our current actual level. We do believe that our workforce development initiatives (as described on Pages 18 and 19 of our budget submission narrative) will provide the long-term solution.

On utilization

4. Can you provide a more specific assessment of where volume has increased above FY2024 budgeted expectations. How have you recalibrated your expectations as to not underpredict your NPR for FY2025?

In FY2024, we are exceeding budgeted volumes in surgery, outpatient surgical procedures, laboratory tests, diagnostic imaging procedures, and specialty physician practice visits. However, these additional volumes have not translated into a significant net patient revenue variance. Per our FY2025 budget submission, we project exceeding our net patient revenue budget by only 0.7%. This is due to unfavorable changes in payer mix with more Medicare Advantage, and unpaid services that fall under fixed payments. We have incorporated current year volume variances into our FY2025 submitted budget.

On pharmaceuticals

5. Why do you expect both pharmaceutical expenses and pharmaceutical revenues to decrease in the coming year?

Per the table on Page 9 and 10 of our FY2025 budget submission narrative, we anticipate the cost of pharmaceuticals to increase by 4.86%. We also expect an increase in pharmaceutical expense due to increased access. However, we are challenging ourselves to implement bedside medication verification within surgical services so that we can optimize 340b pharmaceutical savings. Those savings are significant at $1,250,000. This is an area of risk within our budget; however, it is our responsibility to take on this initiative. This is a tangible example of reducing expenses to keep our rate increase request as low as possible.

On rate changes

6. Why is the increase to professional services almost zero?

Professional services are paid based on fee schedules. As a result, changes in price do not impact what is paid.

On financial indicators

7. Will NMC be out of compliance with your bond covenant for FY24 since your operating margin is projected to be negative?

NMC expects to be in compliance with all of our bond covenants for the Fiscal Year ending September 30, 2024.

On your workbook submission

8. In Table 3 in the workbook, it appears there are still many patients who cannot be seen within 180 days. In your opinion, what are the main obstacles to reducing these wait times?

Table 3 was completed using actual appointments scheduled during the historical time period indicated. It is not a representation of wait times that we anticipate should our FY2025 budget be approved as submitted. The main obstacle to reducing the wait times reported in Table 3 is the need for additional providers. We have done a tremendous job recruiting providers in most areas and our budget submission improves access as discussed on Pages 4 and 5 of our budget narrative.

9. In Table 5 in the workbook, there appeared to be a large jump from FY23 to FY24 in boarders.

Can you attribute this to anything specific? Have you taken any measures to prevent this continued increase in FY25?

We attribute the increase to changes in our "local landscape" that have occurred over the past couple of years. Kings Daughter was a 13-bed assisted living facility that closed, Holiday House was a 30+ assisted living facility that closed, and Giordano Manor was a 13-bed assisted living facility that closed. In addition to that, Franklin County Home Health closed. VNA Hospice of the Southwest Region became the designated agency for our area. That transition contributed to our challenges as well. Measures we have taken to prevent continued increases include:

- Implemented CarePort to increase the geographic reach and efficiency of bed referrals to appropriate outside facilities.
- Working closely with VNA Hospice of the Southwest Region to restabilize and enhance home health services in Franklin and Grand Isle Counties.
- Working closely with the primary care providers in our service area to help proactively prepare patients and families for increased care needs before the "break point" or the emergency occurs.

10. Please review the rate decomposition details you submitted as well as the "summary" tab and explain the following (where available, please show supporting calculations):

1. How did you arrive at the assumed rates of growth for price, volume, and payer mix shifts by payer?

Methods used by column are:

NPR FY24 @ FY25 Comm Prices: For payers that reimburse as a percent of charge, the formula is FY24 Budget x FY25 Change in Charge Request. For payers unaffected by the change in charge, the value is equal to the FY2024 budgeted NPR.

NPR FY24 @ FY25 Utiliz: Overall utilization change was estimated by comparing FY2025 budgeted gross revenue with no change in charge by patient type (Inpatient, Outpatient, Physician) to the approved FY2024 budgeted gross patient revenue for the same patient type. Using the same overall utilization change for all payers isolates general utilization from payer mix shifts. The same utilization effect is shown for all payers within a patient type. For example, FY25 budgeted gross revenue at 0% change in charge for Inpatients is 1.24% lower than the FY24 budgeted gross revenue for inpatients. The values shown in this column for inpatients are all 1.24% lower than the approved FY24 budget.

NPR FY24 @FY25 Public Payer Prices: Due to further clarification from GMCB staff, we will revise the values in this column to reflect the impact of reimbursement changes (market basket increases) for Medicare and Medicaid. We respectfully recommend that this be called "NPR FYXX @FYXX Public Payer Reimbursement" to avoid any confusion.

NPR FY24 @FY25 Payer Mix: Within each patient type, the relative mix was compared for each payer between FY2024 budget and FY2025 budget, and the dollars associated with the relative increase were attributed to payer mix. For example, Inpatient Medicaid was 17.4% of inpatient

revenue in the FY2024 budget and is 17.3% of inpatient revenue in the FY2025 budget. Calculating FY24 NPR at FY25 Payer Mix = 17.3 / 17.4 = .995 x FY24 inpatient Medicaid NPR.

2. For non-zero values in the "other" column, how did you derive these estimates?

The "Other" column is simply the remaining difference between FY25 budgeted NPR and FY24 budgeted NPR, that is not accounted for in the other columns.

Other

11. Do you think Medicaid is underfunding the cost of delivering care to your Medicaid patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.

Medicaid underfunded the cost of care in FY2023 by $10.3 million (41.9%) in FY2023.

Medicaid revenue is calculated as payments and shadow payments on all accounts listing Medicaid as the primary insurance. Costs are derived from our cost accounting system for these same patient encounters.

12. Do you think Medicare is underfunding the cost of delivering care to your Medicare patients? If so, please quantify this amount based on 2023 actuals. Please explain your calculation.

Medicare underfunded the cost of care in FY2023 by $8.0 million (20.9%) in FY2023.

Medicare revenue is calculated as payments and shadow payments on all accounts listing Medicare as the primary insurance. Costs are derived from our cost accounting system for these same patient encounters.

Our biggest opportunity to "live at Medicare rates" is to increase volume without increasing fixed costs. We know that a meaningful amount of market share within our service area chooses to have their care needs met by the next closest hospital. Our strategic plan that places quality and high reliability are the forefront is key to improving our market share. The cost of providing custodial care is another significant opportunity. If NMC did not incur the costs of caring for patients that could be cared for in a lower acuity setting, it would have a positive impact on our ability to match costs with Medicare reimbursement.

13. In the attached spreadsheet, please review the measures of financial health that we have calculated for your hospital. We have included the measure definitions. Confirm that these calculated values reflect your understanding. If your financial measures differ from our calculations, please review our formulas, provide your calculation, and explain why you believe your calculation is a better measure for your organization.

These measure reflect our understanding.