Harrington
HOSPITAL
Total Local Care

September 12, 2014

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 Memorial Hospital is submitting written testimony in response to the questions of the Health Policy Commission in "Exhibit B" and questions of the AGO 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 12, 2014.

Thomas J. Sullivan
Vice President and CFO

Enclosures:
Exhibit B: "HPC Questions"
Exhibit C: "AGO Questions"

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Exhibit B Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

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 in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.**
   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.**
   Harrington Memorial Hospital has experienced an overall growth in utilization as measured by gross patient revenue. Since 2010, gross revenue has increased by 13%. Most of the growth occurred in the outpatient setting which grew 15% while inpatient grew 4%.
   However, since 2011, inpatient revenue has declined 13% while OPD revenue increased by 9%. Consistent with revenue, inpatient discharge increased 9% since 2010 and declined 9% since 2011.

   While inpatient activity experienced a small increase over this period, outpatient has become a larger component of Harrington Memorial Hospital's review. In 2010, OPD revenue represented 77% of the business. In 2013, OPD revenue increased to almost 80% of the Hospital's business.

   Payer Mix
   During this period, Harrington Memorial Hospital has noticed a shift in payer mix. Governmental payer mix, which includes Medicare and Medicaid products, has increased from 57% of its business to almost 64% of its business.

   Comment
   Harrington Memorial Hospital believes the change in payer mix is the result of two factors. The first factor relates to more individuals in Harrington Memorial Hospital's service area are covered by governmental sponsored insurance products. These products will include managed Medicare and Medicaid plans. Harrington Memorial Hospital also believes that the decline in commercial business may be the results of high deductible plans, where the patients are delaying care and tiering products which force the patient to seek services outside the hospital's primary service area.

Expenses

In 2008, Harrington Memorial Hospital began implementing its 2008 strategic plan. The plan produced a physician manpower study that indicated that the primary service area needed more primary care physicians and specialists to meet the needs of the community of Southbridge and Southern Worcester County. The plan also identified certain geographic areas that were deficient in primary care and diagnostic services. The plan also called for an expansion of mental health services. In addition, and working with the Commonwealth, Harrington Memorial Hospital took over the failing Hubbard Hospital in Webster. In order to be successful provider needed services to the Webster area, the Commonwealth required Harrington Memorial Hospital maintain a 24/7 Emergency room with board certified physicians.

Since 2010, Harrington Memorial Hospital's costs have increased 18% or $16m. Approximately 75% of the increase in costs was related to the strategic plan and the addition of Webster. During this period Harrington Memorial Hospital has added a Cancer Care Center, Wound Care, Pre-admission Testing Program, and a Hospitalist Program. Harrington Memorial Hospital also brought needed services to the Charlton area that included Diagnostic Radiology, Mammography, and Vascular Services.

Harrington Memorial Hospital's Behavioral Health Program costs increased almost 40% as the Hospital added programs, expanded locations, and increased access to other programs.

Administratively, Harrington Memorial Hospital saw its patient account costs increase 33% for new staff and purchased services to help in the collection of self-pay balances resulting from the increase in high deductible/co-insurance plans.

The Quality department costs also increased. More staff was added along with software to comply with various and very different reporting requirements required by governmental agencies and third party payers.

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?

Since January 2013, Harrington Memorial Hospital continues to look at ways to expand patient care access to lower cost settings such as a primary care office or an outpatient setting. During this period, Harrington Memorial Hospital added Primary Care Services to the Spencer area, expanded Primary Care Physicians servicing the Charlton and Webster service areas. As indicated earlier, outpatient revenue continues to become a larger portion of Harrington Memorial Hospital's revenues. This trend continued through 2013 and 2014. Harrington Memorial Hospital continued to add staff to its Behavioral Health Program and to serve the needs of the community.

Harrington Memorial Hospital applied for a state grant to establish Mental Health Services in the Primary Care setting. Finally, Harrington Memorial Hospital is hiring a staff person to work with the local teenagers to reduce teenage pregnancy.

Harrington has focused on cost reduction and quality improvement of inpatient and outpatient services across the healthcare system through a broad spectrum of initiatives including enhancement of programs and efforts in place before January 2103. The following list represents the more significant initiatives to reduce actual costs and cost increases while improving overall quality.

- Adjustments to total and per day staffing of individual departments/units based on updated bench marks.
- Increased participation in national (VHA) and regional (Northeast Purchasing Coalition) group purchasing initiatives to achieve maximum leverage in the acquisition cost of supplies and equipment. Harrington has reduced supply and equipment costs by approximately (projections from Programs and Services including Rick and Gene estimates) during the period January 2013 through March 2014.
- Implemented the 340B management system Sentrix in August 2103. The documented savings are $1M for Cancer Pharmaceuticals.
- 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, with health care system wide LEAN initiatives.
- Deployment of pharmacists to inpatient units to review prescribed medications with providers and patients including consults with patients and families at time of discharge.
- Implementation of COPD, CHF and diabetes education programs for inpatients diagnosed with these chronic disease conditions to reduce readmissions.
- Initiation of a Transitions in Care Committee with broad based membership by inpatient, outpatient, behavioral health and post-acute providers as well as MCO's.
- Increased IT investment in physician office and behavioral health EMR's, inpatient/outpatient hospital EMR and HIE capability to improve the integration and interoperability of the Harrington HealthCare System and affiliated providers.
- Maintained Hospital inpatient and outpatient rates with health plans at pre – January 2013 levels.
- Established a new, restructured physician hospital organization to develop and manage alternative payment arrangements including global budget risk and value based. Harrington has subsequently entered into Blue Cross AQC, Medicare Advantage and CMS MSSP arrangements. The CY 2013 preliminary results show the HMO Blue TME to be below budget with strong

physician and hospital quality scores. The first term Medicare Advantage and CY 2013 MSSP performance results have not been finalized. The utilization and cost data show "leakage to" or use of higher cost out of Harrington system providers is decreasing.

- In July 2014 Harrington together with Heywood Healthcare established a management services organization, Community HealthCare Partners to provide infrastructure services and programs for population health management/global budget risk and other value based payor arrangements as well as operation management for their affiliated physician hospital organizations.

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?

Harrington HealthCare System anticipates taking the following actions and measures during FY 2015 to contribute towards the expenditure benchmark:

- Expansion of HIE use within the Harrington HealthCare System and with affiliated and preferred providers;
- Implementation of infrastructure services by Community HealthCare Partners, including evidence based clinical practice guidelines, to support population health management and other value based alternative payment risk arrangements;
- Enhanced integration of behavioral health and primary care;
- Development of a network system of affiliated and preferred providers for population health management and other value based alternative payment risk arrangements;
- The expansion of commercial global budget risk arrangements; increased Medicare Advantage participation through patient and provider education
- Implementation of urgent care services to reduce the use of emergency department services and help address primary care provider capacity issues;
- Hospital services rate reduction for Blue Cross products and Fallon Health Plan commercial products and the continuation of no rate increases for Tufts, Harvard Pilgrim and other health insurance plans; (It should be noted that the rates with Blue Cross had previously not changed since 2011, Tufts rates remain unchanged from 2010, Fallon rates have remained constant since 2010 while Harvard Pilgrim rates are unchanged from 2010. The results of the previous actions, as indicated by DCFHP and Attorney General Reports, were hospital rates at or below the state mean for these health plans.)

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

Harrington Memorial Hospital believes three areas need to be addressed system wide.

1) Eliminate barriers for need care
2) Eliminate redundancy in the system
3) Standardization

Eliminate Barriers

Barriers come in two forms. The first form is the high deductible/co insurance plans. These plans essentially place a road block between the patients and need care. The second barrier is the insurance authorization process. Much time is wasted and money spent to secure the authorization.

(As a side note, the last time Harrington Memorial Hospital studied its authorization approval rate, it was over 95%. Think of the money spent at hospitals, physician offices, and the insurance companies to complete this process)

Redundancy

Every insurance company, including the Commonwealth, requires its own set of documents to credential a physician. There should be a central clearing house for this function. Each insurance company, including the Commonwealth requires distinct and different data for its quality measures and outcome reporting. This is not only confusing to the hospital but also the public.

Standardization

Healthcare is no different than any other industry. Nothing is really standardized. Think of the time and effort saved if every billing format and requirement, every authorization process, every quality/outcome element, case management and referral process was the same.

Harrington Memorial Hospital
HPC/CHIA Exhibit 1

Question 1

	FY 2010	FY 2011	FY 2012	FY 2013
Combined				
Medicare	35.68%	36.73%	36.18%	39.01%
Medicaid	21.12%	21.24%	21.50%	21.71%
Other Gov"t	0.57%	0.68%	0.60%	0.63%
Government	57.37%	58.65%	58.28%	61.35%
Fallon	6.70%	6.17%	5.80%	6.88%
BCBS	16.43%	16.08%	14.56%	13.49%
Harvard Pilgrim	2.93%	2.57%	2.91%	3.46%
Tufts	3.55%	3.80%	4.22%	2.15%
Auto / Comm	3.53%	3.01%	3.68%	3.02%
Other	5.40%	5.66%	6.49%	6.14%
Self-pay	4.09%	4.06%	4.07%	3.51%
	100.00%	100.00%	100.00%	100.00%
Inpatient	48,387,910	57,955,149	53,369,450	50,375,657
OPD	159,894,501	169,175,855	177,230,707	183,948,326
	208,282,411 -	227,131,004 -	230,600,157	234,323,983
Inpatient	23.23%	25.52%	23.14%	21.50%
OPD	76.77%	74.48%	76.86%	78.50%
	100.00%	100.00%	100.00%	100.00%

Harrington Hospital
Operational Expenses By Department

	2013	2012	2011	2010	Comments
HH Operating Room	2,085,421	2,017,596	1,713,547	1,562,649	Addition of an Orthopedic Surgeon and new Pre-Op Program
HH Pre Op-Surgical	172,633	139,336	0	0	
	2,258,054	2,156,932	1,713,547	1,562,649	
HH Emerg Care Ctr	2,577,780	2,587,255	2,304,488	2,175,335	HMH took over rthe former Webster ED. DPH required that HMH staff the ED with Board Certified physician, HMH met the rquirement
HH Webster Emerg Car	1,238,743	1,234,550	1,183,501	1,015,968	
HH Ecc Physicians	3,535,468	2,714,156	2,099,151	1,958,747	
HH Webster Ecc Phys	365,779	981,531	1,218,935	1,112,839	
	7,717,770	7,517,492	6,806,075	6,262,889	
HH Cancer Center	2,881,266	2,505,935	796,347	0	New Service for the community
HH Oncology Services	553,697	265,120	290,732	0	
	3,434,962	2,771,055	1,087,078		
HH Laboratory	4,365,040	4,524,818	4,175,331	3,933,337	Increase in new physicians in the PSA, Referrals have inceased to the lab.
HH Pathology	765,646	776,656	792,249	645,294	
HH Microbiology	577,168	597,062	557,599	373,229	
	5,707,854	5,898,536	5,525,179	4,951,860	
HH Pharmacy	3,882,013	2,901,216	4,271,503	2,921,725	
HH Webster Sleep Lab	216,592	261,085	39,533	36,573	New Service
HH Hospitalist Prog	1,246,120	1,474,247	1,372,482	0	Add Program for better Patient Care

Harrington Hospital
Operational Expenses By Department

	2013	2012	2011	2010	Comments
HH Charlton Physical	206,498	112,882	97,653	0	As part of HMH's strategic plan, HMH identified an access need in Charlton. HMH built and occupied a new building in late 2009.
HH Charlton Mammogra	67,403	78,808	77,516		
HH Charton Radiology	75,322	91,395	68,331	0	
HH Chl-Vascular Imag	87,100				
HH Charlton Registra	127,892	118,848	75,260	0	
HH Charlton Occup. T	2,139	0	0	0	
HH Chrlt-Vascular Cl	21,672	0	0	65,722	
HH Charlton Wound Ca	1,047,665	949,075	719,759	0	
HH Pl-10 N Main St C	739,749	840,215	435,301	0	
	2,375,440	2,191,223	1,473,821	65,722	
HH Mh-Adult Op	1,407,849	1,568,019	1,553,405	1,258,301	Behavorial health is a critical need in the South Worcester County. HMH continues provide resources to meet the demand and changing demand.
HH Dudley Mh-Adult	36,193	4,428	748	0	
HH Mh-Child&Fam	773,941	750,436	657,389	609,472	
HH Webster Mh-Ch&Fam	0	0	0	0	
HH Mh-Inten Stab	340,884	312,778	330,537	316,005	
HH Mh-Gb Wells	580,953	543,056	511,449	6,103	
HH Sa-Recovery Svcs	550,238	386,885	328,123	423,221	
HH Sa-Dui/Daep Svcs	56,123	82,999	62,752	93,826	
HH Sa-Methadone Svcs	20,750	313,845	361,644	0	
HH Dudley Recovery S	14,861	23,185	6,228	0	
HH Brkfield Sa Recovery	21,799	19,982	17,387	15,935	
HH Pl-176 Main St Re	29,774	22,836	0	0	
	3,833,366	4,028,450	3,829,662	2,722,862	
Clinical Costs	30,672,172	29,200,236	26,118,881	18,524,281	12,147,891

Harrington Hospital
Operational Expenses By Department

	2013	2012	2011	2010	Comments
HH Patient Accountin	**1,627,575**	**1,686,325**	**1,487,082**	**1,220,387**	Increase in costs to collect inc large deductable
HH Quality Assessmen	**532,599**	**440,367**	**414,833**	**325,352**	Increase in staffing and software cost to meet the many different needs of the
	2,160,174	**2,126,692**	**1,901,915**	**1,545,739**	
HH Admin & Fringes	**11,281,519**	**12,109,412**	**10,437,425**	**10,128,186**	Increase in Health costs
HH PI-Rte 169 Charlt	**221,691**	**0**	**0**	**0**	
	11,503,210	**12,109,412**	**10,437,425**	**10,128,186**	
Summary of Cost increases	**44,335,556**	**43,436,340**	**38,458,221**	**30,198,206**	14,137,350
Total Costs	**105,951,404**	**108,297,051**	**98,691,268**	**89,466,302**	**16,485,102** 0.18426046

Question 2

C. 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 patterns, and operations?**

Currently Harrington has only two health plan arrangements that include alternative payment methods, the Blue Cross AQC (quality measures and global budget) and Fallon Medicare Advantage (global budget).The quality measures incentives have focused the attention of primary care, as well as, specialty care physicians on the quality performance associated with the measures. The most recent overall quality performance score for Harrington has increased by more than 60% from the initial quality score. The global budget arrangements have helped to focus attention by HHPO on referral patterns of primary and specialty care physicians and the appropriateness of having specific inpatient and outpatient services delivered by providers not affiliated with Harrington. Referrals requiring preauthorization are reviewed daily hand summary reports and detailed data of this "leakage" from the Harrington HealthCare System are reviewed monthly. The reports are used to identify gaps and capacity issues in services as well as to address referral patterns with individual physicians.

b. **Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).**

Harrington has not had sufficient experience with the APM's to analyze the results on non-clinical operations.

c. **Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMS and for your overall patient population.**

Harrington has not had sufficient experience with the APM's to analyze the results on non-clinical operations.

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 population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?**

Harrington PHO has very little experience with health status risk adjustment measures in third party payment contracts. At this time, we participate in risk contracts with Blue Cross (AQC beginning in 2013) and Fallon (Senior Plan beginning in July, 2014). We have yet to complete any year end settlements with these risk contracts.

However, in general, we have the following concerns with risk adjustment methods, especially as they apply to smaller organizations, like ours.

- Lack of transparency regarding the underlying mechanics of proprietary adjustment methodologies, as well as lack of access to specific calculations performed with data from our claims files.
  - What sources of data are utilized? (e.g., Inpatient, outpatient, pharmacy claims, enrollment data, member surveys, etc.)
  - Are abnormal or outlier claims included? (vs. truncated at some level)
  - How, if at all, are claims data audited or validated for completeness, accuracy, etc.?
  - Is the lag time on claims sufficient to guarantee complete profiles of members' health needs?
  - What percentage of an individual's medical expenses has the methodology been validated to accurately predict?
- Concerns that smaller providers do not have the time and resources necessary to completely document and code all related diagnoses and comorbidities.
- Questions about the statistical validity of the adjustment factors given our limited patient panel sizes and potentially insufficient volume of claims.

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

As there are significantly different populations in our two risk contracts, the health status risk adjustment methods are different. Blue Cross AQC uses a DxCG risk adjustment model. The Fallon Senior Plan uses the CMS- HCC (Hierarchical Condition Categories) risk adjustment model.

c. **How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?**

As noted, we have not had much experience with risk contracting. To date, we have favored upside-only, shared savings arrangements for the initial year(s) of these arrangements. As we develop more expertise and broader infrastructure capabilities, we intend to accept additional risk.

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 APMs. What types of data are or would be most valuable to your organization in this regard? 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

The lack of timely, useful information presents a significant challenge in effectively managing under alternative payment methodologies. The following reporting elements would be very useful:

- Summary level medical expense and utilization
- Comparative benchmarking information
- Physician attribution
- Quality and clinical outcomes measures
- Longitudinal health records data
- Referral reports (i.e, out-of-network, or "leakage" data)
- Site of service data (across full continuum of care delivery)
- Readmissions
- Individual member health status profiles
- Identification of high cost cases
- Pharmacy utilization (e.g. frequency, $$$, % use of generics, high cost drugs, etc.)

Question #5:

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

SUMMARY:

a. **Which attribution methodologies most accurately account for patients you care for?**
Retrospective, HMO product

b. **What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?**
Due to the continuing shift from HMO to PPO products, an attribution model for PPO members would be helpful in moving the system toward the c.224 goal of increased APM contracting. Such attribution models would need to be more flexible than those currently used for HMO members because of the broader freedom-of-choice that PPO members retain. Our understanding is that the early experience with some of the CMS demonstration programs indicates a significant amount of in/out migration from year to year. As such, an acceptable attribution model would need to have both prospective, as well as retrospective adjustment, features, and some form of risk corridor protection for providers.

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:

Effort required varies by payer requirement. Very few payers require exactly what the other payer requires and this varies by "wording" in the measure. The medical record does not easily provide clear cut answers to abstraction measures. Payers offer "data dictionaries" that do not clearly discuss what may be interpreted differently by an abstractor, a nurse, a physician, an IT department, and finally the payer validating the data.

Prior to abstracting there needs to be a consistent, comprehensive, no double talk, educational process provided by all payers. The organization should not have to go through a variety of resources to get an answer that is not clear and concise. Differences of opinion are discounted by the payers and often times leave the organization financially penalized.

Private payer measures often require data collection by clinical staff thereby impacting patient care. Collection of data can be current and staff will be working on improvement but payment is dependent on "old data" that has questionable relevance today.

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.**

The attached inpatient and outpatient utilization reports are derived from two commercial and one Medicare Advantage arrangements. The reports reflect the use of in and out of Harrington HealthCare System. Leakage is considered a service provided by a provider or facility not affiliated with Harrington HealthCare Provider Organization.

b. **Please describe your organization's 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 results of these efforts.**

Harrington HealthCare Provider Organization, the hospital physician organization affiliated with Harrington HealthCare System, has monthly Quality and Patient Care Management Committee, Primary Care Physician Committee and Board of Directors meetings where inpatient and outpatient utilization and cost reports are reviewed. The reports are derived from medical claims from Commercial and Medicare Advantage health plan risk arrangements and utilization/care management programs. The HHPO medical director will follow up with individual PCPs about the referral to and use of higher cost facilities and providers by their patients. HHPO initiated the monthly reviews in August 2013.

A Care Manager from the Harrington Hospital Care Management Department is assigned to the Emergency Department to ensure patients are discharged to or placed in the most appropriate clinical setting including inpatient, observation, skilled nursing facility, transitional care unit or home with home care services.

Harrington Hospital has a community-based psychiatric emergency services program located in a distinct, defined area contiguous to the Emergency Department that provides services to patients in behavioral health crisis not requiring medical services, provides consultative services to the Emergency Department for patients requiring emergent medical and behavioral health services and provides in-home counseling interventions.

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.**

Harrington HealthCare Provider Organization has just initiated the analysis of post- acute care provider utilization and cost. The limited analysis currently available from the Medicare Advantage health plan arrangement shows SNF cost and average length of stay to be significantly higher than expected. Harrington will be reviewing the performance of area SNF's and the VNA's including quality of services, utilization and cost to establish a post-acute preferred provider network. Harrington anticipates

establishing a SNF "rounding"service of physicians and nurse practitioners to follow patients affiliated with Harrington at the SNF facilities in the Harrington preferred network.

b. How does your organization ensure optimal use of post-acute care?

The Harrington Hospital Care Management Department works closely with the Hospitalist Service providers, attending PCPs, Emergency Department providers, patients and family members and area post-acute providers to ensure proper placement and treatment plans.

Question 9

9. C.224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organizations 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 requested price information. Additionally, please discuss how patients use this information, and analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of tis increase price transparency for patients.

Harrington Memorial Hospital does not keep records of the number of individuals who have asked for pricing. Anecdotally, a handful of patients have requested this information. Harrington Memorial Hospital is aware of a few patients who have accessed information on the insurance provider's website.

Question 10

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 attaches any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.

Blue Cross is the only insurance provider that has Harrington Memorial Hospital in a bad tier. Harrington Memorial Hospital's Blue Cross revenue volume did decline from 43% of Harrington Memorial Hospital's commercial business to 38%. HPHC, Harrington Memorial Hospital is a better tier, captured half of that decline as its business increased from 7% of Harrington Memorial Hospital's commercial revenues to almost 10%. Tufts and FCHP, Harrington Memorial Hospital's is in a better tier, traded volume. FCHP increased at Harrington Memorial Hospital while Tufts declined.

During 2014, Blue Cross and Harrington Memorial Hospital began negotiations on a new contract. Both parties came to an agreement with a new contract effective January 1, 2015.

Harrington Memorial Hospital
HPC/CHIA Exhibit 2

Question 10

Harrington Hospital
Blue Cross Revenues

	2010	2011	2012	2013
Inpatients				
HBC - BC HMO	2,340,756	3,894,403	2,148,450	2,212,175
HBCE - BLUE CARE ELECT	1,850,507	2,331,702	1,944,359	1,959,079
BCX - BLUE CROSS	206,140	186,161	153,989	174,731
Sub Total	4,397,403	6,412,266	4,246,798	4,345,985
Outpatients				
HBC - BC HMO	16,514,115	16,557,909	15,864,783	14,749,668
HBCE - BLUE CARE ELECT	11,817,368	12,666,822	12,399,071	11,782,243
BCX - BLUE CROSS	2,088,355	1,390,661	1,525,126	1,156,706
Sub Total	30,419,838	30,615,392	29,788,980	27,688,617
Total				
HBC - BC HMO	18,854,871	20,452,312	18,013,233	16,961,843
HBCE - BLUE CARE ELECT	13,667,875	14,998,524	14,343,430	13,741,322
BCX - BLUE CROSS	2,294,495	1,576,822	1,679,115	1,331,437
	34,817,241	37,027,658	34,035,778	32,034,602

Private Pay Detail

	2010	2011	2012	2013
Fallon	**16.55%**	**16.55%**	**15.40%**	**19.58%**
BCBS	**43.11%**	**43.11%**	**38.66%**	**38.37%**
Harvard Pilgrim	**6.89%**	**6.89%**	**7.72%**	**9.85%**
Tufts	**10.18%**	**10.18%**	**11.21%**	**6.13%**
Auto / Comm	**8.08%**	**8.08%**	**9.77%**	**8.61%**
Other	**15.18%**	**15.18%**	**17.23%**	**17.46%**
Private Pay % of Total Revenues	38.54%	37.29%	37.65%	35.14%

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 no 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:

a. **Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.**

Inpatient: Each patient admitted to the psychiatric inpatient unit at Harrington Hospital has an H&P, psychiatric assessment, and their PCP is notified that the patient has been admitted to the hospital inpatient psychiatric unit. The attending psychiatrist will contact the patient's medical provider to discuss treatment options. When the patient is discharged from the hospital, the discharge summary is dictated into the patient's chart in the hospital EMR that enable the PCP to have all discharge information. All community PCPs have access to the Hospital EMR, accessible from their home or office from which they can view this and other information related to the patient's hospital stay.

Outpatient: When a patient is admitted into Outpatient Behavioral Health or Recovery Services, a letter is sent out to the patients PCP notifying the medical provider their patient is in treatment, the name of the therapist or psychiatrist treating the patient, and how to contact the behavioral health provider. Along with a letter to the medical provider, the therapist or psychiatrist will follow-up with a telephone call to the PCP to coordinate treatment.

Recovery Services, Community PCPs and Pain Management Services work together to identify patients at risk for opioid abuse or diversion. Patients are steered toward alternate courses of treatment for their pain management where appropriate, as well as receiving coordinated wraparound services for their recovery.

Many patients battling chronic conditions are hampered in their progress due to behavior health comorbidities as well as lifestyle barriers. PCPs, upon identifying these patients, have local services available for nutrition services in the main Southbridge site as well as two additional sites close to patient's homes. In addition, PCPs work closely with Outpatient Behavioral Health providers to get patients into treatment and facilitate their continued treatment while communicating closely regarding their behavioral health and medical progress.

b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

The medical providers associated with Harrington Healthcare System have been oriented both in Medical Staff Meetings as well as having the Behavioral Health Team meet with the medical provider and their staff to discuss outpatient services and psychiatric emergency services.

Harrington Psychiatric Emergency Services has the ability to provide Mobile Crisis services to the medical provider's office or to the patient's residence to provide a crisis evaluation and to prevent the need for patients to be evaluated in the hospital emergency room. The Mobile Crisis Service is available from 8am – 8pm Monday through Friday for adults, and 24/7 for children and adolescents up to 21 years of age. Along with Mobil Crisis Services, Harrington Psychiatric Emergency Services has a Community Based Location next to the Emergency Room in Southbridge and will soon have a Community Based Location next to the ER in Webster. The Community Based Location enables patient and families to have a psychiatric evaluation without having to go to the emergency room and to be cleared medically by an ER physician before they can have a psychiatric assessment by a Psychiatric Emergency Services Clinician. Patients who are placed on a 12a (psychiatric hold) by the police, ambulance services, or a psychiatric provider are brought to emergency room and must be cleared by the ER doctor before they can be assessed by a Psychiatric Emergency Services Clinician.

After the patient is assessed by a Psychiatric Emergency Services Clinician, the clinician will discusses their evaluation and patient disposition plan with a psychiatrist and the ER doctor if the patient is located in the ER. Over 64% of patients that come to either of our Community Based Locations, ER, or are seen by our Mobile Crisis Team are diverted from being hospitalized. These patients are referred to Harrington Hospital Outpatient Partial Hospitalization Program, Harrington Outpatient Behavioral Services, or to other appropriate outpatient clinical providers.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

In order to address issues regarding integration of services, the Behavioral Health and Substance Abuse Directors individually met with the Medical Providers and their staff to discuss barriers to service, methods to better integrate the services, communication issues, and how to increase patient access to outpatient behavioral health/psychiatry and substance abuse services. Through these meetings, new systems have been designed and implemented that have increased integration and access time to treatment.

The most difficult aspect of integration is the patient's ability to follow through with attending appointments with a behavioral health provider(s). Harrington Hospital Outpatient Services works diligently to engage patients into treatment by contacting the

patient before their first appointment and calling the patient the day before their appointment. When a patient misses an intake appointment, the patient is contacted by the intake office and a second appointment is scheduled. The medical provider's office is also notified of the missed appointment and is provided the new date and time of the appointment. For patients already in treatment, every patient receives a reminder call the day before their appointment. While in treatment with a behavioral healthcare provider, if the patient does not show up for their appointment, the clinical provider will call the patient to follow up and help them make a new appointment.

Clinical coordination of care has been a barrier due to disparate outpatient EMRs. Harrington HealthCare System employed providers are working together to develop parameters by which they can appropriately share patient information across outpatient records, giving PCPs and Behavior Health Providers access to key clinical data elements such as medications, allergies, problem lists and appointment history information on a real-time basis.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

Currently, we collect a great deal of data that is required by The Joint Commission, Medicare, DMH, numerous MCO's, and private insurance providers. Included in our data collection is discharge data.

Question 12

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

Harrington Hospital does not have a PCMH Model in place. Harrington is currently working on CHART 2 Grant Funding to imbed a Licensed Clinical Social Worker in the PCP offices to better integrate medical and mental health/psychiatric services.

e. **What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognize or accredited by PCMHs by one or more national organizations?** N/A
f. **What percentage of your organization's primary care patients receives care from those PCPs or other providers?** N/A
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.** N/A

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:

Out of Pocket Expenses

Harrington Memorial Hospital has seen an increase in high deductibles in its Primary Service Area. Southern Worcester County's demographics and per capita income levels are very different than that of suburban areas around Boston and Worcester. Harrington Memorial Hospital sees high deductible plans more as a barrier accessing to healthcare.

Behavioral Health/Medical Patients

Harrington Memorial Hospital has a large behavioral health program and serves a large area. Many of these patients have a medical condition. This creates certain other problems that increase costs to the system. Many patients are non-compliant for the medical condition. The behavioral health patient, when admitted to a medical floor, tends to be more agitated, violent, and non-compliant. For the safety of the patient, the Hospital hires "sitters". This is an unreimbursed cost in the system.

Post-Acute Transfers

There is a financial incentive for hospitals to transfer a patient to post-acute services because most inpatient payments are a fixed fee (DRG payment, SPAD rate) savings resulting from a decrease in average length of stay accrues to the Provider. Conversely, any extended stays are not reimbursed.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

Completed in Attachment AGO Hospital Exhibit 1

2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital Exhibit 2 with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

Completed in Attachment AGO Hospital Exhibit 2

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 (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.
Harrington HealthCare System through the affiliation with Harrington HealthCare Provider Organization (HHPO) is participating in Blue Cross AQC and Fallon Medicare Advantage global budget arrangements.. The current Blue Cross AQC (CY2014-2018) is structured for shared savings only (no downside risk) for HHPO through Accountable Care Associates. Harrington has structured the assumption of risk in Fallon Medicare Advantage arrangement to parallel the development of supporting infrastructure and experience with managing risk. This HHPO arrangement phases in risk over 3 ½ years. Harrington has no risk for the first year, takes some risk for months 13 through 30 (18 months) and has the majority of risk for financial performance for months 31 through 42 (1year). The arrangement includes a third-party, Accountable Care Associates, which is delegated specific infrastructure services to support the global budget approach. This infrastructure, which is designed to reduce the risk, provides utilization management (inpatient, outpatient and post-acute), care management for chronic and high risk patients, provider documentation and coding education , medical direction and utilization, cost and financial performance reports. H HPO receives monthly reports which track actual results versus budgeted membership, CMS and member premium revenue medical and behavioral health care costs, administrative costs and reinsurance costs.

4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

N/A

Harrington Memorial Hospital
AGO Hospital Exhibit 1

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									18,293,280			13,741,322			
Tufts Health Plan											5,115,603				
Harvard Pilgrim Health Care											8,223,809				
Fallon Community Health Plan											16,347,137				
CIGNA											3,303,910				
United Healthcare											3,737,996				
Aetna											2,753,259				
Other Commercial*											6,479,016				2,574,215
Total Commercial	-	-	-	-	-	-	-	-	18,293,280	-	45,960,730	13,741,322	-	-	2,574,215
Network Health											8,880,518				
Neighborhood Health Plan											5,525,452				
BMC HealthNet, Inc.											6,806,952				
Health New England															
Fallon Community Health Plan											3,555,323				
Other Managed Medicaid											11,525,319				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	36,293,564	-	-	-	-

MassHealth											16,504,104				
Tufts Medicare Preferred											342,633				
Blue Cross Senior Options											2,087,804				
Other Comm Medicare											26,633,219				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	29,063,656	-	-	-	-
Medicare											63,593,898				
Other											-	7,116,246			
GRAND TOTAL	-	-	-	-	-	-	-	-	18,293,280	-	191,415,952	20,857,568	-	-	2,574,215

Notes: Other Commercial includes other traditional commercial products, as well as Auto, Worker's Comp and Occupational Health

Other Managed Medicaid includes MBHP, Out-of-State Medicaid, Commonwealth Care & other various government sponsored products

Other Comm Medicare primarily includes the Fallon Senior insurance product

Other consists of Self-Pay and Uncompensated Care

Harrington Memorial Hospital
AGO Hospital Exhibit 2

Exhibit C Q 2

For each year 2010 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'10 through FY'13 by Payer Group

	FY 2010	FY 2011	FY 2012	FY 2013
Commercial	7,572,314	7,939,598	3,121,292	4,840,764
Government	(11,945,940)	(9,679,337)	(11,976,773)	(7,261,348)
All Other	1,297,316	596,994	239,651	934,925
Total	(3,076,310)	(1,142,745)	(8,615,830)	(1,485,659)

Percent of Gross Business FY'10 through FY'13 by Payer Group

	FY 2010	FY 2011	FY 2012	FY 2013
Commercial	36.4%	35.1%	35.0%	32.96%
Government	60.5%	62.1%	62.3%	64.32%
All Other	3.1%	2.7%	2.7%	2.71%
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 repo 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. Consistent with last year's submission, 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 continues to expect the Medicare Rural Floor Adjustment of $800,000 will negatively impact the Hospital's 2015 budget.**

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.

Exhibit C Q 5

Harrington Hospital
CHIA/OAG Information

2010

	P4P				**Risk**						**FFS**		**Other**		
	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											2,640,757				
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				**Risk**						**FFS**		**Other**		
	Claims-Based Revenue		Incentive-Based		Claims-Based		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				Risk						FFS		Other		
	Claims-Based Revenue		Incentive-Based		Claims-Based		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 -

2013

	P4P Contracts				Risk Contracts			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue	
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Blue Cross Blue Shield								
Tufts Health Plan								
Harvard Pilgrim Health Care								
Fallon Community Health Plan								
CIGNA								
United Healthcare								
Aetna								
Other Commercial*								
Total Commercial	-	-	-	-	-	-	-	-
Network Health								
Neighborhood Health Plan								
BMC HealthNet, Inc.								
Health New England								
Fallon Community Health Plan								
Other Managed Medicaid								
Total Managed Medicaid	-	-	-	-	-	-	-	-
MassHealth								

Tufts Medicare Preferred								
Blue Cross Senior Options								
Other Comm Medicare								
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-
Medicare								
Other								
GRAND TOTAL	-	-	-	-	-	-	-	-

Notes: Other Commercial includes other traditional commercial products, as well as Auto, Worker's Comp
Other Managed Medicaid includes MBHP, Out-of-State Medicaid, Commonwealth Care & other vari
Other Comm Medicare primarily includes the Fallon Senior insurance product
Other consists of Self-Pay and Uncompensated Care

Quality Incentive Revenue		FFS Arrangements		Other Revenue		
HMO	PPO	HMO	PPO	HMO	PPO	Both
18,293,280			13,741,322			
		5,115,603				
		8,223,809				
		16,347,137				
		3,303,910				
		3,737,996				
		2,753,259				
		6,479,016				2,574,215
18,293,280	-	45,960,730	13,741,322	-	-	2,574,215
		8,880,518				
		5,525,452				
		6,806,952				
		3,555,323				
		11,525,319				
-	-	36,293,564	-	-	-	-
		16,504,104				

		342,633				
		2,087,804				
		26,633,219				
-	-	29,063,656	-	-	-	-
		63,593,898				
		-	7,116,246			
18,293,280	-	191,415,952	20,857,568	-	-	2,574,215

and Occupational Health
ous government sponsored products

Harrington Hospital source: schedule V-A (403 report)

	FY 2012			
Gross Patient Service Revenue:	Government	Commercial	Other	Total
Medicare	57,973,308			57,973,308
Medicare Managed	24,640,595			24,640,595
Medicaid	29,497,153			29,497,153
Medicaid Managed	15,584,911			15,584,911
Commonwealth Care	5,352,562			5,352,562
HSN	5,295,284			5,295,284
Workers Comp			2,539,016	2,539,016
Self Pay			2,347,340	2,347,340
Other Gov			1,139,193	1,139,193
Managed Care (HMO's)		70,217,844		70,217,844
Non-Managed Care (BC PPO, Comm)		7,637,606		7,637,606
Total GPSR (Sch VA, Line 44)	138,343,813	77,855,450	6,025,549	222,224,812
	62.25%	35.03%	2.71%	100.00%
Less: Contractual Adj. (Line 45,50,52)	80,876,857	35,653,460	2,761,284	119,291,601
Net Revenue (Line 52.01)	57,466,956	42,201,990	3,264,265	102,933,211
Total Expenses (Sch II column 7, Line 116+123+123.01)				111,549,041
Total Expense Allocation	69,443,729	39,080,698	3,024,614	
Gain (Loss)	(11,976,773)	3,121,292	239,651	(8,615,830)

Exhibit C Q 2

For each year 2010 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'10 through FY'13 by Payer Group

	FY 2010	FY 2011	FY 2012	FY 2013
Commercial	7,572,314	7,939,598	3,121,292	4,840,764
Government	(11,945,940)	(9,679,337)	(11,976,773)	(7,261,348)
All Other	1,297,316	596,994	239,651	934,925
Total	(3,076,310)	(1,142,745)	(8,615,830)	(1,485,659)

Percent of Gross Business FY'10 through FY'13 by Payer Group

	FY 2010	FY 2011	FY 2012	FY 2013
Commercial	36.4%	35.1%	35.0%	32.96%
Government	60.5%	62.1%	62.3%	64.32%
All Other	3.1%	2.7%	2.7%	2.71%
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 repo 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. Consistent with last year's submission, 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 continues to expect the Medicare Rural Floor Adjustment of $800,000 will negatively impact the Hospital's 2015 budget.**

Harrington Hospital
Question 1
Payor Mix and Service Mix Change

	FY 2010	FY 2011	FY 2012	FY 2013
Combined				
Medicare	35.68%	36.73%	36.18%	39.01%
Medicaid	21.12%	21.24%	21.50%	21.71%
Other Gov"t	0.57%	0.68%	0.60%	0.63%
Government	57.37%	58.65%	58.28%	61.35%
Fallon	6.70%	6.17%	5.80%	6.88%
BCBS	16.43%	16.08%	14.56%	13.49%
Harvard Pilgrim	2.93%	2.57%	2.91%	3.46%
Tufts	3.55%	3.80%	4.22%	2.15%
Auto / Comm	3.53%	3.01%	3.68%	3.02%
Other	5.40%	5.66%	6.49%	6.14%
Self-pay	4.09%	4.06%	4.07%	3.51%
	100.00%	100.00%	100.00%	100.00%
Inpatient	48,387,910	57,955,149	53,369,450	50,375,657
OPD	159,894,501	169,175,855	177,230,707	183,948,326
	208,282,411	227,131,004	230,600,157	234,323,983
Inpatient	23.23%	25.52%	23.14%	21.50%
OPD	76.77%	74.48%	76.86%	78.50%
	100.00%	100.00%	100.00%	100.00%

Harrington Hospital
Operational Expenses By Department

	2013	2012	2011
HH Operating Room	**2,085,421**	**2,017,596**	**1,713,547**
HH Pre Op-Surgical	**172,633**	**139,336**	**0**
	2,258,054	2,156,932	1,713,547
HH Emerg Care Ctr	**2,577,780**	**2,587,255**	**2,304,488**
HH Webster Emerg Car	**1,238,743**	**1,234,550**	**1,183,501**
HH Ecc Physicians	**3,535,468**	**2,714,156**	**2,099,151**
HH Webster Ecc Phys	**365,779**	**981,531**	**1,218,935**
	7,717,770	7,517,492	6,806,075
HH Cancer Center	**2,881,266**	**2,505,935**	**796,347**
HH Oncology Services	**553,697**	**265,120**	**290,732**
	3,434,962	2,771,055	1,087,078
HH Laboratory	**4,365,040**	**4,524,818**	**4,175,331**
HH Pathology	**765,646**	**776,656**	**792,249**
HH Microbiology	**577,168**	**597,062**	**557,599**
	5,707,854	5,898,536	5,525,179
HH Pharmacy	**3,882,013**	**2,901,216**	**4,271,503**
HH Webster Sleep Lab	**216,592**	**261,085**	**39,533**
HH Hospitalist Prog	**1,246,120**	**1,474,247**	**1,372,482**
HH Charlton Physical	**206,498**	**112,882**	**97,653**
HH Charlton Mammogra	**67,403**	**78,808**	**77,516**
HH Charton Radiology	**75,322**	**91,395**	**68,331**
HH Chl-Vascular Imag	**87,100**		
HH Charlton Registra	**127,892**	**118,848**	**75,260**
HH Charlton Occup. T	**2,139**	**0**	**0**

HH Chrlt-Vascular Cl	**21,672**	**0**	**0**
HH Charlton Wound Ca	**1,047,665**	**949,075**	**719,759**
HH Pl-10 N Main St C	**739,749**	**840,215**	**435,301**
	2,375,440	**2,191,223**	**1,473,821**
HH Mh-Adult Op	**1,407,849**	**1,568,019**	**1,553,405**
HH Dudley Mh-Adult	**36,193**	**4,428**	**748**
HH Mh-Child&Fam	**773,941**	**750,436**	**657,389**
HH Webster Mh-Ch&Fam	**0**	**0**	**0**
HH Mh-Inten Stab	**340,884**	**312,778**	**330,537**
HH Mh-Gb Wells	**580,953**	**543,056**	**511,449**
HH Sa-Recovery Svcs	**550,238**	**386,885**	**328,123**
HH Sa-Dui/Daep Svcs	**56,123**	**82,999**	**62,752**
HH Sa-Methadone Svcs	**20,750**	**313,845**	**361,644**
HH Dudley Recovery S	**14,861**	**23,185**	**6,228**
HH Brkfield Sa Recovery	**21,799**	**19,982**	**17,387**
HH Pl-176 Main St Re	**29,774**	**22,836**	**0**
	3,833,366	4,028,450	3,829,662
Clinical Costs	**30,672,172**	**29,200,236**	**26,118,881**
HH Patient Accountin	**1,627,575**	**1,686,325**	**1,487,082**
HH Quality Assessmen	**532,599**	**440,367**	**414,833**
	2,160,174	**2,126,692**	**1,901,915**
HH Admin & Fringes	**11,281,519**	**12,109,412**	**10,437,425**
HH Pl-Rte 169 Charlt	**221,691**	**0**	**0**
	11,503,210	**12,109,412**	**10,437,425**
Summary of Cost increases	**44,335,556**	**43,436,340**	**38,458,22**
Total Costs	**105,951,404**	**108,297,051**	**98,691,268**

:

2010	Comments
1,562,649	Addition of an Orthopedic Surgeon and new Pre-Op Program
0	
1,562,649	
2,175,335	HMH took over rthe former Webster ED. DPH required that HMH staff the ED with Board Certified physician, HMH met the rquirement
1,015,968	
1,958,747	
1,112,839	
6,262,889	
0	New Service for the community
0	
3,933,337	Increase in new physicians in the PSA, Referrals have inceased to the lab.
645,294	
373,229	
4,951,860	
2,921,725	
36,573	New Service
0	Add Program for better Patient Care
0	As part of HMH's strategic plan, HMH identified an access need in Charlton.
0	HMH built and occupied a new building in late 2009.
0	**(9,044)**
0	

65,722			
0			
0			
65,722			
1,258,301	Behavorial health is a critical need in the South Worcester County. HMH continues provide resources to meet the demand and changing demand.		
0			
609,472			
0			
316,005			
6,103			
423,221			
93,826			
0			
0			
15,935			
0			
2,722,862			
18,524,281	12,147,891		
1,220,387	Increase in costs to collect increasing large deductable		
325,352	Increase in staffing and software cost to meet the many different needs of the		
1,545,739			
10,128,186	Increase in Health costs		
0			
10,128,186			
21	**30,198,206**	14,137,350	0.7369
	89,466,302	**16,485,102**	0.18426046 .

Harrington Hospital
Blue Cross Revenues

	2010	2011	2012	2013
Inpatients				
HBC - BC HMO	2,340,756	3,894,403	2,148,450	2,212,175
HBCE - BLUE CARE ELECT	1,850,507	2,331,702	1,944,359	1,959,079
BCX - BLUE CROSS	206,140	186,161	153,989	174,731
Sub Total	4,397,403	6,412,266	4,246,798	4,345,985
Outpatients				
HBC - BC HMO	16,514,115	16,557,909	15,864,783	14,749,668
HBCE - BLUE CARE ELECT	11,817,368	12,666,822	12,399,071	11,782,243
BCX - BLUE CROSS	2,088,355	1,390,661	1,525,126	1,156,706
Sub Total	30,419,838	30,615,392	29,788,980	27,688,617
Total				
HBC - BC HMO	18,854,871	20,452,312	18,013,233	16,961,843
HBCE - BLUE CARE ELECT	13,667,875	14,998,524	14,343,430	13,741,322
BCX - BLUE CROSS	2,294,495	1,576,822	1,679,115	1,331,437
	34,817,241	37,027,658	34,035,778	32,034,602

Private Pay Detail

	2010	2011	2012	2013
Fallon	**16.55%**	**16.55%**	**15.40%**	**19.58%**
BCBS	**43.11%**	**43.11%**	**38.66%**	**38.37%**
Harvard Pilgrim	**6.89%**	**6.89%**	**7.72%**	**9.85%**
Tufts	**10.18%**	**10.18%**	**11.21%**	**6.13%**
Auto / Comm	**8.08%**	**8.08%**	**9.77%**	**8.61%**
Other	**15.18%**	**15.18%**	**17.23%**	**17.46%**
Private Pay % of Total Revenues	38.54%	37.29%	37.65%	35.14%