Lahey Health

Mall Road
rlington, MA 01805
781.744.8330 P
781.744.5767 F
LaheyHealth.org

Submitted via email: HPC-Testimony@state.ma.us

September 11, 2015

David Seltz
Executive Director
Health Policy Commission
50 Milk Street
Boston, MA 02109

Dear Mr. Seltz,

Enclosed please find written testimony submitted on behalf of Lahey Health System, Inc. in response to the questions of the Health Policy Commission in Exhibit B and questions of the Office of the Attorney General in Exhibit C, as requested in the letter dated August 6, 2015.

In addition, written testimony submitted on behalf of Lahey Clinic Foundation, Inc. and Lahey Hospital & Medical Center are enclosed in response to select questions not specifically addressed in the Lahey Health System, Inc. testimony, and posed by the Office of the Attorney General in Exhibit C.

I, Howard R. Grant, am legally authorized and empowered to represent Lahey Health System, Inc. and all subsidiary entities, for the purposes of this testimony, and this testimony is signed under the pains and penalties of perjury.

Sincerely,

Howard R. Grant, J.D., M.D.
President & CEO
Lahey Health System, Inc.

2015

Annual Public Hearings on Health Care Cost Trends: Pre-Filed Written Testimony Submission

On Behalf of Lahey Health System, Inc. and Subsidiaries

In Response to Request from The Health Policy Commission (HPC) and The Office of The Attorney General (AGO)

Note: *As per established precedent, LHMC/Lahey Clinic is required to submit a separate response only to those questions not already specifically addressed in the Lahey Health System, Inc. and Subsidiaries response submission.*

TABLE OF CONTENTS

SECTION I	**LAHEY HEALTH Exhibit B: HPC Questions and Responses**	
Question **1**		1
Question **2**		3
Question **3**		4
Question **4**		7
Question **5**		9
Question **6**		10
Question **7**		11
SECTION II	**LAHEY HEALTH Exhibit C: AGO Questions and Responses**	
Question **1**		1
Question **2**		2
Question **3**		2
SECTION III	**LAHEY CLINIC/LHMC Exhibit C: AGO Questions and Responses**	
Question **2**		1

NOTE: *AS PER ESTABLISHED PRECEDENT, LHMC/LAHEY CLINIC IS REQUIRED TO SUBMIT A SEPARATE RESPONSE ONLY TO THOSE QUESTIONS NOT ALREADY SPECIFICALLY ADDRESSED IN THE LAHEY HEALTH SYSTEM, INC. AND SUBSIDIARIES RESPONSE SUBMISSION.*

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 in CY 2013 and CY 2014 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.

*See Attachment B1-a for detail. Data provided by fiscal year (October-September), following the format of previous submissions. The same **ten months** of data (ending July 31) are provided for comparison purposes of FY2014 - FY2015. Data is normalized to assume Winchester was part of Lahey Health System at the start of FY2013 (actually became part of LHS in mid-FY2014).*

Operating Revenue and Expense Trends

- Operating expense growth continues to (and at an increasing rate) exceed operating revenue growth

Comparing **FY2013** (10/2012 – 09/2013) to **FY2014** (10/2013 – 09/2014)

- Operating revenues increased 1.1% and operating expenses increased 1.5%

Comparing Ten Months of **FY2014** (10/2013 – 07/2014) to Ten Months of **FY2015** (10/2014 - 07/2015)

- Operating revenues increased 4.2% and operating expenses increased 8.2%

Utilization Trends

Comparing **FY2013** (10/2012 – 09/2013) to **FY2014** (10/2013 – 09/2014)

- Inpatient discharges remained flat at Lahey Hospital & Medical Center (LHMC, +0.4%), increased at Beverly Hospital/Addison Gilbert Hospital (BH/AGH, +3.1%), and decreased at Winchester Hospital (WH,-8.4%)
- Emergency department (ED) visits increased at LHMC (+1.8%), and decreased at BH/AGH (-1.5%) and WH (-2.9%);
- Observation discharges increased at all sites: LHMC (+13.7%), BH/AGH (+20.8%), and WH (+9.1%)
- Total outpatient visits increased at LHMC (+2.3%) and BH/AGH (+3.5%), and decreased at WH (-1.9%)
- Outpatient imaging increased at LHMC (+7.8%), and decreased at BH/AGH (-2.9%) and WH (-2.7%)
- Home Health visits increased at BH/AGH (+24.8%), WH (+8.7%), and the Visiting Nurse Association of Middlesex-East (VNAME, +10.3%)
- Ambulatory surgeries increased at LHMC (+2.5%), and decreased at BH/AGH (-4.9%) and WH (-1.1%)

Comparing Ten Months of **FY2014** (10/2013 – 07/2014) to Ten Months of **FY2015** (10/2014 - 07/2015)

- Inpatient discharges increased at all sites: LHMC (+5.9%), BH/AGH (+1.6%), and WH (+4.4%)
- Emergency department visits increased at all sites: LHMC (+4.0%), BH/AGH (+3.4%) and WH (+8.9%)
- Observation cases decreased at LHMC (-10.3%), and increased at BH/AGH (+4.0%), and WH (+6.9%)
- Total outpatient visits decreased at LHMC (-2.1%), and increased at BH/AGH (+4.8%), and WH (+7.3%)
- Outpatient imaging increased at LHMC (+4.8%), decreased at BH/AGH (-1.3%), and remained relatively flat at WH (-0.5%)
- Home Health visits remained flat at BH/AGH (+0.9%), and increased at WH (+14.6%), and VNAME (+8.6%)

- Ambulatory surgeries decreased at LHMC (-3.3%), remained relatively flat at BH/AGH (-0.6%), and decreased at WH (-1.7%)

FACTORS DRIVING TRENDS (FY2014 – FY2015)

- Investments in and implementation of Epic electronic health record (EHR) increased expenses
- Closer examination of coding practices contributed to observed decreases in observation cases at LHMC (and potentially, at least in part, to observed increases in inpatient discharges at all sites)
- Inpatient and outpatient volume increases at BH/AGH likely attributable in part to affiliation with/acquisition of new physician practices on the North Shore
- Historic snowfall in January and February 2015 resulted in: decreases in ambulatory visits and surgical volume at LHMC, decreased operating revenues, and increased operating expenses (snow removal)

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?

Generally, and despite growing operating costs referenced in part a), Lahey continued to expand its network of high-value partners across the care continuum, participated in more alternative payment method (APM) contracts and related innovative care redesign pilots, invested in infrastructure to better manage and coordinate care of populations, and most importantly, remained focused on delivering care at the most cost-effective location within the Lahey system. Further, Lahey remained committed to a conservative pricing philosophy and minimization of patient cost-sharing.

SPECIFIC LAHEY HEALTH COST MANAGEMENT INITIATIVES AND RESULTS

INITIATIVES

- Affiliation with WH to expand network of high-value facilities
- Affiliation with VNAME to provide integrated home, palliative, and hospice care
- Participation in an increasing number of APM contracts, including addition/expansion of commercial risk-contracts, and participation in the MSSP and BPCI[1]
- Implementation of Epic EHR at LHMC
- Investment in behavioral health resources and support staff at select primary care sites, in other community settings,[2] and hospital EDs
- Investment in human resources and infrastructure platforms to improve care and performance management capabilities
- Establishment of centralized and standardized clinical and corporate functions/policies across the Lahey System

OUTCOMES

- Lower hospital and physician commercial prices compared to most relevant peers[3]

[1] MSSP = Medicare Shared Savings Program; BPCI = Bundled Payments for Care Improvement Initiative.
[2] For additional details, please see response to Exhibit B, Q5
[3] CHIA Hospital Profiles and Data books (2012 and 2013 data). LHMC peers are academic/teaching hospitals with comparable CMI. BH and AGH peers are community hospitals located in the same or adjacent regions, of similar size and comparable CMI.

- Health-adjusted TME (CY2014, preliminary) and annual TME increase (2013-2014) were lower than relevant peer provider organizations and the cost growth benchmark[4]
- Modest, if any, increases in patient cost-sharing provisions
- Minimal year-to-year price fluctuations
- Generated savings in both the Lahey Clinical Performance ACO (LCPACO) and the Winchester Community ACO (WCACO): Year 2 savings totaled $11.7M and $10.9M for LCPACO and WCACO, respectively

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?

- Continue system-wide implementation of Epic
- Merge the LCPACO and WCACO, and renew MSSP contract for an additional term
- Implement bundled payment programs for Congestive Heart Failure, Coronary Artery Bypass Graft, Hip & Femur Procedures (excluding total joint arthroplasty), Major Bowel Procedures, Total Joint Arthroplasty (lower extremity), and Stroke (note: initially slated to occur primarily at LHMC)
- Continue to pursue high-value partnerships to expand the Lahey Health care continuum
- Redesign primary care network practices around patient-centered medical home (PCMH) principles
- Continue to build out the infrastructure and physician participation in the Winchester PHO

Please refer to responses provided in B3 and B5 for more detailed information about specific initiatives to decrease readmissions and avoidable ED use, and focus on high-risk, high-cost patients.

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

Most impactful policy changes would:

- Require (and hold accountable for) more timely and comprehensive payor data submission and reporting, particularly for patients with chronic disease
- Incent payor/provider collaboration to build care management infrastructure
- Increase state funding for innovative delivery and payment redesign pilots
- Increase state funding to sustain successful pilots and allow for more expedient and efficient widespread implementation
- Help providers and payors to reward consumers who select high-value care providers
- Address reimbursement/benefit design barriers to integrating behavioral and physical health care
- Require greater coordination and streamlined processes among regulatory agencies responsible for accreditation and audits

[4] CHIA 2015 Annual Report Data book.

- Support subsidization of care management infrastructure and human resources, particularly for management of the chronically ill
- Limit health plan administrative retention

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

Barrier #1: Cost

Issue: The cost of both infrastructure and operations to succeed under APMs is significant

Suggestions to Address:

- Subsidization of infrastructure costs; payor/provider cost-sharing to build infrastructure
- Standardized quality and cost reporting across payors

Barrier #2: Data Availability/Accessibility

Issue: Claims data that is required to understand APM performance (and subsequently make appropriate modifications) may be unavailable if attributed patients are treated outside of the Lahey system and/or may not be provided in a timely enough fashion.

Suggestions to Address:

- Enhance access to attributed patient data regardless of care delivery site
- Require more routine and comprehensive claims data reporting

Barrier #3: PPO Benefit Design

Issue: PPOs are typically designed to maximize consumer choice and often do not adequately incent (or adequately inform members to enable) selection of high-value providers.

Suggestions to Address:

- PPO-specific APM contracts designed to reconcile consumer choice with high-value consumer decision-making
- Frequent consumer-directed reporting to PPOs members highlighting lower-cost and equal quality providers

Barrier #4: Carve Outs

Issue: Behavioral health services are generally carved out of APMs, but clearly behavioral health conditions significantly impact the need for and use of medical care services.

Suggestions to Address:

- APM contract design that incents integration of behavioral and physical health care delivery
- APMs focused specifically on patients with co-morbid behavioral and physical health issues

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.

The fourth area –providing focused care for high-risk/high-cost patients – is the primary mechanism by which success is achieved on the previous three areas. Therefore, our response is organized by describing how providing focused care for high-risk/potentially high-cost patients drives more efficient and effective care delivery by targeting spending on post-acute care, reducing readmissions, and reducing avoidable ED use.

Note: please refer to response provided to question B5 for more detailed information on identification of and resource deployment for high-risk/high-cost patients with co-morbid physical and behavioral health issues.

Spending on Post-Acute Care

Integration of Visiting Nurse Association of Middlesex-East (VNAME)

In an effort to better directly manage transitions of care across the continuum, VNAME joined Lahey Health in the fall of 2014.

WH CHART Phase 1: Transitions of Care

WH's CHART 1 Grant supported the creation and implementation of a warm-handoff protocol to actively facilitate transitions to/from post-acute care settings. In the last month of the pilot program, the warm-handoff protocol was followed for 93% of adults discharged from WH's IP units, up 13% vs. the first month of the pilot. The same CHART 1 Grant also supported an ED-based pilot program which entailed care manager rounding to proactively identify candidates for transfer to a skilled-nursing facility (SNF) or discharge. It is anticipated that better facilitating hand-offs and ensuring the appropriateness of post-acute care utilization will reduce WH readmissions for SNF patients.

Preferred Provider SNF Network

Lahey Clinical Performance Network (LCPN) evaluated SNFs across a comprehensive set of performance criteria to establish a preferred provider network. These high-performing SNFs jointly manage care transitions with LCPN physicians and staff to prevent unnecessary readmission. *Please refer to Attachment B3-a for the LCPN preferred provider SNF criteria and scorecard.*

Avoidable Readmissions

AGH CHART Phase I: High-Risk Interventions

A 6-month CHART-funded initiative at AGH piloted the use of High Risk Intervention Teams (HRITs) to provide patient education, medication management, and discharge planning for patients with physical and behavioral health co-morbidities and complex social needs. The HRIT served 149 patients in the first nine months, during which time readmissions decreased from 19% to 9%. Unfortunately, key staff departures resulted in less favorable performance (15% readmission rate) in the final month. Trends in readmissions will be further examined in Phase 2, which is discussed in the response to part (b) of this question.

Leveraging Technology

- Better use of telehealth infrastructure to augment patient tracking capabilities and allow for more proactive identification (and subsequent mitigation) of readmission risk
- Early use of recently implemented Epic system enhanced documentation of readmission risk factors and facilitated more substantive communication upon discharge among LHMC and other Wave 1 sites

Targeted Risk Management

- The Lahey Accountable Care Unit (LACU) stratifies patients according to risk in order to target deployment of the most intensive care management resources at the highest-risk/highest-cost patients
- LACU provides medication therapy management for patients identified at high-risk specific to readmissions, providing medication reviews and developing medication action plans

MAXIMIZING HUMAN RESOURCES

- Placement of behavioral health clinicians into non-behavioral health-focused care settings
- Disease/condition-specific (e.g., CHF) care managers
- Shared intensivist team across the system, reducing unnecessary variation and improving coordination and communication

AVOIDABLE ED USE

COST-EFFECTIVE CARE SITE ALTERNATIVES

- Opened a second Winchester urgent care location
- Developed strategic relationship with CVS to expand urgent care/minute-clinic presence
- Relationship with CareWell Urgent Care offers unassigned patients Lahey Health PCPs; Lahey Health hospitals encourage use of CareWell centers for appropriate patients
- Extended hours at affiliated pediatric practices and large PCP sites

LEVERAGING TECHNOLOGY

- Extended telehealth capabilities to consult with home health providers and support better monitoring of home health patients at risk of requiring emergent intervention

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

SPENDING ON POST-ACUTE CARE

INTEGRATION OF VNAME

Over the next 12 months, Lahey Health at Home, VNAME, and Winchester Home Care will finalize integration within Lahey Health's Population Health Management Division, allowing for centralized oversight, unified management approaches, and more robust standardization of discharge protocols.

WH CHART PHASE 2

- WH's CHART 2 initiatives will expand use of and continue to hone transition protocols developed in the CHART 1 pilot phase; will also implement multidisciplinary HRITs

TARGETED RISK MANAGEMENT

- Provide in-home visit support to facilitate earlier transitions to more cost-effective post-acute settings
- Integrate behavioral health into home care services, including use of nurse practitioners for home visits to support medication management
- Introduce palliative care earlier care delivery, or even upon diagnosis for specific conditions (e.g., dementia, CHF)
- Develop bridge program from palliative to hospice care

MAXIMIZING HUMAN RESOURCES

- [*applies also to avoiding inappropriate admissions and readmissions]* Coordination among LCPACO/WCACO and ambulatory care managers/ social workers to "get to one" – identifying and assigning a single care manager to each patient; protocols are in development to define the most appropriate care manager for a given patient
- Expand use and practice scope (e.g., top-of license role) of advanced practice nurses for home care and other post-acute care services

Avoidable 30-day Readmissions

Preferred Provider Network

The LCPACO will continue to work with preferred providers and potentially extrapolate the program to a larger team of Lahey providers. Expansion of the preferred provider network for SNF patients could realize a savings between $200,000 and $1.4M, based on projected reductions in ALOS at six facilities for the LCPACO.

Leveraging Technology

- [*applies also to avoiding inappropriate admissions and readmissions]* Patient follow-up and tracking capabilities are expected to improve once Epic has been implemented across the Lahey System, and LCPACO and WCACO merge

Maximizing Human Resources

- Implement system wide hospitalist coverage

AGH CHART Phase 2

- The AGH CHART 2 Grant will expand the CHART 1 pilot to a population of 1,000 high utilizers and socially complex patients using multidisciplinary HRITs
  - CHART 2 funds awarded to BH will be used in part to scale AGH's CHART Phase 1 pilot program

Avoidable ED Use

Policies and Standards

- Enhance and expedite communication with PCPs when patients arrive at Lahey affiliated urgent care/minute-clinic sites

Leveraging Technology

- Extend Epic capabilities to enhance value of partnerships, like the one with CVS/CareWell
- Expand telehealth/virtual consult capabilities targeted at avoiding inappropriate ED use

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?

The primary legitimate reason for relatively higher prices and global budgets, as inferred by the question, is objectively superior value. In theory this entails demonstrably better quality, in the form of high

compliances rates with best practices (evidence-based care delivery, enhanced access, communication, coordination) and better outcomes (lower rates of complication and readmission, more satisfied and engaged patients), coupled with relatively lower cost (per unit or on a budget basis, depending on the contract). Of course, value-based metrics should be (and generally are) adjusted to account for the severity and complexity of the patient population. Clearly providers caring for patient panels with a high proportion of chronically ill or co-morbid physical and behavioral health issues should be provided more resources to do so effectively. However, price and budget variation persist even after risk adjustments.

Other legitimate reasons (which should be accounted for but weighted less heavily than value indicators) for price and global budget variation include geographic isolation, disproportionate share of underinsured or socioeconomically at-risk populations (addressed, at least in part by, DSH payments), teaching and research missions, and a higher wage index.

The fundamental unacceptable reason for price variation is providers negotiating higher rates/budgets based on market power. In addition to receipt of higher rates, market power is perpetuated by consumers favoring and therefore utilizing larger and more prestigious providers (at least consumers without compelling economic incentives to choose objectively higher-value providers). This begets incremental market power of already dominant organizations, further strengthening negotiating position with payors.

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.

Price variation due to exertion of market power impedes meeting annual cost benchmarks, the success of lower-cost providers, and the sustainability of local economies.

Impact on Annual Cost Benchmarks

Price variation due to market power increases the overall cost of care without necessarily improving the quality of care delivered. Further, the largest health care provider organizations – those able to successfully wield market power to extract higher rates – disproportionally affect the ability of the entire Commonwealth to limit year-over-year increases in total health care expenditures, as well as to make meaningful positive improvements to health status.

While provider organizations, and particularly those large enough to impact statewide performance, are clearly accountable for their impact on overall spending, this responsibility is shared with payors and consumers. Unless and until there is broad-based payor willingness (backed by provider organization and state-level support) to implement effective value-based incentives and meaningful price transparency measures, consumers utilizing higher-priced (but not necessarily higher-value) facilities and providers will continue to be subsidized by consumers utilizing lower-priced facilities and providers.

Impact on Lower-Cost Providers

Relatively lower-priced providers – typically smaller and community-based organizations – are held to the same quality standards as the largest, highest-priced urban providers. If in fact (as has been proven possible) lower-cost providers are able to deliver similar quality to their higher-priced peers, they are doing so at an inherent disadvantage. It is unreasonable to assume that lower-priced organizations can "do more with less" on a long-term basis, particularly if these organizations have already maximized efficiency or require critical infrastructure investments to sustain performance. Lower-price providers are ultimately forced to make trade-offs to remain solvent, and inevitably become less and less able to attract and effectively serve their patient populations. The result is gradual closure of lower-priced practices and facilities, or acquisition by larger providers, which if not carefully managed, can exacerbate the market disparities driving the root cause of inappropriate price variation.

IMPACT ON THE ECONOMY

Unnecessary price variation is additionally detrimental to local economies, and eventually, will adversely impact economic sustainability and growth at the state level. As noted above, lower-priced providers may succumb to closure, and in cases where these provider organizations represent a major employer and community economic engine, their deterioration in turn negatively impacts a broader economic landscape.

Further, unnecessarily high prices or inappropriately high annual price increases threaten the sustainability of employer-sponsored health insurance. Employers are increasingly shifting costs onto employees and reducing, if not eliminating, benefits in order to maintain reasonable premiums. This results in more out-of-pocket health-related expenditures by individuals, limiting their ability to spend on other goods and services. Employers who choose to maintain more comprehensive employee benefits may have to reduce their workforce, limit hiring, or forego growth opportunities to remain viable. Taken together and over time, these consequences of unnecessary price variation represent a threat to the economic health of the state.

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.

Lahey Health Behavioral Services – a truly robust and regionally unparalleled behavioral health network in scale, capacity, ,and capabilities - works to integrate behavioral and physical health services across the continuum of care. Services include emergency and inpatient psychiatric care, outpatient mental health clinics, home and school-based children's behavioral health services, and addiction treatment. Primary care doctors whose practices do not include a behavioral health expert are requesting to integrate behavioral health services into their practice. Through partnerships with community providers and placing behavioral health experts in community settings, among other initiatives, Lahey Health has made improvements in avoiding unnecessary ED utilization and embedding behavioral health services in patient care. Please refer to the response in question B3 for information regarding CHART grant fund use towards improving care coordination for behavioral health patients.

INTEGRATE PHYSICAL AND BEHAVIORAL HEALTH CARE SERVICES

- Provide care coordination staff and resources to partners managing co-morbid physical-behavioral patients
- Embed behavioral health specialists in Lahey Health primary care sites
- Provide access to a psychiatric emergency mobile crisis team for 24/7, in-person care, referral support, and care management resources
- Provide psychiatry coverage at WH's ED

AVOID UNNECESSARY ED AND INPATIENT UTILIZATION

- Maximize use of 138 detoxification beds and 18 crisis stabilization beds
- Provide services at Lahey Health's two methadone programs and three detox centers for behavioral health patients needing treatment for substance use disorders or addiction

- Collaborate with local law enforcement to intervene in situations of psychiatric crisis
- Develop care protocols using resources from the Chart 2 Grant (awarded jointly to AGH, BH, WH, and Lowell General) focused on behavioral health patients
- Collaborate with community health workers to coordinate behavioral health care in the community after patients have undergone intensive addiction and psychiatric treatment
- As part of AGH's CHART Phase 1 initiatives, worked with the Healthy Gloucester Collaborative to integrate physical and behavioral health and increase collaboration among medical, behavioral health, and law enforcement professionals

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.

Lahey Health will continue to integrate behavioral and physical health care services across the continuum of care. Over the next 12 months, current programmatic evolution efforts will be sustained and (in select cases) programs will be expanded to additional care sites. Lahey Health will continue to seek additional collaborations to provide integrated, high-quality care to behavioral health patients.

In addition to continuing and expanding the above cited programs and efforts, Lahey Health plans to:

- Embed behavioral health specialists in select obstetrics and pediatric practices
- Implement care protocols specific to patients presenting with behavioral health issues
- Apply resources from the Commonwealth Fund to train front-line behavioral health experts to better identify and manage chronic medical conditions, such as diabetes and high blood pressure
- Work with local law enforcement departments to not only intervene once crisis has occurred, but better identify high-risk behavioral health patients and initiate treatment more proactively
- Use Chart 2 Grant funds jointly awarded to AGH, BH, WH, and Lowell General Hospitals to support mobile crisis and urgent care teams, and integrate behavioral services into EDs

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?

CAPABILITIES DEVELOPED AND UNDER DEVELOPMENT

- *EPIC IMPLEMENTATION:* enhances communication and coordination, supports optimal referrals, flags gaps in care, provides best practice alerts, captures and tracks performance data, and integrates data from multiple sources
  - Enables Lahey to more effectively carry out its core transformational care delivery approach of treating patients in the most appropriate and cost-effective care setting within the system
  - *IMPLEMENTATION TIMELINE:*
    - Wave 1 (completed) – LHMC
    - Wave 2 (began August 1, 2015 to be completed spring 2016) – BH/AGO, Northeast Medical Practices, and Bayridge Hospital
    - Wave 3 (planned for 2017) – WH

- *LCPN DATA WAREHOUSE:* tracks and trends utilization and expenditures to help pinpoint unnecessary utilization, identifies use of low-value providers/facilities and other cost-drivers, enables subsequent programmatic intervention
- *THE LAHEY ENHANCED CARE PROGRAM:* provides targeted care managers to identified high-risk patients attributed to the LCPACO
- *PHYTEL OUTREACH:* identifies and notifies patients about recommended visits, tests, procedures and other care management and care follow-up services; currently implementing "Call Me Campaign", a patient education initiative aimed at helping patients identify when to call vs. wait to prevent complications and increase care continuity
- *COMPREHENSIVE CARE INTEGRATION:* embedded behavioral health specialists in select primary care sites (see response to Q5) and embedded pharmacy capabilities within LCPACO practices
- *PRACTICE REDESIGN:* widespread dissemination and implementation of PCMH principles, including team-based care and enhanced access policies (including the addition of same day open-access appointments), along with streamlined practice workflow to improve efficiency; in 2015, there have been incremental increases in the number of WPA practices accredited by NCQA as PCMHs (5 have achieved Level III PCMH status and 2 have achieved Level II status)
- *COMPREHENSIVE MEDICAL ASSISTANT (MA) TRAINING:* trains MAs in partnership with Massachusetts State Community College to ensure consistent and maximized top-of-license care and appropriate role/duties within the care team; MAs are required to be certified as a condition of employment; comprehensive PCMH training guide available to all new MA hires

7. SINCE 2013, LAHEY HEALTH SYSTEM (LAHEY) HAS COMPLETED A NUMBER OF MATERIAL CHANGES, INCLUDING ACQUIRING A COMMUNITY HOSPITAL - WINCHESTER HOSPITAL (WINCHESTER), WINCHESTER'S ASSOCIATED PHYSICIANS, AND A VISITING NURSES ASSOCIATION, AND CREATING A NEW CONTRACTING ENTITY FOR THE WINCHESTER PHYSICIANS. 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 (TME)), referral patterns, quality, and access to care changed after these material changes?

The majority of the material changes referenced above were finalized mid-year 2014 or later. Thus, changes in cost, referral patterns, quality, and access occurring over the past twelve to fourteen months are likely only partially attributable, if at all, to aforementioned material changes. Experience suggests that at least 16-20 months are required before correlation between affiliations/transactions and their impact can be reliably inferred. Further, given the relatively brief time frame under consideration, fluctuations that may be anomalous are magnified and certain externalities that influence results – contract renewal cycles, for example – cannot be controlled for.

Certainly more "quick wins" can be (and have been) achieved within a 12 month time frame, but the specific markers of change requested are outcomes indicators, and require underlying process and systems change, and moreover, a high degree of functional integration, to realize (see response to 7aii, below, for specific examples of process and system standardization and integration achieved or in-process).

Lahey Health leadership is committed to pursuing and executing partnerships that generate meaningful and lasting positive transformation, and believe there is evidence that material changes sought and executed to date are on-track to meet these high standards.

To be as responsive as possible to requests made, data on select indicators is presented below that may be indicative of emerging trends, or at least compares performance for same time frame in 2014 and 2015.

COST

	Q1 2014	Q1 2015	% Change
Unique Members	**76,069**	**69,168**	**-9.1%**
Risk Score	**1.54**	**1.62**	**4.9%**
Medical PM/PM TME	$373.59	$379.08	1.5%
Pharmacy PM/PM TME	$80.22	$92.96	15.9%
Total PM/PM TME	**$453.81**	**$472.04**	**4.0%**

FIGURE 1: *LCPN Commercial* APM Contract Membership, Risk Scores, and Unadjusted PM/PM TME, Q1 2014 and Q1 2015*

*Includes BCBS, HPHC, and THP

The above quarter-to-quarter comparison snapshot – subject to all caveats described above and **unadjusted** for changes in patient acuity/complexity, size of membership, or inflation – shows:

- Slight increase (1.5%) in LCPN APM contract medical PM/PM TME
  - Please note that change is absolute: not relative to peers or reflective of market changes
- Substantial increase (15.9%) in pharmacy PM/PM TME – driven primarily by increasing cost of specialty drugs, namely for treatment of Hepatitis C

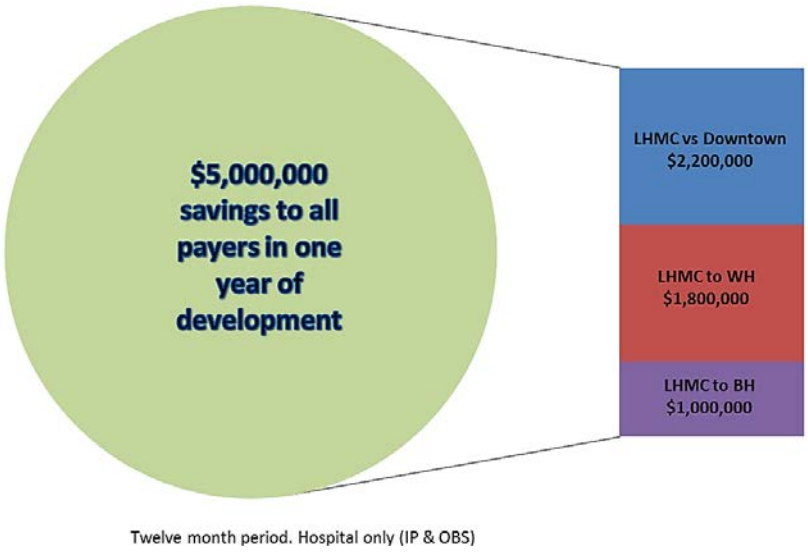


FIGURE 2: *Internal Estimates of Cost Savings Generated Keeping Clinically-Appropriate Care Local, July 2014 - 2015*

Initial internal estimates indicate that over the 12-month period between July 2014 and 2015, keeping IP and observation care local and ensuring it is delivered at the most appropriate site with the Lahey system has yielded ~$5 million in savings across all payors (Figure 2).

REFERRAL PATTERNS

For detailed data regarding changes in LCPN referral patterns between 2014 and 2015, see response to part ai, below.

HOSPITAL REFERRAL PATTERNS

WH discharges and observations, ED transfers, and ambulatory surgical cases increased based on a comparison of data for the first three quarters of 2014 vs. 2015. Lahey Health leadership has reason to attribute incremental volumes to more referrals from Atrius physicians by virtue of gaining access to Lahey's preferred provider status, as well as increases in LACU physician referrals.

Specifically, of WH's overall volume increases, approximately 200 *incremental* discharges and observation cases, 270 *incremental* ED transfers, and 170 *incremental* ambulatory surgical cases have been attributed to affiliation with Lahey.

While volumes at WH have generally increased across all care settings, material changes in indicators of patient accessibility have not been observed.

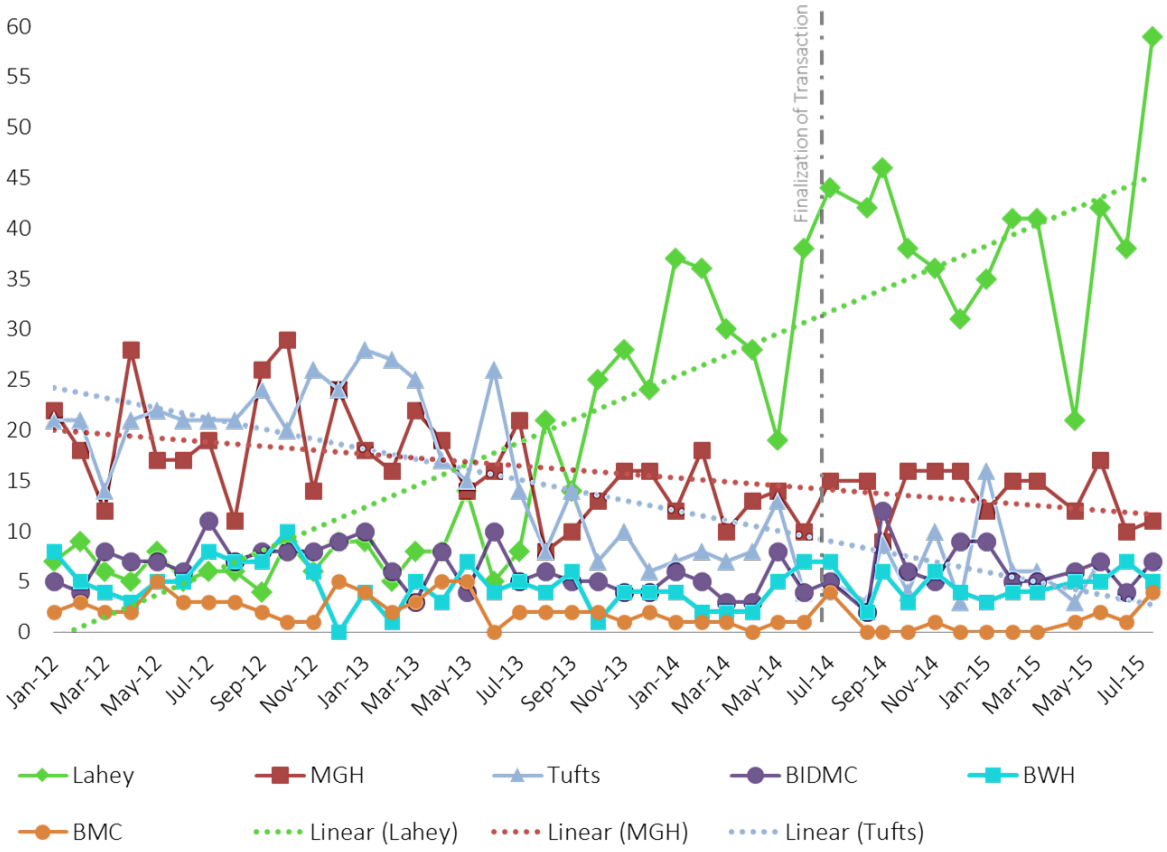


***FIGURE 3**: Tertiary Adult ED Transfers from Winchester Hospital, January 2012- July 2015*

In addition, there has been a clear shift in tertiary ED transfers away from higher-priced downtown hospitals and to Lahey upon initiation of formal partnership discussions in mid-to-late 2013 (Figure 3).

Physician Referral Patterns

Comparison of the same two months in 2014 and 2015 (January and February; Figure 4) shows that LACU physician referrals to WH medical staff specialists were higher in 2015, an increase of 19% January-January, and 55% February-February.

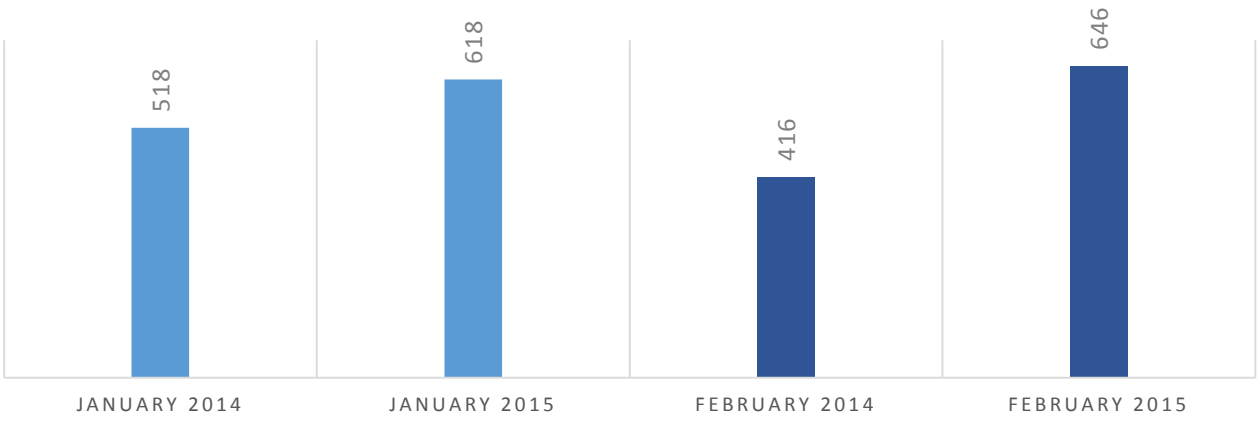


FIGURE 4: *Two-Month 2014 vs. 2015 Snapshot of LACU Referrals to Winchester IPA Specialists*

QUALITY

Comparison of performance on quality indicators on a quarter-to-quarter basis has inherent validity issues, and initially implied trends may turn out to not to be statistically significant when viewed over a longitudinal timeframe.

To be most responsive to requests, we will summarize differences in performance on select high-level quality indicators observed when comparing 2013-2014 results to 2014-2015 results, but reiterate that more data points should be established to reliably infer actual trends.

Review of key care outcome metrics[5] for WH for Q4 2013 – Q1 2014 (pre-affiliation) and Q4 2014 – Q1 2015 (post-affiliation) indicate:

- An increase in average length of stay (though length of stay index variance within .05)
- A decrease in the number of inpatient cases with complications (8 fewer cases, or 4% of total, with complications)
- A decrease in mortality rate (mortality index of 0.968 vs. 0.882)
- An increase in the number of Medicare all-cause 30-day readmissions, though rate remains below national average of 15.1 (13.8% vs. 14.7% of Medicare cases readmitted within 30-days for any reason)
- A decrease in the rate of hospital acquired conditions per 1,000 discharges (from 13.8 /1,000 to 1.4/1,000)

---

i. Specifically please provide summary tables showing, prior to and subsequent to the acquisition of Winchester, the volume of Lahey Clinic, NEPHO, and Winchester Physician

[5] Source: Clinical Data Base/Resource Manager v 1.5.0.10 Copyright © 2015 University HealthSystem Consortium. The UHC risk adjustment methodology incorporates a license of the 3M APR-DRG v32 grouper.

Associates patients referred to each of the top five hospitals to which these physician groups refer.

Claims data on referrals is available only for member lives covered under LCPN's APM contracts, both commercial and Medicare. Claims data represents referrals from physician to physician (more specifically, from PCPS to specialists or from specialists to other specialists), not facility to facility. As such, the summary information provided below (Figure 5) represents LCPN physician referrals to **specialists only,** by specialist's primary health system or hospital affiliation. Commercial risk member referral data is presented in the aggregate, combining BCBS, HPHC, and THP. Medicare risk member referral data are presented separately.

Subject to all caveats noted in the introduction to Q7 a) and per the data specifications/limitations above, a comparison of the same quarter in 2014 vs. 2015 indicates that:

- The proportion of total ***commercial*** risk-patient referrals from LCPN physicians to WH specialists increased from 9% to 12% for commercial risk patients; similar increases observed for referrals to specialists at BH/AGH, MGH, and Brigham and Women's Hospital; and
- The proportion of total ***Medicare*** risk-patient referrals from LCPN physicians to specialists at LHMC and BH/AGH increased (from 64% to 65%, and 14% to 16%, respectively), remained constant for WH specialists, and decreased for MGH and Brigham and Women's Hospital specialists (7% to 6%, and 6% to 4%, respectively)

	Commercial	1Q14	1Q15	% of Total 1Q14	% of Total 1Q15
LCPN	LAHEY CLINIC HOSPITAL, INC	189	173	66.1%	56.4%
	NORTHEAST HOSPITAL CORPORATION	44	49	15.4%	16.0%
	WINCHESTER HOSPITAL	25	36	8.7%	11.7%
	GENERAL HOSPITAL CORPORATION (MGH)	14	30	4.9%	9.8%
	BRIGHAM AND WOMENS HOSPITAL,INC	14	19	4.9%	6.2%
	Total	**286**	**307**	**100.0%**	**100.0%**

	Medicare	1Q14	1Q15	% of Total 1Q14	% of Total 1Q15
LCPN	LAHEY CLINIC HOSPITAL, INC	341	374	63.5%	65.2%
	NORTHEAST HOSPITAL CORPORATION	76	89	14.2%	15.5%
	WINCHESTER HOSPITAL	49	50	9.1%	8.7%
	GENERAL HOSPITAL CORPORATION (MGH)	38	37	7.1%	6.4%
	BRIGHAM AND WOMENS HOSPITAL,INC	33	24	6.1%	4.2%
	Total	**537**	**574**	**100.0%**	**100.0%**

FIGURE 5: *LCPN Risk-Patient Referrals to Specialists by Health System/Hospital, Q1 2014 vs. Q1 2015*

ii. Lahey stated that the acquisition of Winchester "facilitates multi-directional sharing of best practices, policies, and procedures that will not merely bring the lower performing entity up to the level of the higher performing entity, but will also drive continuing system-wide improvements that could not be achieved by any individual affiliate on its own. As a system, Lahey will continue to invest in high quality care and measure and track these improvements in quality as the data becomes available." What progress has been made on these population health and quality improvement programs and what has been the impact to date?

A significant amount of time, organizational focus, and investment has been dedicated over the past year to mutually advancing all Lahey members in accordance with the intentions and commitments referenced above. System-wide planning initiatives, multidisciplinary implementation teams, and investments in integrative infrastructure have yielded enhanced communication, coordination, and standardization. We continue to build our collective capacity for population health management, leverage our expanded care

continuum and clinical expertise, and increase the value of care delivered in order to become and remain better together.

Descriptions of key progress milestones and preliminary indicators of system-level impact are provided below. Please also reference responses provided in part ai, above, that may infer the generation of positive effects due to affiliation with Winchester and other partners.

POLICIES AND STANDARDS

- Development of a system-wide transfer policy to most effectively support transfers among member hospitals, reduce inappropriate and costly outmigration, and facilitate the delivery of care at the most cost-effective setting within the system
- Development of standard post-discharge protocols to maximize impact of individual member hospital CHART experience and benefits across the system
- Development and adoption of system-wide Cancer Institute Conditions of Participation
- Pursuit and achievement of National Accreditation Program for Breast Centers (NAPBC) credentialing at all Lahey Health sites

TEAM AND EVIDENCE-BASED CARE

- Formation of system-wide multidisciplinary care teams for breast cancer, thoracic surgery, gastroenterology, and others
- Single, shared team of LHMC intensivists across member hospitals
- Developed policies and proposed budgetary resources to implement and expand pool of shared care manager resources

MECHANISMS TO IMPROVE COMMUNICATION, TRANSPARENCY, AND COORDINATION

- Chief Medical Officers meet regularly to identify priority issues, compare performance on key indicators, and propose best practices; current focus is on formalizing and streamlining internal evidence-based guidelines in order to reduce system-wide rates of inpatient complications and infections
- Creation of comparative hospital quality and safety scorecards that are broadly shared throughout all member organizations, and leveraged at monthly meetings of system executives and with the Lahey Health System Board of Trustees
- Epic implementation at LHMC and Northeast Health System

MAXIMIZED CLINICAL CAPABILITIES AND COMPETENCIES

- Embedding behavioral health clinical expertise and resources across network of primary care sites
- Development of LHMC neurology program at WH
- Inclusion of Winchester patient population in LHMC clinical research trials
- Extension of Lahey Health Medical and Surgical bariatric program at Lahey Outpatient Center, Danvers

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.

A formal and standard process is in place across Lahey Health member organizations to ensure that consumers are provided with requested charge within the required two business days. Inquiries are documented and response time is monitored and tracked.

Figure 6 summarizes the number of inquiries by method of inquiry for all Lahey Health members for CY2014 and Q1-Q2 of CY2015.

		Number of Inquires via Telephone and In-Person	Number of Inquires via Website	Number of Inquires Resolved
CY 2014	Q1	760	N/A	760
	Q2	1,044	N/A	1,044
	Q3	1,294	N/A	1,294
	Q4	1,177	N/A	1,177
CY 2014 Total		**4,275**	**-**	**4,275**
CY 2015	Q1	1,260	N/A	1,260
	Q2	1,245	N/A	1,245
CY 2015 Total		**2,505**	**-**	**2,505**

FIGURE 6: *Consumer Inquiries Summary for Lahey Health System*

TYPES OF SERVICES FOR WHICH CONSUMER INQUIRIES ARE MOST FREQUENTLY MADE

INPATIENT AND OUTPATIENT SURGICAL PROCEDURES

- Total knee arthroplasty
- Vasectomy
- Cataract removal

OBSTETRICS

- Natural birth delivery
- Cesarean section

SCREENING AND DIAGNOSTIC SERVICES

- Colonoscopy
- MRI
- CT Scan
- EKG
- Ultrasound
- Mammogram
- Lab testing

OTHER

- New patient consult

- Cervical and lumbar injection
- Speech therapy consult

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 PROVIDER 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. INCLUDE IN YOUR RESPONSE ANY PORTION OF YOUR PHYSICIANS FOR WHOM YOU WERE NOT ABLE TO REPORT A CATEGORY (OR CATEGORIES) OF REVENUE.

Please refer to Lahey Health System AGO Provider Exhibit 1.

3. PLEASE EXPLAIN AND SUBMIT SUPPORTING DOCUMENTS THAT DESCRIBE (A) THE PROCESS BY WHICH YOUR PHYSICIANS MAKE AND RECEIVE PATIENT REFERRALS TO/FROM PROVIDERS WITHIN YOUR PROVIDER ORGANIZATION AND OUTSIDE OF YOUR PROVIDER ORGANIZATION; (B) HOW YOU USE YOUR ELECTRONIC HEALTH RECORD AND CARE MANAGEMENT SYSTEMS TO MAKE OR RECEIVE REFERRALS, INCLUDING A DESCRIPTION OF ANY TECHNICAL BARRIERS TO MAKING OR RECEIVING REFERRALS AND ANY DIFFERENCES IN HOW YOU RECEIVE REFERRALS FROM OR MAKE REFERRALS TO OTHER PROVIDER ORGANIZATIONS AS OPPOSED TO YOUR PROVIDER ORGANIZATION; (C) HOW, IF AT ALL, YOU MAKE COST AND QUALITY INFORMATION AVAILABLE TO PHYSICIANS AT THE POINT OF REFERRAL WHEN REFERRING PATIENTS TO SPECIALTY, TERTIARY, SUB-ACUTE, REHAB, OR OTHER TYPES OF CARE; AND (D) WHETHER YOUR ORGANIZATION, IN REFERRING PATIENTS FOR SERVICES, ASCERTAINS THE STATUS IN THE PATIENT'S INSURANCE NETWORK OF THE PROVIDER TO WHOM YOU ARE REFERRING THE PATIENT, AND INFORMS THE PATIENT IF THAT PROVIDER IS NOT IN THE PATIENT'S INSURANCE NETWORK.

Lahey Health is committed to providing the highest value care in the appropriate care setting. The system empowers each physician to make referral decisions based on patient needs and preferences, while also considering value and care setting.

Unlike many other Boston-metro systems, Lahey Health does not set patient retention rate requirements. However, there is system-wide emphasis on the value of treating patients, when appropriate, within a single, high-value network of care providers. Lahey Health providers make an effort to keep patient referrals within the system, where clinically appropriate, to maximize use of Lahey's higher-value facilities and providers, and to minimize fragmentation of care.

(a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization;

Lahey physicians make referrals through an online process that expedites insurance authorization. Both referrer and referee may access the patient's medical record and associated notes, which promotes communication of individual patient needs. In general, communication between and among specialists and primary care physicians is highly valued, enhancing continuity of patient care. Additionally, ease of referrals to specialty physicians and back to the primary care physician for ongoing management within Lahey Health exhibits the system's dedication to PCMH principles, including top-of-license care.

If a Lahey primary care physician is making a referral to a provider within the Lahey Health System, the referral is managed by the physician and a Referral Specialist; the Referral Specialist will process the referral request, create a referral record in Epic, and communicate the referral information to the specialist.

While Lahey Health emphasizes treatment within the Lahey Health system when clinically appropriate, out-of-network referrals may be requested for services if seeing an out-of-network provider would provide continuity of care for the patient's current treatment, if a comparable service is unavailable within the Lahey Health System, or if a second opinion is needed. Out-of-network referral requests may be initiated by a patient's primary care physician, or by the patient directly calling Lahey's Referral Management Center. Regardless of the referral's origin, out-of-network

referral requests are processed internally by a Referral Specialist and Referral Case Manager, in collaboration with the patient's primary care physician. Please refer to **Attachment C3** for supporting documents describing the referral process in greater detail.

(b) how you use your electronic health record and care management systems to make or receive referrals, including a description of any technical barriers to making or receiving referrals and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization;

Epic implementation has allowed Lahey Health providers to more easily refer patients for care across the system, through full data access to and from referring and receiving providers, and a comprehensive and complete clinical record created within Lahey Health. These capabilities will be further enhanced and optimized when Epic is implemented at WH (planned for 2017). Currently, a referral record is automatically created if the referral is requested by a provider using Epic. If the referral request is generated by a provider that is not using Epic, the Referral Specialist will manually create a referral record. Once a referral is completed, the Referral Specialist communicates the referral information to the specialist through Epic, or by phone or fax as needed.

Technical barriers make referring to other provider organizations and interfacing with payors difficult. Information systems are typically not interoperable between health systems, requiring the use of phone calls and faxes to refer patients outside the Lahey Health System. With each health plan requiring its own process for authorization and referrals, the process of interfacing with payors continues to be complex. Lahey Health invests considerable administrative resources to appropriately navigate these disparate processes and systems, which contributes to higher overall system costs.

(c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and

Lahey Health has focused on out-of-network referral requests, and suggesting alternatives within the system. This support is provided to individual patients, and may include information on the status of other providers and their potential out-of-pocket costs. However, cost and quality information at the time of referral is limited. This may be mitigated in the future through additional data transparency and other planned system efforts such as Epic implementation, which will make cost and quality information consistently and more widely available. At the present time, Lahey Health makes the best effort to attain qualitative and quantitative information to ensure physicians can make the best referral choice for each patient.

(d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

Lahey Health makes every effort to provide access to primary and specialty services for patients and minimize the use of outside referrals where clinically appropriate. Patients referred outside the network for care are encouraged to check with their individual health plan regarding whether the provider is in or out of network. Lahey also offers financial assistance and counseling services to assist patients in determining an appropriate financial plan for care.

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.

Please refer to LHMC AGO Hospital Exhibit 1.

Lahey Health System and Subsidiaries

Exhibit B, Question 1

	Fiscal 2013 [1]	Fiscal 2014 [1]	Ten Month Period Ended July 31 Fiscal 2014 [1]	Fiscal 2015
Operating revenues	**$ 1,818,443**	**$ 1,838,798**	**$ 1,520,281**	**$ 1,584,013**
Operating expenses				
Salaries and benefits	$ 1,120,590	$ 1,134,508	$ 937,010	$ 990,338
Supplies and services	533,433	542,858	451,873	515,274
Depreciation and interest	95,119	96,819	83,235	91,340
Health safety net assessment	13,181	13,954	11,914	9,470
Total	**$ 1,762,323**	**$ 1,788,139**	**$ 1,484,032**	**$ 1,606,422**
Operating income (loss)	**$ 56,120**	**$ 50,659**	**$ 36,249**	**$ (22,409)**

[1] Winchester Healthcare Management did not become part of Lahey Health System until 7/1/14. This presentation of revenue and expense assumes Winchester joined effective 10/1/12, the start of fiscal 2013.

Lahey Health System and Subsidiaries

Exhibit B, Question 3

Lahey Clinical Performance Network Quality Standards for ACO SNF Population

A Performance Scorecard

LCPN Collaborative with Preferred SNF Providers to Improve Quality, Efficiency and Patient Satisfaction for the ACO SNF Population

SNF Quality Performance Standards		Met	Not Met	Score
1.	Facility agrees to monitor, report and improve ED visit rates			
2.	Facility achieves favorable ALOS based on ACO Goal: 14 days			
3.	Facility achieves 30 day re-hospitalization rate ACO Goal: 10% or lower			
4.	Facility utilizes preferred homecare providers whenever possible and invites homecare liaison to family meetings on complex discharges			
5.	Facility coordinates PCP follow-up appointment within 5 – 7 days of discharge with patient/family preferences			
6.	Facility reviews and provides a legible written transition plan to patient/caregiver instructions to follow after discharge including medications, diet, homecare/DME, PCP appointment, and symptom management: what to watch for and who to call ensuring "teach back" method			
7.	Facility ensures complete discharge summary is transmitted to PCP and LCPN care manager within 24 hrs of discharge			
8.	Facility coordinates family meeting within 3 days of admission to confirm rehab and transition plan with patient/family (policy in place)			
9.	Facility ensures active communication and care coordination working in collaboration with LCPN care manager via weekly multi-disciplinary rounds and as needed when there is a change in plan			
10.	Facility appropriately utilizes INTERACT Tools to identify opportunity to reduce potentially avoidable acute care transfers and works with ACO to address performance improvement plan (policy in place)			
11.	Facility agrees to work with referring acute care hospitals to track and ensure a "warm hand-off" occurs with all patients			
12.	Facility agrees to ensure a thorough medication reconciliation at admission and discharge			

Scoring: Met = 1, Not Met =0, Goal: achieve all 12 Quality Standards

Lahey Health

Includes for the years 2011-2013:

I. Northeast Health System
a roll up of;
Northeast Hospital Corporation
Northeast Behavioral Health Corporation
Northeast Senior Health Corporation
Northeast Medical Practice, Inc.

II. Lahey Hospital & Medical Center
a roll up of;
Lahey Clinic Hospital, Inc.
Lahey Clinic, Inc.

Includes for the year 2014:

I. Northeast Health System
a roll up of;
Northeast Hospital Corporation
Northeast Behavioral Health Corporation
Northeast Senior Health Corporation
Northeast Medical Practice, Inc.

II. Lahey Hospital & Medical Center
a roll up of;
Lahey Clinic Hospital, Inc.
Lahey Clinic, Inc.

III. Winchester Hospital
Includes Winchester for the full 2014 year
(Winchester offficially joined Lahey Health
7/1/14)

Lahey Health

Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 123,768,830	$ 139,805,797	$ 8,481,705	$ 8,469,927	$ 28,342,495	$ -	$ 912,025	$ -	$ 2,391,573	$ -	$ 4,953,311	$ -	$ 738,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 28,480,483	$ -	$ 508,252	$ -	$ 138,336	$ -	$ 35,164,469	$ 20,613,793	$ 268,902	$ -	$ -
HPHC	$ 66,423,970	$ 25,410,805	$ 688,297	$ 190,029	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,219,278	$ 57	$ -	$ -	$ -
Fallon	$ 7,614,926	$ 1,388,116	$ 37,752	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 233,987	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,296,365	$ 18,884,620	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,530,580	$ 14,844,861	$ -	$ -	$ -
Aetna	$ 2,336,004	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 347,121	$ 19,579,887	$ -	$ -	$ -
Other Commercial	$ 6,838,616	$ -	$ 15,048	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 478,318	$ 57,964,638	$ -	$ -	$ -
Total Commercial	$ 206,982,347	$ 166,604,718	$ 9,222,802	$ 8,659,955	$ 56,822,978	$ -	$ 1,420,277	$ -	$ 2,529,908	$ -	$ 74,223,429	$ 131,887,855	$ 1,007,822	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,293,809	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,479,756	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,434,232	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,242,870	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,033,113	$ 1,160,344	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 80,483,781	$ 1,160,344	$ -	$ -	$ -
Mass Health	$ 7,678,860	$ 4,946,769	$ 102,238	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,940,741	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 66,619,301	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,225,327	$ 360,871	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 755,800	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 271,183	$ 11,577,320	$ -	$ 262,007	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,445,705	$ 1,733,316	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 88,561,516	$ 14,427,307	$ -	$ 262,007	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 391,256,099	$ -	$ 7,327,913	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,768	$ 57,832,347	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,765	$ 8,115,342	$ -	$ 3,273,061	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 64,534	$ 65,947,689	$ -	$ 3,273,061	$ -
GRAND TOTAL	$ 214,661,206	$ 171,551,487	$ 9,325,039	$ 8,659,955	$ 56,822,978	$ -	$ 1,420,277	$ -	$ 2,529,908	$ -	$ 243,333,259	$ 634,620,036	$ 1,007,822	$ 10,862,981	$ -

Lahey Health

Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 48,287,380	$ 141,955,390	$ 2,399,998	$ 8,525,710	$ 84,121,108	$ -	$ (1,450,219)	$ -	$ 6,323,072	$ -	$ 4,139,909	$ -	$ 552,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 25,814,259	$ -	$ 439,793	$ -	$ 103,923	$ -	$ 19,830,759	$ 26,285,754	$ 192,863	$ -	$ -
HPHC	$ 92,239,987	$ 26,060,693	$ 497,916	$ 147,339	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,326,977	$ 42	$ -	$ -	$ -
Fallon	$ 9,075,505	$ 2,011,682	$ 37,301	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 249,513	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,675,762	$ 24,610,276	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,681,038	$ 18,172,791	$ -	$ -	$ -
Aetna	$ 2,346,529	$ -	$ 300,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 226,302	$ 21,608,542	$ -	$ -	$ -
Other Commercial	$ 6,264,682	$ -	$ 13,441	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 528,226	$ 55,959,800	$ -	$ -	$ -
Total Commercial	$ 158,214,082	$ 170,027,765	$ 3,248,656	$ 8,673,049	$ 109,935,367	$ -	$ (1,010,426)	$ -	$ 6,426,995	$ -	$ 56,658,486	$ 146,637,205	$ 745,783	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,248,753	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,948,139	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,576,154	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,130,863	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,222,736	$ 1,615,082	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 91,126,645	$ 1,615,082	$ -	$ -	$ -
Mass Health	$ 8,072,118	$ 6,154,116	$ -	$ 389,595	$ -	$ -	$ -	$ -	$ -	$ -	$ 389	$ 31,581,150	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 33,135,936	$ -	$ 265,360	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,088,100	$ 751,714	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 111,264	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 291,496	$ 12,502,481	$ -	$ 200,000	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,746,732	$ 1,454,025	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 57,262,263	$ 14,819,484	$ 265,360	$ 200,000	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 423,328,632	$ -	$ 11,280,059	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,019	$ 52,226,714	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 74,813	$ 8,755,627	$ -	$ 5,264,213	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 81,832	$ 60,982,341	$ -	$ 5,264,213	$ -
GRAND TOTAL	$ 166,286,201	$ 176,181,881	$ 3,248,656	$ 9,062,644	$ 152,425,358	$ -	$ (2,602,922)	$ -	$ 7,057,235	$ -	$ 205,129,615	$ 678,963,895	$ 1,011,143	$ 16,744,272	$ -

Lahey Health

Health Policy Commission
AGO Exhibit 1 Questions to Providers and Hospitals
Calendar Year 2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 41,003,405	$ 141,416,481	$ 2,140,546	$ 8,798,849	$ 72,014,989	$ -	$ 91,856	$ -	$ 5,482,026	$ -	$ 3,915,204	$ -	$ 417,132	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 24,279,912	$ -	$ 45,897	$ -	$ 22,949	$ -	$ 19,723,075	$ 30,598,997	$ 317,188	$ -	$ -
HPHC	$ 89,607,012	$ 34,870,999	$ 494,123	$ 279,669	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,199,542	$ 2,196	$ -	$ -	$ -
Fallon	$ 9,507,234	$ 2,410,610	$ 38,874	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 263,024	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,660,202	$ 24,542,245	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,244,022	$ 28,057,185	$ -	$ -	$ -
Aetna	$ 1,642,769	$ -	$ 90,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 200,162	$ 20,774,429	$ -	$ -	$ -
Other Commercial	$ 5,899,647	$ -	$ 13,746	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 603,904	$ 49,545,931	$ -	$ -	$ -
Total Commercial	$ 147,660,066	$ 178,698,090	$ 2,777,289	$ 9,078,518	$ 96,294,902	$ -	$ 137,753	$ -	$ 5,504,975	$ -	$ 47,809,136	$ 153,520,983	$ 734,320	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,877,238	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 38,310,802	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,863,427	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,392,629	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 34,500,674	$ 1,967,516	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,944,770	$ 1,967,516	$ -	$ -	$ -
Mass Health	$ 7,836,828	$ 6,484,071	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,605,495	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 30,146,927	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,537,650	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,202,128	$ -	$ 230,999	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,093,667	$ 1,870,705	$ -	$ 5,101	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 60,778,244	$ 15,072,833	$ -	$ 236,100	$ -
Medicare	$ -	$ -	$ -	$ -	$ 83,038,348	$ -	$ -	$ -	$ -	$ -	$ -	$ 353,028,231	$ -	$ 11,914,365	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,296	$ 55,625,452	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 44,730	$ 8,946,541	$ -	$ 2,914,220	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 63,025	$ 64,571,993	$ -	$ 2,914,220	$ -
GRAND TOTAL	$ 155,496,894	$ 185,182,161	$ 2,777,289	$ 9,078,518	$ 222,912,663	$ -	$ (1,201,764)	$ -	$ 5,504,975	$ -	$ 216,595,176	$ 614,767,051	$ 734,320	$ 15,064,685	$ -

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2014

ENTITY: Lahey Health System

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 67,675,259	$ 184,593,757	$ 2,640,111	$ 9,734,843	$ 71,014,272	$ -	$ 490,937	$ -	$ 5,480,660	$ -	$ 4,240,883	$ -	$ (841,269)	$ -	$ -
Tufts	$ 8,783,628	$ -	$ 1,023,282	$ -	$ 23,906,902	$ -	$ (321,342)	$ -	$ 44,951	$ -	$ 19,892,439	$ 40,965,450	$ 80,337	$ -	$ -
HPHC	$ 99,119,020	$ 31,393,906	$ 844,351	$ 105,703	$ 14,910,647	$ -	$ 124,582	$ -	$ 253,125	$ -	$ 1,995,855	$ 1,337	$ (677,336)	$ -	$ -
Fallon	$ 9,521,150	$ 2,158,807	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 297,486	$ 1,823,731	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,534,568	$ 35,809,141	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,047,461	$ 43,115,997	$ -	$ -	$ -
Aetna	$ 1,664,736	$ -	$ 75,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 275,870	$ 29,428,269	$ -	$ -	$ -
Other Commercial	$ 7,087,656	$ -	$ 19,911	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 496,767	$ 71,380,661	$ -	$ -	$ -
Commercial	$ 193,851,449	$ 218,146,470	$ 4,602,655	$ 9,840,546	$ 109,831,821	$ -	$ 294,176	$ -	$ 5,778,736	$ -	$ 48,781,329	$ 222,524,585	$ (1,438,268)	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,252,010	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 53,288,058	$ -	$ (47,147)	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,598,915	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,755,037	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,549,352	$ 1,287,617	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 128,443,372	$ 1,287,617	$ (47,147)	$ -	$ -
Mass Health	$ 6,713,339	$ 14,921,665	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,419,842	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 45,752,795	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 51,766,593	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,436,157	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ 93,658	$ -	$ 234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,530,433	$ 17,028,946	$ -	$ 211,789	$ -
Commercial Medicare Subtotal	$ 93,658	$ -	$ 234	$ -	$ 45,752,795	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 88,733,183	$ 17,028,946	$ -	$ 211,789	$ -
Medicare	$ -	$ -	$ -	$ -	$ 127,893,170	$ -	$ 3,000,000	$ -	$ -	$ -	$ -	$ 376,780,696	$ -	$ 17,689,861	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 41,915	$ 72,449,704	$ -	$ 4,188,750	$ -
Grand Total	$ 200,658,446	$ 233,068,135	$ 4,602,889	$ 9,840,546	$ 283,477,786	$ -	$ 1,668,251	$ -	$ 5,778,736	$ -	$ 265,999,798	$ 726,491,390	$ (1,485,416)	$ 22,090,400	$ -

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2011

ENTITY: LHMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 108,427,591	$ 114,003,426	$ 7,870,694	$ 7,777,849	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 738,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 22,173,905	$ -	$ 508,252	$ -	$ 84,709	$ -	$ 27,403,976	$ 13,383,861	$ 268,902	$ -	$ -
HPHC	$ 52,382,039	$ 18,570,240	$ 408,336	$ 53,645	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,870	$ 57	$ -	$ -	$ -
Fallon	$ 4,367,774	$ 1,388,116	$ 13,566	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,242,981	$ 16,952,991	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,183,247	$ 11,133,886	$ -	$ -	$ -
Aetna	$ 2,336,004	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,186,274	$ -	$ -	$ -
Other Commercial	$ 6,838,616	$ -	$ 15,048	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 351	$ 40,894,395	$ -	$ -	$ -
Commercial	$ 174,352,024	$ 133,961,782	$ 8,307,643	$ 7,831,494	$ 22,173,905	$ -	$ 508,252	$ -	$ 84,709	$ -	$ 58,838,425	$ 96,551,464	$ 1,007,822	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,109,193	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,223,260	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 476,076	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,186,752	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,160,344	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,995,282	$ 1,160,344	$ -	$ -	$ -
Mass Health	$ 7,678,860	$ 4,946,769	$ 102,238	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 47,691,258	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,375,208	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 755,800	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,577,320	$ -	$ 262,007	$ -
Other Commercial Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,979,644	$ 375,437	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 66,046,110	$ 12,708,557	$ -	$ 262,007	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 286,903,553	$ -	$ 7,327,913	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,296,325	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,608,226	$ -	$ 3,273,061	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,904,551	$ -	$ 3,273,061	$ -
Grand Total	$ 182,030,884	$ 138,908,551	$ 8,409,881	$ 7,831,494	$ 22,173,905	$ -	$ 508,252	$ -	$ 84,709	$ -	$ 150,879,816	$ 424,228,469	$ 1,007,822	$ 10,862,981	$ -

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2012

ENTITY: LHMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 32,168,337	$ 114,529,380	$ 1,978,624	$ 7,808,756	$ 63,656,663	$ -	$ (4,071,541)	$ -	$ 4,159,660	$ -	$ -	$ -	$ 552,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 19,844,231	$ -	$ 439,793	$ -	$ 54,974	$ -	$ 12,702,324	$ 17,551,615	$ 192,863	$ -	$ -
HPHC	$ 77,715,923	$ 19,106,749	$ 245,202	$ 26,342	$ -	$ -	$ -	$ -	$ -	$ -	$ 85,343	$ 42	$ -	$ -	$ -
Fallon	$ 5,210,131	$ 2,011,682	$ 11,622	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,639,442	$ 21,754,455	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,278,924	$ 14,016,056	$ -	$ -	$ -
Aetna	$ 2,346,529	$ -	$ 300,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,265,195	$ -	$ -	$ -
Other Commercial	$ 6,264,682	$ -	$ 13,441	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 288	$ 38,245,975	$ -	$ -	$ -
Commercial	$ 123,705,602	$ 135,647,810	$ 2,548,888	$ 7,835,098	$ 83,500,894	$ -	$ (3,631,748)	$ -	$ 4,214,634	$ -	$ 42,706,320	$ 107,833,339	$ 745,783	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,896,156	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,051,787	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 602,852	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,065,962	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,615,082	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 30,616,757	$ 1,615,082	$ -	$ -	$ -
Mass Health	$ 8,072,118	$ 6,154,116	$ -	$ 389,595	$ -	$ -	$ -	$ -	$ -	$ -	$ 389	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 12,250,551	$ -	$ 265,360	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,456,142	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 111,264	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,502,481	$ -	$ 200,000	$ -
Other Commercial Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,305,342	$ 62,543	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 33,012,035	$ 12,676,288	$ 265,360	$ 200,000	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 312,386,247	$ -	$ 11,280,059	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,273,291	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,776,107	$ -	$ 5,264,213	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,049,398	$ -	$ 5,264,213	$ -
Grand Total	$ 131,777,721	$ 141,801,927	$ 2,548,888	$ 8,224,693	$ 125,990,885	$ -	$ (5,224,244)	$ -	$ 4,844,874	$ -	$ 106,335,501	$ 458,560,354	$ 1,011,143	$ 16,744,272	$ -

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2013

ENTITY: LHMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 27,941,377	$ 113,619,285	$ 1,789,921	$ 8,052,686	$ 54,986,529	$ -	$ (1,874,135)	$ -	$ 3,859,467	$ -	$ -	$ -	$ 417,132	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 18,801,910	$ -	$ 45,897	$ -	$ 22,949	$ -	$ 12,910,743	$ 19,514,728	$ 317,188	$ -	$ -
HPHC	$ 77,605,305	$ 20,721,528	$ 281,599	$ 29,113	$ -	$ -	$ -	$ -	$ -	$ -	$ 510,964	$ 2,196	$ -	$ -	$ -
Fallon	$ 5,592,050	$ 2,410,610	$ 12,690	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,599,273	$ 22,332,214	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,820,587	$ 22,910,207	$ -	$ -	$ -
Aetna	$ 1,642,769	$ -	$ 90,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,604,898	$ -	$ -	$ -
Other Commercial	$ 5,899,647	$ -	$ 13,746	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 120	$ 37,323,761	$ -	$ -	$ -
Commercial	$ 118,681,147	$ 136,751,423	$ 2,187,956	$ 8,081,799	$ 73,788,439	$ -	$ (1,828,238)	$ -	$ 3,882,416	$ -	$ 33,841,687	$ 117,688,004	$ 734,320	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,010,075	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,483,412	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,350,700	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,204,479	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,967,516	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 41,048,666	$ 1,967,516	$ -	$ -	$ -
Mass Health	$ 7,836,828	$ 6,484,071	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 12,633,856	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,481,156	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other (Tricare, Champus, etc.)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,202,128	$ -	$ 230,999	$ -
Other Commercial Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,607,929	$ 83,115	$ -	$ 5,101	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 37,722,941	$ 13,285,243	$ -	$ 236,100	$ -
Medicare	$ -	$ -	$ -	$ -	$ 83,038,348	$ -	$ -	$ -	$ -	$ -	$ -	$ 231,354,524	$ -	$ 11,914,365	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,426,712	$ -	$ -	$ -
Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,878,087	$ -	$ 2,914,220	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,304,799	$ -	$ 2,914,220	$ -
Grand Total	$ 126,517,975	$ 143,235,494	$ 2,187,956	$ 8,081,799	$ 200,406,200	$ -	$ (3,167,756)	$ -	$ 3,882,416	$ -	$ 112,613,294	$ 388,600,086	$ 734,320	$ 15,064,685	$ -

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2014

ENTITY: LHMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 26,611,761	$ 114,697,763	$ 1,682,812	$ 8,071,952	$ 55,381,278	$ -	$ (1,550,248)	$ -	$ 4,186,796	$ -	$ -	$ -	$ (841,269)	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 17,896,808	$ -	$ (342,966)	$ -	$ 34,139	$ -	$ 13,271,539	$ 21,266,536	$ 80,337	$ -	$ -
HPHC	$ 61,321,349	$ 20,533,616	$ 575,736	$ 44,318	$ 14,910,647	$ -	$ 124,582	$ -	$ 253,125	$ -	$ 368,663	$ 1,337	$ (677,336)	$ -	$ -
Fallon	$ 5,358,340	$ 2,158,807	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,299,408	$ 23,008,389	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,811,014	$ 25,877,004	$ -	$ -	$ -
Aetna	$ 1,664,736	$ -	$ 75,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,132,103	$ -	$ -	$ -
Other Commercial	$ 7,087,656	$ -	$ 19,911	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 38,360,707	$ -	$ -	$ -
Commercial	$ 102,043,842	$ 137,390,186	$ 2,353,458	$ 8,116,270	$ 88,188,733	$ -	$ (1,768,633)	$ -	$ 4,474,060	$ -	$ 30,750,624	$ 125,646,076	$ (1,438,268)	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,379,879	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,401,731	$ -	$ (47,147)	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,080,568	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,517,695	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 171,527	$ 1,269,238	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 53,551,400	$ 1,269,238	$ (47,147)	$ -	$ -
Mass Health	$ 6,713,339	$ 14,921,665	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 45,477,506	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 13,971,443	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,069,130	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ 93,658	$ -	$ 234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,047,790	$ 13,461,008	$ -	$ 211,789	$ -
Commercial Medicare Subtotal	$ 93,658	$ -	$ 234	$ -	$ 45,477,506	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 44,088,363	$ 13,461,008	$ -	$ 211,789	$ -
Medicare	$ -	$ -	$ -	$ -	$ 127,893,170	$ -	$ 3,000,000	$ -	$ -	$ -	$ -	$ 198,629,354	$ -	$ 17,689,861	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,986,190	$ -	$ 4,188,750	$ -
Grand Total	$ 108,850,839	$ 152,311,851	$ 2,353,692	$ 8,116,270	$ 261,559,409	$ -	$ (394,558)	$ -	$ 4,474,060	$ -	$ 128,390,387	$ 359,991,866	$ (1,485,416)	$ 22,090,400	$ -

Lahey Health System and Subsidiaries

Exhibit C, Question 3

Lahey Accountable Care Unit

Centralized Referral Management

Program Charter

Version 0.1
10/1/2014

Table of Contents

1.0 Introduction

2.0 Background

3.0 Overview

4.0 Team Roles and Responsibilities

5.0 Process for Managing Out of Network Referrals

6.0 Process for Managing In-Network Referrals to Lahey Health Affiliates

7.0 Process for Managing Patient-Initiated Referrals to In-Network Affiliates

8.0 Process for Non-Certification Letters

9.0 Process for Documenting Clinical Reviews and Follow-Up

APPENDICES

Appendix A: Centralized Referral Management Diagram

PROGRAM CHARTER:

Accountable Care Unit: Centralized Referral Management Program

VERSION & REVIEW HISTORY:

Version	Owner	Change	Date	Approved
0.1	LACU Program Management	First draft of standard work	2.19.14	
1.0	LACU Program Management			

DEFINITIONS, ACRONYMS, AND ABBREVIATIONS:

Abbreviation/Acronym	Definition
RM	Referral Management
PCP	Primary Care Provider
SCP	Specialist Care Provider
RMC	Referral Management Center
ACU	Accountable Care Unit
OON	Out of Network

1.0 Introduction

Referral Management (RM) is a centralized process for managing and tracking patient referrals to identify trends, recapture care, and promote the continuity of care delivered to our patients. It provides a mechanism for determining patient access to specialty clinics, standardizing criteria and ensuring high value in both clinical and business outcomes.

Lahey Health has formed partnerships with both community and tertiary physicians growing our Lahey Health Network of both primary and specialty providers to cater to our wide geographic area.

All out of network requests are processed centrally regardless of risk arrangement and every effort will be made to provide services within the integrated Lahey Health referral network.

2.0 Background

The Lahey Accountable Care Unit (LACU) worked collaboratively with the Lahey Hospital and Medical Center's Referral Management Department within Access Services to implement a centralized referral management process that is comprehensive and coordinated across the continuum of care.

We believe the incorporation of a centralized referral system, where care is maintained within the Lahey Health System, will strengthen our organization while ensuring high quality and cost effective healthcare for our patients.

The quality and safety benefits of in-network referrals include:

- Managed Access to Specialties
- Better Quality of Care due to Enhanced Collaboration between PCP and Specialist
- Continuity of care
- Shared Medical Record
- Standardized Criteria
- Ability to Track and Identify Referral Trends

3.0 Overview

3.1. Goals and Objectives

The program's goals include:

- Managing and tracking patient referrals to identify trends
- Recapturing care
- Promoting continuity of care for our patients while enhancing patient experience
- Providing a mechanism for determining patient access to specialty clinics
- Standardizing criteria to ensure high value in both clinical and business outcomes

3.2. Purpose

The Centralized Referral Management Program strives to achieve the following:

- Ensure patients have timely access and receive the highest level of patient-centric, value-based coordinated care
- Enable the practice the ability to communicate the referral information to the referral coordinators
- Provide care at the right time, by the right person, in the right setting
- Optimal health outcomes

4.0 Team Roles and Responsibilities

Roles	Responsibilities
Patient Access Director	Provides oversight and management of Referral Specialist team and provider workflow. Ensures access to appointment scheduling is readily available to the Referral Specialists and ACU team members.
Referral Specialist	Performs intake role with patients requesting referrals, including gathering information about the request and redirecting within the guidelines. Processes and tracks referral outcomes.
Primary Care Physician	Sets the expectation with the patient that specialty care will be provided through the Lahey Health Network. Certifies the Medical Necessity of the Specialty Care. Identifies any mitigating factors that may require Out of Network Referral. Interacts with patient and attempts redirection to an In- Network provider as needed.
Referral Case Manager	Reviews the clinical record; reaches out to the PCP and or SCP for guidance on the clinical aspects of the case and any mitigating circumstances. Engages patient to assess the rationale for going out of the network. Attempts redirection and facilitates care within the system. Forwards cases to the Medical Director for review and determination as needed.
Specialty Physician	Assists with providing timely access to in-network care; consultation with RMC around the medical appropriateness of services; provides patient out-reach and assists with patient redirection and service recapture.
Medical Director	Manages oversight of the entire process and provides internal and external education around the process. Reviews submitted data and reaches out to providers for clarification as necessary. Performs patient out-reach as required. Reaches out to plan Medical Directors and Administrators as necessary.
Program Management	Provides oversight of purpose and status to support project-level activity and ensures program goals are met in conjunction with the overarching goals of the ACU, ensuring delivery of long term improvements to the organization.
Data Analytics and Reporting Management	Management and reporting of key data trends and statistics used for identifying pathways to reduce cost and ensure higher quality of patient care.

5.0 Process for Managing Out-of-Network Referrals

5.1. Centralization

All out of network referral requests regardless of any risk arrangement will be processed centrally. Every effort will be made to provide the services within the Lahey Health Network.

A Lahey PCP in conjunction with a Specialist and or Chair of the Department will collaborate on the determination that there is medical necessity to receive services out of the network.

KEY CONDITIONS REQUIRED FOR APPROVING OUT-OF-NETWORK REFERRALS:

- ***Services of a Specialist are required***
- ***Services not available within the Lahey Network***

5.2. Criteria for Referral Certification

a. The patient has seen their PCP within 9 months
b. Medical Necessity for services is established
c. Medical Necessity of place of service is established

5.3. Reasons for Out-of-Network Referral

a. Services not available within the Lahey Network
b. A Lahey PCP in conjunction with a Specialist and or Chair of the Department determines there is Medical Necessity to receive services out of the Lahey Health network
c. Continuity of care for current treatment plan
    - Any patient seen by the out of network specialist within the last two years is considered a 'Continuation of Care'
    - The continued care is for the specific condition only
        - A transition plan may be developed
d. Second opinion
    - Second opinion will be considered if a patient requests to see an out of network provider for a diagnosis given by a Lahey provider
    - There are no providers within the Lahey Network who can provide a second opinion, or PCP in conjunction with Specialist provides medical necessity to refer out of the network
e. Patients who have not seen their PCP within 9 months
    - Referral Specialist will offer an appointment to see their PCP
    - Referral Specialist will cancel the referral request

5.4. OON Referrals Generated After a Visit

a. Once the provider (PCP) has determined the patient requires a visit with a specialist (SCP), the patient and the PCP will discuss most appropriate place of service.

b. The PCP will provide the patient with information regarding available resources within the Lahey Health Network and the rationale behind using a Lahey Specialist. If the patient requests an out of network specialist, the PCP will attempt to further explain the reasons behind the benefits of receiving care from an in-network Lahey specialist:

- *Enhanced collaboration and coordination between PCP and Specialist*
- *Timely access to in-network appointments*
- *Shared medical records within an integrated system*
- *Efficient communication between providers*

c. If applicable, the PCP should remind the patient there is no clinical justification for certification of Medical Necessity for the patient to go out of the network.

d. The PCP will encourage the patient to contact the Referral Management Center (RMC) to schedule an appointment with a Lahey Health Specialist.

e. The Referral Specialist will explain the insurance plan requirements and procedures to the patient.

f. The Referral Specialist will further attempt to offer a Lahey Specialist appointment and redirect the patient. If the patient consents, the appointment is scheduled and the task is completed. A referral task note is created in the chart for informational purposes.

g. If the patient still insists on a provider outside of the Lahey Health then a task will be sent to the PCP for further review.

h. The PCP will complete the Medical Necessity portion of the referral and determine if there is a medical need for the member to go out of network. At the discretion of the PCP, the patient may be contacted by the primary care practice and further redirection attempted.

i. Once the PCP has completed their response to the task, it is sent back to the Referral Specialist.

j. If the PCP recommends going out of network, the referral task is sent to the Referral Case Manager (CM).

k. The case manager gathers pertinent clinical referral data into a summary.

l. The Department Chair of individual specialties provides consultation on cases as requested, and assists in providing access and patient outreach.

m. The Referral Case Manager will engage the patient, explain the process and offer an appointment with a Lahey specialist. If the patient continues to request services outside of the Lahey network, the patient is referred to their insurance plan to discuss their responsibilities and or options**.**

n. A Non-Certification Letter may be sent to the patient.

o. The Referral CM will initiate a task back to the Referral Specialist that includes determination and rationale. Any specific information for the Referral Specialist will be communicated in the scheduling application.

p. The Referral Specialist will complete the task and copy the note to the PCP for information purposes.

* If the patient accepts the appointment, the task is completed and sent to the PCP for informational purposes.

5.5. Direct Calls to the Referral Management Center for OON Referral

When the patient calls the RMC the Referral Specialist will do the following:

a. Greet the patient and explain the process.

b. Initiate a Referral Record in Epic and fill out all the necessary demographic information.

c. Verify the patient's insurance plan and plan requirements.

d. The Referral Specialist will explain the plan's requirements and procedures.

e. The Referral Specialist will offer a Lahey Specialist appointment.

f. If the patient insists on a provider outside of Lahey Health, an In-Basket message will be sent to the PCP for his or her review.

g. The PCP will fill out the Medical Necessity field of the referral and determine if it is medically necessary for the member to go out of the network. At the PCP's discretion the patient may be contacted by their office and further redirection attempted.

h. Once the PCP has completed the Medical Necessity field, the Referral Record is routed back to the Referral Specialist.

i. If the PCP recommends going out of network, the referral record is routed to the Referral Case Manager's workqueue.

j. The case manager gathers pertinent clinical referral data into a summary.

k. The pertinent clinical information is sent to the Medical Director for review.

l. The Referral Case Manager (CM) will engage the patient, explain the process and offer an appointment with a Lahey specialist. If the patient continues to request services outside of the Lahey network, the patient is referred to their insurance plan to discuss their responsibilities and or options**.**

m. A Non-Certification Letter may be sent to the patient.

n. The Referral Case Manager will route the referral record that includes the determination and rationale back to the Referral Specialist. Any specific information for the Referral Specialist will be communicated in the notes section of the referral record.

o. The Referral Specialist dispositions the referral record with the final status.

6.0 Process for Managing In-Network Referrals to Lahey Health Affiliates

Workflow designed to enable appointments to be made to Lahey Health affiliates, at the time of the visit. Primary care provider confirms medical necessity for service.

6.1. Workflow

a. Provider orders the referral

b. Office staff schedules the appointment

c. If the provider ordering the referral uses Epic, a referral record is automatically created. If the patient is referred from a Lahey affiliate not using Epic, the Referral Specialist manually creates the referral record.

d. Referral Specialists complete the referral. Referral Specialists communicate the referral information to the affiliate specialist either via Epic or by phone/fax.

7.0 Process for Managing Patient-Initiated Referrals to In-Network Affiliates

Workflow process designed to facilitate a seamless insurance referral process for patients receiving services within the Lahey Health network.

7.1. Workflow

a. Patient calls the centralized Referral Office

b. Referral Specialist confirms provider is part of Lahey Health network or on approved list of affiliated providers

c. Referral Specialist processes referral request on Payor website

d. Referral Specialist logs referral in Epic.

e. Referral Specialist reaches out specialist and provides referral information

f. In-Basket message to PCP is not created in electronic health record

8.0 Process for Non-Certification Letters

Workflow process to provide formal communication of the Non-Certification of a referral, if requested by the patient

8.1. Workflow

a.) Use designated template and complete all required fields

b.) At the bottom of Letter CC: PCP and Customer Relationship Management

c.) Name document by Date of letter (space) LC # (space) Patient last name (space) Patient first name

- Date format is YYYYMMDD: Example: 20140401= April 1, 2014
- LC # is just the number
  - Example: 20140401 9999999 Smith Tom

d.) Save work document in: Z:\Referral Process, Forms and Info\Non-Certification Letters

e.) Print copy of letter

- Have Medical Director sign if available. If not, sign his name and place your initials after the signature.
  - Example: Dr. Sebba/SCL

f.) Scan signed letter

g.) Name PDF document by Date of letter (space) LC # (space) Pt last name (space) Patient first name

- Date format is YYYYMMDD: Example: 20140401= April 1, 2014
- LC # is just the number
  - Example: 20140401 9999999 Smith Tom

h.) Save letter in: Z:\Referral Process, Forms and Info\Non-Certification Letters

Send Letter to:

i.) Email: scanned letter to Medical Director, Referral Case Manager and Patient Access Director

j.) Mail scanned letter to PCP(if not emailed) and a hard copy to Patient Access Director

k.) Mail original to patient

9.0 Process for Organizational Determination Letters

Organization determination is any decision made by a Medicare health plan regarding:

1. Receipt of, or payment for, a managed care item or service;
2. The amount a health plan requires an enrollee to pay for an item or service; or
3. A limit on the quantity of items or services.

An enrollee, an enrollee's representative, or any provider that furnishes, or intends to furnish, services to an enrollee, may request a standard organization determination by filing a request with the health plan. This is our workflow procedure for managing these requests.

9.1. Workflow

a. Fax received from Insurance Plan

b. Referral Specialist answers questions and completes request

c. Form is faxed back to originator

d. Copy of completed request is scanned

e. Name PDF document by Date of letter (space) pt first name

- Date format is YYYYMMDD: Example: 20140401= April 1, 2014
  - Example: 20140401 Smith

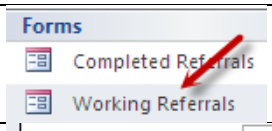
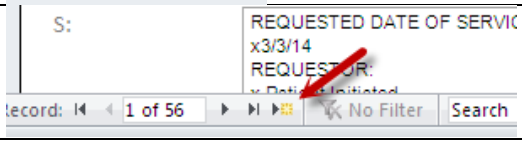
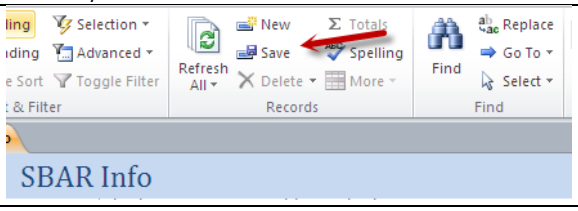
f. Save at: Z:\Referral Process, Forms and Info\Organizational Determination

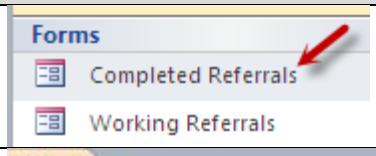
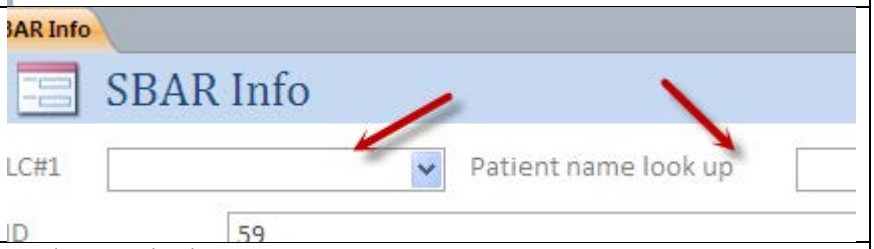
g. Send original copy to Director of Patient Access (Access Center 31 Mall Road Burlington)

10.0 Process for Documenting Clinical Reviews and Follow-up

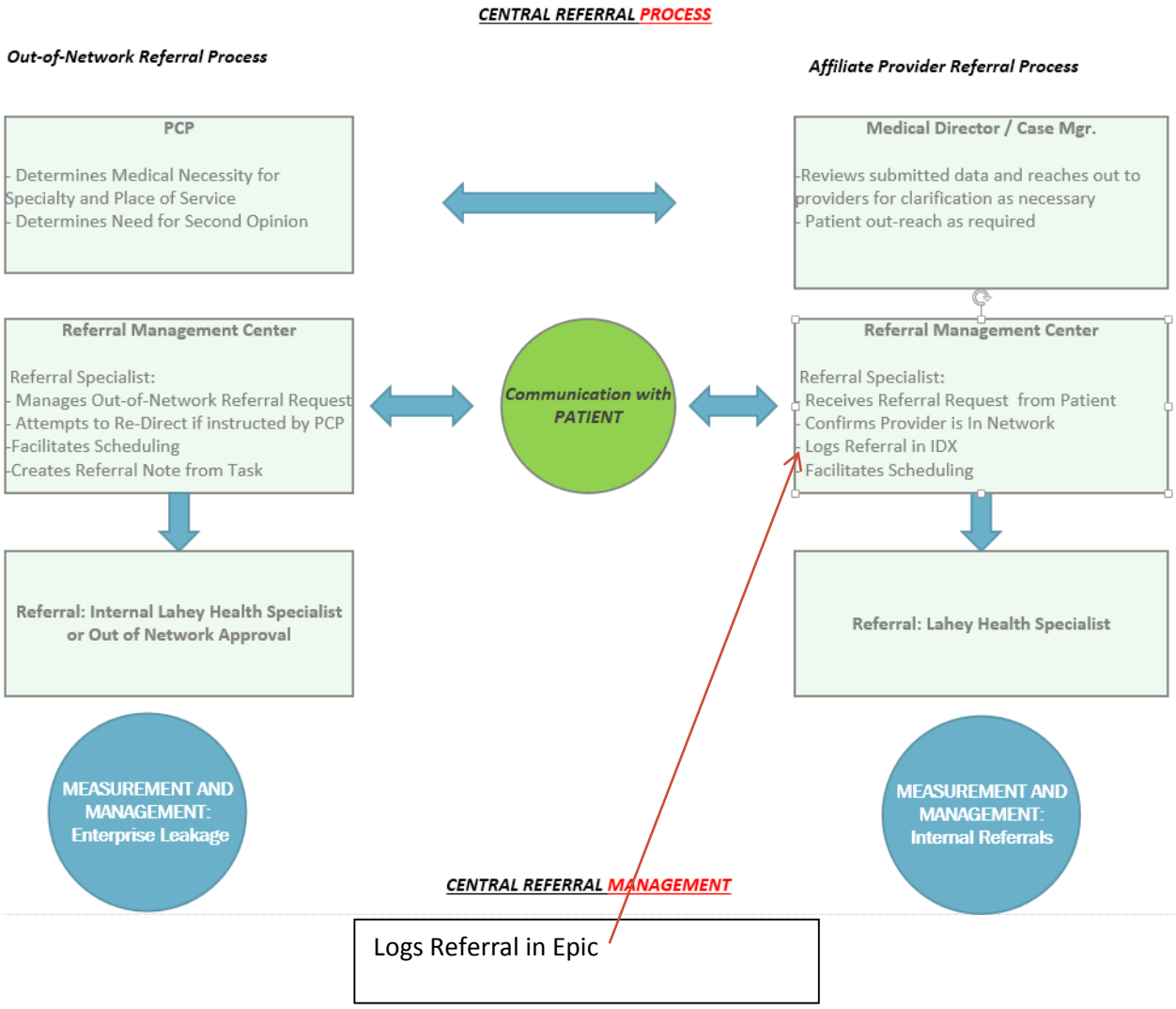
Procedure for documenting Clinical Reviews and Follow-Up in the Care Management Referrals Database:

10.1. Workflow

Documenting Clinical Review	
1. Print task	
2. Click on the Form: "Working referrals" in the CM Referral Access Database	
3. Click to create a new record	
4. Copy and paste or enter task information (saved on your desk top) into "Working referrals" As follows:	
LC#	Must start with an **L** then copy & paste
Dte CM recd	Choose the date off of the calendar that the task was received
Patient Name	Copy & pate off of task
Referral #	Located on task: Copy & paste off of task (Critical to have)
Working referral	Located on task- communication to other referral CM
Final Determination	Choose Certify or not certify
Reason:	Type the patient pertinent background as it relates to the referral
Follow -up	Cut paste the info in your task and you can document other f/u items
Appt made for patient	Check if "yes"
Patient to make appt	Check if "yes"
Pt unsatisfied with the service	Check if "yes
If unsatisfied, which department	Spell out the department
Unsatisfied because	Describe what occurred
CM Notes	Brief CM note
Sent to Med Dir	Check if "yes"
Med Director response	Describe
Chair of specialty input	Check if "yes"
Specialty input	Check if "yes"
5. Save Document as demonstrated or just move to next patient	

Documenting Post referral work or adding to cases that have already been "determined"	
1. Click on the Form: "Completed Referrals" in the CM Referral Access Database	
2. Finding the case: You can look up by either typing the LC # or name and search the dropdown box	
Non certification Letter Date	Date letter was dated
Appeal/OD	Check if one was filed
Appeal/OD provider	List providers given to payer
D'nial let dated	Date the payor's denial letter is dated
D'nial let rcd	Date the payor's denial letter is received
Payor overturned	Check if the payor has overturned our decision

Appendix A


CENTRAL REFERRAL PROCESS
Out-of-Network Referral Process
Affiliate Provider Referral Process
PCP
- Determines Medical Necessity for Specialty and Place of Service
- Determines Need for Second Opinion
Medical Director / Case Mgr.
-Reviews submitted data and reaches out to providers for clarification as necessary
- Patient out-reach as required
Referral Management Center
Referral Specialist:
- Manages Out-of-Network Referral Request
- Attempts to Re-Direct if instructed by PCP
-Facilitates Scheduling
-Creates Referral Note from Task
Communication with PATIENT
Referral Management Center
Referral Specialist:
- Receives Referral Request from Patient
- Confirms Provider is In Network
- Logs Referral in IDX
- Facilitates Scheduling
Referral: Internal Lahey Health Specialist or Out of Network Approval
Referral: Lahey Health Specialist
MEASUREMENT AND MANAGEMENT: Enterprise Leakage
MEASUREMENT AND MANAGEMENT: Internal Referrals
CENTRAL REFERRAL MANAGEMENT
Logs Referral in Epic