SIGNATURE HEALTHCARE

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Kim Hollon, FACHE
President/CEO

September 2, 2016

Health Policy Commission
Attn: Lois H. Johnson
Two Boylston Street, 6th Floor
Boston, MA 02116

Submitted Electronically via HPC-Testimony@state.ma.us

Dear Ms. Johnson:

Pursuant to your request and in accordance with Massachusetts General Laws chapter 6D, §8, please find included herein Signature Healthcare Corporation's 2016 Pre-Filed Testimony responses and Exhibit C along with AGO Hospital Exhibit 1.

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

Sincerely,

Kim Hollon
President/CEO

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)

1. Challenges associated with partnering with community workers to address behavioral health needs.
2. Challenges associated with reducing Emergency Department visits.
3. Health Plan benefit design that challenges our ability to control leakage of referrals outside our network.

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)

1. Develop a role to help good ideas travel further. Be a supportive partner in transformation and the spread of transformation.
2. Exclude payer benefits plans that allow patient self-referral from adherence to the benchmark or eliminate them altogether.

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

Plans to Implement in the Next 12 Months

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

Plans to Implement in the Next 12 Months

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

Currently Implementing

vii. Other: Insert Text Here

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)

We have contracted with a vendor to provide consultative and treatment services to our patients. We have developed streamlined referral processes, and access standards for both routine and urgent needs. We have standing meetings with members of both organizations to review performance. We have added social workers to our PCMH teams, including a 40 hour per week social worker from community links inside our practice with the highest percentage of Medicaid patients. We are now working with our vendor to explore a co-location model in three practices, in order to provide assessment and counseling services onsite.

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)

We have met many challenges in providing behavioral services to our patients. The poor reimbursement for these services has made it difficult to provide them internally. As a DSH organization managing the transition from volume to value, we have had to make many investments in our organization, and are not currently able to subsidize a behavioral health program. Unfortunately, there are not enough external resources to meet the needs of our patients, making access the second major barrier to integrated behavioral health services. Finally, many of these patients also suffer from substance abuse, not all providers manage both issues, and there is poor access for substance abuse treatment as well. Helping patients with both substance abuse and behavioral health disorders is extremely challenging.

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)

We are implementing PCMH across all of our PCP practices. Part of that implementation, is a patient centered approach using clinical staff and case managers to develop care plans with patients. These plans help surface the social and economic barriers to care that patients experience. We have started multi-disciplinary care team meetings to discuss at risk patients and engage providers in the needs of these patients.

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)

We do not have as much data on these social determinants as compared to quality and cost data. It would helpful to see how these issues present in populations of patients, and how they change over time. Currently, we grasp and act on these issues predominantly at the patient level as they come up.

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.

Our primary care physicians are employed and naturally inclined to refer to employed affiliates, or preferred external specialists to ensure patients receive the highest quality, most cost effective care possible.

Monthly data reports to PCPs concerning referral patterns and TME leakage out of our network are distributed and discussed.

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.

39T

ii. If no, why not?

For the Brockton Hospital, Meditech does not provide this information, as the functionality is not available.

For the Signature Medical Group, Allscripts does not provide this information, as the functionality is not available.

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.

39T

ii. If no, why not?

For the Brockton Hospital, Meditech does not provide this information, as the functionality is not available.

For the Signature Medical Group, Allscripts does not provide this information, as the functionality is not available.

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?

Yes

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.

For Brockton Hospital and Signature Medical Group, we interface through the Massachusetts Health Information Highway electronic data exchange, continuity of care documents. This is a unidirectional feed to external organizations.

ii. If no, why not?
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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)

Signature is currently in AQC and TMP capitation risk. A new CMS Bundle Payment contract began 7/1/2016 to include orthopedic joint replacement, and 11 additional 90 day Bundles. Plans are in the works to become a Model A ACO.

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)

1. Physician Compensation: It is difficult to move provider compensation from RVU's to APMs. Providers are resistant to be at risk, and at times do not feel they should be responsible for outcomes they may not control for patients in their panel.
2. Real time Data: Related to physician compensation models is the lack of real time data to provide the PCP with actionable data.
3. Statistical Small Risk Population Size: Signature's populations for APMs tend to be in the order of 2500 – 7000 resulting in statistical uncertainty year to year.

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

Yes, however some arrangements exclude it, as the payers have preferred relationships with vendors. Signature has not traditionally had behavioral health services collocated on site. The PCPR contract is our first real exposure to potential APM risk and behavioral health. Signature is on the learning curve of understanding the needs and demands of our patients concerning behavioral health services.

i. If no, why not?
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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.

To provide our PCPs with timely data Signature has created its own data warehouse. Unfortunately, this requires additional FTEs for data input, programming and reporting. APM contracts in general do not

provide infrastructure payments to support the needed internal infrastructure to meet different quality reporting requirements of the various health plans.

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).

A central quality data warehouse with EMR interoperability would be the cornerstone of reporting alignment. Quality metrics, reporting frequency and data standards should be reviewed frequently by a committee representing providers, as well as payers.

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. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

   We have made every attempt to provide all requested financial information for Signature Healthcare Brockton Hospital in the attached Excel spreadsheets. However, we were unable to supply certain data for 2012 and 2013, due to the recent implementation of a new cost accounting system.

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.

      Please see attached Policy and Procedures

   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.

      Processed requests are reviewed monthly to verify compliance with 48 hour response standard and to check against actual charges (if the service is/was performed at Brockton Hospital).

   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 not encountered any material barriers.

Exhibit 1 AGO Questions to Hospitals

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. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **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.
6. **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.
7. **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.

8. **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).
9. **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.

10. **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.
11. **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.
12. **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

In millions	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	$17.9	$1.9	$.8	$.1	$9.2	-	-	-	$2.2	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.6	-	$.8	-	-	-	$2.4	$1.7			
Harvard Pilgrim Health Care	$10.6	-	$.2	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.2	-			
HPI	-	-	-	-	-	-	-	-	-	-	$3.4	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.3	-			
NHP	-	-	-	-	-	-	-	-	-	-	$1.3	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	$.3	$7.1			
Total Commercial	$28.6	$1.9	$1.0	$.1	$11.8	-	$.8	-	$2.2	-	$14.3	$8.7			
Network Health	-	-	-	-	-	-	-	-	-	-	$4.0	-			
NHP	-	-	-	-	-	-	-	-	-	-	$8.6	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$10.7	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$.7	$.7			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$24.0	$.7			
MassHealth	-	$19.8	-	$1.9	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$5.0	-	-$.9	-	-	-	$2.5	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$2.2	$1.3			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$5.2	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Commercial Medicare Subtotal	-	-	-	-	$5.0	-	-$.9	-	-	-	$11.1	$1.3			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$67.9			
Other	-	-	-	-	-	-	-	-	-	-	-	$12.5			
GRAND TOTAL	$28.6	$21.7	$1.0	$1.9	$16.8	-	-$.1	-	$2.2	-	$49.4	$91.2			

Notes: **The hospital implemented a new cost accounting system and is unable to provide data for Fiscal Year 2012.**
The financial data above is for Signature Healthcare Brockton Hospital only.

2013

In millions	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	$18.1	$1.7	$.9	$.1	$8.5	-	-	-	$1.1	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.9	-	$.2	-	-	-	$2.5	$1.7			
Harvard Pilgrim Health Care	$11.1	-	$.1	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.9	-			
HPI	-	-	-	-	-	-	-	-	-	-	$4.6	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.2	-			
NHP	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	$.3	$7.1			
Total Commercial	$29.3	$1.7	$1.0	$.1	$11.4	-	$.2	-	$1.1	-	$16.3	$8.9			
Network Health	-	-	-	-	-	-	-	-	-	-	$5.2	-			
NHP	-	-	-	-	-	-	-	-	-	-	$8.7	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$12.3	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$.9	$.8			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$27.1	$.8			
MassHealth	-	$19.7	-	$.6	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$5.4	-	$.4	-	-	-	$2.3	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$1.5	$1.1			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$5.8	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Commercial Medicare Subtotal	-	-	-	-	$5.4	-	$.4	-	-	-	$10.8	$1.1			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$64.2			
Other	-	-	-	-	-	-	-	-	-	-	-	$11.5			
GRAND TOTAL	$29.3	$21.4	$1.0	$.7	$16.8	-	$.6	-	$1.1	-	$54.2	$86.6			

Notes: **The hospital implemented a new cost accounting system and is unable to provide data for Fiscal Year 2013.**
The financial data above is for Signature Healthcare Brockton Hospital only.

2014

In millions	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	$19.3	$2.0	$.8	$.1	$8.7	-	-	-	$1.7	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.7	-	$.1	-	-	-	$2.5	$1.8			
Harvard Pilgrim Health Care	$10.3	-	$.1	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$2.2	-			
HPI	-	-	-	-	-	-	-	-	-	-	$5.3	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.0	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.1	-			
NHP	-	-	-	-	-	-	-	-	-	-	$1.5	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$7.0			
Total Commercial	$29.6	$2.0	$.9	$.1	$11.4	-	$.1	-	$1.7	-	$17.1	$8.8			
Network Health	-	-	-	-	-	-	-	-	-	-	$8.2	-			
NHP	-	-	-	-	-	-	-	-	-	-	$9.3	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$15.7	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$2.5	$.6			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$35.8	$.6			
MassHealth	-	$23.7	-	$1.8	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$4.5	-	-$.1	-	-	-	$1.5	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$1.5	$1.9			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$6.3	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Commercial Medicare Subtotal	-	-	-	-	$4.5	-	-$.1	-	-	-	$10.7	$1.9			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$67.3			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.2			
GRAND TOTAL	$29.6	$25.6	$.9	$1.9	$15.9	-	-$.1	-	$1.7	-	$63.6	$86.8			
Cost	$21.5	$29.5	$.0	$.0	$13.0		$.0		$.0		$63.5	$81.1			
Margin	$8.2	-$3.8	$.9	$1.9	$2.9		-$.1		$1.7		$.2	$5.7			

Note: The financial data above is for Signature Healthcare Brockton Hospital only.

2015

In millions	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	$19.1	$1.6	$.6	$.0	$8.9		-	-	$.9	-	$.2	-			
Tufts Health Plan	-	-	-	-	$2.9	-	$.0	-	-	-	$2.8	$1.7			
Harvard Pilgrim Health Care	$11.2	-	$.2	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.7	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.1	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.8	-			
NHP	-	-	-	-	-	-	-	-	-	-	$2.3	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.6	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$8.1			
Total Commercial	$30.3	$1.6	$.7	$.0	$11.8	-	$.0	-	$.9	-	$19.7	$9.8			
Network Health	-	-	-	-	-	-	-	-	-	-	$9.3				
NHP	-	-	-	-	-	-	-	-	-	-	$10.6	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$16.6				
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$4.9	$.1			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$41.3	$.1			
MassHealth	-	$27.0	-	$.8	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$5.6	-	$1.1	-	-	-	$1.4	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$1.6	$2.1			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$7.4	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$2.5	-			
Commercial Medicare Subtotal	-	-	-	-	$5.6	-	$1.1	-	-	-	$12.9	$2.1			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$74.5			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.1			
GRAND TOTAL	$30.3	$28.6	$.7	$.9	$17.5	-	$1.2	-	$.9	-	$73.9	$94.6			
Cost	$23.5	$32.5	$.0	$.0	$14.9		$.0		$.0		$75.3	$89.0			
Margin	$6.8	-$3.9	$.7	$.9	$2.5		$1.2		$.9		-$1.4	$5.7			

Note: The financial data above is for Signature Healthcare Brockton Hospital only.

Signature Healthcare

Patient Financial Services Policy

Policy Date: January 4, 2014

TITLE: Price Transparency

Departments Impacted: Patient Financial Services (Customer Service Representatives); Patient Access (Patient Services Associates, Financial Counselors)

Purpose:
These standards are intended as guidelines to assist in the delivery of accurate and timely pricing information to patients and their representatives, and to insure compliance with Section 108 of Chapter 224 of the Massachusetts General Laws.

Policy:
Brockton Hospital will provide patients and their representatives with pricing information, regardless of insurance status or insurance type. Further, it will make every reasonable effort to provide this information within two (2) working days of receipt of the request and will do so in writing and in plain language. Patients will be advised of the factors that may influence the accuracy of the provided estimate.

Procedure:

1. Patient Access, Patient Services and Customer Service staff will be provided with the Price Transparency Request form and will assist patients with completion of the form.
2. Patients and/or Hospital representatives will forward the request to the Billing Manager for processing.
3. The Hospital Billing Manager will utilize the Contract Management software to determine the price and, if appropriate, the "allowable" charge associated with the procedure (depending on whether the patient is insured and who the insurer is).
4. The request will be processed within 2 business days of receipt and the response will be mailed to that patient.
5. If unable to complete the estimate, the Billing Manager may contact the patient for additional information.
6. All requests and results will be logged in a Price Transparency tracking log.

7. After completion, all requests will be scanned into the appropriate sub-folder in the Patient Accounts folder on the “S” drive for record keeping and audit purposes.
8. Monthly, the Billing Manager will review a selection of prior month requests to check on accuracy of estimates and to review the timeliness of request processing.

Attachment: Price Transparency Request form

Signature Healthcare Brockton Hospital
680 Centre Street,
Brockton, MA 02302

Please e-mail completed form to:

chrisamaral@signature-healthcare.org

Attn: Christine Amaral

Tel 508.941.0907
Fax 508.941.0899

PRICE TRANSPARENCY REQUEST

Date of Request: 10/23/2015

Name: _____ Phone: _____

Address: _____

Email:_____

Insurance Coverage:_____ Insurance ID#: _____

Description of Service: _____

_____

_____

Type of Service: Inpatient Outpatient (circle one)

Type of Service: Diagnostic Screening Routine (circle one)

Anticipated Date of Service : _____

Preferred Method of Response: E-Mail US Mail (circle one)

To be completed by Signature Healthcare

Estimated cost of service:_____

CPT or Procedure Code(s): _____

Estimated Insurance Allowed Amount: _____

To obtain specific Co-Pay, Co-Insurance or Deductible Information, please contact your insurance provider directly by calling _____.

The information provided is only an estimate of costs associated with an average service as described above. Costs may vary due to complications or additional ancillary services provided during the procedure. This is not a guarantee of payment or coverage of services.