Lowell General Hospital

September 19, 2016

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz:

This letter and attached Exhibits B and C include Lowell General Hospital's response to the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, request for written testimony on health care cost trends. I certify that I am legally authorized and empowered to represent Lowell General Hospital for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please feel free to contact me directly at 978-937-6200 or Susan Green, Executive Vice President and Chief Financial Officer at 978-788-7143.

Sincerely,

Normand E. Deschene

Normand E. Deschene
Chief Executive Officer, Lowell General Hospital

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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, 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.

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 (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 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 2, 2016**, 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, and/or 2015 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 Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury 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 Cost 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. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
   a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Lowell General Hospital plays a very important role in delivering low cost, high quality care to the residents of the fourth largest community in the Commonwealth. According to CHIA's report on Massachusetts Hospital Profiles (November 2015), Lowell General Hospital's FY14 Adjusted Cost per CMAD was $8,833, which placed us in the lowest quartile for the cohort of the state's community hospitals. We are proud of our position as a low cost provider, which is the result of our diligent focus on the fiduciary management of hospital resources by controlling operating costs, improving efficiencies and reducing waste.

Lowell General Hospital is fully committed to retaining and furthering our position as a low-cost provider. Lowell General Hospital fully supports the current direction of payment reform through value based payment models which reward providers for cost efficiency and quality outcomes and we believe will be helpful in ensuring high quality health outcomes and in driving down costs. However, we recognize that historically, low cost providers were effectively penalized when it came to negotiating prices with commercial payers, while high cost providers were able to negotiate prices to cover their higher cost structure. These relative prices were baked into historical commercial payer contracts and continue to be a predominant reason for the large disparity in provider pricing and crating inequities in budgets for many alternative payment methodologies.

Population health initiatives and Value based care models require significant investment to ensure the capabilities exist for successful outcomes. If inequities in the ability to finance the necessary infrastructure and resources required of new payment and care delivery models aren't addressed, the low cost providers will continue to be disadvantaged and the state will be unable to make any headway in reducing healthcare costs.

   b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

We applaud the Commonwealth for setting health care cost growth benchmarks through Chapter224 and holding payers and providers collectively accountable to achieve these annual goals. We continue to believe that uniform application of the benchmark is not helping to achieve the goal. The 3.6% benchmark should be more equitably administered by holding the higher-priced hospitals below the benchmark for commercial payer pricing while recognizing that lower-priced hospitals deserve price increases that may be above the 3.6% threshold in order to reduce the long-standing disparity in relative prices. We also believe more should be done to encourage patients to seek care at lower-cost setting. As we have stated in the past, patient migration to high-cost Boston hospitals has a significant financial impact to the Commonwealth. Outmigration of commercial patients is financially detrimental to the Commonwealth given the substantial price disparity between LGH and the top Boston hospitals treating patients from our service area. This price differential for the most part affects and threatens hospitals that treat more Mass Health patients within the state.

2. **Strategies to Address Pharmaceutical Spending.**
   In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.
   a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.
      i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)
      Currently Implementing
      ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends
      Currently Implementing
      iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs
      Currently Implementing
      iv. Establishing internal formularies for prescribing of high-cost drugs
      Currently Implementing
      v. Implementing programs or strategies to improve medication adherence/compliance
      Currently Implementing
      vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending
      Currently Implementing
      vii. Other: Insert Text Here
      viii. Other: Insert Text Here
      ix. Other: Insert Text Here

3. **Strategies to Integrate Behavioral Health Care.**
   Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health

care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

LGH continues to support and build upon the collaborative CHART grant work to improve access to services for patients with complex behavioral health needs through the medical home. Very specifically we have employed 4 social workers and 5 community health workers with this core intention; the Integrated Behavioral Health Social Worker / Community Health Workers is an integral member of the Circle Health team working with patients who have behavioral health diagnoses or substance abuse disorders and are at high risk for increased health care resource utilization. The social workers work closely with community services, as well as the other members of the physician practices under the direction of the patient's Primary Care Physician, working on specific care plans for the patient and monitoring and assisting in their adherence to it.

With a deep understanding that integrating behavioral health into our care and helping to meet the behavioral health needs of our patients in the community setting, we continue to support the behavioral health work of Circle Home, Inc. also a member of Circle Health. A few years ago Circle Home created the Greater Lowell Behavioral Health Home Care Program – including program policies, community outreach, intensive staff education, patient materials and continuing consultation from C&V Senior Care Specialists, Inc., national consultants in behavioral health home care.

Patients with persistent sadness, bipolar disorder, anxiety and schizophrenia are being offered care in their own homes by Circle Home clinicians, in close coordination with the patient's psychiatrist and primary care physician. Through the Circle Home program patients with both mental and physical illnesses, who have difficulty leaving their home, are receiving specialized care for all of their health challenges.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

The top barriers to enhancing behavioral health are adequate payment for behavioral health services, information sharing and access to longer-term outpatient services.

4. **Strategies to Recognize and Address Social Determinants of Health.**

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

Across all measures, the community served by Lowell General Hospital and Circle Health is incredibly diverse, it is home to the second largest Southeast Asian population in the United States, and displays significant diversity across other ethnicities, age, education and

socio-economic background. Circle Health, and its member providers, have taken an approach to understanding and engaging in the social determinants of health both inside the walls and outside the walls of its hospitals. Circle Health has for many years been a strong participant in the Greater Lowell Health Alliance, joining other community health providers to understand the medical, social and cultural needs of the Greater Lowell community and drive programming and services to positively impact those needs. Through the Greater Lowell Health Alliance Circle Health has been able to help drive some very specific strategies to build the cultural competency of its own staff and the staff of other community health and service providers. The Cultural Competency Task Force formed by the Greater Lowell Health Alliance has successfully reached out to the community to increase awareness of cultural diversity and collaborate with community partners to break down barriers and improve cultural sensitivity and competency. And in an attempt to understand the services and/or gaps in services within the community, the Task Force has completed and vetted a provider survey to assess services locally.

Lowell General Hospital and the Lowell General Hospital Physician Organization has also developed programs and models of care that incorporate understanding and help care for the social needs of our patients. One example of this is our Medical Home Initiative, which aims to provide care in the most appropriate setting, reduce avoidable 30-day readmissions and Emergency Department use, as well as provide focused care and connections to community resources to high risk/high cost patients, including those with behavioral health comorbidities. Another targeted approach LGH has taken to address the social health needs of our patients is through our social workers. Social workers at Lowell General Hospital address the emotional and social concerns of patients during their hospital stay, offering services such as supportive counseling for patients and their families, referrals to appropriate community resources, often serving as a patient's advocate with treatment providers and outside agencies. Our social work staff is an integral part of the interdisciplinary team who collaborate with doctors, nurses and other ancillary services to ensure that care plans incorporate the patient's social and emotional needs.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

Some of the unexpected barriers to addressing social determinants of health come from the patient side; often strongly held cultural beliefs or negative experiences with government agencies or healthcare providers can create personal barriers that are difficult to recognize and overcome. The lack of consistent and reliable information sharing among care providers and community organizations also leads to a disjointed approach to addressing social determinants of health.

5. **Strategies to Encourage High-Value Referrals**.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

As a member of the Wellforce system, we share a commitment to being a value driven system; this is evidenced in how we carry out our mission within our own community and how we select and engage with our partner providers to care for our patients. Circle Health and the Lowell General Hospital Physician Organization have been committed to being high-quality, value providers for many years. Through this commitment we have excelled in performance in value based payment models such as the Blue Cross Blue Shield AQC. We have formed several Innovation Councils to identify opportunities for improving the value of care provided by system providers through an integrated local delivery model. Incentive programs are developed annually to target opportunities to engage with providers for improving the delivery of health care, especially to the complex chronically-ill populations. Through our Wellforce membership we have strengthened our clinical relationship with Tufts Medical Center, which from its earliest inception was driven to capitalize on the quality and value of both institutions. In choosing a value provider such as Tufts Medical Center as our preferred tertiary provider we have seen more complex care stay in the community and we have the assurance that our patients are being seen at one of the lowest cost AMCs in the state.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No
    i. If yes, please describe what information is included.
    38T

    ii. If no, why not?

Lowell General Hospital Electronic Health Record (EHR) System (Cerner) currently does not have the functionality to provide cost/quality information to healthcare providers at the point of referral. Lowell General Hospital currently utilizes various systems and data sources to capture, analyze and report information for cost and quality including Crimson Inpatient and Outpatient Quality / Cost data and we have a cost accounting system that captures cost information for inpatient and outpatient services.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting ,that is available at the point of referral?
No
    i. If yes, please describe what information is included.
    38T

    ii. If no, why not?

Too many competing priorities and Lowell General Hospital and its affiliated physician are extremely low cost providers and any redirection of volume from Boston back to Lowell would save the system money.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

LGH provides several avenues to exchange information with other provider organizations that are not corporately affiliated or jointly contracting with LGH Along with providing view only access to the electronic health record for providers who have signed confidentiality agreements with Lowell General Hospital there are two interoperability options:

First being "Push" technology where results interfaces are available for our community provider organizations to support retrieval of laboratory, diagnostic and discharge information within their practice EMRs. For several larger provider organizations an ADT interface/notification is available along with a view only web portal access. Also available is the ability to manually send transition of care documentation via DIRECT Trust for secure messaging and use of Mass HiWay.

Second is "Pull" technology where connections with CommonWell Health Alliance have been established to share patient information for those patients that have consented and enrolled with trusted organizations. LGH has also signed agreement with Mass HiWay for future participation in query and retrieve technology.

ii. If no, why not?
38T

6. **Strategies to Increase the Adoption of Alternative Payment Methodologies.**
In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

LGH has participated in alternative payment models or risk arrangements with Blue Cross Blue Shield, Harvard Pilgrim Health Care and Tufts Health Plan. LGH has participated in the Medicare Shared Savings Program since July 2013 and performed extremely well, with significant savings over the first three performance periods with 11,000 Medicare beneficiaries. We are considering adopting additional downside risk through the highest risk Track 3 to access the appropriate levers required to optimize performance under this program. LGH and our orthopedic surgeons commenced a Bundled Payment for Care Improvement (BPCI) arrangement effective July 2015 for total joints lower extremity. The orthopedic surgeons of LGH are very committed to keeping patients local by preventing transfers to higher cost facilities.

Circle Health and LGH are fully committed to pursuing value-based risk contracting across the system. Additionally, we continue to prepare for participation in the MassHealth ACO program.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Circle Health strongly encourages the Commonwealth to work with health plans to adopt additional flexibility with member liability waivers to support and promote population health management activities specifically aimed at chronic disease conditions (e.g. diabetes, chronic obstructive pulmonary disease, and congestive heart failure) to mitigate barriers to ensure adherence to and compliance with disease-specific treatment programs, such as deductibles that may be cost-prohibitive to getting necessary testing or copays which may inhibit patient optimization of the health care system. Patients with the greatest need most often experience significant obstacles to optimizing the health care system.

In addition, LGH implores the HPC to consider more creative solutions for patient consent. As currently written, the requirements around patient consent create barriers against effective transitions of care across the care continuum.

c. Are behavioral health services included in your APM contracts with payers?
Yes
   i. If no, why not?
   38T

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.
   a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Hospitals are balancing many priorities from a regulatory and reporting perspective. There are the state regulatory requirements (i.e., the DPH, Board of Registration in Medicine), accreditation requirements (i.e. The Joint Commission, CMS Conditions of Participation), CMS quality measures, MassHealth quality measures, and those of other third party payers in addition to internally identified opportunities for improvement. There is the increasing focus on patient safety and elimination of preventable harm, maximization of outcomes, and improvement of patient satisfaction. Hospitals are challenged to accomplish these worthy goals while operating as leanly and as efficiently as possible in order to minimize the increasing cost of care.

There are literally hundreds of metrics that are followed from a quality perspective given the complexity and breadth of services offered in most organizations. Data collection, monitoring, performance improvement, education and retesting all require considerable resources in FTE support, registry memberships, I.T. systems, contracts with vendors, etc. In addition, national vendors that support reporting often may not support individual state reporting requirements. In this case, hospitals are forced to access other vendors who have agreed to participate in certain state initiatives. This creates some redundancy and additional cost.

From a quality reporting standpoint, the variation in measures often forces hospitals to deploy resources in different directions when a more concerted effort in key focus areas

might drive greater rewards and have a more lasting benefit. The time required to analyze, address nuances within measures, and develop multiple action plans creates significant work, and overburdens both administrative and clinical staff in trying to comply with the metric vagaries. In the face of so large a list of metrics to follow and advance, Lowell General has worked to stay focused on truly meaningful indicators. These are indicators that will drive improved outcomes for patients in a safe and healing environment. While we meet the continued requirements for reporting, we prioritize and limit resources towards lesser metrics that may not as valuable so that resources are best directed to those improvement opportunities that are most impactful.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

As a general concept, the focus on broader metrics as opposed to very defined measures is preferable. Looking at outcome measures like mortality and morbidity and resource utilization is more telling about the success and operational acumen of a hospital than very prescriptive metrics. This approach also allows hospitals to focus on their unique needs and those of the community it serves. There should also be some regard for the demographics served by the hospital. The socio-economics of a hospital's clientele play a large role in patient outcomes. Use of national quality and patient safety metrics like AHQR measures are generally sound and most are directionally correct. Metrics that focus on rare occurrences can be problematic as any one instance can greatly skew rates. These are best looked at over a longer period of time or perhaps combined with other rare occurrences.

The frequency of reporting has varied depending on the payer from quarterly to annually and as noted above can involve complex technical resources. Data that can be captured through claims or existing national reporting mechanisms are best options.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
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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 Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. For each year 2012 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 and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.
   See Attached

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

Lowell General Hospital has been an earlier adopter of pricing transparency by proactively providing estimates for services prior to the time of service. We continue to embrace this doing so in an informative manner. Since the implementation of Chapter 224 we made a minor modification to better handle consumer requests for pricing unrelated to care scheduled or booked at Lowell General Hospital, but simply as an inquiry to our organization. We created an internal process to route those requests, make record of them, and respond in the prescribed timeline. The majority of the estimates we generate continue to be not on the request of the consumer, but by the organizational effort to be transparent to our patients on out of pocket costs.

   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 analyses.

We routinely monitor our estimates to ensure that they are both accurate and timely to our patients and the larger market of consumers related to any requests for price information. No less than annually we conduct a formal review across all estimates generated to determine the level of accuracy. In the past, when the estimates have deviated from the actual costs of services the reasons were largely attributed to one of the following: 1) A change in procedure or higher level of complexity in a procedure that was not anticipated or known to us at the time of the request for the estimate 2) a complexity with the patients' health insurance benefits that was not known to us or was not provided to us by the health insurance payer 3) the mix of services for a given procedure had changed and our care bundle in our estimation tool needed to by updated.

   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?

We have not encountered any specific barriers to providing timely responses to consumer inquiries. In general, the only items that would limit our ability would be a lack of information being provided by the consumer or health plan in us generating the estimate. Estimate requests from consumers sometimes provide to us minimal information with which we need to provide an estimate. If the estimate is for a simple diagnostic service that process is relatively straight forward, however the consumer often does not know specifics about the different variations of surgical procedure they may be looking to obtain a price on. This will precipitate internal research and vetting to be sure we are accurately assembling the right care to estimate. We do our best to collect all the necessary elements of information and provide an estimate that is both accurate and timely. In order to ensure we have adequate information all staff have been educated on the minimum necessary elements of information needed from the consumer in order for us to be able to provide the estimate. If for some reason all of the information was not provided, we would follow-up directly with the consumer or their insurer for additional information.

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.

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	Total Net Rev
Blue Cross Blue Shield					34,226,982	24,803,952			21,879,764							80,910,698
Tufts Health Plan					12,937,607		1,175,637		111,960							14,225,204
Harvard Pilgrim Health Care											11,134,843					11,134,843
Fallon Community Health Plan											3,526,141					3,526,141
CIGNA											6,347,662					6,347,662
United Healthcare											12,122,054					12,122,054
Aetna											4,185,018					4,185,018
Other Commercial											11,129,440					11,129,440
Total Commercial	-	-	-	-	47,164,589	24,803,952	1,175,637	-	21,991,724	-	48,445,158					143,581,060
Network Health											11,247,581					11,247,581
Neighborhood Health Plan											7,449,517					7,449,517
BMC HealthNet, Inc.											1,679,077					1,679,077
Health New England											-					-
Fallon Community Health Plan											-					-
Other Managed Medicaid																-
Total Managed Medicaid			-	-	-	-	-	-	-	-	20,376,175	-	-	-	-	20,376,175
MassHealth		19,602,139		611,000							-	-				20,213,139
Tufts Medicare Preferred					16,191,073			665,000								16,856,073
Blue Cross Senior Options																-
Other Comm Medicare											8,403,247					8,403,247
Commercial Medicare Subtotal	-	-	-	-	16,191,073	-	-	665,000	-	-	8,403,247	-	-	-	-	25,259,320
Medicare											-	74,510,882				74,510,882
Other												21,979,166				21,979,166
GRAND TOTAL	-	19,602,139	-	611,000	63,355,662	24,803,952	1,175,637	665,000	21,991,724	-	77,224,580	96,490,048	-	-	-	305,919,742

Saints Medical Center was acquired July 1, 2012 - 3 months of net revenue is captured

AQC Contract
Commercial Plan

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			Full Year of Saints Medical Center acquisition
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							Total
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	Net Rev
Blue Cross Blue Shield					30,831,777	32,519,160			19,677,262							83,028,199
Tufts Health Plan					15,894,766		983,210		198,210							17,076,186
Harvard Pilgrim Health Care									44,783		14,777,568					14,822,351
Fallon Community Health Plan											4,675,085					4,675,085
CIGNA											8,415,959					8,415,959
United Healthcare											16,071,856					16,071,856
Aetna											5,548,648					5,548,648
Other Commercial											12,766,502					12,766,502
Total Commercial	-	-	-	-	46,726,543	32,519,160	983,210	-	19,920,255	-	62,255,618					162,404,786
																-
Network Health											15,895,658					15,895,658
Neighborhood Health Plan											9,876,838					9,876,838
BMC HealthNet, Inc.											1,982,181					1,982,181
Health New England											-					-
Fallon Community Health Plan											-					-
Other Managed Medicaid																-
Total Managed Medicaid			-	-	-	-	-	-	-	-	27,754,677	-	-	-	-	27,754,677
																-
MassHealth		28,689,222		1,000,500							-	-				29,689,722
																-
Tufts Medicare Preferred					19,798,389			2,550,000								22,348,389
Blue Cross Senior Options																-
Other Comm Medicare											11,141,328					11,141,328
Commercial Medicare Subtotal	-	-	-	-	19,798,389	-	-	2,550,000	-	-	11,141,328	-	-	-	-	33,489,717
																-
Medicare											-	123,761,551				123,761,551
																-
Other												28,064,583				28,064,583
																-
GRAND TOTAL	-	28,689,222	-	1,000,500	66,524,932	32,519,160	983,210	2,550,000	19,920,255	-	101,151,623	151,826,134	-	-	-	405,165,036

2014

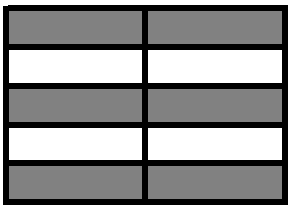
	P4P Contracts					
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue	
	HMO	PPO	HMO	PPO	HMO	PPO
Blue Cross Blue Shield					30,055,398	32,534,117
Tufts Health Plan					14,100,335	
Harvard Pilgrim Health Care						
Fallon Community Health Plan						
CIGNA						
United Healthcare						
Aetna						
Other Commercial						
Total Commercial	-	-	-	-	44,155,733	32,534,117
Network Health						
Neighborhood Health Plan						
BMC HealthNet, Inc.						
Health New England						
Fallon Community Health Plan						
Other Managed Medicaid						
Total Managed Medicaid			-	-	-	-
MassHealth		27,464,566		1,000,000		
Tufts Medicare Preferred					19,142,262	
Blue Cross Senior Options						
Other Comm Medicare						
Commercial Medicare Subtotal	-	-	-	-	19,142,262	-

Medicare						
Other						
GRAND TOTAL	-	27,464,566	-	1,000,000	63,297,995	32,534,117

Risk Contracts				FFS Arrangements		Ot
Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue				
HMO	PPO	HMO	PPO	HMO	PPO	HMO
		19,668,142				
3,174,346		65,560				
		84,436		15,270,166		
		107,320		4,257,893		
				5,846,881		
				15,910,675		
				5,069,750		
				7,923,126		
3,174,346	-	19,925,458	-	54,278,491		
				19,115,114		
				14,236,699		
				2,381,590		
				-		
				-		
-	-	-	-	35,733,403	-	-
				-	-	
	2,290,000					
				28,785,601		
-	2,290,000	-	-	28,785,601	-	-

				-	119,085,443	
					30,648,032	
3,174,346	2,290,000	19,925,458	-	118,797,495	149,733,475	-

ther Revenue		
PPO	Both	Total Net Rev
		82,257,657
		17,340,241
		15,354,602
		4,365,213
		5,846,881
		15,910,675
		5,069,750
		7,923,126
		154,068,145
		-
		19,115,114
		14,236,699
		2,381,590
		-
		-
		-
-	-	35,733,403
		-
		28,464,566
		-
		21,432,262
		-
		28,785,601
-	-	50,217,863



		-
		119,085,443
		-
		30,648,032
		-
-	-	418,217,452

2015

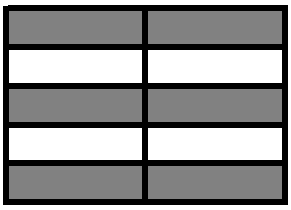
	P4P Contracts					
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue	
	HMO	PPO	HMO	PPO	HMO	PPO
Blue Cross Blue Shield					32,271,000	34,658,754
Tufts Health Plan					14,179,451	
Harvard Pilgrim Health Care						
Fallon Community Health Plan						
CIGNA						
United Healthcare						
Aetna						
Other Commercial						
Total Commercial	-	-	-	-	46,450,451	34,658,754
Network Health						
Neighborhood Health Plan						
BMC HealthNet, Inc.						
Health New England						
Fallon Community Health Plan						
Other Managed Medicaid						
Total Managed Medicaid			-	-	-	-
MassHealth		27,579,572		865,498		
Tufts Medicare Preferred					19,142,262	
Blue Cross Senior Options						
Other Comm Medicare						
Commercial Medicare Subtotal	-	-	-	-	19,142,262	-

Medicare						
Other						
GRAND TOTAL	-	27,579,572	-	865,498	65,592,713	34,658,754

Risk Contracts				FFS Arrangements		Ot
Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue				
HMO	PPO	HMO	PPO	HMO	PPO	HMO
		12,524,884				
2,346,213		106,289				
		120,286		15,270,166		
		185,985		4,246,892		
				5,777,451		
				16,817,353		
				5,235,192		
				10,574,615		
2,346,213	-	12,937,444	-	57,921,669		
				18,048,953		
				17,288,066		
				3,373,263		
				-		
				-		
				1,514,827		
-	-	-	-	40,225,109	-	-
				-	-	
	2,290,000					
				28,785,601		
-	2,290,000	-	-	28,785,601	-	-

				-	121,643,868	
					30,648,032	
2,346,213	2,290,000	12,937,444	-	126,932,379	152,291,900	-

ther Revenue		
PPO	Both	Total Net Rev
		79,454,638
		16,631,953
		15,390,452
		4,432,877
		5,777,451
		16,817,353
		5,235,192
		10,574,615
		154,314,531
		-
		18,048,953
		17,288,066
		3,373,263
		-
		-
		1,514,827
-	-	40,225,109
		-
		28,445,070
		-
		21,432,262
		-
		28,785,601
-	-	50,217,863



		-
		121,643,868
		-
		30,648,032
		-
-	-	425,494,473