1.a. Heywood Hospital has experienced very little growth in its patient revenues for the period 2010 - current. Revenue increases have averaged 1-3 % per year. Price increases from Managed care plans have average this same percentage range. In terms of utilization, outpatient activity has increased while inpatient activity has declined for the period 2010-current. Heywood Hospital has been able to keep its expense growth in line with its revenue growth for this time period. Impacting these results have been the implementation of high deductible plans that have consumers delaying care. Heywood Hospital's focus on 30 day re admissions has had an impact on declining admissions. Heywood Hospital also ceased operations of it's TCC uniton 10/1/13 which resulted in a further decline of its inpatient numbers." See exhibit C

1b. Heywood Hospital, through the Heywood PHO, has negotiated very conservative increases in managed care contracts, the vast majority of which fell below the state mandated cap of 3.6%.

1c. Our hospital is launching a hospital wide Lean/Six Sigma project starting September 17, 2014. The target goal is reduce expenses by 3-5% without negatively impacting quality, and whenever possible to improve quality and safety as part of the process. This improvement in quality, safety, and reduction in expense, can be translated into more conservative contracts with insurers and overall reduction in medical expense.

2.a. Alternative Payment Methods that include significant financial incentives for quality efforts has had a positive impact on the overall performance of quality measures. This has encouraged our hospital to implement educational programs on how best to improve performance and has also allowed us to look at processes to improve our system’s operations to help facilitate improved performance. Most of these efforts were directed to improving our performance on core measures and HEDIS measures.

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

are used to identify gaps and capacity issues in services as well as to address referral patterns with individual physicians.

2.b. The implementation of APMs has created some moderate staffing burden and an incentive to look to innovative ways to improve performance. Alliances and partnerships with other providers is one way we have successfully worked to improve performance and share resources. Heywood has not had sufficient experience with the APM's to analyze the results on non-clinical operations.

2.c. We are in our second year in an APM and we are seeing that our performance in quality measures overall has improved, in particular for Diabetes and Blood Pressure measures. However, it is too early in the year to quantify those improvements

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

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

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

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

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

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

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

5.a. Retrospective, HMO product

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

6. It is nice to see that the private payers are starting to come in line with what public payers are requesting. There are still a few areas where definitions vary, and that may cause some confusion and extra work. Overall the effort to keep up to date is moderately difficult due to limited staffing resources. Deadlines for submissions are met, but just in time. It would be preferable to have time to review and validate data before submission, rather than have to do a retroactive validation. Changes in vendors do cause periodic problems as we try to adjust to new processes, even if the measures are the same. Also, the cost of using vendors is quite high, but direct data submission is not always available.

7.a. We are currently evaluating our out migration patterns. We do recognize that a sizable portion of our population go to tertiary centers for community level problems. We are implementing a referral management system in the near future that will redirect patients to local services when appropriate.

7.b. There have been extensive discussions with our physicians, both employed and private, over the past two years, but until recently, have not had any way to impact those referral patterns. We have recently participated in the formation of a joint venture with another provider group, and as part of the joint venture, additional resources for care management have become available. We anticipate that by the end of 2014 a basic referral management system will be in place. We anticipate between 10% - 20% of the tertiary referrals can eventually be redirected to lower cost providers.

8.a. In 2013, our organization closed is hospital based skilled nursing facility. That was a much appreciated unit for our patients and our physicians. However, we believe that due to the unit being located within the hospital, and the ease of access for our providers, our utilization was higher than average. With the closure of that unit, our patients are going to other community facilities. The utilization rate, although not scientifically measured as yet, does appear to have decreased somewhat. In addition, the cost per day for community nursing homes is much less than what we were receiving for our HBSNF.

8.b. Our case management department works closely with managed care payers to complete a comprehensive assessment of patient needs, and to arrange for post acute services are most appropriate for the patient. Whenever the patient can be safety sent home with home health services that is arranged. We have an excellent working relationship with our local VNA and home health agencies. These community agencies participate in a cross organizational improvement team with our acute care staff to not only reduce readmissions, but to also assure appropriate services for discharged patients.

9. Heywood PHO is in a Medicare Advantage arrangement with Fallon and Blue Cross, and has not received any SNF utilization and cost data that would be helpful in managing those services. Data received to date is simply a report of days at SNF facilities.

10. Heywood is in the top tier for Blue Cross, Harvard Pilgrim and Tufts. Heywood hasn't taken any actions because Heywood is a low-cost hospital placed in the best tiers by the health plans. Subscribers should be encouraged to use HH since we are a lower cost facility to others in the region.

11.a. Heywood Healthcare has adopted accessible behavioral health and substance use disorder services for adults and youth as one of its primary areas of focus. Heywood was a recipient of the Health Policy Commission CHART Phase 1 grant funding and focused all of Phase 1 efforts on testing methodologies and strategic planning to positively impact the behavioral health needs of our service area.

Based on a comprehensive needs assessment (May 2014), Heywood Hospital has developed a comprehensive plan to support physician education and supportive services designed to strengthen the physician's ability to integrate behavioral health care in primary care settings. This initiative will assist patients to receive care for inter-related conditions. Implementation of evidence-based strategies, care coordination and pharmacological supports will assist providers in the identification and delivery of pain management, short-term interventions, trauma interventions, motivational interviewing, and use of health information exchange systems.

11.b. In the emergency setting, Heywood implemented a multi-disciplinary team approach through the addition of licensed therapists and social workers. This approach expanded the capacity for the multi-disciplinary team to assess, treat, and refer for physical, behavioral health and substance use, the provision of therapy in the ED setting eliminated idle non-therapeutic time in the ED, allowed Heywood to conduct independent bed searches, provided for post ED case management, and assisted patients to be connected to resources for homelessness, domestic violence, food/nutrition, insurance issues, reduced or prevention of avoidable admissions.

Additionally, Heywood in partnership with our MBHP Emergency Services Provider, Community HealthLink, provides intensive case management for frequent utilizers of the Emergency Department.

11.c. Lack of a well-networked system of care is among many frustrations of Heywood staff. Emergency service provider response times are significantly lagging, and there is great confusion around protocols relative to specific insurance coverage.

Relative to inpatient behavioral health admissions, Heywood manages complex admissions with a length of stay difference below the statewide adjusted mean, DMH and MBHP both state the Geriatric Psychiatry Unit is an asset to the region, and 18% of inpatient behavioral health admissions have a primary substance use disorder. Heywood perceives a shortage of inpatient beds, due to the fact that more than 2,500 patients are turned away annually due to lack of bed capacity. Substance use is widespread among patients and there is both low-capacity for available treatment and scarcity in range of options, both aspects of a deeply fragmented system of care.

As the only provider of inpatient psychiatric services in the region, it is clear that Heywood is stretching to serve its community with 77.1% of Behavioral Health admissions coming from zip codes within our service area.

Transportation is also a barrier to care for many who suffer with mental illness. Therefore, providing necessary services locally is critical to patient adherence to recommended care plans.

11.d. Heywood is willing to report data.

12. Heywood has just beginning a gap analysis to determine the gap between current services and what needs to be added to become a PCMH. The analysis is expected to be completed by December of 2014.

13. Heywood continues to be a low cost provider and will continue to work with the HPC to remain low cost, possibly reduce costs with new population management programs, and improve quality and safety of services as the same time.

Exhibit C:

Exhibit C1:See break out in Exhibit C2.

Exhibit C2 : See attached.

Exhibit C3: The hospital has determined that any risks in contracts have been determined to be insignificant to the Health Systems overall financial health.

Exhibit C4: We analyze and track referral of patients to other providers by utilizing inpatient data from the Mass Health Data Consortium and inpatient and outpatient data provided to us by managed care plans or other insurers. Referrals to our hospital are tracked via our Meditech system utilizing a variety of modules such as abstracting and admissions. On an ad hoc basis, the Finance department monitors trends such as service utilization, patient origins, and referring physicians. This information is used to evaluate our services and determine if there are mechanisms we may be able to implement to allow us to improve coordination of care with our community providers. It may also be used to determine whether or not it is cost effective to maintain a particular service.

Heywood Hospital
AGO Exhibit C Information
FY 2010 - 2014
Question 2

	2010		2011		2012		2013		Projected 2014	
Govt Payers										
Medicare	$63,494,424		$66,523,373		$69,035,366		$71,474,217		$65,966,079	
Medicare - Sr. HMO plans	$29,843,712		$30,569,873		$29,205,412		$31,443,642		$31,700,383	
Medicaid	$12,810,105		$12,487,258		$14,959,452		$15,182,824		$16,297,363	
Medicaid HMO's	$18,697,476		$21,813,868		$24,061,833		$26,688,410		$30,457,805	
Other Gov't	$1,124,335		$1,232,931		$1,513,724		$2,059,322		$1,895,074	
Total	$125,970,052	59%	$132,627,303	60%	$138,775,787	62%	$146,848,415	63%	$146,316,704	64%
Commercial										
HMO's	$61,735,573		$60,929,897		$60,159,240		$60,160,403		$58,794,369	
Blue Cross Indeminity	$482,150		$402,648		$323,646		$202,541		$126,348	
Other HMO's	$2,419,267		$2,502,837		$2,251,034		$2,381,727		$2,739,709	
PPO's										
Commercial	$3,975,672		$3,994,043		$3,262,145		$2,975,740		$2,983,851	
B/C PPO	$12,145,037		$13,887,290		$12,736,415		$12,401,190		$12,279,263	
Other Insurance	$44,164		$63,255		$33,425		$28,688		$70,761	
Total	$80,801,863	38%	$81,779,970	37%	$78,765,905	35%	$78,150,289	34%	$76,994,301	34%
Other										
Workers Comp	$2,251,170		$2,216,273		$2,344,229		$2,251,875		$2,184,370	
Motor Vehicle										
Self Pay	$4,734,468		$5,000,122		$5,629,118		$5,898,813		$4,312,143	
Total	$6,985,638	3%	$7,216,395	3%	$7,973,347	4%	$8,150,688	3%	$6,496,513	3%
Grand Total	$213,757,553	100%	$221,623,668	100%	$225,515,039	100%	$233,149,392	100%	$229,807,517	100%

Financial Systmes do not break out expenses by insurance carrier therfore margins can not be displayed by insurance product.
Above percentages represent utilization.