Rutland Regional Medical Center
August 26, 2016

General

1. *If you included a rebasing in your proposed budget, why do you believe the Green Mountain Care Board should agree to rebase your budget? How do you plan to contain your growth going forward?

   Our proposed budget does not call for rebasing.

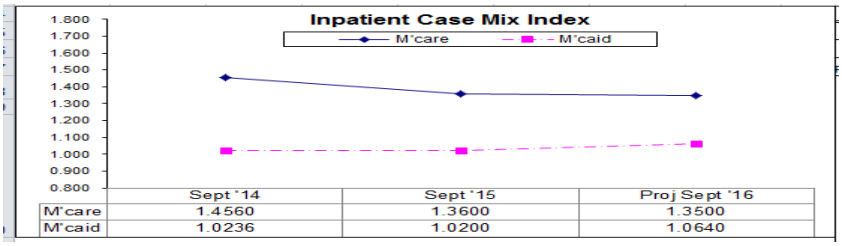
   Our 2017 net patient service revenue budget increases by 4.3% when compared to the 2016 Budget. In accordance with the State regulated 3% growth limitation this represents an increase of $2,237,000 more than the limit would support. We have verified that this growth is related to shifts in market share and will request that our 2016 Budget be rebased to account for these changes. We can document that patients are seeking services at RRMC that in the past were provided by healthcare facilities in other communities or markets or by private physicians within our own community. The services that are driving the market share increases relate to orthopedics and neurology.

   We have put a number of programs in place that are aimed at keeping patients out of the hospital by providing support systems to help align care in an outpatient setting. We have begun case management in the Emergency Room to ensure that patients seeking emergent care can be redirected to primary care to prevent additional visits. We have a transitional care case manager that will provide home visits to high-risk patients have an inpatient stay to ensure patients are following discharge instructions, are seeking follow-up care with their primary care physician, are adhering to their medication plan and in some cases that their home is safe to return to. We also have a medication management program that seeks to ensure that patients are following their medication plan, that there are no drug interactions, and that dosage and frequency for medications are appropriate and followed.

2. What is your expected All-Payer and/or Medicare case mix index for FY17?

   a. Please also provide your case mix index for FY14 (actual), FY15 (actual) and FY16 (budget and projected) along with any drivers (e.g. demographic shifts, product line additions, payer mix changes, etc.) that explain increases or decreases over time.

      Our case mix index has been fairly consistent over the past 3-years and we do not anticipate a significant change given our demographics or service offerings. Any change that we have seen is related to the manner in which Centers for Medicare and Medicaid Services (CMS) changes the case weights of procedures, which happens on an annual basis, the most significant being the transition from ICD-9 to ICD-10.



	Sept '14	Sept '15	Proj Sept '16
M'care	1.4560	1.3600	1.3500
M'caid	1.0236	1.0200	1.0640

b. Please explain the basis for anticipated changes to your case mix index going forward from FY16, if any.

We do not anticipate any significant change in case mix going forward.

3. Please explain the basis of any anticipated changes in your payer mix for FY17. What are the changes you expect to see going forward?

The RRMC 2017 budgeted changes in net revenue are driven by changes in utilization, a shift in market share, changes in payer coverages and patient charge rates. Below is a summary of the net changes by payer.

	Rates	All Other	
Commercial	*-($7,195,518)*	*$5,316,289*	*Rates: Planned rate decrease of 5.1%* *Other: Market Share, Physician Practice Transfers and increased utilization*
Medicaid		*(5,544,226)*	*Rates: No change* *Other: Payer mix decreased to 2015 levels, no expected overall change in reimbursement rates*
Medicare		*$13,822,737*	*Rates: No change* *Other: Payer Mix higher than expected, market share and utilization increased along with slight increase in reimbursement rates.*
Bad Debt and Free Care		*$3,767,998*	*Rates: No change* *Other: Continued enrollment in Health Care Exchange, increased collections from 3rd part collection agency. 2017 Budget consistent with 2016 projection.*

4. As a nonprofit with a duty to benefit your community, please explain any policies your hospital has, if any, to put a reasonable cap on executive pay and on the percentage of your overall budget that is made up of administrative costs.

Rutland Regional Medical Center sets salaries for all staff in the same way. Annually, relevant external market surveys are reviewed for all positions. Whenever possible a least three surveys are examined. If a particular title has fallen out of market, a market adjustment will be considered. In order to recruit the necessary talent for executives, physicians, nurses, technicians, or support staff competitive salaries must be provided. The percentage of our overall budget that is made up of administrative costs is 28.1%.

5. If you have varied your commercial rate increases by program or service, how do you determine these increases? Are they based on projected cost increases by program or service or based on something else?

We have not included a rate increase in our 2017 Budget, rather we have reduced our charges budget to budget by 5.1%. The rate decrease is not an across the board decrease as it is targeted to specific services. We target services to levy price reductions based on a review of our charges compared to other hospital charges that are published as part of the Act 53 data and in response to feedback from concentrated areas of patient and commercial payer compliant.

6. What is your margin target, and how was it determined?

Included in our 2017 Budget is an operating margin of 2.5%. This margin is consistent with the margin budget in 2016, but less than margins budgeted in years previous to 2016. We need to keep our margins at the 2.5% level in order to fund our pension plan, repay principal on our outstanding debt and invest in equipment and buildings to ensure quality and safe care to our patients.

   a. Is this a long-range target for your hospital?

We believe that we could not sustain margins lower than 2.5% for any prolonged period of time given our need to manage our cash flow and fund commitments to our pension plan, service our debt and invest in our infrastructure and equipment. For the long term our margins should average 3.5%

7. Please describe how your budget process would differ if a 3- or 5- year net patient revenue cap were used rather than a yearly cap.

The budget process would not differ.

8. What is your budgeted amount for Medicaid underpayment for FY17?

The Medicaid Cost shift is $27,436,872. This is calculated by subtracting the DSH payments received from the operating expense (including Medicaid bed tax) and dividing this into the overall budgeted FY17 Gross Revenue. This ratio is then applied to Medicaid Budgeted Gross Revenue to calculate the cost of providing care. Net Medicaid receipts are deducted from the cost to determine the cost shift amount.

9. What is the extent of your Choosing Wisely initiative(s), if any?

   a. Please describe the initiative(s) and how you have chosen which departments participate.

   b. Which of these initiatives, if any, have led to identifiable cost savings and/or quality improvement?

The Choosing Wisely Program has been used in two areas of the hospital to date. Specifically the radiation oncology department has used their recommendations to change certain of their treatment protocols. Secondly the hospitalist program has used this program to help guide their ancillary services ordering practices. We believe saving have occurred as a result of these interventions but cannot easily calculate the benefits accruing form these changes as compared to other varying practices.

Community Benefit

10. Please explain how the federal regulations on nonprofit hospital financial assistance policies and billing practices that go into effect on October 1, 2016 affect your budget proposal for FY17 as compared to FY16.

   a. Include how you anticipate the regulations affecting your bad debt and charity care.

   b. Which charges did you base your financial assistance discounts upon in FY16?

The regulations that govern our financial assistance policy do not impact the 2017 Budget as we elected to implement those changes beginning in 2015 when the regulations were in a proposed State. We finalized the policy, based on final regulations, in 2016 with very little change from the initial 2015 implementation. We comply with all regulations and have widely publicized our program and a have comprehensive policy and procedure that support the program..

As written in our policy….We base our financial assistance discounts on a calculation of "amounts generally billed (AGB). AGB is the average amount paid by all private health insurers, Medicare, and Medicaid for emergency or other medically necessary patient services. Rutland Regional uses the "look back method" as defined in section 501 (r) (5) (b) (1) of the Internal Revenue Code. Rutland Regional will limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under this policy to not more than AGB. Rutland Regional will update the AGB annually. For FY2016 the AGB discount is 52.2%.

11. *For all community benefits that you listed on your Form 990 Schedule H, what is the dollar amount you are budgeting for each benefit by year (FY14 Actual, FY15 Actual, FY16 Budget, FY16 Projection, and FY17 Budget)?

FY2014 Actual: ***$4,320,530***

FY2015 Actual: ***$4,082,042***

FY2016 Budget ***$3,424,680***

FY2016 Projection: ***$3,748,638***

FY2017 Budget : ***$3,239,815***

12. *What is your current level of community benefit as a percentage of revenues?

a. *What percentage level are you willing to commit to on an ongoing basis?

b. *Please provide a detailed breakdown of the programs and other components you include in your community benefit calculation.

Based on the most recently filed 990, RRMC contributed $4.5M to benefit the local community. The contributions were provided to support programs that safeguard & improve public health, recruitment of health professionals to medical shortage areas, etc. In 2014 these contributions made up 2.0% of net patient revenue.

Community and Health Improvement Services	***$2,300,000***
Health Professions Education	***$ 380,000***
Research	***$ 159,000***
Cash and In-Kind Contributions	***$1,230,000***
Community Building Activities	***$415,000***

13. How does the money you plan to spend on community benefit align with the top five issues identified in your most recent Community Health Needs Assessment (CHNA)? If your assessment of your top five issues has changed since your last Community Health Needs Assessment, please explain the change as part of your answer.

The top priorities of our CHNA are:

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.

RRMC is employing strategies to address Access to and Utilization of Health Care, with attention to Mental Health, Substance Abuse, and Primary Care. Specifically, we are engaged in activities to improve identification of patients and their needs, and to provide treatment and engage supports for patients to improve and sustain outcomes. These include:

- ***SBIRT (Screening, Brief Intervention and Referral to Treatment)***
- ***MAT enhancements to complement the Opiate Hub Treatment services***
- ***SPOKE support and expansion***
- ***Support and collaborate with the Community Health Centers of the Rutland Region, the Federally-qualified Health Centers serving the region, to integrate and expand their services***
- ***Promote, enhance and expand out Tobacco Cessation programming***
- ***Improve Care Coordination across community organizations for patients with high hospital utilization***

The Community Benefits funding outlined in response to Question #11 is directly related to addressing those Community Health Needs that RRMC has the ability and capacity to directly affect. We continue to enhance the hospital's activities while working with our partners to advance policy change (e.g., tobacco-free campuses), and supporting the strengthening of our community, as highlighted by the figures below.

- ***Free & Discounted Care***
  Rutland Regional provides low- and no-cost care for eligible residents through a financial assistance program. The Free Care Provisions (Gross Charges) for

2015 totaled $4,167,120. We also support patients of the Rutland Free Clinic by providing certain diagnostic services as part of free care.

Commented [MKG1]: From Annual Report

- *Community Health Improvement Initiatives*
  Health care support provided to, in and throughout the community for organizations and individuals to improve the overall health of individuals and populations, reduce inappropriate utilization of services and increase appropriate use of available services. Services include those identified above (SBIRT, etc.), case management, referrals, screenings, educational programming and care coordination. Rutland Regional offers the Community Health Team, Healthier Living Workshops, Tobacco Cessation programming, Asthma Education and Intervention, Breast Care Education Outreach, Advance Directives Explainers, and numerous support groups for individuals and families. Support for these programs exceeded $2,308,302 in fiscal year 2015.

- *Health Profession Education & Training for Non-employee Physicians, Workers & Students, and Workforce Development*
  Collaborating with regional education programs, Rutland Regional provides a variety of training programs for individuals interested in medical-related field. During 2015, Rutland Regional's investment in these areas totaled roughly $381,268.

- *Donations and Grants*
  Rutland Regional works with partner organizations to support programs and events serving the needs of our community, an important complement to our own efforts. Financial contributions support non-profit organizations that are providing a program, event or service identified as a health need, or other programs or services needed to advance the community, to develop workforce or advance environmental improvements. Rutland Regional provided much needed support through donations, sponsorships and employee participation equal to more than $1,233,050.

  For over 20 years, the Bowse Health Trust has provided grant to organizations to provide programs that address the health needs in the Rutland County area. This past year 3 new programs were awarded grant funds. They include:
  - *Southwestern Vermont Hoarding Task Force hosted by BROC*
  - *Marble Valley Grow Farm to School Network hosted by the College of St. Joseph*
  - *Community Impact Program hosted by Wonderfeet Kids' Museum*

a. *Are there needs identified in your CHNA that you would like to address, but feel that additional cooperation by outside entities is required for an effective solution?*

   RRMC participates in and supports many initiatives that work to address social and economic determinants of health, and physical environment factors. We are not typically the best-suited to lead this work.

   More collaboration and support could also be helpful to address the gap in the continuum around tobacco cessation. Our programs, in coordination

with 802 Quits, are successful at engaging and supporting roughly 180 tobacco users each year in our region, to help them quit. Sustaining this requires institution of long-range supports, such as a Tobacco Free Support Group to meet the needs of our population.

Health Information Technology

14. Do you anticipate needing to replace your electronic health records system in the next five years?

We will not be replacing our EMR over the next 5 years. We will however continue to develop and optimize existing functionality to ensure that we leverage the full technical capacity of the system.

15. Do you use any of the services offered by VITL (Vermont Information Technology Leaders)?
    a. If so, which services?
    b. To what extent are VITL's services integrated into the hospital's care delivery?
    c. Has the hospital experienced any cost savings or quality improvement from VITL's services?
    d. Do VITL's services compliment your other health information technology initiatives? If so, how?

No. We do send data to VITL. VITL plays an important role in collecting and integrating data that will be critical to the ACOs if an All Payer Model is agreed upon.

16. *What percent of your employed primary care providers are participating in the Hub and Spoke program? *N/A*
    a. *What is the average number of substance abuse patients that those providers treat?
    b. *How many additional providers would be required to fully meet your community's needs in a reasonable amount of time? Please take into consideration any waitlists for treatment.
    c. *If your hospital is involved in any medication assisted treatment programs, do you have any information on your costs for these programs versus savings to your hospital?

17. *Please explain to what extent mental health patients presenting at your Emergency Department impacts your budget?

a. *Please explain how mental health patients are handled when they present to your Emergency Department or other triage location, including a description of any holding or isolation areas that you use, and how often you expect to use this type of area in FY17.

Our mental health patients (that walk in) come through the emergency room main door and are triaged in the triage area. Once triaged, a patient safety associate is assigned to the patient and they are brought into a private room or a hallway bed. For the patients that come in with EMS or police, they receive immediate bedding in the same space described above. As of 8/14/16, a new area opened within the ED to care for mental health patients. It consists of five private rooms which are built to provide safety to the mental health patient. They are modeled after our inpatient psych beds. We expect to have them utilized consistently throughout FY17.

b. *How do you train your security staff, contracted or in-house, on handling situations involving people experiencing mental health crisis? If some security staff members have been trained but not all, please explain which ones and why.

All staff operating under the direction of the Department of Security and Safety, to include Security Officers and Patient Safety Associates (who provides the immediate continuous monitoring of mental health patients) receive:

-8 Hours of Crisis Prevention Institute's Non Violent Physical Crisis Intervention Training (12 staff on hand that are certified instructors at RRMC)

-1 Hour of Physical Restraint Application Education with a Clinical Education, then review of restraint policy with Security Dept. leadership

-At least 20 hours dedicated exclusively to shadowing with an experienced Patient safety Associate and Security Officer for the new PSA to observe, then demonstrate their abilities to de-escalate and engage with the patient at the bedside

-Receive orientation to features of the environment (power controls, lighting, nurse call, emergency buttons, fire alarms, evacuation).

-Orient to internal departmental documentation

-Review policy pertaining interaction with Law Enforcement and the expectations and limitations surrounding Police Involvement with Mental Health Patients

-Review

New education that has been deployed starting Aug. 1 and being scheduled to everyone with 100% completion by 10/1/16.

-Handouts and discussion pertaining to "Safety and Communication during patient escalations and emergency procedures).

-Handout and discussion pertaining to "Patient Debriefing"

-Hands on Belongings Search competency

-30 Hours of Inpatient Psychiatric Services education and experience to include:

-Understands the Six Core Strategies Model: Preventing conflict and violence in mental health settings to reach the ultimate Goal of Reducing the Use of Seclusion and Restraint

- Understands how Patient-centered Care looks on a Psychiatric Unit

- Understands Disability Rights Vermont (DRVT) services

-Understands the Rights of the Involuntary Patient

-Understands PSIU's culture of Trauma-informed Care and its role in reducing the use of Seclusion/Restraint.

-Time spent on the floor observing and participating in patient de-escalation