Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services
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Ms. Pat Jones, Director of Health System Finances
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620-3101

June 29, 2018

Dear Ms. Jones:

In accordance with the FY 2019 Hospital Budget Guidance and Reporting Requirements we submit our 2019 budget narrative for Rutland Regional Medical Center.

It describes significant changes in operations and highlights areas of interest as have been identified by the Green Mountain Care Board. We have followed the format as provided.

Judi K. Fox
CFO
Attachments
cc: Claudio Fort

FY 2019 Hospital budget Guidance and Reporting Requirements

Narrative Instructions

The budget narrative, a key component of the budget submission, provides the hospitals an opportunity to explain any changes in their budgets and highlight areas of interest for the GMCB. We ask hospitals **to answer each question succinctly, and to strictly follow the format below** by responding in sequence to each of the listed sections (1-15).

1. ***Executive Summary***. *Summarize the changes in the hospital budget submission. Include any information the GMCB should know about programmatic, staffing, and operational changes.*

Rutland Regional Medical Center has met the Green Mountain Care Board's net patient service revenue growth trends in 2019. Our overall budget includes a net revenue growth of 3.2%, which includes 0.4% to support healthcare reform activities. Our 2019 Budget is supported by the 2018 projection and demonstrates reasonable trends from reporting period to reporting period. Volume projections are consistent with actual volume in 2018.

Reimbursement assumptions are supported by proposed regulations from Medicare and Medicaid and specific commercial payer contracts. The largest impact to reimbursement relates to the change in reimbursement related to knee procedures. As of January 1, 2018, Medicare and Medicaid will reimburse knee procedures based on outpatient rates. The impact of this to Rutland Regional Medical Center is a $1.4 million loss of revenue. In addition, we have assumed the proposed Medicaid outpatient prospective payment reimbursement reduction that was published on June 6, 2018. The change in payment reduces Medicaid outpatient payments by $994,000 to Rutland Regional Medical Center.

Rutland Regional Medical Center is expanding its retail pharmacy to include a "meds to beds" program that will allow patients who are being discharged from the hospital to fill their prescriptions at our pharmacy before leaving. This will improve our patient's understanding of their medications and medication compliance. We plan to hire 2.5 FTEs and incur $250,200 of costs to expand the program. The expansion of the "meds to beds" in the retail pharmacy program is expected to generate $1.1 million in revenue. Rutland Regional Medical Center continues to expand the 340B program by contracting with more retail pharmacies. Our 2019 budget includes new 340B contracts for Price Chopper, and 3 specialty pharmacies, and is budgeted to increase in net revenue by approximately $600,000.

Overall Rutland Regional Medical Center's cost structure has increased budget to budget by 4.1%. We have included a 3% wage increase, effective in December 2018. Our Union contract expires in September 2018 and we will be renegotiating rates for the RN bargaining unit. There is immense upward market pressure on RN and physician salaries nationwide. We have also budgeted funds (approximately .75%) to support recruitment efforts in positions, particularly in those areas (RNs, MDs and Techs) where we face highly competitive hiring environments. We have assumed a 3% inflation factor for most supply expenses, but do anticipate that our pharmaceutical costs will rise at a much

greater rate. Our 2019 budget estimates pharmacy costs will rise by 4.8%. Expenses related to contractual obligations have been budgeted consistent with contract terms.

A significant amount of effort was placed on cost control activities. In part, our cost control efforts are related to our membership in a group purchasing organization, Vizient, and our participation in specific cost control initiatives. Our budget includes the following cost savings:

- Pharmaceutical $ 345,000
- Supplies $ 300,000
- 3rd Party Transcription $ 137,000
- Position Eliminations $1,379,000
- Discretionary Spending $ 237,000

2. ***Payment and Delivery Reform***. *Describe how the hospital is preparing for and investing in value-based payment and delivery reform and implementation of the All-Payer Model for FY 2019 and over the next five years. Include answers to the following questions:*

   A. *Has the hospital signed a contract with OneCare Vermont? If yes, for which payers? If not, explain (and skip B. through E., below.)*

   Rutland Regional Medical Center has not signed a contract with OneCare Vermont for 2018. We have requested to be included in the data modeling for all programs and will make a final decision before we formally present our budget in August. Our current assumption is that we would initially join OneCare Vermont for Medicaid only. The assumption is based on 11,000 attributed lives and a total cost of care for all hospital services of $40.1 million. The covered lives and cost of care assumptions are based on a limited set of data. This information will be updated once we receive the OneCare data.

   B. *What is the amount of FPP the hospital expects to receive in FY 2019 based on estimated attributed lives?*

   Rutland Regional Medical Center does not employ primary care physicians and therefore any funds paid to primary care for population health, care coordination or quality, are withheld from payments that we receive. Based on a total estimated cost of $40.1 million, Rutland Regional Medical Center expects to receive $26.6 million, before withholds. We calculate the aggregated withholds to be $682,000, before any consideration for quality and the Accountable Care Organization administrative fee of $330,000. Given the withholds and administrative fee we expect our fixed payment to be $25.5 million.

   Refer to Appendix A

C. *What is the maximum upside and downside risk the hospital has assumed?*

Based on the limited data modeling, we calculate the maximum risk/reward to be $1.2 million. This is based on the current risk corridor of 100% of a 3% corridor.

When you include the administrative cost of OneCare, and the primary care payment enhancements, our total downside risk is $2.4 million with an upside reward of less than $200,000.

Refer to Appendix A

D. *How is the risk (up and downside) accounted for in the financials?*

i. *How will the hospital manage financial risk while maintaining access to high quality care and appropriate levels of utilization?*

We believe that the key to managing financial risk is to develop a robust care management system, that supports the patient relationship with their primary care provider, as the basis for optimizing health care utilization. Toward that end, Rutland Regional Medical Center is working closely with our community partners to develop a community-wide care management system which will deliver coordinated, patient-centered, and primary care focused health services. This management system will reduce avoidable hospital utilization and improve the health status of our patients. Rutland Regional Medical Center and the Community Health Centers of the Rutland Region have jointly funded a Director of Care Management position to lead this collaborative work across inpatient, outpatient, and specialty care settings. There are two key initiatives at the center of the Care Management System. These key initiatives are focused on the relationship between the hospital and primary care, and will also include home health, mental health, and other providers in the future.

First, we have developed and implemented a Shared Care Plan that can be used to coordinate care for patients with complex medical needs. The Shared Care Plan was developed using patient identified health goals and can be accessed by all members of the health care team. This tool is also available to support the needs of all patients, without regard for payer. Currently there are over 120 patients who have active Shared Care Plans in place.

The second major initiative of the Care Management System is the alignment of inpatient and outpatient care teams that provide longitudinal provider-patient and provider-provider relationships. Inpatient care has been shifted to a patient based provider assignment, instead of a unit based assignment. This model allows for patients to have the same team of physicians, case managers, social workers, and therapists working with them each time they are admitted, regardless of the unit or bed to which they are assigned. Additionally, the team assignments are aligned with the patient's primary care physician. If the patient has the same primary care provider, they will have the same inpatient team. This model allows for inpatient and outpatient teams to collaborate more effectively and efficiently, improving continuity of care and mutual accountability for the long-term health status of our shared patients.

Rutland Regional Medical Center has not assumed any upside or downside risk. Our projections assume that we will meet the projected cost of care targets for the 2019 Medicaid model. We have an operable Clinical Integrations Committee that is working to manage care between primary care and hospital services with the goals of decreasing utilization and improving quality.

ii. *How will the hospital track and ensure that provider financial incentives do not have a negative impact on patient care?*

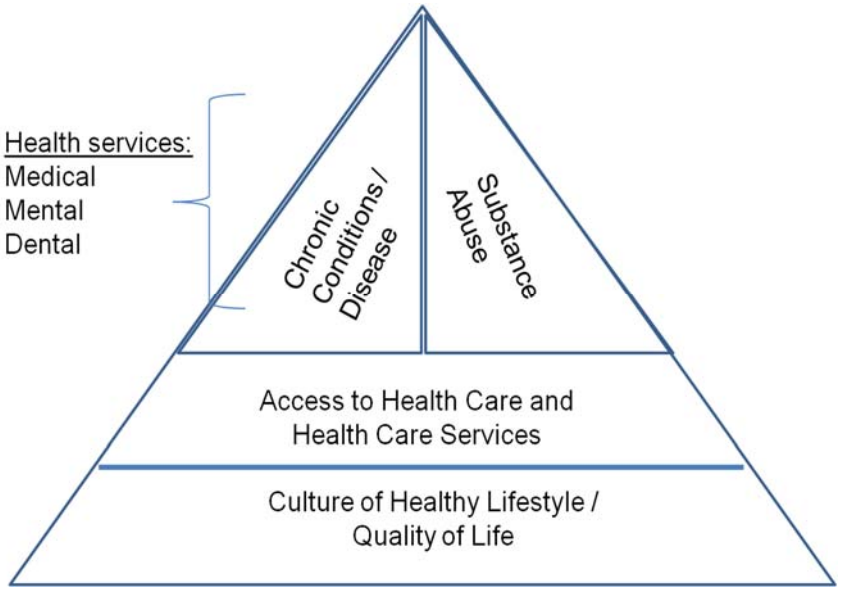
Rutland Regional Medical Center does not change provider financial incentives based on payer or inclusion in risk models. Providers assume all clinical decision-making authority to ensure the best outcome for the patient.

E. *What amount of Other Reform payments does the hospital expect to receive from OneCare Vermont by the end of calendar year 2018? (e.g., payments from OneCare's Value-Based Incentive Program based on quality performance)*

Rutland Regional Medical Center does not expect to receive any OneCare quality payments in 2019. Most of the primary care physicians are employed by Community Health Centers of the Rutland Region, and none are employed by Rutland Regional Medical Center. Therefore, all quality payments would be paid to Community Health Centers of the Rutland Region or other supporting providers. Likewise, although the primary care payment enhancements will be funded by Rutland Regional Medical Center, we will not receive any of the primary care enhancement funding.

3. ***Community Health Needs Assessment***. *Describe the hospital's initiatives addressing its population health goals as identified in the CHNA.*

The most recent Community Health Needs Assessment that was completed in 2015 involved discussion of the many projects and programs that are working to address needs across our community. These needs have been identified through earlier assessments, while drawing our attention to some changes in the needs of our community. These changes are due in part to the changing culture of health and health care. In some ways, we began to think bigger, and in others we found ourselves more focused on specific issues within a category of interest. For example, we continue to see the relationship of health needs, services, and culture in Rutland County, as depicted in the diagram below, but we are seeing more interest and emphasis on strengthening the foundation through culture change.



Community Health Improvement is a broad term that encompasses many aspects and elements from the individual to the health system as a whole. Considering this, and trying to target key issues that will have a significant impact on our community, these are the priority areas we have identified:

Factor	Key issues to address	Importance
Clinical Care	➢ Mental health and substance abuse services for adults and youth. ➢ Recruitment and retention of primary care providers, both medical and dental.	✓ To continue to address the drug problem in our community, through treatment, aftercare, and prevention. ✓ To continue to improve access to care for all community members.
Healthy Behaviors	➢ Life skills for youth ➢ Physical activity for and by adults and youth	• To improve and promote healthy choices and activities to support a healthy community in which to live and raise a family.
Social & Economic Determinants	➢ Recruitment and retention of businesses and people to the area ➢ Societal culture building ➢ Educational attainment	• To improve the health and well-being of our community, making it an attractive place to live and work.
Physical Environment	➢ Housing ➢ Transportation, vehicular	• To improve infrastructure to support a healthy community with access to work, recreational opportunities, and services.

As the priority areas identified through the Community Health Needs Assessment overlap, there are shared purposes of many of the initiatives outlined here. We need the strength of the triad – the hospital's activities, policy change, and community commitment to realize change in the health status of our community and its members.

Rutland Regional Medical Center leads and partners in many collaborative initiatives to address issues of access and utilization of health care services, and to improve and promote healthy choices and behaviors. We support community organizations that work to influence social, physical, and economic factors that are beyond the scope of a healthcare organization's control or expertise. In our rural community, collaboration and coordination are both necessary and beneficial to affecting change. This

Implementation Strategy highlights the actions Rutland Regional Medical Center will employ that are new or significant improvements, building upon existing efforts, to address the prioritized health needs.

Priority #1:	**Mental health and substance abuse services for adults and youth**
Anticipated impact:	• Reduce barriers to care. • Identify issues early to reduce substance abuse. • Improve recovery success. • Reduce inappropriate utilization of services.
Goals:	Increase number of people receiving treatment; Reduce waitlist occupancy; Reduce high school senior binge drinking and misuse of prescription drugs.
Activity:	**Operationalize and integrate Screening, Brief Intervention and Referral to Treatment (SBIRT) model in the Emergency Department at Rutland Regional Medical Center.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center, State of Vermont
Performance Measures:	Number of areas SBIRT employed at Rutland Regional Medical Center; Number of screens completed.
Outcome:	With the assistance of a grant through ADAP, Rutland Regional Medical Center added two full-time substance abuse clinicians who provided SBIRT services to the Emergency Department. Annually, the SBIRT Clinicians screen approximately 3,300 patients, provide 180 brief interventions, and 80 referrals to treatment. Although State funding for this program ended on June 30, 2018, Rutland Regional Medical Center is working to integrate these staff and the core SBIRT functions into the Social Work staffing for the Emergency Department beginning in July 2018.
Activity:	**Medication Assisted Treatment expansion at West Ridge Recovery Center, the opiate treatment hub owned and operated by Rutland Regional Medical Center.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center, State of Vermont
Performance Measures:	Number of patients served; average waitlist occupancy; wait time for appointment.

Outcome:	The West Ridge Center continues to serve between 400 and 425 patients daily. Through streamlining of internal workflows (entry into treatment) and collaboration with SPOKE partners (timely transfer out of treatment), they have successfully eliminated the waitlist for Hub services since January 2018.
Activity:	**Expansion of opiate treatment SPOKEs, by providing support to embed nursing and clinical addictions/behavioral health counselors in practices prescribing buprenorphine.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center, SPOKE Practices
Performance Measures:	Number of SPOKE sites; Number of FTEs; Number of patients served; Increase in SPOKE capacity.
Outcome:	We have increased the number of patients receiving SPOKE services from 358 in 2015 to more than 450 in 2018.
Activity:	**Support the expansion of Community Health Centers of the Rutland Region, our federally qualified health centers, to additional primary care locations, and through exploration of models of service delivery (transitions of care, case management, care coordination).**
Lead Organization/ Partner(s):	Rutland Regional Medical Center, Community Health Centers of the Rutland Region
Performance Measures:	Number of primary care sites.
Outcome:	During this implementation Community Health Centers of the Rutland Region has added a primary care practice in Shoreham, increased their behavioral health services, expanded dental services, and expanded urgent care capacity at Rutland and Castleton.
Activity:	**Implementation and promotion of a Tobacco Free Support Group, to bridge the gap between cessation and sustainability, in collaboration with our community partners.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center, Evergreen Substance Abuse Services, Turning Point Center of Rutland, and Rutland Area Prevention Coalition
Performance Measures:	Number of sites; Number of groups offered; Number of attendees.

Outcome:	This program was offered weekly for more than six months, with very limited patient participation/demand. At the suggestion of the participants who were involved, the program was rolled into the tobacco cessation program.
Activity:	**Tobacco Cessation programming through community-based workgroups.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center
Performance Measures:	Number of sites; Number of workshops; Number of attendees.
Outcome:	In FY 17, we held 47 tobacco cessation workshops at 6 sites, and had 131 completers. Additionally, Rutland Regional Medical Center is working with Vermont Department of Health to initiate a Maternal Smoking Cessation Program for identified pregnant women using tobacco (work began in March 2017). Also, the Inpatient Tobacco Cessation program is under way to support tobacco cessation for inpatients, which began under the All-Cause Readmission project (January 2018). For 2018, we have increased our number of Tobacco Treatment Specialists from 4 to 8.
Activity:	**Continue our recruitment and retention efforts, particularly for medical providers, and psychiatric providers for adults and children.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center, Community Health Centers of the Rutland Region, Rutland Mental Health Services
Performance Measures:	Number recruited; Number of FTEs primary care.
Outcome:	Rutland Regional Medical Center continues to support recruitment of psychiatric providers throughout the community. Rutland Regional Medical Center has filled all vacancies in psychiatric services and has expanded its staff by 1 full-time psychiatrist.

Priority #2: **Promote a Healthy Culture by positively influencing Healthy Behaviors, Social and Economic Determinants, and Physical Environment**

Anticipated Impact:

- Improve and promote healthy choices and activities.
- Improve the health and well-being of our community.
- Improve infrastructure to support a healthy community with access to work, recreational opportunities, and services.

- Increase skills, for person and family.

Goals:

- Increase number of people eating recommended fruits and vegetables.
- Increase percent of Rutland residents that are physically active.
- Reduce Rutland County residents reporting poor mental health days.
- Improve educational attainment.
- Reduce percent of Rutland County residents using tobacco.
- Increase rate of exclusive breastfeeding.

Activity: **Rutland Regional Medical Center to grant funds to community-based projects that aim to improve the health status of residents in the Rutland Region through the Bowse Health Trust.**

Lead Organization/ Partner(s): Rutland Regional Medical Center

Performance Measures: Number of programs funded; Amount of funding awarded.

Outcome: In FY 17, Rutland Regional Medical Center funded 10 community based programs (3 new) for $262,344. In FY 18 we have budgeted $300,000 in community funding.

Activity: **Explore and implement health and wellness services and/or facilities to respond to community health and wellness needs, in collaboration with community partners.**

Lead Organization/ Partner(s): Rutland Regional Medical Center

Performance Measures: Number recruited, Number of programs offered.

Outcome: Rutland Regional Medical Center sponsored the following programs:

- Healthy Homes Initiative – in partnership with Neighborworks of Western Vermont, we offer grant and low-cost loans to Rutland Regional Medical Center patients whose home environments are contributing to their overall health status or increased healthcare utilization.
- Community Care Management System – In collaboration with Community Health Centers of the Rutland Region, a coalition of physician leaders from both organizations has been developed to oversee the development of a single care management system. A

jointly funded Director has been hired and an electronic Shared Care Plan has been implemented for use across the local healthcare community.

Activity:	**Support and promote tobacco free public places, housing, etc. through policies, ordinances and culture change.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center
Performance Measures:	Number of new sites.
Outcome:	Rutland Regional Medical Center initiated a tobacco free campus in 2016. In addition, our Tobacco Treatment Specialist, working through our Community Health Team, has consulted with other major employers in the community to develop tobacco free workplace policies which we expect to be implemented later in 2018.
Activity:	**Operationalize and implement the Centering Pregnancy model for pregnant women, to improve outcomes by engaging patients and promoting healthy choices, such as breastfeeding.**
Lead Organization/ Partner(s):	Rutland Regional Medical Center
Performance Measures:	Number of participants; percent of participants making one health promotion change; percent of breastfeeding at discharge.
Outcome:	Building on the success of Rutland Regional Medical Center's Centering Pregnancy, we helped secure funding and technical support for Community Health Centers of the Rutland Region's Pediatrics to develop a Centering Parenting Program. This is an evidence-based program that has been shown to significantly improve the number of well-child visits attended and to improve skills for new parents. Groups recently began in early 2018 and data is not yet available.

4. ***Quality Measure Results***. *Review Appendix IV, and provide a response to health service area, county or regional performance results for each of the All-Payer Model quality measures. Discuss outcomes, goals, and plans for improvement.*

Vermont All-Payer Model Quality Measures by Hospital Service Area

Measure	Statewide Rate *(All-Payer Model Target)*	Rutland	Outcomes, goals, and plans for improvement
Percentage of Medicaid adolescents with well-care visits	**50%**	44%	Since Rutland Regional Medical Center does not offer any primary care services, we work in partnership with Primary Care Providers through the development Community Care Management System, as well as the Community Collaborative, to address a variety of chronic health conditions. The goals of both work groups include development of clinical pathways that support access to specialist care, improved care navigation, increased provider to provider communication, and utilization of community-wide shared care plans for patients with high medical complexity.
Diabetes HbA1c poor control (part of Medicare composite measure)	**10%**		
Controlling high blood pressure (part of Medicare composite measure)	**67%**	67%	
Appropriate asthma medication management (75% compliance)	**52%**	58%	
Initiation of alcohol and other drug dependence treatment	**36%**	37%	SBIRT Services have been provided in the Emergency Department which resulted in 33 patients being referred to treatment. When medically indicated, we offer inpatient alcohol detoxification services, and to people withdrawing from other substances, when accompanied by additional medical complexities or psychiatric issues. While patients are admitted we support 12-step participation on-site and facilitate step down to the most appropriate level of care. Although State funding for this program ended on June 30, 2018, Rutland Regional Medical Center is working to integrate these staff and core SBIRT functions into the Social Work staffing for the Emergency Department beginning in July 2018.
Engagement of alcohol and other drug dependence treatment	**17%**	19%	Through our collaborative work with the Evergreen Center, and Recovery House through Project Vision, we have identified that the number of patients entering either residential treatment or Intensive Outpatient Treatment has been declining over recent years. However, we do not believe that the incidence rate of alcohol addiction has been going down in our community. Over the next year we will be initiating a collaborative effort to increase the number of patients accessing appropriate treatment for alcohol addiction.
30-day follow-up after discharge for mental health	**68%** (60%)	74%	To facilitate post-hospital follow-up for mental health services, we have created dedicated time slots for new patients at Rutland Regional Behavioral Health. These slots are held open specifically for patients being referred from our Emergency Department following a

			crisis screening, and patients being discharged from inpatient Psychiatry. We have also been working very closely with Community Health Centers of the Rutland Region to streamline access to follow-up care. Community Health Centers of the Rutland Region is the largest provider of outpatient mental health services in Rutland County.
30-day follow-up after discharge for alcohol or other drug dependence	**27%** **(40%)**	28%	As stated above, through our collaborative work with the Evergreen Center and Recovery House through Project Vision, we have identified that many patients entering either residential treatment or Intensive Outpatient Treatment, have been declining over recent years. We do not, however, believe that the incidence rate of alcohol addiction has been going down in our community. Over the next year we will be initiating a collaborative effort to increase the number of patients accessing appropriate treatment for alcohol addiction. Patients needing treatment for opiate addiction or other drugs are referred to residential services or outpatient care. Opiate addicted pregnant women, and patients with life threatening medial complexities related to opiate drug use, are inducted with methadone or buprenorphine while admitted and begin outpatient treatment at the West Ridge Center immediately upon discharge.
Percentage of adults reporting that they have a usual primary care provider	88% (89%)	88%	Any patient admitted to Rutland Regional Medical Center who does not have a primary care provider is offered assistance with obtaining one through Community Health Centers of the Rutland Region.
Prevalence of chronic disease: COPD	6% (≤7%)	9%	In FY 17, we held 47 tobacco cessation workshops at 6 sites, and had 131 completers. Additionally, Rutland Regional Medical Center is working with Vermont Department of Health to initiate a Maternal Smoking Cessation program for identified pregnant women using tobacco (work began in March 2017). Also, the Inpatient Tobacco Cessation program is under way to support tobacco cessation for inpatients, begun under the All-Cause Readmission project (which began in January 2018). For 2018, we have increased our number of Tobacco Treatment Specialists from 4 to 8.
Prevalence of chronic disease: Hypertension	25% (≤26%)	28%	Through the All Cause Readmission Collaborative, the Rutland Heart Center has been working with primary care providers to develop consistent screening and referral guidelines for patients with hypertension.
Prevalence of chronic disease: Diabetes	8% (≤9%)	10%	Through the Community Health Team, Rutland Regional Medical Center offers two self-management programs aimed at diabetes. Prevent T2 is our diabetes prevention course, for which we have 2 local trainers, and are working to run 3 classes per year (each class being approximately 1-year long). We also run the Diabetes Self-Management Program from the Self-Management Resource Center, formerly the Stanford Patient Education Research Center. These are 6-week courses for which we try to run a minimum of 4 per year.

# per 10,000 population ages 18-64 receiving Medication Assisted Treatment for opioid dependence.	**6,110 (155.4)** ***150***	732 (202.1)	As the regional Hub, the West Ridge Center serves between 400 and 425 patients daily. We believe this clinic is right-sized for our community and have no plans to expand at this time. We will continue to focus on shortening the length of time from referral to initiation of treatment.
Deaths related to drug overdoses	122 (2.2) *(115)*	11 (2.1)	The West Ridge Center has moved to an "Open Access" model of intake which allows patients who meet clinical criteria to enter treatment within 7 days from referral. Partnered with other local treatment providers to ensure that there is "no wrong door" for entry into substance abuse treatment.
Rate of Growth in number of mental health and substance use-related ED visits	**6%** *(3%)*	9%	We believe this unsustainable rate of growth (32% over the past 5 years) is directly related to the chronic underfunding of our Community Mental Health Centers which has resulted in a loss of mobile crisis outreach capacity, elimination of accessible outpatient psychiatric services for children, and the inability to develop best practice outpatient models such as Dialectical Behavior Therapy, Assertive Community Treatment, and supportive housing. Rutland Regional Medical Center built a 5-bed psychiatric crisis wing in our Emergency Department that is overflowing most days. We are working closely with our Community Mental Health Center to identify ways that we can support increased mobile crisis services.

5. ***Mental Health****. Provide the following information:*
   A. *The number of mental health beds;*

      Rutland Regional Medical Center has 23 inpatient beds on our Psychiatric Services Inpatient Unit, with six of those beds being designated as Level 1 beds for the State. In addition, we maintain five beds in our Emergency Department in an area that has been specially designed to accommodate patients in psychiatric crisis. The Emergency Department beds are staffed by Emergency Department nursing staff and specially trained psychiatric technicians who are shared with the Psychiatric Services Inpatient Unit.

   B. *The number of patients who waited in the emergency department for an available mental health bed at this hospital or at another facility;*

      See table below.

   C. *The range and average time patients spend in the emergency department awaiting an appropriate mental health placement;*

      See table below.

	FY 2013	FY2014	FY2015	FY2016	FY2017	5-Year Trend	%Change (2013-2017)
No. Holds	1166	1305	1484	1499	1538		32%
Average Holds/Day	3.19	3.57	4.05	4.10	4.20		32%
Total Time (hours)	10863	14850	19399	19192	23349		115%
Total Time (days)	453	619	808	800	973		115%
Average Hold (hrs)	8.9	11.1	13.1	9.3	12.3		38%
Min Hold (hours)	0.30	0.54	0.30	0.75	0.68		128%
Max Hold (hours)	284	216	311	283	310		9%
Avg. No. Holds >8 hours	35	43	54	61	73		108%

D. *Average cost per day for patients awaiting transfer:*

The additional cost per day of patients awaiting transfer in the Emergency Department is $866. This cost is over and above the cost of the clinical and ancillary services incurred as part of the initial treatment and assessment. The additional costs relate to patient supervision, nursing and security resources required to appropriately care for the patients.

E. *List and describe each initiative, program or practice the hospital has implemented, or plans to implement, that focuses on ensuring that Vermonters have access to high quality, timely, and appropriate mental health treatment.*

Rutland Regional Behavioral Health

This team provides interdisciplinary outpatient behavioral health services by providing indicated clinical services to patients through a team that includes psychiatrists, psychologists, advanced practice registered nurses, and licensed clinical social workers. This team provides diagnostic assessments, limited care coordination, group psychotherapy, family therapy, couples therapy, individual psychotherapy, individualized treatment planning, and clinical services that are indicated from the diagnostic assessment. This team provides services Monday through Friday, 8:00a.m. to 5:00p.m., and provides crisis on-call services, when the clinic is closed, via a pager.

Psychiatric Services Inpatient Unit

The Psychiatric Services Inpatient Unit is a twenty-four hour per day locked unit that is located on the fourth floor of Rutland Regional Medical Center. It is an adult unit, servicing individuals from 18 years of age up through the lifespan, who are experiencing a wide array of psychiatric conditions. The unit provides both voluntary and involuntary inpatient services including: intensive psychiatric care, dual diagnosis treatment, detoxification, consultation, and liaison. Clinical services are provided by a multidisciplinary team consisting of: psychiatrists, mid-level providers, nurses, social workers, nurse care manager, an occupational therapist, and

psychiatric technicians. The teamwork is guided by the following collaboratively developed vision: “PSIU thrives on the foundation of innovative leadership, teamwork, and confident engaged professionals who are supported, valued, and respected for individual strengths and diversity. We provide exemplary caring in an empathic, respectful, supportive environment, and take pride in our accomplishments. We create opportunities for growth, and excel in all that we do. We build on the foundation of the past, live in the present, and embrace the future.” The philosophy of the unit was developed collaboratively with the Community Advisory Committee and states: “We believe recovery is possible for all people. We provide patient centered care in a mutually respectful, collaborative environment.”.

Psychiatric Intensive Care Unit

The South Wing 6 bed Psychiatric Intensive Care Unit provides a vital statewide resource for adult psychiatric admissions for patients with severe psychiatric illness that need intensive treatment services. Clinical services are provided by a multidisciplinary team of psychiatrists, a psychologist, mid-level providers, nurses, social workers, a nurse case manager, occupational therapy, and psychiatric technicians.

Emergency Department 5-bed Psychiatric Crisis Wing

A new 5 bed wing in the Emergency Department (ED East Wing) provides a comfortable area for psychiatric patients who are waiting to be screened, or are awaiting disposition. This area of the Emergency Department has been specially designed to accommodate psychiatric crisis patients with single rooms with natural light, limited ligature risks, comfortable seating areas and accessible common space. It is protected from the usual chaos and stimulation associated with tradition Emergency Department treatment spaces and respects the dignity, privacy, and confidentiality of the person seeking care. The space includes a secure area outside the treatment room where a patient can safely move about and engage in therapeutic activities when clinically appropriate. It also includes private access to basic facilities, such as a bathroom and shower. When these rooms are utilized for non-psychiatric patients, or for psychiatric patients with acute medical needs, locked cabinet doors can be opened within the room to allow access to gases, suction, and medical equipment that might otherwise pose a risk.

In addition to ED Nursing, the East Wing is staffed by a team of specially trained Psychiatric Technicians who provide 24/7 direct supervision of patients to ensure patient safety. We have a team of 16.8 fixed FTEs who are augmented by staffing from the inpatient psychiatric unit during peak demand. All the staff providing direct supervision of patients in psychiatric crisis are oriented in the Six Core Strategies, an evidence-based model to minimize the use of seclusion, restraint, and emergency medications (i.e., emergency involuntary procedures). Additionally, they are trained and oriented on the inpatient psychiatric unit to ensure consistency in application of procedures, to maximize patient and staff safety while minimizing emergency involuntary procedures.

Embedded Social Work

This team provides Social Work services and education in the outpatient medical clinics for Rutland Regional Medical Center. This team is responsible for education, psychotherapy, short

term brief intervention, health coaching, resource linkage and referral, individualized treatment planning prevention groups and education, diagnostic assessments and indicated clinical services to patients in each clinic. This team can also provide inpatient medical resources and referrals, and discharge planning when a patient is admitted to a medical unit at Rutland Regional Medical Center. This team is staffed Monday through Friday, 8:00a.m. to 4:30p.m.

De-escalation Training for All Staff

All staff providing supervision of patients in psychiatric crisis maintain active certification in Nonviolent Crisis Intervention through the Crisis Prevention Institute (CPI). The training focuses on prevention, and equips staff with evidence-based strategies for safely defusing anxious, hostile, or violent behavior at the earliest possible stage.

Psychiatric and Social Work Consultation

Our employed psychiatrists assist Emergency Department staff in the provision of clinical services for patients in psychiatric crisis through direct patient assessment and on-call support to the community mental health center crisis team. With increasing demand in the Emergency Department for psychiatric services, we have also expanded our psychiatry staffing to provide coverage 7 days a week.

Suicide Risk Screening

Every patient seeking services in our Emergency Department is screened for suicidal ideation, and admitted patients are screened at least once per shift as part of regular nursing assessment procedures. Additionally, we have implemented use of the Columbia Suicide Severity Rating Scale (C-SSRS), an evidence based tool for suicide, into the assessment procedures for all patients presenting in the Emergency Department in psychiatric crisis and on our inpatient psychiatric unit. Through our Social Work Department, we have also provided training on the C-SSRS to more than 100 members of the community including: community mental health center staff, schools, primary care offices, and private mental health professionals. For more information on the C-SSRS see: http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english.

Community Leadership

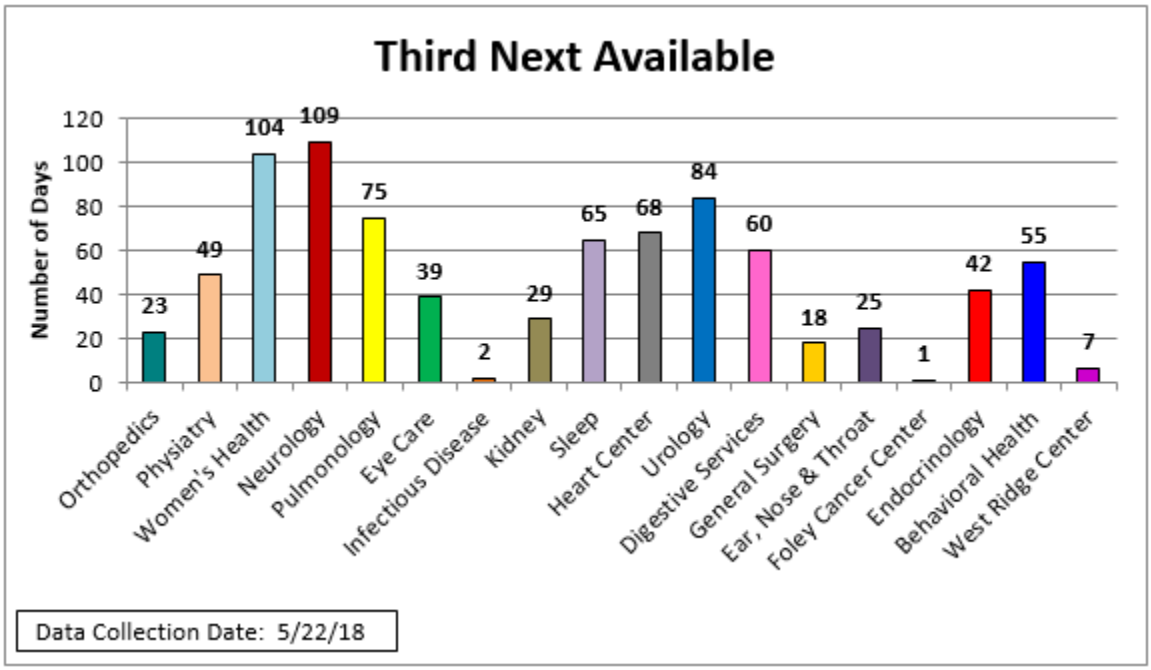
Rutland Regional Medical Center staff provide leadership on two community-wide committees that seek to coordinate services for patients with mental health and substance abuse issues. First, Rutland Regional Medical Center staff lead the Behavioral Health Committee of our Community Collaborative. The Community Collaborative is made up of health care professionals representing all aspects of our local system of care who meet regularly to coordinate efforts to achieve community-wide health targets. Second, Rutland Regional Medical Center staff lead the Health Committee of Project Vision, a grass-roots community-wide initiative, that seeks to make Rutland one of the happiest, safest, and healthiest of communities in the country. The Project Vision Health Committee is made up of healthcare professionals, advocates, political representatives, and many community residents with interest in improving community health. Through the work of these groups we have made considerable

progress in designing and implementing systems that ensure that mental health and substance abuse services are better coordinated, easier to access, and have more flexibility to meet individual patient needs.

6. ***Patient access***. *Provide wait times, by medical practice area, for the "third next available appointment," as defined by the Institute for Healthcare Improvement (IHI)* http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx. *For hospitals that do not use this measure, describe wait times and how they are currently measured.*

Third Next Available Appointment

Using the IHI Primary Care *Third Next Available* appointment definition (as of 5/22/18), the third next available appointment by each of Rutland Regional Medical Center's eighteen specialty clinics is as follows:



7. ***Substance use disorder treatment programs.*** *Describe the hospital's substance use disorder (SUD) treatment programs, and provide the following information:*

A. *A description of the hospital's full range of SUD treatment programs;*

West Ridge Center

West Ridge Center is a state designated Hub for medication assisted treatment in Rutland County. This program serves more than 400 patients daily who are addicted to opiates. We provide professional, confidential, evidenced based counseling and pharmacotherapy to individuals who are opioid dependent. West Ridge Center is an outpatient, hospital-based program that offers the following services:

- Pre-screening/referral information.
- Intake.
- Medication assisted treatment.
- Assessment of opioid dependence and other substances.
- On-site urinalysis screening.
- Breathalyzer.
- Pregnancy testing.
- Medical evaluation, screening, medication education.
- Recovery treatment planning (individual and group).
- Case Management.
- HIV and hepatitis education/referral for testing and/or on-site testing.
- Take home medications for those who meet eligibility requirements.
- Overdose rescue training including Narcan kits and CPR training.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Through a grant from the Vermont Department of Alcohol and Drug Abuse Programs, Rutland Regional Medical Center has provided two full-time staff in our Emergency Department, screening all patients for substance use disorders. When screenings are positive, they offer brief interventions using motivational interviewing strategies, and assist people with finding appropriate follow-up care. In addition, they have served as a liaison to residential and outpatient treatment programs, assisting with transfers of patients in either direction. Although State funding for this program ended on June 30, 2018, Rutland Regional Medical Center is working to integrate these staff and the core SBIRT functions into the Social Work staffing for the Emergency Department beginning in July 2018.

B. *The number of patients currently enrolled in medication-assisted treatment (MAT) programs and other SUD programs; and*

Through the West Ridge Center, we treat between 400 and 425 patients daily.

C. *The number of MAT providers and other SUD providers employed by the hospital.*

We have 2 MAT providers that work through the West Ridge Center.

8. ***Health Reform Investments.***

Part I: Provide updates on all health reform activities submitted under the GMCB's extended NPR cap for FYs 2016 – 2018 including:

Refer to Appendix B (for responses to A-F as well).

A. *The amount of the investment;*
B. *The goals of the program;*
C. *Metrics and other evidence demonstrating the program's ability to meet these goals, highlighting metrics and other evidence that demonstrate alignment with the goals of the All-Payer Model:*
D. *Any other program outcomes, positive or negative;*

E. *Whether the program is ongoing or of limited duration, and why;*

F. *For any program that has been discontinued, describe how ending the program has or will be accounted for in past, current or future budgets.*

Part II: Complete the Table at Appendix V.

Our current assumption is that we would initially join OneCare Vermont Accountable Care Organization for Medicaid only. Rutland Regional Medical Center does not employ primary care physicians and therefore any funds paid to primary care for population health (PMPMs), care coordination or quality, are essentially withheld from payments that hospitals receive. Based on limited data from OneCare, Rutland Regional Medical Center's cost of entry to participate in the OneCare Medicaid program is $1.1 million. We are requesting the additional healthcare reform funds (0.4% NPR) to support the cost.

Refer to Appendix C

9. ***Reconciliation.*** *Provide a reconciliation between FY 2018 approved budget and FY 2018 YTD, showing both positive and negative variances. Explain the variances.*

Rutland Regional Medical Center
Reconciliation of FY 2018 Approved Budget to FY 2018 Projection

OPERATING REVENUE	FY18 Budget	FY 18 Projection	Variance	
Patient Service Revenue	$ 530,938,311	$ 551,322,959	$ 20,384,648	Note A
Total Deductions	$ (272,539,162)	$ (288,174,593)	$ 15,635,431	Note B
Provision for Free Care	$ (6,121,719)	$ (3,969,525)	$ (2,152,194)	Note C
Provision for Bad Debt	$ (5,309,383)	$ (9,553,196)	$ 4,243,813	Note D
Provision for Medicaid DPS Payments	$ 3,995,289	$ 3,995,289	$ -	
Net Patient Service Revenue	$ 250,963,337	$ 253,620,934	$ 2,657,597	
Other Operating Revenue	$ 12,290,376	$ 13,363,394	$ 1,073,018	Note E
Total Operating Revenue	$ 263,253,713	$ 266,984,327	$ 3,730,614	
OPERATING EXPENSES				
Salaries Payments to Physicians	$ 31,552,126	$ 32,928,897	$ 1,376,771	Note F
Total Nursing Inpatient	$ 17,608,075	$ 17,295,623	$ (312,452)	
Total Ancillary Patient Care Services	$ 41,820,531	$ 42,191,644	$ 371,113	
Total Support Services	$ 26,604,624	$ 26,008,373	$ (596,251)	
Total Salaries Excluding Physicians	$ 86,033,230	$ 85,495,640	$ (537,590)	Note G
Supplies Expense	$ 76,547,628	$ 83,712,127	$ 7,164,499	Note H
Admin & General Expense	$ 33,956,235	$ 34,214,511	$ 258,276	
CHCRR Subsidy	$ 233,306	$ 233,306	$ -	
Medicaid DPS Tax Assessment	$ 14,810,108	$ 14,736,369	$ (73,739)	
Depreciation Expense	$ 12,728,164	$ 12,231,805	$ (496,359)	
Interest & Other Bond Expense	$ 1,688,564	$ 1,382,431	$ (306,133)	
Total Operating Expense	$ 257,549,360	$ 264,935,085	$ 7,385,725	
INCOME FROM OPERATIONS	$ 5,704,353	$ 2,049,242	$ (3,655,111)	
Total Non Operating Revenue	$ 8,794,172	$ 6,443,603	$ (2,350,569)	
Excess Revenue Over Expenses	$ 14,498,525	$ 8,492,845	$ (6,005,680)	

Note A:

Overall revenue is $20.3 million over budgeted expectations. Our average daily census of 90.3 exceeded budgeted by 3.4. Inpatient revenue is up $9.4 million from budget 2018. This is a result of increased volume in our emergency department as well as diagnostic imaging and laboratory services. Outpatient volume is over budget $11.1 million led by surgical services (including endoscopy), laboratory services, pharmaceuticals and radiation therapy.

Note B:

Contractual allowances are expected to exceed budget 2018 by $15.6 million. As gross revenue increases so does the need for additional reserves, which in Fiscal Year 2018, will be approximately $10.4 million. The additional variance relates to changes in commercial payment policies and long length of stay patients. As of February 28, 2018, our Medicare average length of stay was 4.07, almost ½ day greater than budget.

Note C:

The reserve for Free Care is down when compared to the levels experienced in Fiscal Year 2017. In Fiscal 2017, there were 1,662 Free Care applications (new & renewals) approved. It is projected that in Fiscal Year 2018 this number will drop to approximately 1,450.

Note D:

The provision for Bad Debt Continues to run higher than the levels experienced in Fiscal Year 2017. As of February 2018, our year to date provision was $3.7 million, or 70% of our total Fiscal Year 2018 budget.

Note E:

There are numerous types of revenue in this category, but four subsets make up 80% of the revenue: 340B Pharmacy, Community Health Grant, Retail Pharmacy and Cafeteria Sales. Fiscal Year 2018 Other Operating Income (OOI) is over budgeted expectations by $1.1 million. The variance relates to an increase in specialty drug volume in our retail pharmacy resulting in an additional $700,000. We are also seeing increased lab utilization relating to the processing of non-patient specimens.

Note F:

Salaries and Payments to physicians is over budgeted expectations by $1.4 million. This, in large part, relates to the need for Locums coverage in our Psychiatric department resulting in an $800,000 negative variance. Recruitment efforts are in place to fill these vacancies. Additional overruns relate to the increased volume and the impact on physician salaries.

Note G:

Salaries (excluding physician) are under budget $537,000. The variance relates to vacant positions primarily in our inpatient nursing units. The organization recently implemented a Registered Nurse Hiring Program. The intent of the program is to hire 72 RNs to reduce the need for travelers and plan for anticipated retirements. As of June 1, 2018, the organization has hired 57 RNs (18 experienced & 39 new grads).

Note H:

Supplies expense (non-salary expense) is over budgeted expectations by $7.1 million. In Fiscal Year 2018 we saw an increased need to hire temporary staff due to the inability to fill vacant positions (see Note G above). This resulted in a budget overrun of $4.6 million. Consulting expense also exceeded budget by $2.0 million because of increases in our IT contract.

10. ***Budget-to-budget growth.***
    A. *Net patient revenues:*
        i. *Provide the budgeted FY 2019 NPR increase over the approved FY 2018 budget. If the GMCB rebased the hospital's budget for the purpose of calculating FY 2019, provide the budgeted increase in NPR for FY 2019 measured from the hospital's rebased budget.*

        The 2019 Budget includes a 3.2% net patient service revenue increase, 2.8% as allowed by the Green Mountain Care Board and 0.4% to support healthcare reform activities related to our proposed participation in the OneCare Medicaid risk program.

        ii. *Describe any significant changes made to the FY 2018 budget (including, but not limited to, changes in anticipated reimbursements, physician acquisitions and certificates of need) and how they affect the FY 2019 proposed budget.*

        Reimbursement assumptions are supported by proposed regulations from Medicare and Medicaid and specific commercial payer contracts. The largest impact to reimbursement relates to the change in reimbursement related to knee procedures. As of January 1, 2018, Medicare and Medicaid will reimburse knee procedures based on outpatient rates. The impact of this to Rutland Regional Medical Center is a $1.4 million decrease in net revenue. In addition, we have assumed the proposed Medicaid outpatient prospective payment reimbursement reduction that was published on June 6, 2018. The change in payment reduces Medicaid outpatient payments by $994,000.

        Our volume related to neurology services has declined budget to budget. This is a result of a physician retirement in October. We are recruiting for this position but have not been successful in attracting a second neurologist to date. The reduction in gross revenue related to the physician vacancy is $534,000.

        Rutland Regional Medical Center is expanding its retail pharmacy to include a "meds to beds" program that will allow patients who are being discharged from the hospital to fill their prescriptions at our pharmacy before leaving. This will improve our patient's understanding of their medications and medication compliance. We plan to hire 2.5 FTEs and incur $250,200 of costs to expand the program. The expansion of the "meds to beds" in the retail pharmacy program is expected to generate $1.1 million in revenue. Rutland Regional Medical Center continues to expand the 340B program by contracting with more retail pharmacies. Our 2019 budget includes new 340B contracts for Price Chopper and 3 specialty pharmacies and is budgeted to increase in net revenue by approximately $600,000.

Overall Rutland Regional Medical Center's cost structure has increased budget to budget by 4.1%. We have included a 3% wage increase, effective in December 2018. Our Union contract expires in September 2018 and we will be renegotiating rates for the RN bargaining unit. There is immense upward market pressure on RN and physician salaries nationwide. We have also budgeted funds (approximately .75%) to support recruitment efforts in positions, particularly in those areas (RNs, MDs and Techs) where we face highly competitive hiring environments. We have assumed a 3% inflation factor for most supply expenses, but do anticipate that our pharmaceutical costs will rise at a much greater rate. Our 2019 budget estimates pharmacy costs will rise by 4.8%. Expenses related to contractual obligations have been budgeted consistent with contract terms.

iii. *Describe any cost saving initiatives proposed in FY 2019 and their effect on the budget.*

A significant amount of effort was placed on cost control activities. Our budget includes the following cost savings:

- Pharmaceutical $ 345,000 – Participation in Vizient Group Purchasing
- Supplies: $ 300,000 – Participation in Vizient Group Purchasing
- 3rd Party Transcription $ 137,000 – Electronic Medical Record efficiencies
- Position Eliminations $1,377,000 - Refer to list
- Discretionary Spending $ 237,000 – Travel, catering services

iv. *Explain changes in NPR/FPP expected for each payer source:*

a. *Medicare revenue assumptions: Identify and describe 1) any significant changes to prior year Medicare reimbursement adjustments (e.g. settlement adjustments, reclassifications) and their effect on revenues; 2) any major changes that occurred during FY 2018 that were not included in the FY 2018 budget, and 3) any anticipated revenues related to meaningful use and 340B funds in FY 2019.*

2019 Budget Assumptions include:

Payment Increases

- Medicare Inpatient Rates – based on proposed regulations 1.75%
- Medicare Outpatient Rates– based on proposed regulations 1.3%
- Medicare Physician Rates– based on regulation .50%

Rate Decreases

- Impact in knee procedure payments: $1,400,000

No Impact

- 340B – Rutland Regional Medical Center is exempt from reimbursement reduction due to Sole Community status.
- Rutland Regional Medical Center is no longer eligible for meaningful use incentive payments.

b. *Medicaid revenue assumptions: Budget for net patient revenues expected from rate changes, utilization and/or changes in services.*

2019 Budget Assumptions:

Payment Increases

- Medicaid Inpatient Rates – based on State recommendation 0.5%
- Medicaid Physician Rates – based on State recommendation 0.5%

Payment Decreases

- Medicaid Outpatient – reduces payments from 96.5% of Medicare Outpatient prospective payments to 88% of Medicare Outpatient prospective payments – impact to Rutland Regional Medical Center is $994,000.

c. *Commercial/self-pay/other revenue assumptions: Commercial insurance revenue estimates should include the latest assumptions available to the hospital and any other factors that may explain the change in net patient revenues.*

2019 Budget Assumptions:

Payment Decreases

- Self-Pay Reserve – set at 2.3% of gross revenue (last year 2.1%)

v. *Complete Appendix VI, Tables 1A and 1B. If the hospital categorizes revenue differently than as indicated in the tables, provide such categories, including labels and amounts, in the "Other" rows.*

Refer to Tables 1A and 1B (also located after the Appendix).

Table 1A:
NPR Bridges - FY 2018 Approved Budget to FY 2019 Proposed Budget

NPR	Total	% over/under	Medicare	Medicaid-VT	Medicaid-OOS	Commercial-Maj	Comm - Self/Sml	Workers Comp
FY 18 Approved Budget	$ 250,966,449		$ 92,029,832	$ 28,573,614	$ 111,190	$ 111,234,258	$ 14,568,645	$ 4,448,910
Commercial Rate	2,736,216	1.090%				2,144,757	507,722	83,737
Rate - Non Commercial	(247,263)	-0.099%	0	(0)	-	-	(247,263)	-
Utilization	6,951,934	2.770%	3,848,118	1,244,502	12,333	1,417,466	1,035,681	(606,166)
Reimbursement/Payer Mix	1,710,386	0.682%	5,342,771	1,690,086	7,786	(4,668,196)	(766,455)	104,394
Bad Debt/Free Care	(1,060,318)	-0.422%					(1,060,318)	
Physician Acq/Trans	-	0.000%						
Changes in Accounting	-	0.000%						
Changes in DSH	(904,359)	-0.360%		(904,359)				
PMPM Primary care, Complex care Level 1 and 2	(682,440)	-0.272%		(682,440)				
Psych ICU and ADAP	(545,494)	-0.217%	0	0	0	0	(545,494.00)	0
FY 19 Budget	$ 258,925,111	3.171%	$ 101,220,721	$ 29,921,404	$ 131,309	$ 110,128,285	$ 13,492,518	$ 4,030,875

Table 1B:

NPR	2018 NPR	2019 Before Rate	Vol/Mix	Variance	2019 NPR	Impact of Rate
	$ -		$ -	$ -	$ -	$ -
Major NPR Contributors						
Imaging						
Perioperative & Anesthesia						
Physician Practices						
Lab						
Drugs & IV Therapy						
Emergency						
Med/Surg/SCU						
Medical/Surgical supplies						
ER & Hospitalist Physicians						
Birthing Center						
Clinics						
Rehabilitation Services						
Other (please label)						
Other (please label)	0		0	0	0	0
	$ -		$ -	$ -	$ -	$ -

B. *Expenses:*

i. *Provide the budgeted FY 2019 net expenditure increase over the approved FY 2018 net expenditure increase.*

Overall Rutland Regional Medical Center's cost structure has increased budget to budget by 4.1%

ii. *Describe any significant changes made to the FY 2018 budget (including, but not limited to, changes in costs of labor, supplies, utilization, capital projects) and how they affect the FY 2019 proposed budget. Provide assumptions about inflation and major program increases.*

We have included a 3% wage increase, effective in December 2018. Our Union contract expires in September 2018 and we will be renegotiating rates for the RN bargaining unit. We have also budgeted funds (approximately .75%) to support recruitment efforts, particularly in those areas where we face highly competitive hiring environments. We have assumed a 3% inflation factor for most supply expenses, but do anticipate that our pharmaceutical costs will rise at a much greater rate. Our 2019 budget estimates pharmacy costs will rise by 4.8%. Expense related to contractual obligations have been budgeted consistent with contract terms.

iii. *Describe any cost savings initiatives proposed in FY 2019 and their effect on the budget.*

A significant amount of effort was placed on cost control activities. Our budget includes the following cost savings:

- Pharmaceutical $ 345,000 – Participation in Vizient Group Purchasing
- Supplies: $ 300,000 – Participation in Vizient Group Purchasing
- 3rd Party Transcription $ 137,000 – Electronic Medical Record efficiencies

- Position Eliminations $1,377,000 - Refer to list
- Discretionary Spending $ 237,000 – Travel, catered service

iv. *Complete Appendix VI, Table 2. If the hospital categorizes expenses differently than as indicated in the tables, provide such categories, including labels and amounts, in the "Other" rows.*

Refer to Appendix D

11. ***Bad Debt.***

A. *Provide the amount of bad debt carried by the hospital at the close of FY 2017 that was incurred prior to FY 2016.*

In terms of expense, the amount of the 2017 bad debt expense that related to reserves for services provided prior to September 30, 2015 was $954,143.

As of September 30, 2017, the outstanding bad debt accounts receivable balance was $7,626,656. Of this amount $770,779 is related to services provided prior to September 30, 2015.

B. *If the hospital contracts with a collection agency, provide the name of the agency.*

Rutland Regional Medical Center uses two collection agencies:

- Asset Recovery, located in our service area Rutland, VT.
- CBCS located in Columbus, OH.

C. *In your opinion, explain whether the agency adheres to "patient friendly billing" guidelines. See* http://www.hfma.org/Content.aspx?id=1033.

We believe that the agencies adhere to patient friendly billing guidelines, both in terms of written and verbal communications. The statements are consistent with other healthcare statements and each of the agencies follows Rutland Regional Medical Center collections, payment and free care policies.

12. ***Rate Request.***

A. *Provide the hospital's budgeted overall rate/price increase or decrease. Explain how the rate was derived and what assumptions were used in determining the increase or decrease.*

Rutland Regional Medical Center is requesting a 3% rate increase, effective October 1, 2018. Each percent of rate increase provides approximately $912,000. The requirement of the rate increase directly relates to significant payment reductions in the Medicare and Medicaid program. The specific payment reductions are:

- Decreased Disproportionate Share Payments - $904,000
- Decreased Medicaid Outpatient Reimbursement - $994,000
- Increased Reserve for Bad Debt and Free Care - $1.4 million

B. *For each payer, if the net patient revenue budget-to-budget increase or decrease is different than the overall rate/price change – for example, if the requested commercial "ask" differs from the rate/price change – explain why they differ.*

We have budgeted to place the rate increase evenly over all payers. Any change in net reimbursement at the payer level is due to payment rule changes levied by the payer.

C. *In April/May, the GMCB will provide a rate schedule for reporting the rate/price change for each major line of business and the gross and net revenues expected from each payer as a result of the rate/price change.*

Refer to Appendix E

13. ***FY 2017 overages.*** *For those hospitals that received a letter regarding their FY 2017 budget-to-actual overages results, specifically address the issues and requirements outlined in the letter.*

Rutland Regional Medical Center did not have any budgeted overages in 2017.

14. ***Capital budget investments.*** *Describe the major investments, including projects subject to certificate of need review, that have been budgeted for FY 2019 and their effect on the FY 2019 operating budget.*

Rutland Regional Medical Center currently has 3 active Certificate of Need projects:

Upgrade Air Handling Units 1 & 2. Project Cost: $5,673,532.

The Certificate of Need for the AHU 1 & 2 was approved on May 11, 2016. Project work is expected to be completed by July 31, 2018. Total spent to date is $3,805,436.

Replacement of Nuclear Medicine Camera. Project Cost: $2,840,596.

The Certificate of Need for the Nuclear Medicine Camera Project was approved in July 2017. Project work began in mid-April 2018. Total spent to date is $127,099.

Medical Office Building, Loading Dock and VOC Renovations. Project Cost: $21.7 million.

The Certificate of Need for the Medical Office Building was approved January 23, 2018. The first phase of the project has begun and includes finalizing of the blueprint designs. Total spent to date is $51,291.

In support of the Uniform Reporting Guidelines, we are not allowed to budget expenditures related to Certificate of Need projects that have not been approved. We have not budgeted any operational expenses related to unapproved certificate of need projects.

We are planning to submit a Certificate of Need to replace our existing CT Scanner in August 2018. The estimated cost of the CT replacement project is approximately $2.03 million.

15. ***Technical concerns.*** *Explain any technical concerns or reporting issues the GMCB should examine for possible changes in the future.*

Rutland Regional Medical Center has technical concerns that relate to the completion of Table 1B.

Table 1B:

NPR	2018 NPR	2019 Before Rate	Vol/Mix	Variance	2019 NPR	Impact of Rate
	$ -		$ -	$ -	$ -	$ -
Major NPR Contributors						
Imaging						
Perioperative & Anesthesia						
Physician Practices						
Lab						
Drugs & IV Therapy						
Emergency						
Med/Surg/SCU						
Medical/Surgical supplies						
ER & Hospitalist Physicians						
Birthing Center						
Clinics						
Rehabilitation Services						
Other (please label)						
Other (please label)	0		0	0	0	0
	$ -		$ -	$ -	$ -	$ -

As requested, Rutland Regional Medical Center will not be able to complete the table. The payment methodologies that are used by Medicare and Medicaid do not support the ability to track net revenue by service line (major contributor). Both Medicare and Medicaid provide fixed payments for services based on diagnosis and complication factors. The payments received do not correlate to any particular service, nor is there any comparability of payments by service line (contributing factor) between payers. To illustrate the technical concern, and provide reasoning as to why we will not be completing the schedule, we offer the following example of two actual claims for like services, one for Medicare and one for Medicaid. What you will note is the difference in payment for the same procedure and the lack of any detailed payment information by service.

To illustrate the services for a Hip Joint Replacement, below is the summary of the revenue by service department for actual February admissions. Medicaid and Medicare reimburse the hospital for hip replacement services a single fixed amount. The surgeon reimbursement is based on the service provided.

Service Provided		Medicare Patient	Medicaid Patient
Room and Care- 1 day		$2,242.00	$2,242.00
Surgical Services		$9,821.00	$10,917.00
Supplies including Implants		$16,950.64	$19,886.85
Pharmacy		$283.95	$605.56
Radiology		$169.00	$169.00
Laboratory		$970.44	$0.00
Physical Therapy		$401.00	$706.00
Occupational Therapy		$305.00	$0.00
	Hospital Services Total	$31,143.03	$34,526.41
Physician Surgical Fee		$5,420.00	$5,420.00
Physician Assistant Surgical Fee		$1,369.00	$1,369.00
	Physician Surgical Services Total	$6,789.00	$6,789.00
Total Hospital and Physician Surgical Charges		$37,932.03	$41,315.41
Payments			
Insurance Payment for Hospital services		$16,337.34	$15,750.95
Patient Deductible Payment for Hospital services		$1,340.00	$0.00
Insurance Payment Physician Surgical Fee		$953.38	$1,082.17
Insurance Payment Physician Assistant Surgical Fee		$143.26	$243.49
Patient Payment for Physician Surgical Fee		$386.38	$0.00
Patient Payment for Assistant Surgeon Fee		$36.54	$0.00
Total Payments		**$19,196.90**	**$17,076.61**
Total Contractual Allowance or Uncollectible			
based on Government Payer plans		$18,735.13	$24,238.80
Payment Percentage			
		50.6%	41.3%

The following represents the level of payment detail that we receive. As you will note, there is no detail that provides payments by service line or contributing factor.

The Medicare payment to RRMC for hospital services is received with the information below.

TOTAL CHGS OTHER PAY COST OUTLIER MSP PAYMENT	DRG NUM DRG AMOUNT DRG OPR AMT DRG CAP AMT	COVD CHGS NCOVD CHGS DENIED CHGS MISC ADJ	COINSURANCE COPAYMENT DEDUCTIBLE PAT OTHER RESP	CONTRACT ADJ REIMB RATE HCPCS AMOUNT PAYMENT AMT
31,143.03	470	31,143.03	0.00	13,465.69
0.00	18,010.76	0.00	0.00	0.00
0.00	9,434.64	0.00	1,340.00	0.00
0.00	767.61	0.00	0.00	16,337.34

The Medicare Payment to RRMC for the Physician Surgical Fee is received with the information below.

TOTAL CHGS OTHER PAY COST OUTLIER MSP PAYMENT	DRG NUM DRG AMOUNT DRG OPR AMT DRG CAP AMT	COVD CHGS NCOVD CHGS DENIED CHGS MISC ADJ	COINSURANCE COPAYMENT DEDUCTIBLE PAT OTHER RESP	CONTRACT ADJ REIMB RATE HCPCS AMOUNT PAYMENT AMT
5,420.00		0.00	243.21	4,080.24
0.00	0.00	0.00	0.00	0.00
0.00	0.00	0.00	143.17	0.00
0.00	0.00	0.00	0.00	953.38

The Medicare Payment to RRMC for the Assistant Surgeon Fee is received with the information below.

TOTAL CHGS OTHER PAY COST OUTLIER MSP PAYMENT	DRG NUM DRG AMOUNT DRG OPR AMT DRG CAP AMT	COVD CHGS NCOVD CHGS DENIED CHGS MISC ADJ	COINSURANCE COPAYMENT DEDUCTIBLE PAT OTHER RESP	CONTRACT ADJ REIMB RATE HCPCS AMOUNT PAYMENT AMT
1,369.00		0.00	36.54	1,189.20
0.00	0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00	143.26

Salary Information

Submit a full copy of the hospital's Form 990 (for Actual 2017), including the most current version of Schedule H (filed in 2018) that has been submitted to the Internal Revenue Service as part of the hospital organization's Form 990 reporting obligations under Section 501 (c)(3) of the Internal Revenue Code. (Note that this information is required under the GMCB Guidelines for the Community Health Needs Assessment, attached. Provide a single copy of these documents.)

A. *Complete the following table*:*

Provide Headcount & Box 5 Wages from 2017 W2s			Employer Portion (allocation method allowed):	
Salary Range	Total # of Staff	Total Salaries (includes incentives, bonuses, severance, CTO, etc.)	Health Insurance Coverage	Retirement Contributions
$0 - $199,999	1864	$ 77,983,064	$ 13,223,092	$ 4,422,896
$200,000 - $299,999	25	$ 6,219,072	$ 325,245	$ 446,850
$300,000 - $499,999	36	$ 13,550,756	$ 565,494	$ 661,235
$500,000 - $999,999	6	$ 3,748,801	$ 123,963	$ 137,700
$1,000,000 +	2	$ 2,227,620	$ 40,394	$ 40,500

B. *Submit the hospital's policy or policies on executive, provider, and non-medical staff compensation.*

Refer to Appendix F (Key Employee Compensation Review Policy)

Refer to Appendix G (Compensation Program Policy)

Refer to Appendix H (Employed Physician Compensation and Benefits Policy)

C. *Identify:*

i. *Outside consultants relied on for benchmarking;*

Data from the HR consulting firms of Mercer, Towers-Watson, Korn Ferry/Hay Group, Medical Group Management Association (MGMA), DataDive Provider Compensation Data, and Vermont Association of Hospitals and Health Systems are used for salary benchmarking purposes.

Physician compensation consultants:

- Kevin C. Stone, Helms & Company, Inc.
- Lisa K. Blumstein, TriNet Healthcare Consultants
- Pinnacle Healthcare Consulting, proprietary Fair Market Value Report, which utilizes data from (1) Medical Group Management Association, Provider Compensation Survey, (2) Sullivan Cotter & Associates Physician Compensation and Productivity Survey Report, (3) Hospital & Healthcare Compensation Service, Physician Salary Survey Report, (4) American Medical Group Association, Compensation and Productivity Survey, (5) Hay Group, Physician Compensation Report.

ii. *Peer groups to which the hospital benchmarks;*

Benchmarks used are typically Revenue, Geography (Northeast, VT/NH, and National), and FTEs, depending on the available labor market.

iii. *Compensation targets in terms of percentiles for each staff category; and*

The compensation target is generally the 50th percentile of the market data.

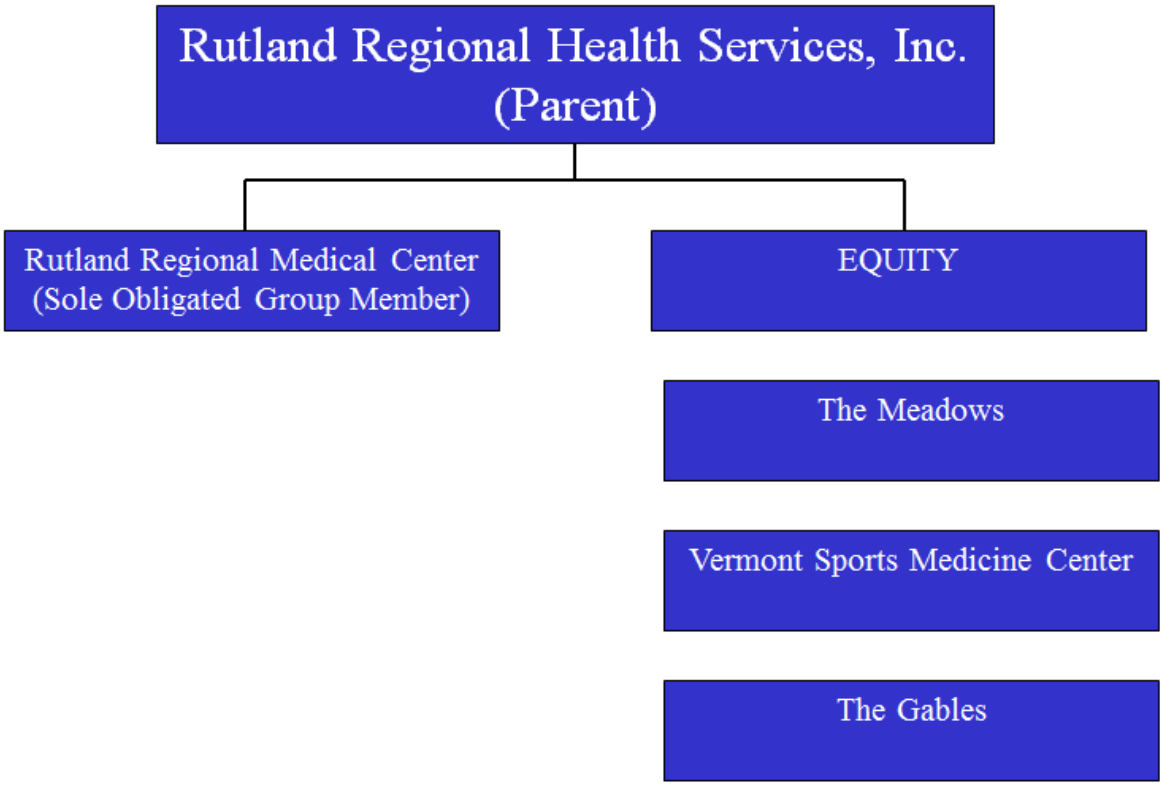
iv. *The hospital's actual compensation level, compared to target, for each employee group (e.g. executive, provider, non-medical staff)*

Actual (average) compensation levels, vs. the 50th percentile, are as shown for the following employee groups:

- Executive: -1.7%
- Advanced Practice Provider: 9.0%
- Non-medical Staff (all non-provider staff): -1.0%
- Bedside RNs: -2.5%
- Physicians: -5.6%

Organizational Structure

Provide the hospital's organizational chart including parent companies, subsidiaries, affiliated entities, etc.



APPENDIX A

OneCare Vermont

Rutland HSA Financial Modeling

		Member Base Assumptions					Risk and Reward Sharing			Primary Care Enhancement			Complex Care Coordination			Quality Incentives					
Rutland* HSA	Year and Data Source	Lives	Total Cost Of Care	FC Stability	Member Months	PMPM	Max Risk	Corridor	Sharing	Lives	PMPM	Total Value	Lives	PMPM	Total Value	Lives	Quality Incentives	OneCare Operations	Total Maximum Upside	Total Maximum Downside	Risk to Reward
Medicaid	2016	11,000	$ 40,144,307	95.2%	125,605	$ 319.61	$ 1,204,329	3.0%	100%	11,000	$ 1.63	$ 214,500	16%	$ 15	$ 301,451	11,000	$ 167,000	$ 330,000	$ 191,378	$ (2,217,280)	11.59

Medicaid Costs - per RRMC Data Warehouse	$	79,729,000
Net to Gross		33.4%
Net Revenue	$	26,656,246
Add: Non Hospital Revenue		50.6%
Based on January 25th Board Retreat Presenation		
All other spend	$	13,488,061
Total spend	$	40,144,307

Per March 2018 Financial Statements

Revenue	
IP Medicaid	$ 17,891,218
OP Medicaid	$ 22,232,243
Pro Fee Medicaid	$ 7,703,773
	$ 47,827,234
Contractual Allowance	
IP Medicaid	$ 9,723,628
OP Medicaid	$ 16,322,086
Pro Fee Medicaid	$ 5,791,171
	$ 31,836,885
Overall Net to Gross	33.4%

-6%

APPENDIX B

Rutland Regional Medical Center
Health Care Reform Investments Updates
Fiscal 2016 - Fiscal 2018

Fiscal 2018

Proposed Investment	Planned Investment	Target Population	Implementation Partners	Health Care Reform Goals	Project Status / Outcome
Emergency Department Social Work	$ 82,800	ED High-risk Patients	RRMC Internal	Improve care coordination for high-risk and high utilizers. Reduce ED utilization	**Ongoing:** ED Social work has been in place full-time since the beginning of the year. This newly created position has been instrumental in addressing the needs of high utilizing patients. We continue to see a reduction in the frequency of visits by our highest utilizing patients.
Care Management System Director	$ 80,300	All shared RRMC/CHCRR Shared patients	CHCRR	Coordination of care between primary care and hospital	**Ongoing:** The Care Management System Director position has been hired with costs shared between RRMC and CHCRR.
Medication REACH Program	$ 289,000	All Inpatients	RRMC Nursing Units	Reduction in readmissions related to medications	**Ongoing:** All planned staff have been hired, including three pharmacy technicians and supervising pharmacist time. Staff have been trained and are now providing medication reconciliation for every patient admitted to the hospital through the Emergency Department. In the four months of full operation the program has conducted more than 1,800 medication reconciliations. We estimate thatthis service has resulted in more than 10,000 significant changes in patient medication histories and more than 2,000 updates to patient allergy histories.
PSIU Peer Specialist	$ 37,000	Psychiatric Patients with SPMI and ED	RRMC Internal; Community Advisory Committee	Reduction of readmissions; shortening of time to medication; lower LOS; reduction in EIPs	**Ongoing:** As planned, two part-time peer specialists have been hired and are orienting on the inpatient psychiatric unit. The hiring process included staff, peers, and members of the Community Advisory Committee
IT Support for Community Care Management	$ 75,000	All shared RRMC/CHCRR Shared patients	CHCRR	Coordination of care between primary care and hospital	**Ongoing:** Work to develop a community-wide shared care plan that will be hosted in RRMC's EMR is well underway. This tool became availle for use on 4/2/2018.

Transitions of Care - Care Manager	$	100,000	High Risk Patients	CHCRR	Coordination of care for high risk patients.. Reduce Readmits	**Ongoing:** A Care Management Social Worker has been hired to support coordination of care and communication between inpatient and primary care offices. This is an exapnsiion of a program that demonstrated clear results from increased care managament post hospital discharge for our most complex patients.
Come Alive Outside	$	20,000	Population Health	Come Alive Outside	Improve the health of the community	**Ongoing:** Additional activities being planned for early spring
BluePrint Shortfall	$	151,300	ALL Shared Hospital/PCMH patients Coordination			**Ongoing:** A Care Management specialist has been hired to support coordination of care and communication between inpatient and primary care offices
SBIRT Year 3 Shortfall $47,300	$	146,055	SA Patients in the ED	RRMC ED	Reduction in SA use of ED; Connection of patients to follow-up care	**Ongoing:** Although State funding for this program ended on June 30, 2018, RRMC is working to integrate these staff and the core SBIRT functions into the Social Work staffing for the Emergency Department beginning in July, 2018. We are also working with Primary Care partners to develop SBIRT services as part of routine, integrated, health screening outside of the Emergency Department.
Community Grant Program Admin	$	92,000	Population Health	RRMC James T. Bowse Health Turst	Support for the Adminsitration of the James T. Bowse Health trust	**Ongoing:** This program provides a minimum of $300,00 in grants to community organizations to support programs that are in alignment with the CHNA priorities.
Total Investment	**$**	**1,073,455**				

Fiscal 2017

Proposed Investment	Planned Investment	Target Population	Implementation Partners	Health Care Reform Goals	Project Status
Case Management in the Emergency Dept.	$ 160,000	ED High-risk Patients	RRMC Emergency Department	Coordination of care between primary care and hospital	**Ongoing**: Added two RN Case Managers to work with patients in the Emergency Department, focusing on reducing unnecessary utilization and increasing successful transition to outpatient follow-up.

Case Management for Transition of Care	$	100,000	At risk discharged patients	RRMC Case Manaegement	Coordination of care after discharge to include medication management, home safety checks, nutrition, checks, etc.	**Ongoing:** We have fired a full time RN who supports the transiton of care for the most medically complex patients. In 2017, this program achieved a readmission rate of 9.9% for the 111 patients seen in this program which is signifacantly better than the general medicare readmission rate. this program is being expanded in 2018 based on these results.
Clinical Social Workers in Specialty Clinics	$	111,000	At risk patients in specialty clinics)	RRMC Specialty Clinics	Enables screening and support of 'whole person' healthcare needs (depression, family issue support, substance abuse)	**Ongoing**: One Social Worker was hired in Fiscal 2017 in the Multispecialty Clinics (Pulmonary, Sleep, Infectious Disease), one in Women's Health and in Cardiology
Member of the ACO (Assessment Fee)	$	54,750				**Ongoing:**
Community Grant Programs	$	330,000	All community members	RRMC Community Health Team	Providing support for various community programs that address sexual abuse prevention, substance abuse recovery, healthy eating, etc.	**Ongoing**:
Healthy Homes	$	36,000				
IT Support for Community Care Management	$	158,250	All shared RRMC/CHCRR Shared patients		Coordination of care between primary care and hospital	Working to develop a community-wide shared care plan that will be hosted in RRMC's EMR.
Total Investment	**$**	**950,000**				

Fiscal 2016

In Fiscal 2016 our Net Patient Service Revenue (NPSR) increase from budget to budget was 4.06%. RRMC included two exception to the 3% allowed increased related to physician transfers. Marble Valley Urology and Marble Valley Eye Care. Excluding these two transfers, our net revenue increase budget to budget was 2.98%, which is below the state allowed increase of 3%.

APPENDIX C

2019 Hospital Investments

Hospital: Rutland Regional Medical Center

Amount: $ 1,003,853.00

						Per GMCB budget guidance, indicate which of the health care reform criteria the investment meets				
	Activities, investments, or initiatives within the X.X% health care reform investment	**Allocation for the investment**	**Was this activity in last year's budget?**	**If yes, describe how the 2019 investment differs from previous investments in the same activity**	**Is this investment supplanting the previous costs, or are they new?**	**Goal 1: Increase Access to Primary Care**	**Goal 2: Reduce Deaths from Suicide and Drug Overdose**	**Goal 3: Reduce Prevalence and Morbidity of Chronic Disease**	**List APM quality measure(s) that the investment is intended to improve**	**Summary of evidence base or rationale that the investment will achieve the intended improvement(s)**
Example	*We are hiring an SBIRT social worker for the Emergency Department to triage substance use for referral to treatment.*	*$150,000*	*Yes*	*We are expanding our SBIRT social worker staff in Emergency Department from 1 to 2 FTE. 1 FTE, salary and benefits, is $150,000.*	*new*		*X*			
Example	*ACO dues*	*$250,000*	*Yes*	*We paid $100,000 in dues last year. We owe $350,000 this year.*	*new*	*X*				
	PMPM to primary care	*$220,440*	*No*		*New*	*X*				
	Complex Care Management Level I	*$297,000*	*No*		*New*					
	Complex Care Management Level II	*$165,000*	*No*		*New*					
	ACO Fee	*$330,000*	*No*		*New*					

APPENDIX D

Rutland Regional Medical Center
GMCB Budget Narrative
Fiscal 2019

Fiscal 2018 Approved Expenses to Budget Fiscal 2019
Appendix VI - Table 2

Expenses			% Over/(Under)
Fiscal 2018 Approved Budget	$	257,549,360	
New Positions (net of reductions)	$	1,282,614	
Inflation Increases			
Salaries	$	2,391,986	
Fringe	$	2,120,976	
Physician Contracts	$	164,538	
Facilities			
Health Reform Programs	$	330,000	
Depreciation Expense	$	176,605	
Interest & Other Bond Expense	$	(156,309)	
Healthcare Provider Tax	$	586,591	
Supplies Expense	$	(393,468)	
Contract Staff	$	(314,333)	
Pharmaceuticals / Pharmacy 340B	$	2,694,424	
IT Related	$	1,671,787	
CHCRR Subsidy	$	7,000	
Admin & General Expense	$	109,024	
Fiscal 2019 Budget	$	268,220,795	4.14%

APPENDIX E

RATE SCHEDULE 2018 - 2019 CHANGE		Rutland Regional Medical Center		Total	Medicare	Medicaid In-State	Medicaid Out-of-State	Medicaid (Uncategorized)	Commercial (Vermont Major - BCBS, MVP CIG)	Commercial (Self Pay/Other Smaller Payers)	Workers Comp	Other (DSH)
Rutland Regional Medical Center	Approximate NPR Value = 1% Rate		$ -									
		OVERALL GROSS FEE REQUEST	0.0%									
		OVERALL COMMERCIAL RATE REQUEST	0.0%									
GRREV		Hospital Inpatient Gross Revenue	0.0%									
GRREV		Hospital Outpatient Gross Revenue	0.0%		THIS DETAIL IS NOT REQUIRED AT THIS TIME.							
GRREV		Physician Outpatient Gross Revenue	0.0%									
GRREV		Chronic/SNF Gross Revenue	0.0%									
GRREV		Swing Gross Revenue	0.0%	$ -								
GRREV		Amount related to budget year rate/price request change		$ -								
GRREV		Amount related to other changes										
				$ -								
GRREV		Amount related to other changes - Hospital										
GRREV		Amount related to other changes - Physician			THIS DETAIL IS NOT REQUIRED AT THIS TIME.							
GRREV		Amount related to other changes - Other										
				$ -								
GRREV		Gross Patient Care Revenue 2018 with Physician Transfers		$ 530,938,307	$ 277,440,560	$ 87,711,910	$ 795,015	$ -	$ 158,668,048	$ -	$ 6,322,774	$ -
GRREV		Gross Patient Care Revenue 2019 with Physician Transfers			THIS DETAIL IS NOT REQUIRED AT THIS TIME.							
GRREV		Gross Patient Care Revenue Change 2018- 2019 (with Physician transfers)		$ (530,938,307)								
NPREV		Net Patient Revenue 2018 with Physician Transfers		$ 250,963,330	$ 92,027,894	$ 24,577,831	$ 111,190	$ -	$ 125,802,233	$ -	$ 4,448,893	$ 3,995,289
NPREV		Net Patient Revenue 2019 with Physician Transfers		$ -								
NPREV		Net Patient Revenue Change 2018-2019 (with Physician transfers)		$ (250,963,330)	$ (92,027,894)	$ (24,577,831)	$ (111,190)	$ -	$ (125,802,233)	$ -	$ (4,448,893)	$ (3,995,289)
FPP		Fixed Prospective Payments, Reserves & Other 2018		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FPP		Fixed Prospective Payments, Reserves & Other 2019		$ -								
FPP		FPP, Reserves & Other 2018 - 2019 Change		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NPR&FPP		Total NPR, FPP, Reserves & Other 2018		$ 250,963,330	$ 92,027,894	$ 24,577,831	$ 111,190	$ -	$ 125,802,233	$ -	$ 4,448,893	$ 3,995,289
NPR&FPP		Total NPR, FPP, Reserves & Other 2019		$ -								
NPR&FPP		Total NPR, FPP, Reserves & Other 2018-2019 Change		$ (250,963,330)	$ (92,027,894)	$ (24,577,831)	$ (111,190)	$ -	$ (125,802,233)	$ -	$ (4,448,893)	$ (3,995,289)
NPREV	RATE	FY19 Rate Changes Necessary to cover inflationary cost increase		$ -								
NPREV	RATE	GMCB Rate Order from 2017 Budget to Actual Performance		$ -								
NPREV	**RATE**	**Amount NPR related to rate/price request changes**		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NPREV	NON-RATE	Amount NPR related to other changes		$ (250,963,330)	$ (92,027,894)	$ (24,577,831)	$ (111,190)	$ -	$ (125,802,233)	$ -	$ (4,448,893)	$ (3,995,289)
				$ (250,963,330)	$ (92,027,894)	$ (24,577,831)	$ (111,190)	$ -	$ (125,802,233)	$ -	$ (4,448,893)	$ (3,995,289)
		NPR NON-RATE/PRICE REQUEST CHANGES										
NPREV	NON-RATE	Physician Transfers - New in FY 2019 Budget		$ -								
NPREV	NON-RATE	Utilization Changes		$ -								
NPREV	NON-RATE	Utilization - Payer Mix Shift		$ -								
NPREV	NON-RATE	Rate Difference: FY18 Budget to Actual Experience		$ -								
NPREV	NON-RATE	Other		$ -								
NPREV	NON-RATE	Other: New Programs, Health Reform, Reimbursement Changes, Misc.		$ -								
NPREV	NON-RATE	Other (Hospital please type description here)		$ -								
NPREV	NON-RATE	Other (Hospital please type description here)		$ -								
NPREV	NON-RATE	Other (Hospital please type description here)		$ -								
NPREV	SPECIAL	Disproportionate Share		$ -								
NPREV	SPECIAL	Graduate Medical Education Payments		$ -								
		Net Patient Revenue Non-Rate Subtotal		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NPREV	SPECIAL	Changes in Bad Debt		$ -								
NPREV	SPECIAL	Changes in Free Care		$ -								
		Net Patient Revenue Non-Rate Subtotal including BD/FC		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
		Net Patient Revenue Change Rate and Non-Rate		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

APPENDIX F

RUTLAND REGIONAL MEDICAL CENTER	Page 1 of 1
DEPARTMENT: Human Resources	APPROVED DATE: 1/1/2016
TITLE: **Key Employee Compensation Review**	PREPARED BY: Lesley Classen, Manager, HR
	ENDORSED BY:
	APPROVED BY: Brian Kerns, VP, HR
	EFFECTIVE DATE: 7/1/2012
	NEXT REVIEW DATE: 1/1/2019
JOINT COMMISSION STANDARD:	CMS FED#

A. SCOPE

This policy applies to all non-physician key employees of RRMC.

B. PURPOSE

To describe how Key Employee compensation is reviewed and administered.

C. POLICY

1. It is the policy of RRMC to offer market-competitive pay so to attract and retain the best talent from our labor market.

D. PROCEDURE

1. Designation of RRMC Key Employees is made in accordance with the prevailing IRS Key Employee definition.
2. The RRMC Key Employee labor market is typically hospitals nationally with similar revenues as RRMC.
3. Key Employee compensation is reviewed annually using three sources of independent competitive market data.
4. Jobs held by Key Employees are matched with similar jobs in market data with an indication of job match strength (weak (-), moderate (=) or strong (+)).
5. The market review produces a report of Key Employee current total cash compensation vs. market total cash compensation with any recommended pay actions.
6. Generally speaking, Key Employee base pay variances of -5% vs. market total cash compensation are considered to be non-competitive prompting a recommended base pay increase to be considered.
7. The results of the review and recommended pay actions are reviewed by the CEO and Board Chair, and approved by the CEO.
8. The CEO pay is reviewed and approved by the Board of Directors.

E. DEFINITIONS

Key Employee: those persons, other than officers, directors, and trustees, who (a) had reportable compensation exceeding the IRS Key Employee limit for the year; (b) had or shared organization-wide control or influence similar to that of an officer, director, or trustee, or managed or had authority or control over at least 10 percent of the organization's activities (the "responsibility test"); and (c) were within that group of the organization's top 20 highest paid persons for the year who satisfied both the compensation test and the responsibility test.

DISCLAIMER

This policy may be altered or modified at any time as required. Where union contract language differs from this policy, the contract language will take precedence.

REFERENCES AND BIBLIOGRAPHY

http://www.irs.gov/instructions/i990/ch02.html#d0e5338

NAME:	BK	BK				
REVIEWED:	12/1/2013					
REVISED:		1/1/2016				

APPENDIX G

A. SCOPE

1. This policy applies to all RRMC non-provider employees.

B. PURPOSE

The RRMC Compensation Program is designed to provide leaders and their employees a basic understanding of the approaches used to manage compensation activities.

C. POLICY

It is the policy of RRMC to ensure that the appropriate internal job worth (*"value"*) hierarchy is in place and that employees receive market competitive compensation for services performed in their jobs.

D. DEFINITIONS

- N/A

E. PROCEDURE

1. **Base Pay:**
   "Base Pay" refers to what an employee is paid per hour or pay period for services performed in their job(s) at RRMC. Employees may also receive pay differentials and premium pay in addition to their base pay. While the rate of pay for all jobs at RRMC is expressed as an hourly rate, jobs and employees in those jobs are classified as either non-exempt (paid by the hour) or exempt (paid by the pay period). In general:

   a. Employees in ***exempt*** (salaried) jobs are generally not eligible for additional pay, i.e., overtime, shift differentials or call pay; over a set base pay (set number of hours per week (typically 40) multiplied by a set rate per scheduled hour).

   b. Employees in an otherwise ***exempt*** (salaried) job, earning less than the prevailing FLSA minimum salary exempt requirements or in a Per Diem status, will be classified as non-exempt (***hourly***) employees.

   c. Employees in non-exempt (***hourly***) jobs qualify for overtime, shift differentials, etc.

2. **Base Pay Structures, Pay Grades and Pay Ranges:**
   RRMC has two Base Pay structures: non-exempt or *hourly* and exempt or *salaried*, each with their own set of pay grades and pay ranges. All pay grades have a Minimum, Midpoint, Maximum and Range Spread. A pay grade's minimum and maximum represents the minimum and maximum ***value*** or ***worth*** the job has in the market and (the lowest and highest) an employee in the job is most often paid. The pay range spread is the distance between the pay range minimum and maximum expressed as a percentage. The differences between the non-exempt and exempt pay plans are as follows:

An employee's placement within their pay range is expressed as a percentage referred to as their "Compa-ratio". Simply put, an employee's Compa-ratio is the relationship of their base rate of pay to the midpoint of their pay grade. For example, an employee with a base rate of pay of $15.97 in the following pay grade would have a Compa-ratio of 93% ($15.97/$17.25 = 93%).

GRADE	MIN	MID	MAX	
Non-Exempt (NE)	$13.89	$17.25	$20.62	Current Pay Grade

Said another way, this employee's current base rate of pay is 93% of their pay grade's range midpoint. An employee's **Compa-ratio** is used in calculating future increases involving job changes described later in this policy. ***Employees are typically not allowed to pass through the Maximum of their pay range by way of any type of increase.***

Base pay structures are reviewed annually and may be adjusted to ensure market competitiveness. This adjustment (called "*structure movement*") is done to remain market competitive and provides employees additional room to grow in their pay ranges. In addition, employees' jobs may be moved to new grades as necessary.

3. **Differential and Premium Pay:**
   Employees in non-exempt (***hourly***) jobs are generally eligible for differential and premium pay in addition to their base rate of pay.

4. **Job Descriptions:**
   Human Resources maintains job descriptions which may be found on the RRMC Insider Portal. Job descriptions are to be reviewed annually by the employee in the job and their leader as part of the Performance Appraisal process.

   If the functions change significantly or a new job needs to be created, leaders and Human Resources should work together to complete the job analysis and evaluation.

5. **Determining Starting Rates of Pay:**
   New employees, or current employees starting a new career path, are most often placed into their pay range based on the number of years of job-related experience they are bringing to RRMC. In some cases, Human Resources may give partial credit for years of experience. A new employee's years of job-related experience yields the Compa-ratio of their starting rate of pay in their pay range using the tables below (one for non-exempt jobs and another for exempt jobs).

Starting Rates of Pay Chart			
Non-Exempt Positions		**Exempt Positions**	
Years Job-Related Experience	Compa-Ratio	Years Job-Related Experience	Compa-Ratio
1yr	82%	1yr	79%
2yrs	84%	2yrs	81%
3yrs	86%	3yrs	83%
4yrs	88%	4yrs	85%
5yrs	90%	5yrs	87%
6yrs	91%	6yrs	88%
7yrs	92%	7yrs	89%
8yrs	93%	8yrs	90%
9yrs	94%	9yrs	91%
10yrs	95%	10yrs	92%
11yrs	96%	11yrs	93%
12yrs	97%	12yrs	94%
13yrs	98%	13yrs	95%
14yrs	99%	14yrs	96%
15yrs	100%	15yrs	97%
		16yrs	98%
		17yrs	99%
		18yrs	100%

For example, a new employee with 7 years of job-related experience hired into the following non-exempt pay range may have a starting rate of $15.87.

GRADE	MIN	MID	MAX
Non-Exempt (NE)	$13.89	$17.25	$20.62

From the table for non-exempt jobs, 7 years of job-related experience places the employee in their pay range with a Compa-ratio of 92%. To arrive at the starting rate of pay, the pay range midpoint is multiplied by the Compa-ratio ($17.25 x .92 = $15.87).

In another example, a new employee with 11 years of job-related experience hired into the following exempt pay range would have a starting rate of $23.98.

GRADE	MIN	MID	MAX
Exempt (EX)	$19.85	$25.79	$31.72

From the table for exempt jobs, 11 years of job-related experience places the employee in their pay range with a Compa-ratio of 93%. To arrive at the starting rate of pay, the pay range midpoint is multiplied by the Compa-ratio ($25.79 x .93 = $23.98).

Please note that for candidates with years of experience not shown on the above tables, each additional year of experience yields an additional percentage over a pay range's midpoint. For example, a new employee with 27 years of job-related experience hired into the following exempt pay range would have a starting rate of $28.11.

GRADE	MIN	MID	MAX
Exempt (EX)	$19.85	$25.79	$31.72

From the table for exempt jobs, 27 years of job-related experience places the employee in their pay range with a Compa-ratio of 109% (18 years of experience yields 100% (or the midpoint of the pay range) and nine additional years with another 1% over the midpoint for each year of experience yields a Compa-ratio if 109%). To arrive at the starting rate of pay, the pay range midpoint is multiplied by the Compa-ratio ($25.79 x 1.09 = $28.11).

6. **Determining Promotional Increases:**
Placement of current employees being promoted into higher pay grades is based on the midpoint differentials between the employee's current and new job pay range, as well as the employee's Compa-ratio in their new pay range using their current (pre-promotion) rate of pay. The following tables illustrate the corresponding promotional increase available as determined by an employee's Compa-ratio in their new range using their current (pre-promotion) rate of pay. **The employee's promotional increase is most often either the percentage difference between the midpoints of their new and current pay ranges or as depicted in the table below, whichever is less.**

Determining Promotional Increases Chart			
Promotions in Non-Exempt Positions		**Promotions in Exempt Positions**	
Compa-Ratio of Current Rate in New Range	Promotional Increase	Compa-Ratio of Current Rate in New Range	Promotional Increase
<70%	10%	<70%	15%
70% - 79%	8%	70% - 79%	13%
80% - 89%	6%	80% - 89%	11%
90% - 99%	5%	90% - 99%	9%
100% - 109%	4%	100% - 109%	7%
110% - 119%	3%	110% - 119%	5%
>119%	2%	>119%	3%

For example, an employee currently earns $16.50 in a job in the following pay range:

GRADE	MIN	MID	MAX	
Non-Exempt (NE)	$13.89	$17.25	$20.62	Current Pay-Grade

and is being promoted in a job with the following pay range:

GRADE	MIN	MID	MAX	
Non-Exempt (NE)	$15.34	$19.05	$22.77	New Pay-Grade

The employee's Compa-ratio in their new job is 87% their current (pre-promotion) rate of pay of $16.50 divided by the midpoint of the new pay range ($16.50/$19.05 = 87%). Accordingly, the employee is eligible for a 6% promotion increase based on the above 'Promotions into Non-Exempt Jobs' table. The midpoint difference between the pay grades is actually 10% ($19.05/$17.25 = 110%), and the promotional increase is the lesser of the two. Therefore the employee will receive a 6% promotion increase with the rate of $17.49 ($16.50 x 1.06 = $17.49).

In another example, an employee currently earns $16.05 in a job in the following pay range:

GRADE	MIN	MID	MAX	
Non-Exempt (NE)	$15.18	$18.87	$22.54	Current Pay-Grade

and is being promoted in a job with the following pay range:

GRADE	MIN	MID	MAX	
Exempt (EX)	$15.96	$20.72	$25.49	New Pay-Grade

The employee's Compa-ratio in their new job is 77% their current (pre-promotion) rate of pay of $16.05 divided by the midpoint of the new pay range ($16.05/$20.72 = 77%). Accordingly, the employee is eligible for a 13% promotion increase based on the above 'Promotions into Exempt Jobs' table. The midpoint difference between the grades is actually 10% ($20.72/$18.87 = 110%). Therefore, the employee will receive a 10% promotion increase with the rate of $17.66 ($16.05 x 1.10 = $17.66).

Employees bypassing several pay grades associated with a promotion and where the promotional increase calculation yields a rate below the new pay grade minimum may be approached as discussed in "Determining Starting Rates of Pay**". *Employees are not typically allowed to pass through the Maximum of their pay range by way of a promotional or any other type of increase.***

7. **Transfers:**
   Transfers from one position to another position within the same pay range, either in the employee's current department or another, will not be eligible for an increase.

8. **Movement Into Lower-Graded Positions:**
   Rate of pay calculations for current employees being moved into lower pay grades for any reason is typically based on the midpoint difference between the employee's current and new position pay ranges or the employee's Compa-ratio in their new pay range using their current (higher pay grade) rate of pay – whichever yields the lower decrease. All efforts are made to maintain equity within a department when calculating movement into lower graded positions.

   The following tables illustrate the corresponding pay rate decreases as determined by an employee's Compa-ratio in their new range using their current (higher pay grade) rate of pay. **The employee's rate of pay decrease will be either the percentage difference between the midpoints of their new and current pay ranges or as depicted in the table below, whichever is the lesser reduction.**

Movement into Lower-Graded Positions Chart			
Movement in Non-Exempt Positions		**Movement in Exempt Positions**	
Compa-Ratio of Current Rate in New Range	Pay-Rate Decrease	Compa-Ratio of Current Rate in New Range	Pay-Rate Decrease
<70%	2%	<70%	3%
70% - 79%	3%	70% - 79%	5%
80% - 89%	4%	80% - 89%	7%
90% - 99%	5%	90% - 99%	9%
100% - 109%	6%	100% - 109%	11%
110% - 119%	8%	110% - 119%	13%
>119%	10%	>119%	15%

For example, an employee currently earns $30.57 ($63,586 annualized) in the following pay range:

GRADE	MIN	MID	MAX	
Exempt (EX)	27.03	35.11	43.19	Current Pay Grade

and is moving into the following lower graded position:

GRADE	MIN	MID	MAX	
Exempt (EX)	24.97	32.42	39.88	New Lower Pay Grade

The employees Compa-Ratio in their new position is 94% their current rate of pay of $30.57 divided by the midpoint of the new pay range ($30.57/32.40 = 94%). Therefore, the employee's pay would be decreased 9% according to the 'Movement in Exempt Positions' table. The midpoint difference between the pay grades is actually 8% ($35.11/32.42 = 108%). Therefore, the employee will receive an 8% decrease for a rate of $28.12 ($30.57 x .92 = $28.12 or $30.57 x .08 = $2.45 subtract $2.45 from $30.57 = $28.12).

An employee whose base rate of pay exceeds the maximum of their new lower pay range will be ***"red-circled"*** regarding future increases. Employees who are "red-circled" will not receive base rate of pay increases of any nature (COLA, market or compression) until the pay range they are in "catches up to them" through the process of structure and/or market movement.
Please reference the Promotions and Transfer Policy for more information on these types of job changes.

9. **Competitive Compensation Market Review**
At least annually RRMC job pay ranges are compared to those of similar jobs in our comparative local and national labor markets. Each year Human Resources participates in wage and salary surveys conducted by local and national Human Resource consulting firms. Using this aggregate wage and salary survey data RRMC's pay ranges and market pay for jobs are compared to determine if market adjustment is necessary to remain competitive. This survey process and pay range comparison may be conducted more frequently, as needed, for certain specialized, typically clinical and/or technical jobs. The competitive compensation market review does not focus on the individuals in the jobs being reviewed rather the job duties themselves.

Employees in jobs that are determined to be "below market" when compared to our competitive labor market may receive a ***market adjustment*** which is a one-time increase to their base rate of pay. This will typically also involve the employee's job being reassigned to a higher pay grade as a result of the competitive market review. ***Employees will not be allowed to pass through the maximum of their assigned pay range as a result of receiving a market adjustment; nor will employees receive a lump sum payment for potential earnings in excess of their range maximum.***

Market adjustment of base rates of pay occurs in accordance with established RRMC budgets for the incremental expense. Therefore, market adjustments should never be perceived as mandatory, required or guaranteed.

10. **Internal Equity Adjustments :**
    In the same manner that RRMC strives to ensure equity to the external market, similar focus is given to internal equity among jobs and the incumbents in them. Human Resources looks at many options including hiring decisions, adjustment of base rates of pay and/or reassignment of pay grades to correct and restore internal equity.
    Internal equity adjustments should never be perceived as mandatory, required or guaranteed. ***Employees will not be allowed to pass through the maximum of their assigned pay range as a result of an internal equity adjustment; nor will employees receive a lump sum payment for potential earnings in excess of their range maximum.***

11. **Cost of Living Adjustment (COLA):**
    Cost of living adjustments are generally considered on an annual basis and are separate from market, internal equity or promotional increases. In addition, cost of living adjustment of base rates of pay occurs in accordance with established RRMC budgets for the incremental expense. Therefore, cost of living adjustment should never be perceived as mandatory, required or guaranteed. ***Employees will not be allowed to pass through the maximum of their assigned pay range as a result of receiving a COLA increase; however employees can receive a lump sum "COLA" payment for earnings in excess of their range maximum.***

RELATED POLICIES AND FORMS

- Shift Differential Policy
- Overtime Policy
- Meal Period and Break Time Policy
- Promotions and Transfers Policy
- Leader Evaluation Manager (LEM)
- Rewards and Recognition Program
- Retirement Savings Plan Summary Plan Document
- Payroll Authorizations
- Wage and Hour Policy

DISCLAIMER

This policy may be altered or modified at any time as required. Where union contract language differs from this policy, the contract language will take precedence. Nothing in the RRMC Compensation Policy should be construed as a contract of employment between RRMC and an employee.

REFERENCES AND BIBLIOGRAPHY

Fair Labor Standards Act of 1938: https://www.dol.gov/whd/regs/statutes/fairlaborstandact.pdf

APPENDIX H

RUTLAND REGIONAL MEDICAL CENTER	Page 1 of 8
DEPARTMENT: Administration	APPROVED DATE: 9/26/2017
TITLE: **Employed Physician Compensation and Benefits**	PREPARED BY: J. Wallace, GC
	APPROVED BY: M. Boynton, CMD
	APPROVED BY: T. Huebner, CEO
	EFFECTIVE DATE: 2/13/2015
	NEXT REVIEW DATE: 10/1/2020

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A. SCOPE

Employed Physicians	Administration
Departments with Employed Physicians	Finance and Human Resources

B. PURPOSE:

To provide a framework for consistency regarding physician compensation, and ensure compliance with the Stark, Anti-Kickback, and tax laws.

C. POLICY:

1. All employment contracts with physicians, for clinical and/or administrative services must be in writing, signed by the parties and be consistent with this policy unless an exception to this policy has been authorized by the physician's Vice President. All payments to employed physicians for such services must be supported by a written contract.
2. The amounts paid to physicians under an employment contract shall be no greater than the Fair Market Value for the services provided, shall not be based upon the value or volume of referrals or any referral relationship between the physicians and RRMC, and shall be commercially reasonable even if no referrals were made to the employer by the physician. Fair Market Value shall be based on an assessment performed in accordance with the Employed Physician Contracting Procedure.
3. *Medical Directorships* – Physicians may be compensated for medical director services provided that there is a business and clinical need for administrative services, a written contract for such services specifying the duties and responsibilities, and the physician obtains a satisfactory performance evaluation and completes necessary documentation of time and effort to support cost reporting requirements. RRMC may not make payments for medical director services unless the applicable department leader approves and signs the documentation of time and effort that is required by the department.
4. *Methods of Compensation* The method of compensation of employed physicians with RRMC may vary based on department and may be based on a fixed salary, shift pay, or minimum annual salary with a productivity incentive bonus basis.
5. *Productivity Requirement* - Certain physicians may be compensated on a minimum annual base salary with a productivity incentive compensation component where it is feasible and furthers organizational goals.

   5.1. Compensation based on productivity may only be based upon services that are personally performed by the employed physician.

   5.2. Physicians earn productivity compensation based on Work RVU's (WRVUs) that are personally performed by the physician. Physicians earn productivity

compensation when their level of productivity exceeds the annual production level of established WRVUs, indicated in Schedule A of their employment contract.

5.3. *WRVU calculation* - WRVUs are calculated on a monthly basis. The source of the WRVU value is the Medicare Physician Fee Schedule (MPFS) unless the procedure/CPT code is not included in the MPFS. The source of the WRVU value for the fiscal year (October 1-September 30) is the MPFS that is effective on January 1 of each year prior to October 1.

5.3.1. *New agreements* - Where the commencement date of the employment contract is before October 1, the source of the WRVU value will be the MPFS that was in effect as of the prior October 1 until the next October 1. The Finance Department calculates productivity compensation on a fiscal year basis so if the commencement dates of the employment contract is after October 1, the annual base WRVU level will be prorated for the remaining period of the fiscal year.

6. *Productivity Compensation Settlement* – A physician can elect to receive an annual settlement payment or quarterly payments for the productivity component. The settlement method should be specified in the employment contract. If not, productivity compensation will be settled annually. Electing quarterly payments involves the risk that physician may owe sums back to RRMC.

7.1 *Annual Compensation Settlement Payments* – The Finance Department is responsible for calculating productivity compensation within 45 days of the end of each fiscal year. The Finance Department will make the annual settlement payment to the physician, if any, in the pay period following the completion of the calculation. .

7.2 *Quarterly Compensation Settlement Payments* - The Finance Department is responsible for calculating productivity compensation within 45 days of the end of each fiscal quarter. The compensation is based on the physician's contracted salary, as well as their WRVU production. If WRVUs produced exceed the targeted amount for their given period, a settlement will be made to the physician during the following pay period. The acceptance of quarterly payments involve a risk that the physician may owe sums back to RRMC at fiscal year end, and in accepting the quarterly payments the physician agrees to reimburse RRMC for such overpayment amounts. If the physician is still employed by RRMC, RRMC will recoup the overpayments on a pro rata basis from the next succeeding four (4) bi-weekly paychecks. If the physician is no longer employed by RRMC, the physician shall pay RRMC the difference within thirty (30) days of the notification to the physician of the amount due from physician.

7. *Calculation for Compensation for Legal Work Services* - Physicians may on occasion perform independent medical exams and other legal work ("Legal Work Services") for RRMC. Legal Work Services are not included in the process for calculating surrogate Work RVU values. To compensate for independent medical exams and

other legal work personally provided by physicians for RRMC, physicians will be credited 1.5 WRVU's per $100.00 if the Legal Work Services are provided without a patient encounter that occurs within a RRMC facility and 1 wRVU per $100.00 if the physician Legal Work Services involves a patient encounter within a RRMC facility. The payment conversion factor for the Legal Work Services shall be physician's tier 1 conversion factor in their employment contract to earn incentive compensation for WRVUs over the annual production level. If physician has more than one tier for conversion factors, the tier 1 conversion factor will be used as the conversion factor for the Legal Work Services. To be compensated for Legal Work Services, the provision of such services must be approved in writing by the Vice President leader of the department at RRMC in which physician provides medical services.

8. *Compensation Cap* - Each physician's final annual total compensation for clinical and administrative services from all RRMC sources may not exceed the 90th percentile for the physician's specialty as published in the MGMA Physician Compensation Survey that was available as of the start of the fiscal year being measured. In exceptional circumstances, a physician's total compensation may exceed the 90th percentile if the organization has obtained a letter or opinion from a qualified third party, which states that the total compensation does not exceed fair market value.

9. *Surrogate WRVU*s – CPT codes with no published WRVU value will qualify for a Surrogate WRVU as long as the service is personally performed by the physician, and RRMC will receive payment for the service.

   9.1. If the CPT code had a published WRVU value in a different version of the Medicare Physician Fee Schedule, the surrogate value will be based on the most recent MPFS WRVU value.

   9.2. If the CPT code does not have a value reported in the MPFS the Finance Department will calculate a system wide surrogate value based on the average Gross Revenue for the CPT divided by weighted conversion. The calculated surrogate value for a CPT will be the same across all departments ever where there are differences in the charge amounts.

   9.3. Surrogate values are recalculated each fiscal year as of September 30, and prior year surrogate values are not carried over to the next fiscal year.

   9.4. If during the fiscal year, a new service is assigned a CPT code with a published WRVU value in a different version of the Medicare Physician Fee Schedule, the service will no longer be subject to the surrogate WRVU process, and Physician will receive WRVU credit when the service is performed based on the published WRVU value, rather than at the fiscal year end reconciliation process with surrogate WRVUs.

10. *Modifiers* – WRVUs that are affected by modifiers are valued based on official guidelines for the use of the applicable modifiers.

    10.1. *Bilateral Services reported with a 50 Modifier* – Bilateral services are procedures that are performed on both sides of the body during the same session or on the same day. For CPT codes that are reported with a modifier 50

(bilateral), the physician is credited for both procedures in that the physician is credited 100 percent of the WRVU value for the first unit, and 50 percent for the second unit for a total of 150 percent of WRVUs for the procedures regardless of whether the payer requires that the bilateral procedures be reported on a single-line or two-lines.

Example: WRVU Credit for Bilateral Procedures Reported with 50 Modifier			
Single-Line Reporting (Medicare/Medicaid) joint injection			
CPT Code	Units	WRVU	Payment
20610-50	1	(0.79)+(0.79 x .50) = 1.185	($46)+(46 x .50)=$69
Two-Line Reporting			
20610	1	.79	$46
20610-50	1	(0.79 x .50) =0.395	($46 x .50) =$23

10.2. *Multiple Procedures subject to a 51 Modifier payment reduction* – Some procedures when performed during that same session are subject to a multiple procedure payment reduction. Multiple procedures are listed in ranked RVU order with the highest weighted procedure listed first. The Modifier 51 multiple procedure payment reduction applies to the second-listed and applicable subsequent procedures.

Example: WRVU Credit for Multiple Procedures Reported with 51 Modifier			
Single-Line Reporting (Medicare/Medicaid) joint Injection			
CPT Code	Units	WRVU	Payment
20610	1	0.79	$47.20
20605-51	1	(0.68 x 0.50)=0.34	($37.15 x 0.50)= $18.57
20605-51	1	(0.68 x 0.50)=0.34	($37.15 x 0.50)= $18.57

10.3. *Assistant at surgery services reported with a Modifier 80 or 81* – For services that are eligible for assistant at surgery reimbursement when reported with a Modifier 80 (assistant at surgery), and Modifier 81 (minimal assistant at surgery) the assisting is be credited with 25 percent of the WRVU value. The bilateral and multiple procedure reductions apply the proportionally the same way as they would for the primary surgeon.

Example: WRVU Credit for Assistant at surgery services reported with Modifier 80 or 81 (low back disk surgery)			
CPT Code	Units	WRVU	Payment
63030	1	13.18	$965.77
63030-80	1	(13.18 x 0.25)=3.295	

10.4. CPT codes that are reported with a Professional Component (PC) modifier are given WRVU credit. There is no WRVU credit for CPT codes that are reported with Technical Component (TC) modifier because they involve a hospital technical service as opposed to a physician professional service.

11. *Supervision* – Physicians may be compensated for reasonable clinical supervision of Advance Practice Providers, other clinical staff, and/or relevant hospital services, provided that the compensation for supervision is allowed under the law and is consistent with Fair Market Value for the supervision, which may be compensated at a set hourly, monthly, or other unit based rate.

12. *Healthcare Reform Transition Process* – This physician compensation policy is intended to be aligned with the current healthcare reimbursement systems. Future changes in reimbursement systems may necessitate changing compensation methods to adapt to new reimbursement models such as global budgets, bundled payments, and/or population based payment.

12.1. *One –Year Transition Period* – RRMC may initiate a transition period for a change in compensation method for an individual specialty or department by providing the affected physicians written notice of the need to change the compensation method. In such an event, RRMC and the physician will have one hundred and eighty (180) days to reach an agreement on changes to the compensation method. If RRMC and any physician are not able to reach an agreement within the one hundred and eighty (180) day period, either party may terminate the employment contract with an additional one hundred and eighty (180) day notice period by providing written notice of intent to terminate the employment contract. Thus, the duration of the transition period that results in a termination of the employment contract is a 360 day period from the start of the process, unless the parties agree otherwise in writing.

13. *Fringe Benefits* - Physicians are eligible to participate in all RRMC physician fringe benefit plans upon meeting requirements for participation. The Fringe Benefits are as set forth in the RRMC *Physician Summary of Benefits* as maintained by the Human Resources Department and change from time to time. RRMC has the right at any time to amend, modify or terminate any of these benefits. Changes in benefits are made to all members of an employee class and changes are not made to individual employees. Nothing in this policy obligates RRMC to put into effect any plans or benefits not presently in existence, to continue in effect any plan or benefit currently in existence, or to provide special benefits to physicians.

14. *Professional Fees, Dues and Education Expenses* – RRMC shall pay (1) physician's Vermont (and New York, if applicable) medical license fee(s); (2) DEA registration fee(s); (3) RRMC Medical Staff dues; (4) membership fees for up to three professional medical societies or academies, and the Vermont Medical Society; (5) the application and testing fees for board recertification; and (6) if the physician is at least a 0.50 FTE employee of RRMC, annual CME costs of up to $6,000. A physician department's Vice President may authorize additional education expenses where it is

necessary to further the needs of the business unit, department, or organization. Such additional authorization must be in writing.

14.1. *CME Payments* - Physicians may use the annual CME allowance to maintain and improve their administrative and clinical skills. CME funds may be used for professional books, journals, and other educational materials, courses and where applicable associated travel costs. CME funds may not be used for electronic devices or hardware or for non-CME expenses. CME expenditures are accrued on the date of receipt and not the date that they are ordered so that the physician must receive the education materials or participate in the conferences by the end of the RRMC fiscal year in order to be recorded as part of that year's CME expense.

14.2. *CME Related Travel* – CME related travel expenses are subject to advance approval in accordance with the RRMC Travel Requisition policy. CME expenses may not be reimbursed without receipts.

14.3. Annual CME amount does not carry over year to year. Any unused CME allowance is forfeited at the end of each RRMC fiscal year. Annual CME allowance is prorated based on employed physician commencement date

15. *Department Coverage* - Physicians are required to work the amount of time that is necessary to perform the clinical and administrative duties as set forth in their employment contract. The physician's department schedules vacation and holiday time off in a manner that ensures that there is sufficient coverage in the department for patient care, call coverage and to ensure adequate time to perform clinical and administrative duties.

16. *Disability* - If a physician becomes disabled as a result of injury or sickness and becomes unable to attend full-time to the material and substantial duties of the job as described in their employment contract, physician's compensation will be as described below. For the purposes of this provision, material and substantial duties means responsibilities that are normally required to perform the job as described in their employment contract and cannot be reasonably eliminated or modified.

16.1. *Short term disability* – Short term disability compensation is paid pro rata based on the length of the period of the disability, until the earlier of one hundred eighty (180) days from the start date of the disability, or termination of the disability, after which the physician will no longer be entitled to disability benefits based upon regular compensation under physician's employment contract.

16.1.1. Short term disability compensation is calculated based on the total cash compensation that RRMC paid to the physician pursuant to physician's employment contract in the four (4) previously completed quarters.

16.1.2. In the event that a physician has been employed by RRMC for less than four (4) complete quarters, the calculation will be based on the physician's base salary as set forth in the physician's employment contract.

16.1.3. The short-term disability benefit is comprised of (1) all compensation payments that the physician receives in their bi-weekly paycheck while they are out-of-work for up to one hundred eighty (180) days; and (2) any additional payments the physician receives pursuant to the calculations described in sections 16.1.1 and 16.1.2.

16.2. *Long Term Disability* – After the expiration of short term disability period, physician will no longer be compensated under physician's employment agreement, and the RRMC Long Term Disability Program, will govern, if physician elected to participate in the RRMC Long Term Disability Program. If a physician does not elect to participate in the RRMC Long Term Disability Program, no benefits shall be payable to physician under that program or the employment contract. For purposes of this provision, RRMC Long Term Disability Program means the long term disability plan/policy that RRMC has in place at the time of the disability that physician would be eligible for benefits under. Meaning and intending that for long term disability, the terms of the plan policy will govern any benefits due to physician and how physician is compensated, not physician's employment contract. Physician must meet the terms of the RRMC Long Term Disability Program for benefits paid under it.

17. Paid Sick Leave –The Vermont Paid Sick Leave law provides standards for employees to take time off from work for certain covered events. Compensation for paid sick time is included within the compensation described in each the physician's employment contract. Physicians employed by RRMC are compensated by different methods of compensation, generally either by (i) fixed salary, (ii) minimum annual salary with a productivity incentive bonus, or (iii) shift pay.

17.1. *Physician Employment Contracts with Combined or Earned Time Off provided for in the contract* - For physician employment contracts that include Combined or Earned Time Off provision in the contract, RRMC already provides *Combined/Earned Time Off* ("CTO") that includes and can be used for time away from work as required by the Vermont Paid Sick Leave law. It is the physician's responsibility to monitor, use and retain sufficient CTO to use as paid sick leave when and if necessary during the course of the year. CTO in the employment contracts includes the paid sick time for the year.

17.2. *Physician Employment Contracts with Productivity Based Compensation* - Physician employment contracts that include productivity based compensation do not place specific requirements on a physician's days at work so long as physician fulfills the duties of the contract, and therefore the physician is afforded time away from work that meets or exceeds the paid sick time required by Vermont law.

17.3. *Physician Employment Contracts with Shift Based Compensation* – Shift based physician employment contracts that do not include specific provision for Combined or Earned Time off provide for a specific number of shifts to be

worked annually for the annual base salary. The physician participates in forming a schedule that meets the requirements of the contract and the physician's time away from work. The number of shifts required for the annual base salary includes earned time off and therefore the physician is afforded time away from work that meets or exceeds the paid sick time required by Vermont law.

17.4. *Paid Sick Leave* - It is the physician's responsibility to monitor and use sufficient time as needed for purposes of paid sick leave when and if necessary during the course of the year.

17.4.1. RRMC will work with physicians when a physician needs time off from already scheduled coverage because of unanticipated needs that would otherwise qualify for paid sick time. Physicians are not responsible for finding a replacement for an absence associated with sick time and are not responsible for making up for missed time.

17.4.2. Physicians should make reasonable efforts to avoid scheduling routine or preventive health care during regularly scheduled hours.

17.4.3. *Notice* - Physicians will provide reasonable notice to their department leader before using sick time and where possible provide the estimated duration of their absence.

17.4.4. *Paid sick time covered events* - The following are examples of events that would qualify for paid sick time: (1) physician's own illness or injury, (2) obtaining professional diagnostic, preventive, routine, or therapeutic health care, (3) caring for a sick or injured parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child, including helping that individual obtain diagnostic, preventive, routine, or therapeutic health treatment, or accompanying your parent, grandparent, spouse or parent-in-law to an appointment related to his/her long-term care, (4) arranging for social or legal services or obtaining medical care or counseling for your own or your parent, grandparent, spouse, child, brother, sister, parent-in-law, grandchild, or foster child, who is a victim of domestic violence, sexual assault, or stalking or who is relocating as the result of domestic violence, sexual assault, or stalking.

OTHER POLICIES AND FORMS

Table 1A:
NPR Bridges - FY 2018 Approved Budget to FY 2019 Proposed Budget

NPR	Total	% over/under	Medicare	Medicaid-VT	Medicaid-OOS	Commercial-Maj	Comm - Self/Sml	Workers Comp
FY 18 Approved Budget	$ 250,966,449		$ 92,029,832	$ 28,573,614	$ 111,190	$ 111,234,258	$ 14,568,645	$ 4,448,910
Commercial Rate	2,736,216	1.090%				2,144,757	507,722	83,737
Rate - Non Commercial	(247,263)	-0.099%	0	(0)	-	-	(247,263)	-
Utilization	6,951,934	2.770%	3,848,118	1,244,502	12,333	1,417,466	1,035,681	(606,166)
Reimbursement/Payer Mix	1,710,386	0.682%	5,342,771	1,690,086	7,786	(4,668,196)	(766,455)	104,394
Bad Debt/Free Care	(1,060,318)	-0.422%					(1,060,318)	
Physician Acq/Trans	-	0.000%						
Changes in Accounting	-	0.000%						
Changes in DSH	(904,359)	-0.360%		(904,359)				
PMPM Primary care, Complex care Level 1 and 2	(682,440)	-0.272%		(682,440)				
Psych ICU and ADAP	(545,494)	-0.217%	0	0	0	0	(545,494.00)	0
FY 19 Budget	$ 258,925,111	3.171%	$ 101,220,721	$ 29,921,404	$ 131,309	$ 110,128,285	$ 13,492,518	$ 4,030,875

Table 1B:

NPR	2018 NPR	2019 Before Rate	Vol/Mix	Variance	2019 NPR	Impact of Rate
	$ -		$ -	$ -	$ -	$ -
Major NPR Contributors						
Imaging						
Perioperative & Anesthesia						
Physician Practices						
Lab						
Drugs & IV Therapy						
Emergency						
Med/Surg/SCU						
Medical/Surgical supplies						
ER & Hospitalist Physicians						
Birthing Center						
Clinics						
Rehabilitation Services						
Other (please label)						
Other (please label)	0		0	0	0	0
	$ -		$ -	$ -	$ -	$ -