Northwestern Medical Center
2018 Budget
Green Mountain Care Board Analytical Questions

1. Income Statement - The hospital NPR is increasing 3.8% which includes 0.4% for health care investments. The amount over the 3% and 0.4% targets is $375,000. Explain the increase.

The $375,000 relates directly to a physician transfer. As part of our new construction we have space that is designated to provide rotating clinics for services that cannot be supported fulltime in the St. Albans region. We are actively working with the University of Vermont Health Network to provide specialty services on a rotational basis. This represents our projection of how much of those services will be provided in 2018.

2. Rate – The submitted 2018 budget rate of 6.0% is higher than the weighted average submitted rate of all hospitals of 2.38%. What is the rationale and the strategic decisions to support the rate at 6%? Does the hospital consider pricing in setting the hospital rates?

It was very difficult for us to move forward with this request as our organization typically has one of the lowest, if not the lowest, rate increases of any organization in the state. As page 6 of your analysis demonstrates, we have been significantly below the weighted average approved rate increases for all hospitals for the last four years. On page 11 of our narrative, we included an analysis that goes back as far as 2011 that shows our average annual increase is only 1.79% which is 3.42% less than the median and .5% lower than the second lowest hospital. Lastly, it is important to note that even with a 6% rate increase, our average prices will be about 2.5% below FY2015 prices.

Yes, pricing is a component of our analysis to determine rate increases. We utilize the data provided by the Vermont Department of Health on Pricing for Common Services which is the best comparative pricing information that we have available to us. 2017 data is available for a variety of ancillary services, including Laboratory, Cardiology, Emergency, a variety of imaging services and a small group of other services. Of the services that we provide, we are the lowest cost provider for 29% of the charges listed and are among the three lowest cost providers 65% of the time. In only 4% of all charges listed are we above the system average. It is important to view this in the context of the rate increase trends since FY2011 that are included in the presentation. We have demonstrated that our prices have increased at the lowest rate since then but it does not show the base from which each hospital started. This price comparison demonstrates that the net effect of this low rate of increase has been to make NMC the lowest cost hospital for nearly 1/3 of all common charges and among the bottom three in nearly 2/3 of all charges.

3. NPR-PAYER Our review suggest that Commercial has a decrease in reimbursement and an increase in utilization. Medicaid shows a decrease in reimbursement and decrease in utilization. Medicare shows about the same reimbursement and an increase in utilization. - Discuss the assumptions you are making for each of these payers, for both reimbursement and utilization. Provide the specific services for the utilization increases and the patients served - how are services changing and when will growth slow?

The changes in utilization for Medicaid and Commercial are entirely related to normal payer mix shifts which occur from year to year and it would be difficult to attribute these changes to any particular service lines. The historical range for Medicaid revenue is between 21.6% and 24.0% of total gross charges since FY2014 and is budgeted to be 22.3% in FY2018 compared to a budget of 24.3% in FY2017. The historical range for Commercial revenue is between 40.4% and 42.1% of total gross charges since FY2014 and is budgeted to be 41.3% in FY2018 compared to a budget of 40.7% in FY2017. Because we use the prior twelve months as a basis for payer mix assumptions by department, these fluctuations end up being reflected in the budget from one year to the next.

The most significant changes from the FY2017 budget are within Medicare where normal fluctuations account for about a quarter of the total changes in utilization. We believe that the remainder can be attributed to an aging population where more individuals are eligible for Medicare and now need services. We are budgeting for growth in physician practices that have a high Medicare patient mix, include Orthopedic, Ophthalmology and Dermatology. These three practices represent a mixture of both "sick care" in terms of performing surgeries and caring for existing conditions as well as preventative care with mild interventions occurring early so that more intensive interventions may be avoided. Within the hospital facility, we are seeing additional Medicare revenue that is associated with increases in acuity and therefore, gross charges per visit. This has an impact in the emergency department, surgical services and the inpatient floors (the same patient often goes through all three of these departments in a single visit). Total emergency department visits and inpatient admissions are budgeted to decrease while surgeries are budgeted to remain roughly the same as the prior year. These three departments have a very high payer mix so Medicare is disproportionally affected by this trend.

Growth is already slow and has been slow since FY2012 in the hospital facility. From FY2012 through projected FY2017, we are observing an average annual growth in net patient revenue of only .9%. Net patient revenue growth at NMC is coming almost entirely from physician practices, in particular, non-surgical practices highly associated with preventative medicine such as primary care, pediatrics, outpatient cardiology and pulmonology, addiction medicine, dermatology and a non-surgical provider in Orthopedics. These services on their own have grown by an average of 19.6% annually since FY2012 through the transfer of community providers and growth of existing services which we feel is appropriate in order to address our community need related to access to providers.

4. Income Statement - Bad Debt as a % of gross revenue is increasing unfavorably from 1.6% to 2.7%.The difference in Bad Debt between the 2017 Budget and the 2018 Budget is an unfavorable change of $2.5 million. What explains the large increase seen in 2017 and why is it expected to continue?

We tend to view Bad Debt and Charity Care as a single grouping of write-offs as both lines can generally be attributed to individuals who are financially unable to pay. The differentiation is due to whether or not the individual meets the requirements set forth in our policy to qualify for charity care which requires that individual to complete a financial disclosure form which is often a big enough barrier to prevent the individual from being classified as Charity Care so that write-off is classified as Bad Debt. The population of patients whose accounts end up in

Charity Care and Bad Debt is really a single population with the bottom line being that they are unable to afford the cost of care so it is most sensible to view the two lines as a single write-off for budgetary purposes. As you will see on page 12 of our narrative we experienced two lower years in bad debt and charity care in 2015 and 2016 due primarily to the increase in the insured population. Often bad debt and to a certain extent charity care can fluctuate from year to year. Last year during the budget process we cautioned the board to not make a conclusion that bad debt and charity care would stay at the extraordinarily lower levels that we experienced in 2016 as the history would show that the number would likely go up. The board asked that we keep the bad debt at the lower level and we complied. This year as we might have expected the bad debt and charity care levels returned to be consistent with our historical levels of roughly 3.75%. We believe that this is being caused by several factors including the continued growth of high deductible health plans and increasing copays.

5. The hospital made a significant amount of investment earnings in 2017, as earnings weren't budgeted for that year. What is the hospital policy regarding budgeting for investment earnings? Discuss your strategy.

We take a financially prudent approach to budgeting non-operating revenue. While we do budget for interest and dividends on our investment accounts, we do not budget for any unrealized gains on our investment accounts. We feel that is appropriate given the uncertainty of stock market performance. In 2017, there are two specific issues driving the non-operating revenue to its current levels. The first item is unrealized gains on investments. The key term is unrealized, as these amounts could change if there were to be a significant change in the current capital markets. The second item in 2017 is gains associated with several interest rate swaps that the hospital has tied to its bond issuance. Each quarter we adjust the value of swaps on our balance sheet to market. The result of those adjustments so far in 2017 has been positive based on the increases in interest rates. However, if interest rates were to go down, the adjustments would be negative. Much like unrealized gains on our investment accounts, the bond swap adjustments are a paper based transaction and do not translate to cash payments received by the hospital.

6. Utilization & Staff - Physician office visits are going up 40.4% and Physician Salaries and contracts are increasing $1.2 million (7.5%). Physicians are increasing by 2 and travelers by 1. Are they the reason for this increase? Discuss these increases and their effect on the utilization and costs?

The increase in physician office visits is mainly being driven by the addition of medical clinics mentioned above in question 1 and the stabilizing of our pediatrics and primary care practices. Physicians are increasing by 2 for the same reasons. Travelers are increasing by 1 as we believe that recruitment will continue to be challenging. Travelers are an expensive alternative to hiring directly and we avoid using them whenever possible.

7. Utilization & Staff - Non-MD FTE's are decreasing by 19, after an increase of 85 last year. Explain the changes in the Non-MD FTE's over the last few years. How does the hospital determine the right level of FTEs?

The number of Non-MD FTE's typically increases as a result of employing existing physician practices within our community and/or as a result of existing physician practices stabilizing or reaching maturity. Because labor is the largest cost within our organization, we are constantly evaluating staffing levels to ensure that they are appropriate. We compare ourselves against QHR labor productivity benchmarks and the senior leadership team reviews every open position to look for opportunities to be more efficient. We have prepared a budget for 2018 that includes the 4th lowest FTE's per 100 adjusted discharges among all of the hospitals, and as noted in the question, we have a decrease of 19 based on expense management initiatives and targets that we are currently working on.

8. The hospital notes the higher costs in it's self-insured plan and the increase in high cost claim cases. Is this budgeted to continue into 2018? We are not budgeting this to continue in 2018. If so, why?

Our history shows that we typically have 2 to 3 high dollar medical issues a year. This year we have had 9 of them. We are basing our budget on a longer timeframe rather than the abnormal results of a single year.

9. Balance Sheet – Cash on Hand is starting to decline, but remains higher than Vermont peers. Describe how the hospital is using cash to fund capital. What are the strategic discussions when determining the cash support of capital?

As you know, we are in the middle of a large CON approved construction project. The project is a $33 Million project that requires a significant equity contribution from NMC. This project is the primary reason that you see a significant decrease in days cash on hand. We continue to evaluate several other significant projects to continue to transform the health care model over the next several years with a significant focus on wellness and prevention that will require additional invest of days cash on hand.

10. Income Statement - Are the 2017 projections still valid? If not, please describe material changes?

Although we just experienced a difficult July with very low volumes, we believe that they are still valid.

11. Refer to the Act 53 price and quality data schedules that were included in the presentation of FY 2018 Hospital Budget Submissions-Preliminary Review on July 27, 2017 and be prepared to address questions the Board may have concerning that information.

This is a portion of our presentation.

12. In the March 31 GMCB hospital guidance, the Board allowed up to 0.4% for new health care reform. The Board directed each hospital to provide a detailed description of each new health care reform activity, investment or initiative included within the designated 0.4%, provide any available data or evidence-based support for the activity's effectiveness or value, and identify the benchmark or measure by which the hospital can

determine that the activity reduces costs, improves health, and/or increases Vermonters' access to health care. With this in mind, please describe how you are investing for new health care reform activities in the four approved areas The full amount of our 0.4% new health care reform is going to the following:

• Support for Accountable Care Organization (ACO) infrastructure or ACO programs;

13. Please identify which ACO(s) you will have a contractual relationship with in 2018. If your hospital plans (or already is) in a risk-bearing contract with OneCare, please explain the effect of the risk on your financial statements. Please explain specific strategies your hospital is developing to move toward population-based payment reform. Finally, what tools does your hospital employ to ensure appropriate, cost effective, quality care when working with providers outside the CHAC or OneCare network?

We consider ourselves to be an active leader in payment reform. We are currently participating in the VT Medicaid Next-Gen program as a risk taking hospital. In 2017, our portion of the shared risk under this program is $182,000. While contracts are not finalized, we fully anticipate participating in the VMNG, Medicare, and Blue Cross/Blue Shield risk based programs in 2018, with current estimates showing that our portion of the risk will be approximately $2.9 million. Explaining the effect of the risk on our financial statements is challenging as this is such new territory. However, it is clear that if we were to lose the entire amount at risk, it would more than eliminate the total margin that we have budgeted for in 2018. For this reason, investing in specific strategies that will allow us to be successful in a risk taking environment is crucial. RiseVT has been selected as the ACO's primary prevention strategy for the participating organizations and the ACO continues to work on a care coordination model as well. We are fortunate in that all of the providers on our medical staff within our health service area are members of an ACO and we have found the Regional Clinical Performance Council to be an effective tool to ensure appropriate, cost effective, quality care when working with providers that are not employed by the hospital.