Harrington
HEALTHCARE SYSTEM
Total Local Care

September 27, 2013

Mr. David Seltz
Health Policy Commission
Executive Director

In accordance with the provisions required by the state law and implemented by the Health Policy Commission, Harrington Hospital is submitting written testimony in response to the questions of the Health Policy Commission in "Exhibit B" and questions of the OAG in "Exhibit C."

The requested written testimony is herewith attached and has been sent for submission to HPC-Testimony@state.ma.us on Friday, September 27, 2013.

Ed Moore

Edward H. Moore
President & CEO

Enclosures:

Exhibit B: "HPC Questions"
Exhibit C: "OAG Questions"

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Exhibit B
Health Policy Commission Questions

1. a. What are the actions your organization has undertaken to reduce the total cost of care for your patients?
Harrington has undertaken many cost reduction, quality improvement initiatives, particularly during the past 6 years. The following list is a small representative sample of the total efforts to reduce costs while improving quality.

- Total and per day staffing of individual departments/units based on bench marks which are periodically updated.
- patient safety and quality - please refer to Appendix A
- Inpatient services utilization review/management system by Crimson implemented in 2010 to monitor and compare with other providers nationally, the use and cost of services.
- Participation in national (VHA) and regional (Northeast Purchasing Coalition) group purchasing organizations to achieve maximum leverage in the acquisition cost of supplies and equipment.
- Value analysis program which reviews and evaluates supplies and equipment to achieve organizational standardization and ensure quality and cost effectiveness.
- Clinical and nonclinical process improvement, which includes an organization-wide LEAN initiative.
- Investment and implementation of CPOE, E-prescribing, physician office EMR, and managed care infrastructure
- Preadmission utilization review/care management intervention in the emergency department to provide patients with the most cost effective and clinically appropriate services after discharge.

1. b. The more significant opportunities for Harrington to improve quality and efficiency of care are:
The availability of medical care data from other providers and facilities that have provided services to patients being treated by Harrington: Clinical care process improvement for the complete episode/spectrum of care (i.e. cardiac heart failure, COPD, joint replacement): Pre and post discharge care and management of chronic and complex care patients.
The factors which limit our ability to address the opportunities are: Lack of standardization of quality measures/standards among payers which increases administrative costs and diverts resources: and commercial and government payment policies are not structured to reimburse the hospital for the actual cost of these initiatives.

1. c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

The policy changes which would assist Harrington to operate more efficiently without reducing quality are:

- standardization of quality standards and measures for all government and commercial payers;
- standardization of filling requirements for all government and commercial payers;
- standardization of utilization review/authorization standards and policies for all government and commercial payers;
- standardization of the data and reports to be provided to the state and commercial payers.

1. d. What steps are you taking to ensure that any reduction in healthcare costs is passed along to consumers and businesses?

The CHIA August 2013 80 Annual Report on the Massachusetts Health Care Market references that "approximately 97% total Massachusetts" at health insurance coverage during the years 2009 through 2011. This means that reductions in healthcare costs and reductions in the increases in healthcare costs are going to be passed along to the payers who have arrangements with Harrington. The consumers and businesses would have to receive the reductions in costs or cost increases from the payers through the premiums and/or benefits (i.e. co-pays, deductibles, services).

2. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?

Harrington has not had or requested an increase in inpatient and outpatient hospital rates from commercial insurance plans including Blue Cross, Tufts Health Plan, Fallon Community Health Plan and Harvard Pilgrim. The rates with Blue Cross have not changed since 2011, Tufts rates remain unchanged from 2010, and Fallon rates have remained constant since 2010, while Harvard Pilgrim rates are unchanged from 2010. In fact, Harrington's rates to Blue Cross and Fallon were reduced in 2009. The results of these actions, as indicated by DCFHP and Attorney General reports, are hospital rates at or below the state mean for these health plans.

3. C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?

Harrington has a long history of behavioral health integration, both mental health and substance abuse services, with the medical services of the organization. The hospital has a broad continuum of inpatient and outpatient services that have expanded since they were established in the 1970s. Behavioral health programs and services are a department of the hospital. The programs include an adult inpatient psychiatry unit, psychiatric emergency services, outpatient child and family mental health, child psychiatry, outpatient adult mental health, adult psychiatry and outpatient drug and alcohol recovery services. The behavioral health services are integrated on the hospital Meditech system, as well as the All Scripts EMR, which is the physician practice EMR used by Harrington.

3. a. What potential opportunities have you identified for such integration?
The more significant opportunities for an enhancing and improving the integration of behavioral health services are the following:

- HIE linkage with the other behavioral health and medical providers/facilities initially in central and Western Massachusetts and eventually throughout Massachusetts and Northern Connecticut;
- Placement of therapists in primary care practices;
- Expansion of inpatient psychiatric services to the Webster campus to service the more than 1000 central Massachusetts patients referred out of area for services;
- Expansion of outpatient services capacity to address the need for services in southern Worcester County and contiguous areas.

3. b. What challenges have you identified in implementing such integration?
The challenges for implementing the opportunities to enhance and improve behavioral health integration are the following:

- The cost and insufficient funding of HIE for linkage of the behavioral health system, as well as, linkage between behavioral health providers and medical care providers;
- Current reimbursement policies do not support the behavioral health medical home model;
- Funding for the capital cost of renovating/converting an unused medical/surgical unit on the Webster campus to an adult psychiatric unit;
- Behavioral health rates are not adequate to support the cost of increasing the staff of psychiatrists and skilled therapists.

3. c. What systematic or policy changes with further promote such integration?
The systematic or policy changes that would support and promote the integration opportunities are the following:

- Grant and enhanced provider reimbursement from government and commercial payers for HIE infrastructure;
- Reimbursement models to support the consultation, navigator, coach and care management services in the different models;
- Financial assistance from the state for funding the conversion of the unused medical/surgical unit on the Harrington Webster campus to an adult psychiatric unit;
- An increase in the Mass Health, MBHP and managed Medicaid outpatient rates to the actual cost of services;

- consistent and well-defined payment policies across all payers

4. C.224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative treatment methods.

4. a. Describe your organizations efforts to promote these goals.
Harrington Healthcare System established a working and contractual relationship with a managed care organization, Accountable Care Associates, to provide managed care infrastructure to support population health management risk arrangements. This infrastructure is integrated with the organizational infrastructure of Harrington's physician hospital organization, Harrington Healthcare Provider Organization. Harrington is currently participating in the CMS ACO shared savings program, Blue Cross AQC and a Medicare advantage risk arrangement with Fallon Community Health Plan. Harrington has established as a strategic priority, the development of population health management arrangements with commercial payers, managed Medicaid plans and, if applicable, Mass Health.

4. b. What current factors limit your ability to promote these goals?
Current factors which limit Harrington's ability to promote our goals and strategic priorities are as follows:

- The lack of a commitment by all payers, including state and federal government, to pay for the infrastructure required to support population health management;
- Insufficient number of current and available primary care providers;
- Inadequate reimbursement for primary care services by all payers including the care management services for the different care delivery models
- The scale of the smaller community healthcare system which compromises and limits the ability of risk assumption needed for population health management.

4. c. What systematic or policy changes would support your ability to promote more efficient and accountable care?
Systematic or policy changes that would support Harrington's ability to promote and provide more efficient and accountable care are the following:

- Standardized risk arrangement terms inclusive of health status adjustment, benefit adjustment, unit price adjustment, quality incentives and risk assumption rates;
- accurate and standardized economic recognition of the transfer of financial risk from the insurance provider to the healthcare provider for population health management risk arrangements;

- Primary care payment rates standards for payers to support the expansion of primary care providers;
- Policy and financial support for ACO/ MCO networks of independent community healthcare systems

5. a. What metrics does your organization use to track trends in your organization's operational costs? What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?

Harrington Memorial Hospital has internal reports to track its productivity, FTE levels, and overtime usage. The reports are produced weekly and sent to the Management Team. The Productivity Report is based upon a four week rolling average of information. Variances are discussed as required.

The FTE report shows general trends in FTE levels. This report provides the manager the general trends in FTE, both productive and non-productive FTE's.

A Weekly Overtime Report is produced to identify usage. A goal is set for each department and the organization. The organization goal is 3.5%.

Each month, the CFO and Controller meet with major departments and review the above information, along with revenue and expense variances.

5. b. How does your organization benchmark its performance on operational cost structure against peer organizations?
Harrington Memorial Hospital does not benchmark against peer organizations. However, Harrington Memorial Hospital has engaged a consultant to look at its productivity bench marks and supply spends to identify opportunities.

5. c. How does your organization manage performance on these metrics?
Not applicable

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.
The Hospital has the Meditech information System. The System is not conducive to providing that data. The Hospital is trying to develop a methodology to meet this requirement. Even if this is accomplished, the Hospital feels that it is unable to provide accurate information. The Hospital does not have access to charges that will be incurred from physicians or other outside clinical services, which will also bill the patient.

Finally, the Hospital believes that it is the patient's insurance provider's responsibility to provide that information. The insurance company has the contracted price for the providers and also has the co-insurance and deductible information in its systems. For full transparency, this information should also be provided to the hospital.

7. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Tiering Products

Tiering Products are a new product introduced into the market. It is aimed at tiering providers at a service level based upon the price of each specific, or type of service under tiering. There are financial incentives for patients to go to different providers for different services. The Hospital has the following concerns:

- There are no standards for tiering. For most insurance providers, the Hospital is rated in the medium tier. However, for another, the Hospital is a tiered 3 provider. For this provider, the closet tier 1 hospital in Worcester County is more than 25 miles away.
- The concept of tiering is contrary to the managed care and population health management initiatives being undertaken by the Commonwealth and insurance providers. It is important to manage the care of these patients and understand the overall health status. If the patient is getting care at different locations/providers, certain results will not be part of the local electronic medical record. This may increase missed results, missed diagnosis or duplicative service.
- Under c.224, the Hospital is classified a "Geographically Isolated Hospital." Clearly, the Commonwealth's legislative body believes that the hospital is the central location for the community to access care and management of that care. Tiering could result in patients not getting appropriate care because of travel distances or cost. As a result, the management of the patients becomes very "choppy."

High Deductible Plans

The OAG reports comments that high deductible plans "shifts cost sharing risks to consumers and may hinder access to medical services." The Hospital is in agreement with that statement.

First of all, depending on your age and income level, these plans are attractive and affordable. However, in economically challenged areas, a patient may make other choices and not seek needed care. Because of the plan, patients may be "under insured." Over time, "being under insured" could create a real financial burden for that individual or family. As an unintended consequence, these plans may shift more cost to the uncompensated care pool.

As a case study, the Hospital effectively eliminated copays and deductibles if an employee and family sought care locally. The Hospital did see its costs increase. The costs increased in three areas, PCP visits, Laboratory services, and Diagnostic Radiology. The

employees did see their contributions increase, but were happier because they were able to received medical care that they had avoided because of the cost. (See attached)

Membership Movement to PPO Products

As commented, Policy makers are encouraging the development of risk contract and managed care. The OAG report indicates that PPO membership, a freedom of choice product, is gaining membership at the expense of managed care. This indicates that consumer is preferring freedom of choice products and not the limited, lower cost networks.

Financial Statement Presentation

OAG's findings make reference to gathering information regarding the employment status of physicians. The Hospital believes that it is a positive step in understanding the cost of a healthcare system.

Because of the medical economics of a physician's practice, many physicians are seeking employment. Currently, State data analyzes only the financial statements of the Hospitals and does not include the physician corporation in the analysis. In order to better understand the true state of the state's healthcare system, the Hospital believes that the state should expand its analysis beyond just the Hospital and include the operations of its physician group.

Risk

Over time, many of the insurance providers retained dollars for the risk it has taken. Now that risk is being transferred to the hospital and physician groups. Should some of the Insurance Company's risk reserves be transferred to the new risk providers?

Exhibit C Q 1

For each year 2009 to present please submit a summary table showing your operating marigins for each of the follwing three categories of your total business: a) comercial,b) governmental and c) all other....

Summary Operating Margins FY'09 through FY'12 by Payer Group

	FY 2009	FY 2010	FY 2011	FY 2012
Commercial	8,480,290	7,572,314	7,939,598	3,121,292
Government	(7,847,886)	(11,945,940)	(9,679,337)	(11,976,773)
All Other	1,381,013	1,297,316	596,994	239,651
Total	2,013,417	(3,076,310)	(1,142,745)	(8,615,830)

Percent of Gross Business FY'09 through FY'12 by Payer Group

	FY 2009	FY 2010	FY 2011	FY 2012
Commercial	39.4%	36.4%	35.1%	35.0%
Government	57.1%	60.5%	62.1%	62.3%
All Other	3.5%	3.1%	2.7%	2.7%
Total	100.0%	100.0%	100.0%	100.0%

Governmental Payors : Medicare, Managed Medicare, Medicaid, Managed Medicad, Commwealth Care and HSN
Commercial Payors: Blue Cross HMO, PPO and Indemnity; Tufts Health Plan; Harvard Pilgram; Fallon; GIGNA; Aetna and others
All Other : Workers' Compensation, Self Pay and other Governmental

***These are estimated based on cost report information. The hospital does not have a cost accounting system, which is expensive to acquire and maintain The Hospital's current system does not track operating margins by payor or payor group. These figures are based on a rough model specifically pulled together to answer the question posed. It relies on cost reporting step down statist many of which have become somewhat obsolete over time. It is likely that cost allocations using this method are very different from what would be seen in a well maintained cost accounting system.**

***Please note that the portions of the Accountable Care Act will be implemented in FY 2014. The Hospital expects that the new formula for the calculation of the Medicare Disproportionate Care payment will negatively impact the Hospital by $450,000. In addition, the Hospital expect the Medicare Rural Floor Adjustment of $1,500,000 will negatively impact the Hospital's 2015 budget.**

Exhibit C

Office of Attorney General Questions

2. If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per remember per month budget against which claims costs are settled for purposes of determining the withhold returned, stir plus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, or patient member type on your opportunities for surpluses.

In February of 2013, Harrington Healthcare System established a new provider organization, Harrington Healthcare Provider Organization (HHPO), to have population health management and other risk arrangements with payers, employers and managed care organizations. Harrington decided to participate effective in January 2013 in the CMS ACO Shared Savings and Blue Cross AQC arrangements of a managed care organization, Accountable Care Associates. HHPO entered into a Medicare Advantage risk arrangement with Fallon Community Health Plan (FCHP) effective August 1, 2013. Accountable Care Associates is providing managed care infrastructure services to HHPO for the FCHP Medicare Advantage arrangement. Data about the impact on service mix and patient member type is not available at this time because the arrangements have just started. Harrington intends to develop population health management arrangements for commercial and Medicaid populations with FCHP as well as other payers, and wants to extend to the managed care infrastructure to these relationships.

3. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk, solvency standards and projections and plans for deficit scenarios.

The Medicare Advantage arrangement with FCHP, does not have risk for HHPO in the first year. HHPO does assume limited risk in year two which increases in year three, for a defined medical services budget.

4. Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups.

Currently Harrington does not have the ability to track changes in health status of service area and patient population except through public health and other health status reports issued by the Commonwealth of Massachusetts.

Exhibit C Q 5

Harrington Hospital
CHIA/OAG Information

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	2,340,756										16,514,115	15,962,370			
Tufts											7,524,241				
HPHC											6,205,974				
Fallon											14,205,152				
CIGNA											2,640,737				
United											2,803,717				
Aetna											2,127,558				
Other Commercial											16,891,336				
Total Commercial	2,340,756										68,912,850	15,962,370			
Network Health											15,763,645				
NHP											287,128				
BMC Healthnet															
Fallon															
Other											8,050,200				
Total Managed Medicaid											24,100,973				
Mass Health											14,649,996				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											19,527,516				
Commercial Medicare Subtotal											19,527,516				
Medicare											56,074,421				
Self Pay											3,340,786				
Uncomp Care											4,219,004				
GRAND TOTAL	2,340,756										190,825,546	15,962,370			

Notes: BX PPO and Indemnity charges are combined
Only BX PPO is indentified.
Commercial other includes Commonwealth Care: Traditional Commercial; Auto and Workers Comp among others

Exhibit C Q 5

Harrington Hospital
CHIA/OAG Information

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	3,894,403										16,557,909	16,575,346			
Tufts											8,739,739				
HPHC											5,919,614				
Fallon											14,216,449				
CIGNA											2,875,517				
United											3,398,693				
Aetna											2,130,212				
Other Commercial											16,376,894				
Total Commercial	3,894,403										70,215,027	16,575,346			
Network Health											16,286,058				
NHP											3,459,069				
BMC Healthnet															
Fallon															
Other											9,049,115				
Total Managed Medicaid											28,794,242				
Mass Health											14,910,055				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											22,826,151				
Commercial Medicare Subtotal											22,826,151				
Medicare											61,759,260				
Self Pay											2,704,933				
Uncomp Care											5,213,857				
GRAND TOTAL	3,894,403										206,423,525	16,575,346			

Notes: BX PPO and Indemnity charges are combined
Only BX PPO is indentified.
Commercial other includes Commonwealth Care: Traditional Commercial; Auto and Workers Comp among others

Exhibit C Q 5

Harrington Hospital
CHIA/OAG Information

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	2,148,450										15,864,783	16,022,545			
Tufts											9,872,530				
HPHC											6,795,704				
Fallon											13,559,503				
CIGNA											3,120,934				
United											4,246,280				
Aetna											2,658,597				
Other Commercial											16,849,372				
Total Commercial	2,148,450										72,967,703	16,022,545			
Network Health											15,816,197				
NHP											4,825,140				
BMC Healthnet															
Fallon															
Other											9,526,285				
Total Managed Medicaid											30,167,622				
Mass Health											16,559,854				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											24,871,267				
Commercial Medicare Subtotal											24,871,267				
Medicare											59,708,097				
Self Pay											3,131,957				
Uncomp Care											5,022,662				
GRAND TOTAL	2,148,450										212,429,162	16,022,545			

Notes: BX PPO and Indemnity charges are combined
Only BX PPO is indentified.
Commercial other includes Commonwealth Care: Traditional Commercial; Auto and Workers Comp among others

Exhibit C
Office of Attorney General

6. Please identify categories of expenses that have grown a) 5% or more and b) 10% or more from 2010 to 2012.

As requested in your letter dated August 23, 2013, below please find Harrington Memorial Hospital's response to Question 6 in Exhibit C. Please note that we have included only the expense categories that have changed greater than 5% between FY 2010 and FY 2011, as well as expense categories that changed greater than 10% between FY 2010 and FY 2012.

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Salaries & Wages	$46,306,067	$49,702,324	7.33%		$46,306,067	$52,577,073	13.54%

Over the time period of FY 2010 to FY 2011 and FY 2010 to FY 2012, the Hospital's Salaries & Wages expense increased by $3,396,257 (7.33%) and $6,271,006 (13.54%), respectively. During this 2 year time period the Hospital had an annual merit program in effect that awarded individuals with a 2% increase in wages. In addition, the Hospital also provided for a market rate adjustment to various clinical positions in the Hospital to remain competitive with surrounding providers. This market rate adjustment amounted to approximately $1,000,000 in wage increases. Also contributing to the increase in wages during this time period was an increase in Information Technology staff to meet & maintain new meaningful use guidelines and ongoing support of electronic medical systems ($514,000), employment of new Emergency Room Physicians ($817,000) to meet requirements established by the Department of Public Health that board certified physicians manage the Hospital's Emergency Departments in Southbridge and a free standing facility in Webster, expansion of service offerings (Wound Care Center ($203,000), Sleep Lab Clinic ($179,000) and Suboxone Clinic ($241,000), as well as growth of existing service offerings at the main facility &/or into new facilities.

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Direct Fringe Benefits	$10,803,949	$10,599,581	-1.89%		$10,803,949	$12,222,485	13.13%

Over the time period of FY 2010 to FY 2011 and FY 2010 to FY 2012, the Hospital's Direct Fringe Benefits expense decreased by $204,368 (-1.89%) and $1,418,536 (13.13%), respectively. Approximately $515,000 of the increase from FY 2010 to FY 2012 pertains to increased employee health insurance costs resulting from the elimination of high deductibles and employees seeking care.

Contributing to the increased health insurance costs for the Hospital was the addition of new participants to the prescription insurance plan that required high cost pharmaceuticals, as well as the incurrence of several high cost health insurance cases. Also contributing to the increase in Direct Fringe Benefits was increased FICA tax expense ($374,000) and Unemployment Insurance costs ($140,000). The increase in FICA tax expense is attributable to the above mentioned increase in Salaries & Wages, while the increase in Unemployment Insurance costs is primarily due to a reduction-in-force plan that the Hospital put in place at the end of FY 2012.

Please note that no explanation for FY 2010 to FY 2011 fluctuation was done, as it does not meet the requested 5% increase from year-to-year.

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Clinical Supplies	$9,818,314	$11,826,052	20.45%		$9,818,314	$12,339,237	25.68%

Annual Clinical Supply costs have increased $2,007,738 (20.45%) from FY 2010 to FY 2011 and $2,520,923 (25.68%) from FY 2010 to FY 2012. Approximately 45% of the increase from FY 2010 to FY 2011 and 48% of the increase from FY 2010 to FY 2012 pertains to increased pharmaceutical costs. The primary reason for the increase in pharmaceutical costs is due to the Hospital opening a new Cancer Center in FY 2010. With the opening of the Cancer Center, oncology pharmaceutical purchases increased $381,000 from FY 2010 to FY 2011 and $590,000 from FY 2010 to FY 2012. The balance of the increase in Clinical Supplies pertains to Medical / Surgical supply purchases & Laboratory Reagent test costs, which is primarily due to increased business volumes in the Hospital.

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Facility Costs	$4,142,227	$4,471,570	7.95%		$4,142,227	$5,018,264	21.15%

Annual Facility Costs have increased $329,343 (or 7.95%) from FY 2010 to FY 2011 and $846,037 from FY 2010 to FY 2012. In the spring of 2010, the Hospital began offering Primary Care Services at a new outpatient facility in Charlton, MA. This lease accounted for $129,000 of the increase from FY 2010 to FY 2011 and $265,000 of the increase from FY 2010 to FY 2012. The balance of the increase in expense totals pertains to smaller rental agreements for outreach facilities that offered community services such as Substance Abuse support and Women, Infant & Children's Program (WIC).

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Depreciation	$6,927,838	$8,291,233	19.68%		$6,927,838	$8,726,596	25.96%

During the time period of FY 2009 thru FY 2012, the Hospital made $38,946,903 in capital acquisitions/improvements to the property, plant and equipment of the Hospital. As a result of these acquisitions/improvements, the Hospital was able to maintain its average age of plant at approximately 7 years (note that in FY 2008, the average age of plant was approximately 10 years). Some of the major acquisitions/improvements consisted of a $13,550,000 renovation of the North Wing in the main facility, $2,500,000 in leasehold improvements at a new outpatient medical facility, $1,600,000 in leasehold improvements for a new Cancer Center and $8,800,000 in various software implementations and upgrades to achieve electronic medical records and meaningful use status.

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Equipment Costs	$3,378,623	$3,615,692	7.02%		$3,378,623	$4,151,326	22.87%

Annual Equipment Costs have increased $237,069 (7.02%) from FY 2010 to FY 2011 and $772,703 (22.87%) from FY 2010 to FY 2012. The growth in expenses for this category is due to increased facility/equipment maintenance agreements, as well as software maintenance agreements. As noted above, the Hospital made significant investments in capital equipment during the time period being analyzed. The growth in maintenance agreement expenses is directly related to the new capital acquisitions/improvements.

	FY 2010	FY 2011	% Change		FY 2010	FY 2012	% Change
Professional Services	$8,164,555	$9,818,654	20.26%		$8,164,555	$9,561,482	17.11%

Annual Professional Services expenses have increased $1,654,099 (20.26%) from FY 2010 to FY 2011 and $1,396,927 (17.11%) from FY 2010 to FY 2012. In FY 2011, the Hospital began subsidizing the Hospitalist program that is administered by a related Physician Group. In FY 2011, the subsidy amounted to $1,162,482 (or 14% of the increase) and in FY 2012 the subsidy amounted to $1,342,522 (or 16% of the increase). In addition to the subsidy, the Hospital also incurred additional professional service fees community based projects/initiatives and staff recruitment services.

Exhibit C

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

Harrington HealthCare System has an active health and wellness program in the communities it serves in Southern Worcester County. Harrington's Health and Wellness Coordinator, in tandem with three per-diem employees, hold health education and health screenings throughout the 17-community area. For the period from Jan. 1, 2013 through Sept. 19, Harrington attended 65 wellness events in the community, reaching 3,388 individuals. The Harrington Wellness team conducted blood pressure screenings at 31 of the events, conducting approximately 25 to 30 screenings at each event, for a total of approximately 800 blood pressure screenings. Harrington conducted glucose screenings at 16 of these events. These events range from community senior center fairs to the Cops 'N Kids program for at-risk youth in Southbridge to fairs in the Hispanic community, such as the Latino Festival in Webster to community events such as Charlton Old Home Day.

Many of these screenings are done out of a medically equipped 35-foot recreational vehicle, called Harrington On Wheels, Mobile Health Unit. At a typical event with Harrington on Wheels, the Wellness Team will conduct sessions on proper nutrition, hand washing, diabetes, heart health and lyme tick disease education. Each year in November, Harrington on Wheels attends a church bazaar in Southbridge and administers free flu shots to those who do not have health insurance. The hospital also brings along a bilingual financial counselor who helps those without insurance with paperwork to apply for insurance. Harrington on Wheels also makes two regular stops a month at public gathering places – the parking lot of the Big Bunny supermarket in Southbridge and the Price Chopper supermarket in Spencer – and administers health screenings and advice on health and wellness.

Appendix

Information on Exhibit B

Question 7

High Deductible Discussion

Exhibit B Q 7 Discussion on High Deductible Plans

Harrington HealthCare

Health Insurance Trends

	Apr-11		Apr-12		Apr-13	
	HMH	Total	HMH	Total	HMH	Total
Physician Services	230,939	525,784	397,220	719,231	361,364	583,865
Radiology	159,829	193,901	352,608	410,805	60,592	162,084
Laboratory	90,774	154,248	254,571	285,580	246,841	283,823
Total Health Insurance Costs	797,556	2,050,685	1,669,396	3,195,722	1,872,920	3,106,700

June claims Prorated to April

2011 High Deductible Plan

2012 and 2013 no deductible plan is HMH is the provider