Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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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: stateBID-Plymouth (formerly Jordan Health System and Jordan Hospital) continues to work arduously to control cost while maintaining high quality care for our patients. Key to achievement of this goal in the periods CY2012 - CY2014 has been creation of the Jordan Community ACO and the merger with BIDMC effective January 1, 2014.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      During the period CY 2010-CY2013, BID-Plymouth experienced a cumulative decline in inpatient admissions of 27%. Reductions in inpatient utilization are attributable to ongoing efforts to reduce unnecessary admissions and readmissions, and increase in patients assigned observation level-of-care, and conversion of certain services from inpatient to outpatient sites of service. Two-thirds of this is decline is comprised of short-stay cases (1 and 2 day stays). Casemix of hospitalized patients has increased by 19%. Outpatient utilization during the same period has increased.
   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 April 2012, BID-Plymouth (then Jordan Hospital) has been a participant in Jordan Community ACO (JCACO), a Medicare Shared Savings Program Accountable Care Organization. Through this initiative, PBMA, a large primary care physician practice, partnering with the hospital and soliciting specialty physician involvement, has fostered meaningful care integration for the first time in Plymouth County. Through effective care management and enhanced clinical attention, JCACO has achieved dramatic results in the community of patients attributed to the ACO: 20% reduction in hospital utilization, 30% reduction in SNF cost, improved management of complex populations for approximately 100 patients with the highest risk profiles, reduction in costs of almost $2.3 million, 100% completion of the CMS quality goals.

      See Appendix for complete response.

   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?
Participation in BIDCO affords us the opportunity to further the efforts begun with JCACO. Further, one of the large independent physician groups in our service area, Plymouth Medical Group, recently joined BIDCO. With this, approximately two-thirds of the physician provider community in Plymouth is now a member of BIDCO. Specifically, we will work with BIDCO to assess and participate in innovative alternative payment models and to engage our provider partners to adopt practice patterns that focus on ensuring patients receive the right care, in the right place, and at the right time.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Policies and regulations that promote administrative simplication and standardization would significantly improve our ability to operate more efficiently. Variation among payers and frequent changes in billing/payment rules, quality/safety measures and the timing/format of reporting requirements necessitates dedicated staff and internal procedures in the areas of patient registration, patient accounts, medical records coding and review, case management, quality review and analysis, and managed care contracting and analysis. Administrative simplication will enable us to redirect resources from simply meeting the demands of the payers to making meaningful improvements in the quality and delivery of care to our patients, families and community.

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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: To date, BID-Plymouth has had limited experience with other than fee-for-service payment models. At present, all contracts with health plans are fee-for-service arrangements, some of which include P4P incentives.
    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?
    For a limited time, BID-Plymouth participated in two APMs with Tufts - a lab capitation arrangement and a risk-based Medicare managed care contract. The lab cap arrangment applied to a limited number of covered lives and the revenue involved was not material. The hospital discontinued this arrangment in 2013. Similarly, a very low number of lives were covered lives under the Medicare risk plan. Several high cost patients resulted in significant losses. The hospital terminated its participation in this arrangement in 2013.
    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).
    Not applicable

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.
Not applicable

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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: BID-Plymouth does not currently have any risk or other APM contracts with payers.
   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?
   Not applicable
   b. How do the health status risk adjustment measures used by different payers compare?
   Not applicable
   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?
   Not applicable

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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: To effectively manage performance under APMs, hospitals need timely and patient-level data from the health plans.
ANSWER: Hospitals are handicapped in that their only ready access to patient utilization is limited to services provided at their own facility or by employed physicians. Health plans have repositories of member utilization data that must be shared with providers to effectively promote management of population health and health services utilization. Our experience to date is that plans provide no data or limited data, and that data is always lagged by at least three to six months, rendering it non-actionable.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: BID-Plymouth endorses the C.224 requirement to attribute members to a primary care provider and encourage standardization of attribution methodologies across all payers. We urge enforcement of this requirement, as well as of the requirement that plans share with providers data on attributed patients.

a. Which attribution methodologies most accurately account for patients you care for?
The most accurate methodology would be one that allows for patient selection of a primary care provider. Our experience with specific attribution methodologies is limited to CMS's attribution logic for the JCACO. Because Medicare does not require members to select a PCP, we are subject to the CMS attribution model that defaults to the provider who provides the multitude of E&M services. This could be a PCP or a specialist.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
We promote a requirement that health plan members select a primary care physician and that attribution is based on PCP. At a minimum, attribution methodologies should be common across health plans to ensure standardization and ease provider management of risk arrangements.

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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: Data abstraction performed by skilled clinical resources requires a significant time commitment. This commitment is exacerbated by the variation in quality metrics and reporting formats across payers.
ANSWER: Variation persists across payers in both how quality metrics are defined and in report format requirements. If metrics are not commonly defined, additional resources must be devoted to data abstraction. Further, reporting of data internally becomes a challenge when data are collected differently for various parties yet are labeled the same, e.g., CMS, PEPPER, and other payers each has a unique metric for "Readmission". Even when metrics are commonly defined, each payer has a different process for reporting, both in timing and format. CMS, Blue Cross and MassHealth have different reporting processes. Of these, Masshealth is the most burdonsome. BID-Plymouth is in the process of implementing a new quality database (Datavision) to help alleviate some of the manual effort required to report quality measures to public and private payers. Datavision is one of very few vendors that supports MassHealth.

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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: BID-Plymouth has long been a low cost community provider, and with our recent merger with BIDMC we join a network of some of the very lowest cost hospitals in Massachusetts. Through this affiliation, BIDMC is helping to augment our clinical capabilities in both specialty and primary care; recruit physicians to our community; support and collaborate on quality programs and initiatives. Also through this affiliation, we participate in BIDCO, which aligns community doctors with their local community hospitals, and fosters maximum utilization and retention of care in the community.
    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.

As noted in response to 1(a), BID-Plymouth has experienced dramatic reductions in inpatient utilization over the past four years. The flow of patients from BID-Plymouth has slowed considerably reflecting our efforts to care for patients in a local community setting whenever clinically appropriate. Med/Surg transfers from our emergency department are actively managed to ensure that only those cases that cannot be treated locally are transferred to an AMC. These are now limited to trauma, highly complex cases requiring specialty care not locally available, and pediatric inpatient care. From CY2010 to CYTD2014, total transfers from our emergency department to another acute care facility have decreased by 34%. Similary, transfers of inpatients to an AMC have declined by 41% during the same time period.

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.

Every transfer from our emergency department is reviewed by a physician for appropriateness and to identify and address reasons for transfers that could have been avoided. When a patient does require tertiary care, whether from the emergency room or from an inpatient setting, every effort is made to transfer the case to our AMC-partner, BIDMC. Our merger with BIDMC was based on our mutual desire to reduce medical spending and trends by delivering the right care in the most appropriate setting - providing high-quality care in a community setting with access to world-class tertiary care. As a percent of total, emergency department transfers to BIDMC have increased from 15% of all acute care transfers in 2010 to 56% in 2014, while transfers to more expensive Partners hospitals has declined from 30% in 2010 to 15%, respectively. Similarly, transfers of inpatient cases to BIDMC have increased from 18% of total inpatient transfers in 2010 to 65% in 2014, while inpatient transfers to Partners hospitals have declined from 16% to 12% during the same period.

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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: BID-Plymouth agrees that management of post-acute care utilization represents a significant opportunity for both cost reduction and improved patient outcomes.

   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.

   Available data to BID-Plymouth is limited to a record of discharge disposition. Health plans have data about post-acute utilization, i.e., days of post-acute care, which is not typically shared with hospital providers. Our data show that in the period CY2010 to CYTD2014, discharges to a SNF or Rehab facility have

remained stable at approximately 20% of total discharges. The majority of these inpatients were admitted from a post-acute facility and are simply being discharged back to the facility from whence they came.

For the cohort of 6200 lives covered under JCACO, performance shows a 30% reduction in SNF cost, suggesting that for this small population, admissions to a SNF and/or days stay in a SNF has declined. It is not possible for the hospital to independently analyze the contributing factors without more specific data from Medicare.

b. How does your organization ensure optimal use of post-acute care?
Case management staff begin discharge planning on the day of patient admission to the hospital. For every inpatient, daily assessments are made to determine the optimal level of post-acute care. Case management confers with the patient, family and providers in developing the post-acute plan of care. In addition, BID-P participates in the STARR group, working directly with area SNFs to reduce the incidence of hospital readmissions after a patient has been discharged to a SNF. One opportunity for improvement may lie in modifications to inpatient rehabilitation practices whereby the level of rehab a patient receives during the inpatient stay is increased with a goal of decreasing reliance on post-acute rehab care after discharge from the hospital.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: BID-Plymouth has established a policy and procedure to address the needs of consumers/patients who seek pricing information. While we have made progress in establishing systems and processes in this area, additional work is needed to complete a website, and to improve our ability to follow up on patient satisfaction with this service.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**	0	25	24h
	Q2	0	37	24h
	Q3	0	15	24h

	TOTAL:	0	77	

** Please indicate the unit of time reported.*

ANSWER: Patients make price inquiries either via telephone or direct meeting with a patient financial counselor. All such inquiries are forwarded to Patient Accounts where each is logged. Information captured in the log includes: Date of inquiry, Point of initial contact (e.g. financial counselor, department manager, patient accounts), Patient name (if provided), Procedure, Payer, Pricing provided, Name of individual who prepare pricing, Mode of communication (written Y/N), and Comments. Pricing is estimated by specialist in the Patient Accounts department using a tool in our contract management system

The top ten procedures for which pricing inquiries have been made are:
1. Routine Mammography
2. Diagnostic Mammography
3. Breast Ultrasound
4. MRI
5. CT Scan
6. Bone Density
7. Inpatient Obstetrical Delivery
8. Colonoscopy
9. Clinic E&M visit
10. X-Ray

Patients generally tell us they want a ballpark estimate to determine approximately what they will owe and/or to compare pricing with other facilities (Shields MRI etc.)

To date, we have not conducted any assessment regarding the accuracy or value of this pricing information. Our ability to do so is hindered by a lack of sufficient resources to follow up with individual patients to determine if they actually came in for services and/or whether they found the pricing information helpful. Also, some patients do not provide contact information, making it impossible for us to reach them subsequent to their initial inquiry.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: To date, tiered and limited network products have had neglible impact on contracting and/or referral practices.
ANSWER: While the hospital does contract with plans that offer tiered or limited network products, volume from patients with those insurance plans is very low. As a result, the impact on contracting and referral practices is neglible. BID-Plymouth has taken no action specifically in response to tier placement. We continuously strive to delivery high quality care and the lowest cost possible.

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: We strongly agree with the Commission that the integration of physical and behavioral health care is critical to caring for patients and managing healthcare costs. BID-Plymouth (BIDP) is working on several initiatives to address the social and medical needs of our high-risk patients through our complex patient program (CPP) and the Integrated Care Initiative (ICI).
    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.
    We have taken numerous steps toward integration over the past year. Through funding provided by the 2013 Increased Capacity Building and Infrastructure (ICB) grant and monies from CHART 1, BIDP staff have been able to successfully expand and implement the Jordan Community Accountable Care Organization (JCACO)'s care management and clinical initiatives, including the CPP for dual eligible patients and the ICI for behavioral health patients. These projects have allowed BIDP to develop a unique, high value, and cost effective approach to managing complex patients. The CPP is part of the BIDP CARES program where staff Connect, Assess, Respond, Educate and Support patients with complex needs across the care continuum.

    See Appendix for complete response.
    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.
    In 2012, the Hospital established the Community Case Management/Complex Patient Program. This initiative is focused on providing care management services to complex, chronically ill Medicare patients. Over the last year, JCACO provided assessment and care management interventions to over 1,100 patients, 665 of which were complex. This program is designed to ensure safe transitions across the care continuum and facilitate access to quality care and proper coordination of health care services. Interventions include, but are not limited to the following: follow-up with primary care physicians; home or clinic visits; transportation; health literacy education/patient empowerment; and medication adherence.

    See Appendix for complete response.

    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.
    The dominant challenge to integrating services has been access to behavioral health services and resources. Without additional reimbursement for behavioral

health services, we will struggle to truly manage the care of our patients. We are hopeful that we will be able to expand our pilot program, made possible through CHART1 funding, by being approved as recipients of CHART2 funding. This, in addition to donations from private funders will help expand to other populations, the integrated care that we have begun in our pilot program.

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.
   BID-Plymouth is most willing to work with the Health Policy Commission to identify ways to adequately capture and report data relative to this unique patient population. Accurate identication of this cohort of the population is often challenging because of the myriad contributing factors to their admission and care. In many cases, psycho-social factors are not the primary cause for admission, but rather present as underlying issues that demand attention during an inpatient stay.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY: To date, BID-Plymouth has not developed a PCMH model.
    e. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
       Not applicable
    f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
       Not applicable
    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.
       Not applicable

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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: Please see response provided by BIDCO
    ANSWER:

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

   Enclosed, please find BID-Plymouth revenue by calendar year and by health plan. At this time, we have not included the level of detail specifically requested because of the lack of standardized approaches, methodology or definitions with regard to the data points requested; the highly proprietary nature of this information; the strong likelihood of significant variation across provider organizations in reporting this data; and concerns regarding the ultimate reliability, accuracy, and value of the data to the public, given the limitations and concerns described above. BID-Plymouth remains committed to transparency, and welcomes the opportunity to work with the HPC and the AGO to provide appropriate safeguards for proprietary information and to ensure that information provided addresses the purpose of its collection.

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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

   Enclosed, please find BID-Plymouth revenue and margin information. At this time, we have not included the level of detail specifically requested because of the lack of standardized approaches, methodology or definitions with regard to the data points requested; the highly proprietary nature of this information; the strong likelihood of significant variation across provider organizations in reporting this data; and concerns regarding the ultimate reliability, accuracy, and value of the data to the public, given the limitations and concerns described above. BID-Plymouth remains committed to transparency, and welcomes the opportunity to work with the HPC and the AGO to provide appropriate safeguards for proprietary information and to ensure that information provided addresses the purpose of its collection.

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.

   Not applicable

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.

   Inpatient volume grouped by each of four major physician groups is tracked on a monthly basis. Data regarding outpatient referrals is aggregated periodically to monitor those trends. This information is used for purposes of monitoring trends, establishing annual budgets, analyzing budget variances and for strategic financial planning initiatives.

Beth Israel Deaconess Plymouth

Appendix to 8/1/2014 HPC and AGO Request

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%.

a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

Response to Question 1(a) continued from template.

From 2010-2013, operating patient service revenue has declined by 2%, while operating expenses have increased by a 2%. These trends have continued in 2014, with a year-to-date decrease in inpatient admissions of 3%, a decrease in patient service revenue of 2%, and an increase in operating expenses of 1%.

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?.

Response to Question 1(b) continued from template.

Since January 2013, 10 new practices have been added to the hospital's primary care network, which will go a long way to promoting efforts to care for patients in our own community – providing the right care, in the right place and at the right time. On January 1, 2014, BIDMC became the sole corporate member of Jordan Health Systems and Jordan Hospital. Jordan Hospital was renamed Beth Israel Deaconess Hospital (BID-Plymouth). Through this affiliation, BIDMC is making strategic investments to support continued expansion of the BID-Plymouth primary care network and clinical capabilities.

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.

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.

Response to Question 1(a) continued from template.

Our focus on complex Medicare patients, and recently as part of CHART 1, the dual eligible and behavioral health populations, has proven to be successful – increasing access to services and decreasing readmissions by 25%. Additionally, these efforts have led to the establishment of the first integrated behavioral health and primary care practice pilot in the community.

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.

Response to Question 1(b) continued from template.

Ongoing communication with aftercare facilities and home health agencies has been crucial to the successful management of this population. Based on initial cost estimates it appears, JCACO program initiatives have potentially saved over $2.3 million by reducing unnecessary readmissions and emergency department visits, shortening lengths of stay and dissipating the effects of co-morbidities.

Beth Israel Deaconess Hospital
Plymouth

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Plymouth, MA 02360
(508) 746-2000 Phone
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bidplymouth.org

Submitted Electronically via HPC-Testimony@state.ma.us

September 15, 2014

Dear Ms. Johnson and Ms. Mercer,

Enclosed please find the responses of Beth Israel Deaconess Hospital-Plymouth, Inc. to the written testimony requested by the Health Policy Commission and found in Exhibit B and Exhibit C in a letter from Executive Director David Seltz to Mr. Peter Holden on August 1, 2014.

Please note that I am empowered to represent Beth Israel Deaconess Hospital-Plymouth, Inc. for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please do not hesitate to contact me if you have any additional follow-up questions or Jason Radzevich in my office at jradzevich@bidplymouth.org or 508-830-2005.

Very truly yours,

Peter J. Holden
President & CEO

2010

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 3.052		$ 4.503		$ 6.752		$ 3.257		$ 0.035		$ 0.041		$ 9.839		$ 7.802	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.047		$ 0.231		$ 0.018		$ 0.103		$ -		$ 0.004		$ 0.065		$ 0.339	
Dermatology	$ 0.499		$ 2.655		$ 0.739		$ 0.992		$ 0.018		$ 0.285		$ 1.257		$ 3.932	
Endocinology	$ 0.781		$ 2.268		$ 1.083		$ 0.819		$ 0.000		$ 0.007		$ 1.864		$ 3.095	
Gastroenterology	$ 3.712		$ 7.282		$ 3.947		$ 2.137		$ 0.004		$ 0.058		$ 7.662		$ 9.477	
General Medicine	$ 1.870		$ 7.135		$ 3.157		$ 1.704		$ 0.002		$ 0.062		$ 5.029		$ 8.900	
General Surgery	$ 4.514		$ 2.432		$ 3.566		$ 0.820		$ 0.040		$ 0.126		$ 8.120		$ 3.378	
Gynecology	$ 0.654		$ 1.713		$ 0.184		$ 0.250		$ 0.006		$ 0.005		$ 0.844		$ 1.968	
Hematology	$ 0.369		$ 1.139		$ 0.611		$ 1.164		$ 0.003		$ 0.002		$ 0.982		$ 2.305	
Infectious Disease	$ 0.006		$ 0.001		$ 0.037		$ 0.001		$ -		$ -		$ 0.043		$ 0.002	
Neonatology	$ 0.919		$ 0.005		$ 0.321		$ 0.001		$ 0.023		$ -		$ 1.263		$ 0.006	
Nephrology	$ 0.638		$ 1.022		$ 3.027		$ 1.066		$ 0.009		$ 0.017		$ 3.675		$ 2.104	
Neurology	$ 1.496		$ 2.770		$ 6.510		$ 0.997		$ -		$ 0.055		$ 8.006		$ 3.822	
Neurosurgery	$ 0.056		$ 0.254		$ 0.144		$ 0.109		$ -		$ 0.016		$ 0.200		$ 0.379	
Normal Newborns	$ 0.786		$ 0.008		$ 0.412		$ 0.002		$ -		$ -		$ 1.198		$ 0.010	
Obstetrics	$ 2.913		$ 0.725		$ 0.551		$ 0.123		$ -		$ 0.003		$ 3.464		$ 0.851	
Oncology	$ 0.268		$ 8.905		$ 0.660		$ 5.555		$ -		$ 0.004		$ 0.928		$ 14.465	
Ophthalmology	$ 0.031		$ 0.207		$ 0.023		$ 0.068		$ -		$ 0.021		$ 0.054		$ 0.296	
Orthopedics	$ 5.583		$ 8.049		$ 6.668		$ 2.650		$ 0.258		$ 0.880		$ 12.510		$ 11.580	
Otolaryngology	$ 0.271		$ 2.233		$ 0.323		$ 0.716		$ -		$ 0.025		$ 0.594		$ 2.974	
Psychiatry	$ 0.814		$ 1.381		$ 1.462		$ 0.729		$ 0.012		$ 0.009		$ 2.289		$ 2.120	
Pulmonary	$ 3.265		$ 1.861		$ 7.367		$ 0.987		$ 0.006		$ 0.014		$ 10.638		$ 2.862	
Rehab													$ -		$ -	
Rheumatology	$ 0.040		$ 2.371		$ 0.121		$ 1.088		$ -		$ 0.162		$ 0.160		$ 3.621	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.349		$ 0.489		$ 0.690		$ 0.150		$ 0.007		$ 0.075		$ 1.045		$ 0.714	
Urology	$ 1.044		$ 3.052		$ 1.066		$ 1.077		$ -		$ 0.011		$ 2.109		$ 4.140	
Vascular Surgery	$ 0.406		$ 0.088		$ 1.021		$ 0.091		$ -		$ -		$ 1.428		$ 0.179	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 0.213				$ 0.180				$ 0.012				$ 0.406	
GRAND TOTAL	$ 34.384	$ -	$ 62.994	$ -	$ 50.459	$ -	$ 26.836	$ -	$ 0.423	$ -	$ 1.894	$ -	$ 85.266	$ -	$ 91.724	$ -

2011

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 2.944		$ 4.140		$ 6.720		$ 3.606		$ 0.008		$ 0.065		$ 9.673		$ 7.811	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.020		$ 0.202		$ 0.052		$ 0.112		$ -		$ 0.005		$ 0.072		$ 0.319	
Dermatology	$ 0.473		$ 2.529		$ 0.723		$ 0.974		$ 0.010		$ 0.321		$ 1.205		$ 3.824	
Endocinology	$ 0.629		$ 2.070		$ 1.002		$ 0.971		$ 0.001		$ 0.022		$ 1.632		$ 3.063	
Gastroenterology	$ 3.580		$ 5.994		$ 4.036		$ 2.056		$ 0.005		$ 0.036		$ 7.621		$ 8.086	
General Medicine	$ 2.135		$ 7.984		$ 3.805		$ 1.995		$ 0.001		$ 0.074		$ 5.942		$ 10.054	
General Surgery	$ 4.319		$ 2.525		$ 3.899		$ 0.778		$ 0.005		$ 0.043		$ 8.222		$ 3.346	
Gynecology	$ 0.616		$ 1.466		$ 0.178		$ 0.257		$ 0.013		$ 0.003		$ 0.808		$ 1.726	
Hematology	$ 0.354		$ 0.968		$ 0.517		$ 1.122		$ -		$ 0.001		$ 0.871		$ 2.090	
Infectious Disease	$ 0.005		$ 0.000		$ 0.034		$ 0.001		$ -		$ -		$ 0.039		$ 0.001	
Neonatology	$ 0.955		$ 0.003		$ 0.270		$ 0.002		$ -		$ -		$ 1.225		$ 0.005	
Nephrology	$ 0.846		$ 0.843		$ 2.752		$ 0.883		$ 0.020		$ 0.012		$ 3.618		$ 1.739	
Neurology	$ 1.306		$ 2.525		$ 6.869		$ 0.917		$ 0.004		$ 0.075		$ 8.179		$ 3.517	
Neurosurgery	$ 0.183		$ 0.148		$ 0.229		$ 0.089		$ -		$ -		$ 0.412		$ 0.238	
Normal Newborns	$ 0.834		$ 0.008		$ 0.479		$ 0.003		$ 0.002		$ 0.000		$ 1.314		$ 0.011	
Obstetrics	$ 3.100		$ 0.850		$ 0.590		$ 0.128		$ 0.009		$ 0.003		$ 3.699		$ 0.981	
Oncology	$ 0.369		$ 10.623		$ 0.668		$ 6.141		$ -		$ 0.093		$ 1.037		$ 16.857	
Ophthalmology	$ 0.014		$ 0.209		$ 0.023		$ 0.068		$ -		$ 0.017		$ 0.036		$ 0.294	
Orthopedics	$ 5.586		$ 7.819		$ 7.045		$ 2.678		$ 0.120		$ 1.020		$ 12.751		$ 11.516	
Otolaryngology	$ 0.247		$ 1.978		$ 0.174		$ 0.701		$ 0.004		$ 0.015		$ 0.425		$ 2.695	
Psychiatry	$ 0.375		$ 1.525		$ 1.319		$ 0.747		$ -		$ 0.008		$ 1.695		$ 2.280	
Pulmonary	$ 3.594		$ 1.772		$ 7.180		$ 1.019		$ 0.001		$ 0.016		$ 10.775		$ 2.806	
Rehab													$ -		$ -	
Rheumatology	$ 0.049		$ 2.308		$ 0.162		$ 0.944		$ 0.014		$ 0.142		$ 0.224		$ 3.395	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.506		$ 0.353		$ 0.529		$ 0.129		$ 0.018		$ 0.062		$ 1.053		$ 0.544	
Urology	$ 1.149		$ 2.929		$ 1.061		$ 1.121		$ -		$ 0.027		$ 2.210		$ 4.077	
Vascular Surgery	$ 0.842		$ 0.049		$ 1.323		$ 0.147		$ 0.006		$ -		$ 2.171		$ 0.195	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 0.230				$ 0.233				$ 0.008				$ 0.472	
GRAND TOTAL	$ 35.030	$ -	$ 62.050	$ -	$ 51.636	$ -	$ 27.820	$ -	$ 0.241	$ -	$ 2.071	$ -	$ 86.908	$ -	$ 91.941	$ -

2012

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 2.470		$ 4.334		$ 6.577		$ 3.893		$ 0.022		$ 0.047		$ 9.069		$ 8.275	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.027		$ 0.213		$ 0.018		$ 0.102		$ -		$ 0.007		$ 0.045		$ 0.322	
Dermatology	$ 0.368		$ 2.411		$ 0.719		$ 1.165		$ -		$ 0.347		$ 1.086		$ 3.923	
Endocinology	$ 0.850		$ 1.699		$ 1.009		$ 1.047		$ -		$ 0.016		$ 1.859		$ 2.762	
Gastroenterology	$ 3.610		$ 5.193		$ 4.016		$ 1.970		$ 0.036		$ 0.039		$ 7.662		$ 7.201	
General Medicine	$ 2.387		$ 8.535		$ 3.254		$ 2.533		$ 0.019		$ 0.073		$ 5.660		$ 11.141	
General Surgery	$ 4.475		$ 2.745		$ 4.415		$ 0.932		$ 0.013		$ 0.057		$ 8.903		$ 3.734	
Gynecology	$ 0.492		$ 1.461		$ 0.192		$ 0.271		$ 0.001		$ 0.006		$ 0.685		$ 1.737	
Hematology	$ 0.318		$ 0.869		$ 0.428		$ 1.115		$ -		$ 0.001		$ 0.746		$ 1.984	
Infectious Disease	$ -		$ 0.000		$ 0.019		$ -		$ -		$ -		$ 0.019			
Neonatology	$ 0.966		$ 0.002		$ 0.437		$ 0.001		$ -		$ -		$ 1.403		$ 0.003	
Nephrology	$ 0.984		$ 0.788		$ 3.013		$ 0.937		$ 0.006		$ 0.014		$ 4.003		$ 1.738	
Neurology	$ 1.559		$ 2.615		$ 6.859		$ 1.223		$ 0.008		$ 0.077		$ 8.426		$ 3.915	
Neurosurgery	$ 0.206		$ 0.263		$ 0.491		$ 0.173		$ -		$ 0.049		$ 0.697		$ 0.486	
Normal Newborns	$ 0.862		$ 0.007		$ 0.726		$ 0.005		$ -		$ 0.000		$ 1.588		$ 0.012	
Obstetrics	$ 3.593		$ 1.085		$ 0.908		$ 0.190		$ 0.006		$ 0.000		$ 4.507		$ 1.276	
Oncology	$ 0.386		$ 9.491		$ 0.746		$ 7.680		$ -		$ 0.095		$ 1.132		$ 17.266	
Ophthalmology	$ 0.031		$ 0.179		$ 0.038		$ 0.098		$ -		$ 0.019		$ 0.069		$ 0.296	
Orthopedics	$ 5.414		$ 8.865		$ 7.317		$ 3.146		$ 0.145		$ 0.994		$ 12.876		$ 13.004	
Otolaryngology	$ 0.241		$ 2.114		$ 0.252		$ 0.782		$ -		$ 0.019		$ 0.493		$ 2.915	
Psychiatry	$ 0.470		$ 1.128		$ 1.391		$ 0.702		$ -		$ 0.007		$ 1.861		$ 1.836	
Pulmonary	$ 3.155		$ 1.902		$ 7.322		$ 1.183		$ 0.038		$ 0.027		$ 10.514		$ 3.112	
Rehab													$ -		$ -	
Rheumatology	$ 0.039		$ 1.971		$ 0.125		$ 1.026		$ -		$ 0.130		$ 0.163		$ 3.127	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.124		$ 0.293		$ 0.452		$ 0.146		$ -		$ 0.049		$ 0.577		$ 0.488	
Urology	$ 0.969		$ 3.185		$ 0.928		$ 1.559		$ 0.002		$ 0.018		$ 1.898		$ 4.762	
Vascular Surgery	$ 0.935		$ 0.067		$ 1.333		$ 0.108		$ -		$ -		$ 2.267		$ 0.176	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 0.001				$ 0.000				$ 0.000				$ 0.001	
GRAND TOTAL	$ 34.930	$ -	$ 61.416	$ -	$ 52.984	$ -	$ 31.987	$ -	$ 0.295	$ -	$ 2.090	$ -	$ 88.209	$ -	$ 95.493	$ -

2013

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 2.071		$ 4.213		$ 5.560		$ 4.618		$ 0.009		$ 0.031		$ 7.640		$ 8.862	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.029		$ 0.224		$ 0.022		$ 0.092		$ -		$ 0.011		$ 0.052		$ 0.326	
Dermatology	$ 0.424		$ 2.422		$ 0.458		$ 1.248		$ -		$ 0.295		$ 0.882		$ 3.966	
Endocinology	$ 0.685		$ 1.733		$ 0.824		$ 1.121		$ -		$ 0.006		$ 1.509		$ 2.859	
Gastroenterology	$ 2.812		$ 5.091		$ 3.451		$ 2.317		$ 0.000		$ 0.030		$ 6.263		$ 7.438	
General Medicine	$ 2.113		$ 8.352		$ 3.224		$ 2.666		$ 0.008		$ 0.120		$ 5.346		$ 11.138	
General Surgery	$ 3.170		$ 2.549		$ 3.803		$ 1.023		$ 0.007		$ 0.140		$ 6.979		$ 3.712	
Gynecology	$ 0.393		$ 1.498		$ 0.133		$ 0.344		$ -		$ 0.001		$ 0.526		$ 1.844	
Hematology	$ 0.200		$ 0.771		$ 0.469		$ 1.265		$ -		$ 0.001		$ 0.669		$ 2.036	
Infectious Disease	$ 0.062		$ -		$ 0.032		$ 0.001		$ -		$ -		$ 0.094		$ 0.001	
Neonatology	$ 1.049		$ 0.003		$ 0.292		$ 0.002		$ -		$ -		$ 1.341		$ 0.005	
Nephrology	$ 0.742		$ 0.757		$ 2.487		$ 1.027		$ 0.000		$ 0.005		$ 3.229		$ 1.789	
Neurology	$ 1.302		$ 2.225		$ 6.101		$ 1.319		$ 0.020		$ 0.079		$ 7.423		$ 3.624	
Neurosurgery	$ 0.182		$ 0.199		$ 0.116		$ 0.104		$ -		$ 0.027		$ 0.299		$ 0.330	
Normal Newborns	$ 0.876		$ 0.006		$ 0.564		$ 0.002		$ 0.002		$ -		$ 1.442		$ 0.008	
Obstetrics	$ 3.748		$ 1.063		$ 0.637		$ 0.154		$ 0.008		$ 0.001		$ 4.393		$ 1.218	
Oncology	$ 0.566		$ 8.808		$ 0.600		$ 7.319		$ 0.005		$ 0.036		$ 1.171		$ 16.164	
Ophthalmology	$ 0.020		$ 0.190		$ 0.013		$ 0.090		$ -		$ 0.019		$ 0.033		$ 0.299	
Orthopedics	$ 5.855		$ 8.428		$ 7.671		$ 3.715		$ 0.222		$ 0.932		$ 13.748		$ 13.075	
Otolaryngology	$ 0.192		$ 2.146		$ 0.223		$ 0.884		$ -		$ 0.018		$ 0.416		$ 3.048	
Psychiatry	$ 0.314		$ 1.101		$ 1.959		$ 0.756		$ -		$ 0.006		$ 2.273		$ 1.863	
Pulmonary	$ 2.957		$ 1.706		$ 7.506		$ 1.282		$ 0.018		$ 0.033		$ 10.481		$ 3.021	
Rehab													$ -		$ -	
Rheumatology	$ 0.063		$ 1.918		$ 0.084		$ 1.077		$ -		$ 0.120		$ 0.147		$ 3.115	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.741		$ 0.307		$ 0.269		$ 0.176		$ 0.010		$ 0.050		$ 1.020		$ 0.533	
Urology	$ 0.880		$ 2.858		$ 0.788		$ 1.475		$ -		$ 0.003		$ 1.667		$ 4.337	
Vascular Surgery	$ 0.624		$ 0.051		$ 1.659		$ 0.071		$ -		$ -		$ 2.283		$ 0.121	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ -				$ -				$ -				$ -	
GRAND TOTAL	$ 32.071	$ -	$ 58.618	$ -	$ 48.944	$ -	$ 34.150	$ -	$ 0.309	$ -	$ 1.965	$ -	$ 81.324	$ -	$ 94.732	$ -

Beth Israel Deaconess Hospital
Plymouth

275 Sandwich Street
Plymouth, MA 02360
(508) 746-2000 Phone
(508) 830-1131 Fax
bidplymouth.org

Submitted Electronically via HPC-Testimony@state.ma.us

September 15, 2014

Dear Ms. Johnson and Ms. Mercer,

Enclosed please find the responses of Beth Israel Deaconess Hospital-Plymouth, Inc. to the written testimony requested by the Health Policy Commission and found in Exhibit B and Exhibit C in a letter from Executive Director David Seltz to Mr. Peter Holden on August 1, 2014.

Please note that I am empowered to represent Beth Israel Deaconess Hospital-Plymouth, Inc. for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please do not hesitate to contact me if you have any additional follow-up questions or Jason Radzevich in my office at jradzevich@bidplymouth.org or 508-830-2005.

Very truly yours,

Peter J. Holden
President & CEO

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

[Remainder of page intentionally left blank]

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: stateBID-Plymouth (formerly Jordan Health System and Jordan Hospital) continues to work arduously to control cost while maintaining high quality care for our patients. Key to achievement of this goal in the periods CY2012 - CY2014 has been creation of the Jordan Community ACO and the merger with BIDMC effective January 1, 2014.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      During the period CY 2010-CY2013, BID-Plymouth experienced a cumulative decline in inpatient admissions of 27%. Reductions in inpatient utilization are attributable to ongoing efforts to reduce unnecessary admissions and readmissions, and increase in patients assigned observation level-of-care, and conversion of certain services from inpatient to outpatient sites of service. Two-thirds of this is decline is comprised of short-stay cases (1 and 2 day stays). Casemix of hospitalized patients has increased by 19%. Outpatient utilization during the same period has increased.
   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 April 2012, BID-Plymouth (then Jordan Hospital) has been a participant in Jordan Community ACO (JCACO), a Medicare Shared Savings Program Accountable Care Organization. Through this initiative, PBMA, a large primary care physician practice, partnering with the hospital and soliciting specialty physician involvement, has fostered meaningful care integration for the first time in Plymouth County. Through effective care management and enhanced clinical attention, JCACO has achieved dramatic results in the community of patients attributed to the ACO: 20% reduction in hospital utilization, 30% reduction in SNF cost, improved management of complex populations for approximately 100 patients with the highest risk profiles, reduction in costs of almost $2.3 million, 100% completion of the CMS quality goals.

      See Appendix for complete response.

   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?
Participation in BIDCO affords us the opportunity to further the efforts begun with JCACO. Further, one of the large independent physician groups in our service area, Plymouth Medical Group, recently joined BIDCO. With this, approximately two-thirds of the physician provider community in Plymouth is now a member of BIDCO. Specifically, we will work with BIDCO to assess and participate in innovative alternative payment models and to engage our provider partners to adopt practice patterns that focus on ensuring patients receive the right care, in the right place, and at the right time.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Policies and regulations that promote administrative simplication and standardization would significantly improve our ability to operate more efficiently. Variation among payers and frequent changes in billing/payment rules, quality/safety measures and the timing/format of reporting requirements necessitates dedicated staff and internal procedures in the areas of patient registration, patient accounts, medical records coding and review, case management, quality review and analysis, and managed care contracting and analysis. Administrative simplication will enable us to redirect resources from simply meeting the demands of the payers to making meaningful improvements in the quality and delivery of care to our patients, families and community.

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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: To date, BID-Plymouth has had limited experience with other than fee-for-service payment models. At present, all contracts with health plans are fee-for-service arrangements, some of which include P4P incentives.
    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?
    For a limited time, BID-Plymouth participated in two APMs with Tufts - a lab capitation arrangement and a risk-based Medicare managed care contract. The lab cap arrangment applied to a limited number of covered lives and the revenue involved was not material. The hospital discontinued this arrangment in 2013. Similarly, a very low number of lives were covered lives under the Medicare risk plan. Several high cost patients resulted in significant losses. The hospital terminated its participation in this arrangement in 2013.
    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).
    Not applicable

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.
Not applicable

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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: BID-Plymouth does not currently have any risk or other APM contracts with payers.
   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?
   Not applicable
   b. How do the health status risk adjustment measures used by different payers compare?
   Not applicable
   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?
   Not applicable

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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: To effectively manage performance under APMs, hospitals need timely and patient-level data from the health plans.
ANSWER: Hospitals are handicapped in that their only ready access to patient utilization is limited to services provided at their own facility or by employed physicians. Health plans have repositories of member utilization data that must be shared with providers to effectively promote management of population health and health services utilization. Our experience to date is that plans provide no data or limited data, and that data is always lagged by at least three to six months, rendering it non-actionable.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: BID-Plymouth endorses the C.224 requirement to attribute members to a primary care provider and encourage standardization of attribution methodologies across all payers. We urge enforcement of this requirement, as well as of the requirement that plans share with providers data on attributed patients.

a. Which attribution methodologies most accurately account for patients you care for?
The most accurate methodology would be one that allows for patient selection of a primary care provider. Our experience with specific attribution methodologies is limited to CMS's attribution logic for the JCACO. Because Medicare does not require members to select a PCP, we are subject to the CMS attribution model that defaults to the provider who provides the multitude of E&M services. This could be a PCP or a specialist.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
We promote a requirement that health plan members select a primary care physician and that attribution is based on PCP. At a minimum, attribution methodologies should be common across health plans to ensure standardization and ease provider management of risk arrangements.

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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: Data abstraction performed by skilled clinical resources requires a significant time commitment. This commitment is exacerbated by the variation in quality metrics and reporting formats across payers.
ANSWER: Variation persists across payers in both how quality metrics are defined and in report format requirements. If metrics are not commonly defined, additional resources must be devoted to data abstraction. Further, reporting of data internally becomes a challenge when data are collected differently for various parties yet are labeled the same, e.g., CMS, PEPPER, and other payers each has a unique metric for "Readmission". Even when metrics are commonly defined, each payer has a different process for reporting, both in timing and format. CMS, Blue Cross and MassHealth have different reporting processes. Of these, Masshealth is the most burdonsome. BID-Plymouth is in the process of implementing a new quality database (Datavision) to help alleviate some of the manual effort required to report quality measures to public and private payers. Datavision is one of very few vendors that supports MassHealth.

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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: BID-Plymouth has long been a low cost community provider, and with our recent merger with BIDMC we join a network of some of the very lowest cost hospitals in Massachusetts. Through this affiliation, BIDMC is helping to augment our clinical capabilities in both specialty and primary care; recruit physicians to our community; support and collaborate on quality programs and initiatives. Also through this affiliation, we participate in BIDCO, which aligns community doctors with their local community hospitals, and fosters maximum utilization and retention of care in the community.
    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.

As noted in response to 1(a), BID-Plymouth has experienced dramatic reductions in inpatient utilization over the past four years. The flow of patients from BID-Plymouth has slowed considerably reflecting our efforts to care for patients in a local community setting whenever clinically appropriate. Med/Surg transfers from our emergency department are actively managed to ensure that only those cases that cannot be treated locally are transferred to an AMC. These are now limited to trauma, highly complex cases requiring specialty care not locally available, and pediatric inpatient care. From CY2010 to CYTD2014, total transfers from our emergency department to another acute care facility have decreased by 34%. Similary, transfers of inpatients to an AMC have declined by 41% during the same time period.

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.

Every transfer from our emergency department is reviewed by a physician for appropriateness and to identify and address reasons for transfers that could have been avoided. When a patient does require tertiary care, whether from the emergency room or from an inpatient setting, every effort is made to transfer the case to our AMC-partner, BIDMC. Our merger with BIDMC was based on our mutual desire to reduce medical spending and trends by delivering the right care in the most appropriate setting - providing high-quality care in a community setting with access to world-class tertiary care. As a percent of total, emergency department transfers to BIDMC have increased from 15% of all acute care transfers in 2010 to 56% in 2014, while transfers to more expensive Partners hospitals has declined from 30% in 2010 to 15%, respectively. Similarly, transfers of inpatient cases to BIDMC have increased from 18% of total inpatient transfers in 2010 to 65% in 2014, while inpatient transfers to Partners hospitals have declined from 16% to 12% during the same period.

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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: BID-Plymouth agrees that management of post-acute care utilization represents a significant opportunity for both cost reduction and improved patient outcomes.

   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.

   Available data to BID-Plymouth is limited to a record of discharge disposition. Health plans have data about post-acute utilization, i.e., days of post-acute care, which is not typically shared with hospital providers. Our data show that in the period CY2010 to CYTD2014, discharges to a SNF or Rehab facility have

remained stable at approximately 20% of total discharges. The majority of these inpatients were admitted from a post-acute facility and are simply being discharged back to the facility from whence they came.

For the cohort of 6200 lives covered under JCACO, performance shows a 30% reduction in SNF cost, suggesting that for this small population, admissions to a SNF and/or days stay in a SNF has declined. It is not possible for the hospital to independently analyze the contributing factors without more specific data from Medicare.

b. How does your organization ensure optimal use of post-acute care?
Case management staff begin discharge planning on the day of patient admission to the hospital. For every inpatient, daily assessments are made to determine the optimal level of post-acute care. Case management confers with the patient, family and providers in developing the post-acute plan of care. In addition, BID-P participates in the STARR group, working directly with area SNFs to reduce the incidence of hospital readmissions after a patient has been discharged to a SNF. One opportunity for improvement may lie in modifications to inpatient rehabilitation practices whereby the level of rehab a patient receives during the inpatient stay is increased with a goal of decreasing reliance on post-acute rehab care after discharge from the hospital.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: BID-Plymouth has established a policy and procedure to address the needs of consumers/patients who seek pricing information. While we have made progress in establishing systems and processes in this area, additional work is needed to complete a website, and to improve our ability to follow up on patient satisfaction with this service.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**	0	25	24h
	Q2	0	37	24h
	Q3	0	15	24h

	TOTAL:	0	77	

** Please indicate the unit of time reported.*

ANSWER: Patients make price inquiries either via telephone or direct meeting with a patient financial counselor. All such inquiries are forwarded to Patient Accounts where each is logged. Information captured in the log includes: Date of inquiry, Point of initial contact (e.g. financial counselor, department manager, patient accounts), Patient name (if provided), Procedure, Payer, Pricing provided, Name of individual who prepare pricing, Mode of communication (written Y/N), and Comments. Pricing is estimated by specialist in the Patient Accounts department using a tool in our contract management system

The top ten procedures for which pricing inquiries have been made are:
1. Routine Mammography
2. Diagnostic Mammography
3. Breast Ultrasound
4. MRI
5. CT Scan
6. Bone Density
7. Inpatient Obstetrical Delivery
8. Colonoscopy
9. Clinic E&M visit
10. X-Ray

Patients generally tell us they want a ballpark estimate to determine approximately what they will owe and/or to compare pricing with other facilities (Shields MRI etc.)

To date, we have not conducted any assessment regarding the accuracy or value of this pricing information. Our ability to do so is hindered by a lack of sufficient resources to follow up with individual patients to determine if they actually came in for services and/or whether they found the pricing information helpful. Also, some patients do not provide contact information, making it impossible for us to reach them subsequent to their initial inquiry.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: To date, tiered and limited network products have had neglible impact on contracting and/or referral practices.
ANSWER: While the hospital does contract with plans that offer tiered or limited network products, volume from patients with those insurance plans is very low. As a result, the impact on contracting and referral practices is neglible. BID-Plymouth has taken no action specifically in response to tier placement. We continuously strive to delivery high quality care and the lowest cost possible.

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: We strongly agree with the Commission that the integration of physical and behavioral health care is critical to caring for patients and managing healthcare costs. BID-Plymouth (BIDP) is working on several initiatives to address the social and medical needs of our high-risk patients through our complex patient program (CPP) and the Integrated Care Initiative (ICI).
    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.
    We have taken numerous steps toward integration over the past year. Through funding provided by the 2013 Increased Capacity Building and Infrastructure (ICB) grant and monies from CHART 1, BIDP staff have been able to successfully expand and implement the Jordan Community Accountable Care Organization (JCACO)'s care management and clinical initiatives, including the CPP for dual eligible patients and the ICI for behavioral health patients. These projects have allowed BIDP to develop a unique, high value, and cost effective approach to managing complex patients. The CPP is part of the BIDP CARES program where staff Connect, Assess, Respond, Educate and Support patients with complex needs across the care continuum.

    See Appendix for complete response.
    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.
    In 2012, the Hospital established the Community Case Management/Complex Patient Program. This initiative is focused on providing care management services to complex, chronically ill Medicare patients. Over the last year, JCACO provided assessment and care management interventions to over 1,100 patients, 665 of which were complex. This program is designed to ensure safe transitions across the care continuum and facilitate access to quality care and proper coordination of health care services. Interventions include, but are not limited to the following: follow-up with primary care physicians; home or clinic visits; transportation; health literacy education/patient empowerment; and medication adherence.

    See Appendix for complete response.

    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.
    The dominant challenge to integrating services has been access to behavioral health services and resources. Without additional reimbursement for behavioral

health services, we will struggle to truly manage the care of our patients. We are hopeful that we will be able to expand our pilot program, made possible through CHART1 funding, by being approved as recipients of CHART2 funding. This, in addition to donations from private funders will help expand to other populations, the integrated care that we have begun in our pilot program.

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.
   BID-Plymouth is most willing to work with the Health Policy Commission to identify ways to adequately capture and report data relative to this unique patient population. Accurate identication of this cohort of the population is often challenging because of the myriad contributing factors to their admission and care. In many cases, psycho-social factors are not the primary cause for admission, but rather present as underlying issues that demand attention during an inpatient stay.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY: To date, BID-Plymouth has not developed a PCMH model.
    e. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
       Not applicable
    f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
       Not applicable
    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.
       Not applicable

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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: Please see response provided by BIDCO
    ANSWER:

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

   Enclosed, please find BID-Plymouth revenue by calendar year and by health plan. At this time, we have not included the level of detail specifically requested because of the lack of standardized approaches, methodology or definitions with regard to the data points requested; the highly proprietary nature of this information; the strong likelihood of significant variation across provider organizations in reporting this data; and concerns regarding the ultimate reliability, accuracy, and value of the data to the public, given the limitations and concerns described above. BID-Plymouth remains committed to transparency, and welcomes the opportunity to work with the HPC and the AGO to provide appropriate safeguards for proprietary information and to ensure that information provided addresses the purpose of its collection.

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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

   Enclosed, please find BID-Plymouth revenue and margin information. At this time, we have not included the level of detail specifically requested because of the lack of standardized approaches, methodology or definitions with regard to the data points requested; the highly proprietary nature of this information; the strong likelihood of significant variation across provider organizations in reporting this data; and concerns regarding the ultimate reliability, accuracy, and value of the data to the public, given the limitations and concerns described above. BID-Plymouth remains committed to transparency, and welcomes the opportunity to work with the HPC and the AGO to provide appropriate safeguards for proprietary information and to ensure that information provided addresses the purpose of its collection.

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.

   Not applicable

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.

   Inpatient volume grouped by each of four major physician groups is tracked on a monthly basis. Data regarding outpatient referrals is aggregated periodically to monitor those trends. This information is used for purposes of monitoring trends, establishing annual budgets, analyzing budget variances and for strategic financial planning initiatives.

Beth Israel Deaconess Plymouth

Appendix to 8/1/2014 HPC and AGO Request

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%.

a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

Response to Question 1(a) continued from template.

From 2010-2013, operating patient service revenue has declined by 2%, while operating expenses have increased by a 2%. These trends have continued in 2014, with a year-to-date decrease in inpatient admissions of 3%, a decrease in patient service revenue of 2%, and an increase in operating expenses of 1%.

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?.

Response to Question 1(b) continued from template.

Since January 2013, 10 new practices have been added to the hospital's primary care network, which will go a long way to promoting efforts to care for patients in our own community – providing the right care, in the right place and at the right time. On January 1, 2014, BIDMC became the sole corporate member of Jordan Health Systems and Jordan Hospital. Jordan Hospital was renamed Beth Israel Deaconess Hospital (BID-Plymouth). Through this affiliation, BIDMC is making strategic investments to support continued expansion of the BID-Plymouth primary care network and clinical capabilities.

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.

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.

Response to Question 1(a) continued from template.

Our focus on complex Medicare patients, and recently as part of CHART 1, the dual eligible and behavioral health populations, has proven to be successful – increasing access to services and decreasing readmissions by 25%. Additionally, these efforts have led to the establishment of the first integrated behavioral health and primary care practice pilot in the community.

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.

Response to Question 1(b) continued from template.

Ongoing communication with aftercare facilities and home health agencies has been crucial to the successful management of this population. Based on initial cost estimates it appears, JCACO program initiatives have potentially saved over $2.3 million by reducing unnecessary readmissions and emergency department visits, shortening lengths of stay and dissipating the effects of co-morbidities.

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	
Blue Cross Blue Shield	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		25,299,489	20,181,878		1
Tufts Health Plan													6,304,133	2,935,342		2
Harvard Pilgrim Health Care													10,491,743	4,420,193		3
Fallon Community Health Plan															380,913	4
CIGNA															1,307,178	5
United Healthcare															3,107,109	6
Aetna													1,057,314	1,961,617		7
Other Commercial															5,671,511	8
Total Commercial													43,152,679	29,499,030	10,466,711	9
Network Health	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				599,557	10
Neighborhood Health Plan															1,468,128	11
BMC HealthNet, Inc.															4,086,850	12
Health New England																13
Fallon Community Health Plan															10,992	14
Other Managed Medicaid															70,694	15
Total Managed Medicaid													0	0	6,236,221	16
MassHealth	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				7,425,491	17
Tufts Medicare Preferred	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		4,011,509	218,370	41,970	18
Blue Cross Senior Options													460,269			19
Other Comm Medicare															1,905,759	20
Commercial Medicare Subtotal													4,471,778	218,370	1,947,729	21
Medicare	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				68,267,335	22
Other	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				5,305,208	23
GRAND TOTAL	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		47,624,457	29,717,400	99,648,695	24

176,990,552
176,990,552
0

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	
Blue Cross Blue Shield	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		22,961,002	20,094,263		1
Tufts Health Plan													5,880,147	3,459,775		2
Harvard Pilgrim Health Care													11,430,468	5,378,945		3
Fallon Community Health Plan															241,036	4
CIGNA															1,497,044	5
United Healthcare															3,886,675	6
Aetna													1,897,366	564,570		7
Other Commercial															5,041,949	8
Total Commercial													42,168,983	29,497,553	10,666,704	9
Network Health	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				1,468,268	10
Neighborhood Health Plan															1,700,758	11
BMC HealthNet, Inc.															4,118,194	12
Health New England																13
Fallon Community Health Plan															4,142	14
Other Managed Medicaid															198,432	15
Total Managed Medicaid													0	0	7,489,794	16
MassHealth	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				6,561,602	17
Tufts Medicare Preferred	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		4,243,148			18
Blue Cross Senior Options													698,763			19
Other Comm Medicare															1,191,524	20
Commercial Medicare Subtotal													4,941,911	0	1,191,524	21
Medicare	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				71,203,484	22
Other	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				5,126,565	23
GRAND TOTAL	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		47,110,894	29,497,553	102,239,673	24

178,848,120
178,848,119
1

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	
Blue Cross Blue Shield													22,503,312	20,090,039		1
Tufts Health Plan													5,620,834	3,284,551		2
Harvard Pilgrim Health Care													11,097,523	4,817,088		3
Fallon Community Health Plan	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				340,097	4
CIGNA															1,128,071	5
United Healthcare															3,647,322	6
Aetna													2,320,599	286,671		7
Other Commercial															5,128,672	8
Total Commercial													41,542,268	28,478,349	10,244,162	9
Network Health															2,340,180	10
Neighborhood Health Plan															1,522,720	11
BMC HealthNet, Inc.															3,624,319	12
Health New England	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"					13
Fallon Community Health Plan															8,935	14
Other Managed Medicaid															318,935	15
Total Managed Medicaid													0	0	7,815,089	16
MassHealth	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				7,708,211	17
Tufts Medicare Preferred													4,703,288			18
Blue Cross Senior Options	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		1,436,026			19
Other Comm Medicare															1,139,880	20
Commercial Medicare Subtotal													6,139,314	0	1,139,880	21
Medicare	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				75,494,303	22
Other	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				5,140,113	23
GRAND TOTAL	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		47,681,582	28,478,349	107,541,758	24

183,701,689
183,701,690
-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	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		20,456,970	19,752,128		1
Tufts Health Plan													4,767,592	4,058,253		2
Harvard Pilgrim Health Care													9,801,318	4,504,928		3
Fallon Community Health Plan															688,341	4
CIGNA															1,058,308	5
United Healthcare															3,243,965	6
Aetna													2,227,565	350,423		7
Other Commercial															4,687,950	8
Total Commercial													37,253,445	28,665,732	9,678,564	9
Network Health	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				2,927,530	10
Neighborhood Health Plan															1,262,170	11
BMC HealthNet, Inc.															2,856,587	12
Health New England																13
Fallon Community Health Plan															2,654	14
Other Managed Medicaid															129,621	15
Total Managed Medicaid													0	0	7,178,562	16
MassHealth	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				6,978,840	17
Tufts Medicare Preferred	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		4,956,281	2,154		18
Blue Cross Senior Options													1,044,205			19
Other Comm Medicare															1,366,911	20
Commercial Medicare Subtotal													6,000,486	2,154	1,366,911	21
Medicare	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				74,322,197	22
Other	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"				4,609,288	23
GRAND TOTAL	Included in "Other Revenue"				NOT APPLICABLE						See "Other Revenue"		43,253,931	28,667,886	104,134,362	24

176,056,179
176,056,180
-1

2010

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 3.052		$ 4.503		$ 6.752		$ 3.257		$ 0.035		$ 0.041		$ 9.839		$ 7.802	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.047		$ 0.231		$ 0.018		$ 0.103		$ -		$ 0.004		$ 0.065		$ 0.339	
Dermatology	$ 0.499		$ 2.655		$ 0.739		$ 0.992		$ 0.018		$ 0.285		$ 1.257		$ 3.932	
Endocinology	$ 0.781		$ 2.268		$ 1.083		$ 0.819		$ 0.000		$ 0.007		$ 1.864		$ 3.095	
Gastroenterology	$ 3.712		$ 7.282		$ 3.947		$ 2.137		$ 0.004		$ 0.058		$ 7.662		$ 9.477	
General Medicine	$ 1.870		$ 7.135		$ 3.157		$ 1.704		$ 0.002		$ 0.062		$ 5.029		$ 8.900	
General Surgery	$ 4.514		$ 2.432		$ 3.566		$ 0.820		$ 0.040		$ 0.126		$ 8.120		$ 3.378	
Gynecology	$ 0.654		$ 1.713		$ 0.184		$ 0.250		$ 0.006		$ 0.005		$ 0.844		$ 1.968	
Hematology	$ 0.369		$ 1.139		$ 0.611		$ 1.164		$ 0.003		$ 0.002		$ 0.982		$ 2.305	
Infectious Disease	$ 0.006		$ 0.001		$ 0.037		$ 0.001		$ -		$ -		$ 0.043		$ 0.002	
Neonatology	$ 0.919		$ 0.005		$ 0.321		$ 0.001		$ 0.023		$ -		$ 1.263		$ 0.006	
Nephrology	$ 0.638		$ 1.022		$ 3.027		$ 1.066		$ 0.009		$ 0.017		$ 3.675		$ 2.104	
Neurology	$ 1.496		$ 2.770		$ 6.510		$ 0.997		$ -		$ 0.055		$ 8.006		$ 3.822	
Neurosurgery	$ 0.056		$ 0.254		$ 0.144		$ 0.109		$ -		$ 0.016		$ 0.200		$ 0.379	
Normal Newborns	$ 0.786		$ 0.008		$ 0.412		$ 0.002		$ -		$ -		$ 1.198		$ 0.010	
Obstetrics	$ 2.913		$ 0.725		$ 0.551		$ 0.123		$ -		$ 0.003		$ 3.464		$ 0.851	
Oncology	$ 0.268		$ 8.905		$ 0.660		$ 5.555		$ -		$ 0.004		$ 0.928		$ 14.465	
Ophthalmology	$ 0.031		$ 0.207		$ 0.023		$ 0.068		$ -		$ 0.021		$ 0.054		$ 0.296	
Orthopedics	$ 5.583		$ 8.049		$ 6.668		$ 2.650		$ 0.258		$ 0.880		$ 12.510		$ 11.580	
Otolaryngology	$ 0.271		$ 2.233		$ 0.323		$ 0.716		$ -		$ 0.025		$ 0.594		$ 2.974	
Psychiatry	$ 0.814		$ 1.381		$ 1.462		$ 0.729		$ 0.012		$ 0.009		$ 2.289		$ 2.120	
Pulmonary	$ 3.265		$ 1.861		$ 7.367		$ 0.987		$ 0.006		$ 0.014		$ 10.638		$ 2.862	
Rehab													$ -		$ -	
Rheumatology	$ 0.040		$ 2.371		$ 0.121		$ 1.088		$ -		$ 0.162		$ 0.160		$ 3.621	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.349		$ 0.489		$ 0.690		$ 0.150		$ 0.007		$ 0.075		$ 1.045		$ 0.714	
Urology	$ 1.044		$ 3.052		$ 1.066		$ 1.077		$ -		$ 0.011		$ 2.109		$ 4.140	
Vascular Surgery	$ 0.406		$ 0.088		$ 1.021		$ 0.091		$ -		$ -		$ 1.428		$ 0.179	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 0.213				$ 0.180				$ 0.012				$ 0.406	
GRAND TOTAL	$ 34.384	$ -	$ 62.994	$ -	$ 50.459	$ -	$ 26.836	$ -	$ 0.423	$ -	$ 1.894	$ -	$ 85.266	$ -	$ 91.724	$ -

2011

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 2.944		$ 4.140		$ 6.720		$ 3.606		$ 0.008		$ 0.065		$ 9.673		$ 7.811	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.020		$ 0.202		$ 0.052		$ 0.112		$ -		$ 0.005		$ 0.072		$ 0.319	
Dermatology	$ 0.473		$ 2.529		$ 0.723		$ 0.974		$ 0.010		$ 0.321		$ 1.205		$ 3.824	
Endocinology	$ 0.629		$ 2.070		$ 1.002		$ 0.971		$ 0.001		$ 0.022		$ 1.632		$ 3.063	
Gastroenterology	$ 3.580		$ 5.994		$ 4.036		$ 2.056		$ 0.005		$ 0.036		$ 7.621		$ 8.086	
General Medicine	$ 2.135		$ 7.984		$ 3.805		$ 1.995		$ 0.001		$ 0.074		$ 5.942		$ 10.054	
General Surgery	$ 4.319		$ 2.525		$ 3.899		$ 0.778		$ 0.005		$ 0.043		$ 8.222		$ 3.346	
Gynecology	$ 0.616		$ 1.466		$ 0.178		$ 0.257		$ 0.013		$ 0.003		$ 0.808		$ 1.726	
Hematology	$ 0.354		$ 0.968		$ 0.517		$ 1.122		$ -		$ 0.001		$ 0.871		$ 2.090	
Infectious Disease	$ 0.005		$ 0.000		$ 0.034		$ 0.001		$ -		$ -		$ 0.039		$ 0.001	
Neonatology	$ 0.955		$ 0.003		$ 0.270		$ 0.002		$ -		$ -		$ 1.225		$ 0.005	
Nephrology	$ 0.846		$ 0.843		$ 2.752		$ 0.883		$ 0.020		$ 0.012		$ 3.618		$ 1.739	
Neurology	$ 1.306		$ 2.525		$ 6.869		$ 0.917		$ 0.004		$ 0.075		$ 8.179		$ 3.517	
Neurosurgery	$ 0.183		$ 0.148		$ 0.229		$ 0.089		$ -		$ -		$ 0.412		$ 0.238	
Normal Newborns	$ 0.834		$ 0.008		$ 0.479		$ 0.003		$ 0.002		$ 0.000		$ 1.314		$ 0.011	
Obstetrics	$ 3.100		$ 0.850		$ 0.590		$ 0.128		$ 0.009		$ 0.003		$ 3.699		$ 0.981	
Oncology	$ 0.369		$ 10.623		$ 0.668		$ 6.141		$ -		$ 0.093		$ 1.037		$ 16.857	
Ophthalmology	$ 0.014		$ 0.209		$ 0.023		$ 0.068		$ -		$ 0.017		$ 0.036		$ 0.294	
Orthopedics	$ 5.586		$ 7.819		$ 7.045		$ 2.678		$ 0.120		$ 1.020		$ 12.751		$ 11.516	
Otolaryngology	$ 0.247		$ 1.978		$ 0.174		$ 0.701		$ 0.004		$ 0.015		$ 0.425		$ 2.695	
Psychiatry	$ 0.375		$ 1.525		$ 1.319		$ 0.747		$ -		$ 0.008		$ 1.695		$ 2.280	
Pulmonary	$ 3.594		$ 1.772		$ 7.180		$ 1.019		$ 0.001		$ 0.016		$ 10.775		$ 2.806	
Rehab													$ -		$ -	
Rheumatology	$ 0.049		$ 2.308		$ 0.162		$ 0.944		$ 0.014		$ 0.142		$ 0.224		$ 3.395	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.506		$ 0.353		$ 0.529		$ 0.129		$ 0.018		$ 0.062		$ 1.053		$ 0.544	
Urology	$ 1.149		$ 2.929		$ 1.061		$ 1.121		$ -		$ 0.027		$ 2.210		$ 4.077	
Vascular Surgery	$ 0.842		$ 0.049		$ 1.323		$ 0.147		$ 0.006		$ -		$ 2.171		$ 0.195	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 0.230				$ 0.233				$ 0.008				$ 0.472	
GRAND TOTAL	$ 35.030	$ -	$ 62.050	$ -	$ 51.636	$ -	$ 27.820	$ -	$ 0.241	$ -	$ 2.071	$ -	$ 86.908	$ -	$ 91.941	$ -

2012

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 2.470		$ 4.334		$ 6.577		$ 3.893		$ 0.022		$ 0.047		$ 9.069		$ 8.275	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.027		$ 0.213		$ 0.018		$ 0.102		$ -		$ 0.007		$ 0.045		$ 0.322	
Dermatology	$ 0.368		$ 2.411		$ 0.719		$ 1.165		$ -		$ 0.347		$ 1.086		$ 3.923	
Endocinology	$ 0.850		$ 1.699		$ 1.009		$ 1.047		$ -		$ 0.016		$ 1.859		$ 2.762	
Gastroenterology	$ 3.610		$ 5.193		$ 4.016		$ 1.970		$ 0.036		$ 0.039		$ 7.662		$ 7.201	
General Medicine	$ 2.387		$ 8.535		$ 3.254		$ 2.533		$ 0.019		$ 0.073		$ 5.660		$ 11.141	
General Surgery	$ 4.475		$ 2.745		$ 4.415		$ 0.932		$ 0.013		$ 0.057		$ 8.903		$ 3.734	
Gynecology	$ 0.492		$ 1.461		$ 0.192		$ 0.271		$ 0.001		$ 0.006		$ 0.685		$ 1.737	
Hematology	$ 0.318		$ 0.869		$ 0.428		$ 1.115		$ -		$ 0.001		$ 0.746		$ 1.984	
Infectious Disease	$ -		$ 0.000		$ 0.019		$ -		$ -		$ -		$ 0.019			
Neonatology	$ 0.966		$ 0.002		$ 0.437		$ 0.001		$ -		$ -		$ 1.403		$ 0.003	
Nephrology	$ 0.984		$ 0.788		$ 3.013		$ 0.937		$ 0.006		$ 0.014		$ 4.003		$ 1.738	
Neurology	$ 1.559		$ 2.615		$ 6.859		$ 1.223		$ 0.008		$ 0.077		$ 8.426		$ 3.915	
Neurosurgery	$ 0.206		$ 0.263		$ 0.491		$ 0.173		$ -		$ 0.049		$ 0.697		$ 0.486	
Normal Newborns	$ 0.862		$ 0.007		$ 0.726		$ 0.005		$ -		$ 0.000		$ 1.588		$ 0.012	
Obstetrics	$ 3.593		$ 1.085		$ 0.908		$ 0.190		$ 0.006		$ 0.000		$ 4.507		$ 1.276	
Oncology	$ 0.386		$ 9.491		$ 0.746		$ 7.680		$ -		$ 0.095		$ 1.132		$ 17.266	
Ophthalmology	$ 0.031		$ 0.179		$ 0.038		$ 0.098		$ -		$ 0.019		$ 0.069		$ 0.296	
Orthopedics	$ 5.414		$ 8.865		$ 7.317		$ 3.146		$ 0.145		$ 0.994		$ 12.876		$ 13.004	
Otolaryngology	$ 0.241		$ 2.114		$ 0.252		$ 0.782		$ -		$ 0.019		$ 0.493		$ 2.915	
Psychiatry	$ 0.470		$ 1.128		$ 1.391		$ 0.702		$ -		$ 0.007		$ 1.861		$ 1.836	
Pulmonary	$ 3.155		$ 1.902		$ 7.322		$ 1.183		$ 0.038		$ 0.027		$ 10.514		$ 3.112	
Rehab													$ -		$ -	
Rheumatology	$ 0.039		$ 1.971		$ 0.125		$ 1.026		$ -		$ 0.130		$ 0.163		$ 3.127	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.124		$ 0.293		$ 0.452		$ 0.146		$ -		$ 0.049		$ 0.577		$ 0.488	
Urology	$ 0.969		$ 3.185		$ 0.928		$ 1.559		$ 0.002		$ 0.018		$ 1.898		$ 4.762	
Vascular Surgery	$ 0.935		$ 0.067		$ 1.333		$ 0.108		$ -		$ -		$ 2.267		$ 0.176	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 0.001				$ 0.000				$ 0.000				$ 0.001	
GRAND TOTAL	$ 34.930	$ -	$ 61.416	$ -	$ 52.984	$ -	$ 31.987	$ -	$ 0.295	$ -	$ 2.090	$ -	$ 88.209	$ -	$ 95.493	$ -

2013

$ in millions	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns													$ -		$ -	
Cardiology Total	$ 2.071		$ 4.213		$ 5.560		$ 4.618		$ 0.009		$ 0.031		$ 7.640		$ 8.862	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery													$ -		$ -	
Dental	$ 0.029		$ 0.224		$ 0.022		$ 0.092		$ -		$ 0.011		$ 0.052		$ 0.326	
Dermatology	$ 0.424		$ 2.422		$ 0.458		$ 1.248		$ -		$ 0.295		$ 0.882		$ 3.966	
Endocinology	$ 0.685		$ 1.733		$ 0.824		$ 1.121		$ -		$ 0.006		$ 1.509		$ 2.859	
Gastroenterology	$ 2.812		$ 5.091		$ 3.451		$ 2.317		$ 0.000		$ 0.030		$ 6.263		$ 7.438	
General Medicine	$ 2.113		$ 8.352		$ 3.224		$ 2.666		$ 0.008		$ 0.120		$ 5.346		$ 11.138	
General Surgery	$ 3.170		$ 2.549		$ 3.803		$ 1.023		$ 0.007		$ 0.140		$ 6.979		$ 3.712	
Gynecology	$ 0.393		$ 1.498		$ 0.133		$ 0.344		$ -		$ 0.001		$ 0.526		$ 1.844	
Hematology	$ 0.200		$ 0.771		$ 0.469		$ 1.265		$ -		$ 0.001		$ 0.669		$ 2.036	
Infectious Disease	$ 0.062		$ -		$ 0.032		$ 0.001		$ -		$ -		$ 0.094		$ 0.001	
Neonatology	$ 1.049		$ 0.003		$ 0.292		$ 0.002		$ -		$ -		$ 1.341		$ 0.005	
Nephrology	$ 0.742		$ 0.757		$ 2.487		$ 1.027		$ 0.000		$ 0.005		$ 3.229		$ 1.789	
Neurology	$ 1.302		$ 2.225		$ 6.101		$ 1.319		$ 0.020		$ 0.079		$ 7.423		$ 3.624	
Neurosurgery	$ 0.182		$ 0.199		$ 0.116		$ 0.104		$ -		$ 0.027		$ 0.299		$ 0.330	
Normal Newborns	$ 0.876		$ 0.006		$ 0.564		$ 0.002		$ 0.002		$ -		$ 1.442		$ 0.008	
Obstetrics	$ 3.748		$ 1.063		$ 0.637		$ 0.154		$ 0.008		$ 0.001		$ 4.393		$ 1.218	
Oncology	$ 0.566		$ 8.808		$ 0.600		$ 7.319		$ 0.005		$ 0.036		$ 1.171		$ 16.164	
Ophthalmology	$ 0.020		$ 0.190		$ 0.013		$ 0.090		$ -		$ 0.019		$ 0.033		$ 0.299	
Orthopedics	$ 5.855		$ 8.428		$ 7.671		$ 3.715		$ 0.222		$ 0.932		$ 13.748		$ 13.075	
Otolaryngology	$ 0.192		$ 2.146		$ 0.223		$ 0.884		$ -		$ 0.018		$ 0.416		$ 3.048	
Psychiatry	$ 0.314		$ 1.101		$ 1.959		$ 0.756		$ -		$ 0.006		$ 2.273		$ 1.863	
Pulmonary	$ 2.957		$ 1.706		$ 7.506		$ 1.282		$ 0.018		$ 0.033		$ 10.481		$ 3.021	
Rehab													$ -		$ -	
Rheumatology	$ 0.063		$ 1.918		$ 0.084		$ 1.077		$ -		$ 0.120		$ 0.147		$ 3.115	
Transplant Surgery													$ -		$ -	
Trauma	$ 0.741		$ 0.307		$ 0.269		$ 0.176		$ 0.010		$ 0.050		$ 1.020		$ 0.533	
Urology	$ 0.880		$ 2.858		$ 0.788		$ 1.475		$ -		$ 0.003		$ 1.667		$ 4.337	
Vascular Surgery	$ 0.624		$ 0.051		$ 1.659		$ 0.071		$ -		$ -		$ 2.283		$ 0.121	
Other Inpatient	$ -				$ -				$ -				$ -			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ -				$ -				$ -				$ -	
GRAND TOTAL	$ 32.071	$ -	$ 58.618	$ -	$ 48.944	$ -	$ 34.150	$ -	$ 0.309	$ -	$ 1.965	$ -	$ 81.324	$ -	$ 94.732	$ -