MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Hospitals

Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 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 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, 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 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@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.

Exhibits B and C: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, 2015, and/or 2016 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. Strategies to Address Health Care Spending Growth

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. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Reduce provider price variation
   ii. **Priority 2**: Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
   iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?
   We are consistently engaging state officials with oversight and our state house delegation, highlighting the negative impact of provider price variation to their constituents and our community, and asking them to support and advance legislation to establish a rate floor. This was one of the key recommendations of the Provider Price Variation Commission that concluded their work earlier this year. An amendment to the House budget to establish a floor of 90% of the average commercial rate, called a "Minimum Wage for Hospitals" was introduced and sponsored by 45 members of the Massachusetts House of Representatives.

   Further efforts are underway to engage elected officials, their key contacts, and leadership in the legislature surrounding the need for a minimum wage for providers, so that consumers have access to high value, affordable health care in Massachusetts, and these low providers rates are not embedded in risk contracting, reducing the funding available to manage population health under risk arrangements, relative to other better paid providers. This would be tremendously unfair to the populations who live in communities where their hospital is among the lowest paid providers.

   ii. What barriers does your organization face in advancing this priority?
   We need champions for a provider minimum wage within the state and in legislative leadership who will advance the remedy recommended to the legislature in the Provider Price Variation Commission report. We need a structural fix, not rather than modest, short term funding supports which come with requisite expenditures, and do not support care delivery and maintaining access on an ongoing basis. Short term funding streams while helpful in the near term are not the remedy we need to resolve the crisis which will result if price variation is not remedied with a permanent structural fix.

   What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

Our priority is a change in statute that would set a minimum wage for hospitals so that providers are paid a minimum of .90 of the average or the health plan contract is presumptively disapproved by the Division of Insurance. Specifically this language below:

Section 229. Approval of Contracts

The subscriber contracts, rates and evidence of coverage for health benefit plans shall be subject to the disapproval of the commissioner of insurance. No such contracts shall be approved if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate, or unfairly discriminatory.

To address unwarranted commercial insurance price variation for underpaid acute hospitals and to maintain access to high value acute hospital care in the Commonwealth, for all commercial insured health benefit plan rates effective for rate years on and after October 1, 2017, the carrier's health benefit plan rates filed with the division of insurance are considered presumptively disapproved if the carrier's network provider reimbursement rates, inclusive of rates and targets within alternative payment contacts, do not reimburse acute hospitals at or greater than a minimum of 90 percent of the average rate of commercial insurance reimbursement calculated separately for acute hospital inpatient and outpatient services in accordance with requirements established by the division of insurance, based on the most recent relative price analysis by the center for health information and analysis."

AND

SECTION XX. Chapter 176A of the General Laws is hereby amended in section 6, as so appearing, by adding the following after the word "discriminatory":-

"The subscriber contracts, rates and evidence of coverage for health benefit plans shall be subject to the disapproval of the commissioner of insurance. To address unwarranted commercial insurance price variation for underpaid acute hospitals and to maintain access to high value acute hospital care in the Commonwealth, for all commercial insured health benefit plan rates effective for rate years on and after October 1, 2017, the carrier's health benefit plan rates filed with the division of insurance are considered presumptively disapproved if the carrier's network provider reimbursement rates, inclusive of rates and targets within alternative payment contacts, do not reimburse acute hospitals at or greater than a minimum of 90 percent of the average rate of commercial insurance reimbursement calculated separately for acute hospital inpatient and outpatient services in accordance with requirements established by the division of insurance, based on the most recent relative price analysis by the center for health information and analysis."

AND

SECTION XX. Chapter 176B of the General Laws is hereby amended in section 4, as so appearing, by inserting the following after the word "discriminatory":-

"The subscriber contracts, rates and evidence of coverage for health benefit plans shall be subject to the disapproval of the commissioner of insurance. To address unwarranted commercial insurance price variation for underpaid acute hospitals and to maintain access to high value acute hospital care in the Commonwealth, for all commercial insured health benefit plan rates effective for rate years on and after October 1, 2017, the carrier's health benefit plan rates filed with the division of insurance are considered presumptively disapproved if the carrier's network provider reimbursement rates, inclusive of rates and targets within alternative payment contacts, do not reimburse acute hospitals at or greater than a minimum of 90 percent of the average rate of commercial insurance reimbursement calculated separately for acute hospital inpatient and outpatient services in accordance with requirements established by the division of insurance, based on the most recent relative price analysis by the center for health information and analysis."

AND

SECTION XX. Chapter 176G of the General Laws is hereby amended in section 16, as so appearing, by inserting the following after the word "reasonable":-

"To address unwarranted commercial insurance price variation for underpaid acute hospitals and to maintain access to high value acute hospital care in the Commonwealth, for all commercial insured health benefit plan rates effective for rate years on and after October 1, 2017, the carrier's health benefit plan rates filed with the division of insurance are considered presumptively disapproved if the carrier's network provider reimbursement rates, inclusive of rates and targets within alternative payment contacts, do not reimburse acute hospitals at or greater than a minimum of 90 percent of the average rate of commercial insurance reimbursement calculated separately for acute hospital inpatient and outpatient services in accordance with requirements established by the division of insurance, based on the most recent relative price analysis by the center for health information and analysis."

c. Please complete the following questions for **Priority 2** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?
   Through risk contracting relationships and partnerships with local providers throughout the continuum of care on alternative payment methodology contracting, we have achieved some success at keeping patients who rely on affiliated primary care providers to rely on our services in our lower cost setting. We are working with local health care providers, who are members of our Physician Hospital Organization (PHO) on referral networks and measuring the cost of leakage to higher cost provider systems have been helpful to advance this.
   ii. What barriers is your organization facing in advancing this priority?
   Changing patterns of care delivery without benefit design changes, cost sharing incentives, and health plan design driven motivation is challenging. It requires resources to change referral patterns, to educate patients and encourage patients to use lower cost provider. Health plans could provide more incentive within their benefit design to support our efforts.
   iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
   The adoption of policy or regulation that encourages higher cost sharing for patients relying on higher cost providers for community-based care. Enhanced transparency surrounding pricing so that patients can make more informed choices, particularly when they have high deductibles and high cost sharing.

2. STRATEGIES TO REDIRECT CARE TO COMMUNITY SETTINGS

The HPC has identified significant opportunities for savings if more patients were treated in the community for community-appropriate conditions, rather than higher-priced academic medical centers.

a. What are the top barriers that you face in directing your patients to efficient settings for community-appropriate care rather than to more-expensive settings, such as academic medical centers? (select all that apply)
   - ☒Patient perception of quality
   - ☒Physician perception of quality
   - ☒Patient preference
   - ☒Physician preference
   - ☐Insufficient cost-sharing incentives
   - ☒Limitations of EMR system
   - ☒Geographic proximity of more-expensive setting
   - ☐Capacity constraints of efficient setting(s)
   - ☒Referral policies or other policies to limit "leakage" of risk patients
   - ☐Other (please specify): Click here to enter text.

b. How has your organization addressed these barriers during the last year?
Physician Leadership has met with Physician Providers in the community to discuss leakage and services within the area to prevent patients from being sent into Boston. Development of referral system within the hospital to help refer patients to services within the network. Development of a PHO. Development of Patient Experience team. Care Management making referrals within network. Developing workflows with community partners to encourage seamless transitions for our patients and physicians throughout the continuum.

3. INFORMATION ON PHYSICIAN COMPENSATION MODELS

Please answer the following questions regarding the current compensation models for your *employed* physicians. Indicate N/A if your organization does not employ physicians. ☐N/A

a. For **primary care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	3.33%
Salary	90%
Panel size	0
Performance metrics (e.g., quality, efficiency)	3.33%
Administrative/citizenship	3.33%
Other	0

b. For **specialty care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	0
Salary	90%
Panel size	0
Performance metrics (e.g., quality, efficiency)	5%
Administrative/citizenship	5%
Other	0

c. Describe any plans to change your organization's compensation models for primary care and/or specialty care physicians that you employ.

In FY 2018, we hope to redesign compensation for our primary care physicians so that some compensation, likely bonus, is based on factors such as quality, panel size, and citizenship.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030. **If a question is not applicable to your organization, please indicate so in your response.**

1. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a. Please use the following table to provide available information on the number of individuals that seek this information. Required Question.

Health Care Service Price Inquiries CY2015-2017			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**		42
	Q2		39
	Q3		69
	Q4		62
CY2016	**Q1**		36
	Q2		29
	Q3		31
	Q4		27
CY2017	**Q1**		45
	Q2		32
	TOTAL:		412

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.

   We are currently assessing software to check estimates to actual, although, patients do call us if the bill is higher than the estimate provided. However, this is most always additional services that were performed but not inquired about when asking for the initial estimate. We respond to a request within 2 business days

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

   Patients do not always have the correct information in order to provide a complete estimate. They often call requesting information for 1 test or procedure when they in fact are having more than one. We address this barrier by informing each patient that this is an estimate and we are basing it on the information provided.

2. For each year 2014 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain whether and how your revenue and margins may be

different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

	FY 2014 Estimated Margin	FY 2015 Estimated Margin	FY 2016 Estimated Margin
Government	$ (10,473,427)	$ (16,744,220)	$ (16,779,377)
Other	(1,096,793)	(4,244,293)	(4,609,852)
Commercial	5,703,171	3,001,039	5,600,687
	$ (5,867,049)	$ (17,987,474)	$ (15,788,542)

Medicare Advantage	Medicare FFS	Medicaid MCO	Medicaid FFS	Workers Compensation	Self	Other Government	Managed Care	Non - Managed Care	Other	Commonwealth Care	Health safety Net
Evercare	Medicare Parts A&B	Network Health (Tufts) MCO	MassHealth	Various carriers	Self pay	OOS Medicaid	HMO Blue	Commercial Insurers		BMC CommCare	HSN
BX Medicare Advantage		Neighborhood Health MassHealth			Incarcerated persons	CHAMPUS	Other HMO/PPO	Blue Cross Indemnity		Network CommCare	
All Other Medicare Advantage		BMC HealthNet MassHealth-CURRENT YEAR			Auto and other liability	Public Health	CIGNA	Veterans Administration		NHP CommCare	
		All other MCO					United Healthcare			Other CommCare	
							Coventry/HCVM				
							Tufts				
							Harvard Pilgrim				
							PPO Blue Cross				
							Out of State BC				
							U.S. Healthcare				
							Fallon Commercial				
							Celticare of Mass				

As a hospital with a high proportion of revenues sourced from public (government) payors LGH is dependent upon positive margins from non - public payors to mitigate losses on its public payor book of business. However, based upon the Center for Health Information and Analysis annual reporting of providers' relative prices, LGH is consistently in the lowest quartile, as is the case in CHIA's most recent 2017 Report (based on 2015 data). As such, it's ability to cover public payor shortfalls - even partially - is vitiated.

	Aetna	BCBS	BMC	CeltiCare	Cigna East	Cigna West	Fallon	HNE	HPHC	Minutema n	Network Health	NHP	Tufts	UniCare	United	Arithmetic Average
Baystate Wing Hospital		0.89			0.53		0.59	0.72	0.80		0.74	0.43	0.64	0.67		0.67
Baystate Noble Hospital		0.73			0.34		0.66	0.65	0.87		0.85		0.63	0.82		0.69
Beth Israel Deaconess Hospital - Milton	0.84	0.77	0.77		0.47		0.42		0.81		1.03	0.59	0.61	0.72		0.70
Anna Jaques Hospital	0.68	0.77	0.91		0.43		0.51		0.80		0.64	0.94	0.69	0.81		0.72
Mercy Medical Center	0.72	0.77	0.86				0.61	0.88	0.82		0.51	0.62	0.63	0.90	0.59	0.72
Heywood Hospital	0.78	0.75	0.88		0.35		0.65	0.79	0.73	0.89	0.82	0.93	0.72	0.78		0.76
Holyoke Medical Center		0.75	0.79		0.42	0.73	0.86	0.75	0.67		0.94		0.72	0.81	0.91	0.76
Lawrence General Hospital	0.91	0.75	0.93		0.51		0.83		0.78		0.90	0.52	0.73	0.82	0.76	0.77
Milford Regional Medical Center	0.81	0.88			0.50		0.76		0.84		0.85	1.06	0.78	0.75	0.76	0.80
Beth Israel Deaconess Hospital - Plymouth	0.89	0.89		1.06	0.56	0.74	0.49		0.89		0.78	0.85	0.84	0.93		0.81
Signature Healthcare Brockton Hospital	0.68	0.77	0.92		0.50		0.92		0.85	0.88	0.92	0.83	0.76	0.91		0.81
Holy Family Hospital	1.03	0.86	0.91		0.49	0.45	0.76		0.89	0.84	1.04	0.80	0.89	0.89		0.82
Steward Morton Hospital	0.79	0.86	0.93		0.38	0.71	0.91		0.94		0.86	0.86	0.87	0.94		0.82
Harrington Memorial Hospital	1.04	0.91	1.07	0.71	0.39		0.90		0.77			0.99	0.79	0.80		0.84
Lahey Health - Winchester Hospital	0.90	0.92			0.51		0.83		0.93	1.07	0.85	0.78	0.94	0.83	0.87	0.86
Lowell General Hospital	0.79	0.83		0.95			0.88		0.89		1.04	0.91	0.83	0.85	0.77	0.87
Northeast Hospital	0.96	0.91	0.96	1.17	0.52	0.95	0.76		0.87		0.76	0.79	0.87	0.88		0.87
HealthAlliance Hospital		0.76	0.90		0.70	1.08	0.99		0.75		1.09	1.02	0.72	0.86		0.89
Sturdy Memorial Hospital	0.75	1.05	0.89		0.62	0.71	1.02		1.02		0.88	0.91	1.21	0.74	0.87	0.89
Baystate Mary Lane Hospital		0.92					0.92	0.98	0.91					0.82	0.84	0.90
Hallmark Health	1.12	0.90	1.02		0.66	1.33	0.72		0.98		0.72	0.65	1.00	0.81		0.90
Southcoast Hospitals Group	0.89	0.90	0.89		0.56		0.98		0.90	0.96	0.97	0.96	1.03	0.88		0.90
Steward Nashoba Valley Medical Center	0.91	0.89			0.48		0.70		0.86	0.75	1.23	1.78	0.86	0.78	0.71	0.90
Steward Norwood Hospital, Inc.	0.93	0.91	0.95	0.85	0.57	1.31	0.93		0.91	0.79	0.94	0.95	0.93	0.82		0.91
Clinton Hospital	1.07	0.92					1.07		0.97				0.70	0.79		0.92
Steward Good Samaritan Medical Center	1.04	0.91	1.03		0.55	1.32	0.94		0.94	0.94	0.86	0.69	0.92	0.90		0.92
MetroWest Medical Center	1.07	0.86	0.71		0.73	1.45	1.05		0.87	0.96	0.95	0.96	0.88	0.92	0.93	0.95
South Shore Hospital	1.00	1.03	0.82		0.61	0.47	1.21		1.42		0.64	1.28	0.95	0.89	1.19	0.96
Emerson Hospital	0.90	0.89			0.75	2.67	0.61		0.81		0.69	0.90	0.88	0.82	0.72	0.97
Steward Saint Anne's Hospital, Inc.	0.86	0.87	0.95		0.69	1.21	0.67		1.26	1.41	1.18	0.86	0.91	0.90		0.98
Newton-Wellesley Hospital	0.83	1.05			0.97	1.00	0.94		1.08			0.69	1.02	1.36	1.10	1.00
Beth Israel Deaconess Hospital - Needham	1.04	0.83	0.95		2.31				0.83		1.03	0.78	0.88	0.73	0.92	1.03
North Shore Medical Center	0.93	1.05	1.26		0.60		0.97		1.09			0.90	1.02	1.33	1.11	1.03
Baystate Franklin Medical Center		1.01		0.94	0.59	1.92	1.05	0.97	1.05		0.99		0.97	1.01		1.05
Brigham and Women's Faulkner Hospital	1.08	1.05			1.07	0.93	1.13		1.09			0.88	1.05	1.26		1.06
Cooley Dickinson Hospital	0.98	0.88	0.85		0.94		1.35	1.09	1.40		0.95		1.15	0.96		1.06
Marlborough Hospital	1.29	0.81	1.04		0.64		0.71		0.77		1.18	1.08	0.73	0.99	3.24	1.13
Berkshire Medical Center Inc	1.33	1.10		1.02	1.06		1.47	1.09	1.33		1.18	1.56	1.29	0.90		1.21

Note: **Reflects only community hospitals and community DSH hospitals. F that population, critical access hospitals ("CAHs"; Fairview, Martha's Vineyard, Athol) are excluded as are hospitals in unique geographies (Nantucket, Cape Cod, Falmouth).**

The above reflects LGH's position across the entire population of private payors included in CHIA's 2017 report. When only "major" private payors are considered (i.e., health plans with more than 75,000 members, according to the Commonwelath's Division of Insurance reporting for 2015) the Hospital's average relative payment declines further.

	BCBS	Fallon	HNE	HPHC	NHP	Tufts	Arithmetic Average
Beth Israel Deaconess Hospital - Milton	0.77	0.42		0.81	0.59	0.61	0.64
Baystate Wing Hospital	0.89	0.59	0.72	0.80	0.43	0.64	0.68
Baystate Noble Hospital	0.73	0.66	0.65	0.87		0.63	0.71
Mercy Medical Center	0.77	0.61	0.88	0.82	0.62	0.63	0.72
Lawrence General Hospital	0.75	0.83		0.78	0.52	0.73	0.72
Anna Jaques Hospital	0.77	0.51		0.80	0.94	0.69	0.74
Holyoke Medical Center	0.75	0.86	0.75	0.67		0.72	0.75
Heywood Hospital	0.75	0.65	0.79	0.73	0.93	0.72	0.76
Beth Israel Deaconess Hospital - Plymouth	0.89	0.49		0.89	0.85	0.84	0.79
Emerson Hospital	0.89	0.61		0.81	0.90	0.88	0.82
Marlborough Hospital	0.81	0.71		0.77	1.08	0.73	0.82
Signature Healthcare Brockton Hospital	0.77	0.92		0.85	0.83	0.76	0.83
Beth Israel Deaconess Hospital - Needham	0.83			0.83	0.78	0.88	0.83
Holy Family Hospital	0.86	0.76		0.89	0.80	0.89	0.84
Northeast Hospital	0.91	0.76		0.87	0.79	0.87	0.84
HealthAlliance Hospital	0.76	0.99		0.75	1.02	0.72	0.85
Hallmark Health	0.90	0.72		0.98	0.65	1.00	0.85
Milford Regional Medical Center	0.88	0.76		0.84	1.06	0.78	0.86
Harrington Memorial Hospital	0.91	0.90		0.77	0.99	0.79	0.87
Lowell General Hospital	0.83	0.88		0.89	0.91	0.83	0.87
Lahey Health - Winchester Hospital	0.92	0.83		0.93	0.78	0.94	0.88
Steward Good Samaritan Medical Center	0.91	0.94		0.94	0.69	0.92	0.88
Steward Morton Hospital	0.86	0.91		0.94	0.86	0.87	0.89
Steward Saint Anne's Hospital, Inc.	0.87	0.67		1.26	0.86	0.91	0.91
Clinton Hospital	0.92	1.07		0.97		0.70	0.92
MetroWest Medical Center	0.86	1.05		0.87	0.96	0.88	0.92
Baystate Mary Lane Hospital	0.92	0.92	0.98	0.91			0.93
Steward Norwood Hospital, Inc.	0.91	0.93		0.91	0.95	0.93	0.93
Southcoast Hospitals Group	0.90	0.98		0.90	0.96	1.03	0.95
Newton-Wellesley Hospital	1.05	0.94		1.08	0.69	1.02	0.96
North Shore Medical Center	1.05	0.97		1.09	0.90	1.02	1.01
Baystate Franklin Medical Center	1.01	1.05	0.97	1.05		0.97	1.01
Steward Nashoba Valley Medical Center	0.89	0.70		0.86	1.78	0.86	1.02
Sturdy Memorial Hospital	1.05	1.02		1.02	0.91	1.21	1.04
Brigham and Women's Faulkner Hospital	1.05	1.13		1.09	0.88	1.05	1.04
Cooley Dickinson Hospital	0.88	1.35	1.09	1.40		1.15	1.17
South Shore Hospital	1.03	1.21		1.42	1.28	0.95	1.18
Berkshire Medical Center Inc	1.10	1.47	1.09	1.33	1.56	1.29	1.31