Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) 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, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits 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 complete your responses in the provided **Microsoft Word** template. 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**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

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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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 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 in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

       Beth Israel Deaconess Medical Center (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.

       During the 2014-2015 period, the volume of patient activity at BIDMC has been affected by two very different factors. First, our active efforts to reduce unnecessary utilization of hospital services has resulted in reductions in hospital readmission rates, avoidance of unnecessary admissions, and reduced use of the Emergency Department for non-emergent purposes. However, these overall trends in reduced utilization have been more than 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.

       During 2014, the volume of hospitalized patients (inpatients plus floor observation patients) increased by 2.7% due to the increased volume of tertiary admissions from clinical affiliates, as also reflected in the 2.1% increase in overall patient acuity. During the same time period, Emergency Department visits remained essentially flat, while outpatient clinic volume grew by 3.5%. Patient service revenue increased by 5.9% in 2014, while operating expenses, excluding research-related costs, also increased by just over 5.9%, including 5.0% growth in labor costs.

       The same trends of reduced utilization of services, supplemented by increasing tertiary referrals from clinical affiliates, have continued into 2015. Volume of hospitalized patients has increased by 1.8%, while average patient acuity has continued to grow. Emergency Department volume has also increased by 1.8%, and ambulatory clinic volume has grown by 9.6%. Patient revenue has grown by 7.0% thus far in 2015, while operating expenses have increased by 7.9%, including 7.0% growth in labor costs.

       Please also see response provided by Beth Israel Deaconess Care Organization (BIDCO).

    b. What actions has your organization undertaken since January 1, 2014 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 improve our operational efficiency, outpacing industry benchmarks.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

As we noted last year, 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?

As we noted last year, policies, guidelines and regulations that are sensitive and responsive to the current health care market, and recognize the need for a high-quality, cost-effective, premier health care network could enhance BIDMC's efforts to transform our care delivery system. Policies that hinder constructive market innovations could have a significant detrimental impact on the Commonwealth's cost-containment efforts. In addition, reductions in the regulatory and administrative burden on providers remain critical to our long-term cost-containment efforts. Please also see the response provided by BIDCO.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

Please see response provided by BIDCO. Barriers to increased adoption of alternative payment methods include the significant challenge of adequate budgets; initial and ongoing investments in care management and cost management infrastructure; and effective and appropriate attribution of members.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care;

2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.

a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

Please see response provided by BIDCO. We would also note BIDMC's continued membership in 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 HVHCC is working to improve healthcare value – defined as quality and outcomes over costs --in a sustainable way, and includes a focus on variation in use of post-acute care. BIDMC has also implemented a Post-Acute Care Transitions program (PACT) focused on improving post-acute care and reducing hospital readmissions.

As part of an effort to improve patient care and reduce avoidable use of our Emergency Department, BIDMC has piloted a new "Healthy Lives" program. "Healthy Lives" creates pathways for high-need, high cost patients to assume responsibility for their own care in less than a year, saving an average of $21,000 in medical costs annually. Working with patients at Beth Israel Deaconess Medical Center, Bowdoin Street Health Center, and Brookline Community Mental Health Center, the "Healthy Lives" program utilizes an efficient, community-based "care connection" model that engages high-cost patients right where they live; assesses patient needs and provider realities; and strengthens patient connections with their current providers to build a durable system in which patients can assume responsibility for their own care in less than a year.

This program differs from other programs that target high-cost, high need patients in a few ways:

- We are focused on a small population of the most challenging patients with chronic medical and behavioral health challenges;
- The program is patient-centered and community based, adapting to the needs and realities of the patient; and
- Ours is an integrated approach that understands the interaction of medical, behavioral, social and community challenges and the realities of our patients' lives.

The goal of "Healthy Lives" is to transform the way patients steward their own health.

In addition, as described in more detail in last year's testimony, we have also increased our urgent care capacity in the community.

Finally, at our owned clinical affiliates, including BID-Milton, we have collaborated to implement certain programs, such as a Home Discharge Pathway for joint replacement patients, which has dramatically shifted the number of patients who are discharged to home, rather than to post-acute care. In addition, we have implemented case management in our Emergency Departments, which has reduced unnecessary admissions in several ways. Working under the Pioneer ACO SNF waiver, we have also avoided unnecessary hospital stays, and expedited patient transfer to skilled nursing facilities, where the level of care is appropriate to the patient's needs. Finally, we have

implemented ICU physician staffing models in collaboration with the BIDMC Department of Medicine that enhance the ability of our member community hospital affiliates to retain patients in the community who would otherwise have been transferred to a tertiary facility.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

Please see response provided by BIDCO. In addition, BIDMC will continue the programs referenced above.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
   a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

   As recognized by the Special Commission on Provider Price Reform,[1] we agree that there are variables in payment that reasonably contribute to price variation. As the report notes, this is illustrated by Medicare's Inpatient Prospective Payment System (IPPS), which "uses a base Diagnosis Related Group (DRG) rate with adjustments for specific factors. The base rate reflects the national average inpatient cost per discharge from a prior period, trended forward to the rate period using annual update factors." The rate is then adjusted for geographic factors, including wage area and capital factors; case intensity; scope of commitment to medical education; status as a disproportionate share (DSH) provider; and very high cost (outlier) patients. In addition, we believe there are other justified variables in payment, including reimbursement for achieving health care quality benchmarks; trauma and emergency service capacity; stand-by capacity; geographic location; scope of commitment to biomedical research; and commitment to serving underserved, low-income and uninsured patients. Regarding global budgets, the foregoing factors remain relevant, and additional factors would include accommodation for short term and long term investments in the infrastructure needed to create a sustainable, long-term model that improves care for patients, fosters network integration, and ultimately lowers total medical expense. This may include expenses related to technology, care-coordination, and other care management and cost management tools.

   b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

[1] See Recommendations of the Special Commission on Provider Price Reform, November 9, 2011.

Unjustified and dramatic variation in prices paid to like providers continues to have a significant impact on the healthy functioning of the health care market in Massachusetts, both for low-cost community providers, and for providers of similar size and capability who provide precisely the same services and fulfill the same mission at dramatically different prices within the market. Unjustified price variation has contributed to the historic destabilization of hospitals, including community hospitals, those that serve disproportionate numbers of low income patients, and some academic medical centers. It is also clear that price variation is a major contributor to the growth of health care costs in the Commonwealth. This market dysfunction has been harmful to consumers in the Commonwealth, particularly in communities where access to care has eroded or disappeared.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 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 has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

    Beth Israel Deaconess Medical Center strives to provide comprehensive care and services to our patients and community. We recognize our communities' 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. 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. Recent efforts and pilots include:

    - Providing telephone 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, worked to enhance the capacity of OCHS primary care providers (PCPs) to treat patients with behavioral health issues in the patient's primary care/medical home. A BIDMC psychiatrist is available to the PCP to discuss cases and provide psychiatric expertise.

    - BIDMC's Department of Psychiatry continues a pilot project with a Needham internal medicine practice that is part of BIDMC's Affiliated Physician Group (APG). A BIDMC psychiatrist provides weekly telephone consultation services to physicians.

- In September 2014, the BIDMC Department of Psychiatry expanded its on-site and telephone consultation to the Joseph M. Smith Community Health Center (JMSCHC). The health center has a low-income, racially and ethnically diverse, limited English-proficient patient population, many of whom (46%) remain uninsured. As such, JMSCHC faces significant challenges in providing mental health services to their patients. BIDMC's Psychiatry department offers 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 APG practices in Brookline and Lexington are piloting an arrangement with a psychiatrist whereby the psychiatrist and/or psychologist have been 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. The initial one-year phase of the pilot was successful, and will be expanded in its second year.

- 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, referenced and described in Question 3, 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. The Healthy Lives program has been expanded to serve patients at our Bowdoin Street Health Center.

- 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 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), this effort relies on support from BIDMC 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 describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

BIDMC conducts universal screening for substance abuse in our Emergency Department. We have trained Emergency Department residents, attending physicians and nurses to administer Screening, Brief Intervention, Referral and Treatment (SBIRT). We continue to include 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 with the goal of linking the patient to appropriate community-based detoxification and substance use treatment. We also notify the patient's primary care provider when a patient screens positive for substance abuse. This increases the opportunities for dialogue on treatment options.

Despite our efforts to integrate behavioral health care with medical care/primary care, patients with comorbid mental health and other chronic conditions are often admitted to our medical inpatient units. Emergency room and medical inpatient stays for this cohort are often 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 untreated depression, he/she may not fill a prescription for cardiac medication or adhere to a medication regimen. BIDMC recognizes that these patients may need extra help to keep them out of the hospital and in their communities where they can obtain care in their medical homes. In an effort to avoid unnecessary utilization of the Emergency Department (ED) and inpatient care, BIDMC addresses this need several different ways, including:

- A BIDCO team of 17 nurse (RN) care managers and four nurse practitioners assist many patients with behavioral health and psychosocial problems to prevent unnecessary utilization of the 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 many low-income, racially, ethnically and linguistically diverse patients who access care at three of our affiliated health centers.
- The BIDMC Department of Psychiatry offers an urgent care program that offers access to rapid psychiatric consultation. Primary care providers can speak with an on-call psychiatrist to discuss a patient's situation and determine if the patient needs an urgent psychiatric visit, evaluation in the ED or at a routine ambulatory session, for

diagnostic assessment and treatment planning. This program has been in existence for more than a decade.

- Working with BIDCO, in FY2014, three of our health centers (Bowdoin Street, Dimock, and Joseph M. Smith) have designed and implemented a House Calls program for some patients in the Pioneer ACO. This program is now being used BIDCO-wide for appropriate Pioneer ACO patients.
- A hospital-wide Task Force has begun meeting to assess the needs of our patients who are opioid abusers, our current ability to respond to those needs, and to make recommendations as we identify challenges, opportunities, and areas in need of improvement.
- A comprehensive, system-wide assessment of mental health services at BIDMC in Boston, Plymouth, Needham and Milton is underway to identify ways that the system can improve the care of the patients we serve.

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, ED and inpatient care to office-based, integrated care with the patient's primary care provider and psychiatrist working collaboratively. Likewise, our BIDCO care management team addresses mental health and psychosocial needs of patients on an on-going basis thereby preventing readmissions and unnecessary hospitalizations and use of the Emergency Department. Because some of the above programs are either grant funded or pilots, we face funding challenges. A key to 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, because of inadequate reimbursement, the Commonwealth's mental health services are fragile and highly uneven, which makes it even more difficult to manage the care of patients. So, for example, given the shortage of inpatient beds, 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 an impediment to effectively managing the patient's care. Lastly, there is a concerning shortage of bilingual behavioral health professionals, child and adolescent providers, and in general, significantly 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 ED's for days at a time waiting for beds to become available. This adds substantially to the cost of care delivery.

We would note that the Office of the Attorney General in its report on June 30, 2015 entitled, "Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D, § 8" did an excellent and compelling job of describing how our current mental health insurance system with "carve outs" for mental health services works against efforts to integrate mental health care with the rest of medical care, provides little or no incentive to optimize utilization of services, and keeps reimbursement for mental health services at a "historical low." A system in which there are two separate and distinct budgets for mental health care and the rest of health care is not consistent with our goal of providing better care to the patients we serve at a lower cost.

We would further draw attention to the CHIA data cited in the Attorney General's report. The report summarizes it as follows: *"Among 18 general acute care hospitals that reported inpatient behavioral health margins for commercial and government business from 2010 to 2013 - including academic medical centers, teaching hospitals, community hospitals, and disproportionate share hospitals across all geographies - the cumulative margin for all of these hospitals over those four years was negative 39%.*" Unfortunately, BIDMC is among those hospitals that bear a significant negative margin for the mental health services that we provide. This represents a serious impediment toward reaching the above stated goals. When we are in a deficit situation, it is particularly difficult to invest in much-needed innovative programs aimed at developing cost-effective care for our entire population.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

   Please see the response provided by BIDCO and please also see BIDMC's testimony from 2014 relative to Patient Centered Medical Homes (PCMHs), described in Question 12 of 2014.

   As noted in 2014, 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 hospitals and physician groups the structure to contract, share risk, and build care management systems together, with the goal of providing the highest quality care in the most appropriate setting and in the most cost-effective way.

   In addition, as described in last year's testimony, many primary care practices within and affiliated with BIDMC have significant experience with PCMHs, including our affiliated community health centers and Health Care Associates (HCA), a large primary care practice within BIDMC, which is certified as a Level II PCMH and is in the process of applying for status as a Level III PCMH.

7. Since 2013, Beth Israel Deaconess Medical Center (BIDMC) has completed a number of material changes, including acquiring Beth Israel Deaconess-Plymouth (BIDH-Plymouth,

formerly Jordan Hospital), and developing clinical affiliations with Signature Healthcare-Brockton (Brockton), Cambridge Health Alliance (CHA), and New England Baptist Hospital. Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.

a. How have costs (e.g. prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes? Please include summary tables showing, prior to and subsequent to the acquisition of BIDH-Plymouth, the volume of Jordan Physician Associates patients referred to each of the top five hospitals to which these physicians refer.

Costs, Referral Patterns, Quality, and Access to Care

BIDMC has continued to create a network of low cost community providers, within a distributed geography, who are among the very lowest cost hospitals in Massachusetts. Each of our clinical affiliates plays a significant role locally in providing a safety net for low-income and vulnerable patient populations. BIDMC's goal is to continue to work closely with our clinical affiliates to augment their clinical capabilities locally in primary and specialty care; to conduct physician recruitment in their local communities; to develop new clinical programs locally; to market the availability of services in the community; to collaborate on quality programs and initiatives; and to invest financial and human resources in the community. These actions improve patient access to care close to home, and reduce costs by providing the right care in the most appropriate setting. BIDMC, along with our physician practice partners, also spearheaded creation of Beth Israel Deaconess Care Organization (BIDCO), which aligns community doctors with their local community hospitals, and fosters maximum utilization and retention of care in the community.

As a result of the clinical affiliations referenced above, greater numbers of patients in the Greater Brockton, Plymouth, and Cambridge Health Alliance (CHA) communities are accessing lower cost care in their local communities. Too, they are seamlessly utilizing BIDMC, one of the lower cost, academic medical centers (AMCs) in Eastern Massachusetts, as shown in CHIA's January 2015 Massachusetts Hospital Profiles report (based on 2013 adjusted cost per CMAD).

Given that each of our clinical affiliates may be characterized as a very low cost provider in Eastern Massachusetts, increased patient care volume at our clinical affiliates will contribute to efforts to lower overall cost growth within the Commonwealth – a goal of Chapter 224 of the Acts of 2012. Once the 2014 CHIA statewide inpatient data is available, we anticipate that it will support our belief that more care is being kept in the community as appropriate to patient needs. Similarly, more consistent utilization of BIDMC has resulted in greater numbers of patients accessing tertiary care in a lower cost AMC, again contributing to the lowering of overall cost growth in Massachusetts.

Finally, as a result of joining BIDMC, our owned clinical affiliates have also been able to achieve cost savings in several ways, including significant cost savings to operations; savings yielded through our group purchasing organization; and refinancing of long-term debt at substantial savings to each of our owned clinical affiliates. In addition, the

incorporation of our owned clinical affiliates into BIDCO has also contributed to savings in Total Medical Expense (TME) as a component member of BIDCO, which was recognized as the top performing ACO in Massachusetts last year. This recognition stems from generating significant savings of $17.3 million for the Pioneer ACO initiative in 2014, reducing spending on inpatient services by 2%, and significantly improving care and care management in several areas, including: diabetes care; depression screening and early intervention for patients who show signs of depression; and increasing patient fall risk assessments.

Quality

We continue to work closely with our affiliates to establish linkages between BIDMC's health care quality team and the quality teams at our clinical affiliates, in order to leverage our collective expertise and experience. BIDMC provides our clinical affiliates access to BIDMC's quality and performance improvement expertise and infrastructure through regularly scheduled meetings of Chief Medical Officers and health care quality staff; participation in monthly quality meetings at BIDMC; and participation in annual health care quality and patient safety symposiums. For BIDMC's owned affiliates, our organizations have also pursued reciprocal participation in Board level quality oversight Committees through membership on Patient Care Assessment Committees, and have developed a standardized quality performance dashboard.

Access to Care

As more fully detailed below, in collaboration with our clinical affiliates we have successfully enhanced local health care services across multiple service lines, including primary and specialty care.

Among BIDMC's owned clinical affiliates, key collaborative initiatives in Emergency Medicine and Hospital Medicine have significantly improved consistency among our institutions and improved local patient admissions, clinical protocols, clinical standards for transfer, and quality improvement metrics. We have also streamlined local Emergency Department throughput. These improvements have significantly enhanced both patient satisfaction and primary care clinician (PCC) satisfaction.

Overall, the improved strength of our low-cost clinical affiliates, relative to significantly higher-cost providers within the same market, will achieve the twin goals of improving patient access to high quality, cost-effective care, while moderating overall cost growth within the Commonwealth.

Of note, our collaboration with New England Baptist Hospital is still in its early stages and strategic planning is ongoing. The goals articulated in our HPC "Notice of Material Change" filing remain, which include developing opportunities to bring high quality and high value orthopedic care to broader patient populations, with improved efficiency and outcomes.

The tables of data requested relative to Jordan Physician Associates (JPA) are included as an attachment and include the major hospitals to which patients were transferred.

a. BIDMC indicated that through its acquisition of Jordan Hospital and affiliations with Brockton and CHA, it was seeking to optimize the provision of primary care and improve equitable primary care delivery to patients in these service areas. What progress has been made toward this goal, and what measurable improvements have been made in the provision of primary care in the service areas of these three hospitals?

As noted above, a key shared goal with our clinical affiliates is to meet the primary care needs of the communities they serve based on an assessment of those specific needs. As each of our clinical affiliate's needs have varied, likewise our collaboration with each differs based on local circumstances. In each case, however, we have striven to fully understand the local environment and in a collaborative fashion execute on plans to meet those identified needs. In some cases execution of this strategy included jointly employing PCP's through BIDMC's Affiliated Physicians Group (APG). In others it was through joint planning and shared recruitment efforts. In addition, of critical importance in our collaborations is a shared recognition of the importance of each of these community providers in serving as a local safety net for underserved and vulnerable patient populations. BIDMC maintains a strong and shared commitment to supporting the mission of our clinical affiliates, to ensuring greater access to high quality care in these communities, and to seamlessly serving their tertiary needs.

<u>BID-Plymouth</u>
Together, BIDMC and BID-Plymouth have accomplished a significant expansion of primary care in communities that comprise the Plymouth service area. Since coming together with BIDMC in 2013, BID-Plymouth has added 5 new primary care physicians into the Plymouth service area as members of APG. We have also enhanced alignment of the Plymouth Medical Group into the BIDMC Network, strengthening this group's important relationship with BID-Plymouth locally and providing for tertiary care alignment with BIDMC.

<u>Signature Health Care – Brockton (SHC-Brockton Hospital)</u>
To date, the strategy for primary care enhancement in the Greater Brockton service area has been locally driven and independently implemented by SHC – Brockton Hospital. BIDMC, however, remains committed to working with SHC-Brockton Hospital should the need for enhanced primary care recruitment emerges as an area where BIDMC could add value to the process. BIDMC has worked closely with SHC-Brockton Hospital however, to enhance specialty care locally in a number of key areas.

<u>Cambridge Health Alliance (CHA)</u>
Building upon a primary care presence in the Malden, Chelsea, Revere, Everett and the broader CHA service area, BIDMC and CHA have collaborated to improve our understanding of our ability to meet the primary care needs of patients served in the above communities and to address community primary care expansion. With several communities showing a clear need for greater primary care access, and particular need for

family practice and internal medicine, CHA has significantly enhanced the complement of primary care clinicians in the CHA service area. Additionally, BIDMC has continued to add primary care providers and expand specialty care services at its long-established Beth Israel Deaconess Health Care (BIDHC)-Chelsea location. Further, Whidden Hospital in Everett and the BIDHC-Chelsea practice jointly collaborate in several key areas, including emergency care, primary care, and specialty care; in enhancing coordinated and convenient patient care; in collaborating to lower costs; and in keeping appropriate care in the community.

As an important commitment to improving community health and equitable primary care delivery, BIDMC recently became a board member of the Institute for Community Health (ICH), a unique collaboration founded in 2000 by three Massachusetts health care systems. ICH is dedicated to health status improvement through its sponsorship of community-based research, needs assessment, information dissemination, and educational activities. Together with BIDMC's Community Benefits Department, a collaboration with ICH will further enhance our joint commitment to advancing community health; promoting education and training; and forging strong linkages among health care systems, community partners, and academic institutions with shared community health objectives.

b. BIDMC indicated that it would "work to enhance and expand the range of services offered locally at CHA sites through various means which may include the joint recruitment of physicians, [Harvard Medical Faculty Physicians] providers holding specialty and sub-specialty clinics at CHA sites under various arrangements, shared medical education and quality improvement efforts, and other similar collaborative arrangements." BIDMC made similar statements regarding enhancement and expansion of services offered locally by BIDH-Plymouth and Brockton. What specific steps have been taken at CHA, BIDH-Plymouth, and Brockton, respectively, to enhance and expand the range of services offered locally? Which services have been enhanced or expanded as a result of the affiliation?

A key strategy for keeping patient care in the local community and in lower cost settings is to add specialty care in the community based upon local needs and when clinically appropriate. We support our clinical affiliates in enhancing their specialty capabilities in a number of ways, including: assisting the local institution in their recruitment efforts; jointly recruiting new specialists that will practice in the community and also at BIDMC; and placing Harvard Medical Faculty Physicians (HMFP) specialists either full-time or on an as-needed session basis into the community based on local patient needs.

<u>BID-Plymouth</u>

At BID-Plymouth, our collaborative efforts to expand the availability of specialty and sub-specialty care have been extensive and include the following clinical services:

- Anesthesia/Intensive Care
- Cancer Care
- Cardiology

- Emergency Medicine
- Hospital Medicine
- Podiatry
- Thoracic Surgery
- Urology, and
- ENT (Otolaryngology), which is still in development.

Many of these services represent a new investment and new presence at BID-Plymouth, and for other services, our intent has been to meet the need and demand for those services within our lower-cost, high-value network.

Signature Health Care – Brockton (SHC-Brockton Hospital)

Working collaboratively with SHC-Brockton Hospital, we jointly identified several areas of opportunity to provide care locally at SHC-Brockton Hospital or to jointly recruit and hire specialists to provide care in the community. A key area of focus in SHC-Brockton Hospital has been a significant enhancement of orthopedic surgery at SHC-Brockton Hospital, which is part of a larger strategy to enhance the level and scope of services provided locally. This effort provides patients with increased choice and increased access for joint replacement surgeries and other orthopedic procedures. In addition to orthopedics, we have jointly collaborated to expand specialty care in Electrophysiology, Gynecology, Surgical Oncology, and Podiatry. BIDMC also successfully assumed sponsorship of SHC-Brockton Hospital's transitional year residency program and has placed medical and surgical residents at SHC-Brockton Hospital, further enhancing our shared goals regarding enhanced medical education training. We are continuing to collaborate in a range of areas to improve patient access to care locally, including establishing Medical Oncology services at SHC-Brockton Hospital.

Cambridge Health Alliance (CHA)

In collaboration with Cambridge Health Alliance (CHA), we have jointly recruited a number of specialists to fill patient needs at both organizations and we are collaborating in a number of other programs that bring physician resources to the local communities CHA serves. BIDMC, HMFP, and CHA have successfully enhanced dermatology care at CHA during the initial phase of the affiliation, bolstering needed dermatology services in the CHA communities. We have also collaborated on Primary Care, Cardiology, Gastroenterology, Hematology/Oncology and Pulmonology, with additional collaboration expected for General and Surgical Specialty Services including Thoracic. Together in the CHA service area, the BIDHC-Chelsea practice is working collaboratively with CHA's extensive network of behavioral health providers and exploring opportunities to embed providers within the primary care/medical home setting, with the overall goal of integrating and coordinating needed services for patients living and working in the area.

In addition to the foregoing, other important collaborative efforts in education and health care quality are occurring through BIDCO as well as on the ground at both Cambridge and Whidden Hospitals. BIDMC and HMFP specialists provide educational programs at CHA, and CHA physicians participate in grand rounds at BIDMC. Additionally, there are numerous opportunities for physicians and patient care staff to participate in educational

activities such as BIDMC's annual health care quality symposium, sponsored by BIDMC's Silverman Institute for Healthcare Quality.

BIDMC and CHA have begun close collaborative efforts in Cancer Care and plans are underway for expansion of care at CHA in several areas including Breast, Lung and Thoracic Cancer Care. Additionally, there is a unique opportunity to work collaboratively with CHA in its role as the Public Health Department for the City of Cambridge in extending and expanding community health cancer screening, educational programs, and other initiatives.

In addition to successful efforts to expand primary care locally, and enhance specialty capabilities locally, and to generally provide seamless, coordinated and integrated care among our providers and sites, BIDMC and CHA have implemented bi-directional electronic medical record exchange between our organizations, supporting both high quality patient care and timely clinical information flow between providers and sites.

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 provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	47	42	89	Labor and Delivery, Surgery-various, Office visits, Colonoscopies, Lab Work and Radiology
	Q2	48	63	111	Same as above
	Q3	46	147	193	Same as above
	Q4	30	159	189	Same as above
CY2015	Q1	15	192	207	Same as above
	Q2	18	178	196	Same as above

38T

2. Please submit a summary table showing for each year 2011 to 2014 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. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.
38T

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.

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											$ 119,661,629	$ 125,507,124			
Tufts Health Plan											$ 29,011,676	$ 38,895,703			
Harvard Pilgrim Health Care											$ 94,771,386	$ 54,502,314			
Fallon Community Health Plan											$ 2,493,289				
CIGNA											$ 7,269,409				
United Healthcare											$ 9,313,417				
Aetna											$ 19,910,957				
Other Commercial											$ 46,075,208				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 328,506,971	$ 218,905,141	$ -	$ -	$ -
Network Health											$ 18,199,027				
Neighborhood Health Plan											$ 23,547,913				
BMC HealthNet, Inc.											$ 8,439,609				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 2,836,946				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 53,023,495	$ -	$ -	$ -	$ -
MassHealth											$ 49,911,357				
Tufts Medicare Preferred											$ 27,108,187				
Blue Cross Senior Options											$ 9,658,494				
Other Comm Medicare											$ 15,096,815				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 51,863,496	$ -	$ -	$ -	$ -
Medicare											$ 306,402,422				
Other											$ 30,517,113				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 820,224,854	$ 218,905,141	$ -	$ -	$ -

Total	$ 1,039,129,995	
Current Year	$ 1,063,772,129	
Prior Year	$ 2,675,922	
Per Financial Statement	$ 1,066,448,051	
Bad Debt Expense	$ (22,265,218)	Booked as expense on P&L
UC Pool Shortfall	$ (5,052,838)	Booked as expense on P&L
Adjusted Net Revenue	$ 1,039,129,995	
	$ 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											$ 105,544,371	$ 132,653,931			
Tufts Health Plan											$ 29,684,375	$ 42,023,010			
Harvard Pilgrim Health Care											$ 107,479,478	$ 46,199,904			
Fallon Community Health Plan											$ 3,317,542				
CIGNA											$ 7,281,811				
United Healthcare											$ 10,897,132				
Aetna											$ 19,828,704				
Other Commercial											$ 39,575,299				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 323,608,712	$ 220,876,845	$ -	$ -	$ -
Network Health											$ 28,026,063				
Neighborhood Health Plan											$ 28,625,801				
BMC HealthNet, Inc.											$ 7,359,777				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 3,453,936				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 67,465,577	$ -	$ -	$ -	$ -
MassHealth											$ 53,639,500				
Tufts Medicare Preferred											$ 26,620,374				
Blue Cross Senior Options											$ 8,184,258				
Other Comm Medicare											$ 10,835,171				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 45,639,803	$ -	$ -	$ -	$ -
Medicare											$ 306,714,527				
Other											$ 27,754,576				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 824,822,695	$ 220,876,845	$ -	$ -	$ -

$ 1,045,699,540

Per Financial Statement	$ 1,081,101,445	
Bad Debt Expense	$ (26,869,452)	Booked as expense on P&L
UC Pool Shortfall	$ (8,532,453)	Booked as expense on P&L
Adjusted Net Revenue	$ 1,045,699,540	

$ (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											$ 96,776,363	$ 130,404,379			
Tufts Health Plan											$ 27,904,355	$ 46,794,677			
Harvard Pilgrim Health Care											$ 115,542,215	$ 40,150,750			
Fallon Community Health Plan											$ 3,927,268				
CIGNA											$ 8,847,550				
United Healthcare											$ 10,170,712				
Aetna											$ 18,776,760				
Other Commercial											$ 38,519,231				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 320,464,454	$ 217,349,806	$ -	$ -	$ -
Network Health											$ 32,081,487				
Neighborhood Health Plan											$ 31,625,163				
BMC HealthNet, Inc.											$ 11,174,789				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 4,770,681				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 79,652,120	$ -	$ -	$ -	$ -
MassHealth											$ 45,951,782				
Tufts Medicare Preferred											$ 29,875,810				
Blue Cross Senior Options											$ 8,488,299				
Other Comm Medicare											$ 13,058,576				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 51,422,685	$ -	$ -	$ -	$ -
Medicare											$ 314,477,831				
Other											$ 22,162,626				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 834,131,498	$ 217,349,806	$ -	$ -	$ -

Total	$ 1,051,481,304
Per Financial Statement	$ 1,051,481,304
Variance	$ -

2014

	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											$ 99,581,307	$ 138,530,376			
Tufts Health Plan											$ 29,778,313	$ 47,911,709			
Harvard Pilgrim Health Care											$ 142,490,830	$ 17,626,536			
Fallon Community Health Plan											$ 5,402,335				
CIGNA											$ 9,196,816				
United Healthcare											$ 8,801,820				
Aetna											$ 18,317,606				
Other Commercial											$ 42,772,840				
Total Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 356,341,867	$ 204,068,621	$ -	$ -	$ -
Network Health											$ 35,784,945				
Neighborhood Health Plan											$ 38,693,280				
BMC HealthNet, Inc.											$ 16,355,536				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ 2,558,399				
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 93,392,160	$ -	$ -	$ -	$ -
MassHealth											$ 48,006,757				
Tufts Medicare Preferred											$ 32,817,387				
Blue Cross Senior Options											$ 12,071,155				
Other Comm Medicare											$ 13,897,311				
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 58,785,853	$ -	$ -	$ -	$ -
Medicare											$ 327,279,431				
Other											$ 25,632,535				
GRAND TOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 909,438,603	$ 204,068,621	$ -	$ -	$ -

Total	$ 1,113,507,224
Per Financial Statement	$ 1,113,507,224
Variance	$ 0

BETH ISRAEL DEACONESS HOSPITAL-PLYMOUTH

JPA PRIMARY CARE PHYSICIANS

PATIENTS TRANSFERRED TO OTHER ACUTE CARE HOSPITALS - FROM INPATIENT STATUS

Discharge Status Code	Discharge Status Description	2013	2014	2015 THROUGH 8/24/15	Grand Total
AH	OTHER ACUTE HOSP-NOT LISTED		2	4	6
AHBI	BETH ISRAEL DEACONESS BOSTON	6	22	16	44
AHBMC	BOSTON MEDICAL CENTER	1			1
AHBW	BRIGHAM & WOMEN'S	2	1	2	5
AHMG	MASS GENERAL	1	1	1	3
AHNEM	NEW ENGLAND MEDICAL CENTER	7			7
AHSS	SOUTH SHORE HOSPITAL	1			1
AHSTEL	ST. ELIZABETH'S MEDICAL CENTER			1	1
AHTMC	TUFTS MEDICAL CENTER			1	1
Grand Total		**18**	**26**	**25**	**69**

BETH ISRAEL DEACONESS HOSPITAL-PLYMOUTH

JPA PRIMARY CARE PHYSICIANS

PATIENTS TRANSFERRED TO OTHER ACUTE CARE HOSPITALS - FROM E.D. STATUS

Discharge Status Code	Discharge Status Description	2013	2014	2015 THROUGH 8/24/15	Grand Total
AH	OTHER ACUTE HOSP-NOT LISTED			1	1
AHBI	BETH ISRAEL DEACONESS BOSTON	7	32	39	78
AHBMC	BOSTON MEDICAL CENTER	3	2	1	6
AHBW	BRIGHAM & WOMEN'S	5	1	3	9
AHCC	CAPE COD HOSPITAL		1		1
AHCH	CHILDREN'S HOSPITAL		1		1
AHMEE	MASS EYE AND EAR			1	1
AHMG	MASS GENERAL		1	3	4
AHNEM	NEW ENGLAND MEDICAL CENTER	15			15
AHSS	SOUTH SHORE HOSPITAL		1		1
AHTMC	TUFTS MEDICAL CENTER			3	3
Grand Total		**30**	**39**	**51**	**120**