Lahey Health

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Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, Sixth Floor
Boston, MA 02116

Via email: HPC-Testimony@state.ma.us

Dear Mr. Seltz,

Enclosed please find written testimony submitted on behalf of Lahey Health System, Inc., in response to the questions of the Health Policy Commission in Exhibit B and questions of the Office of the Attorney General in Exhibit C, as requested in the letter dated August 28, 2013.

I, Howard R. Grant, am legally authorized and empowered to represent Lahey Health System, Inc. for the purposes of this testimony, and this testimony is signed under the pains and penalties of perjury.

Sincerely,

Howard R. Grant, JD, MD
President and Chief Executive Officer
Lahey Health System, Inc.

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 and CY2013 and CY2012 and CY2014 is 3.6%. What are the actions your organization has undertaken to reduce the total cost of care for your patients? What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities? What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality? What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?**

   A principal rationale for forming Lahey Health was a perceived value gap in our regional marketplace – insufficient access to locally based, high quality and lower-cost care. The ultimate goal is a balanced and coordinated system characterized by optimal distribution of health care services, thoughtful utilization of clinical and financial resources and a regionalized platform for effective population health management. Our most critical cost reduction efforts involve:

   - Restructuring of care network components to comprehensively address accessibility
     - Inclusive of physical care sites, service scope, availability/scheduling, personal, cultural and gender-specific accommodation and multimodal communication channels between patient and provider
     - Deemphasizing the hospital and urban centers as hubs
   - Reorientation toward and substantial investment in the services, providers and infrastructure that prevent illness, proactively identify and diminish risk, and maintain and extend healthy lives
   - Redesign of care models to hardwire multi-specialty integration, team-based approaches and cross-continuum coordination
   - Meaningful and enduring realignment of incentives such that simultaneous achievement of more effective (better quality) and more efficient (less costly) care is possible

   While these strategies accurately describe Lahey Health's long-term approach to reducing health care expenditures, we recognize the transformative and fundamental change required. To remain sustainable in the near-term and incrementally reduce costs, Lahey Health has pursued expense management and operational cost control tactics, many of which were the direct result of the Lahey-Northeast partnership.

   The Lahey-Northeast partnership enabled centralization of services at the system level, built scale and critical mass to more broadly distribute costs and risk, and identified both waste to be eliminated and best practices to be replicated. More detailed descriptions of cost-reduction initiatives and examples of resulting savings are provided below.

   - Consolidation of key functions and infrastructure at the system level, which has resulted in over $4.5M in savings to date (and projected to yield $40M in savings over the first five years of operations)
   - Establishment of system wide leadership positions dedicated to reducing inappropriate utilization and coordinating care - Vice President of Care Management and Medical Director of Care Transitions
   - Organization-wide information technology platform investments in Oracle/PeopleSoft, Orion health information exchange, athenaClarity, and Epic to accelerate information sharing and coordination

- Unified (relevant) cost and quality data reporting and benchmarking, most notably University Healthcare Consortium (UHC)
- Continuous and standard workforce management processes, including metrics-based assessments of open positions
  - Achievement of department staffing levels at or below the University Healthcare Consortium (UHC) 25th percentile
- Creation of supply chain analysis and value-driven group purchasing task forces
- Cultivation of stronger performance improvement capabilities
  - "La^{3}hey Thinking", an internally developed performance improvement system grounded in LEAN thinking and the principle that significant impact can come from modest change. This framework is physician-driven to create and maximize value at the point of service.
  - Six Sigma teams trained at the system level and deployed locally to analyze processes from operating room throughput to appointment scheduling processes
- Identification and systematization of best practices and policies, with emphasis on consistent use of evidence-based standards and clinical resource utilization management
- Establishment of a unified physician management services organization

Additionally, our new system establishes the foundation from which to more effectively pursue long-term cost reduction goals.

- Community and tertiary teaching hospital settings allow for redirection of care to the most clinically appropriate and cost-effective setting
- Contiguous geographic service areas provide opportunities to appropriately distribute care regionally and improve local and lower-cost access
- Combination of service scopes broaden care continuum coverage and enable development of multidisciplinary care models to manage chronic and co-morbid patients more effectively
- Different physician-hospital relationship models create new risk-sharing and incentive alignment opportunities

Primary limiting factors include:

- Capital and operating resource requirements to fund innovation and establish a robust population health management infrastructure
- Current reimbursement model continues to reward volume regardless of value
- Restrictions on sharing of pharmaceuticals among partner organizations
- Consumer perceptions of the relationship between prestige and quality health care

- Reliance on payer claims data to support success under risk-based contracting
- Inherent operational inefficiencies associated with academic mission components

The most impactful systematic or policy changes to reduce costs without reducing quality include:

- Funding to pilot innovative care delivery models
- Improved health plan benefit design to incorporate patient engagement initiatives
- Partial subsidization of primary care and care management resources for the chronically ill
- More timely and comprehensive reporting of payer claims data, particularly for patients with chronic disease
- Limitations on health plan administrative retention and standardization of health plan administrative requirements
- Incentives for payor/provider collaboration and co-investment in care management infrastructure to reduce current duplication of utilization and case management outreach

As a provider only, Lahey Health has limited ability to ensure that reductions in health care costs are passed along to consumers and business, with the exception of our employees, and though indirectly, by maintaining a low-cost position to minimize consumer cost-sharing burden.

2) **The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?**

Lahey Health employs a conservative pricing philosophy relative to the majority of Boston metro-area providers. Prices are reevaluated annually and set at a level just above the insurer's fee schedule amounts. This has three important results:

- Modest, if any, increases in patient cost sharing (a core element of Lahey Health's pricing philosophy)
- Prices are generally much lower than peer organizations
- Minimal year-to-year fluctuations in pricing (FY2012 – FY2013 price increase is approximately 1.3%)

3) **C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration? What potential opportunities have you identified for such integration? What challenges have you identified in implementing such integration? What systematic or policy change would further promote such integration?**

Lahey Health promotes integration of mental and physical health by directly embedding behavioral health expertise and services into primary and specialty care practices to support holistic and person-centered care. We have historically focused on the adult population, in particular those over age 65+, given the disproportionate impact of behavioral health challenges for this age cohort, and our nationally recognized geriatric primary care and behavioral health providers co-evaluate and co-manage this sub-set of patients.

Our vision is to establish a multidisciplinary and coordinated delivery and management system that engages patients and their families to proactively identify issues and successfully manage both mental and physical health. We aspire to evidence our vision achievement by improving both behavioral and physical health status and reducing the overall cost of care for both providers and patients.

Through the LH&MC Department of Psychiatry and Behavioral Medicine, the robust network of Lahey Health Behavioral Services (LHBS) and the Lahey Health Senior Care (LHSC) (in addition to affiliations with the Massachusetts Behavioral Health Partnership (MBHP) and North Shore Collaborative), Lahey Health continuously looks for opportunities to maximize these relationships to strengthen and further integrate mental and physical health services:

- "Curbside" consultations, co-evaluation and collaborative treatment of patients in conjunction with select specialties and subspecialty programs for which behavioral health issues are prominent, including cardiac rehabilitation, transplantation, and bariatric surgery
- Incorporate psychiatric, emotional/wellness surveys, and substance use evaluations, as well as behavioral health navigators, into our system wide patient centered primary care model, beginning with pilots in select primary care sites
- Educate and train providers to better identify and address behavioral health issues or co-morbidities that may go undiagnosed in a traditional primary care settings
- Facilitate referrals and streamline access to behavioral health consults by leveraging centralized EMR and scheduling capabilities
- Network wide implementation of Epic is intended to advance integration by streamlining access to comprehensive patient health data to improve timeliness and efficacy of decision-making across providers, as well as foster virtual care coordination

Infrastructure and associated costs have been the primary challenges identified in implementing integration plans for behavioral and physical health. Examples include:

- Educating and training, and associated workforce development costs, for clinical and non-clinical providers behavioral and primary care providers
- Establishing a clinical model expansion to a team-based setting that promotes the integration of behavioral and primary care
- Allocation of organizational resources properly to account for fluctuations in patient demand within individual practices
- Integration of and lack of interoperability between multiple, diverse EMRs and the behavioral health system

- Payment and reimbursement policies that do not align incentives to promote integrated care and interfere with the incorporation of behavioral health into care teams
- Concerns over patient privacy and provider sharing
- Prevention and early identification and intervention of behavioral health issues for young children and their families

Lahey Health concurs with Behavioral Health Integration Task Force findings regarding the primary policy changes needed to comprehensively support behavioral and physical health and wellness:

- Incorporating behavioral health payments into alternative payment methodologies to encourage providers to be proactive in planning and reactive to the needs of behavioral health patients
- Ensuring reimbursement across all payors for all child behavioral health screenings
- Aligning performance measures, such as quality, across innovative care delivery models like that patient-centered medical home pilot

4) **C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alterative payment methods. Describe your organization's efforts to promote these goals. What current factors limit your ability to promote these goals? What systematic or policy changes would support your ability to promote more efficient and accountable care?**

As it relates to innovative care delivery, Lahey Clinic's care model since inception – the group practice model – has featured blended specialty co-location, the expectation of team-based care and frequent real-time multispecialty consults. As a system, Lahey Health actively promotes care model innovation and as previously noted, one of our core long-term cost reduction aims is redesign of care models to hardwire integration and coordination. Other promotion efforts include:

- Funding implementation and training costs for health IT hardware, software and tools to more effectively communicate, share information and coordinate care (e.g., Epic, athenaClarity)
- Deploying care model assessment and transformation teams to primary care practices to implement patient centered medical home principles, support patient engagement and self-management, and facilitate practice transformation and NCQA certification
- Providing clinical pharmacist support to physicians to identify opportunities for more cost-effective prescribing practices and pinpoint patients with fill-rate gaps for chronic disease management medications
- Using case managers to schedule post-discharge follow-up appointments and assess home care needs
- Institution of emergency department clinical management protocols such as foot exams for all diabetic patients regardless of reason for visit, dedicated ED case manager follow-up based on risk-profiling and patient engagement assessments
- Integrating translational and comparative effectiveness research seamlessly into patient care
- Dedicating system resources to unified quality, safety and cost performance data capture, tracking, benchmarking and reporting

Alternative payment methodology involvement is detailed throughout Lahey Health's responses in Exhibit C, and include sponsorship of a Medicare Shared Savings ACO, pay-for-performance with cost and quality-based upside potential, pm/pm budget contracts, tiered network participation and CMMI Bundled Payment-for-Care Improvement Program.

The barriers to and policy initiative recommendations associated with care model innovation and alternative payment approaches mirror those cited in the response provided to Exhibit B, question 1.

5) **What metrics does your organization use to track trends in your organization's operational costs? What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)? How does your organization benchmark its performance on operational cost structure against peer organizations? How does your organization manage performance on these metrics?**

As a member of UHC, Lahey Health tracks operational costs on multiple metrics and at multiple levels throughout the organization – system level, facility level, department level, operating unit or cost center level, practice level and provider level. Furthermore, operating cost metrics are incorporated into incentive compensation methodology, including at the system level. Some examples of key metrics tracked include[1:]

- Adjusted cost per discharge
- Price per discharge and patient day
- Average length of stay
  - In 2012, LH&MC was the lowest cost academic hospital nationally[2]
  - Additionally, for at least the last eight quarters of measure, LH&MC has performed in the top quartile or better[3] on all UHC hospital wide cost, price and average length of stay metrics
- Labor, supply and drug expenses per patient
- Operating costs per member per month (specific to risk contracts)

[1] Indicators listed are all case mix and wage index adjusted; certain metrics apply more complicated formulas to determine intensity or weighting factor. The same metrics can be tracked at multiple levels of the organization.
[2] Out of 116 academic medical and major teaching hospitals, or 95% of all academic/teaching hospitals nationally. Source: University HealthCare Consortium, Q1-Q4, 2012.
[3] For cost and price metrics, the top quartile is the 25th percentile; for quality and safety indicators, the top quartile is the 75th percentile.

LH&MC is a member of multiple benchmarking organizations including UHC and Council on Teaching Hospitals (COTH). As of 2013, all Lahey Health partners have been integrated on the UHC platform to streamline reporting, ensure consistency and accurately capture system wide performance. As highlighted in Exhibit B-5, Attachment A, UHC quarterly efficiency reports measure comparative efficiency by area; costs per unit in pharmacy, supply chain, and CMI adjusted costs and expenses per case; and compares Lahey Health metrics to teaching, academic, and community hospitals.

In addition, Lahey Health routinely leverages publically available national and state performance data to derive meaningful benchmarks. These sources include CHIA, HPC and the OAG at the state level, and Centers for Medicare & Medicaid Services (CMS) Core Measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Physician Quality Reporting System (PQRS), Healthcare Effectiveness Data and Information Set (HEDIS) and the Agency for Healthcare Research and Quality (AHRQ) at the national level.

Lahey Health and its members manage metrics performance in the following ways:

- Lahey Clinic has developed incentive compensation targets (for 900+ physicians and managers) that are outcomes based and reflect our relative performance on value (cost/quality) indicators as well as experience of care indicators
- We utilize multiple data capture, tracking and benchmarking tools and systems to comprehensively monitor, report, and compare performance (see metrics and benchmarking sources identified above)
- Transparent exchange of performance metrics across the organization at quarterly town hall meetings

6) **Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.**

In collaboration with health plans and prior to January 1, 2014, Lahey Health will finalize its cost information disclosure process. Lahey Health plans to estimate costs at the CPT code level using fee schedules, and provide responses within two working days of request. For our insured patients, we will also indicate the respective health plan's toll-free phone number and website resources.

We address patient requests for cost information today and are able to support accurate estimates of out-of-pocket expenditures. Further, Lahey Health representatives attended a recent Massachusetts Hospital Association (MHA) seminar on the topic, and are currently establishing the vendor selection process and implementation timeline.

Lahey Health plans to make investments in infrastructure as well as human resources – an anticipated addition of two (2) additional patient navigator FTEs who will support this requirement through focusing on communicating with patients about their care, benefits, and out-of-pocket expenses.

7) **After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.**

Perhaps the most striking difference between the two reports is in identification of the core driver of health care costs in Massachusetts. The OAG report attributes rising health care costs to provider price increases. In contrast, the CHIA report concludes that actual medical expenses borne by providers rose 3.8% annually, but insurer retention (funds not spent on medical care, but retained for administrative expenses and profits) increased more than 20% in each of the last two years. Therefore, while actual medical expenses recently have been increasing at roughly the rate of inflation, premiums continue to rise at a rate about one-third higher, largely due to non-medical cost growth.

As always, and as reflected in our response to question 1, Lahey Health takes its responsibility to control health care costs very seriously, and sees delivery network restructuring, reorientation toward proactive health care services, care model redesign, and incentive realignment as critical elements of driving sustainable change.

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.**

   Please reference the table below (and Exhibit C-1, Attachment A), which provides the requested information for the legacy Lahey Clinic Foundation, Inc. and affiliate entities, legacy Northeast Health System, Inc. and affiliate entities, as well as the proxy for Lahey Health (simple addition of inputs).

	Calendar 2009		Calendar 2010		Calendar 2011		Calendar 2012	
	Percent of Total Business *	Operating Margin	Percent of Total Business *	Operating Margin	Percent of Total Business *	Operating Margin	Percent of Total Business *	Operating Margin
Lahey Health System (proxy)								
Commercial business	49.7%	16.7%	50.4%	18.8%	48.9%	20.9%	47.6%	21.7%
Government business	47.4%	-14.4%	47.0%	-16.9%	48.2%	-13.5%	49.8%	-12.8%
All other business	2.8%	4.5%	2.6%	3.0%	2.9%	7.3%	2.6%	1.9%
Total business	100.0%	1.6%	100.0%	1.6%	100.0%	4.0%	100.0%	4.0%
Lahey Clinic Foundation and Affiliates								
Commercial business	52.6%	16.4%	53.4%	19.4%	52.1%	21.9%	50.9%	22.6%
Government business	43.8%	-16.7%	43.4%	-20.3%	44.3%	-15.7%	46.0%	-15.6%
All other business	3.6%	20.1%	3.2%	18.9%	3.6%	20.9%	3.1%	16.5%
Total business	100.0%	2.0%	100.0%	2.2%	100.0%	5.2%	100.0%	4.9%
Northeast Health System and Affiliates								
Commercial business	43.6%	17.3%	43.8%	17.2%	41.1%	17.9%	39.3%	18.8%
Government business	55.1%	-10.5%	55.0%	-11.0%	57.6%	-9.3%	59.3%	-7.5%
All other business	1.2%	-90.2%	1.3%	-86.5%	1.3%	-85.5%	1.4%	-80.2%
Total business	100.0%	0.7%	100.0%	0.4%	100.0%	0.9%	100.0%	1.8%

* as calculated using net patient service revenue.

Carrier / Program Roll-up		
Commercial business	**Government business**	**All other business**
Aetna HMO	Mass Health	Self pay / free care
BCBSMA - HMO	Medicare	International
BCBSMA Sr HMO	Network Health	Other
BMC Healthnet	NHP	
Cigna HMO	Other Commercial Medicare	
Fallon	Other Commercial Medicare HMO	
HPHC HMO	Other Medicaid	
Tufts HMO	Tufts Medicare Preferred	
Aetna		
BCBSMA - PPO		
BCBSMA Sr		
Cigna		
HPHC PPO		
Other Commercial		
Tufts PPO		
United		

The margins for HMO business and PPO business are largely similar. Over the last 4 years, HMO margins were in the 17% to 24% range while PPO margins were in the 15% to 21% range. Business reimbursed through risk contracts accounted for approximately 10% of total business between 2010 and 2012, with margins in the 12% to 25% range. Lahey Clinic Foundation entities did not have any risk contracts in 2009.

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 return, 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 changes to your physician recruitment or patient referral practices. Include in your response 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 our opportunities for surplus.**

Lahey Health physicians, including those in the Lahey Clinical Performance ACO, Lahey Clinic accountable risk unit (ACU) and Northeast Physician Hospital Organization (NEPHO) ACU[1] currently participate in two system wide risk contracts, the Medicare Shared Savings ACO and a Tufts commercial risk contract. The Lahey ACU, separate from the NEPHO ACU, also currently participates in a Tufts Medicare HMO risk contract and the BCBSMA Alternative Quality Contract.

In order to better manage population health under risk contracts, Lahey Health uses athenaClarity℠, a cloud-based analytics tool to aggregate claims data across network providers and disparate EHR systems. The tool captures overall clinical, financial and operational performance, as well as insight on performance variations and trends. To leverage athenaClarity℠ to improve quality and efficiency under risk, Lahey Health has developed the following business practices and associated capabilities:

- Monthly group review of performance data
  - Identify need for care coordination intervention across providers and sites
  - Identify opportunities to provide care in a more appropriate setting
  - Minimize any redundant services, particularly higher-cost ancillary services
  - Increase transparency of performance and practice patterns
- Care management and coordination programs
  - Target placement of care managers
  - Improve care transitions
  - Provide home-based support and monitoring
- Integration of pharmacy support into the care team
  - Improve medication management

[1] Both ACU's are part of the Lahey Clinical Performance Network (LCPN).

- Ensure comprehensive management for chronic disease and patients with co-morbidities

It is difficult to attribute changes in service mix, payer mix, member type, or overall risk performance to one particular business practice, or even a set of business practices, given the myriad factors (or confluence of factors) collectively impacting service utilization fluctuations and shifts in payer and product mix.

Based on the information we capture and monitor regarding member type, enrollment in BCBSMA, HPHC and Tufts commercial HMO products has declined. Our hypothesis, corroborated at the state-level in the 2013 OAG and CHIA reports, is that PPO enrollment has subsequently increased, though confirmation of this hypothesis would require currently unavailable payer data.

Based on the information we capture and monitor regarding payer mix, we also note an increase in the proportion of patients enrolled in government plans.

Both the shift away from HMO products and increase in proportion of government plan patients negatively impacts the potential to earn surpluses.

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 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 cost or risk capital needs would change due to changes in the risk you bear on your commercial or governmental business.**

LCPN, in collaboration with local ACUs, uses health plan claims data and other provided reports, in conjunction with the athenaClarity℠ tool, to quantify, analyze and project performance under risk. Analyses calculate and stratify patient population risk using health behavior and status indicators, as well as historical utilization data, to generate projections at the individual provider, local ACU and LCPN levels. Contract quality metrics and other participation parameters/terms provide additional context to better understand resource and capability requirements for effective risk management. As discussed in response to question 2, we are then able to develop or prescribe existing business practices to support population health management.

For those risk contracts that do not exclude outlier cases, we have acquired stop loss insurance, for which policy terms are renegotiated annually. In 2012, the LCPN stop loss insurance had an attachment point of $250,000 and covered up to $5,000,000 in per member maximum annual claims payments at a cost of $12.24 pm/pm. Neither the human resource costs for care management (cited in response to question 2), nor those for the provision of our physician contracting and management services are allocated or analyzed (at this time) based on pm/pm costs of bearing risk.

In regards to pre-determined solvency thresholds, Lahey Health's (and LCPN's) financial position and projected performance are such that establishing formal solvency standards has yet to be required.

If specific contract terms generate projections indicating substantial probability of deficit, LCPN would engage in discussions with the payer to realign risk-sharing parameters or performance metrics. If the LCPN risk stratification and modeling processes were unable to accurately project performance and a payer deficit was experienced, LCPN has a multi-step methodology in place to cover the shortfall. Initially, performance at the ACU level is evaluated by benchmarking outcomes against pre-established

and approved targets that incorporate contract metrics and additional cost and quality indicators. If an ACU has not met these targets, the first source of funds are the withholds (10% per ACU per contract from claims payments made and held in escrow by the payer during the contract performance period). If a deficit still remains, dollars would flow from the LCPN reserve pool. If the reserve pool is insufficient to reconcile the deficit, the withholds from ACUs achieving performance targets would be accessed. Finally, in the unlikely event that the shortage persists, LCPN would spread the remaining deficit across ACUs in proportion to membership size, risk profile sand relative performance.

Clearly, there is a direct and positive correlation between the degree of risk assumed and the degree of cost or risk-capital required to effectively bear the risk, and therefore cost and capital estimates can be derived prior to contract formalization. If an excessive level of atypical costs are indicated, LCPN would work with the health plan to limit risk exposure through modified risk-sharing terms to ensure better alignment of incentives and would collaboratively dedicate resources to improve performance.

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

   The same data sources, methodology and tools referenced in responses to questions 2 and 3 are utilized to longitudinally capture and monitor health status changes and the related changes in the risk associated with managing the health of a patient population or sub-population. Interventional population management resources and practices are adjusted to reflect changes in health status over time. Currently these analyses are performed at the contract level, and not across contracts to assess differences by carrier, product type or geography.

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 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.**

   Please reference Exhibit C-5 attachments A, B and C.

   Since Lahey Health was not in place until May 2012, the data is presented as three different Excel files. One file provides data for legacy Lahey Clinic Foundation entities, one file provides data for legacy Northeast Hospital Corporation entities and the third file is a proxy for Lahey Health (Lahey and Northeast data added together). All revenue related to the hospitals and employed physicians is included[2].

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

   Overall expenses for Lahey Health increased by $114.7 million or 8.8%, driven primarily by labor and associated costs, with non-labor operating costs increasing by less than 2.0%.

[2] Northeast Hospital Corporation (NHC) derives revenues from certain health plans that are also reflected in the testimony submitted by NEPHO in Exhibit 1. It should be noted that in some cases the revenues reported by NEPHO are a subset of those reported by NHC.

Salaries and wages for non-physician clinical staff increased by $38.3 million, or 7.7% The increase is primarily attributable to implementation of a new compensation and bonus program designed to align financial incentives with achievement of organizational and individual performance goals. Goals span seven performance areas : system financial sustainability, productivity, quality, care experience, colleague engagement and cost. The 7.7% increase is the result of achieving at least threshold performance (assigned using national benchmarks) for all seven metrics, including top decile performance on the cost metric (cost per adjusted discharge), and earning Lahey Hospital & Medical Center the honor of being the lowest cost teaching hospital nationally (UHC, 2012).

It is also important to note that the number of non-physician clinical FTE's increased by 25.1 during this time period, and expenses related to our benefit program increased more than in a typical two-year period due to augmentation of employee health insurance premium discount rates.

Salaries and wages for physician employees increased by $19.8 million or 10.78% due to the new compensation and bonus program outlined above. The number of FTE's increased by 14.3 during the time period.

Employee benefits increased by $28.2 million or 17.6%, largely the result of a defined benefit pension plan expense increase of $19.2 million. Lahey Clinic Foundation made the decision in 2013 to freeze the defined benefit plan effective December 31, 2014. Further, costs associated with employee health insurance coverage increased by $9.0 million and included expenses associated with augmented health insurance premium employee discount rates for employee wellness initiatives.

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (a) patients for whom you are the primary care provider; (b) patients for whom you are not the primary care provider; and (c) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

(a) As described in Exhibit B responses to questions 3 and 4, Lahey Health is committed to primary care model redesign to improve quality, accessibility and integration of physical and mental health services. The well-established Lahey team and interdisciplinary approach enables top-of-license and coordinated care practices among our physicians, nurse practitioners, physician assistants, registered nurses, pharmacists, health educators, behavioral health providers and dieticians. The team approach provides comprehensive service coverage and multiple touch points for frequent communication, resulting in more engaged patients and families. Protocols for timely risk mitigation and preventative screenings further reiterate a focus on wellness. Lahey has consistently exceeded the national 90th percentile in HEDIS (Healthcare Effectiveness Data and Information Set), and providers routinely achieve recognition for timeliness of breast, cervical and colon cancer screenings, and for high-quality care of diabetic patients, as well as those with depression.

(b) The primary avenue for delivery of wellness services to individuals not managed by Lahey Health physicians is through member organization community benefit programs and initiatives, in conjunction with local providers and organizations aligned with our efforts to improve the health and quality of life for community residents. Not surprisingly, our community-based wellness efforts mirror current care delivery and population management priorities including, and include myriad programs, events and

tools, as documented online in the community benefit annual reports produced by Lahey Hospital & Medical Center and Northeast Hospital Corporation.

(c) Lahey Health colleagues share a common dedication to wellness, and have proactively implemented system wide policies and programs to create and sustain a healthy and active workforce. The wellness initiatives highlighted below demonstrate our commitment to upholding this cultural and behavioral pillar of our system:

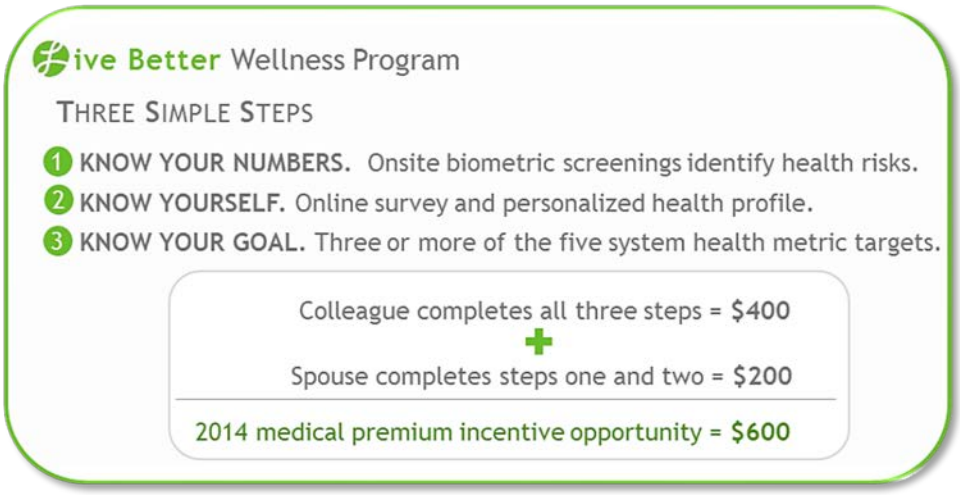
- Lahey Health has partnered with Harvard Pilgrim Health Plan to reduce insurance premiums for colleague participation in wellness screenings/survey and demonstrating reductions in risk
  - Preventative care covered @ 100%
  - No copay
  - On-site and earned time for participation
- Biometric screenings, online health behavior survey and subsequent development of personalized health plans to target wellness opportunities

Key biometric screening indicators and the five target health measures set and tracked at the system level

Biometric Indicator	Metrics and Targets
Body Mass Index (BMI)	2013 BMI = 19 - 25 **OR** 2012 BMI = 25.1-29.9 **and** 2013 BMI = at least 2.0 points lower **OR** 2012 BMI = 30.0+ **and** 2013 BMI = at least 3.0 points lower
Blood Pressure	Systolic: <140 / Diastolic: <90
Non-Fasting Cholesterol	Total cholesterol < 200 HDL > 40 (male) or > 50 (female)
Blood Sugar	Non-fasting glucose <126
Nicotine	No trace from mouth swab

- Over 4,000 Lahey Health employees completed both the biometric screen and online survey; over 4,600 employees completed the biometric screen only

Colleagues and families are engaged and supported to improve health



- Discounts for gym and fitness studio membership and direct membership payroll deductions
- On-site Weight Watchers® nutrition and fitness classes
- Sodas and high fat, high fructose foods have been replaced by healthier option in hospital cafeterias and vending machines
- Lower-cost access to health coaches
- All employees are eligible for reimbursement for participation in smoking cessation programs

Lahey Health plans to conduct a return on investment analysis for the Live Better employee wellness program in 2014.