Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

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

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

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

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

a. For the timeframe covering Lawrence General Hospital's (LGH) fiscal year 2012 through the first nine months of our fiscal year 2015 we have noted the following trends:

i. Revenue

As can be seen in the table below, LGH experienced an average increase of 1.7% in net revenue per adjusted discharge from FY 2012 through the first nine months of FY 2015.

	2012	2013	2014	2015 (nine months through 6/30/2015)
Average NPSR per adjusted discharge	$ 6,133.50	$ 6,370.90	$ 6,662.50	$ 6,446.68
% annual change in NPSR per adjusted discharge		3.87%	4.58%	-3.24%
Average annual change in NPSR/adjusted discharge, 2012 through 3Q2015				1.70%

Source: NPSR per audited financial statements, FY 2012 through FY 2014; internal financial statements through June 30, 2015 for Adjusted discharges = actual discharges/(inpatient charges/total charges)

- As an institution which meets the Commonwealth's definition of a DSH hospital, LGH is significantly dependent upon government payors, including Medicare, MassHealth, the Health Safety Net and Medicare and Medicaid managed care organizations. As such, there have been limited opportunities for LGH to realize greater increases in net revenues through negotiation of higher payment rates from non – government payors. This is confirmed through review of CHIA's annual reports on health care costs in which LGH has been consistently shown to be in the lowest quartile of hospitals for casemix/service mix –adjusted commercial payments.

  Additional impacts on LGH's revenues include the following:

  - Since mid – 2013 the Medicare Program has reduced all payments by two percent (2%) as a means to address ongoing federal budget shortfalls.
  - Affordable Care Act/Health Care Reconciliation Act payment reductions to Medicare DSH reimbursement have partially offset gains realized as the result of a favorable area wage index (AWI).

- The application of retroactive "budget neutrality" adjustments by Medicare, intended to offset presumed overpayments resulting from the program's change to MS-DRGs has reduced annual market basket (inflation) updates since FY 2014. In its FY 2016 IPPS final rule, CMS appears to indicate that this negative adjustment may continue through federal FY 2017.
- As is the case with all hospitals and also given our organization's focus on providing the right care in the right setting , LGH continues to experience an increase in the care provided in outpatient settings where reimbursement for complex cases can be as low as $340 or $425 per encounter (the MassHealth and HSN PAPEs, respectively).

- With its expanded relationship with the Beth Israel Deaconess Care Organization (BIDCO) LGH will experience greater participation in reimbursement agreements that call for some form of risk sharing. It is expected that in the long term these arrangements will reduce revenues but should also reduce the cost of providing quality care to people in our service area.

ii. Operating and Capital Costs

As shown in the table below, LGH experienced an average increase of 3.33% in net expense (total expense less the costs associated with Delivery System Transformation Initiative (DSTI) programs) per adjusted discharge from FY 2012 through the first nine months of FY 2015.

	2012	2013	2014	2015 (nine months through 6/30/2015)
Average expense per adjusted discharge (net of waiver expense)	$ 6,463.84	$ 6,726.76	$ 7,029.85	$ 7,109.99
Average net operating expense per adjusted discharge	$ 6,240.50	$ 6,470.63	$ 6,697.64	$ 6,733.78
Average capital cost per adjusted discharge	$ 223.34	$ 256.13	$ 332.21	$ 376.22
% Growth in net operating cost per adjusted discharge		3.56%	3.37%	0.51%
% Growth in capital cost per adjusted discharge		0.51%	1.13%	0.63%
% Growth in total cost per adjusted discharge		**4.07%**	**4.50%**	**1.14%**
Average annual change in expense/adjusted discharge, 2012 through 3Q2015				**3.33%**

Source: Expense per audited financial statements, FY 2012 through FY 2014; internal financial statements through June 30, 2015 for FY 2015. ***Net of amounts spent on DSTI initiatives***
Adjusted discharges = actual discharges/(inpatient charges/total charges)

- During FY 2014 and 2015, LGH has undertaken various internal initiatives with an eye toward reducing its operating costs. These include changes in health insurance programs offered to employees, which provide coverage at a more reasonable cost as

a result of the use of LGH and providers with similar cost structures and a reevaluation of hospital staffing during FY 2015 which primarily affected middle and upper management. Given the lassitude with which reimbursement rates shall increase, as well as the incentives toward efficiency in increasingly risk sharing payment arrangements, LGH management does not foresee any future scenario where operating costs will not be strictly controlled.

As can be seen in the above table, LGH's capital costs have become – and will remain – an important component of the hospital's annual increased costs in the near to intermediate term. The reasons for this are as follows:

- Until relatively recently, LGH's annual capital spend was low and was almost always funded through cash generated from operations. The result was a physical plant, which while well – maintained, was significantly aged and equipment that in some cases lagged the current standards of care. As such, LGH has found itself in a catch up mode in terms of capital spending.
- With the growing importance of risk – sharing payment arrangements that seek to provide quality care in the least costly setting, it is incumbent upon LGH to develop the infrastructure that will allow more patients from our service area to seek their care locally and to forego the use of more expensive teaching facilities and academic medical centers. To put it plainly, LGH understands that these investments will increase the organization's capital costs in the near to intermediate term but should reduce overall medical expense over the longer run.

iii. Utilization

In the table below the trends for inpatient and outpatient utilization demonstrate the following:

- LGH's ongoing investments in care management and primary care have contributed to a significant decline in the use of the Hospital's emergency department. We expect that this trend will continue as we expand our primary care footprint with additional sites in our service area through our affiliate, Community Medical Associates (CMA) and our contracting partner, Beth Israel Deaconess Care Organization (BIDCO).
- The evident increase in our day surgery cases and outpatient procedures indicates that more individuals from our service areas are availing themselves of these types of care at a local institution in a lower (than inpatient) cost setting.

	2012	2013	2014	2015 (nine months through 6/30/2015)
N of Discharges	12,496	12,868	12,664	9,228
ED Visits	73,107	71,025	69,946	52,740
SDC	3,615	4,465	4,861	3,695
Endo	3,383	3,139	3,518	2,903
Total OP	**6,998**	**7,604**	**8,379**	**6,598**

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?

Lawrence General Hospital has been supporting the 3.6% health care cost growth target. As of July 1, 2014 the hospital became a member of the Beth Israel Deaconess Care Organization in order to assist our local BIDCO small, independent practices manage the risk contracts offered by BIDCO, including the Blue Cross Alternative Quality Contract (AQC), Harvard Pilgrim Healthcare, Tufts Health Plan and Medicare Pioneer ACO contracts. As a member of BIDCO, Lawrence General became a risk sharing participant in those alternative payment contracts as well. Those contracts all include incentives for managing health care expense within a budget as well as improving quality. We are changing work flow and using personnel to actively manage these patients so that care is provided more efficiently with improved outcomes as further described in the response to question 3. Through our own contract negotiations with other payers we have accepted payment rate increases well below the 3.6% target in most instances. We have also been educating community physicians through our Physician Hospital Organization (PHO) of the Choosing Wisely guidelines for avoiding non-beneficial care, and that includes patient education materials as well. Our PHO also fosters use of local community specialists and the local hospital in order to keep appropriate care in the lower cost setting, rather than a tertiary hospital.

And as was described previously, LGH has begun the process of investing in primary care physicians both through our affiliate, Community Medical Associates as well as our partner, Beth Israel Deaconess Care Organization. These investments should reduce inpatient hospitalizations and emergency department utilization by providing individuals in our service areas with access to lower cost care alternatives that also focus on disease prevention.

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?

Lawrence General has increased its adoption of alternative payment methods. As of July 1, 2015 Lawrence General embarked on participation in the CMS Bundled Payments for Care Initiative (BPCI) through a convener, Remedy Partners, for congestive heart failure patients. This cohort of patients represented the largest number of bundled episodes in the data from CMS and thus is a significant opportunity to learn how to manage these patients in a way that will reduce cost yet improve outcomes. Lawrence General is participating in the Pioneer ACO through BIDCO thereby sharing risk with BIDCO physicians locally for both managing expense within a budget and improving quality. We have embarked on new ways to identify and these patients and try to treat these patients in the most optimal care setting. In order to succeed in this program and in the BPCI, we have been engaging our post-acute care community as further described in our response to question 3. All of these efforts should result in a lower total medical expense for these patient populations.

Currently we have approximately 12,350 covered lives in the risk sharing contracts in which the hospital participates and fee for service net revenue under those contracts accounts for 14% of our payer mix overall (excluding bundled payments). We care for additional Pioneer ACO patients that are patients of Pentucket Medical Associates but we are not in a risk sharing arrangement for that patient population. We are working to recruit additional primary care physicians who will be members of BIDCO and expect that our panel of patients under alternative payment methodology contracts will expand as those physicians come on board. Participation in Medicare Advantage contracts with risk sharing elements as well as an alternative payment contract with a Medicaid managed care organization are also being discussed for 2016.

Finally, as an employer, Lawrence General plans to expand its employee wellness program utilizing population health data and offer programs to employees that will begin to improve their health and over time have a corollary downward effect on healthcare spending.

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

Availability of comprehensive utilization, quality and medical expense data
The **timely** availability of comprehensive utilization quality and efficiency patient data will assist providers and provider networks on a number of levels: First, for existing patients in current panels, timely data will allow organizations to focus on patients who may need care management. If these data are not available until two or three quarters after the close of a contract year, their usefulness – except for risk sharing settlement purposes – is moot.

Second, understanding the needs of a patient panel in something that is closer to real time should support the creation of programs which support better health via the provision of

focused preventive services, for example. In addition, from a financial management/reporting perspective, providers would be able to understand reserve requirements and reinsurance needs before a shortfall in reserves or reinsurance coverage becomes a material financial reporting matter.

Payment/Reimbursement gaps

Currently, payment differences among providers remain unfair and are as easily attributed to market dominance or prestige as to the quality of care provided to patients. Providers which consistently find themselves among the lowest paid – and especially those providers with a high reliance upon patients covered by government insurance programs – find themselves faced with the prospect of poor operating results. When continued over any period of time, operating losses or consistent break even performance strips such providers of the ability to maintain capital spends not only for patient care related assets but also for the IT investments necessary to manage risk in patient populations. While intercession on the Commonwealth's part in terms of MassHealth DSH or DSTI funds is helpful and appreciated, such assistance on a continuing basis is probably not sustainable from either a fiscal or a political perspective. It may be possible that certain providers warrant payment that is a significant multiple of another provider's reimbursement for the same case/service and for similar patients but such differences should be supported by objective evidence.

Uniform and transparent payment rules

There should be a uniform base payment format across all providers within a provider type, such as a single base fee schedule (note that this does not preclude negotiation for fee schedule multipliers). Likewise, claims submission format, the use of consistent DRG groupers/CPT4 versions and payment policies across all payers will help reduce providers' administrative burdens and possibly establish some balance and transparency in the market. Administrative complexity has continued to increase with payer strategies to form limited provider networks and forced movement to shifting risk to providers without any relief in other administrative requirements.

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

Lawrence General Hospital does face constraints on its ability to expand participation in alternative payment methods. We are contracting with several payers now through our membership in BIDCO, which has finite administrative resources to be able to analyze potential new contract arrangements, manage multiple negotiations and bring them to reasonable conclusion. Similarly, we too have only so much bandwidth to do due diligence working with payers to take on new payment arrangements, ensure that we will be provided with timely, actionable data in order to manage the risk and to be able to engage with the physicians in the community to accomplish the goals of the arrangements.

Lawrence General only directly employs one small group of primary care providers and therefore it is harder to drive change in physician practice than if we were a system that employs most of the community physicians. Our physician community is comprised of a large federally qualified health center, a large multi-specialty physician group and many small independent primary care physician

practices (most are in BIDCO) and specialists. The specialists typically service at least two community hospitals and may be in multiple contracting organizations which makes it harder for us to create aligned incentives under risk contracts. In fact, although Lawrence General supports a physician hospital organization (PHO), the member physicians are participating in major payer contracts through other entities such as BIDCO, Steward, Partners, Children's Hospital PPOC, etc. And again, at the level of the primary care practice, they are already overwhelmed by the complexities of what is expected of them for adequate financial and quality performance under these arrangements and it is hard to imagine creating additional requirements for them. In order to address the problem of complexity, it would be much better to have a single method of sharing risk, and measuring quality, so that the physician could more easily translate the expectations into the daily demands of caring for their patients.

There are also financial barriers to expanding the adoption of alternative payment methods. As a small community hospital we have to balance the added cost of the resources needed to manage risk contracts and any potential downside financial exposure with the potential benefit if we succeed in creating shared savings, for example. We do not have the large financial reserves of the insurance companies or a larger hospital system, so we have to be careful to right-size our level of participation in risk. The state has recognized this with its new policy of requiring registration of risk-bearing provider organizations which we support. It would be ill-advised and impossible logistically to rapidly increase the number and type of risk sharing contracts. We need to proceed at a pace that allows us to be thorough in our analysis and preparation for the benefit of our community of patients and as one of the largest employers in the city of Lawrence.

Finally, we need to consider our patient population here in Lawrence. As a disproportionate share hospital we know that health literacy, language issues and poverty can be barriers to achieving optimal patient outcomes. We are beginning to measure HEDIS quality results across our PHO population and we do see disparities in certain areas between those patients and others from higher socio-economic status communities. We appreciate that the Commonwealth is seeking provider input in planning for future payment methodologies for the Medicaid population since the health care needs of this population are so varied and social determinants play a large role in achieving population health improvements. We cannot enter those contracts lightly since this is such a large percentage of our patient population and revenue on which we rely to provide high quality patient care.

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.

      1) Spending on post-acute care: During FY 2015, LGH spent significant time in this area to build relationships and work to manage better health, increased quality and lower cost

into the post acute sector. LGH has continued to run its community collaborative committee which is comprised of representatives across the continuum of care including skilled nursing facilities (SNF), rehabs, visiting nurse agencies (VNA), assisted livings, primary care groups and elder service organizations. A new charter was formulated that focuses on improvements of medication reconciliation, ways to choose the correct setting for patient placement and "at risk" patient identification. LGH also built a preferred provider network with post-acute organizations that have specific conditions of participation. Additionally, a "SNF/Rehab-ist" program has been created with area physicians who are LGH affiliated and treat our patients in the post acute setting. This group has identified standardized workflows and opportunities for improvement in the handoff between the hospital and the post-acute arena. LGH's transformation team has visited each facility to educate administrators and staff regarding changes in health care overall and how LGH is responding to these changes. The addition of a clinical nurse leader, care manager, who has begun attending all discharge planning meetings and works directly with post acute staff, at the point of care to improve transitions and manage length of stay, has been initiated. LGH's participation in the SNF waiver program through Beth Israel Deaconess Care Organization's Pioneer ACO program has provided opportunities to strengthen the relationships with the post-acute world. Ongoing education of this work has been provided to hospital staff and physicians as well as members of the Physician Hospital Organization.

2) Reducing avoidable 30-day readmissions; During the past year LGH has performed full assessments on their 30 day readmissions which was done during the CHART phase 1 initiative. LGH was the recipient of a planning grant to create a strategy to care manage high-risk patients across the continuum with the goal of readmission reduction. The hospital has reviewed the discharge planning and transition work done by its nursing and medical staff as patients move from one setting to the next. Better tools for handoff and communication have been the result of this work. The nursing team continues to provide warm handoffs at discharge to the next provider of care. Throughout the past year, LGH continued active participation in the community care transitions program (CCTP) sponsored by Centers for Medicare and Medicaid (CMS) and run locally by Elder Services of the Merrimack Valley (ESMV). This program provided transition coaches to those patients, which were defined as medium and high-risk for readmission. The program yielded a decrease in readmissions for the enrolled population but was discontinued this past August secondary to outcome reduction not hitting targets nationwide. LGH, ESMV and Home Health Visiting Nurse Agency (HHVNA) had created bi-weekly case conference reviews to discuss difficult cases that present barriers during the course of this program. These meetings have allowed for the teams to collaborate on learning and will continue at LGH despite funding lapse for the CCTP program.

   Further assessment of current readmission reduction strategies have ensued with high-risk populations such as Diabetes, CHF and COPD patients from the

Greater Lawrence Family Health Center. Over the past 3 years, readmission rates for these diagnoses, specifically CHF and diabetes, have been decreased secondary to efforts of increased care coordination, increased handoffs between the hospital and the providers as well as clinical pharmacy led medication reconciliation at discharge. CHART grant phase 2 application and "implementation planning period" has allowed for further evaluation of the current readmission rate for all patients and for a targeted population made up of socially and medically complex patients. The CHART grant phase 2 is funding the implementation of a transitional care program being launched 10/1/15. Patients with medical and/or social complexity will be identified and enrolled in the program. Care managers and social workers will use motivational interviewing techniques to work individually with enrolled patients and provide services for 90 days following an inpatient admission. Elder Services of the Merrimack Valley will partner with LGH and use innovative technology tools to promote continuity and follow up. The primary aim of the transitional care program is to reduce 30 day readmissions in the total target population by 20% by the end of 2 years, reducing avoidable hospitalizations.

3) Reducing avoidable emergency department (ED) use: CHART phase 1 activities focused on an assessment and report of the use of avoidable emergency department utilization. Over the last three years, LGH has worked with Greater Lawrence Family Health Center (GLFHC) to educate patients on the appropriate use of the emergency room. This work has allowed for the creation of a co-located patient centered medical home (PCMH) site through GLFHC that is stationed at the hospital. Over the past twelve months LGH has been participating in the implementation-planning period for Chart phase 2. A secondary aim for the transitional care program in Chart phase 2 will be to reduce emergency department re-visits within 30 days for high utilizers by 20% by the end of 2 years (patients who have > 7 ED visits in the baseline period). Additionally, LGH has begun work with GLFHC to identify "super-utilizers" (patients who have >7 ED visits in the baseline period) that the hospital shares with the PCMH and has stationed staff such as social workers and case managers in the Emergency Department to start to work on risk stratification and care planning for this population in collaboration with the health center team.

4) Providing focused care for high-risk/high-cost patients: Within the past twelve months LGH has taken an assessment of our ability to provide a cross continuum care management program with strategic planning funding from Chart phase 1 funding. Our larger strategic planning activity for the system included population health and healthcare transformation needs over the next five years. LGH has added case management staffing in the ED to identify high risk and potentially high cost patients through an ACO patient identification and activation project. Strategies directed at the point of entry to assess for alternative discharge planning has been successful in affecting total medical expense for this at risk group. The physician director of population health

provides real time evaluation of patients that are identified, as needed, to determine the optimal care setting. LGH, as previously mentioned, has also been actively pursuing engagement in CMS's Bundled Payment Care Initiative program (BPCI) and has chosen the high-risk population of Congestive Heart failure to focus on. Again Chart phase 2 activities have identified high risk and high cost patients as those with medical and/or social complexity for the transitional care program.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
As noted above, the CHART grant is funding the transitional care program that addresses all 4 of the areas:

1. Spending on post-acute care: Over the next twelve months LGH will work on the development of a quality dashboard for all preferred providers to help compare organization's clinical outcomes and help us to make more informed decisions on the capabilities of our partners to manage our patients effectively. The hospital will be continuing to develop decision support tools to assist inpatient staff and patients to make the right decision on post acute services. Claims data through BIDCO ACO and the BPCI program will further assist the hospital on following spend trends in the post acute setting that affect total medical expense. In addition to our own BPCI program the hospital is also planning to partner with Home Health VNA and Genesis Healthcare on their programs to help identify and manage patients across the spectrum. This involvement will allow us to establish baselines with particular preferred providers on key outcome related metrics such as length of stay, readmission rates and ED utilization rates. New physician contracts for LGH affiliated skilled nursing facility/ rehab providers will offer incentives that focus on readmission reduction and managing length of stay. The CHART grant is funding the implementation of the transitional care program, which again is being launched on 10/1/15. Patients with medical and/or social complexity will be identified and enrolled in the program. Patients that utilize a post acute provider in this program will be followed by the care manager in the facility and handed back off to care managers and social workers who will use motivational interviewing techniques to work individually with enrolled patients and provide services for 90 days following the inpatient admission. Elder Services of the Merrimack Valley will partner with LGH and use innovative technology tools to promote continuity and follow up.
2. Reducing avoidable 30-day readmissions; the primary aim of the transitional care program is to reduce 30 day readmissions in the total target population by 20% by the end of 2 years, reducing avoidable hospitalizations. The program is to be implemented over the next month. Targeted work for readmissions as it relates to ACO and bundled payments will also be a large focus this year.

3. Reducing avoidable emergency department (ED) use; The secondary aim of the transitional care program through Chart phase 2 is to reduce emergency department re-visits within 30 days for high utilizers by 20% by the end of 2 years (patients who have > 7 ED visits in the baseline period). Interventions such as shared care plans designed to target local PCMH super-utilizers are in the process of being designed and carried out.
4. Providing focused care for high-risk/high-cost patients LGH will be working with high risk and high cost patients (those with medical and/or social complexity) for the transitional care program through Chart phase 2 funding. Again, focusing and developing interventions for subpopulations through our ACO like "rising risk" patients and our bundled payment population will be further enhanced.

In addition to the CHART initiatives, there are the following six (6) major projects that the DSTI waiver funding is supporting that also incorporate some of these areas:

1. Acute and Post-acute network development
2. Health information exchange
3. Care transitions
4. Clinical pharmacy for geriatric patient population
5. Capacity to respond to alternative payments
6. Development of information management capability

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?

    Circumstances that could support variation in prices for similar services among providers could include, but would not be limited to the following:
    - The presence of teaching programs, including both post graduate medical education and allied health training where the provider incurs substantially all of the costs of such training and amounts paid by Medicare are not sufficient to cover the cost of these programs
    - The need to assure access to hospital services in areas which are geographically isolated or medically underserved
    - The need to support programs that are necessary to serve the community but which are, generally speaking, under reimbursed and which may generate consistent negate contribution margins; e.g., neonatal critical care services

- The frequent use of innovative technologies whose efficacy is supported by research and demonstrated in current practice, has met FDA approval and whose cost may not be accounted for in either a provider's base rate or in a DRG weight

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.

In CHIA's most recent "Relative Price" analysis, which is based on FY 2013 data, the money quote appears early in the Agency's report. On page 6, the headline is: "***In each of the top six payers'*** (sic) ***networks, more than half of total acute hospital payments for inpatient care were concentrated among hospitals that had relative prices that were at least 20% higher than the network average.***" (Italics and bold added) CHIA goes on to note that there are similar results for outpatient payments for those payors.

One doesn't need to be an actuary to understand that providers who demand and receive higher relative payment rates and who represent a disproportionately large percentage of those payors' business will have an upward impact on members' premiums. This is a phenomenon that is exacerbated by patients migrating to academic medical centers for services that may be provided as easily at community hospitals. There is no indication that despite the transparency these cost hearings have provided, the existing disparities/relativity in payment levels have been addressed to bring providers all closer to the average. When payer rate renewals are held to less than the cost growth benchmark for all, then the disparities are perpetuated and those of us in the lowest quartile will never move up in the relative rankings, and will remain at potentially unsustainable payment levels, despite our best efforts at expense reduction.

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.

   During LGH's FY 2015 the Hospital's affiliated medical group, Community Medical Associates has hired a psychiatrist who provide psychiatric assessments for inpatients, and provides continuity as outpatients for those patients who receive their primary care at Greater Lawrence Family Health Center.

   LGH social workers are aware of these issues and provide information to patients on all local resources including how to access mental health treatment, detoxification facilities, short and long term rehabilitation, including Lahey's mental health network with whom we collaborate for emergency services. LGH has also placed a social worker full time in

the emergency department to provide resources there and decrease unnecessary utilization.

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.

LGH will hire a psychiatric nurse practitioner to leverage the psychiatrist's hospital practice. This hire will assist our hospitalists and emergency department physicians to assess patients with mental health and medical diagnoses. This will enhance our ability to reduce lengths of stay for patients whose mental health issues prevent their discharge to the community due to medication or post-acute placement issues. We are aware that our large primary care practices in the community are also recruiting additional behavioral health providers for more integrated primary care and behavioral health services.

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?

As described above, as of July 1, 2015 Lawrence General embarked on participation in the CMS Bundled Payments for Care Initiative (BPCI) through a convener, Remedy Partners, for congestive heart failure patients. This cohort of patients represented the largest number of bundled episodes in the data from CMS and thus is a significant opportunity to learn how to manage these patients in a way that will reduce cost yet improve outcomes. As was also discussed above, LGH is a risk sharing participant in the BIDCO Pioneer ACO and is developing models for better coordinated, patient-centered care, starting with an emergency room visit. LGH also cares for Pioneer ACO patients whom are patients of Pentucket Medical Associates but we are not currently in a risk sharing arrangement for that patient population.

Our employed primary care physicians of Community Medical Associates are preparing to apply to become a certified patient-centered medical home. The Greater Lawrence Family Center in Lawrence is an NCQA Level III certified PCMH already and has one site here at the hospital. We have worked closely with them on information technology integration and improved care transitions over the past three years.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

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

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1				
	Q2				
	Q3				
	Q4				
CY2015	Q1				
	Q2				

37T

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.
37T

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

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

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1				
	Q2				
	Q3				
	Q4	130 (full year)	3 (full year)	133 (full year)	Laboratory Radiology Elective inpatient procedures Maternity/L&D
CY2015	Q1				
	Q2	65 (YTD)		65 (YTD)	Laboratory Radiology Elective inpatient procedures Maternity/L&D

37T

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.
37T

Exhibit 1 AGO Questions to Hospitals

NOTES:

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

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 11,231	$ 10,134	$ 241	$ 217	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Health Plan	$ 5,177	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Harvard Pilgrim Health Care	$ 3,838	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,926	$ -	$ -	$ -
Total Commercial	$ 20,246	$ 10,134	$ 241	$ 217	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,926	$ -	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,219	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,736	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,955	$ -	$ -	$ -	$ -
MassHealth	$ -	$ 18,722	$ -	$ 560	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,304	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,304	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 65,370	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 31,738	$ -	$ -	$ -
GRAND TOTAL	$ 20,246	$ 28,856	$ 241	$ 777	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,955	$ 125,338	$ -	$ -	$ -

Notes:

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2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 10,871	$ 9,751	$ 329	$ 295	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Health Plan	$ 4,527	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Harvard Pilgrim Health Care	$ 4,295	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,140	$ -	$ -	$ -	$ -
Total Commercial	$ 19,693	$ 9,751	$ 329	$ 295	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,140	$ -	$ -	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,234	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,084	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 222	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 22,540	$ -	$ -	$ -	$ -
MassHealth	$ -	$ 19,234	$ -	$ 870	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,019	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,019	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 70,165	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 35,692	$ -	$ -	$ -
GRAND TOTAL	$ 19,693	$ 28,985	$ 329	$ 1,165	$ -	$ -	$ -	$ -	$ -	$ -	$ 35,680	$ 115,876	$ -	$ -	$ -

Notes:

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2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 10,294	$ 10,219	$ 306	$ 303	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Health Plan	$ 4,589	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Harvard Pilgrim Health Care	$ 4,634	$ -	$ 17	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,612	$ -	$ -	$ -
Total Commercial	$ 19,517	$ 10,219	$ 323	$ 303	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,612	$ -	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,363	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,634	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,006	$ -	$ -	$ -	$ -
MassHealth	$ -	$ 19,301	$ -	$ 680	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,561	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,561	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 70,927	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,047	$ -	$ -	$ -
GRAND TOTAL	$ 19,517	$ 29,520	$ 323	$ 983	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,006	$ 119,147	$ -	$ -	$ -

Notes:

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2014

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 9,475	$ 10,994	$ 253	$ 293	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Health Plan	$ 4,880	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Harvard Pilgrim Health Care	$ 4,962	$ -	$ 17	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,533	$ -	$ -	$ -
Total Commercial	$ 19,317	$ 10,994	$ 270	$ 293	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,533	$ -	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,394	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,569	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,542	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,505	$ -	$ -	$ -	$ -
MassHealth	$ -	$ 21,034	$ -	$ 1,024	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,370	$ -	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,370	$ -	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 75,298	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,435	$ -	$ -	$ -	$ -
GRAND TOTAL	$ 19,317	$ 32,028	$ 270	$ 1,317	$ -	$ -	$ -	$ -	$ -	$ -	$ 140,608	$ 17,533	$ -	$ -	$ -

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