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.

    New England Baptist Hospital (NEBH) is an acute care hospital, specializing in orthopedics and musculoskeletal care. Between CY2013 and 2014, our volume of patients cared for increased by 9.5%, total expenses by 8.9% and total operating revenue by 7.3%. NEBH opened a new outpatient facility in Dedham at the end of CY2013. The expense increase of 8.9% from CY13 to CY14 includes the incremental startup cost of that facility. Without the incremental cost associated with the outpatient care center in Dedham, our expense increase was 4.8%.

    More recently, comparing CY2015 July YTD to CY2014 July YTD, our patient volumes have grown by 3.5%, revenue by 1.8% and expenses have increased by 0.6%.

    Salaries, benefits and implant costs are the largest drivers of expenses at our facility. Other expense increases included:

    - Incremental costs associated with surgical supplies, implants and drug costs
    - Incremental staffing needs for ambulatory services in rehabilitation, occupational health and spine programs
    - New model of inpatient care, requiring additional physician staffing for perioperative care
    - Pay-for-Performance salary increases and market based adjustments for staff

    Our operating margins have dropped from 4.8% (FY12) to 1.0% (FY14 & FY15) as the cost of doing business has outpaced increases in rates from all payers.

    For example, more than 50% of our patients are over 65 years of age, and CMS rate adjustments have averaged less than two percent (2.0%). In addition, commercial rate increases have been minor over the last three years averaging less than 2.0% with little movement towards pay for value for hospital care.

    We have plans in place to reduce our cost base by 2.0% - 3.0% annually to be able to respond to these pressures and continue to generate a positive margin.

    Most of the pressure is from five major areas:

    1. Cost of new information technology
    2. Cost of drugs and medical devices
    3. Start-up costs associated with strategic initiatives to advance the New England Baptist brand of care.

4. Employment of critical physicians to support the hospital
5. Competitive wages and benefits for the labor force.

See Appendix for Detail: Items 1, 2 and 3

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?

NEBH is a Tier 1 provider in all commercial insurance products and is recognized as a high value provider. We continue to make investments that allow us to deliver excellent quality of care, at optimized costs, while improving the health of our patients.

- NEBH has aggressively pursued every avenue to lower the cost of doing business as a niche specialty provider. We have restructured management, redesigned work flows, streamlined services and continue to refine our demand-based staffing system to increase productivity and lower total labor expense.
- We practice evidence-based medicine and use demand matching to optimize the cost of implants for patients and have negotiated price reductions with our suppliers.
- Our continuous improvement efforts have reduced unnecessary utilization of ancillary services. For example we have experienced a 27% reduction in blood transfusions and an 11% reduction in utilization of lab services, between FY14 and FY15 YTD.
- Implementation of LEAN methods focused on workflow improvements have resulted in reduced redundancy of work effort and increased efficiency.
- We have implemented a new model for perioperative care. This model brings together an interdisciplinary team of clinical experts (e.g., hospitalist, nurse, case manager, pharmacist, and rehabilitation professionals) who work together to coordinate and manage the care of our patients and has reduced the need for specialty consultation during the inpatient stay.
- We are actively moving patient activity to the lowest cost environment. We have shortened inpatient length of stay by placing an emphasis on proactive discharge planning prior to the surgical episode allowing the majority of our patients to recover safely at home.
- We continue to pilot and implement protocols that allow our patients to return to function as soon as possible. Appropriate patients are selected to go through an accelerated rehabilitation program which requires them to mobilize on the day of surgery and prepares them to be discharged home the following day, rather than to a post-acute facility. We have a plan to implement same day surgery for a subset of our patients requiring joint arthroplasty moving them to a lower cost outpatient setting.
- We have implemented an electronic medical record which allows our providers to improve their ability to make well-informed treatment decisions, reduce waste, and coordinate care more effectively.

See Appendix for Detail: Item 4

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?

NEBH is an active participant in alternative payment models which reward our hospital and physicians for providing high value care. We are currently participating in a surgical episode of care bundle for the Group Insurance Commission (GIC) through one of its commercial insurers. We are also building bundled episodes of care with our ACO partners. We will be working with self-insured employer groups as a Center of Excellence for orthopedics under bundled care arrangements.

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

- We need policies that promote "Centers of Value and Excellence" for specialty care in this market. The New England Baptist Hospital is already a highly efficient and effective provider for specialty orthopedic care. However, we continue to be challenged by denial of patient access by higher priced networks despite our demonstrated value which is recognized locally and nationally.

- We urge the Health Policy Commission to continue to look into Connecticut's newly signed healthcare law – Public Act No. 15-146: An Act Concerning Hospitals Insurers and Health Care Consumers – which has a number of provisions that allow for a competitive market that supports high value providers. Some key provisions are highlighted below:
  - The law promotes transparency around PCP incentives/disincentives for managing outmigration from networks to high value providers. A majority of Massachusetts' PCPs are part of hospital-based networks. These networks encourage their employed PCPs to refer to their affiliated specialists to streamline population health management and retain patient information within a single EMR system. However, there are technologies in place – such as the Mass HIway – which allow providers to share patient information in a secure manner. In addition, EMR vendors are working to build interoperability features across multiple products.
  - We would support policies which require PCPs and other providers to disclose to patients, the nature of any financial incentives received that are associated with managing "outmigration". This would be consistent with policies and practices in place in most organizations today requiring physicians to disclose personal financial arrangements with industry. Patients must be given the choice to see any provider of their choosing – in or outside the PCPs' network – within the parameters of their insurance plan.
  - Another provision of the law endorses the development of a study to make recommendations about establishing reasonable maximum provider price

variation limits, along with a state-wide median rate for certain services and procedures.

- Health plans need be an active partner and take accountability for reimbursing providers based on patient outcomes and experience and recognize the current price disparity.

- The Medicaid payment model must take into account unique attributes of specialty hospitals, so that payment rates do not create catastrophic financial results.

- While tiered products are being increasingly adopted, insurers should also play an active role in directing care to lower cost facilities to bring down Total Medical Expense (TME). We need more meaningful incentives for consumers to choose high value providers in the insurance marketplace. Reference Pricing would encourage patients to use high value centers, while forcing high cost providers to look for efficiencies within their systems to reduce costs. (Example: California Public Employees' Retirement System (CalPERS) saved more than 5 million dollars through an initiative that set standard prices for knee and hip replacements and prompted beneficiaries to select higher-value hospitals for the procedures.)

- The current regulatory environment does not allow the provider community to innovate, work in novel ways or invest in moving care to lower cost settings. For example, the moratorium on Ambulatory Surgery Centers results in outpatient surgery being provided in a hospital-based site which inherently has a higher cost profile. Swing bed capability to allow for flexible use of expensive inpatient resources, including critical care units have been allowed in other states, and need to be considered in Massachusetts as well.

- Finally, the cost burden of increasing administrative infrastructure to support ever increasing regulatory requirements adds to the cost problem. The current system of pre-certification, authorization and re-authorization of service delivery; auditing contract payments and retrospectively negotiating administrative denials with every health plan is costly for all providers. Insurance reform should address the onerous burden for providers who now bear greater risk for the total cost of care.

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

   Bundled payment programs – such as CMS’s BPCI program – set price based on the institution’s own historical cost, instead of against the market. Pricing relative to the market would recognize and reward high value providers. NEBH is already among the top performers nationally for appropriate utilization of services and low costs.

Participating in programs such as BPCI would require significant infrastructure investments without value accruing to NEBH due to our existing efficiency.

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) Post-Acute Spending:
NEBH makes a strong effort to discharge patients to their home. Care management, which begins prior to surgery, allows us to establish goals and expectations for discharge and is designed to ensure that the patient's home environment is safe and can foster their recovery. For patients that do need facility-based post-acute care, we have partners who follow our protocols for care for our population at value driven cost structures. Our care management team ensures that all care transitions include detailed discharge summaries and orders to the receiving clinical team.

NEBH has been identified by the HPC and CMS as a top performer on discharges to the post-acute setting. Analyses published in the 2014 Cost Trends Report indicate that only 36% of NEBH's patients are discharged to a post-acute facility, compared to 63% state statewide.

See Appendix for Detail: Item 5

2) & 3) Reducing Avoidable 30-Day Readmissions/ Reducing Avoidable ED Use:
NEBH has processes in place to ensure that patients receive post-discharge communication and care planning, including a physician appointment post-surgery and follow up call to ensure that recovery is continuing as planned. Discharge summaries are also sent to the PCP office for coordination of care among providers.

Prior to surgery, patients are educated on their recovery process and are instructed on wound care management to prevent infections and return to the hospital.

A June 2015 report by CHIA (http://www.chiamass.gov/assets/docs/r/pubs/15/CHIA-Readmissions-Report-June-2015.pdf) that reviewed hospital readmissions shows that NEBH's readmission rate decreased by 22% between 2011 and 2013.

See Appendix for Detail: Item 6

4) Focused Care for High-Risk/ High-Cost Patients:
Throughout the comprehensive pre-admission screening process, clinicians follow NEBH protocols to identify high-risk patients. A care team consisting of physicians, nurses, physical therapists and care managers complete a thorough review of patient information prior to surgery and create the plan of care for the patient to avoid complications and

adverse events. Specialist consultations for patients with multiple comorbidities, and related ancillary services, if needed, are completed prior to surgery reducing Medicare Part B costs, longer hospital stays, unnecessary utilization of services, thereby reducing the total cost of care.

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

1) Post-Acute Spending:
We will continue our efforts to control spending in the post-acute setting. Market demographics continue to show that patients are getting older, have multiple comorbidities, are living longer, and are requiring surgical intervention for severe arthritis. Patients like these require more intensive inpatient services and post-acute services. In order to provide these patients with the best outcomes, NEBH will continue to develop its preferred provider relationships with high value post-acute care providers that will follow its clinical pathways for its patients.

2) & 3) Reducing Avoidable 30-Day Readmissions/ Reducing Avoidable ED Use:
We will continue to strengthen our care pathways and protocols to ensure that patients with post-operative issues will be effectively managed in a timely fashion by our care management team for any needs post discharge to avoid urgent care or ER visits.

We are working on key processes to provide our affiliates and partners with access to electronic medical record information about their patients to ensure seamless continuity of care.

4) Focused Care for High-Risk/ High-Cost Patients:
We are improving our workflows to enhance the communication between our pre-admission screening providers and the post-surgical providers, improving our coordination of care across the entire episode.

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 only unacceptable reason for variation in prices is market power.

    We understand and agree that hospitals that provide essential tertiary services such as trauma, burn care, and organ transplantation must offset the costs of operating such

services. Effective rationalization of tertiary and quaternary services would address excess capacity and higher costs over time.

We see no reason for physicians throughout the Commonwealth to be paid differently for the same professional services based on the market power of the group.

Unit price should not be the focus. All providers need to be paid for the value they create. Defining that value and its measures is a critical need and important next step.

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.

Current practices and historical contracting strategies have resulted in significant price variation and disparity being institutionalized. While there are now caps on price increases, there is no current plan to address price variation among all providers, including physicians.

Without an effectively designed regulatory framework that allows providers to be rewarded for the value they bring to consumers, the sustainability of these providers is likely poor.

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.

    Our comprehensive pre-admission screening program allows us to best manage patients who have underlying behavioral health issues, including addiction, which could affect their ability to be discharged home safely. Our expert team of care managers work with community resources, the patient's physicians and family members to ensure that all necessary home based services are arranged prior to surgery. Their efforts are developed in coordination with the behavioral medicine team who follow the patient and create a plan for the patient and family. Patients who may have addiction issues are directed to detox programs prior to surgery to address underlying addiction issues prior to addressing their musculoskeletal needs.

Further, NEBH has been partnering with a major payer on an opioid reduction initiative focused on:

- Education
- Pain assessment
- Alternative non-narcotic supplemental therapies for pain control
- Drug prescribing/disposal

Trained pain management nurses create differentiated programs for patients designed to meet their pain management requirements while limiting the risk of dependence and addiction.

We also employ behavioral health specialists for crisis intervention to prevent exacerbation of any behavioral health issues. During the discharge process, we ensure that continuity of care is maintained and we communicate with the patient's behavioral health provider and PCP to ensure smooth transition of care.

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.

We will continue to improve the level of integration between our pre-admission and inpatient teams to ensure that we are able to care appropriately for our patients with behavioral health needs. We will also continue to improve our care transition process of these patients to their providers in the community.

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?

The New England Baptist Hospital is a "Perioperative Surgical Home".

A Perioperative Surgical Home (PSH) is designed to provide coordinated, organized care from the time of the shared decision making for surgery all the way through post-discharge. It covers the preoperative phase of working with patients to optimize their condition prior to surgery, the interoperative phase, the immediate postoperative phase, and then post-discharge. The concept is to provide team-based, coordinated care to manage the patient's experience, to improve quality, and to decrease costs. *(Source: American Association of Orthopedic Surgeons)*

NEBH offers services to the patient for their entire surgical episode. Our comprehensive pre-admission evaluation includes a multi-disciplinary approach to patient care. We are able to successfully manage patients with multiple comorbidities. In fact, our Case Mix Index for FY15 YTD is 2.41. We have protocols for anti-coagulation, wound care, and infection control in order to prevent readmissions and unnecessary ED visits. Our care management process begins prior to

admission and continues post-discharge. We have effective care transition processes to the patient's PCP and post-acute providers to ensure that the patient is returned to their community for care continuity.

As a specialty provider, we consider ourselves to be a valuable partner to Accountable Care Organizations which advances the quality and value to patients, providers and payers, meeting the goals of true accountability for improved outcomes at a lower cost of care.

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	83	7	90	Hip/ Knee Replacement
	Q2	81	6	87	Cardiac Cath, Knee Replacement
	Q3	84	3	87	Spinal Stenosis, Knee Replacement
	Q4	88	6	94	Hip Replacement, MRI, Cervical Fusion, Excision
CY2015	Q1	87	5	92	Shoulder Arthroscopy, Wrist Surgery, ACL Surgery
	Q2	110	7	117	Meniscectomy, ACL Surgery, Hip Replacement, Knee Replacement

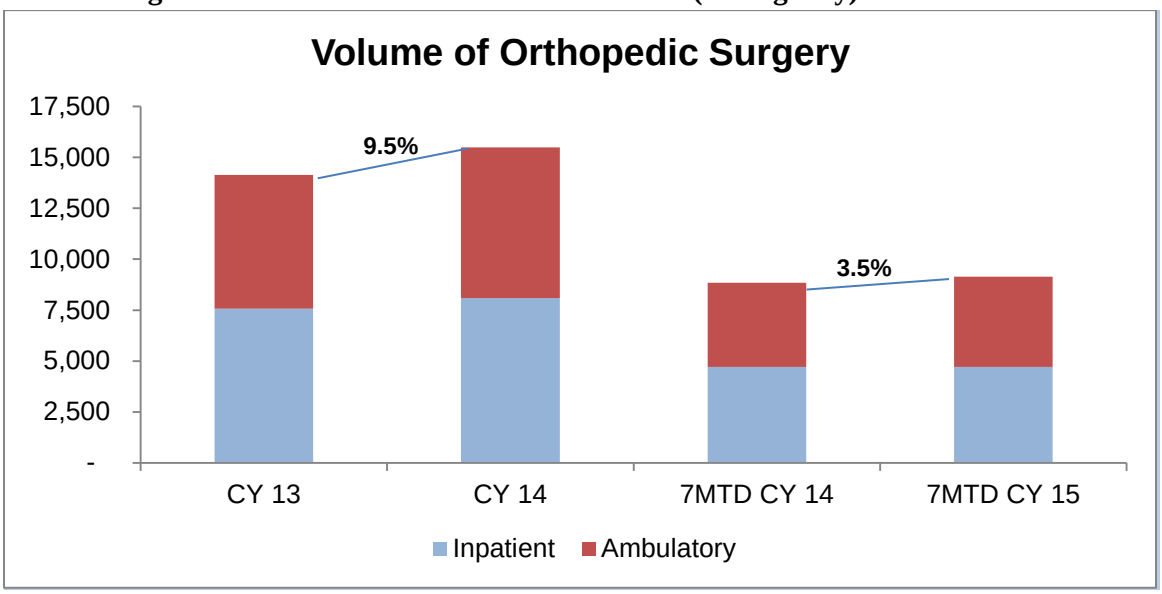
* All of our self-pay patients are provided an estimate via phone or in-person
** Sample of inquiries

See Appendix for Detail: Item 7

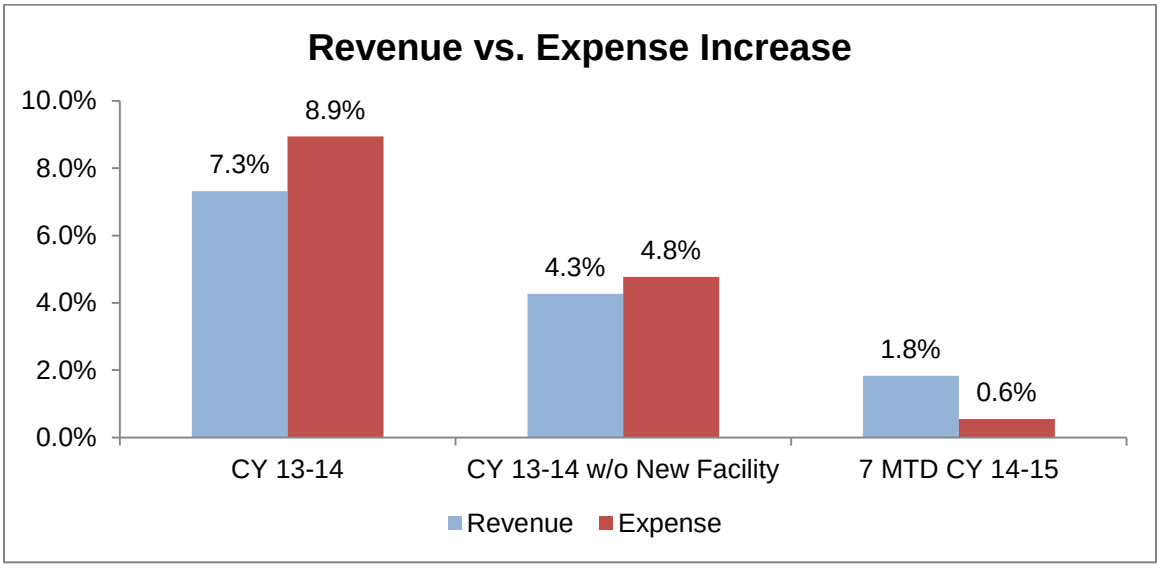
2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **AGO Hospital Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

Question 1a)

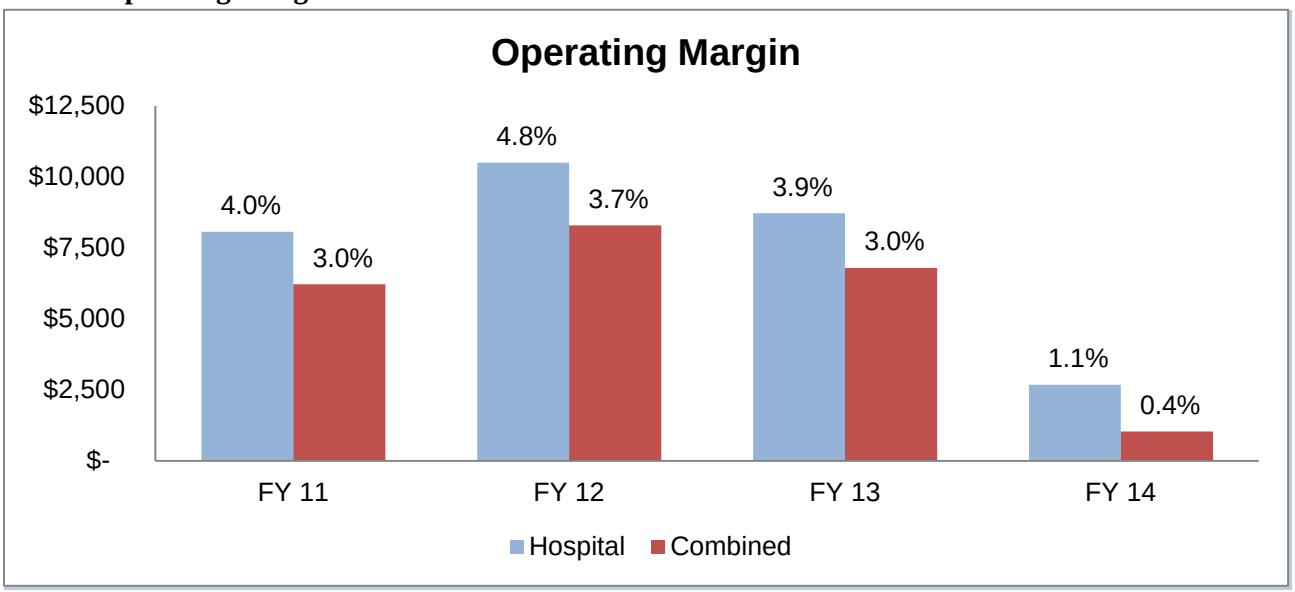
Item 1: Surgical Volume Increase: CY13 to CY15YTD (ending July)



Item 2: Revenue and Expense Increase: CY13 to CY15YTD (ending July)

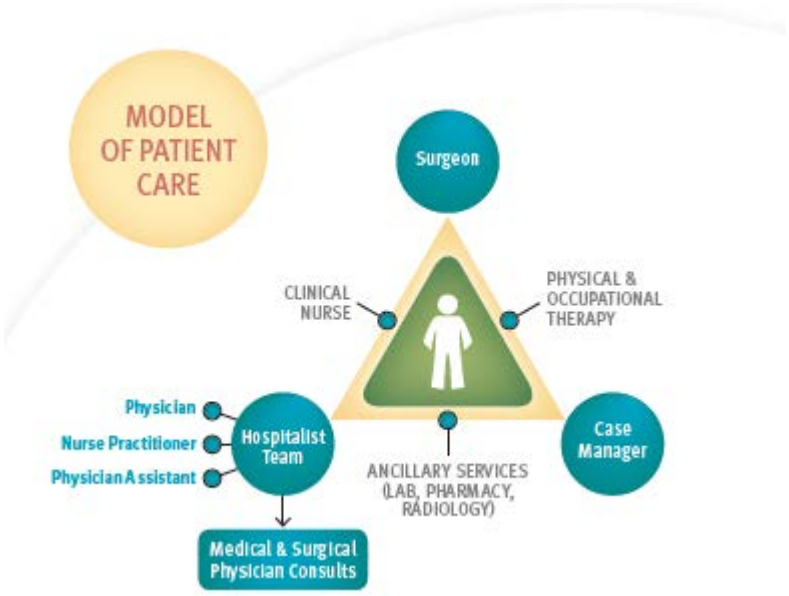


Item 3: Operating Margins: FY11 to FY14



Question 1b)

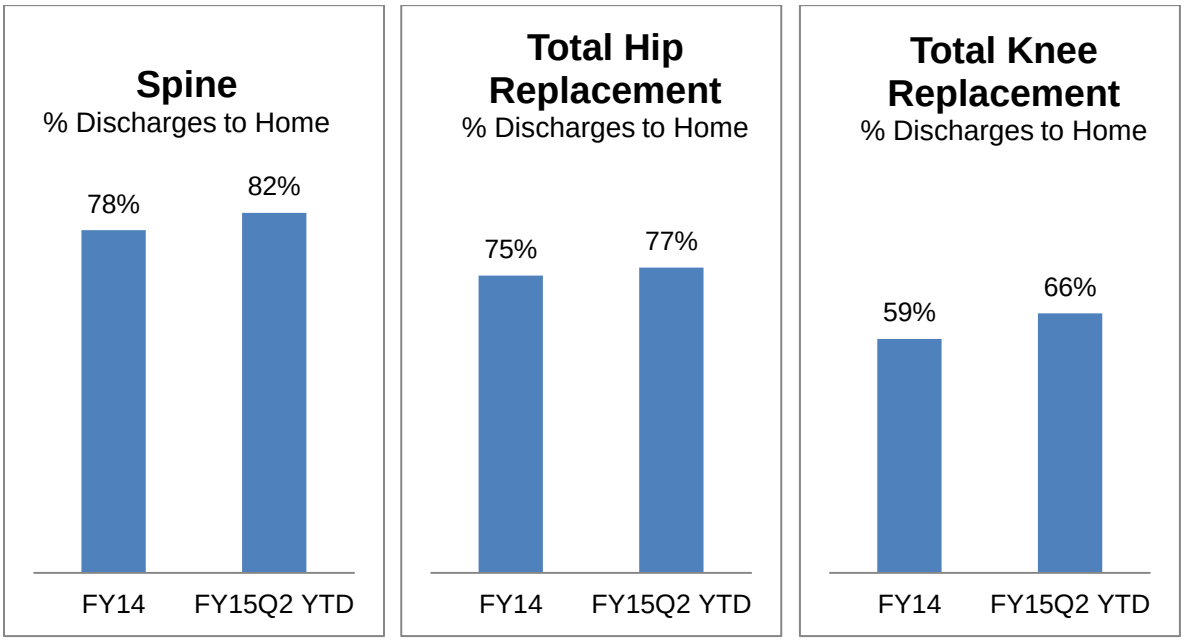
Item 4: NEBH Model of Patient Care



Question 3a)

Item 5: Discharge to Home: FY2014 to FY2015Q2 YTD

(Source: NEBH Internal Data)



Item 6: 30 Day Readmission Rate (Unplanned): FY2013 to FY2015Q3 YTD

(Source: Premier Inc)

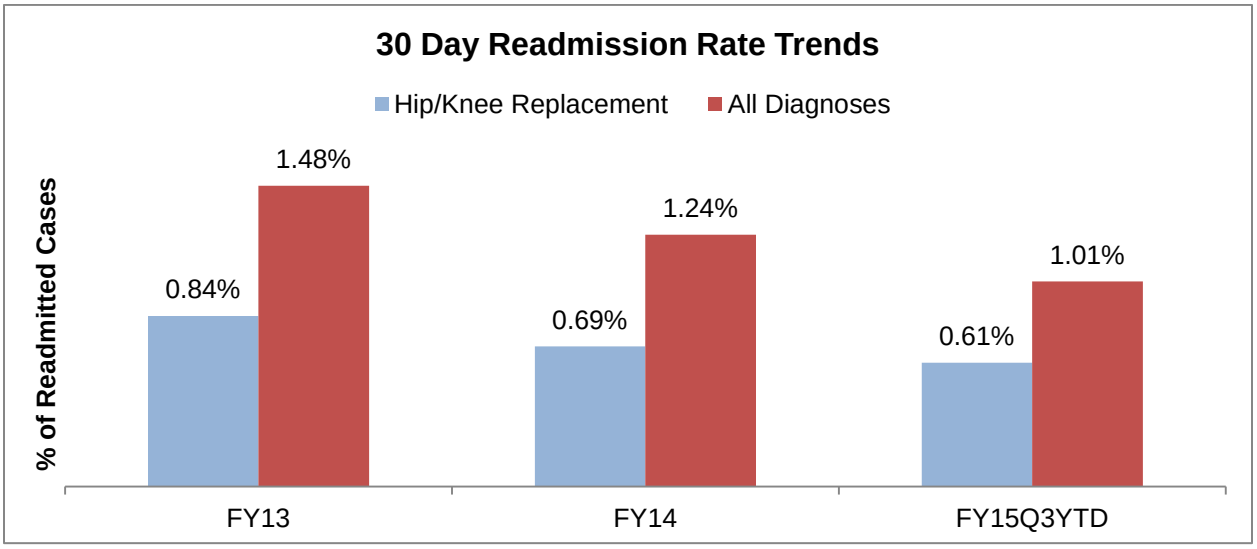


Exhibit C: AGO Questions for Written Testimony

Question 1

Item 7: Snapshot of NEBH's web page for patients requesting a cost estimate

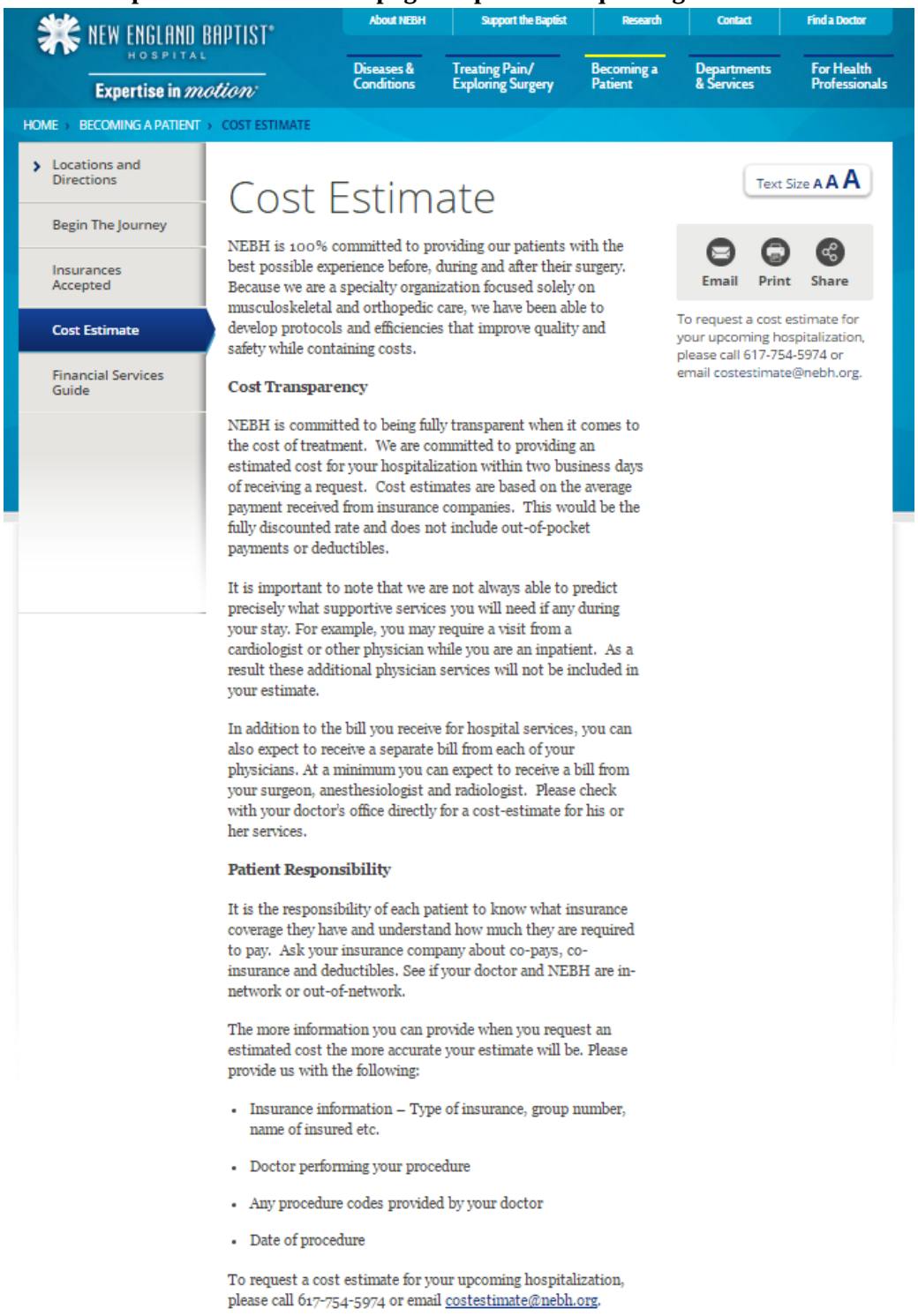


Exhibit 1 AGO Questions to Hospitals

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.

Exhibit C: Instructions and AGO Questions for Written Testimony

Question 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.

2011: New England Baptist Hospital

	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		ALL	HMO	PPO	Both
Blue Cross Blue Shield	$45.5m	$13.9m	$1.5m	$0.5m											
Tufts Health Plan	$6.8m	$3.3m	$30k	$15k											
Harvard Pilgrim Health Care	$16.2m	$4.7m	$0.3m	$0.1m											
Fallon Community Health Plan												$0.5m			
CIGNA												$1.7m			
United Healthcare												$3.6m			
Aetna												$2.3m			
Other Commercial												$25.4m			
Total Commercial	$68.5m	$21.9m	$1.8m	$0.6m	x	x	x	x	x	x		$33.5m	x	x	x
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	$0m	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x		$1.1m	x	x	x
Tufts Medicare Preferred												$4.4m			
Blue Cross Senior Options												$1.4m			
Other Comm Medicare												$2.3m			
Commercial Medicare Subtotal	x	x	x	x	x	x	x	x	x	x		$8.1m	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x		$53.0m	x	x	x
Other	x	x	x	x	x	x	x	x	x	x		x	x	x	x
GRAND TOTAL	$68.5m	$21.9m	$1.8m	$0.6m	x	x	x	x	x	x		$95.7m	x	x	x

2012: New England Baptist Hospital

	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		ALL	HMO	PPO	Both
Blue Cross Blue Shield	$49.9m	$15.3m	$1.6m	$0.5m											
Tufts Health Plan	$7.3m	$3.6m	$32K	$14k											
Harvard Pilgrim Health Care	$17.8m	$5.2m	$0.3m	$0.1m											
Fallon Community Health Plan												$1.0m			
CIGNA												$2.4m			
United Healthcare												$4.0m			
Aetna												$2.4m			
Other Commercial												$25.3m			
Total Commercial	$75.0m	$24.1m	$1.9m	$0.6m	x	x	x	x	x	x		$35.1m	x	x	x
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x		$0m	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x		$0.9m	x	x	x
Tufts Medicare Preferred												$4.8m			
Blue Cross Senior Options												$1.7m			
Other Comm Medicare												$0.9m			
Commercial Medicare Subtotal	x	x	x	x	x	x	x	x	x	x		$7.4m	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x		$60.7m	x	x	x
Other	x	x	x	x	x	x	x	x	x	x		x	x	x	x
GRAND TOTAL	$75.0m	$24.1m	$1.9m	$0.6m	x	x	x	x	x	x		$104.1m	x	x	x

2013: New England Baptist Hospital

	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		ALL	HMO	PPO	Both
Blue Cross Blue Shield	$49m	$15m	$1.6m	$0.5m											
Tufts Health Plan	$7.4m	$3.1m	$28k	$14k											
Harvard Pilgrim Health Care	$19m	$6.0m	$0.3m	$0.1m											
Fallon Community Health Plan												$1.3m			
CIGNA												$2.5m			
United Healthcare												$3.7m			
Aetna												$2.4m			
Other Commercial												$21.1m			
Total Commercial	$75.4m	$24.1m	$1.9m	$0.6m	x	x	x	x	x	x		$31.0m	x	x	x
Network Health															
Neighborhood Health Plan												$0.2m			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan												$0.2m			
Other Managed Medicaid															
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x		$0.5m	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x		$1.1m	x	x	x
Tufts Medicare Preferred												$5.1m			
Blue Cross Senior Options												$1.7m			
Other Comm Medicare												$2.2m			
Commercial Medicare Subtotal	x	x	x	x	x	x	x	x	x	x		$9.0m	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x		$64.5m	x	x	x
Other	x	x	x	x	x	x	x	x	x	x		x	x	x	x
GRAND TOTAL	$75.4m	$24.1m	$1.9m	$0.6m	x	x	x	x	x	x		$106.1m	x	x	x

2014: New England Baptist Hospital

	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	$49m	$15m	$1.6m	$0.5m											
Tufts Health Plan	$6.3m	$3.1m	$28k	$14k											
Harvard Pilgrim Health Care	$22m	$6.4m	$0.4m	$0.1m											
Fallon Community Health Plan												$1.5m			
CIGNA												$3.6m			
United Healthcare												$7.0m			
Aetna												$2.5m			
Other Commercial												$24.0m			
Total Commercial	$77.3m	$24.5m	$1.7m	$0.6m	x	x	x	x	x	x	x	$38.6m	x	x	x
Network Health															
Neighborhood Health Plan												$0.2m			
BMC HealthNet, Inc.												$13k			
Health New England															
Fallon Community Health Plan												$0.2m			
Other Managed Medicaid															
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	$0.5m	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	$1.8m	x	x	x
Tufts Medicare Preferred												$6.5m			
Blue Cross Senior Options												$1.5m			
Other Comm Medicare												$1.7m			
Commercial Medicare Subtotal	x	x	x	x	x	x	x	x	x	x	x	$9.7m	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	$66.8m	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GRAND TOTAL	$77.3m	$24.5m	$1.7m	$0.6m	x	x	x	x	x	x	x	$117.4m	x	x	x