Hallmark Health System, Inc.

Health Policy Commission Testimony Response to Questions
September 8, 2014
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Question 1

Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth of the state's economy

SUMMARY:

a. What trends has your organization experienced in revenue, utilization and operating expenses from CY2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

Over the referenced time period Hallmark Health has experienced differing trends in revenue, utilization and operating expenses. During Calendar years (CY), 2010 through 2012, Hallmark Health saw modest growth in total revenue and net patient services revenue (NPSR) from 2010 through 2012 with mixed utilization trends. In CY10 Hallmark Health's total revenue was $280,423,673 and increased to $296,361,586 by CY12. Hallmark Health saw declines in inpatient discharges from CY10 (16,535 discharges) to CY12 (13,802 discharges), while outpatient billing units rose modestly from 2,725,728 in CY10 to 2,747194 in CY12. During this same time period, Hallmark Health's operating expenses increased slightly by three percent (3%) (CY10 –CY12).

The latter portion of the requested time period, the end of 2012, 2013 and year-to-date 2014, Hallmark Health's total revenue, NPRS and patient utilization have declined significantly. In CY2011 HHS had a combined total of 15,722 patient discharges from MWH and LMH; by FY13, HHS's total patient discharges had declined by approximately 28% to 12,231. Additional declines in inpatient discharges are being experienced year-to-date in the current calendar year. HHS has seen its operating revenue decline from $288,726,185 in CY11 to $263,181,683 in CY13, due to declining patient volume. Hallmark Health believes that the reduced utilization, and resulting decline in revenue, is largely related to the development and implementation of high deductible consumer health insurance products. A growing number of patients in the Commonwealth no longer have first dollar health insurance coverage. The impact of larger co-pays and annual deductibles, ranging into the thousands of dollars, is causing individuals to delay care, seek care based upon price not quality or elect not to seek care at all.

During this time period, CY2012 to YTD2014, Hallmark Health has experienced an increase in operating expenses. Some of the increases in operating expenses are a result of labor costs related to minimum clinical staffing requirement and patient volume declines that create operating inefficiencies. Other increased expenses relate to costs added to meet the additional regulatory reporting requirements, many of which involve reporting similar data in different formats to multiple oversight agencies.

b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

Hallmark Health has engaged in a number of activities in an effort to reduce the rate of increase in healthcare costs. These efforts include:

Participation is CHART Phase 1: Hallmark Health in its CHART program has implemented standardized care protocols for back pain patients in its emergency departments and urgent care centers in an effort to improve the consistency and quality of care provided to patients and to address public health concerns about the abuse of opioid prescriptions, which can lead to increased healthcare costs resulting from additional healthcare treatment required for substance abuse issues. Since implementation, the programs have reduced opioid prescription use by 26% at the Melrose-Wakefield Hospital Emergency Department and 43% at the Lawrence Memorial Hospital Emergency Department.

Readmissions: Hallmark Health has devoted significant resources to reduce its' 30 day readmission rate across all payers and patients. These efforts include coordination of care plans across disciplines and providers including the patient's primary care physicians and post-acute care providers such as the Hallmark Health Visiting Nurses Association and Hospice. In CY12 was the all payer, all cause readmission rate was 12.75. Hallmark Health's initiatives have reduced the readmission rate to 11.97 in CY13, and 11.94 CY14 YTD.

Urgent Care Center expansion: Hallmark Health opened a second Urgent Care Center (UCC) at Reading (November 2013) to go along with our UCC at LMH (opened Nov 2012). These UCC's offer lower cost settings compared to traditional emergency department and are designed to coordinate follow up care when appropriate with PCPs and specialists. Information about Hallmark Health's urgent cares centers is further delineated in Hallmark Health's response to Question 7.

Process Improvements: Hallmark Health has implemented significant cost savings initiatives and performance improvement projects since January 1, 2013. These activities include right sizing the Organization to ensure administrative functions are efficient, benchmarking staffing /volume ratios and LEAN process improvement projects to redesign workflow to improve patient care and efficiency. These efforts have enabled Hallmark Health to be better than its FY14 Budget, which projected HHS to have a negative 7.0% operating margin and a

negative 5.2% total margin. Through May 2014, HHS's operating margin is a negative 5.86%, and the process improvements and saving initiatives coupled strong investments gains have enabled HHS to produce a negative 1.41% total margin.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

As the HPC is aware, Hallmark Health intends to join the Partners Healthcare System and will be part of a new vision for care delivery in northeastern Massachusetts. This vision is expressly designed to fulfill many health care reform cost containment goals, including those of Chapter 224 of the Acts of 2012, through community infrastructure investments, care redesign, and expanded behavioral health and other clinical services in the community. Partners and HHS will significantly reconfigure the HHS and the Partners affiliated North Shore Medical Center (NSMC) campuses to address unmet community need, including short stay beds, urgent care, PHM for chronic conditions and integrated subspecialty cancer care. The resulting rationalized facilities will enable Partners and HHS to redirect significant volumes of care to community-based facilities, away from the higher-cost academic medical center setting of MGH. This vision of a redesign of healthcare delivery north of Boston is explained in more detail in Hallmark Health's and Partner's submissions to the HPC as part of the Cost and Market Impact Review process.

a. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

There are two (2) specific systematic/policy changes that would enable hospitals to reduce administrative costs and focus on delivery of quality care;

1. Establishment of a single centralized reporting structure for hospitals to report clinical and financial data. This would reduce administrative overhead costs and complexity that currently exists with the requirements of reporting the same or similar data to multiple regulatory agencies, each with a different set of formatting requirements for the data submitted.

2. Delegated Credentialing – If the Commonwealth was to permit delegated credentialing by hospitals for review of medical staff appointments there would be administrative cost savings for hospitals. The practice of delegated credentialing is recognized and accepted by the Joint Commission and permitted in other states.

Question 2

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

SUMMARY:

a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patters, and operations?

Through Hallmark Health PHO's PCHI affiliation, Hallmark Health System hospitals and affiliated physicians participate in APM contracts with BCBS, HPHC, Tufts, Tufts Medicare Preferred and the Medicare Pioneer ACO. Hallmark Health PHO has established physician-led committees to identify and implement initiatives to reduce medical expenses and improve quality and the patient experience in the hospital and the physician office. Following are some examples of these initiatives:

Centralized Referral and Radiology Management: A centralized referral management and radiology authorization system was created in 2012 to reduce the administrative burden on primary care physicians and to ensure that Hallmark patients are referred to our lower cost, local community hospital and community specialists wherever possible. From 2012 to 2013, our percentage of referral "leakage" (services rendered outside of Hallmark) was reduced from 30% to 25% as a result of the centralized referral management system.

Urgent Care Centers: Please see Hallmark Health's responses in Question 1 and Question 7 related to Hallmark Health's Urgent Care Centers.

PCMH: Hallmark Health PHO has a goal for all Primary Care Physicians to become NCQA-Recognized Patient Centered Medical Homes (PCMH) by 2018. We believe that well-coordinated, team-based care with a focus on continual performance improvement is key to promoting high-quality, efficient care. Through this initiative, we have trained physicians and office staff in LEAN performance improvement methodology, held Medical Assistant Academies to improve competencies of physician office staff and leveraged technology such as patient portal to increase patient engagement in their care.

Integrated Care Management and Behavioral Health : In conjunction with our PCHI colleagues and local community services, we have developed an integrated care management program whereby nurse care managers, social workers and other community providers

manage high-cost, high-risk patients and patients with behavioral health needs in order to keep them in the lowest cost setting with the best possible health outcomes.

Specialist Engagement and Evidence-based Guidelines: Hallmark Health PHO is working with our local community Specialists to better engage them in care coordination and the delivery of cost-effective care. They are currently developing evidence-based guidelines, many of which will be selected from "*Choosing Wisely*" in order to standardize treatment and promote cost-effective, quality care.

Question 3

Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.

SUMMARY:

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient acuity, including in particular sub-populations (e.g. pediatric) or those with behavioral health conditions?

In our experience, health status risk adjustment measures do not adequately account for changes in patient population acuity. There is significant data lag when health plans report changes in health status and higher health status risk adjustment appears to be more of a function of billing and coding system sophistication and resources rather than a true measure of patient acuity.

b. How do the health status risk adjustment measure used by different payers compare?

Most Commercial health plans use DxCG software to calculate risk adjustment. Medicare Advantage plans such as Tufts Medicare Preferred uses the CMS system of Hierarchical Chronic Conditions (HCC) to calculate risk adjustment factors. We do not have any data showing how the various risk adjustment indices compare.

c. How does the interaction between risk adjustment measures and other risk contract elements affect your organization?

Under our APM contracts, our global budgets and quality measure performance are health status adjusted and thus affect our share of efficiency and quality financial return.

Question 4

A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APM's. What types of data are or would be the most valuable to your

organization in this regards? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

SUMMARY:

Receiving real time out of network activity information would allow for more coordinated care and meaningful actions. In addition, receiving real time clinical alerts from our own EHR for patients entering the hospital would allow for high value care. For more in-depth and population level data, the biggest enhancement would be timeliness. Other types of data that would be useful in population health management would be greater insight into behavioral health, TME views by hospital and specialist, and sharing of best practices.

ANSWER:

i. Real time data to manage patient care

<u>Clinical alerts</u>: An electronic alert system for communication of critical and meaningful clinical data to enhance patient management would be extremely useful. Mining data from the EHR with real time alerts to the physician would provide faster response, safer care, less errors and likely reduced length of stay. There also could be benefit for receiving alerts on specific patient populations, with internal and external data.

<u>Out of network activity</u>: Receiving real time notification of when one of our patients visits an outside facility would greatly enhance our ability to manage patient care. This could include notification of admission or discharge at an outside facility or real time notification of a claim for high cost test/procedure. Receiving this information real time would allow for more productive dialogue with all stakeholders involved in managing that patient's health.

ii. Historic data or population-level data

<u>Timeliness</u>: The biggest enhancement needed for the historic data is timeliness. The months lag in reporting the data plus adding the time to research and analyze the data makes finding actionable root causes of trends more difficult.

<u>Behavioral Health</u>: Greater insight into behavioral health treatment, utilization and outcomes would allow for greater health management.

<u>Other TME views</u>: Looking at TME from views other than Primary Care would allow for insights and actions into other drivers of cost.

<u>Best practice sharing</u>: Insight into top performing organizations would allow for sharing of best practices and would accelerate the downward trend of the cost curve, something all healthcare stakeholders are trying to achieve.

Question 5

C. 224 requires health plans to attribute all members ot a primary care provider, to the maximum extent feasible.

SUMMARY:

a. Which attribution methodologies most accurately account for patients you care for?

Non-PPO privately insured patients are typically required to notify their insurers of their PCP selection. Public managed care program PCP selection is similar to the private insurance industry. With respect to those with public plans, Medicare and Medicaid patients typically do not have to select a PCP.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

We have no recommendations to make at this time, as there are pros and cons to the different approaches. But we will note that requiring patient selection of a PCP gives the provider certainty about their patient panel and, in terms of population health management, the care they need to oversee and coordinate. Patient freedom for a patient to see who they want, when they want appears at odds with the PCMH goals.

Question 6

Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers. And the resulting impact(s) on your organization.

SUMMARY:

ANSWER**:**

Hallmark Health System reports data that is collected through UHC and Outcome Science to Centers for Medicare and Medicaid Services, The Joint Commission, MassHealth and Massachusetts Department of Public Health. In addition, to satisfy the commercial payers request for data, quality and cost data are provided to Partners Community Health, Inc. given the system's contracting relationship with that entity. A great deal of effort is put in place to assure that our reporting is accurate and that changes are made in areas that need improvement.

The Hallmark Health System Quality Department is committed to abstracting the data in a timely manner. The abstraction process begins as soon as coding for the month is complete, which is months ahead of when the data is actually due to be reported. This is an intensive process

requiring abstraction of data from multiple sources. The data is then reported internally to a leadership team that includes administration, quality improvement leadership and staff, physicians, nursing and information systems staff at a monthly Publicly Reported Data Meeting. All publically reported quality measures are monitored by this committee. That structure was created given the varied reporting requirements to multiple agencies and contracting entities. These reports are also shared with the Medical Staff and with the Board of Trustees.

In order to be as concurrent as possible, the Quality Improvement Department uses a vendor to abstract the cases. Outside vendor use was needed given the large volume of data that is collected and the resultant manpower needs. Data are then reviewed by measure experts in-house before the data is reported internally. Monthly dashboards are created showing areas in need of improvement. The Dashboards are reviewed at the Publicly Reported Data Meeting. Fallouts are immediately addressed and shared with physicians and nursing, areas of improvement are discussed and action steps are initiated.

The Infection Control Department is involved in identifying and analyzing infections that may be hospital acquired. This is a manual process that relies on a Registered Nurse and physician epidemiologist for intensive case review. Infections are reported through National Healthcare Safety Network and then posted on the CMS website.

The Nursing Department utilizes National Database of Nursing Quality Indicators as a database to report nurse sensitive quality measures. This data is gathered through the patient safety system and then analyzed by Quality Department staff. Falls, falls with injury and decubitus ulcers are reported publically on the Massachusetts Patient Care Link website.

The Quality Department also reports claims based measures, such as readmissions, and mortality rates at the Publicly Reported Data Meeting, and shares the data with the relevant departments should there be any needs for improvement that are identified.

In addition to the monthly data collected by UHC and Outcome Science, the Quality Department also oversees quality measures collected by other departments through a Quality Oversight Committee (QOC). This data is monitored internally and much of it is reported the Board of Registration of Medicine through a semi-annual report.

The Quality department also reports to private payers and other agencies upon request. Lastly, quality reports are provided to Leapfrog as requested by their survey. The completion of the survey is a labor intense process which involves report requests from Information Systems and data gathering from patient care departments throughout the organization. Leapfrog shares the data with the public as well as private payers.

Question 7

An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

SUMMARY:

a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

Please find attached four charts (Addendum #1) showing a decline of inpatient utilization in Hallmark Health System during Fiscal Years 2013 and 2014. The cumulative decline of inpatient utilization at Hallmark Health during this period is 11%, while the attached analysis shows a cumulative increase of inpatient utilization at Massachusetts General Hospital and Lahey Health of 12% and 4%, respectively, during the same period.

The attached analysis also shows inpatient utilization declines at neighboring community hospitals, which indicates the flow of Hallmark Health's patients to AMCs more than to other community hospitals.

b. Please describe your organizations efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the result of these efforts.

Hallmark Health System has undertaken a number of actions to engage patients in lower-cost settings for medical care. In recent years, these actions have included opening two Urgent Care Centers, recruiting new Primary Care Physicians, investing in Information Technology for greater population health management, improving the cohesiveness of medical service lines for patient convenience, and improving community awareness of Hallmark Health's medical services.

Hallmark Health opened its first Urgent Care Center in November, 2012, at Lawrence Memorial Hospital of Medford, and a second Urgent Care Center opened a year later in Reading. These Urgent Care Centers are staffed with Physician Assistants and with lower-cost Physicians than in Hallmark Health's acute care hospital settings.

The attached chart (Addendum #2) shows Hallmark Health's Urgent Care volume growing from approximately 1000 patients per month to approximately 1400 patients per month during the past eighteen months.

In recruitment of physicians, Hallmark Health has this year added four primary care physicians, eleven specialists and fourteen MD extenders. Due to retirements and transfers of

other physicians, this recruitment has not resulted in an overall increase of inpatient volume, but the recruitment of primary care physicians and MD extenders will remain an integral part of Hallmark Health's strategy to increase the utilization of care at Hallmark Health's lower cost settings.

Investment in IT platforms has been an integral part of Hallmark Health's strategy for outreach to patients. Most recently, Hallmark Health has implemented an inpatient patient portal for patient safety and convenience, and has maintained its status as a Most Wired health care system. There efforts don't show a direct correlation to inpatient volume, but being a Most Wired health care system remains a key element of Hallmark Health's quality of care, and a necessary ingredient to attract and retain patients in lower-cost community settings.

Also, Hallmark Health has worked closely with its physicians, both private and employed, to offer a cohesive line of medical services to patients within Hallmark Health System. Inpatient volume has not increased in the past two years of these continuing efforts, but collaboration among hospital administrators and practicing physicians has offset some of the volume decline during this period. Since Fiscal Year '12, the percentage of patients going outside Hallmark Health System for their medical care has been reduced as mentioned before. This significant improvement in retaining patients within Hallmark Health System through service line development will continue to be a key strategy to attract and retain patients in our lower-cost care settings.

Question 8

The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

SUMMARY:

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

The post-acute analyses (Addendum #3) was conducted by Hallmark Health System to assess the variation in post-acute settings and assess overall utilization trends. The analysis reveals 38% of patients being discharged from both the inpatient and observation setting are being discharged with a post-acute provider. Of that 38%, 19% of those patients were transferred to a skilled nursing facility, 15% were discharged to home with home health services, 2% received hospice services and 2% were transferred to an acute rehab setting.

b. <u>How does your organization ensure optimal use of post-acute care?</u>

Hallmark Health System has a number of processes in place to assure safe patient discharge and optimal use of post-acute care services.

- There is a discharge planning policy and procedure that outlines steps Case Managers and others are expected to take in planning safe and effective post-discharge care transitions. That policy and procedure includes ensuring the most effective use of post-acute care services.
- All patients are assessed by Case Managers at admission to determine baseline functioning, clinical status, current health issue, and potential discharge needs. The patients' families/ caregivers are included in the assessment.
- All patients are reassessed by Case Managers throughout the admission and prior to discharge to identify changes in status and needs for post-discharge support. Again, the patients' families/caregivers are included in the reassessment.
- As indicated, rehabilitation staff (physical, occupational, and speech therapy) assesses patients' status, goals, and abilities to determine the appropriate level and type of rehabilitation needed.
- Case Managers, nursing staff, and other staff collaborate with patients' physicians to clarify the patient's clinical status and the physician's assessment of the patient's post-discharge needs.
- A discharge plan is formulated by the Case Managers in collaboration with the patients' physicians and the multidisciplinary team. That plan includes the actual/potential need for post-acute care services and is updated if the patient's condition changes.
- A current list of post-acute levels of care and their services and clinical parameter is available and used routinely by staff. This is reviewed with all new Case Management staff and periodically reviewed with staff.
- New Case Management staff are educated about the discharge planning process with a focus on ensuring a safe patient/family discharge during orientation. This is also included in annual employee performance reviews.
- Periodically, representatives from post-acute care providers offer education focused on identifying the most appropriate match between patient condition and services offered by the facility.

Question 9

C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requests price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY:

ANSWER:

Hallmark Health System utilizes a software tool called the Patient Payment Estimator, which is supported by Passport, our insurance eligibility vendor, in order to comply with the requirements of Chapter 224 referenced in item #9. The software provides hospital staff with the ability share estimates of the cost and patient financial responsibility for the service that is planned to be provided. All staff that have primary contact or upfront interactions (approximately 130 people) with patients prior to a service being provided have been trained on the software at this point in time. The information being provided was tested during the software implementation process and has been determined to be fairly accurate. For patients that we know have inquired, it has been primarily by phone and the response from HHs staff can be almost immediate. The more significant use of the product has been in helping to improve patient communication by estimating the patient financial responsibility at the time of or prior to a service. The organization is currently working to implement this process in as many outpatient areas as possible. We believe that providing this type of information has been helpful for patients trying to assess the affordability and/or budgeting of payment for the services they need or desire. We also believe that for patients that have inquired about the estimated cost of a procedure by telephone, that the data is probably being utilized to compare pricing for different organizations.

In addition to the statement above, attached a presentation we had previously prepared to address what HHS was doing to comply with the requirements of Chapter 224. This may be helpful as well. (Addendum #4)

Question 10

Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices and attach any analyses your organization has conducted on this issue. Describe any actions your organization has taken in response to tier placement and any impacts on volume you have experienced based on tier placement.

SUMMARY:

ANSWER:

Hallmark Health System is very aware of the growth in Limited and Tiered Network products and would like to continue to serve the health needs of patients residing in our community in the most cost-effective way possible. However, it has been challenging to understand the tiering methodology employed by the health plans for hospitals and physicians. The methodology is different for each health plan and is usually based on claims cost or quality data, with disproportionate weight on the former and with significant time lag. Based on the multitude of factors which influence a patient's decision on where to seek care, it is difficult to assess the volume impact of tier placement. Anecdotally, we are aware of some loss of maternity case

volume due to tier placement. In the case of limited network products, it is not always clear why certain hospitals or physicians are included or excluded. When we have approached health plans for an explanation, we were informed, in some cases, that the selection was based on geographic need and not on any cost or quality data available.

Question 11

The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but hot behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

SUMMARY:

Hallmark Health provides an array of behavioral health services across the continuum of care to address the costs associated with this cohort of high risk patients. Lawrence Memorial has 34 inpatient beds for geriatric patients with comorbid behavioral health and chronic medical needs. This service provides integrated, high quality and cost effective care that lowers the likelihood of multiple inpatient admissions between psychiatry and medicine. Hallmark Health recently launched the Center for Healthy Minds which is an outpatient evaluation and treatment program for patients with dementia and dementia related psychiatric conditions. In addition to patients with dementia, the psychiatric staff at the Center for Healthy Minds treats geriatric patients with depression and comorbid medical illnesses. The early identification, family education, primary care collaboration, and intervention strategies for this group of patients minimizes the need for emergency department and inpatient admissions for the at risk elderly in the Hallmark Health communities. Behavioral Health Services also includes a nursing home consultation program which provides onsite assessments for high risk seniors at local nursing homes. These psychiatric clinicians are on call 24/7 and can be consulted at any time by nursing home staff to divert an unnecessary trip to the emergency room for a resident with acute behavioral disturbances.

Melrose Wakefield Hospital has 22 adult psychiatric inpatient beds for treatment of acute psychiatric illnesses and co-occurring substance use disorders. The inpatient psychiatrists and staff also provide services to the emergency department psychiatric area to facilitate rapid disposition planning for behavioral health patients, including a return to the community when appropriate. The dedicated emergency room area provides a safe and respectful environment where patients with behavioral health concerns can be treated and potentially discharged from the ED setting, rather that transferring to a higher level of inpatient care.

Behavioral health services includes a 24/7 psychiatric triage team to ensure that clinicians are always available for consultation and evaluation of behavioral health patients on the medical floors and in the emergency departments of both hospitals. Each hospital campus has

consultation liaison psychiatrists who meet with hospitalists, case managers, nursing, and other non-psychiatric staff to develop appropriate treatment and discharge recommendations for medical patients with behavioral health presentations. These interventions often interrupt the automatic referral of a medical/behavioral health patient to a psychiatric hospital post discharge from acute care.

In an effort to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care the behavioral health services continuum includes Community Counseling. Community Counseling is an outpatient evaluation and treatment program providing psychopharmacology and therapy services for adults with behavioral health concerns at two locations in the Hallmark Health service area. Community Counseling, inpatient and emergency department clinicians collaborate regularly to maintain patients in the lower cost, highly effective outpatient care setting. Community Counseling developed a rapid response program to facilitate outpatient appointments for patients needing immediate care outside of the emergency department setting. An intensive outpatient program, with enhanced expertise for older adults, provides an additional alternative to inpatient and emergency department treatment for patients with urgent psychiatric needs.

There is a cohort of patients who are high, repeating utilizers of inpatient behavioral health and emergency department services. Hallmark Health clinicians work collaboratively with outpatient behavioral health agencies, primary care physicians and state agencies such as the Department of Mental Health to develop coordinated treatment plans that aim to reduce these hospital readmissions. Most recently, Hallmark Health behavioral health leaders met with the Department of Mental Health to identify new strategies for effectively managing patients with serious and persistent mental illness in the community. While Hallmark Health recognizes that the hospital setting will be necessary for a small group of patients, strategic initiatives are aimed at enhancing community based services and partnerships to position outpatient settings as the strongest point on the continuum of care.

The integration of behavioral health services and primary care is underway at Hallmark Health. Behavioral Health clinicians are embedded in two primary care locations, and plans are in development to expand the scope of this program. Behavioral Health psychiatrists and clinicians meet regularly with the integrated care management team to review high risk and complex patients in the Hallmark Health primary care practices. The integrated care management team works collaboratively to develop an individualized treatment plan that reduces reliance on inpatient services, multiple psychiatric medications and supports the use of community based services. Select primary care physicians are participating in an office based depression screening program to provide evidence based support and support patient wellness. The CHART Phase 1 funds provided the opportunity to impact opiate prescriptions for patients presenting in the emergency departments with back pain.

There are multiple challenges in providing care for behavioral health patients. The lack of appropriate, supervised housing for people with mental illness and/or substance use disorders contributes to the revolving door of readmissions, long lengths of stay and overuse of emergency services. Additionally, the limited number of crisis, respite and detox beds is another challenge for managing patients with behavioral health problems and inhibits the development of robust outpatient treatment plans. In the inpatient setting, there is an ongoing need for evidence based research and training on best practices in managing the most difficult patients who present with high assault risk, fall risk, and medical co-morbidities. The integration of behavioral health and primary care services is challenged by the current payment structure for clinicians who are currently reimbursed based on a fee for service basis. Going forward, fully integrated behavioral health clinicians in primary care settings will provide brief consultations to physicians, patient education, and case management services. These types of services are critical to the successful management of patients in the primary care setting, but are not currently reimbursed.

Finally, Hallmark Health reports data on Behavioral Health patients to the Department of Mental Health and other agencies including . . . . Hallmark Health is willing to report available discharge data as requested.

Question 12

Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

SUMMARY:

As part of PCHI, the majority of HHS primary care physicians, affiliated and employed, are participating in a multi-year effort to achieve NCQA accreditation by 2018. For 2013, 28 out of 44 (or 64%) of HHS's PCP sites achieved preliminary NCQA readiness through PCHI's Primed Status Program. HHS exceeded PCHI targets. Pursuing accreditation is a huge challenge for our busy providers and their staff given their existing patient care workload and responsibilities.

e. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

   There are no PCP's with NCQA accreditation at this time. However, there are two practices in the process of applying for NCQA accreditation this calendar year.

f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

   None at this time.

g. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

   Results thus far are related to learning and sharing lessons with other practices with respect to the NCQA certification journey.

Question 13?

After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

SUMMARY:

ANSWER:

Not Applicable

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.

2010

	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			$ 421,062	$ 283,032			$ 32,098,160	$ 21,575,911			
Tufts Health Plan			See Note 1	See Note 1							$ 18,224,239	included in HMO figure			
Harvard Pilgrim Health Care			See Note 1	See Note 1							$ 16,643,843	included in HMO figure			
Fallon Community Health Plan											x	$ 1,342,582			
CIGNA											x	$ 3,914,307			
United Healthcare											x	$ 3,602,998			
Aetna											x	$ 3,593,912			
Other Commercial											x	$ 10,551,215			
Total Commercial							$ 421,062	$ 283,032			$ 66,966,242	$ 44,580,925			
Network Health											x	$ 9,216,599			
Neighborhood Health Plan											x	$ 4,373,694			
BMC HealthNet, Inc.											x	see Other Managed Medicaid			
Health New England											x	x			
Fallon Community Health Plan											x	see Fallon above			
Other Managed Medicaid											x	$ 10,067,015			
Total Managed Medicaid												$ 23,657,308			
MassHealth											x	$ 3,178,251			
Tufts Medicare Preferred							$ 85,505				$ 12,626,263	x			
Blue Cross Senior Options											x	x			
Other Comm Medicare											$ 3,946,785	x			
Commercial Medicare Subtotal											$ 16,573,048	x			
Medicare												$ 87,553,890			
Other											$ 3,558,935				
GRAND TOTAL							$ 506,567	$ 283,032			$ 87,098,225	$ 158,970,374			

Note 1: For 2010, Hallmark Health System, Inc. ("HHS") had approximately $4,228,454 at risk via PCHI contracts negotiated with BCBSMA, HPHC, and Tufts.
82.5%, or $3,487,683, was retained by HHS, and the remaining balance of $740,771 was forfeited to Partners Community Healthcare, Inc. ("PCHI").

Dollars under BCBSMA Budget Surplus/(Deficit) Revenue represent Hallmark share of PCHI Shared Savings.

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.

2011

	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			$ 325,238	$ 246,110			$28,963,495	$21,916,894			
Tufts Health Plan			See Note 1	See Note 1			$ 155,899				$19,072,166				
Harvard Pilgrim Health Care			See Note 1	See Note 1			$ 23,600				$17,861,896				
Fallon Community Health Plan															
CIGNA												$4,283,100			
United Healthcare												$3,013,134			
Aetna												$4,254,113			
Other Commercial												$12,300,493			
Total Commercial							$ 504,737	$ 246,110			$65,897,557	$45,767,734			
Network Health															
Neighborhood Health Plan												$3,089,782			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid												$11,867,530			
Total Managed Medicaid												$14,957,312			
MassHealth												$10,438,691			
Tufts Medicare Preferred							$ (73,381)				$13,104,725				
Blue Cross Senior Options															
Other Comm Medicare												$3,298,986			
Commercial Medicare Subtotal											$13,104,725	$3,298,986			
Medicare												$86,176,202			
Other												$3,804,159			
GRAND TOTAL							$ 431,356	$ 246,110			$79,002,282	$164,443,084			

Note 1: For 2011, Hallmark Health System, Inc. ("HHS") had approximately $3,753,491 at risk via PCHI contracts negotiated with BCBSMA, HPHC, and Tufts. 96.3%, or $3,613,425, was retained by HHS, and the remaining balance of $140,066 was forfeited to Partners Community Healthcare, Inc. ("PCHI").

Dollars under BCBSMA, HPHC, and Tufts Budget Surplus/(Deficit) Revenue represent Hallmark share of PCHI Shared Savings.

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.

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											$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			Not available	Not available	Not available	Not available	$21,049,919	$21,916,162			
Tufts Health Plan			See Note 1	See Note 1			Not available	Not available	Not available	Not available	$16,473,831				
Harvard Pilgrim Health Care			See Note 1	See Note 1			Not available	Not available	Not available	Not available	$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							Not available	Not available	Not available	Not available	$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			See Note 1	See Note 1								$85,762,501			
Other												$3,656,287			
GRAND TOTAL											$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.

AGO Hospital Exhibit 2

2010

Service Category	Commercial				Government				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	2164306	-78492	2005711	618522	12243355	-618756	2080128	-436096	41188	-298173	9355	-9170	14448849	-995421	4095194	173256
Invasive																
Medical																
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	10595	-2318	0	0	36493	8816	0	0	0	0	0	0	47088	6498	0	0
Dermatology	405454	71678	0	0	1678012	-23905	0	0	10919	-40341	0	0	2094385	7432	0	0
Endocrinology	477009	148176	727611	71083	1624651	19490	474569	-103355	11234	-43109	1919	-1796	2112894	124557	1204099	-34068
Gastroenterology	2532598	394074	7507441	1805815	7856470	-1220774	2769017	-1187546	41802	-229235	8798	-18312	10430870	-1055935	10285256	599957
General Medicine	885611	4360	4938840	-716838	3876910	-218464	2501938	-1011172	24060	-93261	45198	-33962	4786581	-307365	7485976	-1761972
General Surgery	5745832	752419	0	0	9344607	-1750221	0	0	35004	-142891	0	0	15125443	-1140693	0	0
Gynecology	1235035	290775	0	0	567719	-22730	0	0	0	-12770	0	0	1802754	255275	0	0
Hematology	246272	6583	0	0	887383	-111876	0	0	0	-3421	0	0	1133655	-108714	0	0
Infectious Disease	7763	-4697	0	0	23308	-6181	0	0	0	0	0	0	31071	-10878	0	0
Neonatology	1185852	-262814	0	0	1228374	-1172425	0	0	11853	-21816	0	0	2426079	-1457055	0	0
Nephrology	393664	50429	0	0	3935935	-374663	0	0	15364	-49475	0	0	4344963	-373709	0	0
Neurology	711666	116852	104639	67867	4857451	38456	81233	13970	7511	-40030	1111	19	5576628	115278	186983	81856
Neurosurgery	22313	10827	0	0	40251	-14567	0	0	0	0	0	0	62564	-3740	0	0
Normal Newborns	721519	-35809	0	0	1092305	805047	0	0	5354	4799	0	0	1819178	774037	0	0
Obstetrics	5432438	-1279638	1816697	54978	2409121	-861583	659124	-237840	3310	-9551	3632	-3104	7844869	-2150772	2479453	-185966
Oncology	236652	-11937	7527305	2117998	1550717	63101	8909933	-3595060	5354	-13723	12161	-64442	1792723	37441	16449399	-1541504
Ophthalmology	0	0	0	0	35391	5995	0	0	0	0	0	0	35391	5995	0	0
Orthopedics	2570324	1008312	0	0	6741178	900509	0	0	134116	-37018	0	0	9445618	1871803	0	0
Otolaryngology	160149	1829	0	0	552759	-65182	0	0	6824	-20977	0	0	719732	-84330	0	0
Psychiatry	2245405	-338840	704149	-292736	12022776	-2631629	1295531	-723544	135852	-630559	14716	-44201	14404033	-3601028	2014396	-1060481
Pulmonary	1683628	183507	204085	26645	8939058	-1416285	196850	-154391	11503	-125839	0	-3504	10634189	-1358617	400935	-131250
Rehab	0	0	2095002	522909	0	0	1729272	283848	0	0	193742	-19637	0	0	4018016	787120
Rheumatology	20417	-2247	0	0	412471	-55513	0	0	0	-8957	0	0	432888	-66717	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	6028	325	11758755	2898822	266786	44499	9767543	-363316	720	-596	1341163	-627513	273534	44228	22867461	1907993
Urology	176360	41289	0	0	653878	36633	0	0	0	-9455	0	0	830238	68467	0	0
Vascular Surgery	367682	-13330	0	0	1685237	-689748	0	0	0	0	0	0	2052919	-703078	0	0
Other Inpatient	0	0	0	0	113277	-45478	0	0	0	0	0	0	113277	-45478	0	0
Imaging	0	0	17446480	11612379	0	0	5987174	1768491	0	0	218797	114348	0	0	23652451	13495218
Other Treatments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laboratory	0	0	10365559	5418365	0	0	4098137	27903	0	0	105620	41329	0	0	14569316	5487597
Ambulatory Surgery	0	0	9377387	2016340	0	0	3600566	-1734172	0	0	360120	-98326	0	0	13338073	183842
Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Outpatient	0	0	5022557	-75340	0	0	3766602	-1355436	0	0	199636	-306586	0	0	8988795	-1737362
GRAND TOTAL	**29644572**	**1051313**	**81602218**	**26146809**	**84675873**	**-9377434**	**47917617**	**-8807716**	**501968**	**-1826398**	**2515968**	**-1074857**	**114822413**	**-10152519**	**132035803**	**16264236**

Observation: included in
OUTPT Categories Above

General Medicine			2779105	-1110190			1147246	-1026852			11818	-7314	0	0	3938169	-2144356
Obstetrics			919090	146422			390002	-78086			2009	-1051	0	0	1311101	67285
Total Observation			**3698195**	**-963768**			**1537248**	**-1104938**			**13827**	**-8365**	**0**	**0**	**5249270**	**-2077071**

NOTES:

1. Margin Represents Net Patient Service Revenue less Total Cost

2011

Service Category	Commercial				Government				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	2774169	401021	1970938	675330	11256674	-1609580	1831226	-553566	46645	-192939	6913	-6512	14077488	-1401498	3809077	115252
Invasive																
Medical																
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	4591	1299	0	0	26053	-9650	0	0	0	-3537	0	0	30644	-11888	0	0
Dermatology	344664	96723	0	0	1302848	-389849	0	0	9169	-3640	0	0	1656681	-296766	0	0
Endocrinology	435608	95454	755765	-23948	2083469	-197010	528358	-126541	18745	-79533	3709	-955	2537822	-181089	1287832	-151444
Gastroenterology	3645505	908212	7878129	2011576	7699475	-1143935	2521068	-1112011	25682	-167623	17932	-8930	11370662	-403346	10417129	890635
General Medicine	895603	37366	4310479	-640720	3895307	-911678	2335746	-1637027	14285	-109138	44933	-54884	4805195	-983450	6691158	-2332631
General Surgery	7606687	954783	0	0	8291368	-2271077	0	0	63742	-172282	0	0	15961797	-1488576	0	0
Gynecology	1104337	154739	0	0	451679	3583	0	0	3530	-28224	0	0	1559546	130098	0	0
Hematology	169283	40094	0	0	881599	-243619	0	0	4985	-17574	0	0	1055867	-221099	0	0
Infectious Disease	12824	-3060	0	0	22213	-21847	0	0	0	0	0	0	35037	-24907	0	0
Neonatology	1212592	-218554	0	0	1175382	-1384605	0	0	0	0	0	0	2387974	-1603159	0	0
Nephrology	462983	70388	0	0	3675984	-305666	0	0	4089	-41821	0	0	4143056	-277099	0	0
Neurology	636371	110524	108445	67318	6007557	-329947	63413	6111	44817	-48625	1004	394	6688745	-268048	172862	73823
Neurosurgery	93190	-111908	0	0	81810	2646	0	0	0	0	0	0	175000	-109262	0	0
Normal Newborns	705797	167936	0	0	1152734	878994	0	0	981	103	0	0	1859512	1047033	0	0
Obstetrics	5660075	-733682	1382231	-721242	2217841	-1043128	459179	-538328	9521	-7124	1428	-1435	7887437	-1783934	1842838	-1261005
Oncology	241630	-20658	7839339	1207285	1137602	-28587	9308905	-3085016	0	-44601	3109	-67560	1379232	-93846	17151353	-1945291
Ophthalmology	4771	3806	0	0	60843	28	0	0	0	0	0	0	65614	3834	0	0
Orthopedics	1956512	639028	0	0	7028930	148423	0	0	94147	-67010	0	0	9079589	720441	0	0
Otolaryngology	142210	3608	0	0	451026	-60960	0	0	4089	-11356	0	0	597325	-68708	0	0
Psychiatry	1885722	-111872	641129	-95522	11472373	-3251579	1505574	-929964	121804	-801955	25353	-50033	13479899	-4165406	2172056	-1075519
Pulmonary	2250748	579176	252943	38982	9131001	-2167823	219465	-179701	31954	-153122	0	-1499	11413703	-1741769	472408	-142218
Rehab	0	0	2220341	477657	0	0	1299602	-154567	0	0	178173	-34193	0	0	3698116	288897
Rheumatology	10287	3346	0	0	18207	-4009	0	0	0	0	0	0	28494	-663	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	41873	-47587	12869430	3064920	207275	34618	8922014	-1115986	0	0	1412853	-705965	249148	-12969	23204297	1242969
Urology	546816	188531	0	0	576053	-163724	0	0	3178	-17398	0	0	1126047	7409	0	0
Vascular Surgery	355479	-37595	0	0	1042352	-441509	0	0	0	-28365	0	0	1397831	-507469	0	0
Other Inpatient	0	0	0	0	51569	-1772	0	0	0	0	0	0	51569	-1772	0	0
Imaging	0	0	16817530	10498887	0	0	5123414	953155	0	0	218260	105110	0	0	22159204	11557152
Other Treatments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laboratory	0	0	10104227	5023448	0	0	3655190	-283006	0	0	104053	44977	0	0	13863470	4785419
Ambulatory Surgery	0	0	9736489	2098867	0	0	3131153	-1158142	0	0	435980	-184914	0	0	13303622	755811
Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Outpatient	0	0	5186594	-316361	0	0	3346648	-1442837	0	0	243277	-318835	0	0	8776519	-2078033
GRAND TOTAL	**33200327**	**3171118**	**82074009**	**23366477**	**81399224**	**-14913262**	**44250955**	**-11357426**	**501363**	**-1995764**	**2696977**	**-1285234**	**115100914**	**-13737908**	**129021941**	**10723817**

Observation: included in
OUTPT Categories Above

General Medicine			2506124	-999107			1281943	-1423964			16687	-24595	0	0	3804754	-2447666
Obstetrics			372996	-198143			140025	-137939					0	0	513021	-336082
Total Observation			**2879120**	**-1197250**			**1421968**	**-1561903**			**16687**	**-24595**	**0**	**0**	**4317775**	**-2783748**

NOTES:

1. Margin Represents Net Patient Service Revenue less Total Cost

2012

Service Category	Commercial				Government				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	2296450	43360	1901350	645203	10599669	-604901	2087639	-609874	93827	-211372	6683	-1821	12989946	-772913	3995672	33508
Invasive																
Medical																
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	8568	877	0	0	0	0	0	0	0	0	0	0	8568	877	0	0
Dermatology	315320	69788	0	0	1463334	64389	0	0	21495	-49438	0	0	1800149	84739	0	0
Endocrinology	590160	60449	832984	-131442	2161571	-62489	646238	-206196	21422	-24782	3090	-3321	2773153	-26822	1482312	-340959
Gastroenterology	3132088	741423	7492785	1423886	7184944	-299993	2644357	-1115659	81579	-145588	20485	427	10398611	295842	10157627	308654
General Medicine	1308983	172986	4113593	-865272	5590991	101708	3937132	-3242758	46173	-94107	147454	-195954	6946147	180587	8198179	-4303984
General Surgery	6848412	811447	0	0	9608991	-1053741	0	0	63662	-237373	0	0	16521065	-479667	0	0
Gynecology	1219019	133262	0	0	498561	-36069	0	0	8959	-10998	0	0	1726539	86195	0	0
Hematology	238721	28967	0	0	967396	32218	0	0	-4100	-36986	0	0	1202017	24199	0	0
Infectious Disease	98300	44113	0	0	70748	-2436	0	0	0	0	0	0	169048	41677	0	0
Neonatology	1160379	-106014	0	0	1141676	-1790396	0	0	16569	-34770	0	0	2318624	-1931180	0	0
Nephrology	560146	136905	0	0	4415798	133200	0	0	28624	-22242	0	0	5004568	247863	0	0
Neurology	774751	219407	90534	47066	6318736	-250878	59342	3458	38795	-6667	1129	19	7132282	-38138	151005	50543
Neurosurgery	3237	-2804	0	0	22521	-5418	0	0	0	0	0	0	25758	-8222	0	0
Normal Newborns	712957	279310	0	0	1270118	1057739	0	0	0	-1494	0	0	1983075	1335555	0	0
Obstetrics	5276506	-744314	1192514	-1046964	2380352	-551851	434354	-785948	25983	-11229	620	-2981	7682841	-1307394	1627488	-1835893
Oncology	261744	33290	7792451	946387	1351679	114240	8910019	-3487074	19435	-49939	9373	-48640	1632858	97591	16711843	-2589327
Ophthalmology	9518	6304	0	0	15587	4144	0	0	0	0	0	0	25105	10448	0	0
Orthopedics	2094515	648892	0	0	7196894	478375	0	0	108538	-28335	0	0	9399947	1098932	0	0
Otolaryngology	137556	38608	0	0	373378	-23612	0	0	8274	-12751	0	0	519208	2245	0	0
Psychiatry	1768127	36394	536344	-116757	11456853	-3340987	1411032	-1397831	137000	-675642	25074	-40467	13361980	-3980235	1972450	-1555055
Pulmonary	1855884	234962	227782	-5300	8368159	-380750	191363	-247838	41142	-122640	80	-486	10265185	-268428	419225	-253624
Rehab	0	0	2389390	444262	0	0	1405263	-204164	0	0	143108	-84107	0	0	3937761	155991
Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	0	0	13169501	2905037	142298	40129	9910130	-895703	5600	-369	1564895	-476216	147898	39760	24644526	1533118
Urology	198250	17142	0	0	516760	-33771	0	0	0	-8169	0	0	715010	-24798	0	0
Vascular Surgery	239542	19293	0	0	1227657	-454753	0	0	0	0	0	0	1467199	-435460	0	0
Other Inpatient	0	0	0	0	57894	-5266	0	0	0	0	0	0	57894	-5266	0	0
Imaging	0	0	16260914	10371133	0	0	5415973	1444470	0	0	203062	101227	0	0	21879949	11916830
Other Treatments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laboratory	0	0	9834735	4493170	0	0	3761043	-562197	0	0	117693	54463	0	0	13713471	3985436
Ambulatory Surgery	0	0	10227598	2026441	0	0	3228943	-1329575	0	0	408045	-200107	0	0	13864586	496759
Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Outpatient	0	0	6528441	-598644	0	0	4092456	-2330393	0	0	240213	-335087	0	0	10861110	-3264124
GRAND TOTAL	**31109133**	**2924047**	**82590916**	**20538206**	**84402565**	**-6871169**	**48135284**	**-14967282**	**762977**	**-1784891**	**2891004**	**-1233051**	**116274675**	**-5732013**	**133617204**	**4337873**

Observation: included in
OUTPT Categories Above

General Medicine			2435311	-1204686			2823324	-3071461			101520	-150986	0	0	5360155	-4427133
Obstetrics			277543	-274801			130817	-205294					0	0	408360	-480095
Total Observation			**2712854**	**-1479487**			**2954141**	**-3276755**			**101520**	**-150986**	**0**	**0**	**5768515**	**-4907228**

NOTES:

1. Margin Represents Net Patient Service Revenue less Total Cost

2013

Service Category	Commercial				Government				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology Total	2756245	321026	1789338	495205	9345937	-578330	2346249	-696713	34820	-81725	8755	-9576	12137002	-339029	4144342	-211084
Invasive																
Medical																
Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental	0	0	0	0	23864	-20260	0	0	0	0	0	0	23864	-20260	0	0
Dermatology	516174	109282	0	0	1275748	13550	0	0	15957	-40165	0	0	1807879	82667	0	0
Endocrinology	527544	119509	1001352	-177719	1670992	-188775	863314	-261374	23097	-18590	6721	-6628	2221633	-87856	1871387	-445721
Gastroenterology	2926545	815064	6450808	657272	6007252	-209768	2423660	-1116549	74597	-184507	4562	-16537	9008394	420789	8879030	-475814
General Medicine	1442105	161327	3834237	-924307	5627650	-431076	5072101	-4692467	24508	-80580	172275	-238692	7094263	-350329	9078613	-5855466
General Surgery	4408575	570063	0	0	7444843	-464561	0	0	19840	-202546	0	0	11873258	-97044	0	0
Gynecology	928680	92060	0	0	482768	-13357	0	0	0	-4378	0	0	1411448	74325	0	0
Hematology	177196	-13748	0	0	602010	-44995	0	0	4604	-3035	0	0	783810	-61778	0	0
Infectious Disease	3324	467	0	0	46859	-24799	0	0	7034	-2354	0	0	57217	-26686	0	0
Neonatology	952380	-278318	0	0	1273281	-1710268	0	0	2394	988	0	0	2228055	-1987598	0	0
Nephrology	712127	182534	0	0	4063085	105517	0	0	8204	-2033	0	0	4783416	286018	0	0
Neurology	829860	150598	39714	16987	5643145	-334555	44901	-6007	0	-22340	154	-727	6473005	-206297	84769	10253
Neurosurgery	30689	13083	0	0	57620	22632	0	0	0	0	0	0	88309	35715	0	0
Normal Newborns	680295	230181	0	0	1061395	838320	0	0	3890	1508	0	0	1745580	1070009	0	0
Obstetrics	5054731	-537586	1154154	-1090970	2151288	-565431	408333	-788725	12248	-31255	9363	-11930	7218267	-1134272	1571850	-1891625
Oncology	278698	27050	7259468	445360	1113867	22763	9098935	-3407871	14098	2653	43095	-94050	1406663	52466	16401498	-3056561
Ophthalmology	5292	3148	0	0	58629	16032	0	0	0	0	0	0	63921	19180	0	0
Orthopedics	2338933	838525	0	0	7101341	841564	0	0	48627	1338	0	0	9488901	1681427	0	0
Otolaryngology	112854	37397	0	0	366085	-69814	0	0	0	-3911	0	0	478939	-36328	0	0
Psychiatry	1717644	-100515	721390	-72420	11835774	-3857875	1419651	-1277408	81014	-467474	33774	-50552	13634432	-4425864	2174815	-1400380
Pulmonary	1993144	422957	213342	-4806	9731920	-789857	189436	-186847	32995	-105217	107	-1091	11758059	-472117	402885	-192744
Rehab	0	0	2187111	509571	0	0	1315284	-145729	0	0	97840	-47237	0	0	3600235	316605
Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transplant Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma	37021	23594	11543586	2329517	174013	9374	9499342	-838551	4789	-2468	1324161	-451928	215823	30500	22367089	1039038
Urology	161920	58912	0	0	533516	-177959	0	0	0	0	0	0	695436	-119047	0	0
Vascular Surgery	203904	-399999	0	0	684026	-435069	0	0	0	0	0	0	887930	-835068	0	0
Other Inpatient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Imaging	0	0	13099421	8008365	0	0	4691316	1006618	0	0	194868	88074	0	0	17985605	9103057
Other Treatments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laboratory	0	0	9596287	4485131	0	0	3736951	-558228	0	0	94796	38466	0	0	13428034	3965369
Ambulatory Surgery	0	0	9449842	1097902	0	0	3437871	-1438109	0	0	371058	-232205	0	0	13258771	-572412
Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Office Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Outpatient	0	0	9792384	1134654	0	0	5477744	-2399241	0	0	339327	-212497	0	0	15609455	-1477084
GRAND TOTAL	**28795880**	**2846611**	**78132434**	**16909742**	**78376908**	**-8046997**	**50025088**	**-16807201**	**412716**	**-1246091**	**2700856**	**-1247110**	**107585504**	**-6446477**	**130858378**	**-1144569**

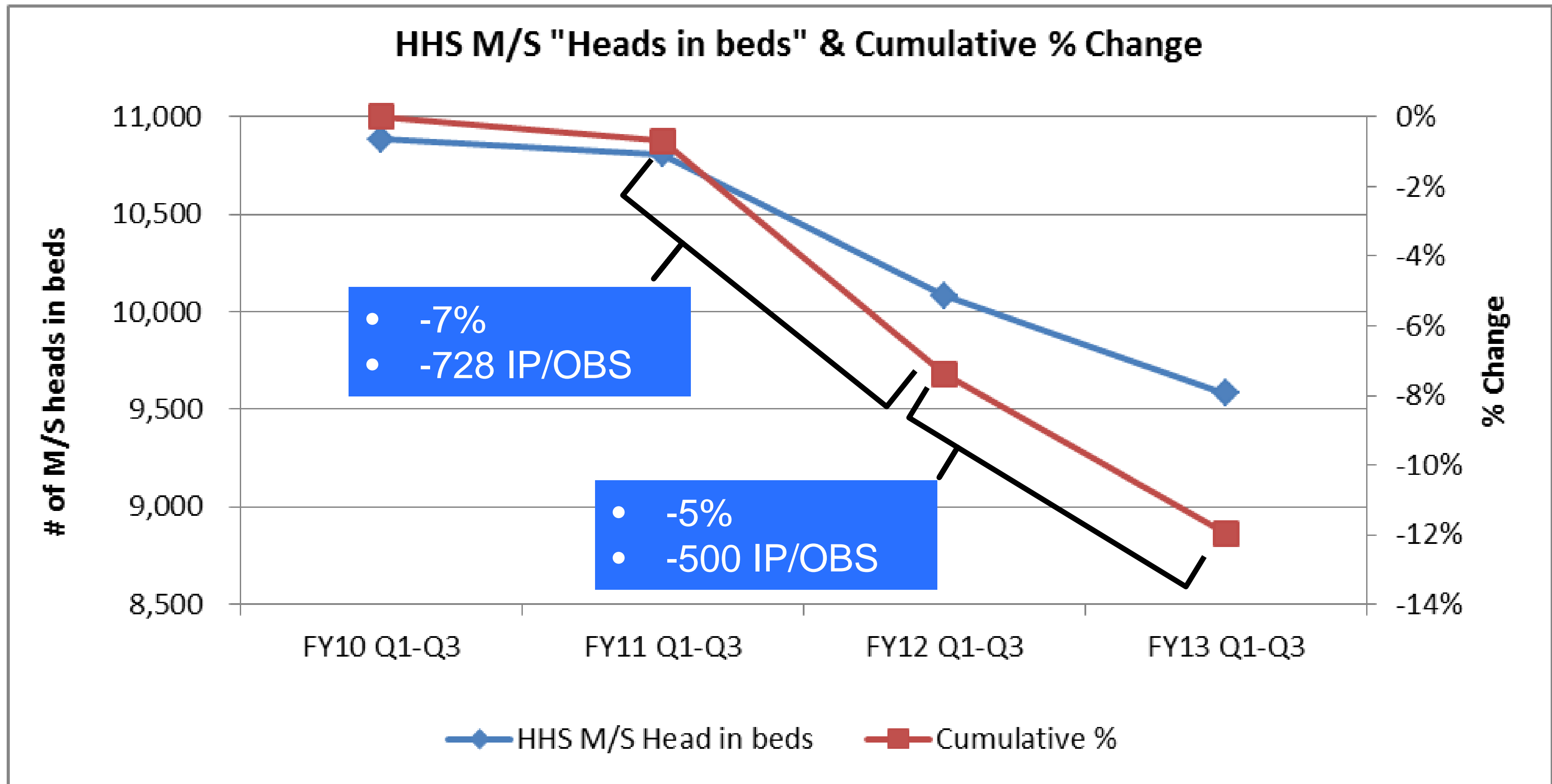
Observation: included in
OUTPT Categories Above

General Medicine			2435311	-1204686			2823324	-3071461			101520	-150986	0	0	5360155	-4427133
Obstetrics			277543	-274801			130817	-205294					0	0	408360	-480095
Total Observation			**2712854**	**-1479487**			**2954141**	**-3276755**			**101520**	**-150986**	**0**	**0**	**5768515**	**-4907228**

NOTES:

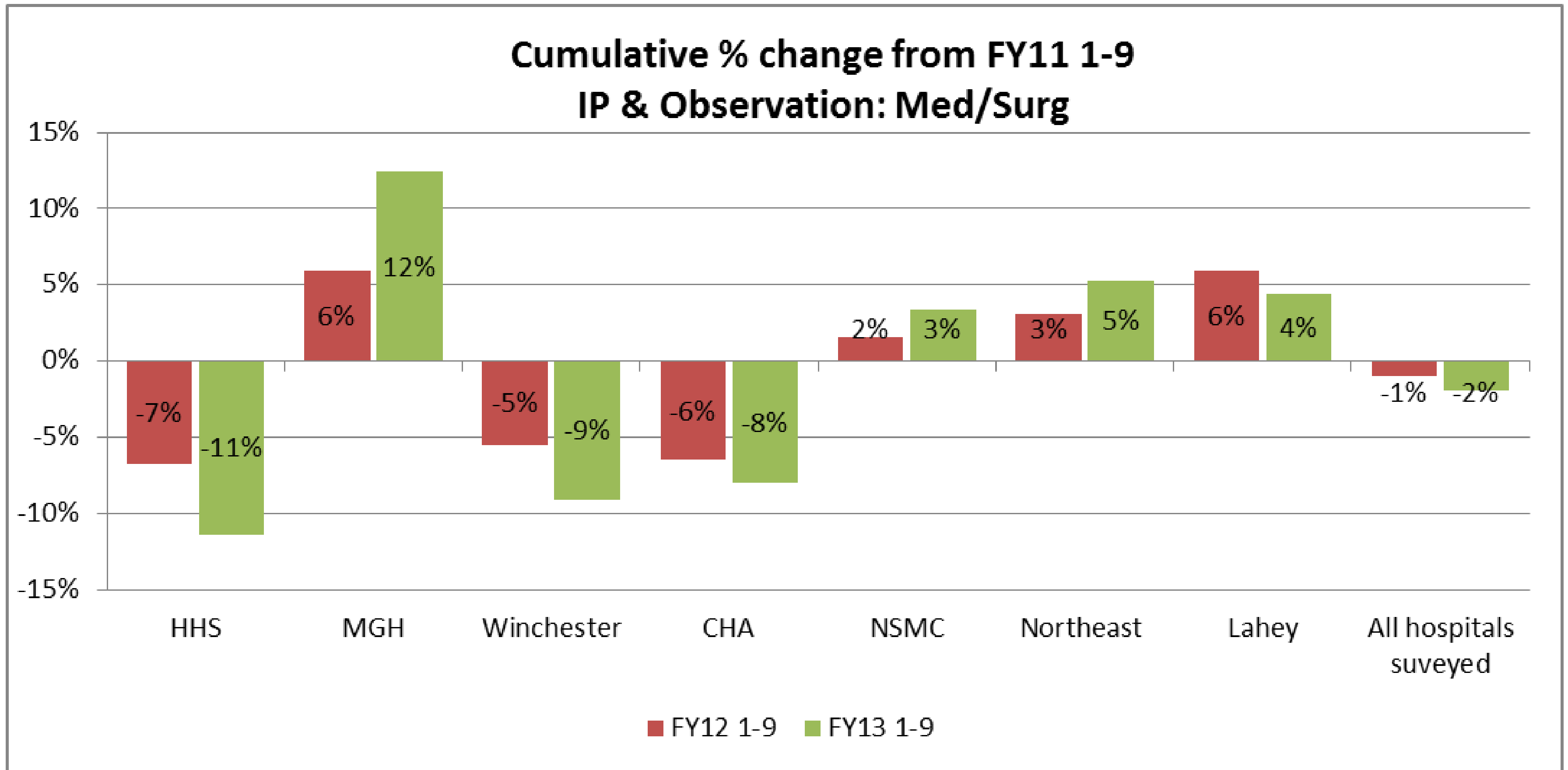
1. Margin Represents Net Patient Service Revenue less Total Cost

HHS has experienced a 11% decline in admitted & observation med/surg patients (i.e. heads in beds) since FY11. Annualized, this is a reduction of -1,637.



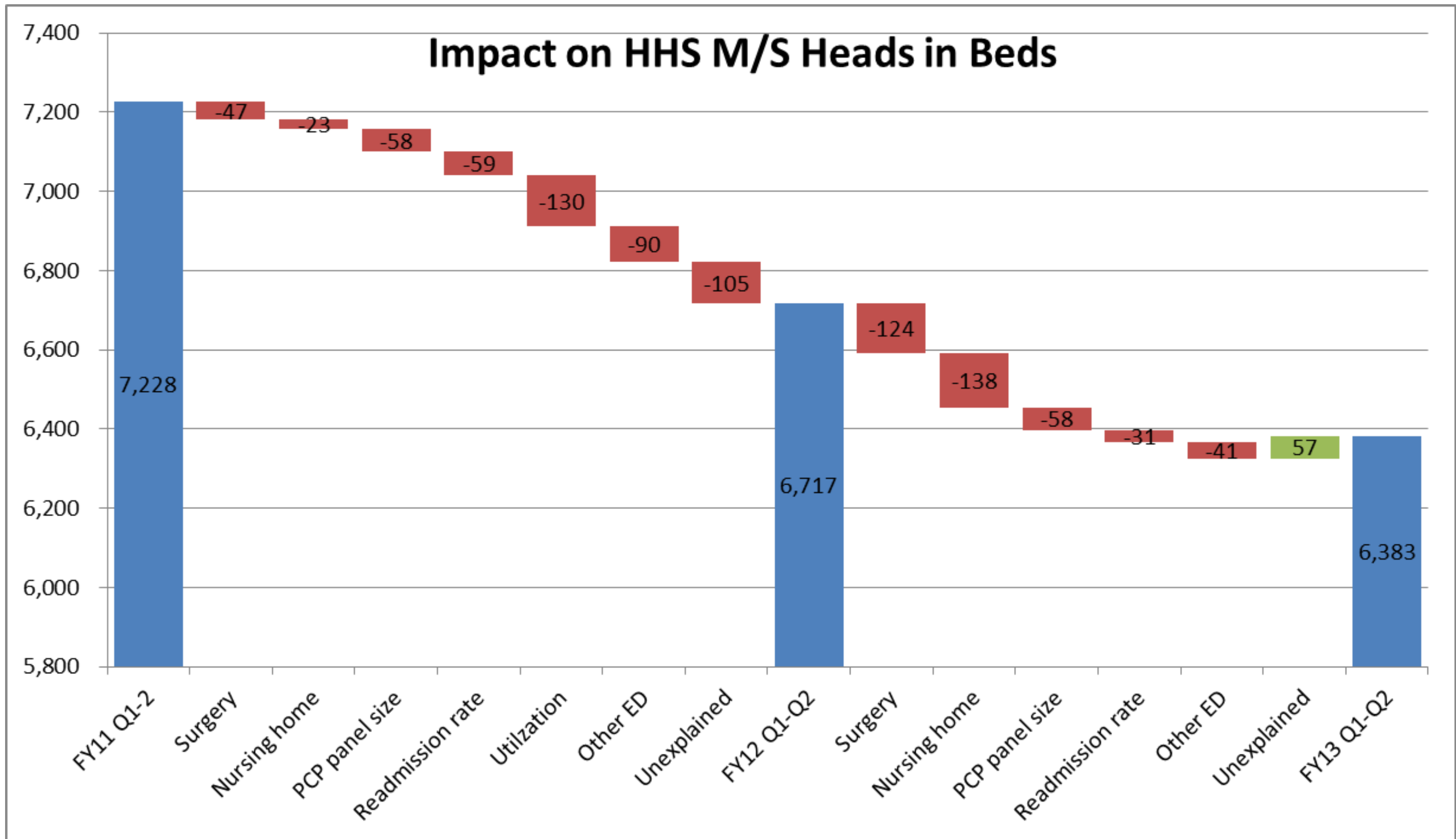
Hallmark Health

While many MA hospitals have reported a volume decline, HHS' loss has been greater



Source: BMC survey. M/S only. Excludes deliveries and assumed OB volume

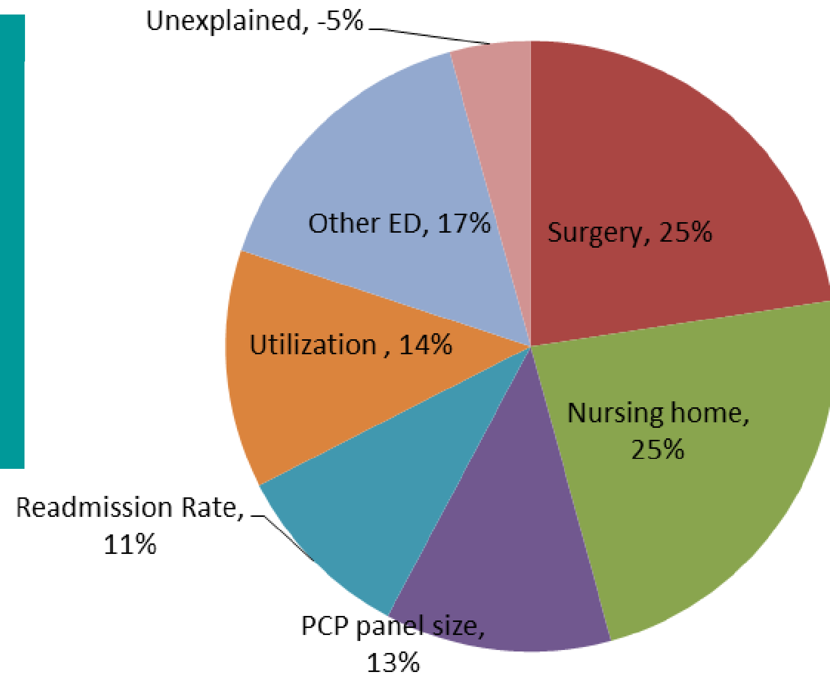
What caused the heads in beds decline?



Heads in beds is M/S only

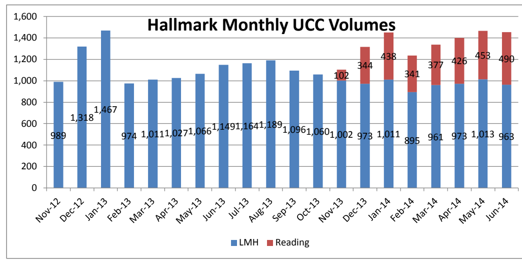
Impact summary

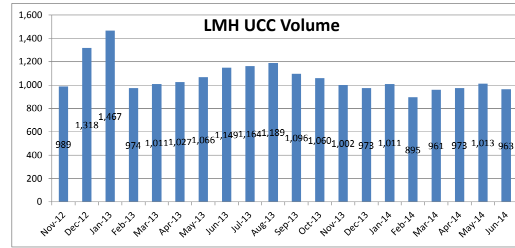
HHS M/S Heads in Beds: Periods 1-9			
Impact	**FY11-FY12**	**FY12-FY13**	**Total**
Surgery	-87	-217	-304
Nursing home	-80	-231	-311
PCP panel size	-81	-81	-161
Readmission Rate	-85	-45	-130
Utilization	-169		-169
Other ED	-41	-169	-210
Unexplained	-186	243	58
Total	**-728**	**-500**	**-1228**
Annualized total			**-1637**



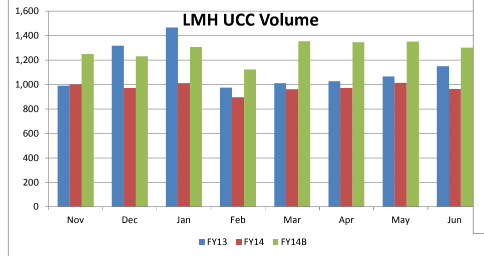
Heads in beds is M/S only

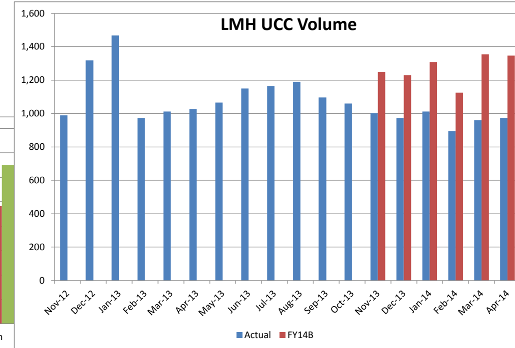
HHS UCC Visits		
	LMH	Reading
Nov-12	989	
Dec-12	1,318	
Jan-13	1,467	
Feb-13	974	
Mar-13	1,011	
Apr-13	1,027	
May-13	1,066	
Jun-13	1,149	
Jul-13	1,164	
Aug-13	1,189	
Sep-13	1,096	
Oct-13	1,060	
Nov-13	1,002	102
Dec-13	973	344
Jan-14	1,011	438
Feb-14	895	341
Mar-14	961	377
Apr-14	973	426
May-14	1,013	453
Jun-14	963	490
Jul-14	939	481
Aug-14	987	458



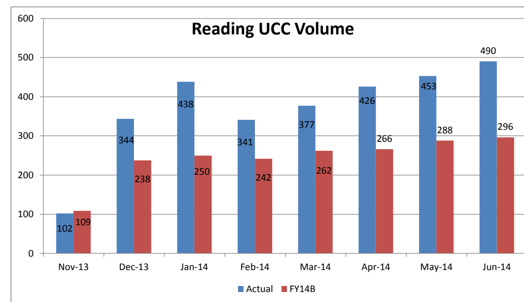


	FY13	FY14	FY14B	FY15B
Nov	989	1,002	1,250	
Dec	1,318	973	1,230	
Jan	1,467	1,011	1,308	
Feb	974	895	1,124	
Mar	1,011	961	1,354	
Apr	1,027	973	1,346	
May	1,066	1,013	1,352	
Jun	1,149	963	1,302	
Jul	1,164			
Aug	1,189			
Sep	1,096			
Oct	1,060			

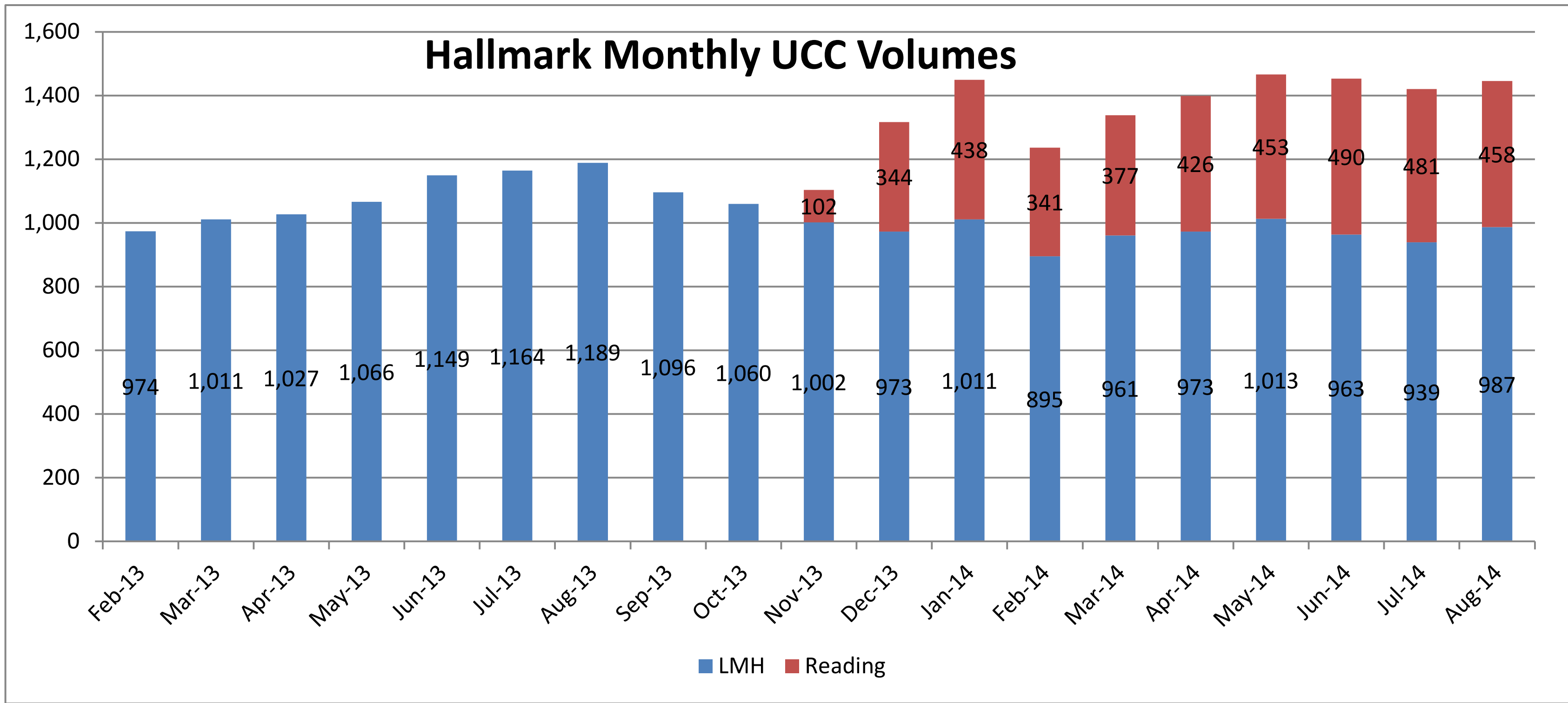




LMH UCC Visits		
	Actual	FY14B
Nov-12	989	
Dec-12	1,318	
Jan-13	1,467	
Feb-13	974	
Mar-13	1,011	
Apr-13	1,027	
May-13	1,066	
Jun-13	1,149	
Jul-13	1,164	
Aug-13	1,189	
Sep-13	1,096	
Oct-13	1,060	
Nov-13	1,002	1,250
Dec-13	973	1,230
Jan-14	1,011	1,308
Feb-14	895	1,124
Mar-14	961	1,354
Apr-14	973	1,346
May-14	1,013	1,352
Jun-14	963	1,302



Reading UCC Visits		
	Actual	FY14B
Nov-12		
Dec-12		
Jan-13		
Feb-13		
Mar-13		
Apr-13		
May-13		
Jun-13		
Jul-13		
Aug-13		
Sep-13		
Oct-13		
Nov-13	102	109
Dec-13	344	238
Jan-14	438	250
Feb-14	341	242
Mar-14	377	262
Apr-14	426	266
May-14	453	288
Jun-14	490	296



Addendum #2

Hallmark Health: Inpatient Dispositions

HHS Discharge Dispositions	
Disposition Category	% of DC
Home	57%
SNF	19%
VNA	15%
Acute Care Hospital	3%
Acute Rehab Hospital	2%
Hospice	2%
Psych	2%

DISCHARGE TO SNF	%
COURTYARD HURSING HOME	11%
GLENRIDGE NURSING HOME	10%
ELMHURST NURSING HOME	9%
BEAR HILL NURSING HOME	7%
WAKEFIELD CARE & REHAB	7%
LIFE CARE CENTER	6%
EPOCH	3%
GOLDEN LIVING CENTER	3%
BLANK	3%
WINGATE	3%
ABERJONA NURSING HOME	3%
SAUGUS CARE AND REHAB	3%
MEADOWVIEW	2%
HAMMERSMITH	2%
DEXTER HOUSE	2%
LEONARD FLORENCE	2%
WOODBRIAR	2%
All other less than 2%	24%

DISCHARGE TO VNA	%
HALLMARK VNA	70%
UNABLE TO DETERMINE	4%
ALL CARE	4%
PARTNERS VNA	3%
BLANK	2%
MEDFORD VNA	2%
NIZHONI VNA	2%
All other less than 2%	12%

DISCHARGE TO ACUTE REHAB	%
NEW ENGLAND REHAB	50%
SPAULDING	16%
KINDRED NORTH SHORE	12%
UNABLE TO DETERMINE	6%
WOBURN REHAB	3%
BLANK	2%
LEMUEL SHATTUCK JAMICA	2%
LEONARD FLORENCE CHELSEA	2%
All others less than 2%	7%

DISCHARGE TO HOSPICE CARE	%
BLANK	38%
HALLMARK HOSPICE	36%
UNABLE TO DETERMINE	19%
HOSPICE OF THE NORTH SHORE	4%
ALL CARE HOSPICE	1%
PETER SANDBORN PLACE	1%
SAWTELLE HOUSE READING	1%

Date range: 11/1/12 – 2/28/13
Source: Meditech, Admissions Module.
Includes observations. Excludes deceased, and against medical advice discharges
Actual location is derived from free text field

Addendum #3

How is HHS complying?

- Purchased a pricing transparency tool from Passport
  - Patient Payment Estimator
  - Organization wide access to the tool
- Will allow users to create an accurate cost and patient portion estimate before or at the point of service.
- Organizational support in Patient Financial Services/Financial Counseling

The Process

- **Consistency**
  PPE combines data from the provider's chargemaster, payer contract terms and the patient's insurance benefits. It eliminates the need for interpreting complex benefit data and contract terms, manually updating price lists, and ends the tedious process of searching through potentially outdated information.
- **Clarity**
  PPE presents a clear, easy-to-explain price estimate of services to patients so that they can make informed decisions about their care. These estimates remain in the system and can be recalled easily for future reference.
- **Transparency**
  PPE itemizes the cost of the proposed services and displays them in the estimate. Patients can quickly see what the total cost will be, what their insurance will cover and the balance that they are responsible to pay.

Hallmark Health

PATIENT RESPONSIBILITY ESTIMATE

Patient Information

Insurance: TUFTS NAVIGATOR
Account Number:
MRN:
Subscriber #:
Service Date: 1/9/2014

Estimated Charges

Code - Service	Charges	Charges Allowed	Qty	Est. Total
70546 -MRA HEAD W/O & W/CONTRAST	$2,645.40	$1,290.65	1	$1,290.65
		Total Estimated Charges		**$1,290.65**

Total Estimated Charges	**Estimated Patient Responsibility**
$1,290.65	**$350.00**

Benefit	Benefit Category
	CT/MRI Imaging
Payer	Primary
Insurance Adjusted Charges	$1,290.65
Ind Deductible	$250.00
Ind Deductible Remaining	$250.00
Family Deductible	$750.00
Family Deductible Remaining	$750.00
Ind Out of Pocket	$99,999.99
Ind Out of Pocket Remaining	$99,999.99
Family Out of Pocket	$999,999.99
Family Out of Pocket Remaining	$999,999.99
Co-Pay	$100.00
Co-Insurance	$0.00
Estimated Patient Responsibility	$350.00
Total Estimated Responsibility	$350.00

The information provided is a hospital estimate and is not a guarantee of final billed charges. Final billed charges may vary from hospital estimates for many reasons, among them are the patient's medical condition, unknown circumstances or complications, final diagnosis and recommended treatment ordered by the physician. Professional fees, such as physician, radiologist, anesthesiologist and pathologist fees are not included in this estimate.

Insurance benefit information (where applicable) is based on information provided by your insurance company as of the date of this estimate. Benefits and eligibility are subject to change and are not a guarantee of payment.

Patient Signature **Date** **Hospital Representative Signature** **Date**

The Benefits

- Development and adherence to consistent pricing policies
- Improved communication with patients around patient financial responsibility
- Increased point of service collections opportunities
- Reduced bad debt and other write-offs
- More accurate insurance information

Roll out Plan

- All point of service employees with access to Passport for insurance eligibility also have access to the Patient Payment Estimator. This includes all front end registrars at all locations.

- Meeting scheduled for 1/9/14 with key point-of –service directors and managers to review Chapter 224 and introduce software tool.

- Assigning a central number in Patient Financial Services for patient calls to be routed.

- Passport Webex trainings available to all employees on request.

- Organization-wide announcement via email.

- Leadership meeting presentation.

- HHMA will comply using a manual estimate and is currently pursuing the Patient Payment Estimator to automate the process.