Exhibit C Questions

1. For each year 2009 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.

Summary Response: BIDCO operates as an ACO, which incorporates physicians (individual and group practices) and hospitals into one entity for purposes of joint contracting, medical management, quality improvement, and centralized administrative functions such as enrollment and provider relations. Therefore, BIDCO itself does not have an operating margin on payer revenues as it is not providing direct services to patients; only entities that are participating providers in the organization are providing direct medical services to patients.

2. If you have entered a contract with a public or commercial payer for payment for health care services that incorporates 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 do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully-insured v. self-insured) on your opportunities for surpluses.

Summary Response: BIDCO's risk contracts have focused on medical cost management and quality measure performance and this has caused us to shift the focus of our resources accordingly. Among the changes we have made include intensifying our focus on improving quality measures as a means to improve patient care and satisfaction; increased focus on high risk patients; reviewing practice variation among providers; and new care management programs in a range of areas including after-hours care and urgent care, use of clinical protocols for the most common clinical conditions, enhanced skilled nursing facility care and coverage, improved home care opportunities, enhanced community-based care with our community

providers, and encouraging in-network care to avoid duplication of services. Efforts to expand our covered lives continue, even as patients/purchasers increase migration to PPO products, and PCP practices are in flux throughout the Commonwealth's health systems.

BIDCO has risk contracts with public and commercial payers which incorporate the ability to earn surplus in both upside only and upside/downside agreements. The movement to contracts which focus on medical cost management and quality measure performance has shifted the focus of our resources toward staffing in care management and quality improvement functions. We have also added dedicated resources in technical EMR staff that are focused on the correct documentation of quality metrics into the EMR, and the subsequent collection and assimilation of those quality metric components into a centralized and reportable data repository.

BIDCO has entered contracts for total cost of care, or so-called "risk contracts" with the three major commercial payers and with CMS, the latter as a Pioneer ACO. The focus on these contracts has resulted in a number of changes including:

1) intensified focus on improving our quality measures as a means to improve care to patients and patient satisfaction and thereby investing in significant human resources as well as a network-wide infrastructure of electronic registry and patient outreach function;

2) engagement with a vendor to provide software that allows for patient severity scoring, high-risk patient identification and practice variation functions; and

3) Launching a variety of care management programs to help reduce unnecessary care.

These care management efforts include encouraging and fostering after-hours care including creation of urgent care sites with those payers who allow for such sites; renewed development and use of clinical protocols for most common clinical conditions; collaboration with other networks around Skilled Nursing Facility (SNF) care and coverage arrangements; contracts with home-based care providers to enable patients to have care at home without frequent hospitalizations or emergency room visits; coordination with our affiliated hospitals to coordinate care in the community; and encouraging that care be coordinated within our network to ensure electronic communication and hence reduced duplication of services.

We hope to expand our network of primary care physicians and to expand covered lives, to create the most actuarially sound risk pools and to compensate for the decreasing number of HMO lives in our risk based contracts. This decrease in covered lives can be attributed to both the movement of PCP groups to competitor health care systems as well as the plans' movement of HMO members to PPO products.

3. Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

Summary Response: BIDCO relies on its own systems and timely payer information to manage our risk. We have designed our risk contracts to limit the risk passed on to participating providers and to establish maximum deficit and surplus levels. In addition, BIDCO has individual patient stop-loss coverage in its major contracts, outside reinsurance in certain contracts, and reserves. We also have internal methods in place to mitigate the financial impact of providers in deficit.

BIDCO creates financial reports that aggregate our performance across all payers. We regularly track liabilities against projected withholds and reserves. The availability of current withhold information from the payers is crucial to our ability to determine if we are able to meet any deficit obligation. Our risk contracts are designed in a way that limits the risk that is passed on to our participating providers. The risk contracts contain maximum surplus and deficit levels. We also have annual individual patient stop loss, which decreases our liability for patients who have medical costs that are more of an insurance risk. We work closely with our reinsurance company to monitor high cost patient liabilities, and again we rely on receiving claims on a timely and complete basis. BIDCO Members also have reserves that it has built up over the years and will continue to fund these reserves from current and future surplus and bonus payments.

BIDCO's risk contracts have stop-loss coverage in all but one payer, and for that one payer we have purchased outside reinsurance.

We have developed an internal financing system that sets PCP group-specific budgets and pools risk across all payer agreements, thereby creating greater risk pools and minimizing the potential for a PCP group to be in deficit.

As part of our performance year 2 as a Pioneer ACO, we were required to have certain levels of financial reserves in place, which we accomplished through an aggregate reinsurance policy.

4. Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups (e.g., subgroups by carrier, product, or geographic area).

Summary Response: BIDCO tracks changes across our entire membership each quarter, based on supporting detail provided by the payers. BIDCO also employs a vendor product that identifies patients who may be at high risk for hospitalization, based on a change in their health status or care history. These two sources of information inform our initiation of care management services for our primary care providers to their most vulnerable patients.

5. Please submit a summary table showing for each year 2009 to 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue. ***Responses must be submitted electronically using the Excel version of the attached exhibit. To receive the Excel spreadsheet, please email HPC-Testimony@state.ma.us.***

6. Please identify categories of expenses that have grown (a) 5% or more and (b) 10% or more from 2010 to 2012. Please explain and submit supporting documents that show your understanding as to the factors underlying any such growth.

Summary Response: Between 2010 and 2012, BIDCO operating expenses have grown to support our movement into risk-based contracts that also have a strong link to quality results. Each of our main categories of expense increased more than 10% to accommodate the infrastructure needed to be successful in global budget contracts. The main areas of increase were in staff to support care management, analytic capabilities and clinical/EMR technical support; increased office space; our investment in PCP groups and PCP leadership; consultant services; and the purchase of vended software application services for high risk patient identification and provider variation analytics.

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you

are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

Summary Response: BIDCO's participating providers, including a hospital and physicians, have their own health and wellness programs for their patients and employees, and we have included some examples below. These health and wellness programs range from efforts to manage chronic disease, to programs to address substance abuse, stress, pain-management, and weight management and control for patients. BIDCO staff participate in the BIDMC employee health and wellness offerings formally launched this year and described below.

BIDCO's diverse hospital and physician participating providers, including individual PCP and specialist practices, may have their own health and wellness programs for both patients and employees. We have outlined below some programs available to a) patients in the primary care practice Health Care Associates, b) BIDMC employees, and c) Bowdoin Street Health Center employees.

Health Care Associates has various programs available to patients who have chronic diseases such as diabetes, hypertension, asthma and COPD, and weight management. There are also social work group programs to help patients address and manage substance abuse, stress, pain management, and weight-related health issues.

BIDCO employees are able to take advantage of the significant health and wellness programs available to BIDMC employees. BIDMC is entering its second year of this effort, and does not have cost benefit data on the programs described. The first year focus of BIDMC's efforts was on employee participation.

Below is an overview of the wellness programs offered to employees in 2013, which will be offered in 2014, along with additional programs. BIDMC also has an onsite fitness center, a robust employee assistance program (EAP), a portal page dedicated to employee health and wellness, and external web pages dedicated to patient and employee health and wellness information.

- Biometric Screenings (Feb – Mar): Conducted on-site by BIDMC's health plan, and consisting of blood pressure, height and weight for BMI, non-fasting glucose, and cholesterol finger stick – total and HDL. Participants had the option to review their results with a health plan counselor.

- On-line Health Questionnaire (Mar-Dec): Provided by BIDMC's health plan to all benefit-eligible employees.

- Weight is Over (Mar-May): Eight-week weight management program led by Exercise Physiologists, Tanger Be Well Center (located on site at BIDMC) and Registered Dieticians, Nutrition Services department. Individuals and teams (up to 5) participated with the goal of reducing their body weight by 5%.

- Be Well, Walk Well (Jun-Aug): Six-week walking program. Individuals and teams of up to 10 participated. Pedometers were distributed to all participants. The goal was to increase the weekly number of steps by 50% from the baseline week.

- Wellcoin (May-Dec): On-line program that rewards employees for participating in healthy activities. Employees earn Wellcoins for reporting the activity and substantial bonuses for verifying that they did it. Participants can redeem Wellcoins for rewards provided by BIDMC.

  Webpage Links:

  Health and Wellness Education (with more links to educational videos, information, and podcasts):

  http://www.bidmc.org/AboutBIDMC/TangerBeWellCenter/HealthandWellnessEducation.aspx

  iHealth (with an extensive health library, interactive tools, newsletter sign-up and more):

  http://www.bidmc.org/YourHealth.aspx

Bowdoin Street Health Center (BSHC) also participated in a "Workplace Wellness Challenge" with "Boston Moves for Health," which was a multi-tiered approach to incorporating different avenues of health and wellness into the workplace environment and in the daily lives of staff, with particular attention to long-term sustainability. BSHC is now exploring how to inspire change in their diverse patient population, given the success and enthusiasm for this program.

Comment on the Center for Health Information and Analysis (CHIA) Annual Report on the Massachusetts Health Care Market. We continue to appreciate CHIA's evolving work, including its production of the Annual Cost Trends Report, Provider Price Variation Reports, and Hospital Financial Performance reports, all of which shed important light on the Commonwealth's health care market. CHIA's "Cost Trends" Report, however, provides a very broad overview of the Massachusetts health care market, and stands in sharp contrast to the in-depth analysis and approach of the Office of the Attorney General. We believe that regulators, policy makers, and

the general public would benefit from continued clarity and refinement of the CHIA reports, and specifically, we recommend the following:

1) Common Definitions of Key Market Terms. CHIA should clearly and specifically define the various entities within its examination, including, for example, a definition of "health system." Such definitions would improve public understanding of the nature and functioning of such entities. It is relevant, for example, to understand whether a "health system" is engaged in system-level contract negotiations with payers, and whether all "health system" participants share common characteristics that are relevant to CHIA's examination of cost trends and cost growth in the Commonwealth.
2) Illuminate Key Findings. CHIA's Cost Trends Report has made key findings that, when read in isolation from critical data and factual information, are not beneficial to the reader's clear understanding of the Massachusetts health care market and underlying tensions and dysfunction.
3) Clarify Clear "Exceptions" to CHIA's General Findings. CHIA makes a number of general findings relative to providers that tend to obscure the clear and important exceptions to these general findings. CHIA also fails to note that such exceptions exist. We believe that illuminating these exceptions is critically important to the public's understanding of cost growth and cost trends in the Commonwealth. For example, CHIA has found that "higher prices were also associated with … those [hospitals] affiliated with larger health care systems." Such is not the case with key community hospitals in the Commonwealth that are members of larger providers or health systems, and CHIA should strive to make these exceptions clear. Otherwise, the public has not been provided with a clear and fair understanding of the market and its participants.

We look forward to working with CHIA in our shared goal of providing useful and clear information on cost trends in the Commonwealth.