Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

Jamie W. Katz
General Counsel

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

September 8, 2014

Dear Ms. Johnson and Ms. Mercer,

Enclosed please find the responses of Beth Israel Deaconess Medical Center 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 Dr. Kevin Tabb on August 1, 2014.

Please note that I am empowered to represent Beth Israel Deaconess Medical Center 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 Patricia McMullin in my office at pmcmulli@bidmc.harvard.edu or 617-667-7324.

Very truly yours,

Jamie Katz

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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: BIDMC continues to work to lead the region's efforts to reduce medical spending and trends by delivering the right care in the most appropriate setting; providing high quality community-based care with access to world class tertiary care; eliminating the inappropriate use of health care services; effectively managing the health of high cost patient populations; and coordinating care across our network. Please also see response provided by Beth Israel Deaconess Care Organization (BIDCO).

   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 2010-2013 period, Beth Israel Deaconess Medical Center experienced declines in utilization of hospital services consistent with the overall trend in Eastern Massachusetts. This reduction in utilization resulted from reductions in hospital readmission rates, avoidance of unnecessary admissions, and reduced use of the Emergency Department for non-emergent purposes. These overall trends in reduced utilization were somewhat offset by the impact of growth in clinical affiliations. BIDMC expanded its network of clinical affiliates during this period, resulting in increasing numbers of admissions for tertiary services from a broader geography.
      See appendix for complete response.

   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?

      BIDMC maintains its continued focus on leading the region's efforts to reduce medical expense trends as described in our summary above, and implemented the BIDCO structure to align our hospitals and physicians in pursuing shared goals. In addition, we grew our network of community-based providers with Beth Israel Deaconess Hospital - Plymouth, Cambridge Health Alliance, the Dedham Urgent Care Center, BID Health Care-Chestnut Hill, and the Cancer Center at BID Hospital-Needham. BIDMC and BIDCO continue to expand our medical management infrastructure and BIDMC is continuing efforts to imrove our operational efficiency, outpacing industry benchmarks.

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?

BIDMC will continue our work to reduce medical expenditures through the efforts articulated above and by performing health care services in lower cost settings; reducing unit costs; growing covered lives while managing risk and reducing total medical expenditures; pursuing innovations in care management and care delivery; and improving care across the entire continuum, from primary care, to community-based acute care, to tertiary/quaternary care, to post-acute care.

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

Policies, guidelines, and regulations that are sensitive and responsive to the current dynamics of the health care market and which recognize the need and value of a high-quality, cost-effective premier health care network could enhance the efforts of BIDMC and other providers to more effectively and seamlessly transform our care delivery system. Policies that hinder important innovations underway in the market could have significant detrimental impacts on the Commonwealth's cost-containment efforts. In addition, reductions in the regulatory burden faced by providers are critical to our long term cost-containment efforts.

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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: BIDMC is a founding member of Beth Israel Deaconess Care Organization (BIDCO),a value-based physician and hospital network and an Accountable Care Organization (ACO). BIDCO offers physician groups and hospitals the structure to contract, share risk, and build care management systems together, with the goal of providing the highest quality care in the most cost-efficient way. BIDMC achieves the items below through its relationship with BIDCO, as such, please refer to BIDCO for responses to these questions.
    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?

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).

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.

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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: Please see response provided by BIDCO.
   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?

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

   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?

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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: Please see response provided by BIDCO.
   ANSWER:

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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: Please see respone provided by BIDCO.
   a. Which attribution methodologies most accurately account for patients you care for?

   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

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: Please see response provided by BIDCO.
   ANSWER:

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: BIDMC has created a network of low cost community providers, within a distributed geography, which are among the very lowest cost hospitals in Massachusetts. We are working closely with them to augment their clinical capabilities in specialty and primary care; physician recruitment in the community; new program development locally; marketing of services available in the community; collaboration on quality programs and initiatives; and investment of financial and human resources in the community. BIDMC, along with our physician partners, also spearheaded creation of 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.
      Please see response provided by BIDCO.
   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.
      Please see summary answer above.

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: Please see BIDCO response. In addition, BIDMC is the only Massachusetts member of the High Value Health Care Collaborative (HVHCC), which is a consortium of 19 healthcare delivery systems and The Dartmouth Institute for Health and Clinical Practice. The HVHC is working to improve healthcare value -- defined as quality and outcomes over costs -- in a sustainable way. (More information in Appendix). BIDMC has also implemented a Post-Acute Care Transitions program (PACT) focused on improving post-acute care and reducting hospital readmissions.
   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.
      Please see BIDCO response.
   b. How does your organization ensure optimal use of post-acute care?

Please see BIDCO response.

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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: BIDMC has made progess in this area. BIDMC's average response to inquiries is 1 business day.

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	48	77	1
	Q2	50	83	1
	Q3	31	43	1
	TOTAL:	129	203	

** Please indicate the unit of time reported.*

ANSWER: BIDMC implemented an estimator tool prior to January 2014 to assist patients with obtaining out-of-pocket cost information. This tool allows BIDMC to enter charges, contracted amounts and tie them to patient benefits. In order to assist patients in easily accessing this information as well as complying with Chapter 224, BIDMC established an email address and a phone line for patients to request this information. We are experiencing approximately a 50/50 split between patients who are trying to plan for out-of-pocket costs as compared to those who are comparison shopping based on costs.

BIDMC has an internal project specialist and a training team specialist, both of whom did extensive testing on the procedure sets prior to adding them to the estimator tool. This testing included comparing estimates to the actual charges and out-of-pockets costs after services. We have also done look backs at the estimates given to ensure that they were as accurate as possible.

The following is what BIDMC is experiencing as our top 10 requests:
1. Labor and Delivery
2. Newborn charges
3. Colonoscopy
4. Endoscopy
5. Shoulder Arthroscopy

6. Knee Arthroscopy
7. Gastric Bypass
8. Hematology Oncology Office visits
9. Labs
10. Radiology

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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: While tiered and limited networks have not had a significant impact on BIDMC, they have contributed to administrative complexity in implementation, especially with regard to the variation in patient responsibility under such products.
ANSWER: We continue to work to understand the rationale for tier classification, which can vary across payers and products, and even service lines. Tiered products may be tied to price only, or tied to both price and quality. For limited network products, BIDMC has been willing to engage and participate in these products with payers, depending upon agreement of mutually agreeable terms. Although not a current issue, for a period of time, BIDMC was excluded from the network of one of the Medicaid MCO's which at the same time did hold contracts with several of our affiliated community health centers. This situation caused disruption and confusion for patients, many of whom were non-English speaking, and created considerable extra work for BIDMC and health center staff to obtain "out of network " authorizations and to develop workarounds to ensure that claims for authorized services would be paid. For vulnerable populations, limited networks have the potential to reduce patient access to needed care at the hospital, and to disrupt longstanding patient-physician relationships and longstanding referral relationships between community providers and BIDMC clinicians. Greater use of limited network products could create significant concerns regarding patient access to care. BIDMC is not able to determine whether we have experienced changes in volume that are due to tier placement and we have not made any material pricing changes in response to tier placement.

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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: BIDMC is working on a number of fronts outlined below to improve care for patients suffering with behavioral health issues, against the continued challenge of under-reimbursement for mental health and substance abuse care; an extremely fragmented and fragile delivery system for these patients; and insufficient inpatient and community resources to care for these patients across the entire health care continuum.

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.

Beth Israel Deaconess Medical Center strives to provide comprehensive care and services to our patients and community. We recognize our communitys' and patients' health and well-being are affected by numerous factors including mental health and substance abuse issues. Within Health Care Associates (HCA), BIDMC's primary care practice, Bowdoin Street Health Center, and our inpatient settings, our usual care includes calling upon and consulting with psychiatrists, psychologists, and social workers to assist patients in need.

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.

BIDMC conducts universal screening for substance abuse in our Emergency Department. We are currently training Emergency Department residents, attending physicians and nurses to administer Screening, Brief Intervention, Referral and Treatment (SBIRT). We are also including resource social workers in this training and have created an automatic page/flag in our system to alert and involve our social work team when patients present for substance abuse and/or overdose. This process allows social work to be involved at the beginning of the patient's care in the hope of linking the patient to appropriate community-based detoxification and substance use treatment.

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.

BIDMC has had many successes in caring for patients who have mental health conditions. As outlined in the above answers, BIDMC and our affiliates have been successful in integrating behavioral health care with primary care. The Psychiatry Urgent Care program routinely diverts patients from episodic, emergency department and inpatient care to office-based, integrated care with the patient's primary care provider and psychiatrist working collaboratively. Likewise, our BIDCO care management and social worker addresses mental health and psychosocial needs of patients on an on-going basis thereby preventing re-admissions and unnecessary hospitalizations and use of the Emergency Department.

See appendix for complete response.

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.

BIDMC is always willing to partner to identify data needs and better understand the impact on health due to behavioral health issues. Our organization cautions that the number of patients discharged specifically with a psychiatric diagnosis is probably limited and that the larger cohort are those who are admitted for a presenting medical condition and may have a contributing, underlying or co-morbid mental health or substance abuse issue.
See appendix for complete response.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: BIDMC and our affiliated community health centers and physician practices have significant experience with PCMH as described more fully herein.

    a. 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?

    BIDMC's licensed and affiliated health centers are all patient centered medical homes. With the exception of Sidney Borum Jr. Health Center, a small highly specialized Fenway health practice focused on street and at-risk youth and young adults, all of our six health centers' 13 sites are recognized or accredited Patient Center Medical Homes (PCMH). Three health centers (7 sites) are Level III NCQA (Bowdoin, Fenway, and South Cove), two health centers (3 sites) are Level II NCQA PCMH (Dimock and Joseph M. Smith Community Health Center), and one health center (3 sites) is JCAHO accredited (Outer Cape Health Services). These six health centers employ over 165 FTE physicians and 30 mid-level providers, all of whom are trained and practice in a medical home.

    See appendix for complete response.

    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

    All of the nearly 105,000 primary care patients at our licensed and affiliated health centers receive care from primary care providers who are trained in and practice as part of a Patient Centered Medical Home. Likewise, approximately 40,000 patients who are seen in the 10 PCMH teams at HCA receive care from these PCMH providers. The PCMH is evolving but all providers are working within the team structure.

c. 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.

The employment of patient-centered, coordinated care models has improved both the patient and provider experience. Likewise, PCMH allows for organized, evidence-based care and population management centered around preventive health. As such, it enables better patient access and acute care delivery, enhanced care management of high-risk patients and those with targeted chronic diseases, health promotion and disease prevention initiatives, all of which have the potential to improve quality and reduce costs over time.

See appendix for complete response.

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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

   Please also see BIDCO response.

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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 BIDMC 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. BIDMC 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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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.

   Please see response provided by BIDCO.

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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.

Beth Israel Deaconess Medical Center is unable to provide this highly confidential and proprietary information. We remain committed to transparency and are willing to work with the HPC and the AGO to provide this information under appropriate safeguards regarding its use.

Beth Israel Deaconess Medical Center

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%.

Summary:

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.

Between 2010 and 2013, the volume of hospitalized patients (inpatients plus floor observation patients) declined by 1.7% despite the increased volume of tertiary admissions from clinical affiliates, as reflected in the 5.4% increase in overall patient acuity. During the same time period, Emergency Department visits also declined, by 0.8%. Patient service revenue increase by an average of just more than 1% per year during the 2010-2013 period while operating expenses, excluding non-recurring items, increased by slightly more than 2% per year.

The same trends of reduced utilization of services, supplemented by increasing tertiary referrals from clinical affiliates, have continued into 2014. Volume of hospitalized patients has increased by 2.2%, while Emergency Department volume has declined by 0.2%. Patient revenue and operating expenses have both increased by 5.9% in the year-to-date period.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

Summary:

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

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

Response to question 8 continued from template:

Healthcare member organizations of HVHC collectively serve a market of more than 70 million people across the United States, and the mission of HVHC is to improve healthcare value – defined as quality and outcomes over costs, in a sustainable way.

Specific aims of the HVHC are to define, test, and disseminate advanced measures and tools to support clinicians, health systems, and payers in their efforts to delivery high value care; to identify, test and rapidly disseminate best practice care models and payment models that are safe, improve care, have better outcomes, and reduce costs; and to establish a collaborative "learning network" to encourage broader membership, help implement best practices in new member organizations, and distribute findings publicly so that they can be more broadly considered for implementation.

One example of improved use of post-acute care is through a patient engagement program for patients with hip or knee osteoarthritis. The overall program goals are to improve care, health, and cost of care for these patients by implementing patient engagement interventions including shared decision making, expectation management for length of stay, patient education for discharge to self-care, and interdisciplinary pre-operative clinics. BIDMC is a pilot site for this project, described in more detail below, courtesy of the HVHC.

High Value Healthcare Collaborative: Hip and Knee Patient Engagement

Project Goals: The overall goals are to improve care, health, and cost of care for patients with hip or knee osteoarthritis by implementing patient engagement interventions including shared decision making, expectation management for length of stay, patient education for discharge to self-care, and interdisciplinary pre-operative clinics.

Improve care: >50% eligible patients referred to patient engagement interventions and >50% of referred patients/families participate in interventions

Improve health: Improve health status measures (function, pain) for > 50% of patients considering hip and knee surgery at one year

Reduce costs: Reduce rates of hip & knee surgeries and episode costs resulting in 5% total cost reduction (aggregate relative rate)

Background

The lifetime risk of symptomatic knee osteoarthritis is estimated to be nearly 50 percent, and the two major risk factors are aging and obesity. In 2008, total knee replacement inpatient costs exceeded $9 billion—the highest aggregate cost among the ten procedures for which demand is growing the fastest. Between 2005 and 2030, the demand for primary knee arthroplasty in the United States is projected to grow by 673 percent to 3.48 million procedures annually. More resource-intensive total knee revisions — a procedure that repairs or replaces a previous replacement — are projected to grow by 601 percent between 2005 and 2030.3 In 2005, medical expenditures for the treatment of arthritis

were $353 billion, and they are expected to rise because of increases in the number of people with osteoarthritis.

Total knee replacement (TKR) is one of the most successful surgical procedures ever studied and is highly effective at restoring mobility and reducing pain when nonsurgical options fail. Current evidence suggests that medical management, although reasonably effective in treating mild to moderate osteoarthritis, is much less effective than surgery in treating severe knee disease. Despite the evidence of its efficacy, the wide variation in TKR rates among HVHC members highlights the opportunity to work together to process and determine the right rate of surgery.

Patient Engagement Interventions

Based on comparative analysis of the co-lead member data, the Hip & Knee Team identified care models associated with those members with better performance around specific metrics. The following patient engagement interventions were prioritized for implementation at pilot member sites:

Shared Decision Making (SDM): Based largely on the Dartmouth-Hitchcock care model, the SDM intervention offers patients “decision aid” videos describing the risks and benefits of hip or knee surgery versus non-surgical treatments; utilizes web-based tools to assess patients’ preferences, values, and knowledge about their decision; and engages health coaches to assist patients with their treatment decision.

Length of Stay (LOS) Expectation Management: Length of Stay expectation management was proposed by Mayo Clinic as a way to prepare patients for discharge from the hospital. They had found that the messaging from staff to patients about the availability of post-operative rehabilitation or physical therapy provided a disincentive for patients to push themselves to be mobile enough for discharge. This intervention provides education and consistent messaging from all members of the care team that healthy patients (defined as having <2 co-conditions) will be discharged from the hospital 2-3 days after their surgery.

Discharge to Self-Care: Planning and training healthy patients to be discharged to self-care (with no home health visits) was developed by Mayo Clinic as a way to get their healthy patients home safely after total knee or hip replacement. Prior to admission, patients and a primary relative are taught what to expect after discharge and the physical exercises they are expected to perform. Mayo has been able to discharge their patients to self-care with no current evidence of negative outcomes.

Pre-operative Clinic: Interdisciplinary pre-operative clinics were proposed as a method to streamline the post-operative care of patients by engaging the caregivers early in the pre-operative process. Hospitalists or internists engage early in preparation for the patient’s

surgery and are better prepared to care for the patient post-operatively, reducing complications and costs by avoiding clinical mistakes or mismanagement. This intervention provides patient education, discharge planning and risk assessment prior to surgery.

Beyond these patient engagement interventions, another pilot project being considered is the consistent operating room team model identified as a potential reason for Intermountain's shorter operating times.

Standard metrics are being used across all pilots, including: length of stay, discharge disposition, operating room time, inpatient complications, post-op complications, readmissions, and patient-reported outcomes such as pain, function, and quality of life.

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

Summary:

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

Response to question 11a continued from template:

As remuneration for these behavioral health services is often insufficient and the need so great, we are forced to continually seek alternative sources of funding to expand these efforts. Likewise, we strive to identify creative, cost-effective options to integrate and expand care to more patients in need. Current efforts and pilots include:

- Providing tele-psychiatry consultative services to Outer Cape Health Services (OCHS). The health center, located on the Outer Cape, is geographically isolated and faces significant barriers and obstacles in recruiting and retaining psychiatrists. As many providers on the Cape do not accept public insurance, patients with behavioral health issues have very few options. Thus, BIDMC, a long-time partner of OCHS, is building OCHS' primary care providers (PCP) capacity to treat patients with behavioral health issues in the patients' primary care/medical home. A BIDMC psychiatrist is available to PCP to discuss cases and provide psychiatric expertise.
- BIDMC's Department of Psychiatry has a pilot project with a Needham internal medicine practice that is part of BIDMC's Affiliated Physician Group. A BIDMC psychiatrist provides weekly tele-consultation services to physicians. In September, BIDMC's

Psychiatry Department will expand its on-site and tele-psychiatry consultation to the Joseph M. Smith Community Health Center. The health center has a low-income, racially and ethnically diverse, limited English-proficient patient population, many of whom (46%) remain uninsured despite health care reform. As such, JMSCHC's faces significant challenges in providing mental health services to their patients. BIDMC's Psychiatric department will offer clinical assistance to JMSCHC's primary care providers and behavioral health staff to build the team's capacity to manage patient's mental health issues in the primary care setting.

- BIDMC's Affiliated Physician Group practices in Brookline and Lexington are piloting an arrangement with psychiatrist whereby the psychiatrist and/or psychologist will be co-located in the primary care office. Literature has shown that offering mental health services in the same office as primary care increases collaborative care and consultation, while also reducing stigma for patients – thereby increasing access.
- Bowdoin Street Health Center, a BIDMC licensed facility, has a social worker embedded within its adult primary care practice. Having the social worker co-located with the medical home team allows for 'warm hand-offs' between the patient's trusted long-term primary care provider and a behavioral health provider. This seamless integration between physical and behavioral health care has decreased no-show rates for behavioral health appointments.
- An HCA internist is participating with the Brookline Community Mental Health Center on the Robert Wood Johnson Foundation-funded Healthy Lives Super Utilizer Pilot Project. The Healthy Lives Program works to improve health outcomes and patient engagement while reducing unnecessary utilization of health care resources. It is a patient-centered model of care integration, which successfully includes social and environmental determinants of health in its integration model. Over the next several months, the Healthy Lives program will be expanding to serve patients at our Bowdoin Street Health Center.
- Lastly, BIDMC is collaborating with The Dimock Center in efforts to streamline our joint processes to enable patients in need of substance abuse treatment to more easily access detoxification services.

As always, BIDMC remains committed to serving our patients and addressing the needs of our community. It should be noted that there is no reimbursement for the consultative services provided by psychiatrists in the programs described above. It has been demonstrated that such efforts would yield cost savings in a fully-implemented global payment system. However, in our current mixed reimbursement system (with both fee-for-service and global payment arrangements in place), we rely on support from the medical center and our physician groups to support these projects. We continue to seek funding for further pilots and have applied for funds for such initiatives with mixed success.

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 11b Continued from Template:

Likewise, we are in process of creating an automatic flag to notify the patient's primary care provider when a patient screens positive for substance abuse. This will enlist the patient's medical home and increase the opportunities for dialogue on treatment options.

Despite the previously mentioned efforts to integrate behavioral health care with medical care/primary care, we find that patients with comorbid mental health and other chronic conditions often end up in our medical inpatient units. Emergency room and medical inpatient stays for this cohort are typically caused by the patient's inability to optimally manage their chronic medical conditions due to underlying mental health and substance abuse issues. For example, if a patient suffers from uncontrolled depression, he/she may not be able or motivated to fill their prescriptions for cardiac medications or adhere to their medication regimen. BIDMC recognizes that these patients may need extra help to keep them out of the hospital and in their community where they can obtain care in their medical home. In an effort to avoid unnecessary utilization of the emergency room department and inpatient care, BIDMC addresses this need several different ways, including:

- A BIDCO team of 17 nurse (RN) care managers and four nurse practitioners who assist many patients with behavioral health and psychosocial problems to prevent unnecessary utilization of ED and inpatient care. Working with our licensed and affiliated health centers, we are also adding a House Calls Pilot initiative to address the needs of the low-income, racially, ethnically and linguistically diverse patients who access care at our three of our affiliated health centers.
- The BIDMC Department of Psychiatry offers an urgent care program that offers access to rapid psychiatric consultation. The program is offered to the BIDMC's primary care practices which include Health Care Associates and our Affiliated Physician Group (APG). Primary Care Providers can speak with an on-call psychiatrist to discuss and triage psychiatric care for patients in need to determine if they need an urgent psychiatric visit, or need to be evaluated in the emergency department, for diagnostic assessment and possible admission. This program has been in existence for more than a decade.
- Working with BIDCO, three of our health centers (Bowdoin Street, Dimock, and Joseph M. Smith) are designing and piloting a house calls program for some patients in the Pioneer ACO.

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.

Response to 11C continued from template:

As the majority of the above programs are either grant funded or pilots, we face funding challenges. A key success is comprehensive care management for this cohort, yet, an enormous challenge is that care management is not reimbursed on fee-for-service contracts and instituting such a program under global payment requires up-front investment. Additionally, the Commonwealth's mental health services are not conducive to integration under global payment. There is a shortage of inpatient beds and given this shortage, we are forced to send patients wherever a bed becomes available, which can routinely be outside of our 'network'. In addition to being disruptive to continuity and coordination of patient care, referring patients outside of our network is not sustainable in a global payment model. Lastly, there is a dearth of bilingual behavioral health professionals, child and adolescent providers and in general, inadequate capacity of community based treatments for chronically mentally ill. The inadequacies of the current systems result in, among other things, patients who require psychiatric admission waiting in emergency rooms for days at a time waiting for beds to become available. This, of course, adds substantially to the cost of care delivery.

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.

Response to 11D continued from template:

Capturing those who are psychosocially challenged when it is not the precipitating reason for admission is probably not coded and captured in our system despite the psychosocial issue being the underlying reason/cause for the admission. Although worthwhile to capture and review this larger cohort, it would be an ambitious undertaking to code these patients and would be quite resource and labor intensive. Our staff believes that it could be useful to take a look at all admissions in the hospital to examine the extent to which psychiatric illness contributes to admissions. We are willing to participate in thinking and working with the Health Policy Commission to identify the best means for capturing and reporting data.

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

Summary:

a. 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?

Response to 12a continued from template:

BIDMC's own licensed health center, Bowdoin Street Health Center (Bowdoin), has been working on practice transformation since 2008 and has been a Level III NCQA PCMH for three years. Bowdoin will be applying in 2014 to renew its accreditation. Over

the past three years, Bowdoin has transformed the way care is provided to patients by ensuring that all patients have a designated primary care provider and Bowdoin has improved the rate at which patients get back to see their own provider. Bowdoin has four fully functioning primary care teams. Moving forward, Bowdoin will be working to increase care management for chronic medical conditions including diabetes, hypertension and pediatric asthma. Likewise, Bowdoin will expand its successful work to integrate behavioral health within primary care which includes social workers on the medical floor. This enables social workers to respond to immediate behavioral health needs of patients.

Health Care Associates (HCA), the hospital-based, academic primary care practice of Beth Israel Deaconess Medical Center (BIDMC) consists of 10 care teams comprised of 64 faculty members, 134 residents rotating through, 2-4 fellows each year and 7 Nurse Practitioners. HCA is progressing rapidly in its transformation into a PCMH. HCA has achieved NCQA Level II recognition the past year, each team has been assigned a panel and implemented team based care. This has enabled more patient-centered and personalized care, and has also streamlined patient flow and communication among providers and staff - all of which has led to improved visit experiences for providers, staff, and patients.

c. 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.

Response to 12c continued from template:

Since implementing PCMH, patients have experienced enhanced access and care coordination including same or next day access for patients, evening and weekend hours. Patients are less likely to need to be seen in the Emergency Department for primary care issues due to HCA's implementation of an acute treatment unit that enables the administration of IV fluids, nebulizer treatments and IV antibiotics. For those patients requiring HCA follow up care after visiting the Emergency Department, the ED can now directly schedule into HCA. All HCA patients that visit the ED receive follow up phone calls within 72 hours. Similarly, at Bowdoin the co-location of PCMH team members and redesign of the clinic has enhanced communication and access for patients. Furthermore, the embedding of a social worker on the primary care floor has allowed for immediate attention of acute issues, better triage, and bridging care prior to formal intake visits.

Likewise, both HCA and Bowdoin Street have shown improvements in population management and preventive health screenings. Such screening improvements have occurred with breast and colorectal cancers. Additionally, chronic disease management has been strengthened by standardized care guidelines, developing and maintaining chronic conditions registries, care management, and conducting outreach and expanded patient education for diabetes mellitus, hypertension, COPD/asthma and depression.

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											$ 123.2	$ 127.7			
Tufts Health Plan											$ 27.5	$ 36.9			
Harvard Pilgrim Health Care											$ 87.8	$ 47.8			
Fallon Community Health Plan											$ 2.0				
CIGNA											$ 7.5				
United Healthcare											$ 9.6				
Aetna											$ 18.4				
Other Commercial											$ 30.7				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 306.7	$ 212.4	$ -	$ -	$ -
Network Health											$ 17.1				
Neighborhood Health Plan											$ 20.0				
BMC HealthNet, Inc.											$ 7.5				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 44.6	$ -	$ -	$ -	$ -
MassHealth											$ 52.0				
Tufts Medicare Preferred											$ 18.7				
Blue Cross Senior Options											$ 7.5				
Other Comm Medicare											$ 27.0				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 53.2	$ -	$ -	$ -	$ -
Medicare											$ 285.6				
Other											$ 52.7				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 794.7	$ 212.4	$ -	$ -	$ -

Total	$ 1,007.1
Financials	$ 1,007.1
Variance	$ (0.0)

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											$ 119.7	$ 125.5			
Tufts Health Plan											$ 29.0	$ 38.9			
Harvard Pilgrim Health Care											$ 94.8	$ 54.5			
Fallon Community Health Plan											$ 2.5				
CIGNA											$ 7.3				
United Healthcare											$ 9.3				
Aetna											$ 19.9				
Other Commercial											$ 23.7				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 306.1	$ 218.9	$ -	$ -	$ -
Network Health											$ 18.2				
Neighborhood Health Plan											$ 23.5				
BMC HealthNet, Inc.											$ 8.4				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50.2	$ -	$ -	$ -	$ -
MassHealth											$ 52.0				
Tufts Medicare Preferred											$ 27.1				
Blue Cross Senior Options											$ 9.7				
Other Comm Medicare											$ 15.1				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 51.9	$ -	$ -	$ -	$ -
Medicare											$ 306.4				
Other											$ 52.6				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 819.2	$ 218.9	$ -	$ -	$ -

Total	$ 1,038.1
Financials	$ 1,038.1
Variance	$ (0.0)

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											$ 102.5	$ 129.1			
Tufts Health Plan											$ 28.8	$ 40.9			
Harvard Pilgrim Health Care											$ 104.8	$ 45.6			
Fallon Community Health Plan											$ 3.2				
CIGNA											$ 7.1				
United Healthcare											$ 10.6				
Aetna											$ 19.3				
Other Commercial											$ 25.7				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 302.1	$ 215.6	$ -	$ -	$ -
Network Health											$ 28.0				
Neighborhood Health Plan											$ 27.5				
BMC HealthNet, Inc.											$ 7.4				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 62.9	$ -	$ -	$ -	$ -
MassHealth											$ 56.6				
Tufts Medicare Preferred											$ 26.6				
Blue Cross Senior Options											$ 8.2				
Other Comm Medicare											$ 10.8				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 45.6	$ -	$ -	$ -	$ -
Medicare											$ 306.7				
Other											$ 55.9				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 829.8	$ 215.6	$ -	$ -	$ -

Total	$ 1,045.4
Financials	$ 1,045.4
Variance	$ 0.0

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											$ 95.3	$ 127.0			
Tufts Health Plan											$ 27.4	$ 46.0			
Harvard Pilgrim Health Care											$ 113.0	$ 39.8			
Fallon Community Health Plan											$ 3.5				
CIGNA											$ 8.7				
United Healthcare											$ 10.1				
Aetna											$ 18.5				
Other Commercial											$ 25.7				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 302.2	$ 212.8	$ -	$ -	$ -
Network Health											$ 29.0				
Neighborhood Health Plan											$ 31.1				
BMC HealthNet, Inc.											$ 11.2				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 71.3	$ -	$ -	$ -	$ -
MassHealth											$ 50.0				
Tufts Medicare Preferred											$ 30.2				
Blue Cross Senior Options											$ 10.0				
Other Comm Medicare											$ 13.0				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 53.3	$ -	$ -	$ -	$ -
Medicare											$ 317.8				
Other											$ 44.1				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 838.7	$ 212.8	$ -	$ -	$ -

Total	$ 1,051.5
Financials	$ 1,051.5
Variance	$ (0.0)

2010

	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	$ 26.104		$ 7.767		$ 43.490		$ 8.705		$ 0.717		$ 0.351		$ 70.311		$ 16.823	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery	$ 9.921		$ 0.193		$ 13.716		$ 0.159		$ 0.293		$ -		$ 23.930		$ 0.352	
Dental													$ -		$ -	
Dermatology			$ 3.527				$ 2.724				$ 0.051		$ -		$ 6.302	
Endocinology	$ 3.018		$ 0.575		$ 2.570		$ 0.124						$ 5.588		$ 0.699	
Gastroenterology	$ 5.263		$ 26.849		$ 6.307		$ 10.673		$ 0.370		$ 0.842		$ 11.940		$ 38.364	
General Medicine	$ 34.115		$ 43.524		$ 73.419		$ 31.903		$ 1.833		$ 5.279		$ 109.367		$ 80.706	
General Surgery	$ 36.292		$ 20.887		$ 31.786		$ 5.141		$ 3.990		$ 1.149		$ 72.068		$ 27.177	
Gynecology													$ -		$ -	
Hematology	$ 28.774		$ 18.966		$ 15.394		$ 11.469		$ 0.678		$ 0.483		$ 44.846		$ 30.918	
Infectious Disease	$ 0.059		$ 1.756		$ 0.013		$ 1.069				$ 0.134		$ 0.072		$ 2.959	
Neonatology	$ 25.102		$ 0.415		$ 9.158		$ 1.113		$ 0.010		$ 0.037		$ 34.270		$ 1.565	
Nephrology	$ 1.279		$ 1.198		$ 1.566		$ 0.850				$ 0.265		$ 2.845		$ 2.313	
Neurology	$ 7.733		$ 6.740		$ 11.327		$ 3.457		$ 0.413		$ 0.210		$ 19.473		$ 10.407	
Neurosurgery	$ 11.483		$ 1.139		$ 11.935		$ 0.507		$ 1.003		$ 0.054		$ 24.421		$ 1.700	
Normal Newborns													$ -		$ -	
Obstetrics	$ 36.264		$ 17.466		$ 8.522		$ 5.765		$ 0.231		$ 0.452		$ 45.017		$ 23.683	
Oncology	$ 3.042		$ 1.328		$ 2.584		$ 0.805		$ 0.276				$ 5.902		$ 2.133	
Ophthalmology			$ 2.221				$ 3.692				$ 0.027		$ -		$ 5.940	
Orthopedics	$ 19.067		$ 13.814		$ 19.662		$ 5.546		$ 2.224		$ 1.515		$ 40.953		$ 20.875	
Otolaryngology													$ -		$ -	
Psychiatry	$ 1.960		$ 0.661		$ 4.821		$ 0.579		$ 0.116		$ 0.008		$ 6.897		$ 1.248	
Pulmonary	$ 12.196		$ 0.655		$ 24.773		$ 0.495		$ 1.091		$ 0.039		$ 38.060		$ 1.189	
Rehab													$ -		$ -	
Rheumatology							$ 1.484				$ 0.082		$ -		$ 1.566	
Transplant Surgery	$ 8.387		$ 0.474		$ 9.445		$ 0.456		$ 1.100		$ 0.028		$ 18.932		$ 0.958	
Trauma													$ -		$ -	
Urology	$ 3.978		$ 3.544		$ 3.453		$ 2.125		$ 0.059		$ 0.077		$ 7.490		$ 5.746	
Vascular Surgery	$ 5.471		$ 0.879		$ 16.745		$ 1.251		$ 0.135		$ 0.032		$ 22.351		$ 2.162	
Other Inpatient	$ 1.904				$ 0.344				$ 0.233				$ 2.481			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 63.110				$ 24.278				$ 26.714				$ 114.102	
GRAND TOTAL	$ 281.412	$ -	$ 237.688	$ -	$ 311.030	$ -	$ 124.370	$ -	$ 14.771	$ -	$ 37.829	$ -	$ 607.213	$ -	$ 399.887	$ -

2011

Service Category	Commercial				Government				All Other				Total			
	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	$ 22.518		$ 10.680		$ 42.567		$ 11.159		$ 0.706		$ 0.274		$ 65.791		$ 22.113	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery	$ 11.104		$ 0.257		$ 17.060		$ 0.225		$ 0.325		$ 0.008		$ 28.489		$ 0.490	
Dental													$ -		$ -	
Dermatology			$ 3.699				$ 2.978				$ 0.135		$ -		$ 6.812	
Endocinology	$ 4.712		$ 0.922		$ 3.525		$ 0.249		$ 0.080		$ 0.004		$ 8.317		$ 1.175	
Gastroenterology	$ 6.153		$ 26.743		$ 6.526		$ 12.006		$ 0.457		$ 0.595		$ 13.136		$ 39.344	
General Medicine	$ 34.740		$ 57.341		$ 72.299		$ 34.859		$ 1.968		$ 5.513		$ 109.007		$ 97.713	
General Surgery	$ 34.904		$ 23.866		$ 29.842		$ 9.499		$ 3.507		$ 1.026		$ 68.253		$ 34.391	
Gynecology													$ -		$ -	
Hematology	$ 29.346		$ 22.151		$ 16.437		$ 14.487		$ 1.125		$ 0.261		$ 46.908		$ 36.899	
Infectious Disease	$ 0.019		$ 1.685		$ 0.011		$ 1.078				$ 0.164		$ 0.030		$ 2.927	
Neonatology	$ 25.066		$ 0.416		$ 8.740		$ 1.096		$ 0.016		$ 0.056		$ 33.822		$ 1.568	
Nephrology	$ 0.878		$ 1.178		$ 1.638		$ 0.958		$ 0.013		$ 0.301		$ 2.529		$ 2.437	
Neurology	$ 9.341		$ 7.017		$ 13.267		$ 4.153		$ 0.525		$ 0.260		$ 23.133		$ 11.430	
Neurosurgery	$ 12.857		$ 1.111		$ 10.713		$ 0.808		$ 1.074		$ 0.033		$ 24.644		$ 1.952	
Normal Newborns													$ -		$ -	
Obstetrics	$ 38.499		$ 18.050		$ 9.543		$ 6.824		$ 0.378		$ 0.575		$ 48.420		$ 25.449	
Oncology	$ 2.612		$ 1.645		$ 2.040		$ 0.886		$ 0.224		$ 0.013		$ 4.876		$ 2.544	
Ophthalmology			$ 2.782				$ 3.708				$ 0.075		$ -		$ 6.565	
Orthopedics	$ 21.299		$ 15.411		$ 22.147		$ 6.694		$ 1.755		$ 1.445		$ 45.201		$ 23.550	
Otolaryngology													$ -		$ -	
Psychiatry	$ 1.989		$ 0.607		$ 5.510		$ 0.669		$ 0.349		$ 0.040		$ 7.848		$ 1.316	
Pulmonary	$ 13.320		$ 0.652		$ 27.391		$ 0.591		$ 1.019		$ 0.085		$ 41.730		$ 1.328	
Rehab													$ -		$ -	
Rheumatology			$ 2.063										$ -		$ 2.063	
Transplant Surgery	$ 7.907		$ 0.500		$ 9.946		$ 0.553		$ 1.186		$ 0.025		$ 19.039		$ 1.078	
Trauma													$ -		$ -	
Urology	$ 4.116		$ 4.066		$ 3.393		$ 2.281		$ 0.087		$ 0.073		$ 7.596		$ 6.420	
Vascular Surgery	$ 5.137		$ 1.018		$ 16.873		$ 1.583		$ 0.281		$ 0.035		$ 22.291		$ 2.636	
Other Inpatient	$ 1.794				$ 0.927				$ 0.118				$ 2.839			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 32.830				$ 22.764				$ 26.405				$ 81.999	
GRAND TOTAL	$ 288.311	$ -	$ 236.690	$ -	$ 320.395	$ -	$ 140.108	$ -	$ 15.193	$ -	$ 37.401	$ -	$ 623.899	$ -	$ 414.199	$ -

2012

Service Category	Commercial				Government				All Other				Total			
	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	$ 18.332		$ 11.934		$ 37.158		$ 14.493		$ 0.856		$ 0.278		$ 56.346		$ 26.705	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery	$ 7.683		$ 0.201		$ 15.933		$ 0.274		$ 0.332		$ 0.010		$ 23.948		$ 0.485	
Dental													$ -		$ -	
Dermatology			$ 4.155				$ 3.447				$ 0.127		$ -		$ 7.729	
Endocinology	$ 5.013		$ 1.125		$ 3.575		$ 0.339		$ 0.150		$ 0.006		$ 8.738		$ 1.470	
Gastroenterology	$ 7.691		$ 28.463		$ 6.116		$ 14.223		$ 0.101		$ 0.550		$ 13.908		$ 43.236	
General Medicine	$ 30.835		$ 57.066		$ 67.016		$ 38.446		$ 1.780		$ 5.293		$ 99.631		$ 100.805	
General Surgery	$ 34.108		$ 24.021		$ 25.781		$ 11.871		$ 3.970		$ 0.854		$ 63.859		$ 36.746	
Gynecology													$ -		$ -	
Hematology	$ 29.714		$ 23.132		$ 19.113		$ 17.104		$ 0.848		$ 0.397		$ 49.675		$ 40.633	
Infectious Disease	$ 0.009		$ 1.571		$ 0.008		$ 1.273				$ 0.168		$ 0.017		$ 3.012	
Neonatology	$ 23.138		$ 0.415		$ 9.306		$ 0.990		$ 0.017		$ 0.050		$ 32.461		$ 1.455	
Nephrology	$ 0.796		$ 1.242		$ 1.483		$ 1.124		$ 0.033		$ 0.178		$ 2.312		$ 2.544	
Neurology	$ 7.850		$ 7.284		$ 11.626		$ 4.699		$ 0.731		$ 0.269		$ 20.207		$ 12.252	
Neurosurgery	$ 9.634		$ 1.142		$ 11.910		$ 0.863		$ 0.777		$ 0.051		$ 22.321		$ 2.056	
Normal Newborns													$ -		$ -	
Obstetrics	$ 38.342		$ 18.792		$ 10.677		$ 7.851		$ 0.327		$ 0.644		$ 49.346		$ 27.287	
Oncology	$ 4.135		$ 4.426		$ 3.087		$ 1.869		$ 0.227		$ 0.035		$ 7.449		$ 6.330	
Ophthalmology			$ 2.563				$ 4.322				$ 0.103		$ -		$ 6.988	
Orthopedics	$ 19.265		$ 14.914		$ 25.875		$ 7.410		$ 1.770		$ 1.288		$ 46.910		$ 23.612	
Otolaryngology													$ -		$ -	
Psychiatry	$ 2.641		$ 0.624		$ 4.186		$ 0.756		$ 0.378		$ 0.038		$ 7.205		$ 1.418	
Pulmonary	$ 14.030		$ 0.654		$ 29.583		$ 0.674		$ 1.075		$ 0.137		$ 44.688		$ 1.465	
Rehab													$ -		$ -	
Rheumatology			$ 2.183				$ 1.791				$ 0.087		$ -		$ 4.061	
Transplant Surgery	$ 6.943		$ 0.553		$ 8.090		$ 0.968		$ 0.513		$ 0.011		$ 15.546		$ 1.532	
Trauma													$ -		$ -	
Urology	$ 4.433		$ 4.139		$ 2.780		$ 2.939		$ 0.072		$ 0.064		$ 7.285		$ 7.142	
Vascular Surgery	$ 4.120		$ 1.120		$ 13.897		$ 1.983		$ 0.435		$ 0.028		$ 18.452		$ 3.131	
Other Inpatient	$ 0.190				$ 0.697				$ 0.035				$ 0.922			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 37.080				$ 24.190				$ 30.810				$ 92.080	
GRAND TOTAL	$ 268.902	$ -	$ 248.799	$ -	$ 307.897	$ -	$ 163.899	$ -	$ 14.427	$ -	$ 41.476	$ -	$ 591.226	$ -	$ 454.174	$ -

2013

	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	$ 19.130		$ 13.214		$ 39.731		$ 16.510		$ 0.508		$ 0.302		$ 59.369		$ 30.026	
Invasive													$ -		$ -	
Medical													$ -		$ -	
Cardiac Surgery	$ 10.311		$ 0.235		$ 15.241		$ 0.219		$ 0.151		$ 0.005		$ 25.703		$ 0.459	
Dental													$ -		$ -	
Dermatology			$ 4.210				$ 3.703				$ 0.146		$ -		$ 8.059	
Endocinology	$ 5.061		$ 0.966		$ 4.365		$ 0.372		$ 0.050		$ 0.005		$ 9.476		$ 1.343	
Gastroenterology	$ 5.628		$ 27.461		$ 5.917		$ 14.343		$ 0.269		$ 0.535		$ 11.814		$ 42.339	
General Medicine	$ 30.765		$ 56.114		$ 69.205		$ 39.862		$ 1.472		$ 5.091		$ 101.442		$ 101.067	
General Surgery	$ 29.220		$ 24.814		$ 26.473		$ 12.929		$ 3.300		$ 0.810		$ 58.993		$ 38.553	
Gynecology													$ -		$ -	
Hematology	$ 23.277		$ 23.768		$ 21.311		$ 18.521		$ 0.899		$ 0.449		$ 45.487		$ 42.738	
Infectious Disease			$ 1.508		$ 0.024		$ 1.229				$ 0.152		$ 0.024		$ 2.889	
Neonatology	$ 24.363		$ 0.314		$ 9.652		$ 0.788		$ 0.020		$ 0.041		$ 34.035		$ 1.143	
Nephrology	$ 0.651		$ 1.031		$ 1.012		$ 1.145				$ 0.212		$ 1.663		$ 2.388	
Neurology	$ 7.865		$ 7.091		$ 12.302		$ 4.975		$ 0.656		$ 0.209		$ 20.823		$ 12.275	
Neurosurgery	$ 11.499		$ 1.861		$ 13.884		$ 1.894		$ 0.891		$ 0.083		$ 26.274		$ 3.838	
Normal Newborns													$ -		$ -	
Obstetrics	$ 40.149		$ 19.867		$ 10.220		$ 8.204		$ 0.377		$ 0.527		$ 50.746		$ 28.598	
Oncology	$ 3.468		$ 5.574		$ 3.123		$ 2.715		$ 0.256		$ 0.046		$ 6.847		$ 8.335	
Ophthalmology			$ 2.644				$ 4.312				$ 0.121		$ -		$ 7.077	
Orthopedics	$ 20.433		$ 15.921		$ 25.247		$ 7.878		$ 1.804		$ 1.448		$ 47.484		$ 25.247	
Otolaryngology													$ -		$ -	
Psychiatry	$ 2.473		$ 0.903		$ 4.668		$ 0.892		$ 0.241		$ 0.059		$ 7.382		$ 1.854	
Pulmonary	$ 14.225		$ 0.771		$ 29.641		$ 0.741		$ 1.099		$ 0.092		$ 44.965		$ 1.604	
Rehab													$ -		$ -	
Rheumatology			$ 2.061				$ 1.820						$ -		$ 3.881	
Transplant Surgery	$ 6.785		$ 0.647		$ 9.099		$ 0.956		$ 0.941		$ 0.018		$ 16.825		$ 1.621	
Trauma			$ 4.269										$ -		$ 4.269	
Urology	$ 4.081		$ 1.469		$ 3.151		$ 3.300		$ 0.078		$ 0.069		$ 7.310		$ 4.838	
Vascular Surgery	$ 4.944				$ 12.992		$ 2.587		$ 0.206		$ 0.037		$ 18.142		$ 2.624	
Other Inpatient	$ 0.161				$ 0.036				$ 0.046				$ 0.243			
Imaging															$ -	
Other Treatments															$ -	
Laboratory															$ -	
Ambulatory Surgery															$ -	
Therapies															$ -	
Office Visits															$ -	
Observation															$ -	
Other Outpatient			$ 33.800				$ 25.210				$ 20.379				$ 79.389	
GRAND TOTAL	$ 264.489	$ -	$ 250.513	$ -	$ 317.294	$ -	$ 175.105	$ -	$ 13.264	$ -	$ 30.836	$ -	$ 595.047	$ -	$ 456.454	$ -

BIDMC
Operating Margins

	2010		2011		2012		2013	
Payor Group	Mix	%	Mix	%	Mix	%	Mix	%
All Other	3.7%	-18.7%	3.6%	-19.2%	3.6%	-21.6%	3.3%	-17.5%
Commercial	47.5%	18.8%	46.3%	18.6%	44.7%	18.1%	43.4%	20.3%
Government	48.7%	-6.9%	50.1%	-7.4%	51.7%	-8.5%	53.3%	-9.3%
Grand Total	100.0%	4.8%	100.0%	4.3%	100.0%	3.7%	100.0%	4.1%