

1. For each year 2009 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

Please reference the table below (and Exhibit C-1, Attachment A), which provides the requested information for the legacy Lahey Clinic Foundation, Inc. and affiliate entities, legacy Northeast Health System, Inc. and affiliate entities, as well as the proxy for Lahey Health (simple addition of inputs).

	Calendar 2009		Calendar 2010		Calendar 2011		Calendar 2012	
	Percent of Total Business *	Operating Margin	Percent of Total Business *	Operating Margin	Percent of Total Business *	Operating Margin	Percent of Total Business *	Operating Margin
<i>Lahey Health System (proxy)</i>								
Commercial business	49.7%	16.7%	50.4%	18.8%	48.9%	20.9%	47.6%	21.7%
Government business	47.4%	-14.4%	47.0%	-16.9%	48.2%	-13.5%	49.8%	-12.8%
All other business	2.8%	4.5%	2.6%	3.0%	2.9%	7.3%	2.6%	1.9%
Total business	100.0%	1.6%	100.0%	1.6%	100.0%	4.0%	100.0%	4.0%
<i>Lahey Clinic Foundation and Affiliates</i>								
Commercial business	52.6%	16.4%	53.4%	19.4%	52.1%	21.9%	50.9%	22.6%
Government business	43.8%	-16.7%	43.4%	-20.3%	44.3%	-15.7%	46.0%	-15.6%
All other business	3.6%	20.1%	3.2%	18.9%	3.6%	20.9%	3.1%	16.5%
Total business	100.0%	2.0%	100.0%	2.2%	100.0%	5.2%	100.0%	4.9%
<i>Northeast Health System and Affiliates</i>								
Commercial business	43.6%	17.3%	43.8%	17.2%	41.1%	17.9%	39.3%	18.8%
Government business	55.1%	-10.5%	55.0%	-11.0%	57.6%	-9.3%	59.3%	-7.5%
All other business	1.2%	-90.2%	1.3%	-86.5%	1.3%	-85.5%	1.4%	-80.2%
Total business	100.0%	0.7%	100.0%	0.4%	100.0%	0.9%	100.0%	1.8%

* as calculated using net patient service revenue.

Carrier / Program Roll-up		
Commercial business	Government business	All other business
Aetna HMO	Mass Health	Self pay / free care
BCBSMA - HMO	Medicare	International
BCBSMA Sr HMO	Network Health	Other
BMC Healthnet	NHP	
Cigna HMO	Other Commercial Medicare	
Fallon	Other Commercial Medicare HMO	
HPHC HMO	Other Medicaid	
Tufts HMO	Tufts Medicare Preferred	
Aetna		
BCBSMA - PPO		
BCBSMA Sr		
Cigna		
HPHC PPO		
Other Commercial		
Tufts PPO		
United		

The margins for HMO business and PPO business are largely similar. Over the last 4 years, HMO margins were in the 17% to 24% range while PPO margins were in the 15% to 21% range. Business reimbursed through risk contracts accounted for approximately 10% of total business between 2010 and 2012, with margins in the 12% to 25% range. Lahey Clinic Foundation entities did not have any risk contracts in 2009.

- 2. If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold return, surplus 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, payer mix, or patient member type (e.g. HMO v PPO, fully insured v. self-insured) on our opportunities for surplus.**

Lahey Health physicians, including those in the Lahey Clinical Performance ACO, Lahey Clinic accountable risk unit (ACU) and Northeast Physician Hospital Organization (NEPHO) ACU¹ currently participate in two system wide risk contracts, the Medicare Shared Savings ACO and a Tufts commercial risk contract. The Lahey ACU, separate from the NEPHO ACU, also currently participates in a Tufts Medicare HMO risk contract and the BCBSMA Alternative Quality Contract.

In order to better manage population health under risk contracts, Lahey Health uses athenaClaritySM, a cloud-based analytics tool to aggregate claims data across network providers and disparate EHR systems. The tool captures overall clinical, financial and operational performance, as well as insight on performance variations and trends. To leverage athenaClaritySM to improve quality and efficiency under risk, Lahey Health has developed the following business practices and associated capabilities:

- Monthly group review of performance data
 - Identify need for care coordination intervention across providers and sites
 - Identify opportunities to provide care in a more appropriate setting
 - Minimize any redundant services, particularly higher-cost ancillary services
 - Increase transparency of performance and practice patterns
- Care management and coordination programs
 - Target placement of care managers
 - Improve care transitions
 - Provide home-based support and monitoring
- Integration of pharmacy support into the care team
 - Improve medication management

¹ Both ACU's are part of the Lahey Clinical Performance Network (LCPN).

- Ensure comprehensive management for chronic disease and patients with co-morbidities

It is difficult to attribute changes in service mix, payer mix, member type, or overall risk performance to one particular business practice, or even a set of business practices, given the myriad factors (or confluence of factors) collectively impacting service utilization fluctuations and shifts in payer and product mix.

Based on the information we capture and monitor regarding member type, enrollment in BCBSMA, HPHC and Tufts commercial HMO products has declined. Our hypothesis, corroborated at the state-level in the 2013 OAG and CHIA reports, is that PPO enrollment has subsequently increased, though confirmation of this hypothesis would require currently unavailable payer data.

Based on the information we capture and monitor regarding payer mix, we also note an increase in the proportion of patients enrolled in government plans.

Both the shift away from HMO products and increase in proportion of government plan patients negatively impacts the potential to earn surpluses.

- 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 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 how your cost or risk capital needs would change due to changes in the risk you bear on your commercial or governmental business.**

LCPN, in collaboration with local ACUs, uses health plan claims data and other provided reports, in conjunction with the athenaClaritySM tool, to quantify, analyze and project performance under risk. Analyses calculate and stratify patient population risk using health behavior and status indicators, as well as historical utilization data, to generate projections at the individual provider, local ACU and LCPN levels. Contract quality metrics and other participation parameters/terms provide additional context to better understand resource and capability requirements for effective risk management. As discussed in response to question 2, we are then able to develop or prescribe existing business practices to support population health management.

For those risk contracts that do not exclude outlier cases, we have acquired stop loss insurance, for which policy terms are renegotiated annually. In 2012, the LCPN stop loss insurance had an attachment point of \$250,000 and covered up to \$5,000,000 in per member maximum annual claims payments at a cost of \$12.24 pm/pm. Neither the human resource costs for care management (cited in response to question 2), nor those for the provision of our physician contracting and management services are allocated or analyzed (at this time) based on pm/pm costs of bearing risk.

In regards to pre-determined solvency thresholds, Lahey Health's (and LCPN's) financial position and projected performance are such that establishing formal solvency standards has yet to be required.

If specific contract terms generate projections indicating substantial probability of deficit, LCPN would engage in discussions with the payer to realign risk-sharing parameters or performance metrics. If the LCPN risk stratification and modeling processes were unable to accurately project performance and a payer deficit was experienced, LCPN has a multi-step methodology in place to cover the shortfall. Initially, performance at the ACU level is evaluated by benchmarking outcomes against pre-established

and approved targets that incorporate contract metrics and additional cost and quality indicators. If an ACU has not met these targets, the first source of funds are the withholds (10% per ACU per contract from claims payments made and held in escrow by the payer during the contract performance period). If a deficit still remains, dollars would flow from the LCPN reserve pool. If the reserve pool is insufficient to reconcile the deficit, the withholds from ACUs achieving performance targets would be accessed. Finally, in the unlikely event that the shortage persists, LCPN would spread the remaining deficit across ACUs in proportion to membership size, risk profile and relative performance.

Clearly, there is a direct and positive correlation between the degree of risk assumed and the degree of cost or risk-capital required to effectively bear the risk, and therefore cost and capital estimates can be derived prior to contract formalization. If an excessive level of atypical costs are indicated, LCPN would work with the health plan to limit risk exposure through modified risk-sharing terms to ensure better alignment of incentives and would collaboratively dedicate resources to improve performance.

4. Please describe and submit supporting documents regarding how you track changes in the health status of your patient population or any population subgroups (e.g., by carrier, product type, geography)

The same data sources, methodology and tools referenced in responses to questions 2 and 3 are utilized to longitudinally capture and monitor health status changes and the related changes in the risk associated with managing the health of a patient population or sub-population. Interventional population management resources and practices are adjusted to reflect changes in health status over time. Currently these analyses are performed at the contract level, and not across contracts to assess differences by carrier, product type or geography.

5. Please submit a summary table showing for each year 2009 to 2012 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 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. Include in your response any portion of your physicians whom you were not able to report a category (or categories) of revenue. Responses must be submitted electronically using the Excel version of the attached exhibit.

Please reference Exhibit C-5 attachments A, B and C.

Since Lahey Health was not in place until May 2012, the data is presented as three different Excel files. One file provides data for legacy Lahey Clinic Foundation entities, one file provides data for legacy Northeast Hospital Corporation entities and the third file is a proxy for Lahey Health (Lahey and Northeast data added together). All revenue related to the hospitals and employed physicians is included².

6. Please identify categories of expenses that have grown a) 5% or more and b) 10% or more between 2010 and 2012, and explain and submit supporting documents that show your understanding as the factors underlying any such growth.

Overall expenses for Lahey Health increased by \$114.7 million or 8.8%, driven primarily by labor and associated costs, with non-labor operating costs increasing by less than 2.0%.

² Northeast Hospital Corporation (NHC) derives revenues from certain health plans that are also reflected in the testimony submitted by NEPHO in Exhibit 1. It should be noted that in some cases the revenues reported by NEPHO are a subset of those reported by NHC.

Salaries and wages for non-physician clinical staff increased by \$38.3 million, or 7.7%. The increase is primarily attributable to implementation of a new compensation and bonus program designed to align financial incentives with achievement of organizational and individual performance goals. Goals span seven performance areas: system financial sustainability, productivity, quality, care experience, colleague engagement and cost. The 7.7% increase is the result of achieving at least threshold performance (assigned using national benchmarks) for all seven metrics, including top decile performance on the cost metric (cost per adjusted discharge), and earning Lahey Hospital & Medical Center the honor of being the lowest cost teaching hospital nationally (UHC, 2012).

It is also important to note that the number of non-physician clinical FTE's increased by 25.1 during this time period, and expenses related to our benefit program increased more than in a typical two-year period due to augmentation of employee health insurance premium discount rates.

Salaries and wages for physician employees increased by \$19.8 million or 10.78% due to the new compensation and bonus program outlined above. The number of FTE's increased by 14.3 during the time period.

Employee benefits increased by \$28.2 million or 17.6%, largely the result of a defined benefit pension plan expense increase of \$19.2 million. Lahey Clinic Foundation made the decision in 2013 to freeze the defined benefit plan effective December 31, 2014. Further, costs associated with employee health insurance coverage increased by \$9.0 million and included expenses associated with augmented health insurance premium employee discount rates for employee wellness initiatives.

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

- (a) As described in Exhibit B responses to questions 3 and 4, Lahey Health is committed to primary care model redesign to improve quality, accessibility and integration of physical and mental health services. The well-established Lahey team and interdisciplinary approach enables top-of-license and coordinated care practices among our physicians, nurse practitioners, physician assistants, registered nurses, pharmacists, health educators, behavioral health providers and dietitians. The team approach provides comprehensive service coverage and multiple touch points for frequent communication, resulting in more engaged patients and families. Protocols for timely risk mitigation and preventative screenings further reiterate a focus on wellness. Lahey has consistently exceeded the national 90th percentile in HEDIS (Healthcare Effectiveness Data and Information Set), and providers routinely achieve recognition for timeliness of breast, cervical and colon cancer screenings, and for high-quality care of diabetic patients, as well as those with depression.
- (b) The primary avenue for delivery of wellness services to individuals not managed by Lahey Health physicians is through member organization community benefit programs and initiatives, in conjunction with local providers and organizations aligned with our efforts to improve the health and quality of life for community residents. Not surprisingly, our community-based wellness efforts mirror current care delivery and population management priorities including, and include myriad programs, events and

tools, as documented online in the community benefit annual reports produced by [Lahey Hospital & Medical Center](#) and [Northeast Hospital Corporation](#).

(c) Lahey Health colleagues share a common dedication to wellness, and have proactively implemented system wide policies and programs to create and sustain a healthy and active workforce. The wellness initiatives highlighted below demonstrate our commitment to upholding this cultural and behavioral pillar of our system:

- Lahey Health has partnered with Harvard Pilgrim Health Plan to reduce insurance premiums for colleague participation in wellness screenings/survey and demonstrating reductions in risk
 - Preventative care covered @ 100%
 - No copay
 - On-site and earned time for participation
- Biometric screenings, online health behavior survey and subsequent development of personalized health plans to target wellness opportunities

Key biometric screening indicators and the five target health measures set and tracked at the system level

Biometric Indicator	Metrics and Targets
Body Mass Index (BMI)	2013 BMI = 19 - 25 OR 2012 BMI = 25.1-29.9 and 2013 BMI = at least 2.0 points lower OR 2012 BMI = 30.0+ and 2013 BMI = at least 3.0 points lower
Blood Pressure	Systolic: <140 / Diastolic: <90
Non-Fasting Cholesterol	Total cholesterol < 200 HDL > 40 (male) or > 50 (female)
Blood Sugar	Non-fasting glucose <126
Nicotine	No trace from mouth swab

- Over 4,000 Lahey Health employees completed both the biometric screen and online survey; over 4,600 employees completed the biometric screen only

Colleagues and families are engaged and supported to improve health

 **ive Better** Wellness Program

THREE SIMPLE STEPS

- 1 **KNOW YOUR NUMBERS.** Onsite biometric screenings identify health risks.
- 2 **KNOW YOURSELF.** Online survey and personalized health profile.
- 3 **KNOW YOUR GOAL.** Three or more of the five system health metric targets.

Colleague completes all three steps = \$400

+

Spouse completes steps one and two = \$200

2014 medical premium incentive opportunity = \$600

- Discounts for gym and fitness studio membership and direct membership payroll deductions
- On-site Weight Watchers® nutrition and fitness classes
- Sodas and high fat, high fructose foods have been replaced by healthier option in hospital cafeterias and vending machines
- Lower-cost access to health coaches
- All employees are eligible for reimbursement for participation in smoking cessation programs

Lahey Health plans to conduct a return on investment analysis for the Live Better employee wellness program in 2014.