Lawrence General Hospital

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September 27, 2013
Via email: HPC-Testimony@state.ma.us

David Seltz
Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz,

On behalf of Lawrence General Hospital, enclosed please find our written testimony to Exhibits B and C of the Health Policy Commission's letter dated August 28, 2013.

Please let me know if we can be of further assistance.

Sincerely,

Dianne J. Anderson

Dianne J. Anderson

President and Chief Executive Officer

Lawrence General Hospital

Exhibit B
Responses to Questions

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

a. What are the actions your organization has undertaken to reduce the total cost of care for your patients?

Total Medical Expense (TME) and Relative Price reported by CHIA and the OAG for Lawrence General and our community are among the lowest statewide. Therefore our actions to reduce cost have focused on keeping more care local with our lower cost community providers. We are working to reduce outmigration for care for patients in our community by adding services and bringing specialty physicians and clinics to the Hospital. For example, we have brought specialty clinics to the Hospital in pediatrics, endocrinology, and cardiology, among other specialty care. We have also formed a PHO that brings most of the physicians and physician entities in the region under one organization to manage care, and we are working to improve communication between the hospital and physicians.

We have significantly enhanced connectivity between the hospital and physician community including bidirectional lab and radiology results reporting. And we are working to improve quality and patient satisfaction. Both our patient satisfaction scores and specific new quality metrics and reporting have been a focal point of effort that has produced improved results.

b. 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?

The greatest opportunity for us lies in creating an HIE to improve interconnectivity among the community physicians and the hospital, which will pave the way for enhanced efficiency and improved quality. Limiting factors that impact our ability to address these opportunities include the challenges associated with keeping pace with the changing dynamics in the health care industry. We are working hard to develop a strong regional system, but given the financial constraints we have been operating under as a high public payer disproportionate share provider, with relative prices below the median, we have financial and infrastructure constraints. We have also found the current system of health plan product tiering confusing, and not transparent. As a high quality provider with low rates of payment the Hospital it would be natural to assume that the Hospital would be among those in the most affordable tiers. However, we are not, and cannot typically anticipate nor work

directly toward being included among the most favorable tiers because health plans are not transparent about the criteria providers must meet in order to qualify.

The lack of data available from private and government insurers also hinders our ability to act to improve quality and efficiency. In addition the proliferation of metrics used to measure quality, when improvements can take time, makes it more challenging to prioritize and hone in on particular areas of improvement opportunity.

Finally the data that health plans rely on for quality reporting lags behind current experience by longer time frames than ideal; sometimes it is data that is more than 2 years old. This disadvantages providers and fails to recognize success. Ideally, the data would be as current as possible. Providers report it readily and frequently. Health plans should be required to use the latest data available.

c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

We would like greater access to data from all payers so that we can identify opportunities to reduce cost and improve efficiency and quality. We would like policies controlling data exchange to facilitate the flow of information, and access to funding to support HIE.

We would like health plans to make more transparent for patients how their health care provider choices affects the cost of their health insurance. In particular, we would like to see cost sharing, such as deductibles, copayments and co-insurance, reflect the relative differences in price, even if it were only for those services that are offered in both community and academic medical center settings.

d. What steps are you taking to ensure that any reductions in health care costs is passed along to consumers and businesses?

While we do not have direct control over ensuring that reductions in health care costs are passed along to consumer and businesses, we are very focused on identifying care that we can provide and coordinate locally, rather than have patients access care at high cost academic medical centers, when the services are provided in our local community at substantially lower cost. Attracting physicians to ensure local access has been one key area to support this effort to reduce outmigration, and is a critical building block for success. We are bringing specialty clinics to Lawrence. We are maintaining our low cost structure, and higher quality so that we remain a Tier 1 provider with every plan possible, lowering copayments and deductibles for patients. We are working with local providers to reduce Emergency Department visits by educating non-emergent patients who visit our ER about appropriate ER use. And we are also connecting non-emergent ER patients with primary care providers if they do not have one.

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?

We have undertaken a number of initiatives including reducing non-emergent ER use, and establishing specialty clinics at the Hospital to keep care local where it is not only less expensive but is more easily accessed. We are also educating patients and physicians about the right care delivered at the right place.
We have established several readmission avoidance programs, which led us to establish a new palliative care program, and a greater reliance and relationship with the local Hospice provider that is already resulting in fewer readmissions. Through the Delivery System Transformation Initiative (DSTI) within the Commonwealth's Demonstration Waiver with CMS, we have established a number of patient transition of care enhancement programs, all aimed at improving outcomes and reducing cost. In addition, we are changing our own employee health care to reduce costs and encourage wellness. We plan to go self-insured with a tiered health insurance design in 2014 which is anticipated to reduce health care costs.

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?

a. What potential opportunities have you identified for such integration?

We have begun to identify areas of opportunity by reviewing the data for readmissions and high utilization of the emergency department. We have found that it was challenging to ascertain which patients who were admitted for acute medical issues, also had behavioral health issues. Therefore, we have begun to educate staff to recognize signs and symptoms. As a provider without an inpatient psych unit, this has been key. We have also worked closely with community providers, particularly Elder Services because depression and loneliness were identified as particularly sensitive issues for seniors, and their success post-discharge was in part dependent on their addressing these issues. We have also hired a dedicated social worker who is performing patient assessments for those patients who are identified as having behavioral health issues, and we seek to expand our access to connect these inpatients with resources on an outpatient basis.

b. What challenges have you identified in implementing such integration?

We have found there needs to be more best practice models for integration established in order to successfully integrate care. Psychiatric providers are not necessarily working in collaboration with primary care and vice versa. However,

primary care cannot bear all of the responsibility for the coordination. Massachusetts Behavioral Health Plans (MBHP), Department of Mental Health (DMH) and other outpatient psychiatric providers and services need to collaborate and design best practice models together with primary care for managing population health from this perspective.

c. What systematic or policy changes would further promote such integration?

Policy that fosters greater collaboration and sharing of patient data, as well as case managers being required to connect and collaborate with other providers. In addition, thoughtful consideration of how to remedy the long emergency department visits that occur as a result of the limited access to psychiatry and inpatient services statewide.

4. C.224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.

a. Describe your organization's efforts to promote these goals.

We have developed a physician hospital organization comprised of over 350 physicians in the community and have developed a leadership training program for local physicians to become informed and help us chart a path for success with alternative payment methods. We have instituted reporting within the PHO including leakage reporting. We have embraced P4P adoption and have added significant P4P opportunities within our contracts to help us advance future success under alternatives to fee for service. We are exploring opportunities for risk adoption and putting the building blocks in place (e.g. referral systems) that would position us to accept bundled or global payments. We have also embarked on discussions with payers about new care delivery models. We are establishing significant connectivity among providers.

b. What current factors limit your ability to promote these goals?

Inspiring physicians who have practiced independently to embrace and adapt to dynamic industry changes is one factor that slows down our ability to promote those goals and is challenging. Aligning disparate providers, when there are not immediate and clear financial incentives poses hurdles that need to be overcome. Encouraging providers to work collaboratively when they have operated in silos, without reliance on a system takes time for people to adapt.

c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

- Greater transparency at the physician, provider and consumer level surrounding costs and utilization.
- A policy initiative that arms patients with tools to make decisions about where they seek care, and concurrently uses carrots and sticks such as higher cost sharing for care accessed at higher cost providers, and lower cost sharing when care is accessed at lower cost providers.
- Consistent quality metric measurement that is universally applied

5. What metrics does your organization use to track trends in your organization's operational costs?

a. What unit(s) of analysis do you use to track cost structure (e.g. at organization, practice, and/or provider level)?

We track costs at the organizational level and at the department level. Our expense variance analysis process includes a review of costs, volume and net revenue. Through this process, we identify areas of concern and opportunity. We are currently in the process of implementing a cost accounting system. This system will significantly enhance our ability to measure performance on a service line basis. This system will significantly enhance our performance reporting capabilities.

b. How does your organization benchmark its performance on operational cost structure against peer organizations?

LGH is a member of a group purchasing organization. We review supplies and expense costs and opportunities through our participation in the GPO. We have also obtained operational metrics through other consulting engagements, including peer information on FTEs per adjusted occupied bed, and expenses per patient day. We also measure our performance against "Rating Agency" performance metrics in terms of operational performance and liquidity.

c. How does your organization manage performance on these metrics?

Each month, we complete the organization's financial statements and compare key metrics to budgeted targets as well as industry information. We distribute expense variance report to departmental leadership requiring explanations for variances. Action plans are developed to manage costs and create operational efficiency opportunities. We have also provided "lean" training for more than 96 of our staff in order to yield operational efficiencies. This past year, we hired a Director of Operations Improvement & Efficiency to continue our focus on operational efficiency. Our Annual Operating Plan has key metrics and we report on the AOP on a quarterly basis.

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.

Lawrence General Hospital is currently developing processes and evaluating tools that will allow the hospital to provide patients with cost information for health care services and procedures. These tools will require data exchange with the health plans to create estimates for each member. Currently the health plans are creating various solutions to this requirement for their members. LGH will be compiling information relating to each plan type, so we can assist our patients in accessing this information.

In order to implement a solution, the Patient Financial Services group at LGH will be coordinating an internal team to respond to these cost information requests. This team will work closely with the payers and the new tools. The current information requested by the payers to meet these requests include detail data by CPT, diagnosis codes, National Provider Identifier (NPI), expected date of service and description of service. Many patients will find this difficult to understand and will require help moving through the detail billing information. This will require training of all staff on the new process to meet the needs of our patients. Internal systems are also under evaluation to identify charge amounts for services and procedures. This will require detail review of the charge master and interface into our current estimator tools. As patients become more responsible for higher out of pocket costs this data becomes more important to our patients. In order to provide patients with accurate cost estimates, working with the health plans is critical since their systems hold this detail data.

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.

It is troubling to read these reports again this year and see that Lawrence General Hospital has extraordinarily low relative commercial rates of payment, as well as TME that is among the lowest statewide.

It is apparent that the cost drivers are still that more patients are accessing care at the higher cost providers. Eighty percent of care is delivered by providers who are paid above the median relative price, and there are no policy initiatives in place to direct consumers to make decisions that will reduce this trend. Tiered products have not reversed this trend.
Also, the market clout that was identified in 2010 as a major advantage for providers with large volumes of commercial payments, continues to advantage them, and disadvantage disproportionate share hospitals. Nearly every DSH

hospital in the August 2013 CHIA report was paid below the median, reflecting the ongoing disparity in market leverage among DSH hospitals.

Lawrence General Hospital

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 from 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.

   RESPONSE

   Refer to attached Appendix A

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 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 y our opportunities for surpluses.

   RESPONSE

   Lawrence General Hospital has not entered into any contract with a public or commercial payer for health care services that incorporates a per member per month budget against which claims costs are settled during the period 2009 to present.

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 cots or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

RESPONSE

Lawrence General Hospital does not currently participate in any risk contracts and has not for the period since 2009 as stated in Question 2 above.

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).

RESPONSE

Typically, under risk contract arrangements, health plans will utilize health status indicators and report changes in health status for their populations to providers. Since we have not been in risk contracts, we have not received these types of reports. However, we have begun exploring opportunities to receive this data and capabilities to better manage the care of our patients to achieve optimal health status.

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.

RESPONSE

Refer to attached Exhibit 1 AGO Questions to Providers and Hospitals

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.

RESPONSE

Expense Category	FY2012	FY2010	Percentage Increase	Comment
Salaries & Wages	97,148,000	84,724,351	14.7%	The increase in this category is due to additional FTEs related to both new and expanded service lines and average wage increases of 3% per year
Fringe Benefits	20,463,954	18,303,470	11.8%	The increase in this category is due to additional FTEs related to both new and expanded service lines; the increase in health insurance premiums; and moderate expansions of various employee benefit plans
Supplies and Expenses	67,218,301	55,986,180	20.1%	The increase in this category is due to outsourced labor services related to expansion of service lines; increased scopy of physician-related services; increase in cost of drugs; increasing property insurance related to an increase in fair market valuation of the Hospitals and its' assets. Another contributing factor is the overall increases in the cost of all other insurances
Depreciation & Amortization	6,397,999	5,532,725	15.6%	The increase in this category is due to more capital purchases in 2011 and 2012, which led to a higher depreciation expense (more capital purchases were made to support expanded operations)
Bad Debt Expense	-	10,926,665	-100.0%	The decrease in this category is due to an adoption in categorying principle in 2012, bad debt expense is now included within "net patient service revenue". It was included in "operating expeneses" in 2010.
Interest Expenses	217,205	139,465	55.7%	The increase in this category is due to increase in interest rates
Total	191,445,459	175,612,856	9.0%	

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.

RESPONSE

The Hospital does not employ or own physician group practices (other than a practice with less than 5 providers). Instead we have recently formed a PHO which includes 350 physicians. We envision expanding our wellness programs that are currently focused on discharged inpatients ongoing care, and community-based wellness to expand to include programs for patients who rely on our PHO primary care physicians. For our patients, we have cancer support groups, and community chronic disease support groups in connective with Elder Services of the Merrimack valley. We also have Schwartz Rounds which provides support for caregiver community at large. We also offer car seat clinics for community, bicycle safety helmet checks and awareness education, and stroke education programs for elderly.

For employees we have a number of wellness programs. They include flu shot clinics, smoking cessation, heart depot, and walking programs. We are planning to become self-insured effective January 1, 2013, and as a result are in the planning process for including additional wellness opportunities.

Attestation:

I, Dianne J. Anderson, am legally authorized and empowered to represent Lawrence General Hospital for the purposes of this testimony, and this testimony is signed under the pains and penalties of perjury.

Dianne J. Anderson

Dianne J. Anderson, RN, MS
President and Chief Executive Officer
Lawrence General Hospital

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

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 do not subject you to any "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 Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements 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.

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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.

Exhibit 1 AGO Questions to Providers and Hospitals

2009

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$13.9M	$8.9M	$356K	$218K	X	X	X	X	X	X	X	X	X	X	X
Tufts	$4.5M	$1.1M	$22K	$540K	X	X	X	X	X	X	X	X	X	X	X
HPHC	X	X	X	X	X	X	X	X	X	X	$3.9M	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$907K	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$650K	$650K	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$600K	$600K	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$600K	$600K	X	X	X
Other Commercial *	X	X	X	X	X	X	X	X	X	X	$4.5M	X	X	X	X
Total Commercial	$18.4M	$10.0M	$378K	$758K	X	X	X	X	X	X	$11.2M	$1.9M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$8.9M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$11.7M	X	X	X	X
BMC Healthnet *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$20.6M	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	$19.1M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$1.5M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$7.6M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$9.1M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$55.2M	X	X	X	X
GRAND TOTAL	$18.4M	$10.0M	$378K	$758K	X	X	X	X	X	X	$115.2M	$1.9M	X	X	X

*Note: Data for BMC HealthNet is included in Other Commercial

Exhibit 1 AGO Questions to Providers and Hospitals

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$12.9M	$9.3M	$396K	$286K	X	X	X	X	X	X	X	X	X	X	X
Tufts	$3.9M	$1.1M	$49K	$17K	X	X	X	X	X	X	X	X	X	X	X
HPHC	X	X	X	X	X	X	X	X	X	X	$3.9M	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$982K	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$550K	$550K	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$600K	$600K	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$700K	$700K	X	X	X
Other Commercial *	X	X	X	X	X	X	X	X	X	X	$10.6M	X	X	X	X
Total Commercial	$16.8M	$10.4M	$445K	$303K	X	X	X	X	X	X	$17.3M	$1.9M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$6.9M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$10.2M	X	X	X	X
BMC Healthnet *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid		X	X	X	X	X	X	X	X	X	$17.1M	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	$19.6M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$1.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$8.2M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$9.4M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$57.0M	X	X	X	X
GRAND TOTAL	$16.8M	$10.4M	$445K	$303K	X	X	X	X	X	X	$120.4M	$1.9M	X	X	X

*Note: Data for BMC HealthNet is included in Other Commercial

Exhibit 1 AGO Questions to Providers and Hospitals

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$10.9M	$9.4M	$247K	$211K	X	X	X	X	X	X	X	X	X	X	X
Tufts	X	X	X	X	X	X	X	X	X	X	$3.4M	$1.6M	X	X	X
HPHC	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$658K	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$550K	$550K	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$600K	$600K	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$950K	$950K	X	X	X
Other Commercial *	X	X	X	X	X	X	X	X	X	X	$15.1M	X	X	X	X
Total Commercial	$10.9M	$9.4M	$247K	$211K	X	X	X	X	X	X	$26.3M	$3.7M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$6.9M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$10.0M	X	X	X	X
BMC Healthnet *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$16.9M	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	$20.1M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$1.0M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$7.3M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$8.3M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$64.5M	X	X	X	X
GRAND TOTAL	$10.9M	$9.4M	$247K	$211K	X	X	X	X	X	X	$136.1M	$3.7M	X	X	X

*Note: Data for BMC HealthNet is included in Other Commercial

Exhibit 1 AGO Questions to Providers and Hospitals

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$10.0M	$8.5M	$337K	$287K	X	X	X	X	X	X	X	X	X	X	$650K
Tufts	$2.7M	$1.4M	X	X	X	X	X	X	X	X	X	X	X	X	X
HPHC	$3.8M	X	$3.8M	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$605K	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$750K	$750K	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$2.2M	$2.2K	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$750K	$750K	X	X	X
Other Commercial *	X	X	X	X	X	X	X	X	X	X	$3.7M	X	X	X	X
Total Commercial	$16.5M	$9.9M	$4.1M	$287K	X	X	X	X	X	X	$8.0M	$3.7M	X	X	$650K
Network Health	X	X	X	X	X	X	X	X	X	X	$9.1M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$13.4M	X	X	X	X
BMC Healthnet *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$22.5M	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	$20.1M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$1.1M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$8.9M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$10.0M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$70.2M	X	X	X	X
GRAND TOTAL	$16.5M	$9.9M	$4.1M	$287K	X	X	X	X	X	X	$130.8M	$3.7M	X	X	$650K

*Note: Data for BMC HealthNet is included in Other Commercial

Lawrence General Hospital

Appendix A

(Exhibit C, Question 1)

	FY2012			
	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Gross Patient Service Revenue	107,629,055	295,425,113	27,188,696	430,242,864
Cost to Charge Ratio	48.4%	48.4%	48.4%	48.4%
Total Patient Expenses	52,134,076	143,099,978	13,169,841	208,403,895
Net Patient Service Revenue	43,207,143	132,977,668	22,366,900	198,551,711
Operating Income	(8,926,933)	(10,122,310)	9,197,059	(9,852,184)

Net Revenue	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Managed Care	40,674,229			40,674,229
Non-Managed	2,532,914			2,532,914
Medicare Managed		10,018,979		10,018,979
Medicare FFS		70,164,953		70,164,953
Medicaid Managed		22,540,377		22,540,377
Medicaid FFS		20,103,786		20,103,786
Commonwealth Care		4,657,939		4,657,939
HSN		3,245,216		3,245,216
Other Government		2,246,418		2,246,418
Workmans Compensation			1,033,788	1,033,788
Self Pay			21,333,112	21,333,112
Total Net Revenue per Sch VA	43,207,143	132,977,668	22,366,900	198,551,711
Percent of Total NPSR	21.76%	66.97%	11.27%	

* Sources: D-403 Filings; Cost per Schedule II; Net Revenue per Schedule VA

** The operating income reflected in this schedule does not include incentive payments received from the Waiver

Lawrence General Hospital

Appendix A

(Exhibit C, Question 1)

	FY2011			
	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Gross Patient Service Revenue	119,985,701	278,846,823	19,428,566	418,261,090
Cost to Charge Ratio	44.7%	44.7%	44.7%	44.7%
Total Patient Expenses	53,649,841	124,682,254	8,687,197	187,019,292
Net Patient Service Revenue	50,763,972	120,374,779	14,658,248	185,796,999
Operating Income	(2,885,869)	(4,307,475)	5,971,051	(1,222,293)

Net Revenue	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Managed Care	47,013,792			47,013,792
Non-Managed	3,750,180			3,750,180
Medicare Managed		8,304,124		8,304,124
Medicare FFS		64,520,354		64,520,354
Medicaid Managed		16,955,907		16,955,907
Medicaid FFS		20,132,366		20,132,366
Commonwealth Care		3,312,141		3,312,141
HSN		6,173,268		6,173,268
Other Government		976,619		976,619
Workmans Compensation			1,288,869	1,288,869
Self Pay			13,369,379	13,369,379
Total Net Revenue per Sch VA	50,763,972	120,374,779	14,658,248	185,796,999
Percent of Total NPSR	27.32%	64.79%	7.89%	

* Sources: D-403 Filings; Cost per Schedule II; Net Revenue per Schedule VA

Lawrence General Hospital

Appendix A

(Exhibit C, Question 1)

	FY2010			
	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Gross Patient Service Revenue	110,727,690	266,705,988	17,695,330	395,129,008
Cost to Charge Ratio	44.7%	44.7%	44.7%	44.7%
Total Patient Expenses	49,495,392	119,217,854	7,909,831	176,623,077
Net Patient Service Revenue	47,134,266	112,315,627	14,926,271	174,376,164
Operating Income	(2,361,126)	(6,902,227)	7,016,440	(2,246,913)

Net Revenue	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Managed Care	43,224,562			43,224,562
Non-Managed	3,909,704			3,909,704
Medicare Managed		9,463,628		9,463,628
Medicare FFS		57,039,315		57,039,315
Medicaid Managed		17,121,849		17,121,849
Medicaid FFS		19,613,726		19,613,726
Commonwealth Care		3,280,634		3,280,634
HSN		4,955,209		4,955,209
Other Government		841,266		841,266
Workmans Compensation			1,238,669	1,238,669
Self Pay			13,687,602	13,687,602
Total Net Revenue per Sch VA	47,134,266	112,315,627	14,926,271	174,376,164
Percent of Total NPSR	27.03%	64.41%	8.56%	

* Sources: D-403 Filings; Cost per Schedule II; Net Revenue per Schedule VA

Lawrence General Hospital

Appendix A

(Exhibit C, Question 1)

	FY2009			
	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Gross Patient Service Revenue	101,885,292	254,618,154	16,263,590	372,767,036
Cost to Charge Ratio	45.8%	45.8%	45.8%	45.8%
Total Patient Expenses	46,657,889	116,601,184	7,447,834	170,706,908
Net Patient Service Revenue	42,632,817	111,562,412	14,053,862	168,249,091
Operating Income	(4,025,072)	(5,038,772)	6,606,028	(2,457,817)

Net Revenue	(a) Commercial Business	(b) Government Business	(c) All Other Business	Total
Managed Care	38,784,312			38,784,312
Non-Managed	3,848,505			3,848,505
Medicare Managed		9,063,712		9,063,712
Medicare FFS		55,223,982		55,223,982
Medicaid Managed		20,677,439		20,677,439
Medicaid FFS		19,065,737		19,065,737
Commonwealth Care		5,020,130		5,020,130
HSN		2,409,357		2,409,357
Other Government		102,055		102,055
Workmans Compensation			1,342,821	1,342,821
Self Pay			12,711,041	12,711,041
Total Net Revenue per Sch VA	42,632,817	111,562,412	14,053,862	168,249,091
Percent of Total NPSR	25.34%	66.31%	8.35%	

* Sources: D-403 Filings; Cost per Schedule II; Net Revenue per Schedule VA