



Strata Decision  
**Summit** 2012  
CHICAGO October 23-24

## **Decision Support in an ACO World**

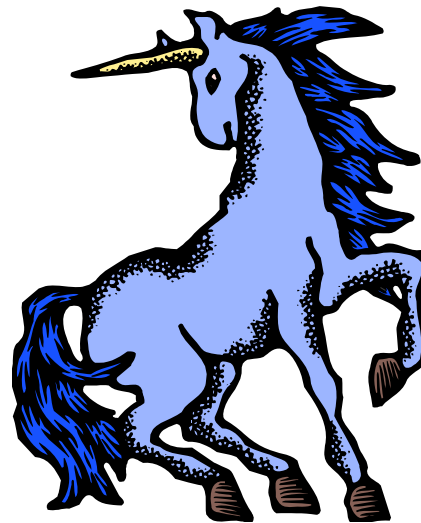
Anne Farmer, TriNet Healthcare Consultants

October 24, 2012

## What is an ACO?

**“The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one.”**

***Mark Smith, MD, MBA, President and CEO; California Healthcare Foundation.***



# Outline

- I. New Importance of Performance Management / Analytics
- II. Considerations in DSS systems
  - Expansion to other providers
  - New data sources
- III. Cost Accounting – What's different this time around?
- IV. Analytics Examples
  - Determining a global rate
  - Bundled payment
  - Leakage and other reports

## Accepting the Charge

*“In agreeing to become accountable for a group of Medicare beneficiaries, we generally expect that participating ACOs are able to, or are working toward, independently identifying and producing the data they believe are necessary to best evaluate the health needs of their patient population, improve health outcomes, monitor provider/supplier quality of care and patient experience of care, and produce efficiencies in utilization of services. Moreover, this ability to self-manage is a critical skill for each ACO to develop, leading to an understanding of the unique patient population that it serves.”*

ACA Section 3022 Shared Savings Program, CMS proposed rule.

# Metrics Under Health Care Reform (1990's and today)

	Performance Measures Under Fee-For-Service		Performance Measures Under Capitation (Global Budget)
<i>Market Share</i>	Number of Admissions Number of Procedures Number of Visits	→	Number of Covered Lives
<i>Costs</i>	Cost Per Procedure Cost Per Stay (DRG)	→	<b>Cost Per Life (PMPM)</b> Inpatient Days/1,000 Visits/1,000
<i>Management Focus</i>	High Occupancy Rates Expanded Outpatient Services	→	Low Occupancy Rate Correct Modality (Medical Home)

**The correct service, in the correct amount, in the correct setting.**

## ACO's/Global Payments, Some Preliminary Conclusions

- **Providers Encouraged to Develop Integrated Delivery System**
  - Providers Required to Coordinate the Delivery of Care
- **Encourages the Development of Consistency of Payment Methods Across Payers**
  - Mix of Payment Methods Produces Negative Financial Performance
- **Global Payment Method is Based Upon Population Served**
  - Payers Must Provide Utilization and Cost Per Unit Data to IDS for Budget Purposes
  - Payment Method Requires an Understanding of Risk (Insurance; Performance; Data; Liability)
    - Law of Large Numbers Requires that Risk be Managed (Stop-Loss; Re-insurance etc.)
- **Encourages Cost Management and Reduction**
  - Cost Accounting Will Become Increasingly Important (more on that later)
- **Requires the Development of Data Management Systems for Quality and Performance Indicators**
  - Quality Indicators (Between 20 and 65)
  - Cost / Performance Benchmarks
    - ETG's – Episodes Treatment Group (Symmetry/Ingenix)
    - MEG's – Medical Episode Group (Thomson Reuters)(3M)
    - Severity Adjusted Measures such as DxCG

# Information Requirements

## What data do we need in the new ACO/Global Payment environment?

- **Financial and Clinical Data for services in *all* settings**
  - Hospital
  - Physician office
  - Home health
  - Other
- **Cost accounting data for services in all settings;**
  - Direct Cost per Unit
  - Indirect Cost per Unit
- **Claims data for population covered**
- **Membership data or profile of members**
- **Risk adjuster data if available (e.g. DxCG)**
- **Use rates for validation of Total Medical Expense (TME) build-up**

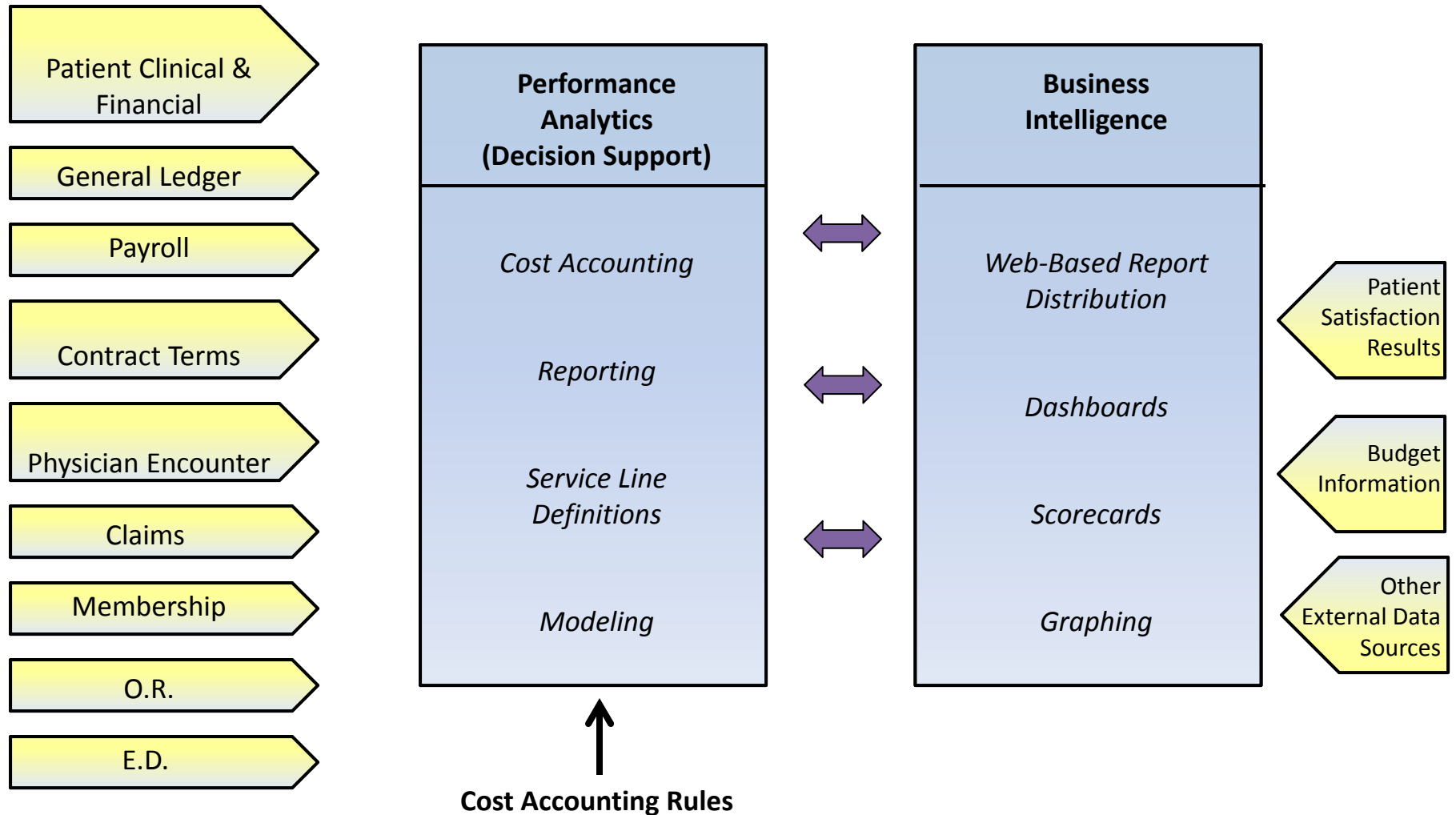
# Claims and Membership Data

*DSS/Performance Management systems are able to accommodate claims and membership data within the existing data model.*

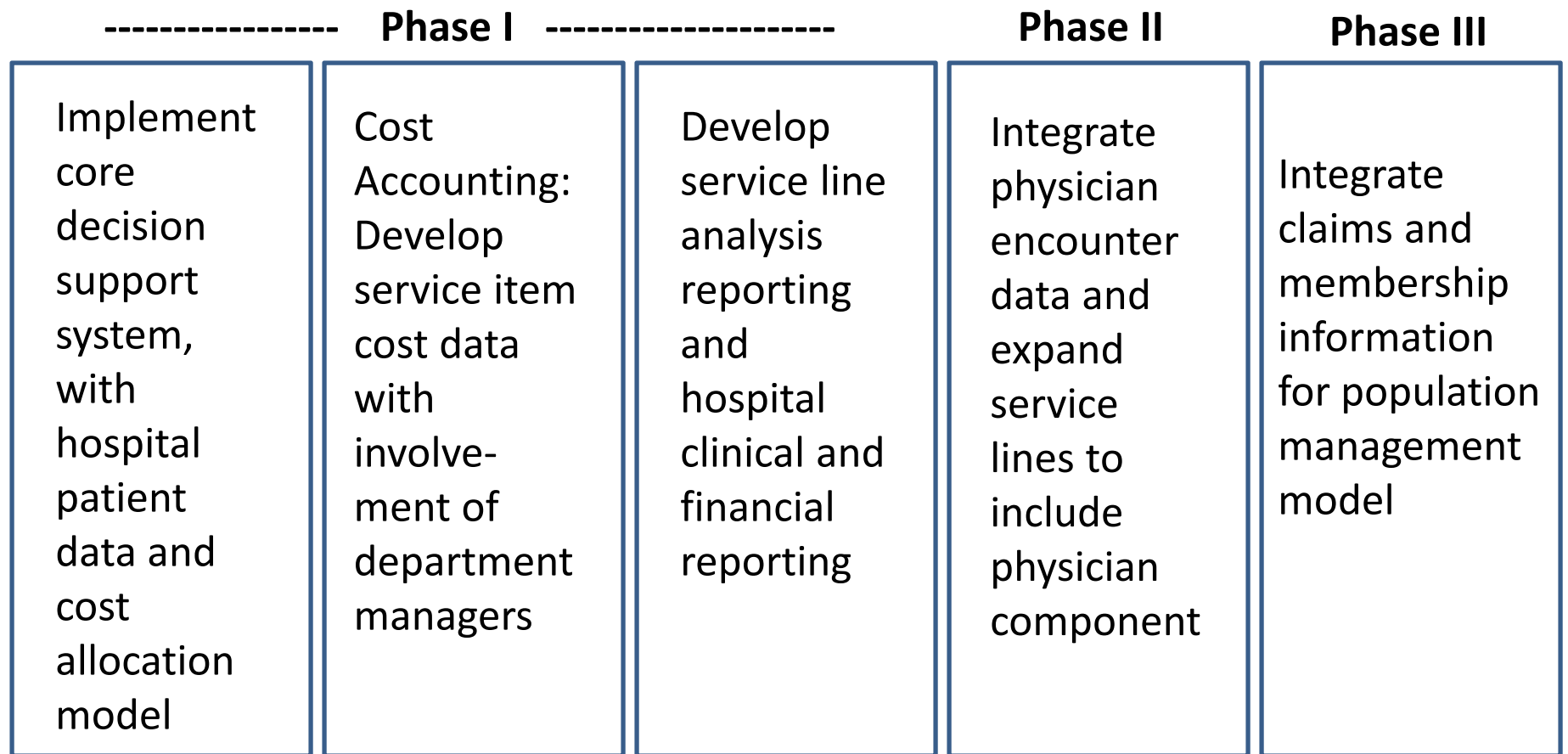
Data Source	Data Fields	Data Transformations
Claims	For all claims (hospital, physician, Rx): <ul style="list-style-type: none"><li>- CPT, UB detail</li><li>- Charges, payments</li><li>- PCP, service provider</li><li>- Provider</li><li>- DRG</li><li>- Insurance product</li><li>- Dates (service, posting, etc.)</li></ul>	Physician claims: <ul style="list-style-type: none"><li>- Cross-walk providers (vendors) to health system's own specialties or service lines</li></ul> Hospital claims: <ul style="list-style-type: none"><li>- Apply service line definitions based on DRG, UB, other fields</li></ul>
Membership	Member identification PCP Member months Insurance product	Integrate severity data by member, such as DxCG scores



# Performance Management: Example of Data Flow Diagram for a Healthcare Organization



# An Example of a Phased Implementation Approach



# New Role of Cost Accounting

*“Costing systems will have to be redesigned, repositioned, and re-implemented as providers create new, innovative organizational structures and relationships to capture market opportunities, update transactional systems, and make decisions based on data that went relatively unexamined before.”*

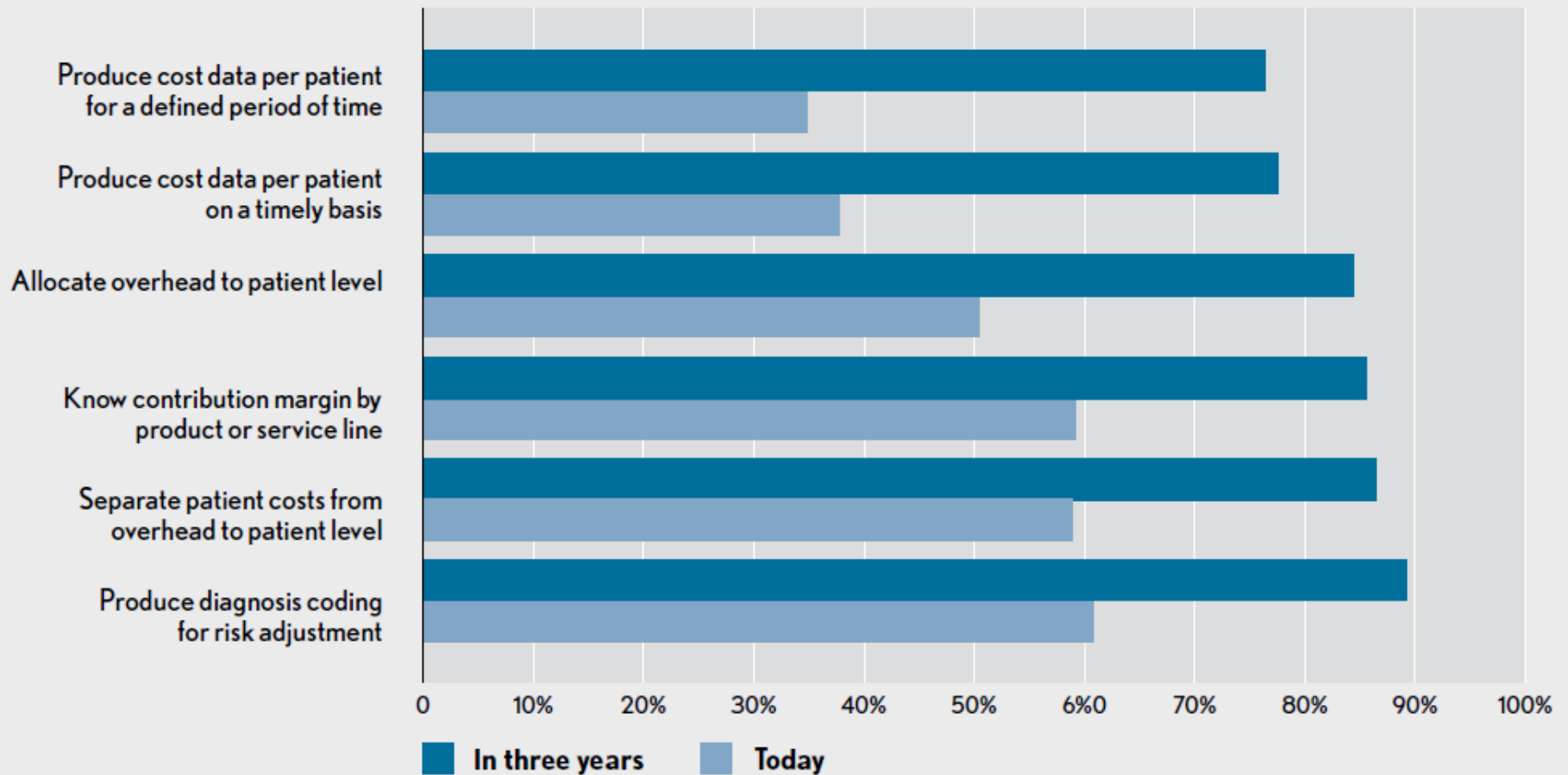
	Cost Accounting: The Present	Cost Accounting: Post Reform
<b>Focus</b>	<ul style="list-style-type: none"> <li>. Product/Service Line</li> <li>. Payer</li> <li>. Overall Patient Population</li> </ul>	<ul style="list-style-type: none"> <li>. <b>Specific services</b></li> <li>. <b>Specific population clusters</b></li> <li>. Specific patients, in some instances</li> </ul>
<b>Data Usage</b>	<ul style="list-style-type: none"> <li>. Market volume and profit trends across several years</li> <li>. Strategic planning and priorities</li> <li>. Budgets</li> </ul>	<ul style="list-style-type: none"> <li>. Comparing financial results of care choices</li> <li>. <b>Evaluating bundled payment arrangements</b></li> <li>. Evaluating make/buy opportunities</li> <li>. Finding best practices</li> <li>. Setting tactical priorities around departmental efficiencies and/or affecting outcomes</li> </ul>
<b>Costing Approach</b> (method and frequency)	<ul style="list-style-type: none"> <li>. Ratio of cost to charge</li> <li>. RVUs</li> <li>. Limited microcosting</li> <li>. Annual cost finding</li> </ul>	<ul style="list-style-type: none"> <li>. Enhanced RVUs</li> <li>. <b>Increased microcosting</b></li> <li>. More frequent standards revisions</li> <li>. <b>Monthly and/or “real time” costs</b></li> </ul>

Paul Selivanoff, “The Impact of Healthcare Reform on Costing Systems”, Healthcare Financial Management, May 2, 2011.

# HFMA Value Project: Survey indicates healthcare organizations will improve costing capabilities significantly over next 3 years

## ANTICIPATED IMPROVEMENTS IN INPATIENT COSTING-RELATED CAPABILITIES

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.

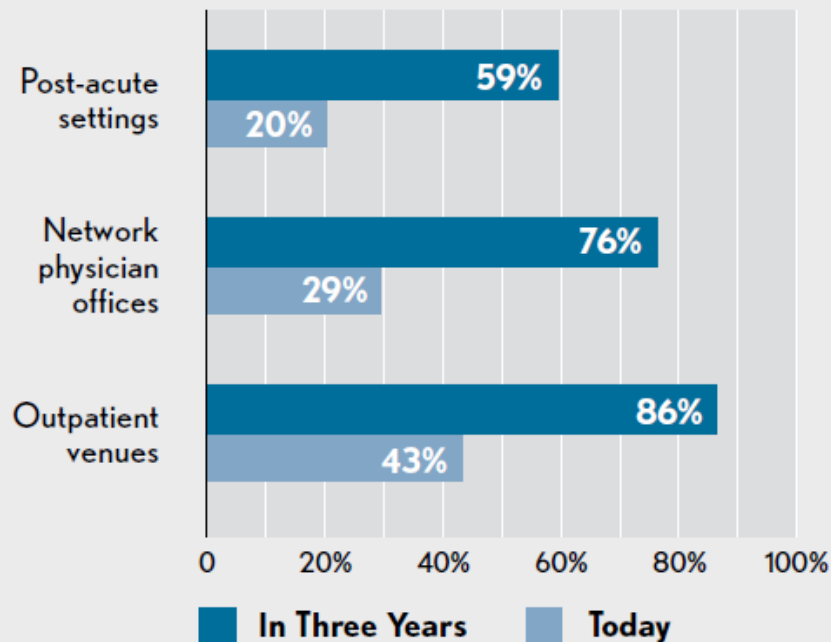


Source: HFMA Value Project February 2012

# HFMA Value Project: Cost accounting will expand to encompass other care settings (beyond hospital)

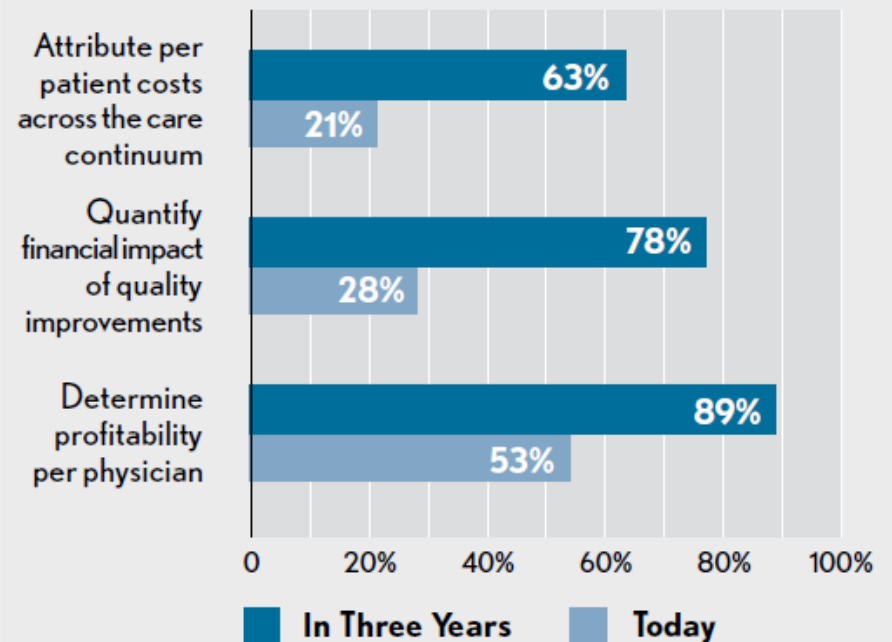
## ANTICIPATED IMPROVEMENTS IN COSTING-RELATED CAPABILITIES ACROSS CARE SETTINGS

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.



## ANTICIPATED CROSS-ORGANIZATIONAL STRATEGIC COSTING DATA USE CAPABILITIES

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.



Source: HFMA Value Project February 2012

# Cost Accounting of Physician Practices

## *I. Macro Level / Department*

Approach	Pro (Advantage)	Con (Disadvantage)
By Practice	Uses existing expense structures in the GL or accounting system	Does not reflect unique cost of each physician
By Provider	More granular, reflects unique cost of each physician (compensation, staffing, other costs)	Will involve assignments/allocations of shared costs, including RN's and other Clinical Staff, Admin Staff, and Mid-Level Practitioners.

# Example: Costing by Practice

## DERMATOLOGY

	<u>\$ Month</u>
NET REVENUE	\$122,669
<u>DIRECT EXPENSES</u>	
SALARY AND BENEFITS	\$69,916
OTHER EXPENSE (MALPRACTICE, SUPPLY, ETC).	<u>\$3,388</u>
TOTAL DIRECT COSTS	\$73,304
SUPPORT COSTS	<u>\$60,637</u>
TOTAL PRACTICE COSTS	\$133,941
DIRECT MARGIN	<b>(\$11,272)</b>
<u>INDIRECT COSTS (Allocation Statistic)</u>	
CLINICAL FLOATS (Provider FTE's)	\$1,182
FINANCE (Provider FTE's)	\$763
CODING/CHARGE (Gross Rev)	\$1,765
PRE REGISTRATION (Gross Rev)	\$514
CASH/CENTRAL REGISTRATION (Gross Rev)	\$1,166
TRANSCRIPTION (Gross Rev)	\$251
TELECOMMUNICATIONS (Provider FTE's)	\$1,115
INFO SYSTEMS (Provider FTE's)	\$1,243
ADMINISTRATION (Provider FTE's)	\$3,594
FACILITIES (Provider FTE's)	\$8,864
REFERRAL MGMT (Gross Rev)	\$889
PURCHASING (Provider FTE's)	\$1,841
HUMAN RESOURCES (Provider FTE's)	<u>\$419</u>
SUBTOTAL INDIRECT COSTS	\$23,606
PROFIT (LOSS)	<b>(\$34,878)</b>

# Physician Cost Accounting

## Approach: Physician-Specific Costing

Type of Cost	Approach
Physician Salary	Break out by individual physician (create physician “cost centers” within the cost model)
Clinical Salaries (RN & Other)	Assign to physician level based on a time study or staffing schedules
Mid-Level Practitioners	Assign to individual physicians based on time study or other allocation assumptions
Malpractice	Use physician-specific amounts
Supplies & Other	Allocate across physicians based on RVU’s, physician FTE’s, or another statistic
Support & Overhead Costs	Allocate based on relevant statistic for each area; e.g. RVU’s, provider FTE’s, total FTE’s, gross charges, square footage



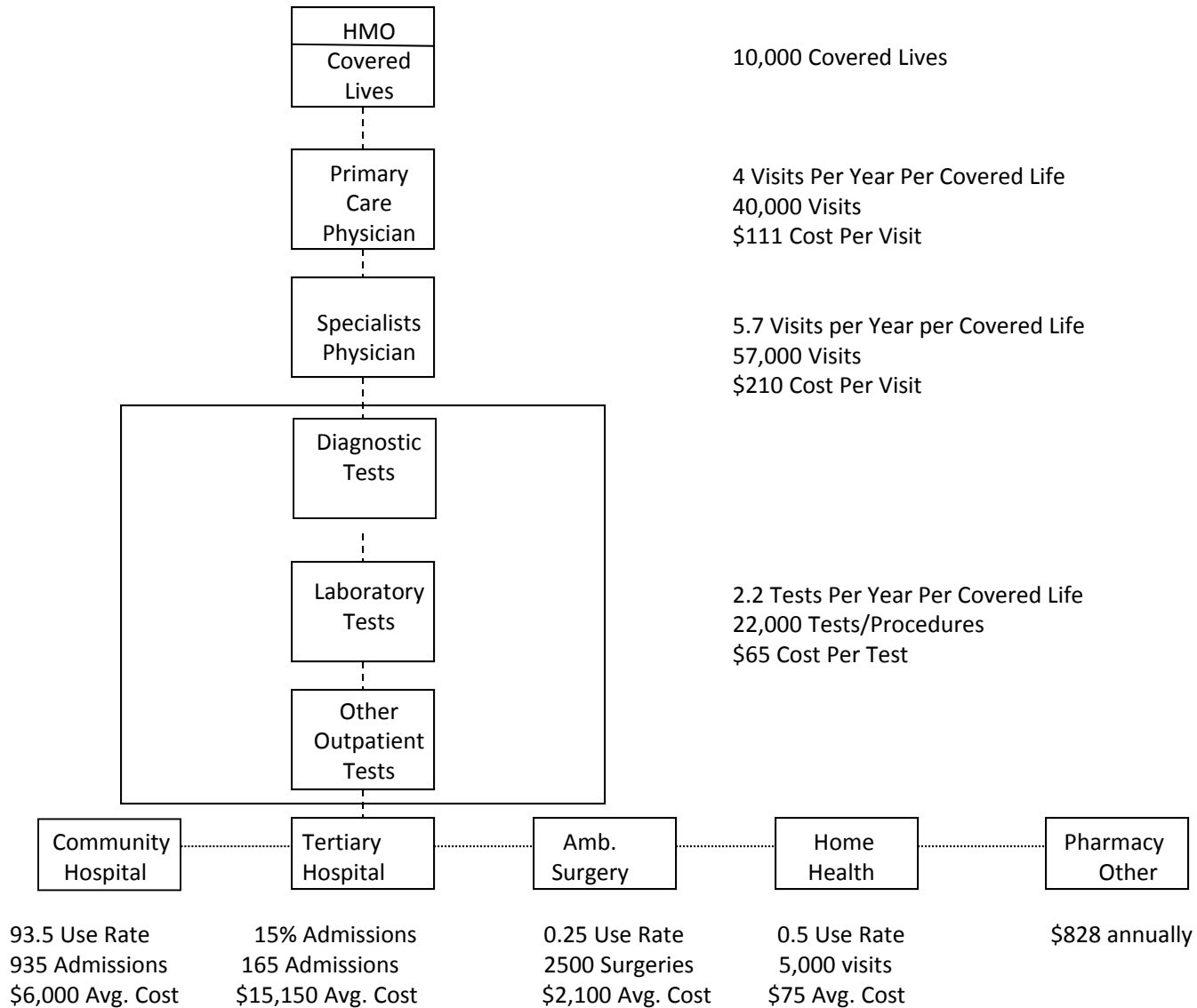
# Cost Accounting of Physician Practices

## *II. Micro Level/CPT & Encounter Costing*

Approach	Pro (Advantage)	Con (Disadvantage)
Medicare RBRVS Values	Industry standard, explainable to physicians	Not customized to the individual practice or organization  RVU values not available for any “homegrown” codes used in billing
RVU Studies (practice-specific)	Specific to the practice  Buy-in from physicians	Requires significant resources for implementation as well as maintenance on an ongoing basis

## Accountable Care Organization / New Organization New Metrics

### Activity Based Costing & Economic Chain Costing - Population Profiling



# Global Budgeting

## Development of Global Payment (Capitation) Rates

### Approaches to Developing Global Payment Rates

- Historical ***Preferred method***

Use Total Medical Expense data for population  
(Source: Claims Data provided by the insurer)

- Prospective ***Use to validate historical method, or to model a global rate***

Compile Use Rates and Cost/Payment Data

# Global Budgeting

## Development of Global Payment (Capitation) Rates

### I. Assess Member Population

- Obtain member detail, if available
- Compile age/sex breakouts, risk adjusters if available

### II. Develop Use Rate Assumptions

- ***Population Covered (Inpatient/Outpatient/Physician)***
- Use Rate by Age/Sex Cohorts (Inpatient/Outpatient/Physician)
- Use Rate by Service (Inpatient/Outpatient/Physician)
- Use Rate by DRG or Clinical Subspecialty (Inpatient)
- Use Rate by Site of Service (Outpatient)

# Global Budgeting

## Development of Global Payment (Capitation) Rates

### Sources of Use Rates:

- State inpatient data  
(Divide utilization data by population in an area)
- Advisory Board
- CDC
- MGMA
- Medical Associations by Specialty
- Kaiser data by state
- MedPar data for Medicare
- (among others)

***Note: The preferred data source is actual Claims Data. The purpose of use rates is to validate the build-up of Total Medical Expense from claims.***

# Global Budgeting

## Development of Global Payment (Capitation) Rates

### III. Determine Delivery System Cost Base For Population Covered

- Compile Statistics By Insurer
- Obtain Claims Data from Insurer if Available
  
- Develop Payment Base by Insurer and by Service:
  - Internal:  
Compile payment rates by type of service
  
  - External (Leakage):  
Use claims data or other external source  
(e.g.: MHDC inpatient data, All-Payer Claims Database)
  
- Develop Cost Base by Insurer and by Service:
  - Internal:  
Direct Cost (determine direct margin on services)  
Indirect Cost (determine profit/(loss) on services)
  
  - External:  
*Costs of external services (i.e. leakage)  
will be payment rates paid to other providers*

**Development of a Global Budget: COMMERCIAL  
Cost of the Entire Economic Process**

<u>Component</u>	<u>Use Rate</u>	<u>Description</u>	<u>Units</u>	<u>Cost Per Unit</u>	<u>Total Cost</u>	<u>Cost PMPM</u>	<u>% Cost</u>
<b><u>Medical Expense</u></b>		Panel Size	10,000				
<b>Primary Care Physician</b>							
Internal	3.5	Encounters per Year	35,000	\$107	\$3,727,500	\$31.06	
External	<u>0.5</u>	Encounters per Year	<u>5,000</u>	<u>\$142</u>	<u>\$710,000</u>	<u>\$5.92</u>	
Subtotal Primary Care	4.0		40,000	\$111	\$4,437,500	\$36.98	
<b>Specialist Physician</b>							
Internal	4	Encounters per Year	40,000	\$191	\$7,650,000	\$63.75	
External	<u>1.7</u>	Encounters per Year	<u>17,000</u>	<u>\$255</u>	<u>\$4,335,000</u>	<u>\$36.13</u>	
Subtotal Specialist/Other	5.7		57,000	\$210	\$11,985,000	\$99.88	
<b>Total Professional</b>	9.7				\$16,422,500	\$136.85	30%
<b>Hospital Inpatient</b>							
Acute Medical/Surgical	0.0935	Admissions per Year	935	\$6,000	\$5,610,000	\$46.75	
Tertiary Hospital I/P	0.0165	Admissions per Year	165	\$15,150	\$2,499,750	\$20.83	
Obstetrics & Nursery	0.0115	Births per Year	115	\$6,200	\$713,000	\$5.94	
Neonatal Intensive Care	0.0017	Admissions per Year	17	\$9,500	\$161,500	\$1.35	
Rehab	0.004	Admissions per Year	40	\$6,400	\$256,000	\$2.13	
SNF	0.221	Days per Year	2,210	\$425	<u>\$939,250</u>	<u>\$7.83</u>	
<b>Total Hospital Inpatient</b>					\$10,179,500	\$84.83	18%

**Development of a Global Budget: COMMERCIAL  
Cost of the Entire Economic Process (cont.)**

<u>Component</u>	<u>Use Rate</u>	<u>Description</u>	<u>Units</u>	<u>Cost Per Unit</u>	<u>Total Cost</u>	<u>Cost PMPM</u>	<u>% Cost</u>
<b><u>Medical Expense</u></b>		<b>Panel Size</b>	<b>10,000</b>				
<b>Hospital Outpatient</b>							
Outpatient Surgery	0.25	Cases per Year	2,500	\$2,100	\$5,250,000	\$43.75	
Emergency Dept	0.11	Visits per Year	1,100	\$575	\$632,500	\$5.27	
Observation	0.1	Cases per Year	1,000	\$1,600	\$1,600,000	\$13.33	
Imaging	0.45	Exams per Year	4,500	\$290	\$1,305,000	\$10.88	
Lab	2.2	Tests per Year	22,000	\$65	\$1,430,000	\$11.92	
Radiation Therapy	1.1	Treatments per Year	11,000	\$100	\$1,100,000	\$9.17	
Outpatient Rehab	0.2	Treatments per Year	2,000	\$80	\$160,000	\$1.33	
Other Outpatient	25	Expense per Year	250,000	\$1	<u>\$250,000</u>	<u>\$2.08</u>	
<b>Total Outpatient</b>					<b>\$11,727,500</b>	<b>\$97.73</b>	<b>21%</b>
<b>Home Health</b>	<b>0.5</b>	<b>Visits per Year</b>	<b>5,000</b>	<b>\$75</b>	<b>\$375,000</b>	<b>\$3.13</b>	<b>1%</b>
<b>Pharmacy and DME</b>	<b>\$828</b>	<b>per member annually</b>	<b>8,280,000</b>	<b>\$1</b>	<b>\$8,280,000</b>	<b>\$69.00</b>	<b>15%</b>
<b>Total Medical Costs</b>					<b>\$46,984,500</b>	<b>\$391.54</b>	<b>85%</b>
<b>Insurer Percentage</b>						<b>\$69.09</b>	<b>15%</b>
<b>Total Budget / Premium</b>						<b>\$460.63</b>	<b>100%</b>



**Development of a Global Budget: MEDICARE  
Cost of the Entire Economic Process**

<u>Component</u>	<u>Use Rate</u>	<u>Description</u>	<u>Units</u>	<u>Cost Per Unit</u>	<u>Total Cost</u>	<u>Cost PMPM</u>	<u>% Cost</u>
<b><u>Medical Expense</u></b>		<b>Panel Size</b>	<b>5,000</b>				
<b>Primary Care Physician</b>							
Internal	7.1	Encounters per Year	35,500	\$107	\$3,780,750	\$63.01	
External	<u>0.75</u>	Encounters per Year	<u>3,750</u>	<u>\$142</u>	<u>\$532,500</u>	<u>\$8.88</u>	
Subtotal Primary Care	7.85		39,250	\$110	\$4,313,250	\$71.89	
<b>Specialist Physician</b>							
Internal	7.5	Encounters per Year	37,500	\$218	\$8,156,250	\$135.94	
External	<u>1.8</u>	Encounters per Year	<u>9,000</u>	<u>\$290</u>	<u>\$2,610,000</u>	<u>\$43.50</u>	
Subtotal Specialist/Other	9.3		46,500	\$232	\$10,766,250	\$179.44	
<b>Total Professional</b>	17.15				\$15,079,500	\$251.33	29%
<b>Hospital Inpatient</b>							
Acute Medical/Surgical	0.35	Admissions per Year	1,750	\$7,500	\$13,125,000	\$218.75	
Rehab	0.013	Admissions per Year	65	\$6,200	\$403,000	\$6.72	
SNF	1.1	Days per Year	5,500	\$425	<u>\$2,337,500</u>	<u>\$38.96</u>	
Total Hospital Inpatient					\$15,865,500	\$264.43	30%
<b>Hospital Outpatient</b>	1250	Expense per Year	6,250,000	\$1	\$6,250,000	\$104.17	12%
<b>Home Health</b>	5.2	Visits per Year	26,000	\$75	\$1,950,000	\$32.50	4%
<b>Pharmacy and DME</b>	\$1,159	per member annually	5,796,000	\$1	\$5,796,000	\$96.60	11%
<b>Total Medical Costs</b>					\$44,941,000	<b>\$749.02</b>	85%
<b>Insurer Percentage</b>						\$132.18	15%
<b>Total Budget / Premium</b>						\$881.20	100%

# Global Budgeting

## Development of Global Payment (Capitation) Rates

### IV. Develop Global Payment (Capitation) Rates

- Calculate Total Medical Expense per member per month
- Add Reinsurance Expense, other administrative costs as required
- Address IBNR as necessary, depending on timing

### V. Identify and Assess Risks

- Population Covered (Demographics too Small to Predict Use Rate?)
- Out of Plan Services/PCP Coordination of Care
- Payer's Strategy to Mitigate Risk & Reduce Leakage
- Strength of Plan
- Re-Insurance
- Catastrophic Loss
- Loss of Subscribers
- Loss of Physicians
- Risk Sharing (Stop Loss)
- Operational Issues (Utilization Review)

# Global Budgeting

## Development of Global Payment (Capitation) Rates

*In conclusion, what data do we need to develop a global budget?*

- Claims data for population covered
- Membership data or profile of members
- Risk adjuster data if available (e.g. DxCG)
- Use rates for validation of Total Medical Expense (TME) build-up
- Payment data for services in all settings (hospital, physician office, home health, etc.)
- Cost accounting data for services in all settings;
  - Direct Cost per Unit
  - Indirect Cost per Unit

*Cost data should reflect the specific population.*

**Development of a Bundled Payment: ORTHOPEDIC  
Cost of the Entire Economic Process**

<u>Component</u>	<u>Use Rate</u>	<u>Description</u>	<u>Units</u>	<u>Cost Per Unit</u>	<u>Total Cost</u>	<u>Cost PMPM</u>
<u>Medical Expense</u>		Panel Size	25,000			
<u>Hospital Inpatient Acute</u>	12	Ortho Admissions per 1000 population				
DRG 466 Revision of hip or knee replacement w MCC		Admissions	8	\$17,050	\$136,400	\$0.45
DRG 467 Revision of hip or knee replacement w CC		Admissions	12	\$14,786	\$177,435	\$0.59
DRG 469 Major joint lower extremity w MCC		Admissions	40	\$14,620	\$584,800	\$1.95
DRG 470 Major joint lower extremity w/o MCC		Admissions	218	\$13,741	\$2,995,456	\$9.98
DRG 488 Knee procedures w/o pdx of infection w CC/MCC		Admissions	10	\$6,170	\$61,704	\$0.21
DRG 489 Knee procedures w/o pdx of infection w/o CC/MCC		Admissions	<u>12</u>	<u>\$6,048</u>	<u>\$72,570</u>	<u>\$0.24</u>
			300		\$4,028,365	\$13.43
<u>Rehab</u>						
Transitional Care Unit / Rehab	80%	of Ortho Admissions	240	\$4,650	\$1,116,000	\$3.72
<b>Total Hospital Inpatient</b>					<u>\$5,144,365</u>	<u>\$17.15</u>
Outpatient Rehab	15	Visits per Ortho Admission	4,500	\$45	\$202,500	\$0.68
Home Health	10	Visits per Ortho Admission	3,000	\$69	\$207,000	\$0.69
Outpatient Imaging	0.82	Exams per Ortho Admission	246	\$175	\$43,050	\$0.14
Outpatient Lab	1.6	Tests per Ortho Admission	480	\$38	\$18,240	\$0.06
Pharmacy and DME	\$45	\$ per Ortho Admission	13,500	\$1	<u>\$13,500</u>	<u>\$0.05</u>
<b>Total Outpatient</b>					<u>\$484,290</u>	<u>\$1.61</u>
Primary Care Physician	0.5	Encounters per Ortho Adm	150	\$105	\$15,750	\$0.05
Specialist Physician	3	Encounters per Ortho Adm	900	\$215	<u>\$193,500</u>	<u>\$0.65</u>
<b>Total Professional</b>					<u>\$209,250</u>	<u>\$0.70</u>
<b>Total Medical Costs</b>					<u>\$5,837,905</u>	<u>\$19.46</u>
<b>Per Inpatient Ortho Admission</b>					<u>\$19,460</u>	

# Global Budgeting

## New Metrics for Performance Reporting

**Reporting on Coordination of Care is essential under a global budget:**

- Utilization
- Site of Service
- Practice Pattern Variation
- Quality

### **Suggested Reports by PCP:**

- Utilization: E.D. Visits (*internal and external*)
- Utilization: Specialist Visits (ratio to PCP visits)
- Utilization: Admissions and Days
- Leakage: External Purchased Services, by Specialty/Service
- Total Expense PMPM

# ACO or New Organization

## PCP Physician - New Metrics

(Example: 500 Covered Members)

Service	PCP Units	Target Units	Percent Variance	PCP Cost Per Unit	Target Cost Per Unit	PCP Cost PMPM	Target Cost PMPM
Inpatient Med/Surg Admissions	58	55	-5.5%	7,345	\$ 7,500	\$71.00	\$68.75
E.D. Visits	49	55	10.9%	610	575	\$4.98	\$5.27
Primary Care Visits	1988	2000	0.6%	120	111	\$39.76	\$37.00
Specialist Visits	2985	2950	-1.2%	197	210	\$98.01	\$103.25

**New Metrics for Performance Reporting**  
**External/Leakage Report**  
**(Source: Claims Data)**

<b>Specialty</b>	<b>Annual \$</b>	<b>PMPM</b>
<b>ANESTHESIA</b>	<b>\$ 557,783</b>	<b>\$ 9.30</b>
<b>EMERGENCY DEPT MD's</b>	<b>\$ 450,112</b>	<b>\$ 7.50</b>
<b>INTERNAL MEDICINE</b>	<b>\$ 210,021</b>	<b>\$ 3.50</b>
<b>OB/GYN</b>	<b>\$ 206,697</b>	<b>\$ 3.44</b>
<b>OPHTHALMOLOGY</b>	<b>\$ 146,142</b>	<b>\$ 2.44</b>
<b>ONCOLOGY</b>	<b>\$ 122,685</b>	<b>\$ 2.04</b>
<b>ORTHOPEDIC</b>	<b>\$ 105,797</b>	<b>\$ 1.76</b>
<b>CARDIOLOGY</b>	<b>\$ 105,029</b>	<b>\$ 1.75</b>
<b>PEDIATRICS</b>	<b>\$ 103,786</b>	<b>\$ 1.73</b>
<b>SURGERY</b>	<b>\$ 89,027</b>	<b>\$ 1.48</b>
<b>GASTROENTEROLOGY</b>	<b>\$ 70,899</b>	<b>\$ 1.18</b>
<b>NEUROSURGERY</b>	<b>\$ 70,341</b>	<b>\$ 1.17</b>
<b>PATHOLOGY</b>	<b>\$ 69,939</b>	<b>\$ 1.17</b>
<b>ORAL SURGERY</b>	<b>\$ 60,795</b>	<b>\$ 1.01</b>
<b>ALL OTHER</b>	<b>\$ 199,251</b>	<b>\$ 3.32</b>
<b>Total External Costs - Professional</b>	<b>\$ 2,568,305</b>	<b>\$ 42.81</b>

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