Hallmark Health System

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September 9, 2016

VIA Electronic Mail

David Seltz, Executive Director
Massachusetts Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

Dear Mr. Seltz:

Enclosed, transmitted electronically, please find written testimony from Hallmark Health System, Inc. for the upcoming public hearings on health care cost trends as requested by the Massachusetts Health Policy Commission in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis.

By my signature below, I certify that I am legally authorized and empowered to represent Hallmark Health System, Inc. for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

I can be reached at 781-979-3050 if you have any questions.

Sincerely,

Charles R. Whipple, Esq., M.H.S.A.
Executive Vice President, Chief Legal Officer
Hallmark Health System, Inc.

CRW/lh

Enclosures

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. **Strategies to Address Health Care Cost Growth.**
   Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
   a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

      Hallmark Health, as a community based health care provider, is driven by its mission to ensure access to quality care in the most cost effective setting and works to keep pace with policy, payment model and reimbursement changes that significantly impact the delivery of care; but the growing gap between expenses to successfully implement and meet progressive changes and funding to cover the costs associated with these initiatives have an impact. Without adequate funding, we are significantly challenged to implement many of the changing care models designed to manage cost and improve outcomes, such as PCMHs, and achieve the long-term benefits these models are intended to provide.

      Additionally, Hallmark Health is challenged by direct drivers of cost that include keeping pace with competitive wages, accelerated pharmaceutical cost, the demand of new technology to successfully provide effective and efficient care, and the strain of cross subsidizing for the delivery of other inadequately funded services, such as behavioral health.

   b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

      Adequate funding built into changes in care models for the successful implementation and sustainability of programs and quicker changes away from fee-for-payment model to reimbursements that more adequately fund progressive models of population health management (wellness, prevention).

      More appropriate funding and reimbursement of behavioral health services for the support of investment in appropriate outpatient and inpatient resources that help break the cycle of higher-cost ED utilization.

      Policies that incentivize patients to take advantage of more value based services that are of equal quality.

2. **Strategies to Address Pharmaceutical Spending.**
   In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.
   a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other***: Additional Notes****: Embedded in the LMMER (Lawrence Melrose Medical Electronic Record) EMR workflow is the PCPO (PCHI) formulary, which takes into account drug cost. When the physicians enter in a medication, the system will display red/yellow/green indicators that show the physicians whether the medication is a good choice based on the criteria used to define the formulary, which includes a drug cost component. The medical directors of the PHO create EMR pop-ups that will alert physicians about high cost medications and will also provide alternate medication to consider that might not be as high-cost.*

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

Hallmark Health has been highly focused on community needs as they relate to behavioral health, including substance use disorders. We have a comprehensive behavioral health service line that includes 56 inpatient adult and geriatric psychiatry beds, an outpatient program including an intensive outpatient program and a geriatric evaluation program, and a 24/7 crisis team to provide mental health and substance use evaluation in the emergency departments. We have been the recipient of two significant CHART grants for the support of innovative approaches to addressing behavioral health and substance use disorders in the Hallmark Health service area. CHART 1 reduced the use of opioid prescriptions in the ED for patients with back pain by 11% through the development of standardized and sustainable clinical practice guidelines. CHART 2 is in month 10 of a 24-month grant and provides an innovative, community based approach to meeting the complex needs of patients with high ED utilization. Additionally, the CHART 2 team is working with patients with opioid overdoses and with pregnant women with opioid use disorders. Hallmark Health will address the range of behavioral health needs including mental health and substance use treatment, chronic pain, and other social determinants of health including housing, financial insecurity, employment, and access to care. Strategies include the continued integration of behavioral health clinicians and case managers in primary care setting. Most recently Hallmark Health is working to establish a specific work group to create a practice paradigm that looks at leveraging all available behavioral health resources for the successful and sustained integration of behavioral health care in the primary care office, with the potential development of community based outreach services.

Additionally, Hallmark Health partners with broad reaching agencies and programs. We are a supporting founding member of the Eastern Middlesex Opioid Task Force co-founded by DA Marian Rayan and State Senator Jason Lewis, bringing together elected officials, emergency response providers, health care providers, law enforcement and community agencies to identify and address growing SUD needs in the community. Hallmark Health is also a community partner of the Mystic Valley Public Health Coalition Massachusetts Opioid Abuse Prevention Collaborative. By integrating itself into broader community-based initiatives, Hallmark Health increases its understanding, reach, and impact collaboratively. Specific to SUD, Hallmark Health has established its own Substance Use Disorders Work Group under its CEO as executive sponsor to serve as a resource for the organization. The purpose of the Work Group is to support Hallmark Health clinical providers and first responders in the care and management of patients (and their families) with SUD by providing tools and resources relevant to the prevention and treatment of substance use disorders and help successfully integrate and/or support needs resulting from broader regional or state initiatives. Work is built on the principle that addiction is a chronic medical illness.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

There are a number of challenges to successful integration of behavioral health services starting with inadequate funding and reimbursements for integration of the most appropriate resources for behavioral health patients in the primary care setting. SUD and mental health illness become illnesses of manageability requiring different skill sets and resources beyond the scope of traditional primary care. This includes case management and outreach workers who can help and support patients manage the many determinants to health including food, housing, safety and employment. Currently, case management and outreach services are not reimbursed in the fee-for-service payment models.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

In recognizing the ever evolving impacts on successfully meeting the health care and wellness needs of its communities, Hallmark Health engages in number of efforts to understand and address social determinants of health. Three key strategies include data collection, developing shared knowledge, and community based programming.

1. Understanding the need

This includes collecting data through CHNA process, grant funders, and reputable organizations such as the American Cancer Society; gaining knowledge through memberships in AHA, MHA, ACHI (Association for Community Health Improvement), and extensive participation on committees and agency boards such as the GBFB Food Security Task Force; Malden's Promise (improving graduation rates); the local poverty agency, Action for Boston Community Development (ABDC); and many others.

2. Developing shared knowledge around health impact

By collaboratively developing shared knowledge around the social determinants to health and wellness we can have greater reach and impact in addressing these issues.

We partner extensively with other agencies and participate on agency board with respected groups on domestic violence such as MAAV, WAAV, SAAV and Portal to Hope and facilitate a monthly domestic violence roundtable. We attend regional and statewide Community Health Area Network (CHNA) meetings and host numerous meetings, seminars and other gatherings including PTA and CHNA (16 meetings). We support Everett's Healthy Neighborhood Study by the Conservation Law Foundation to better understand the impact of neighborhood development on health and the work overseen by the Joint Committee for Children's Health Care in Everett (JCCHCE). HHS is a member of the JCCHCE.

3. Addressing the need through programming

Hallmark Health provides, partners with and engages in numerous programs and services that specifically look to address social determinants to health. Specifically, Hallmark Health works to address food insecurity through its highly regarded monthly Mobile Food Market. With 1034 families enrolled, serving an average of 400 families per month, the program is acting as a role model for a minimum of three other new sites this year in Allston/Brighton, Lawrence, and Framingham. This program was featured in an SG2 strategy document in promoting development of a market-driven chronic care strategy. Additionally, through the Senior Health Program in Medford, low-cost locally grown food is provided at a low-income senior housing site, and Hallmark Health 3000 enrolled participants served at WIC.

Through CHART 2 grant, Hallmark Health established the COACHH program. Now in month 10 of a 24-month grant; the program provides an innovative, community based approach to meeting the complex needs of SUD patients with high ED utilization. The CHART 2 team is working with patients with opioid overdoses and with pregnant women with opioid use disorders. Hallmark Health will address the range of behavioral health needs including mental health and substance use treatment, chronic pain, and other social determinants of health including housing, financial insecurity, employment, and access to care. Strategies include the continued integration of behavioral health clinicians and case managers in primary care setting.

Hallmark Health also offers multidisciplinary mentoring resources to support students in nursing, pharmacy, nutrition, facilities/engineering and many other disciplines and offer scholarships for our pharmacy technician program.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

1. ***Varied professional understanding of the value of this work.*** *State and federal differences in reporting for example.*
2. ***Challenges of consistently measuring the impacts of the work.*** *Food insecurity is addressed by many programs for WIC, school lunch/breakfast, summer food programs, church groups, and food pantries; but how do we identify, track, and measure the unique changes made by our programs? Cultural perspective and political climate must be included when measuring need.*
3. ***Lack of sustained and adequate and intense competition for funding.*** *Especially in a challenging fiscal environment; state, federal and internal funding is challenging. Many of the most successful programs are initiated by grants, but then must be sustained in other ways.*

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

Hallmark Health is continuously focused on creating access to services that are of quality and value for its communities and physicians. This includes collecting quality data on our providers and specialists who use the system. While this data is not presented at time of referral, the system does indicate whether or not a referral is within the network. As a member of the Hallmark Health PHO, there is an expectation of commitment to quality and cost effectiveness, and all specialists within HHPHO have signed a Participation Agreement to provide high quality, cost-effective care. Additionally, HHPHO has a central services department that handles patient referral requests and ensures patients receive timely access to high quality, cost-effective specialty care within HHPHO or outside HHPHO if services are not available within Hallmark Health.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   38T

   ii. If no, why not?

Cost and quality data is not available at the point of referral, however:

- *The majority of Hallmark Health PHO (HHPHO) Primary Care Physicians are on an integrated record called LMMER (Lawrence Melrose Medical Electronic Record) that indicates which specialists are within the HHPHO Referral Circle. All Specialists within HHPHO have signed a Participation Agreement and agree to provide high quality, cost-effective care.*
- *Additionally, most of the specialists on LMMER are participating in the Meaningful Use program.*
- *Most of the specialists on LMMER have been submitting data to CMS for PQRS (Physician Quality Reporting System). CMS has increased the importance of this program and the data they receive from physicians by giving each physician a quality score (value based modifier).The quality score is given based on how the physicians perform compared to the benchmark set for each measure. LMMER is monitoring and tracking each physician's quality score to ensure they are in the range to avoid a penalty and/or receive an incentive payment. CMS is also going to make these quality scores publicly reported at some point.*
- *HHPHO has a central services department which handles patient referral requests and ensures patients receive timely access to high quality, cost-effective specialty care within HHPHO or outside HHPHO if services are not available within Hallmark Health. HHPHO medical directors review requests for out-of- PHO referrals to make sure patients are directed to the most appropriate specialist.*
- *HHPHO utilizes Athena Population Health Management software, which includes health plan claim and electronic medical record data to allow us to report on quality and cost measures for our managed care populations. This data is used to identify areas for cost savings and quality improvement opportunities.*

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   38T

   ii. If no, why not?
   Please see 5b

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
No

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
38T

ii. If no, why not?

Hallmark Health has certified EHR technology in place in both the inpatient and ambulatory environment, which supports interfacing with other provider organizations' systems. Additionally Hallmark Health is a participating member of both the Mass HiWay and Surescripts exchange networks.

While Hallmark Health possesses the technical capability to query or 'pull' a summary of care document from another organization, the current use case is the 'push' method of sending a SOC via direct address using one of the above exchange networks at the point of referral in the ambulatory setting. The exception is an automatic receipt of clinical documents from outside health care organizations part of exchange within Surescripts (i.e. CVS Minute Clinic).

Outside organizations must have similar EHR capabilities, direct addresses and participation in exchange networks to satisfy requirements of the exchange.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

Hallmark Health continues to explore appropriate payment models in the interest of best serving its communities and currently participates in risk-based contracts, ACOs and PCMH.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Barriers include the high cost specialty drugs and we see a need for price limits in the pharmaceutical industry, especially for patients with chronic conditions. Often patients with chronic conditions can't afford to pay for medications to manage their conditions or the pay the co-pay for the frequent office visits needed. Covering services in full for these patients would help reduce overall costs.

Additionally, there is the need to improve access to behavioral health and substance abuse services, including improved reimbursement for these services; and offering training grants to incentivize more providers to practice in this area.

c. Are behavioral health services included in your APM contracts with payers?
Yes

i. If no, why not?
38T

7. **Strategies to Improve Quality Reporting.**

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Hallmark Health reports on over 300 quality and safety related measures to various entities that include government payers, commercial payers, regulatory, accreditation and oversight agencies at the federal, state and community levels. New measures and reporting requirements are added frequently, such as the opioid dependent newborn related syndrome reporting, and additional measures being added to the AHRQ PSI-90 composite measure effective October 2016.

The complexity of the measures and different definitions of measures used by the various entities highlights the lack of alignment among the payers and regulatory agencies. For example; CMS and MassHealth use different definitions for readmissions and health care acquired condition measures. MassHealth employs a definition that requires proprietary software (3M) that is not available to all hospitals, thus making it difficult to track and improve results in an efficient and effective manner. It also requires that hospitals collect, track and improve results on multiple versions of similar measures with nuanced differences. The CMS publicly reported data on quality, safety and patient experience measures are for different date ranges and some measures report on just Medicare patients and some measures apply to an all-payer population. Commercial payers often add additional requirements for reporting that are hospital specific. A minority of these measures are fully electronic. The measures that are based on electronically captured administrative claims data are dependent on highly accurate documentation and coding. The coding rules recently underwent significant changes with the conversion from ICD-9 to ICD-10 coding in October 2015.

Hallmark Health is actively addressing these challenges by automating as much data collection as possible. However, some clinical areas are not utilizing electronic documentation systems and continue to document manually in paper medical records, creating a barrier to automating data collection and reporting. Reporting the data to clinicians for timely analysis and improvement work requires a team of data analysts familiar with the myriad of quality reporting vendors and data bases to write upload files, write reports for display of validated data, and to develop data visualization tools and strategies to present the data to clinicians for action. Use of electronic health records in addition to measure alignment will reduce the resources necessary to abstract the data from the patient medical record, submit the data through an approved vendor, validate the "outlier" cases, display the aggregate data and track and trend the measures. Aligning and consolidating quality data reporting is critical to managing the costs of collecting quality data and ensuring it is captured accurately.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

Entities requesting performance data should take advantage of the national trend towards using a common set of performance measures with definitions approved and agreed upon by measure stewards and approvers such as AHRQ, NQF and NCQA. Steps should be taken to align measure reporting timeframes. For example, the CMS quality reporting generally uses the federal fiscal year; however the CDC NHSN data is reported only by calendar year, making it difficult to have an aligned report on all quality metrics. Measures that allow for electronic collection of data should be favored, but systems need to allow hospitals adequate time to set up the infrastructure for automatic collection of such measures and validating the data.

A focus on establishing the infrastructure needed to enable electronic data collection across all health provider systems as well as the creation of electronic health record based specifications would support the further

development of electronic Clinical Quality Measures (eCQMs) for automated collection and reporting of quality measures.

At a minimum, new and proposed measures should be required to have agreed upon standard definitions consistent with those of a recognized measure steward approver, along with electronic standards and definitions for automated collection and reporting. Alignment among government and commercial payers, for quality measure specifications (all payer populations), performance period, reporting frequency and reporting vehicles/interfaces, would be helpful. Payers must be willing to accept the agreed upon measures as well as regulatory agencies.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
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Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.
   See exhibit 1

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

      Hallmark Health has a "request a price estimate" line for patients to call. Hallmark Health utilizes the Experian Passport System along with MedAssets Harvest system to determine price for admissions, procedures and services. These gross prices are periodically updated as contracts are updated and new procedures added. This pricing list is available internally to our scheduling, customer service and registration staff.

      We recommend to the consumer/patient that he or she contact his or her health insurance provider to obtain a more accurate out-of-pocket expense associated with the service or procedure. If the consumer/patient is not insured, we offer our discount policy and refer them to our financial councilors. Since the inception of Chapter 224 we have added many services and procedures to our list.

      The "request a price estimate" line is promoted both internally and externally (via the website).

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

      A log is kept to track calls. We average 20 to 25 calls per month on our "request a price estimate" call line. All pricing requests are answered within 24 hours.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

      We have difficulty with requests for surgical and inpatient services. It is difficult to predict what will be the exact costs. We estimate our price range from the highest to the lowest possible cost and explain to the patient that this is estimated based on the information we currently have.

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield			See Note 1	See Note 1			$ 41,893	$ 39,674	$ 42,393	$ 40,146	$ 24,281,095	$ 22,994,477			
Tufts Health Plan			See Note 1	See Note 1			$ 32,694		$ 33,084		$ 18,949,110				
Harvard Pilgrim Health Care			See Note 1	See Note 1			$ 33,270		$ 33,666		$ 19,282,925				
Fallon Community Health Plan												$ 28,496			
CIGNA												$ 5,058,780			
United Healthcare												$ 3,332,192			
Aetna												$ 4,061,375			
Other Commercial												$ 12,719,780			
Total Commercial							$ 107,857	$ 39,674	$ 109,143	$ 40,146	$ 62,513,130	$ 48,195,100			
Network Health															
Neighborhood Health Plan												$ 2,967,462			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid												$ 13,254,228			
Total Managed Medicaid												$ 16,221,690			
MassHealth												$ 10,385,190			
Tufts Medicare Preferred							$ (278)				$ 14,005,948				
Blue Cross Senior Options															
Other Comm Medicare												$ 3,212,578			
Commercial Medicare Subtotal							$ (278)				$ 14,005,948	$ 3,212,578			
Medicare												$ 90,788,531			
Other												$ 4,344,001			
GRAND TOTAL							$ 107,579	$ 39,674	$ 109,143	$ 40,146	$ 76,519,078	$ 173,147,090			

Note 1: For 2012, Hallmark Health System, Inc. ("HHS") had approximately $3,513,736 at risk via the PCHI Internal Performance Framework for contracts negotiated with BCBSMA, HPHC, and Tufts. 97.6%, or $3,429,550, was retained by HHS, and the remaining balance of $84,126 was forfeited to Partners Community Healthcare, Inc. ("PCHI").

Dollars under BCBSMA, HPHC, and Tufts Budget Surplus/(Deficit) Revenue represent Hallmark share of PCHI External Surplus allocated based on FFS revenue.
Dollars under BCBSMA, HPHC, and Tufts Quality Incentive Revenue represent Hallmark share of PCHI External Quality Bonus allocated based on FFS revenue.

Due to system limitations, much of the Managed Medicaid business is only available on an aggregated basis.
Due to system limitations, the splits between NHP Commercial and NHP-MassHealth cannot be identified.
Due to system limitations, much of the commercial HMO/PPO split cannot be identified.
Medicare and Other Revenue are neither HMO or PPO.

Source: Eclipsys Decision Support
Notes: The methodology used was as follows for each year:
1. Campus P/L Qualset for patient population
2. Calculated Global ZB PAF for Inpatient and Outpatient (same methodology for Campus P/L)
3. Calculated Net Rev as follows:
Total Payments plus (Account Balance X PAF)--IP or OP
4. Payment Categories-Reports were run by Reimb Group and then grouped into HPC buckets with guidance from Reimbursement Manager.
5. Results will not tie to Audited F/S due to reconciling items between Decision Support System and GL.

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield			See note 1	See Note 1					$ 33,800	$ 35,191	$ 21,049,919	$ 21,916,162			
Tufts Health Plan			See note 1	See Note 1					$ 23,924		$ 16,473,831				
Harvard Pilgrim Health Care			See note 1	See Note 1					$ 29,067		$ 18,102,617				
Fallon Community Health Plan															
CIGNA												$ 5,301,071			
United Healthcare												$ 3,520,093			
Aetna												$ 3,395,647			
Other Commercial												$ 13,215,107			
Total Commercial									$ 86,791	$ 35,191	$ 55,626,367	$ 47,348,080			
Network Health															
Neighborhood Health Plan												$ 3,188,377			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid												$ 13,932,423			
Total Managed Medicaid												$ 17,120,800			
MassHealth												$ 10,296,735			
Tufts Medicare Preferred											$ 14,824,211				
Blue Cross Senior Options															
Other Comm Medicare												$ 3,808,920			
Commercial Medicare Subtotal											$ 14,824,211	$ 3,808,920			
Medicare												$ 85,762,501			
Other												$ 3,656,287			
GRAND TOTAL									$ 86,791	$ 35,191	$ 70,450,578	$ 167,993,323			

Note 1: For 2013, Hallmark Health System, Inc. ("HHS") had approximately $3,221,377 at risk via the PCHI Internal Performance Framework for contracts negotiated with BCBSMA, HPHC, and Tufts and participation in the Partners Pioneer ACO. 90.2%, or $2,907,213, was retained by HHS, and the remaining balance of $314,164 was forfeited to Partners Community Healthcare, Inc. ("PCHI").

BCBSMA, HPHC, and Tufts FFS revenue includes revenue generated from shared savings and quality bonuses in external PCHI contracts.

Due to system limitations, much of the Managed Medicaid business is only available on an aggregated basis.
Due to system limitations, the splits between NHP Commercial and NHP-MassHealth cannot be identified.
Due to system limitations, much of the commercial HMO/PPO split cannot be identified.
Medicare and Other Revenue are neither HMO or PPO.

Source: Eclipsys Decision Support
Notes: The methodology used was as follows for each year:
1. Campus P/L Qualset for patient population
2. Calculated Global ZB PAF for Inpatient and Outpatient (same methodology for Campus P/L)
3. Calculated Net Rev as follows:
   Total Payments plus (Account Balance X PAF)--IP or OP
4. Payment Categories-Reports were run by Reimb Group and then grouped into HPC buckets with guidance from Reimbursement Manager.
5. Results will not tie to Audited F/S due to reconciling items between Decision Support System and GL.

2014

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield			See Note 1	See Note 1					See Note 2	See Note 2	$ 22,069,104	$ 20,447,490			
Tufts Health Plan			See Note 1	See Note 1					See Note 2	See Note 2	$ 16,432,973				
Harvard Pilgrim Health Care			See Note 1	See Note 1					See Note 2	See Note 2	$ 17,940,059				
Fallon Community Health Plan															
CIGNA												$ 5,329,036			
United Healthcare												$ 3,621,195			
Aetna												$ 3,240,672			
Other Commercial												$ 19,679,962			
Total Commercial											$ 56,442,136	$ 52,318,355			
Network Health															
Neighborhood Health Plan												$ 3,571,941			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid												$ 10,288,657			
Total Managed Medicaid												$ 13,860,598			
MassHealth												$ 10,263,449			
Tufts Medicare Preferred											$ 12,941,929				
Blue Cross Senior Options															
Other Comm Medicare												$ 4,590,838			
Commercial Medicare Subtotal											$ 12,941,929	$ 4,590,838			
Medicare								$ 269,096				$ 81,867,586			
Other*												$ 6,808,857			
GRAND TOTAL								$ 269,096			$ 69,384,065	$ 169,709,683			

Note 1: For 2014, Hallmark Health System, Inc. ("HHS") had approximately $3,111,205 at risk via the PCHI Internal Performance Framework for contracts negotiated with BCBSMA, HPHC, and Tufts and participation in the Partners Pioneer ACO. 83.7%, or $2,604,675, was retained by HHS, and the remaining balance of $506,530 was forfeited to Partners Community Healthcare, Inc. ("PCHI").

Note 2: Hallmark Health System, Inc. received $54,253 from quality bonuses related to BCBSMA, HPHC, and Tufts via PCHI.

Due to system limitations, much of the Managed Medicaid business is only available on an aggregated basis.
Due to system limitations, the splits between NHP Commercial and NHP-MassHealth cannot be identified.
Due to system limitations, much of the commercial HMO/PPO split cannot be identified.
Medicare and Other Revenue are neither HMO or PPO.
*Includes Free Care, Government, Industrial, and Self-Pay categories

Source: Eclipsys Decision Support and Hallmark Health System, Inc. Comparison on NPSR by Payor-FY14
Notes: The methodology used was as follows for each year:
1. Campus P/L Qualset for patient population
2. Calculated Global ZB PAF for Inpatient and Outpatient (same methodology for Campus P/L)
3. Calculated Net Rev as follows:
Total Payments plus (Account Balance X PAF)--IP or OP
4. Payment Categories-Reports were run by Reimb Group and then grouped into HPC buckets as determined by category.
5. Results will not tie to Audited F/S due to reconciling items between Decision Support System and GL.

2015

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield			See Note 1	See Note 1			See Note 2	See Note 2	See Note 2	See Note 2	$ 20,931,455	$ 20,189,341			
Tufts Health Plan			See Note 1	See Note 1			See Note 2	See Note 2	See Note 2	See Note 2	$ 15,240,782				
Harvard Pilgrim Health Care			See Note 1	See Note 1			See Note 2	See Note 2	See Note 2	See Note 2	$ 17,799,911				
Fallon Community Health Plan															
CIGNA												$ 5,012,668			
United Healthcare												$ 3,925,326			
Aetna												$ 3,826,343			
Other Commercial												$ 17,852,052			
Total Commercial											$ 53,972,148	$ 50,805,730			
Network Health															
Neighborhood Health Plan												$ 4,256,499			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid												$ 10,363,820			
Total Managed Medicaid												$ 14,620,319			
MassHealth												$ 9,181,897			
Tufts Medicare Preferred											$ 13,251,208				
Blue Cross Senior Options															
Other Comm Medicare												$ 5,360,000			
Commercial Medicare Subtotal											$ 13,251,208	$ 5,360,000			
Medicare							See Note 3					$ 85,743,474			
Other*												$ 7,573,550			
GRAND TOTAL											$ 67,223,356	$ 173,284,970			

Note 1: For 2015, Hallmark Health System, Inc. ("HHS") had approximately $3,096,326 at risk via the PCPO Internal Performance Framework for contracts negotiated with BCBSMA, HPHC, and Tufts and participation in the Partners Pioneer ACO. 75.9%, or $2,349,662, was retained by HHS, and the remaining balance of $746,664 was forfeited to Partners Community Physicians Organization, Inc. ("PCPO").

Note 2: Surplus dollars and quality bonus dollars available in external contracts between PCPO and these insurers do not contain final results.
Note 3: Final 2015 Pioneer ACO Surplus has not been determined. Based on available information, there will not be any surplus dollars for CY15.
Due to system limitations, much of the Managed Medicaid business is only available on an aggregated basis.
Due to system limitations, the splits between NHP Commercial and NHP-MassHealth cannot be identified.
Due to system limitations, much of the commercial HMO/PPO split cannot be identified.
Medicare and Other Revenue are neither HMO or PPO.
*Includes Free Care, Government, Industrial, and Self-Pay categories

Source: Eclipsys Decision Support and Hallmark Health System, Inc. Comparison on NPSR by Payor-FY15
Notes: The methodology used was as follows for each year:
1. Campus P/L Qualset for patient population
2. Calculated Global ZB PAF for Inpatient and Outpatient (same methodology for Campus P/L)
3. Calculated Net Rev as follows:
Total Payments plus (Account Balance X PAF)--IP or OP
4. Payment Categories-Reports were run by Reimb Group and then grouped into HPC buckets as determined by category.
5. Results will not tie to Audited F/S due to reconciling items between Decision Support System and GL.