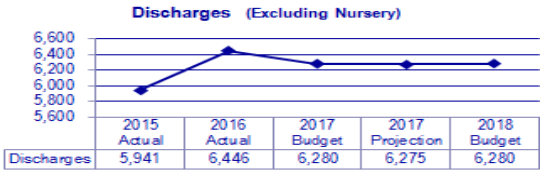
Rutland Regional Medical Center
2018 Budget
Response to State Analysis and Questions

1. **INCOME STATEMENT - The NPR is budgeted to increase 3.34%, and includes health care reform investments of $974,000 (0.4%). Gross revenue is up 6%, suggesting increased utilization and a 5% rate increase. However, adjusted admissions utilization shows a reduction in utilization. Many categories of utilization show increases. Explain what is happening in utilization.**

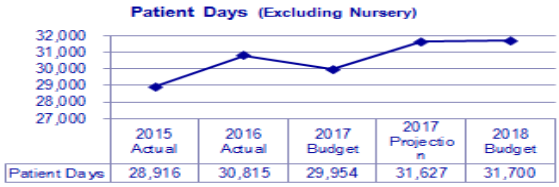
The growth in gross revenue is due to an increase in patient days, pharmaceuticals, orthopedic market share and the rate increase, as outlined below.

Patient days – Budget to budget our patient days are increasing by 1,746 or 4.7 patients per day. The increase in patient days is not a result of increased admissions but rather an increase in the length of time each patient stays with us. In Budget 2017 we anticipated an overall length of stay of 4.7 days however based on actual performance our average length of stay has been 5 days per stay. We set the 2018 Budget at the actual performance as of February 2017. The increase in length of stay accounts for the entire patient day increase and is driven by patient populations that are challenging to place back in the community, namely our psychiatric, geriatric and dementia patients. Our admission/discharge volume is consistent with 2017 Budget and 2017 Projection.

As the length of stay becomes longer there are certain supportive ancillary services that also show increases in utilization. Both laboratory and respiratory services also increased budget to budget by approximately $3.3 million as a result of additional patient days.



	2015 Actual	2016 Actual	2017 Budget	2017 Projection	2018 Budget
Discharges	5,941	6,446	6,280	6,275	6,280



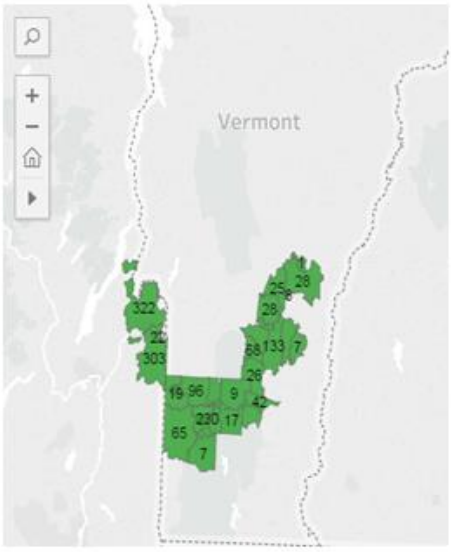
	2015 Actual	2016 Actual	2017 Budget	2017 Projection	2018 Budget
Patient Days	28,916	30,815	29,954	31,627	31,700

Pharmaceuticals – We continue to be challenged in projecting the annual gross revenue of pharmaceuticals given our oncology program. Oncology medications tend to be very expensive and one drug alone can drive significant changes in revenue. To illustrate the top 15 most expensive outpatient medications in our formulary represent nearly 40% of total outpatient pharmacy revenue. The introduction of new drugs to market, changes in treatment protocols and sudden changes in manufacturer pricing can have a significant impact for one medication alone. The budget to budget increase in pharmaceutical revenue is $2.4 million.

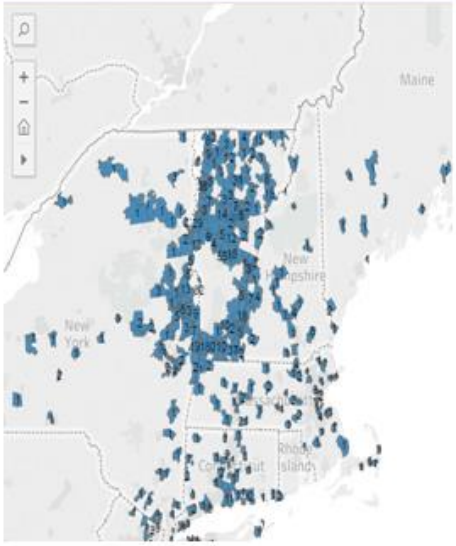
Orthopedic Market Share: RRMC's orthopedic program has been very successful and has received national recognition for quality and patient satisfaction. In 2017 Health Grades gave RRMC a Five-Star performance award for total knee replacement, in the 2016/2017 Report the U.S. News rated RRMC high performing in hip replacement and for the past few years Blue Cross has listed RRMC as "Blue Distinction" for total hip and knee procedures. As a result of this recognition our market share has grown and patients well outside our market area are choosing Rutland for their orthopedic care. Over the past two years RRMC has seen an additional 95 patients who do not reside in our market area but seek treatment at RRMC for hip and knee replacements. This volume is driving $2.5 million in additional revenue and is demonstrated in the following two maps.

Utilization:
Inpatient Volume Trends – Secondary Market

DRG Family	DRG Family Description	Avg Charge	Growth Volume	Growth Gross Revenue
469 - 470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	$ 56,805	32	$ 1,817,764
870 - 872	SEPTICEMIA OR SEVERE SEPSIS	$ 69,661	12	$ 835,928
483	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	$ 58,008	5	$ 290,040
242 - 244	PERMANENT CARDIAC PACEMAKER IMPLANT	$ 49,691	5	$ 248,456
668 - 670	TRANSURETHRAL PROCEDURES	$ 31,683	6	$ 190,099
391 - 392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS	$ 21,046	9	$ 189,416
180 - 182	RESPIRATORY NEOPLASMS	$ 33,739	4	$ 134,957
602 - 603	CELLULITIS	$ 23,543	5	$ 117,715
291 - 293	HEART FAILURE & SHOCK	$ 22,833	5	$ 114,166
551 - 552	MEDICAL BACK PROBLEMS	$ 22,564	5	$ 112,819
100 - 101	SEIZURES	$ 24,813	4	$ 99,250
542 - 544	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG	$ 31,117	3	$ 93,350
867 - 869	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	$ 30,883	3	$ 92,649
539 - 541	OSTEOMYELITIS	$ 28,409	3	$ 85,227
765 - 766	CESAREAN SECTION	$ 24,174	3	$ 72,521
562 - 563	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH	$ 23,978	3	$ 71,933
341 - 343	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG	$ 22,136	3	$ 66,408
314 - 316	OTHER CIRCULATORY SYSTEM DIAGNOSES	$ 20,150	3	$ 60,449
299 - 301	PERIPHERAL VASCULAR DISORDERS	$ 18,287	3	$ 54,860
202 -203	BRONCHITIS & ASTHMA	$ 12,914	3	$ 38,742
				$ 4,786,751
			Estimated Contractual Allowance	$ (2,384,044)
			Estimated Net Patient Service Revenue	$ 2,402,706



Utilization:
Inpatient Volume Trends: Other VT & Out of State

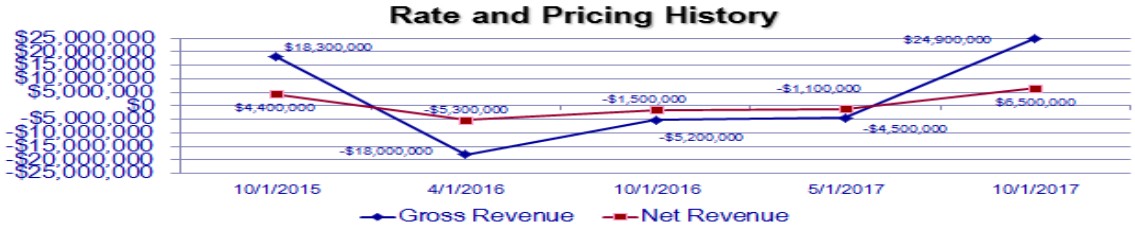


DRG Family	DRG Family Description	Avg Charge	Growth Volume	Growth Gross Revenue
469 - 470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	$ 56,805	63	$ 3,578,723
459 - 460	SPINAL FUSION EXCEPT CERVICAL	$ 95,074	6	$ 570,446
870 - 872	SEPTICEMIA OR SEVERE SEPSIS	$ 69,661	7	$ 487,625
064 - 066	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	$ 34,949	6	$ 209,695
207 - 208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT	$ 82,323	2	$ 164,646
881	DEPRESSIVE NEUROSES	$ 20,383	8	$ 163,064
463 - 465	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS	$ 68,975	2	$ 137,949
438 - 440	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	$ 23,411	5	$ 117,054
291 - 293	HEART FAILURE & SHOCK	$ 22,833	5	$ 114,166
510 - 512	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC	$ 35,696	3	$ 107,089
308 - 310	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 21,256	4	$ 85,023
492 - 494	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR	$ 38,506	2	$ 77,011
643 - 645	ENDOCRINE DISORDERS	$ 24,967	3	$ 74,902
515 - 517	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC	$ 37,057	2	$ 74,113
133 - 134	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	$ 36,352	2	$ 72,703
922 - 923	OTHER INJURY, POISONING & TOXIC EFFECT DIAG	$ 23,620	3	$ 70,859
190 - 192	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	$ 18,697	3	$ 56,090
082 - 087	TRAUMATIC STUPOR & COMA	$ 21,214	2	$ 42,428
314 - 316	OTHER CIRCULATORY SYSTEM DIAGNOSES	$ 20,150	2	$ 40,299
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	$ 5,892	6	$ 35,354
				$ 6,279,240
			Estimated Contractual Allowance	$ (3,016,977)
			Estimated Net Patient Service Revenue	$ 3,262,264

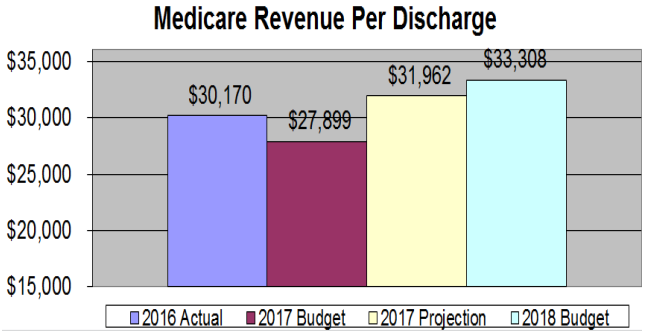
Rate Increase: Over the past months RRMC has lowered prices three times, equivalent to nearly $27.7 million in gross revenue. Unfortunately the reimbursement challenges that we face in the 2018 Budget prevent us from continuing to keep the rate reductions in effect. Essentially we are requesting to raise prices to cover shortfalls in Medicare and Medicaid reimbursement, growth of bad debt and free care and a significant decline in Medicare Disproportionate Share payments.

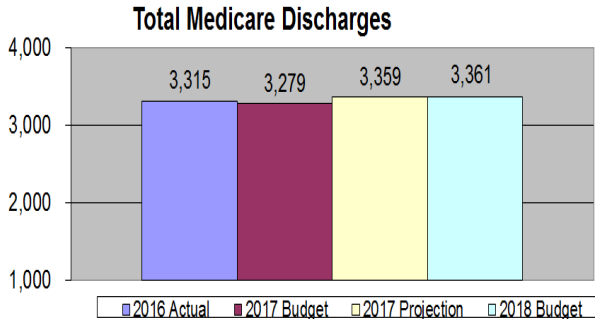
- Budget 2018 includes a 4.9% rate increase ($6.5 million net)
  - A result of decrease Disproportionate Share Payments of $1.2 million
  - Increased reserve for Free Care of $2.6 million
  - Underfunding in Medicare and Medicaid – Medical and Staffing inflation of 3.5%

- Medicare IP reimbursement rate increase 1.6%
- Medicare OP reimbursement rate increase 1.0%
- Medicaid reimbursement rates expected to remain flat

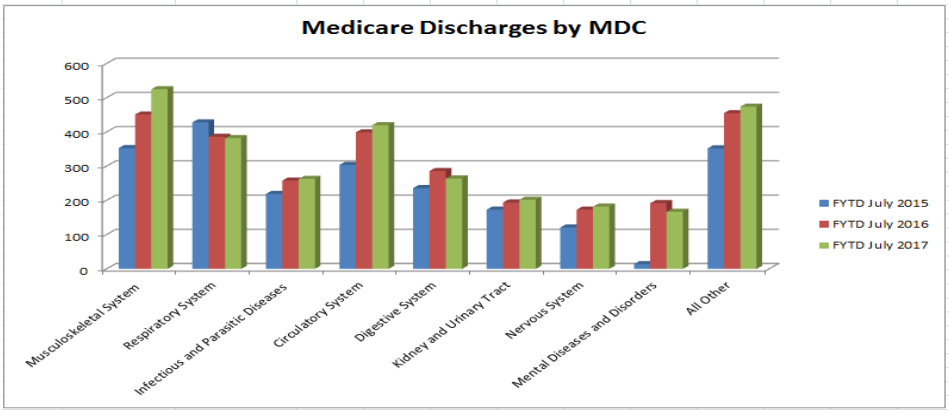


2. NPR PAYER - Medicare shows less favorable reimbursement and much higher utilization. Specifically describe the increase you are seeing in utilization – more patients, types of services, complexity, etc. Also, why do you expect to see less reimbursement? Provide a schedule supporting this lower reimbursement estimate.





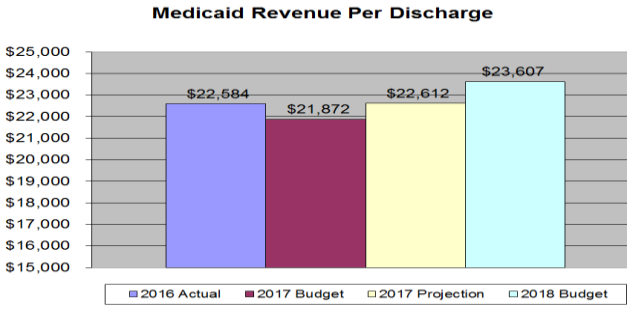
We continue to see growth in Medicare utilization for orthopedic services. We have seen an increase of 74 more admits this year for musculoskeletal services through the same time period in 2016. This result is also depicted in the volume maps illustrated in the response to question 1.

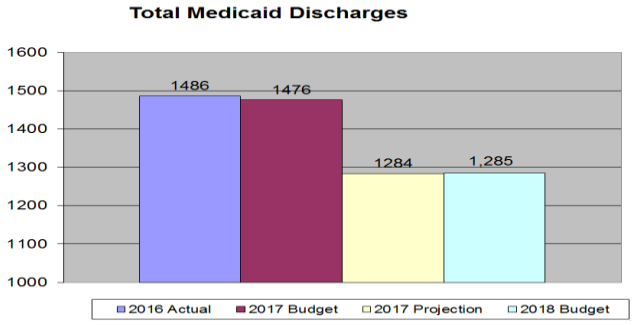


The decline in reimbursement is the net impact of two offsetting factors. On the positive side we do expect minimal increases in rates from Medicare for both inpatient and outpatient services. Overall we expect that our reimbursement will increase by approximately $1.0 million from year to year as a result of a net rate increase of 1.6% on inpatient services and 1% outpatient services. These increases are completely negated by the fact that we are requesting a rate increase of 4.9%, of which other than the $1.0 million increase Medicare will not participate in. As rates increase and reimbursement stays the same the result is a lower net to gross ratio.

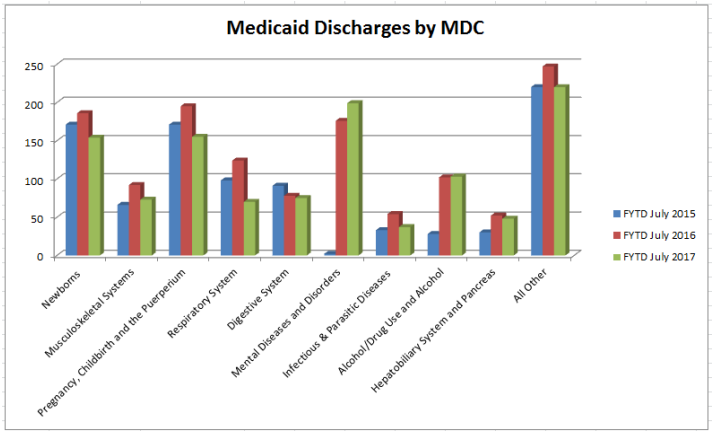
	Before Rate Increase	After Rate Increase
Medicare Revenue	$ 242,598,500	$254,581,100
Medicare Contractual Allowances	($159,087,700)	($171,070,300)
Medicare Reimbursement (Net Revenue)	$ 83,510,800	$ 83,510,800
Medicare Net to Gross	34.4%	32.8%

3. NPR PAYER - Commercial and especially Medicaid, show decreases in utilization. Specifically describe the decreases you are seeing in utilization - patients, types of services, complexity, etc.



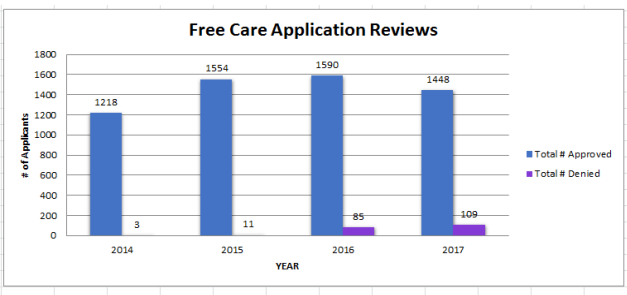


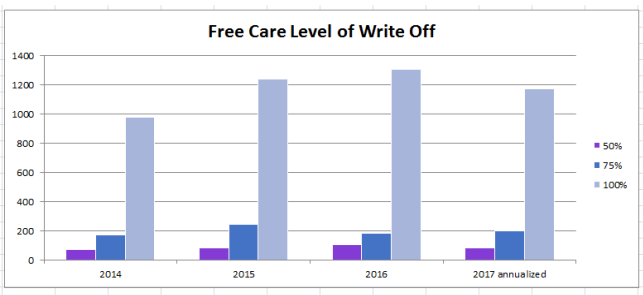
Our 2018 Budgeted Medicaid discharges are lower than our actual activity for services from October 2016 to July 2017 would now suggest. The annualized Medicaid utilization based on July 2017 would be approximately 1,360 discharges. The decline in Medicaid utilization from 2016 to the July re-projected volume is largely the result of a decline in women's health and pediatric care for pregnancy and newborn services. Together we have seen 73 few admits this year for pregnancy and new born services than through the same time period in 2016. We continue to see growth in Medicaid utilization for mental health disease and substance abuse. The change in mix of patients has impacted our case mix index and our Medicaid revenue per discharge. The mental health and substance abuse patients tend to be higher acuity and drive the need for more services than the pregnancy and newborn patient population.



4. DASHBOARD - Bad debt and free care as a % of gross revenue is increasing unfavorably from 2% to 2.2%. While bad debt is trending favorably, free care shows a large unfavorable increase. Discuss the changes occurring with free care.

RRMC's Free Care contractual allowance is budgeted consistent with projection 2017. RRMC provides a comprehensive Financial Assistance program to meet the healthcare needs of the RRMC community. Free Care expense is expected to continue at the current levels into 2018 driven by patient need. For the first 10 months of the year (October through July) there have been 1,298 applications reviewed, of these applications 93% were determined to meet program eligibility requirements. The two graphs below summarize a four-year trend of Financial Assistance application activity.





RRMC's free care program is based on the 2017 Federal Poverty guidelines. There is a sliding scale with varying levels of free care coverage. Patients whose earnings are less than 300% of the federal poverty level receive full free care. Patients with income between 301% and 500% of the federal poverty level receive partial free care and share in the cost of their care. Our guidelines for approving free care are outlined in the following grid:

2017 Federal Poverty Guidelines

Persons in Family or Household	90% FPL for SSI	100% FPL	Medicaid 133% FPL	ADAP 250% FPL	Up to 300% FPL	301-400% FPL	401-500% FPL
1	$10,692	$11,880	$15,800	$29,700	$35,640	$47,520	$59,400
2	$14,418	$16,020	$21,307	$40,050	$48,060	$64,080	$80,100
3		$20,160	$26,813	$50,400	$60,480	$80,640	$100,800
4		$24,300	$32,319	$60,750	$72,900	$97,200	$121,500
5		$28,440	$37,825	$71,100	$85,320	$113,760	$142,200
6		$32,580	$43,331	$81,450	$97,740	$130,320	$162,900
7		$36,730	$48,851	$91,825	$110,190	$146,920	$183,650
8		$40,890	$54,384	$102,225	$122,670	$163,560	$204,450
Allowed Discount		100%	100%	100%	100%	75%	50%
Amount Owed		0%	0%	0%	0%	25%	50%

Grimm Fund Rutland City **Agan Fund** Ludlow Residents **Goodrich Fund** Maternity Only

Medicare applicants will be denied when liquid assets are more than the Medicare Low Income Beneficiary Limitation:
Single $7,280
Couple $10,930

5. INCOME STATEMENT - Other operating revenue in increasing $1.3 million that is related to the 340B pharmacy program. Describe the risks associated with this program.

The 340B Pharmacy program is at risk for significant revision and restriction by Federal lawmakers and pharmaceutical companies. Proposed guidance and program clarifications have been delayed pending rewrite and review by the current administration. The stated intent of the 340B program is to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Pharmaceutical manufacturers do not support the program which allows RRMC to purchase eligible drugs at the lowest available cost. Proposed and discussed potential legislation has included limiting eligible drugs, restricting the definition of an eligible patient, restricting contract pharmacy participation and increasing the administrative burden of participation.

For RRMC, income from operations is 2.5% of net patient care revenue, or $6.3 million. The 340B Contract Pharmacy business income budget is $5.3 million, offset by the cost of pharmaceuticals of $1.8 million, for a net contract pharmacy gain of $3.5 million. There is an additional reduction in expenses for pharmaceutical purchases of $4.7 million for eligible RRMC outpatients. That said the 340B program is more than our budgeted operating margin. Without the 340B funding we would be faced with significant programmatic changes in current service offerings and would have to restrict our ability to provide free care. With the 340B funds we are currently we are able to provide financial assistance up to 500% of the federal poverty level, have expanded access to behavioral health and women's health services, provided cancer screening services and fund our local ambulance service with medications. These services would need to be reevaluated along with other clinical and care management services if we were to lose 340B funding.

5b. Non-Operating revenue is increasing by $1.7 million, of which $1.3 million is listed as "all other." What is included in "all other"?

The $1.3 million is the result of investment earnings related to the unrealized portion of the projected 6.5% rate of return on our board designated assets.

6. NARRATIVE - The Defined Benefit Pension Plan is currently under funded by $26.7 million. The hospital plans to make a $2.0 million contribution that equals a reduction of 3.2 cash days on hand. Is the hospital required to make minimum contributions ongoing to fund the balance? Is the plan regulated by another government agency?

Although RRMC's Defined Benefit pension plan has been frozen since 2006 there are numerous administrative aspects of the plan that must continue to be addressed and managed. The annual funding plan, the investment strategy of plan assets and the annual impact of the continued carrying cost of the plan are all areas that require both short-term and long-term strategies. RRMC's approach is to manage the plan in a way that allows for consistency in funding requirements with the goal of becoming fully funded within the next 5-7 years.

RRMC is not required to make annual contributions to our Pension Plan as a result of electing to use an amendment provided in the Highway and Transportation Funding Act of 2014 (HATFA) and specifically within the Internal Revenue Code, Section 430, referred to as MAP-21. The amendment serves to smooth the interest rate used in calculating required contributions by using a 25-year rolling average. This 25-year average method essentially eliminates and/or reduces current required contributions and delays the funding to future years. For RRMC the election of the MAP-21 reduces our required contribution from $2.9 million per year to $0.

Although we are not required to make contributions due to the MAP-21 election RRMC has continued to fund $2.0 million to the pension plan each year to allow for a more predictable and consistent funding plan. The MAP-21 rules are set to expire in 2023 at which time funding requirements could be significant. Secondly, all Defined Benefit plans are required to fund a Pension Benefit Guaranteed Insurance Plan (PBGC). The funding mechanism for the PBGC is based on a fixed per beneficiary cost and a variable cost that is based on the plan's unfunded status. The PBGC rates are increasing fairly dramatically each year whereby they are becoming more and more expensive. RRMC's contribution to the plan helps to mitigate growth of PGBC expense by decreasing the unfunded status and therefore the exposure of the variable rates.

Funding Stablization with Highway and Transportation Funding Act

	Jan. 1, 2017	Jan. 1, 2017	Jan. 1, 2016
Assumptions and Methods:			
Funding Relief/Stabilization	HATFA	No stabilization	HATFA
Effective Interest Rate	5.87%	4.06%	6.07%

Minimum Funding Requirement:			
Minimum Required Contribution (before CB)	$0	$2,981,955	$0

PBGC Premium Schedules

	2017	2018*	2019*	2020*
Flat-Rate	$69	$74	$80	$81

Variable Rate	3.4%	3.8%	4.2%	4.3%

There are many laws and regulations concerning pension plans. The laws and regulations that most commonly affect defined benefit (DB) pension plans include:

Internal Revenue Code Rules:

- Payment limits
- Nondiscrimination and Top Heavy Rules
  - prohibits plans from giving large amount of benefit to highly compensated employees
  - mandates equity in benefits between non-highly compensated employees and highly compensated employees
- Rules on distributions of lump sum payments
- Rules against assignment, garnishment

Generally Accepted Accounting Principles (GAAP)

- Annual expense calculations
- Financial statement disclosures

Employee Retirement Income Security Act (ERISA) of 1974.

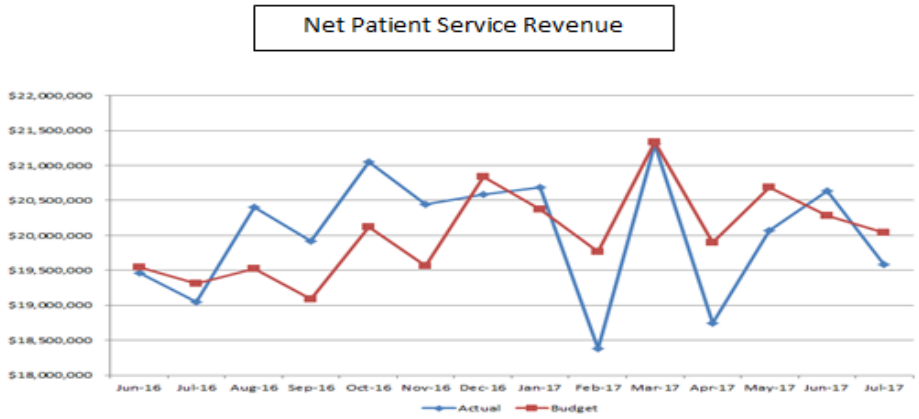
- Fiduciaries rules that ensure sponsors do not misuse plan assets
- Communication – plans must provide participants with information about plan features and funding

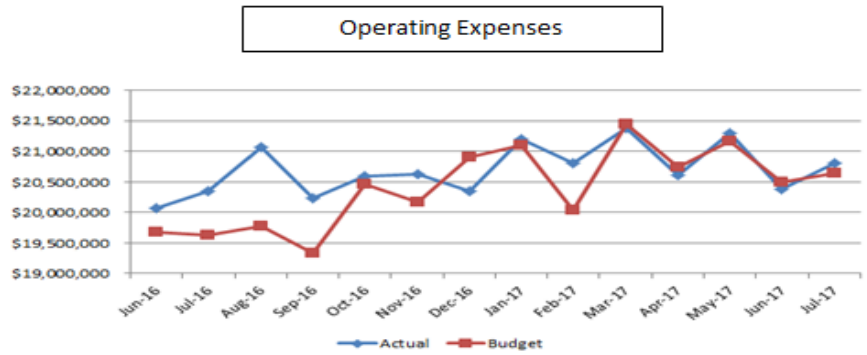
7. INCOME STATEMENT - Are the 2017 projections still valid? If not, please describe material changes.

Our Fiscal 2018 budget is prepared using actual results through February 2017. We do not expect to exceed the Green Mountain Care budget guidelines with any of the measures. In reviewing actual results for the 10 month period end July 31, 2017 our Patient Service Revenue is over budgeted expectations by $7.4 million or 1.78%. This projection is similar to the projection included in the 2018 Budget whereby we projected $9.5 million more revenue than budget. Our 2018 Budget remains consistent with actual revenue performance.

Our year-to-date Net Patient Service Revenue (NPSR) is lower than budgeted expectations by $1.4 million or 0.7%. Compared to our original projection submitted with the budget our NPSR is $3.2 million less than submitted. Although our reimbursement assumptions for Medicare and Medicaid are consistent with actual payment methodologies we do face other reimbursement variance. The major driver is the increasing need to reserve for free care and bad debt. This increase has been most prevalent in the last 3 months. Year-to-date the financial assistance program is $1.6 million over budget. Since October 2016 our Patient Financial Services team has processed 1,382 free care applications. Year-to-date the bad debt allowance is $793,000 over budget. Bad debt as a percentage of total revenue has increased from 1.3% to 1.5%. Our growth in bad debt relates to patients who have high deductible plans with no financial means to support the deductible and patients who have left the exchange due to affordability and their inability to pay premiums.

Operating expenses continue to run close to budget as year-to-date we are only over budget by $902,000 or less than a 0.5% variance. This 10-month performance is consistent with our original projections included in the 2018 Budget.





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

RRMC uses the Act 53 price schedules to support strategic pricing decisions related to planned rate changes, both increases and decreases. The price schedules should be reviewed with caution as there are many factors that must be considered when prices are compared across Vermont hospitals. Considerations include patient demographics, prevalence of underlying complications and comorbidities and payer mix that drives the need to cost shift. Should the Board have specific questions relating to RRMC's submitted Act 53 data RRMC can provide formal responses upon request.

9. Please be prepared to address the following issues during your GMCB Budget Presentation. Given the uncertainty of the federal actions, what are the potential implications of actions that the federal government may take to include;

a.) 340B pricing (if applicable) and its effect on your hospital

b.) Potential risks for your hospital to include economic viability

c.) Effects on bad debt/free care

Risk associated with reimbursement and payment rules continues to increase and extends not only to State and Federal payers but to commercial payers as well. Along with Medicare and Medicaid proposed rules there continues to be numerous payment and eligibility changes that challenge reimbursement from commercial insurers. Due to timing of Medicare and Medicaid payment rules budget assumptions are based on preliminary and proposed regulations and therefore are at risk of changing after the budget has been submitted. Effective dates of payment rules are not consistent by payer. Medicare inpatient rules are usually effective on October 1st of each year yet Medicare outpatient and physician rules are effective in January 1st of each year. Medicaid programs update their rates annually on July 1st, consistent with the State fiscal year. Changes in commercial reimbursement rates are based on individual contract between payers and hospitals. All of these inconsistent dates lead to reimbursement assumptions that are subject to change. Since RRMC submitted our 2018 Budget we have been tracking a number of potential risks and changes in reimbursement assumptions. While some of the assumptions are still proposed and could continue to change there is a total of $1.2 million of known reimbursement changes that will now know will lower our reimbursement and challenge our ability to manage net patient service revenue and operating margins. If we include the known reimbursement changes our budget to budget increase in Net Patient revenue falls from 3.4% to 2.9%. and our operating margin will from 2.5% to 2.0%.

	Known	Proposed/At Risk
IP Medicare		
Final Rule Rates	148,000	
Total Knee Replacements moved to OP setting		(845,000)
OP Medicare Payments		
Rate adjustment (Wage Index, Market Basket)		705,900
Payment Reductions for 340B Drugs		(2,850,000)
Medicaid		
DSH payment Reduction (State and Federal Changes)	(583,000)	
Rebasing – 2017 actual payments compared to 2018 estimates	(500,000)	
Commercial Insurers		
Changes in Payment Policies	(278,000)	
Uncompensated Care		
Actual bad debt and free care over 2018 Budget		(1,584,000)
Federal ACA Changes: Based on AHA study		(1,900,000)
Total	**(1,213,000)**	**(6,473,000)**

10. **In the March 31 GMCB hospital guidance, the Board allowed up to 0.4% for new health care reform. The Board directed each hospital to provide a detailed description of each new health care reform activity, investment or initiative included within the designated 0.4%, provide any available data or evidence-based support for the activity's effectiveness or value, and identify the benchmark or measure by which the hospital can determine that the activity reduces costs, improves health, and/or increases Vermonters' access to health care. With this in mind, please describe how you are investing for new health care reform activities in the four approved areas:**

- **Support for Accountable Care Organization (ACO) infrastructure or ACO programs;**
- **Support of community infrastructure related to ACO programs;**
- **Building capacity for, or implementation of, population health improvement activities identified in the Community Health Needs Assessment, with a preference for those activities connected with the population health measures outlined in the All-payer Model Agreement;**
- **Support for programs designed to achieve the population health measures outlined in the All-payer Model Agreement.**

The list below describes a number of programs that RRMC will fund as part of community support and care management programs. The aim of each of these programs is to support our transition to risk based models by promoting population health, care management and healthy lifestyle services through a series of long-term and short-term goals that are managed with various structures: internal, collaborative and/or by community action agencies.

This list does not include time and commitment from RRMC staff to work in collaboration with State, Federal and National agencies or the ACO to design, test or promote the All Payer Model and payment reform initiatives. Whenever appropriate RRMC takes an active role and commits sufficient resources at all levels of the organizations.

Healthcare Reform: $974,000 annual cost

- Expanding Clinical Social Workers - $82,800
  - Emergency Room
- Community Care Management - $80,300
  - Care collaborative team between CHCRR and RRMC
- Community Investment & Population Health Funding - $520,000
  - Medication REACH (Reconciliation, Education, Access, Counseling, Healthy Patient)
  - Peer Specialists – Psychiatric and Substance Abuse Disorders (Patient compliance and Transitions of Care)
  - Come Alive Outside
- Blue Print – Medical Homes - $151,300
  - Costs over State and Payer funding
- Screening, Brief Intervention, Referral to Treatment (SBIRT) - $47,300
  - Costs over Federal grant funding
  - Emergency department patient screening by trained clinicians
  - Identify patients who are at risk for development of substance use disorders
- Community Support: $92,300 grant funding
  - Continued funding to Community Grant Programs provided through the Bowse Health Trust
  - Expense growth from prior years

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

RRMC will not be able to participate in a full two-sided risk contract in 2018. Most importantly, our region's primary care provider (Community Health Centers of the Rutland Region) is not willing to participate at this stage. RRMC would have considered being at full risk in 2018 if they had agreed. We will participate in the Shared Savings model in 2018 through CHAC.

RRMC still believes the All Payer Model (APM) with two-sided risk is the right approach. We are hopeful that the experience in 2018 will convince our partners and RRMC that it is viable and that the details are appropriate. To be ready for this, RRMC will continue to do work in four areas:

- We will build a community-wide care management system that combines the case management functions of RRMC, CHCRR and other community providers.
- We will continue to build data feeds and a data warehouse that will allow us to analyze the information required to be successful.
- We will review the offerings, risk and financial model proposed to ensure we can accept it.
- We will alter our physician compensation program to ensure aligned incentives.