Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 Tuesday, October 7. 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 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, 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.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk 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 Kelly.A.Mercer@state.ma.us a minimum of two 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. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses 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 begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

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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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:

   Please refer to Exhibit 1 for all responses

   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

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

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
   SUMMARY:

   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

   b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
   SUMMARY:
   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

   b. How do the health status risk adjustment measures used by different payers compare?

   c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

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4. Another theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
   SUMMARY:

   ANSWER:

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY:
   a. Which attribution methodologies most accurately account for patients you care for?

   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY:

   ANSWER:

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
   SUMMARY:
   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially by hospital.
   SUMMARY:
   a. Please describe ways that your organization is collaborating with primary care providers and hospitals to (i) optimize appropriate use of post-acute care after hospital discharge and (ii) identify the appropriate setting of care.

   b. Please describe your organization's efforts to manage the appropriate intensity and duration of post-acute care for your patients.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
   SUMMARY:

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER:

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
    SUMMARY:

    ANSWER:

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 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.
    SUMMARY:
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

    c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

    d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY:
    a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

    c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY:

    ANSWER:

Exhibit 1

Health Policy Commission Questions

1. **Chapter 224 of the Acts of 2012(c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 is 3.6%.**

SUMMARY:

Radius Specialty is licensed for 207-beds and currently operates two Long Term Acute Care Hospitals (LTACHs) located in Boston and Quincy. The Hospital cares for chronically, critically ill patients including those with complex respiratory conditions, ventilator dependency, post-surgical complications, traumatic injuries, complex wound care, cardiac myopathy, comorbid behavioral and medical illnesses, and more. Typically patients seek care in a LTACH, often referred to as a post-acute car e hospital, when they have recently undergone treatment in an acute care hospital and need short-term intensive rehabilitation services; require assistance in recovering from a major medical problem or chronic condition; and/or need intensive and daily therapeutic or skilled nursing care not otherwise available in a post-acute setting. However, given the specialized services that post-acute hospitals provide, many patients also come from their local communities – including direct admissions from nursing homes, assisted living facilities, or their own residences.

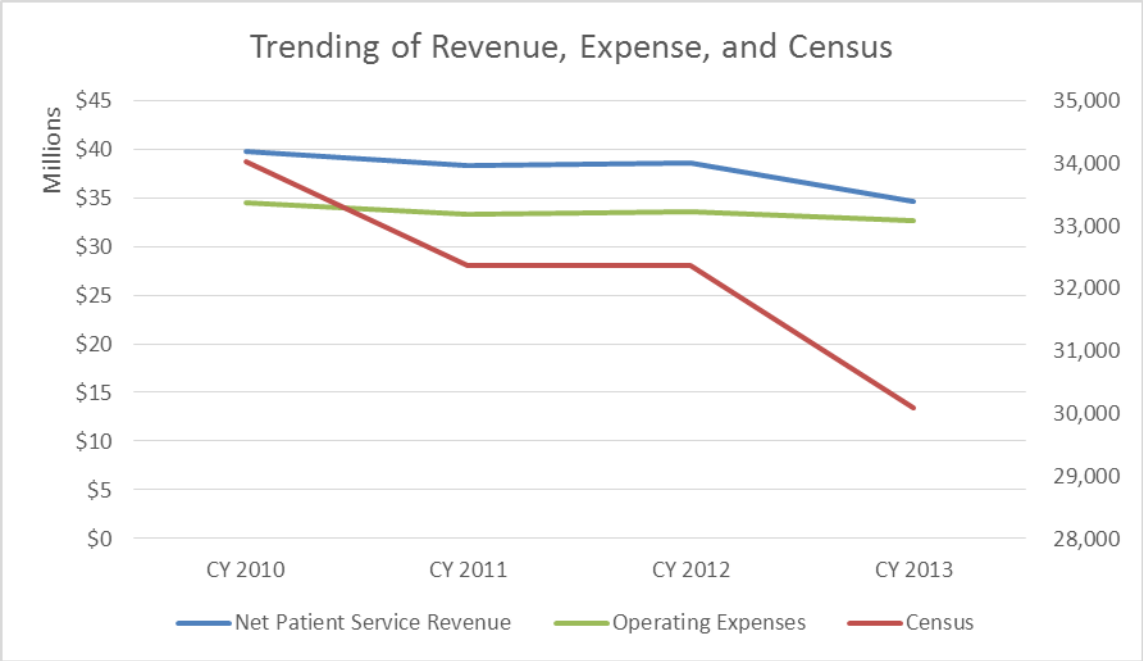
Post-acute hospitals provide essential services that are separate and apart from acute care hospitals. They provide aggressive specialized interdisciplinary care to medically complex patients who require an extended recovery time. These patients are critically and chronically ill and have few options left; they come to the hospital because they require the kind of care and prolonged recovery time that conventional short-term acute care hospitals may not be equipped to provide.

Because post-acute care hospitals are staffed and equipped to rapidly respond to changes in medical conditions about which they are most accustomed, they reduce the costs and traumas associated with the short-term hospital readmissions. After acute-care hospital inpatient care, or through the referral of a primary care physician, post-acute patients are able to seamlessly transition to essential inpatient or outpatient post-acute rehabilitation services.

a. **What trends has your organization experienced in revenue, utilization, and operating expenses from CY2010-CY2014? Please comment on the factors driving these trends.**

Please see trending graph below.

RSH has experienced gradual decline in inpatient census over CY2012 and CY2014 across all patient types. Beginning in August 2014 RSH has experienced a dramatic decline in inpatient volume as a result of Accountable Care Organizations influencing the flow of referrals from acute care hospitals. Patients that were historically referred to LTACHs are now being directed into skilled nursing facilities.



b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

RSH has undertaken numerous efforts, particularly over the past five years, to provide quality care in the most efficient and economical fashion which will advance the goal of helping the Commonwealth meet this benchmark. The following is a representative, but not exhaustive, list of efforts taken by RSH since January 1, 2013 to reduce costs while improving quality:

A re-design of the Hospital's Quality Council and its Patient Care Assessment Program, including a new organization-wide system for data collection, storage, and reporting of quality measures.

Use of new advanced data systems in the Fiscal Department to provide more meaningful, real-time management reports and sensitivities for select financial benchmarks such as overtime utilization, labor utilization, etc.

Renegotiated numerous vendor contracts to enhance service while reducing cost.

Consolidated responsibilities among the moonlighter program and nursing leadership team which resulted in the reduction of 3.5 FTE's.

Development of Electronic Health Record (EHR) as described in 1(c), below.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

RSH has embarked on a long-term IT strategic plan in 2012 to further advance the currently installed Electronic Health Record (EHR). The Hospital had an EHR system that was implemented for administrative and some clinical systems and is now focused on continued implementation of modules such as the nursing module and the eMAR to create a more complete EHR. As part of this plan, the Hospital upgraded the internal IT infrastructure to prepare for the new modules. The Hospital then implemented a number of clinical modules including clinical documentation, bedside medication verification, and an electronic medication administration record (eMAR). In implementing these modules the nursing, rehab, nutrition, case management, and other clinical staff are now able to document care delivery directly in the system as opposed to document in a paper medical record. These upgrades to the EHR have provided RHS' clinicians access to more real-time data on which to base clinical decisions, along with providing additional reporting opportunities to further enhance patient care. In addition, the implementation of bedside medication verification with eMAR has increased the controls over medication administration, which continues to improve the quality and safety of the care delivered at the Hospital. RSH is progressing towards the next major advancement, which is implementation of Computerized Physician Order Entry (CPOE).

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

If EHR incentives, including grants and other funding, would be available to LTACHs, RSH would be able to expand its existing EHR system and long-term IT strategic plan described above to continue to operate more efficiently without reducing quality. Currently, LTACHs are excluded from government-funded incentive programs for the development of meaningful use electronic health records.

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery

a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality improvement, care delivery practices, referral patterns, and operations.

RSH is contracted with BMC HealthNet to participate in the CMS-initiated Capitated Financial Alignment Demonstration (CFAD) model for persons dually eligible for Medicare and Medicaid. Since RSH's enrollment as a CFAD provider no discernible changes to referral patterns have been noted. RSH does not participate in any other APMs.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

RSH has not experienced significant expenses or burdens related to APMs. As such, no formal analysis has been conducted

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

RSH has not conducted a formal analysis.

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contract with payers.

RSH is not engaged in any risk contracts, nor does it have provisions for health status risk adjustment measures in any of its contracts. RSH receives its funding primarily through the Medicare and Medicaid programs.

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

Please see response above.

b. How do health risk adjustment measure used by different payers compare?

Please see response above.

c. How does the interaction between risk adjustment measure and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

Please see response above.

4. Another theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

Real time data is essential to providing optimal patient care, particularly during transitions in care between providers and/or care settings. The exclusion of federal funding for LTACH's to advance and develop EHRs has been a hindrance to the efficient development of such systems at the expense of other initiatives or needed upgrades such as routine capital repairs and purchases. Inclusion of LTACHs in the government-funded incentive plans could accelerate system

development, such as CPOE and provide greater opportunities for LTACHs to integrate electronically with other providers.

5. **C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.**

   a. **Which attribution methodologies most accurately account for patients you care for?**

This question has limited applicability in the context of the LTACH environment. The patients RSH admits are all covered by a primary care provider. RSH utilizes a hospitals service to service the majority of its patients. Upon admission, a fax notification is sent to the community-based primary care physician, notifying him/her that their patient is at RSH and encouraging involvement in the clinical management and discharge planning of the patient.

   b. **What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?**

Please see above response to 5a.

6. **Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.**

RSH welcomed the introduction of CMS-required LTACH quality reporting in 2012. The absence of nationally standardized clinical measures had long since been a concern among the LTACH providers. The quality reporting requirements necessitated the addition of one (1.0) FTE in order to ensure timely, accurate data submission.

RSH has not encountered quality measure reporting requirements among non-government payers.

7. **An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.**
   a. **Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or higher cost care settings.**

RSH does not have a formal analysis relative to inpatient utilization trends with AMCs or other higher cost providers. As an inpatient LTACH caring for chronically, critically ill patients RSH may need to transfer patients acutely to a traditional short term acute care hospital, which could include an academic medical center. If a transfer is required, the patient is generally transferred back to his or her referring hospital (i.e. the hospital that originally transferred the patient to RSH). In the case of an emergency, the patient is transferred to the nearest emergency department.

RSH is committed to facilitating placement in the most appropriate, lowest cost setting without compromising clinical outcomes. Patient who stabilize and can benefit from inpatient placement

or care in lower-cost community settings are transitioned as appropriate. RSH employs a team of clinical case managers who are expert in placing patients in the most appropriate post-acute setting at the most clinically opportune time. The clinical case management team is well-networked with community-based providers, including home care, skilled nursing, and home infusion therapy providers. Patients are transitioned into the most appropriate post-acute arrangement as quickly as possible, based on the individual patient's needs.

b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community setting, to the extent clinically feasible, and the results of those efforts.

Not applicable – as stated above, no formal analysis has been completed.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation an that the use of post-acute care varies substantially by hospital.

a. Please describe ways that your organization is collaborating with primary care providers and hospitals to (i) optimize appropriate use of post-acute care after hospital discharge and (ii) identify the appropriate care setting.

As a LTACH, RHS plays an important role in caring for chronically, critically ill patients in a post-acute setting. We collaborate closely with acute care hospitals in an effort to optimize appropriate use of the LTACH. Through direct outreach to referring hospitals senior leaders at RSH have conducted education forums on the essential role LTACHs play in managing complex patients, reducing acute care hospitals length of stay, and reducing unnecessary re-hospitalizations. As described above, RSH regularly discharges patients who have stabilized to skilled nursing facilities or to home with home care services. RSH is well networked with dozens of post-acute providers and its team of clinical case managers is very skilled at facilitating a safe discharge to a lower-cost setting at the optimal time.

b. Please describe your organization's efforts to manage the appropriate intensity and duration of post-acute care for your patients.

As a LTACH the management of intensity and length of stay is a top priority. RSH has a very active Utilization Review Committee and holds itself accountable to admission, continued stay, and discharge criteria. The need for continued stay is addressed formally for all patients on a weekly basis via an interdisciplinary team meeting. RSH utilizes government-approved medical necessity criteria as a guide in assessing intensity and duration.

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information,

any analyses you have conducted to assess the accuracy of this increased price transparency for patients.

As a LTACH all admissions to RSH are pre-planned regardless of point of origin. As part of the preadmission process the hospital's admitting staff assesses each patient's insurance coverage and proactively discusses with the patient or his/her responsible party, any possible charges that may be incurred during the stay. That dialogue is typically in the context of Medicare deductibles and/or copays. Though no formal analysis has been conducted, RSH knows that the accuracy of the estimates provided is extremely high. With all admissions being pre-planned, RSH knows before admission what the precise number of remaining benefit days are, and what the corresponding patient liability may be.

10. **Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization has taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.**

Tiered and limited network products have had little, if any, effect on our organization. Statistically, managed care payers account for less than 5% of RSH's inpatient volume, and none of our managed care contracts have tiered provisions. This question has limited applicability in the context of a LTACH provider.

11. **The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 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 is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.**

RSH has an inpatient program dedicated to the treatment of patients with comorbid behavioral health and chronic medical conditions. RSH works collaboratively with area hospitals and crisis teams and serves as an important placement option for this challenging, high-risk population. RSH provides intensive medical and psychiatric intervention with the goal of returning the patient to a safe, lesser cost setting, as quickly as possible. Most patients transition from this program to skilled nursing facilities for continued care and treatment of their comorbid conditions.

b. **Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.**

Through the provision of the program described in our answer to 11a RSH directly contributes to the avoidance of unnecessary utilization in emergency departments and inpatient psychiatric

hospitals. In a post-acute environment RSH provides the intensity of service to accommodate a wide range of patients with comorbid behavioral health and chronic health conditions.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

One challenge RSH has faced is obtaining adequate funding for the program. Although payors have payment policies for the provision of care to medically complex patients,and payment policies for the provision of care to behavioral health patients, there often is not an adequate payment structure for the care of patients with comorbid behavioral health and chronic medical conditions. Often, patients are denied access to our program because they don't neatly fit into existing contractual parameters. This lends to higher utilization of emergency room departments and psychiatric inpatient care.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

RSH is both willing and able to report discharge data to the extent such data can be obtained from our electronic health record.

12. Describe your organiztion's efforts and experience with implementation of patient-centered medical home (PCMH) model.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

This question is not applicable to a LTACH.

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Please see response above.

c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcoems, quality, and costs of care.

Please see response above.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

No additional comments provided at this time.