SOUTHCOAST
HOSPITALS GROUP

September 5, 2014

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

Dear Mr. Seltz,

Thank you for requesting Southcoast Hospitals Group's written testimony to the questions posed by the Health Policy Commission and Office of the Attorney General in conjunction with the State's public hearings concerning the current trends in healthcare costs.

We hope our testimony is helpful to you as we continue to seek collaborative and innovative opportunities to improve healthcare in the Commonwealth. Please find attached our responses to the questions in "Exhibit B" and "Exhibit C," which as President and CEO of Southcoast Health System and Southcoast Hospitals Group, I submit under the pains and penalties of perjury. We stand ready to provide further input in necessary.

Sincerely,

Keith A. Hovan
President & CEO
Southcoast Health System & Southcoast Hospitals Group

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

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

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: Southcoast Health System employs multiple initiatives to control cost growth, including Performance Excellence Projects (PEP) targeting labor productivity, clinical resource and supply chain management. Lean and Six Sigma™ tools implementation has resulted in reduced variation in service and cost savings of approximately $40 million since 2009. Southcoast has successfully controlled costs within its own employee health plan, resulting in an estimated cost savings of $29 million over three years. These savings are passed to employees via stable health insurance premiums. As a result of increased market competition, chronic underpayment for services from state and federal programs, and anticipated future reductions in payments, Southcoast restructured and reduced the workforce in 2013 by 105 positions resulting in cost savings in the amount of $10 million.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      Southcoast Health System continues to see a decline in inpatient volume, due in part to our own efforts focused on reducing readmissions, preventing avoidable admissions and improving clinical utilization. Southcoast must adjust to changes within our market due to newly formed physician alliances. Hospital outpatient revenue continues to be strong with ancillary services and outpatient clinic/procedural volumes. Volumes in Emergency Departments (EDs) have also remained high, although we would expect to see this volume decline in coming years, along with medical inpatient, as we continue to focus our efforts on wellness programs, chronic disease management and interventions aimed at improving behavioral health services. [See Appendix A for additional information.]
   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      Since the inception of Lean and Six Sigma™ in 2009, Southcoast estimates a conservative, total cost savings in the order of $19 million by the end of this year (2014), derived from multiple iterations of the Lean practice known as Waste Walks. Six Sigma projects have contributed to clinical and non-clinical performance improvement and operational efficiencies.

      In 2014, Southcoast formed an Operational Excellence Department staffed by 2 full-time experts, certified in Lean methodologies and six sigma concepts. This Department is able to take on process improvement projects throughout the

organization, and is working to continue the engagement and training for employees who want to take an active role in improving operations. [See Appendix B for more information.]

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?
Southcoast is in the midst of several initiatives to ensure patient centered care while reducing costs. Southcoast aims to implement the Epic electronic health record platform and suite of applications throughout the Southcoast Health enterprise. Our vision: one record for each patient.

Southcoast ACO is committed to the development of a patient centric, primary care aligned care management program. Southcoast ACO will continue to deploy registered nurses into the Southcoast Physician Group's primary care offices to provide care management services. Through the use of disease registry functionality within the Epic system and by direct physician referral, both emerging and high risk patients are referred for care management services. [See Appendix C for more information.]

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
• Require insurance companies to assume the responsibility for the collection of co-pay and deductible balances rather than providers. With health insurance carriers offering a myriad of products to consumers with larger co- pay and deductible responsibilities, payors should be held responsible for collecting these payments. The Providers have not created these complex health insurance products, and should not be the ones to collect various financial obligations.

• Payors should not be able to deny payment for claims due to "technical" difficulties in obtaining prior approval – if the care was rendered to the subscriber. The provider should not be denied payment for service – for both private and government payors, including Medicare and Medicaid. [See Appendix D for more information.]

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
SUMMARY:
    a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
•Quality Performance: Due to the geographic distance between many of our practices, there are also four Medical Directors that are responsible for reviewing

and discussing the results of quality and efficiency with the providers assigned to them. One of the contracts has a direct link between quality results and the portion of surplus sharing. So the combination of a desire to improve the quality of care for our patients, with a contract model that rewards higher quality, a great deal of emphasis has been placed on improving the process and outcome metrics. SPN has improved its BC AQC quality score, by 162% since 2009. In particular, the results of the Outcome measures have been greatly enhanced. As of 2013, on the four metrics that count as triple weighted, SPN only miss the maximum on 91 test outcomes out of 3,300 outcomes required.

•Care Delivery Practices: Concerted efforts to improve access to care, with expanded but unified care delivery locations started with a three hospital merger in 1996, forming Southcoast Health System. When care is kept in the local communities like the South Coast region, it enhances not only the economics of the region but more importantly allows patients and their families to access high quality convenient services. To further enhance care delivery to patients, clinics for Diabetes and Heart Failure have been created, and the use of Nurse Practioners and Physician Assistants has been used to reduce the shortage of primary care physicians in the region.

•Referral Patterns: Southcoast has implemented a Call Center that assists providers and office staff with scheduling referrals to other providers within the SPN network. For the 9 months of June 2014 versus June 2013, there was a 14% increase in the outpatient services referred to Southcoast Hospitals from providers in Southcoast Physicians Group. The amount of services referred out of the Southcoast network in the early years of the BC AQC contract was 70%. Through education of payment differences and increased use of Doctors within our expanded physician network, the out of network percentage has changed to 30%.

•Operations: Southcoast will soon implement a major information technology system to integrate all our delivery locations into one, cross-continuum IT platform to advance efficiencies to deliver accountable and integrated care. This will improve the access to timely patient information at all of our care locations, and reduce the man hours needed to collect certain quality metrics. In addition, this will help to reduce total medical expenses in our various APMs, caused by unnecessary testing, medication errors, unnecessary admissions or emergency room visits to mention a few areas.

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

When Southcoast Physicians Network and Southcoast Hospitals Group joined the BCBS AQC contract in 2009, there was an immediate need for individuals with clinical skills to work on the quality metrics; data analysts to identify areas for improvement; accountants to identify interim payments and perform final settlements to SPN members; individuals to educate physician members on the contract; individuals to schedule network meetings and prepare presentations; and

physician champions to rally each practice location with goals on various initiatives. The added expense has only been partially offset to a small degree by infrastructure funding from the payors. It is necessary to have a substantial number of covered lives in an APM, so that infrastructure funding or surplus sharing or quality sharing is enough to offset the required expenses. At this time, internal infrastructure costs have been in the 3 million dollar range. But within the next year that will need to grow to 6 million due to the hiring of care managers and quality and data analysts to support growing number of APMS. We have not received the data files for the CMS Bundled Payment Initiative that we joined in April 2014, and as such have not incurred substantial expense on this project other than joining the Premier Collaborative that has other BPI members.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
Southcoast is in the midst of analyzing the cost of implementing all of the various services required under new and existing risk contracts risk contracts, – quality only contracts, – and bundled payment contracts. When it is completed, it will give Southcoast a better handle on the costs that will need to be negotiated as part of the APMs. One of the issues however with the CMS Medicare Shared Savings Program, is that CMS provides no infrastructure funding to assist with finding ways to reduce TME. So in essence, an organization has to outlay expenses first, before it knows if there will be any surplus to pay for those costs.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
SUMMARY: Adjustments for health status risk lack an industry standard that all payers that we contract with should follow. As a result, inefficiencies abound in the process of both understanding these elements and adhering to constantly changing algorithms. Accurately trending performance over time is affected, though at the most general level the nature of the adjustments are broadly understood.
    a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?
    The exact level at which various algorithms applied by the payers attend to the acuity level of our patients is unknown. Within a given payer, it is generally accepted that the risk factor adjustments made at the patient level are reflective of their conditions. The extent to which health factor adjustments are accurately reflected is due, in part, to our internal ability to code to the specific algorithm's standards.

    For example, CMS may look at several levels of diagnoses (e.g., primary, secondary, tertiary, etc.) in determining risk adjustment factor to be applied. Whether we consistently code in a manner appropriate to the adjustment algorithm determines whether or not the algorithm sufficiently accounts for population acuity level. The same holds true for sub-populations and/or

behavioral health conditions. This generally accepted fact hinges upon the healthcare industry's trust that the individual payers have appropriate algorithms. While we generally trust in the appropriateness of the algorithms as a matter of business, we have not had the occasion to test the validity of the algorithms.

b. How do the health status risk adjustment measures used by different payers compare?
The methodology differs by payer, and often will change even within the same payer after a period of time. This renders historical trending useless as no crosswalk methods are provided by the payers. The algorithm used by any given payer is a "black box" and there is no way to recreate the risk adjustment score or factor exactly. With no discrete knowledge of the fundamental algorithms used by each payer, it is difficult to ascertain which payer's method is preferred over another. Consistency in approach, then, is what is most desired.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?
The risk adjustment enters relevance into the determination of the percentage of premium or TME budget. The risk adjustment for able-bodies vs. disabled persons appears proportional to their TME, but this is one of our newest contracts so only time will tell if it is accurateThe risk adjustment occurs and differential treatment may be applied to those of greater risk (i.e. in greater need of treatment and care delivery), but the availability of incentives is not an interactive component to the delivery of our care to those who need it most (via risk stratification or otherwise).

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
SUMMARY: Valuable, real-time data would include full claims data, including inpatient, outpatient, ambulatory, medication and behavioral health data from all payers including MassHealth; data should be available within 30 days of claims payment, with subsequent data file transmissions including updated claims data based on adjustments since the original claim was paid. Each payer, including MassHealth, should provide reliable systems to transmit new and updated data on a monthly basis. In addition, there should be an easy means to access historical data to help manage patients who have changed health plans during the year.

   As more payors are moving to APMs, it is becoming increasing complex to manage all the disparate forms of data that are/are not available to providers. The State could assist with mandating a degree of uniformity among the payors that offer APMs to providers.
   ANSWER: Reports should be received at least on a monthly basis to be most actionable. The types of data that are most valuable include: diagnosis related groupings; primary and secondary diagnosis and procedures; health status risk adjustment; claim payments;

referring physician; CPT or HCPC codes for outpatient; emergent or urgent case designation; post acute utilization; complete prescriptions from Pharmacy Benefit Managers; complete and current demographics per patient, PCP designation or attribution model methodology. The data must reconcile to claims data and EHR clinical data.

Payor methodology to submit and receive data as well as methods of reporting on quality and total medical expenses needs to be made uniform, as providers are being overwhelmed with the ability to keep track of each payor's requirements. [See Appendix E for more information.]

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY: A favorable attribution methodology would be to require each payer to offer a means for patients to name their PCP and for the payer to store and transmit the designated PCP with claims files. It would also be desirable to have uniform standards across all payers including MassHealth.
   a. Which attribution methodologies most accurately account for patients you care for?
      The CMS MSSP attribution methodology is effective and provides a standard that all payors should be able to adopt. However, a more favorable approach would require each payor to offer reliable means for patients to name their primary care provider (PCP) and for the payer to store and transmit the designated PCP with claims files.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
      Uniform standards across all payers, including MassHealth would be highly desirable; consider use of the CMS MSSP attribution methodology as a basic approach in lieu of other alternative methods. CMS has spent incredible research time and monies developing an attribution model that we do not need to recreate.

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY: The data abstraction and reporting process is complex, requiring substantial administrative costs in human resources and/or in combination with outsourced services. Presently, Southcoast Health manages approximately 300 metrics for inpatient, outpatient and ambulatory reporting, exclusive of measures used for additional external reporting such as MHA's PatientsFirst, Leapfrog, the DPH Serious Reportable Events and the CDC's NHSN reporting requirements. While many measures are reportable to more than one entity, each entity likely has its own file formatting requirements, denominator inclusions/exclusions, time periods for reporting and methods of data submission -- all of which create extensive work to track and prepare for external reporting.
   ANSWER: The data abstraction and reporting process is complex, requiring substantial administrative costs in human resources and/or in combination with outsourced services. Presently, Southcoast Health manages approximately 300 metrics for inpatient, outpatient

and ambulatory reporting, exclusive of measures used for additional external reporting such as MHA's PatientsFirst, Leapfrog, the DPH Serious Reportable Events and the CDC's NHSN reporting requirements. While many measures are reportable to more than one entity, each entity likely has its own file formatting requirements, denominator inclusions/exclusions, time periods for reporting and methods of data submission -- all of which create extensive work to track and prepare for external reporting.

For example, CMS pneumonia measures are chart-abstracted metrics that are reportable via a 3rd party data warehouse to both CMS and to the hospital's accreditation agency; a sub-set of the same metrics are reportable to MassHealth, but the same sampling methodology may not be used as MassHealth requires 100% reporting for all MassHealth patients, whereby CMS permits patient sampling regardless of payer. Another subset of the same metrics may be reportable to any number of commercial payers, where a payer may permit the health system to report data to the payer while other payers only derive performance from the CMS HospitalCompare? website which is very dated and not reflective of recent performance to align with incentives and reportable time periods within an APM agreement.

Another example of varied reporting occurs with stroke measures for state-certified stroke centers. CMS reporting includes a set of standard measures, yet state reporting includes additional measures that require additional abstraction and a separate reporting process through a dedicated vendor identified by the state, which adds additional cost to the health system to now contract with two different data vendors for the submission of the same core data elements. The annual MassHealth RFA also creates interesting challenges in that the date of issue for a new RFA may name new quality metrics, but the reporting period for the new metrics occurs at a date prior to the effective data for the new RFA. As a result, hospitals receive an RFA with measure requirements in a pay-for-performance arrangement that have performance start dates that pre-date the agreement, offering no opportunity for hospitals to prepare and/or focus improvement efforts for the duration of the performance period. [See Appendix F for more information.]

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

   SUMMARY: Approximately 15-20% of Southcoast area patients utilize higher-cost AMCs for their inpatient care. The organization has been recruiting subspecialists to meet these needs to minimize unnecessary outmigration to Boston or Providence. Additionally, Southcoast has been developing lower cost settings outside of the hospitals to provide ambulatory and urgent care.

   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
      Southcoast annually reviews publicly available inpatient discharge data to determine patient outmigration from our service area to academic medical centers (AMCs) in Boston and Providence. These data lag by at least a year. Overall, Southcoast serves approximately 65% of the patients in its service area for

inpatient services, with another 15-20% going to local competitors, and 15-20% going to AMCs. The types of cases leaving the area are analyzed to determine which services might be provided more conveniently and cost-effectively by specialists locally. These trends have guided our recruitment efforts in a variety of medical and surgical subspecialties. While these analyses are based on publicly available data, the information is considered proprietary. Southcoast also analyzed data available from any risk contracts to determine what cases should have been admitted locally.

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

Southcoast's program development is guided by locating services in the most convenient, lower-cost community settings. Major program development efforts this year include: 1) analysis of multi-specialty ambulatory care center expansion recognizing the shift from inpatient to outpatient services; 2) development of urgent care centers to enhance access for patients who do not require expensive emergency services; 3) expanded access to inpatient behavioral health services; 4) development of specialty services and recruitment of specialists to compete with AMCs; and 5) continued development of the Southcoast Health Plan tiered network to incentivize our own employees to select lower-cost alternatives.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
SUMMARY: Southcoast is committed to a solution for post acute care that enhances quality outcomes, increases patient satisfaction and effectively manages cost.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

The Southcoast Post Acute Care Program was developed to maximize resources in a team-based approach, to deliver high quality post acute care in a timely manner and to achieve efficient movement of patients across the continuum. In February 2011, an in-depth analysis of post acute care options for Skilled Nursing Facilities (SNF) was initiated. A survey of 36 SNFs in the core market of Wareham, New Bedford and Fall River was conducted. Upon receiving the responses from the SNFs, a site visit was then performed. Factors considered included quality performance and customer satisfaction scores as evidenced by Department of Public Health standards, implementation of the Interact II Program, clinical capabilities, RN staffing, and technology. To date, there are nine SNFs participating in this program.

Southcoast has evaluated acute rehabilitation sites located within a 25 mile radius. Limited IRF (Inpatient Rehabilitation Facility) and LTACH (Long Term Acute

Care Hospital) options were identified in this market. Southeast Rehabilitation Center, a licensed 32-bed Inpatient Rehabilitation Facility (IRF) is located at Southcoast's Charlton site. Southcoast is beginning the evaluation of the clinical effectiveness of the post acute care program by reviewing clinical outcomes and hospital readmissions.

b. How does your organization ensure optimal use of post-acute care?
The team based model of the Post Acute Care Program includes a physician lead, supported by a nurse practitioner and a liaison. The Post Acute Liaison promotes linkages to Southcoast's three hospital sites, VNA and Physician Network.

Weekly meetings are held at the nine SNFs. Focused discussions on clinical, quality, readmission and interventions are reviewed. Staff education and specialty program development linked to the hospital promotes service alignment. To optimize use of the Post Acute Care Program, communication and education have been initiated with case management, hospitalists, emergency departments and VNA constituents.

There has been ongoing communication with Providers affiliated with Southcoast Physicians Network and Southcoast Physicians Group. Communication continues to be an area of opportunity for enhancement to optimize outcomes and improve transitions in care.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: Southcoast established a committee to review the new law created by Chapter 224. Southcoast uses a Cost Estimator tool to meet the needs of the patient. Southcoast has worked with payors and the Massachusetts Hospital Association 9MHA(MHA) to review other online web tools for the Cost Estimator.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**	0	0	0
	Q2	0	0	0
	Q3	0	0	0
	TOTAL:	0	0	

** Please indicate the unit of time reported.*

ANSWER: Southcoast:

a. Provides estimates upon request: The current patient estimator tool in place is able to accommodate most requests. For other requests, Southcoast uses the permitted number of two working days to research internal data in order to provide an estimate, even if the result is an estimated maximum for the requested service.

b. Provides third party payor contact information as needed: Southcoast can provide contact information for most, significant third party payors. If necessary, Southcoast will assist the patient by researching other payors. Patients normally ask for this information to determine their out of pocket expenses when there is a deductible or co-insurance involved with their plan.

c. Southcoast has not tracked the number of inquiries received, in order tocomplete the grid provided. By observation, Southcoast receives very few inquiries. When inquiries are received, a response is typically generated on the day of the call.

d. Southcoast feels that having both payors and providers trying to supply pricing data is duplicative, sometimes contradictory in amounts and adding administrative costs to providers. Payors should be the sole source of this information, as they are aware of the benefit structure that the particular patient has selected.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: The introduction of tiered and limited network products prevents patient choice and restricts providers to refer to certain facilities. The inherent nature of these product impacts our volume by steering patients to other facilities either through tier placement or by network exclusion entirely. Since Chapter 224 requires these products be priced at a minimum discount from a standard health plan, we anticipate future negotiations with payors will be impacted if they request rate concessions to meet the requirement. The launch of a limited network plan in our direct market has brought on additional challenges. Providers are becoming much more competitive with each other as illustrated by our own tiered network for employees and area employers.
ANSWER: Southcoast's three hospitals are ranked in the middle tier for all MA commercial tiered products based on meeting quality benchmarks and scoring as moderate for cost. The ranking of our physician network varies by insurance product. With the evolution of tiered products based on quality and cost measures, Southcoast made a conscious effort to focus on meeting or exceeding quality metrics and putting patient care first, and we have succeeded. To further improve the ranking of Southcoast's three hospitals, we recognize the need to focus on cost, yet we are not provided with any data from the carriers to substantiate our tier placement as moderate cost. Transparency is lacking for both quality and cost results. If the insurers would provide information on

where Southcoast ranks on specific quality or cost measures and/or provide us with the results of our data we would have the ability to identify improvement opportunities and would be better positioned to determine the tactics to employ to improve our tier status. [See Appendix G for more information.]

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
SUMMARY: Southcoast seeks creative ways to manage costs and proactively manage the health of individuals who are predicted to be higher users of acute care and emergency services. St. Luke's Hospital emergency department has a volume of 73,000 visits annually, making it among the busiest community hospital EDs in Massachusetts.
Of the patients cared for at SHS, 18.7% have a mental health or substance abuse disorder, and 51.1% are chronically ill, disabled or elderly. Patients with mental health disorders (MHDs) use the ED for acute psychiatric emergencies, for injuries and illnesses complicated by, or related to, their MHD, or when psychiatric or primary care options are inaccessible or unavailable. Southcoast seeks to reduce ED utilization of behavioral patients by enhancing staff capcities, collaborating with community-based providers, analyzing utiliization data, and improving efficiency.
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
    Southcoast strives to develop an integrated community of care, which requires the involvement and ongoing partnership with community-based groups and community health center providers. Recent strategic initiatives have focused on collaborating for excellence, transforming care through integration, driving value, and strengthening the community through innovation.

    Southcoast is currently working to establish a web-based tool that will facilitate access to community supports and resources focused on behavioral health and substance abuse. This project will result in a behavioral health gap analysis and asset map, as well as a number of new Memoranda of Understanding (MOUs) and similar agreements with service providers throughout the Greater New Bedford area. [See Appendix H for more information.]
    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.
    In a recent meeting of the Southcoast Health System (SHS) Board of Directors, the issue of behavioral health was present in every dialogue and every concern relating to managing patients. The Patient and Family Advisory Committee (PFAC) has advocated for better care coordination via the Emergency Department (ED) for several years. Southcoast has responded to the concerns voiced by both the Board of Directors and PFAC through implementation of a plan to develop a

safety net of care for behavioral health and to proactively manage behavioral health in the ED. [See Appendix I for more information.]

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
To better meet the needs of behavioral health and substance abuse patients requiring outpatient care and support, Southcoast has improved coordination of community resources, improved the efficiency of care for behavioral health patients presenting at the ED, and created an implementation plan for an outpatient medication management clinic. This combination of activities will offer behavioral health patients continuity of care and easier access to clinical and community-based resources (e.g., transportation assistance). It is believed that, over time, this multi-faceted approach will help decompress the pressure on the ED to care for these patients who could be more effectively served through other supports. [See Appendix J for more information.]

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.
Southcoast will share data that is blinded to protect patient confidentiality in an effort to improve quality services and outcomes for our patient populations.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: Southcoast Health Primary Care Center has set out on the journey of seeking National Committee for Quality Assurance (NCQA) accreditation for all primary care practices within the Southcoast Physicians Group (SPG) as well as the Southcoast Physician Network (SPN). The organization started its journey by identifying three pilot practice sites. These practice sites began their PCMH transformation in December 2013 and have actively engaged over the last 8 months utilizing the NCQA 2011 guidelines. The pilot practices are due to submit an application for accreditation to NCQA by the end of month of August 2014. [See Appendix K for more information.]

    a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
    Southcoast Health is submitting its first application for NCQA Level III accreditation for Patient Centered Medical Home (PCMH) August 2014.

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

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

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY: Southcoast's strategic initiatives related to value based purchasing, cost-effectiveness, alternative payment methodologies and transparency correlate with recent HPC analysis of cost trends.

The Commission's 2013 Cost Trends Report findings promote value-based markets; promote efficient high quality delivery systems; advance the implementation of alternative payment methods; and enhance transparency and data availability. These are all efforts that Southcoast has embraced. As outlined below, Southcoast is at various stages of implementation and success with these four findings. Some efforts will take longer to achieve due to the magnitude of the internal and external changes that need to take place, but others have already been in place for over a decade.
ANSWER: Southcoast brings value to our area communities by constantly evaluating our services, quality, patient satisfaction and cost of care. The Medicare program has deemed Southcoast as being effective in giving value for services as denoted by our positive results on the Value Based Purchasing Program. This includes AMI, Surgical Infections, Heart Failure, and Pneumonia results that have all gradually improved over the last few years. Southcoast has also developed its own programs specifically for the most critical health care needs of our communities, such as a diabetes management , heart failure clinics, smoking cessation programs and urgent care centers.

Due to Southcoast's own very favorable health plan results, Southcoast created a health care product for local businesses. The product is a winner on three fronts, as it keeps care local, reduces costs for businesses, and improves the health of employees and their families.
Southcoast leadership is also committed to improving the patient experience results, as evidenced by the hiring of a Chief Experience Officer to lead the system in such efforts. Not all projects are focused around a financial return; some have been developed specifically to address the needs of our communities, including the monthly local farm food markets where healthy fruits and vegetables are sold in order to promote healthy lifestyles.
Efficient, high-quality delivery system

During the last year, Southcoast has implemented many Performance Excellence Plans to drive down the cost of providing care. These efforts have reached into every branch of our organization, from billing to supplies to labor productivity. Due to the proposed reimbursement cutbacks in the Medicare program, Southcoast needs to continue to find more potential efficiencies in the delivery of care.

In regards to high quality, Southcoast has brought some of the most talented primary and specialty care physicians to the region, to reduce outmigration to expensive teaching facilities in Boston and Providence. In addition, as recently announced, Southcoast is working with Acadia Healthcare to bring more expansive behavioral health services to the Southcoast region. Through this effort, Southcoast will reduce the number of patients

waiting in the emergency department in need of behavioral health care, and providing timelier access to inpatient and outpatient psychiatric care. [See Appendix L for more information.]

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 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 Hospital 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.

   Completed in Attachment AGO Hospital Exhibit 1

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2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital Exhibit 2 with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

   Completed in Attachment AGO Hospital Exhibit 2

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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 whether you consider the risk you bear to be significant.

   For any new risk contract at Southcoast, only upside risk is assumed until such time as a sufficient amount of reserves are set aside in case of a deficit situation. In the case of a deficit, Southcoast limits the amount of exposure through the use of maximum deficit limits. Southcoast utilizes stop- loss coverage within each contract to limit the out of pocket maximum cost for claims using specific and aggregate levels. Southcoast maintains fiduciary responsibility to only enter into contracts where substantial protection exists. Therefore, whether the contract covers commercial or government business, the need to establish and maintain reserves does not change. [See Appendix M for more information.]

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4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from

those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

Southcoast captures data upon admission regarding the PCP of record; attending physician; and performing physician. In this manner Southcoast can track the admissions source. This data is reviewed for providers within our network, so to minimize out migration and to keep total medical expense low. In addition Southcoast reviews the clinical out migration data, to evaluate if there is a substantial clinical need in our communities.

Appendix A

Internally, and in response to our volume changes, we have continued to work on multiple fronts to improve our current cost structure. Improvements in labor costs have been achieved through productivity benchmarking against industry-defined performance standards and a reduction in force that occurred at the end of fiscal year 2013. We have been successful in reducing our inpatient length -of-stay through progression of care rounds and multi-disciplinary focus. The implementation of computerized order entry and physician leadership support has allowed for decreased utilization for non evidence-based tests and treatments.

Additionally, in 2013, Southcoast formed a new team titled Personal Responsibility in Delivering Excellence (PRIDE) In Process. The PRIDE In Process team is comprised of front line staff and leaders that bring ideas and energy together to review operational improvement projects for the Southcoast Health system. The ideas have come from a variety of sources: An on-line process where all staff are able to submit improvement ideas and suggestions, and ideas identified during Leadership rounding and ideas that come directly from the PRIDE In Process Team. The PRIDE In Process team will review all ideas generated, and help to implement any viable changes.

Southcoast has engaged consultants to lead multiple, simultaneous performance improvement projects known as PEPs in effort to control operating costs. The PEP efforts launched in FY13, were scheduled to continue for approximately two years and will conclude in 2014. Current focus areas include: labor productivity, revenue cycle improvements, maximizing value from supplier contracts, length of stay and clinical effectiveness. In FY14, Southcoast expects to yield net financial improvements of $54 million. Examples of PEP projects:

Labor Productivity:

- Implementation of system-wide productivity to align staffing with volumes resulting in a reduced staffing cost structure
- Formation of a system-wide vacancy management review process to promote efficient hiring practices and to evaluate the necessity of proposed new hires or replacement positions
- Implementation of a labor management productivity system to monitor system-wide productivity performance at a departmental level.

Non-Labor/Supply Chain:

- Implementation of a system-wide cost reduction initiative in the areas of purchased services and clinical supplies through improved pricing and utilization practices.
- Development of a monitoring process for implemented initiatives to monitor and evaluate purchasing spend against targets

Clinical Effectiveness

- Implementation of an improved process for inpatient cases to lower overall unnecessary length-of-stay.
- Development of improved clinical practices and protocols for management of high cost cases (e.g. COPD and CHF) focusing on reducing readmissions and preventing avoidable high cost services.
- Development of physician and operational scorecards to monitor performance and address significant variations in clinical practice patterns.

Revenue Integrity

- Implementation of tools and processes to monitor and evaluate charge capture and clinical documentation practices

Appendix C

Through the use of disease registry functionality within the Epic system and by direct physician referral both emerging risk and high risk patients are identified and referred for care management services. Care managers work with the patient and other members of the healthcare team to formalize an individualized, goal directed plan of care designed to ensure efficient, effective and satisfying healthcare experience for the patient. Care management activities will fulfill the patient care planning requirement necessary earn NQCA Patient Centered Medical Home recognition. Southcoast has committed to implement the NQCA patient centered medical home system of care at 16 primary care sites with 54 practice primary care physicians over the next two years.

Epic offers a multitude of benefits that span across the continuum of care settings including:

- Ambulatory Primary Care
- Specialty Care
- Urgent Care
- Home Care
- Post-Acute Care
- Emergency Department
- In-Patient
- Critical Care
- Operative Care
- Laboratory/Pathology Services
- Pharmacy Services
- Imaging
- Non-Invasive and Invasive Testing and Procedural care
- Patient Access and Revenue
- Patient Portal

Patient Engagement

Epic provides the ability to engage patients through the use of a robust patient portal.. Epic facilitates patient engagement by allowing patients to be more up close and personal with their own health records, providing a platform for interactive participation in their own medical care. Improved patient engagement will improve patient compliance with treatment, which will improve quality outcomes and reduce costs.

Health Information Exchange

Through the use of the “Care Everywhere, Care Elsewhere” tool, Southcoast will have the ability to share information with providers outside the Southcoast Health network. This robust Health Information Exchange platform will narrow the communication gap when patient care is provided over multiple health systems. Timely information improves outcomes, utilization and costs.

Dashboards and KPI’s

Epic provides the ability to capture and view an outstanding set of reports that will improve our ability to analyze and improve service line operations, utilization and cost. Each user of the system will have customized dashboards with real-time data to view key performance indicators that are pertinent to their scope of work. The functionality of the Dashboards will evolve, with performance capabilities increasing over time as Clinical and Administrative users evaluate their requirements and become familiar with the specific functionality they need from the system.

Informatics

With the technology to collect and document data in a comprehensive and standardized fashion, Southcoast recognizes that a disciplined data governance infrastructure must exist to ensure the integrity and validity of the data. Therefore, Southcoast Informatics established an enterprise data governance team to oversee the principles associated with defining, collecting, auditing, monitoring and sharing of the data that flows across the health system. With clean and reliable data, Informatics is able to provide Southcoast Health the service of complex analytics to improve health outcomes and lower health costs.

Steps to Reduce Clinical Errors

The biggest effort underway right now is our recent implementation of computerized, physician order entry for all inpatient and emergency department patient care locations, use of standardized order sets, and the conversion and initial implementation of Epic as our new electronic health record information system. Epic provides one record for each patient regardless of the number of locations within Southcoast where care could be delivered. This integrated approach provides insight into all aspects of a patient's care to reduce redundancy and improve provider to provider communications; patient-provider communications are also enhanced with Epic's technology.

- Medications are bar coded at the bedside prior to administration to ensure safety and accuracy for the right patient, at the right time, with the right medication.
- Southcoast purchased NICOM devices to provide non-invasive, continuous fluid monitoring for patients with sepsis and for patients receiving specialty dialysis needs (CVVH) to better protect patients from fluid overload.
- Southcoast has also implemented patient bedside nurse to nurse hand off and also progression of care rounds, to improved continuity and communications between care givers.
- Southcoast has implemented bar code technology to assure correct blood type of the patient.
- Applied the use of a back up system for cardiac (telemetry) monitoring which messages remotely to the nurse if there is a problem.
- Southcoast provides a patient call back system to be sure that everything is understood at the time of discharge.
- Southcoast has implemented a standardized communication methodology called SBAR (Situation, Background, Assessment, Plan)
- Southcoast uses a template for prioritization that is added to the paging system so that staff can indicate the level of concern when paging providers.

- Southcoast provides the use of electronic handcuffs between Hospitalists which ensures that vital information is consistently communicated between Hospitalists.
- Southcoast has a catheter removal protocol and post removal algorithm which cut down on the use of catheters and reduces hospital acquired urinary tract infections associated with catheters.
- Multidisciplinary Rounds applies a team approach to developing, implementing**,** and evaluating patient care plans.

Diabetes Intervention to Reduce Cost

Background

Diabetes affects the Southcoast region disproportionately compared to Massachusetts. In 2010, the prevalence of diabetes in adults in Fall River was 13.8% and in New Bedford 12.3% compared to the state average of 7.5% (Source: BRFSS, via MassCHIP as reported in the SCH Community Needs Assessment, 2013).

Diabetes contributes significantly to the development of heart disease, kidney failure, blindness, non-traumatic amputations, depression and neuropathy as well as pre-mature death. While mortality rates for heart disease and diabetes have decreased from 1999 to 2010 throughout the southcoast region and statewide, the southcoast region has a higher mortality rate than the rest of the state.* (see below).

Deaths per 100,000, 1999-2010

Fall River	27.3 - 20.5*
New Bedford	21.6 - 16.1*
Wareham	37.6 - 12.9
State	19.5 – 13.2

(Source: MADPH, MassCHIP age adjusted rates, as reported in the SCH Community Needs Assessment, 2013)

Interventions

Southcoast aims to reduce healthcare costs to by decreasing preventable admissions and readmissions to hospital, emergency department visits, and providing care in the right location at the right time using the appropriate resources necessary to achieve quality care.

To that end, Southcoast have highly skilled professionals available to assist patients with diabetes management and education. Our *Diabetes Prevention and Management Program*, "Recognized by the American Diabetes Association" since 2002, has certified diabetes educators (nurses, dietitians and an exercise physiologist) who provide education to adult persons with both new onset and established diabetes (includes type 1, type 2, diabetes and pregnancy) using the latest technology (e.g. professional and personal continuous glucose monitoring devices, insulin pumps etc). The program is individualized, designed to empower patients with actionable knowledge, using coaching and behavior change strategies to self-manage their condition and prevent/delay the onset of complications. The program has demonstrated an average of 1%-2% decrease in HgA1c (ADA target < 7%) pre and post program completion.

To improve patient access to diabetes education/management, the diabetes program is in the process of providing services directly within selected physician practices. In the short term,

(CHART Grant Phase 1) this strategy has decreased no-show rates (47% to 10% in 2.5 months) as well as increase the numbers of patients referred for diabetes education. This close affiliation has further facilitated collaboration amongst the diabetes educators, care managers and the primary care physicians in a team based model of care for complex patients.

Four physician practices have indicated their interest in Shared Medical Appointments and are planned for launch in 2015. A pilot program at a large primary care practice has been well received by both patients and providers. These models of care have improved patient access to service, enhanced clinical outcomes, advanced peer support, shared learning and patient satisfaction.

Furthermore, studies have demonstrated that through the use of evidence based clinical protocols, patients can achieve target glycemic goals earlier than the standard process. Southcoast plans to use clinical protocols by the diabetes team to more proactively advance therapies to improve patient safety and quality of care (e.g. initiation and titration of insulin, oral medications).

In addition, we have participated in two grant opportunities (BCBSMA and CHART Grant Phase 1) that allowed us to develop a "diabetes community health worker (CHW) program" that links the primary care physicians to the CHWs. These CHWs have received over 50 hours of diabetes education by the diabetes team. The CHW's meet regularly with the primary care physicians and the team to identify and reduce barriers to care. To date, in the combined programs, the CHWs have provided care for 90 patients since February 20th, 2014 that has demonstrated improvements in patient adherence to recommended therapies, clinical outcomes and improved patient engagement. Preliminary findings have further demonstrated that the diabetes education effects are potentiated with the use of CHWs to support behavior change strategies between medical visits. A cost savings analysis is pending.

The Glycemic Management Steering Committee was established in 2013, co-chaired by the Diabetes Medical Director (Board certified endocrinologist, Dr Beatriz DeMoranville) and the Diabetes Management Program Director (Jennifer Pritchard, RN, Certified Diabetes Educator). The committee meets monthly and is comprised of a multidisciplinary team who review and analyze glycemic metrics, provide clinical expertise for program development, identify opportunities for improvement, drive and evaluate performance improvement initiatives within the system.

The inpatient program has a physician assistant (Charlton) and a hospitalist (St Luke's) whose clinical focus is dedicated to treating patients with glycemic management issues. Each provider runs a daily 24 hour glucose report to pro-actively identify patients with blood glucose values < 70 mg/dL or > 225 mg/dL. This report allows the providers to reach out to the attending physicians to assist with management and improve outcomes. Charlton Memorial Hospital has consistently remained in the first quartile of performance compared to peers within the RALS Data Report (Roche AccuChek Glucometer POC Testing with over 200+ hospitals in the database).

Additional education for the hospitalists at all three hospitals is scheduled for FY2015 using our newly appointed Diabetes Medical Director to facilitate learning. With the national shortage of endocrinologists, specialized training of the hospitalists in glycemic management is critical to the successful management of patients with diabetes to reduce morbidity, mortality and associated costs. The Cleveland Clinic Diabetes Management Mentor program has been initiated at Tobey Hospital (under the CHART Grant) to engage staff nurses in diabetes management practices. Each unit has identified a nurse champion who has received a minimum of 16 hours of intensive diabetes education and who will be required to mentor their peers each month with a new initiative supported by the diabetes management team. This model has demonstrated improved clinician knowledge, reduced hypoglycemic events and improved quality of care.

- Require payors to provide claims data to hospitals and physician groups, whether or not the claims are part of a risk-sharing contract. Efforts to reduce variation and standardize treatment are somewhat hindered by the lack of access to payor claims data to identify utilization trends from non-shared risk plans. Access and use of claims data would enable the ability to promote cost efficiency and quality improvements.

- There is a significant need to improve care transitions and access to care for mental, behavioral and substance abuse health on a daily basis, including weekends and holidays.

- Access to additional funding sources through the Health Policy Commission and other state agencies, such as the Community Hospital Acceleration, Revitalization and Transformation Investment Program (CHART), promote wellness and provide for improved care transitions, efficient care management and access to care for mental, and behavioral and substance abuse health on a daily basis, including weekends and holidays.
- Promote and facilitate more community/regional partnerships to meet patient needs at the local level.

- Explore options for making payor mix data publicly available for Providers.

- Expand state-wide higher education collaborations to ensure that future healthcare workforce needs are met with healthcare workers educated on both the clinical and operational side of healthcare, post-reform. Assess and resolve challenges and barriers that contribute to the health care skills gap, including access to nursing programs, educational financing, and career ladders.

Appendix E

- Standardized quality metrics per population i.e. Medicare vs. Medicaid vs. Commercial that have common definitions for inclusions or exclusions in the numerators and denominators.
- Standardized ability to appeal numerators and denominators, which is not true with all payors.
- Standardized quality thresholds i.e. should diabetes HbA1c be less than 8.0 or 9.0
- Standardized quality starting periods and submission periods for data i.e. not all on calendar year basis start date, and some submit quarterly while others are reported annually.
- Quality measurement that provides credit for incremental improvement rather an all or none outcome frequently used.
- Use of a clearinghouse for data submission to payors.
- Standardization of total medical expense i.e. should it include behavioral health claims or out of network claims.
- Standardization of chronically ill patient reports to assist providers with population health management i.e. reports on Diabetes, CHF, AMI populations,
- Availability of free standardized reports from the All Payor Claims Database regarding population health against national or statewide thresholds.
- Standardization of payors using HL7 formatting for data transfers.
- Data provided to the providers rather than posting on individual payor's websites.
- Standardization of clinical thresholds; e.g. HbA1c ≤ 9 or ≤ 8.

Appendix F

A final example of administrative burden occurred when a commercial payer in Massachusetts established transition in care report requirements in its pay-for-reporting agreement with hospitals, while MassHealth nearly simultaneously required transition of care report requirements, and both sets of requirements were not the same. As a result, hospitals were forced to find means to combine all requirements into one transition report, or duplicate efforts and provide a transition in care report only to discharged inpatients in the commercial plan, and a separate report used solely for MassHealth patients. Since that time, CMS now requires summary of care requirements under its Hospital Conditions for Participation and separately (and differently) under its Meaningful Use program for EHR incentives with still different and additional requirements than the MassHealth current requirements. Data gathering would be easier for providers if Medicaid MCO's could be required to follow the same metrics as MassHealth, and Medicare MCO's the same metrics as Medicaid.

Appendix G

Southcoast's three hospitals are ranked in the middle tier for all MA commercial tiered products based on meeting quality benchmarks and scoring as moderate for cost. The ranking of our physician network varies by insurance product. With the evolution of tiered products based on quality and cost measures, Southcoast made a conscious effort to focus on meeting or exceeding quality metrics and putting patient care first, and we have succeeded. To further improve the ranking of Southcoast's three hospitals, we recognize the need to focus on cost, yet we are not provided with any data from the carriers to substantiate our tier placement as moderate cost. Transparency is lacking for both quality and cost results. If the insurers would provide information on where Southcoast ranks on specific quality or cost measures and/or provide us with the results of our data we would have the ability to identify improvement opportunities and would be better positioned to determine the tactics to employ to improve our tier status.

As required by Chapter 224, insurers are implementing alternative payment strategies that reward hospitals for improved quality and lower total cost of care. However, this payment mechanism is having an unintended consequence with respect to the cost rankings within the tiered network products. If a hospital improves quality and reduces total cost of care, then the reimbursement earned for that success is added into the cost structure of the hospital system. This results in the hospital appearing less cost effective, potentially resulting in a lower tier placement when in fact the hospital has achieved exactly what payment reform is trying to accomplish.

Another challenge for Southcoast with the structure of tiered products occurs when the Southcoast physician network is placed in a different tier than our facilities. This causes member confusion on how to best access services. If the physicians are in a higher cost tier, then patients will not be incented to use them, limiting referrals back into our facility even when it is in a more favorable tier. Tiered products also create member confusion when there is a misperception that facilities in a more costly tier are not covered at all. Our providers are also frustrated when they are placed in one tier by one carrier and then they have a different ranking within another carriers' product. Again supporting and transparent data is not available to defend or correct the situation. The misalignment is particularly frustrating if the opportunity to change tier position within an insurer's product is restricted to an annual or even less frequent review. The cycle for tiering currently varies by insurer.

Another challenge is that our pricing with payors must offset a substantial level of Medicare, Medicaid, and Free Care. So it is only natural that SHG's rates would need to be higher than a hospital with minimal payor mix. This fact is missed when data is produced which shows SHG or others as high cost.

Having a limited network product anchored by a hospital right in our backyard has impacted our business, particularly for outpatient services. The physician incentives within a limited network product have been designed to have the provider refer only within that hospital or small network of hospitals even if these providers have admitting privileges at Southcoast. If the limited network product is the only health plan choice for an employee in our region, then we have been excluded as an option for care even when our quality and breadth of services compares to that of

many academic/tertiary medical centers in the state. The market threat of local limited network products has resulted in Southcoast becoming more aggressive in our own provider referral patterns to protect our volume. In addition, we have had to take a defensive posture to consider partnering with payors and providers to develop our own limited or high performing tiered network to prevent further leakage of services and reductions in our commercial payor mix.

Appendix H

The web based community asset map will yield specific pathway protocols for behavioral health patients who present at the Emergency Department to ensure that the supports and connections are leveraged for the benefit of patients and their families.

Outcomes are expected to result in improved connectivity between Southcoast, behavioral health providers and community and public health agencies, as well as series of pathway protocols at Southcoast and partner community health centers to ensure that new and established connections are fully leveraged to provide support for behavioral health patients and their families. Southcoast will develop and communicate alternative methods of care delivery using Lean and Six Sigma methods to eliminate waste and improve performance and efficiency, and will conduct asset mapping to identify areas where partner organizations may not have the services needed by the patient population, and will seek out additional behavioral health partners as needed.

The process of creating the asset map can have a positive effect in engaging South Coast providers and community members in a regional effort. Additionally, a comprehensive asset mapping process will lead to a deeper understanding of the ways in which the Southcoast institutions interact with each other and with entities outside of the region. With a new perspective on well-established institutions, hospital administrators can more accurately assess Southcoast's current role and contributions. Southcoast's Behavioral Health leadership team will also identify ways in which to strengthen institutions, build linkages between them, and, ultimately, improve the system of care.

Appendix I

Recent strategic planning initiatives include Southcoast's committment to providing a behavioral health/ medication management clinic as an outpatient alternative to acute care and inpatient services. Southcoast and its partners have the capacity to provide the capital and facility space to house such a clinic. Ongoing strategic planning initiatives include the close examination of the needs of patients and the status of the behavioral health support available in the community. Southcoast has developed a plan for developing this outpatient behavioral health clinic to alleviate the strain on the ED and better support behavioral health patients with consistent, accessible care. Our goal in 2014 is to reduce (ED) length of stay for behavioral health and substance abuse patients requiring outpatient referrals. To date, Southcoast has achieved a 25% reduction in ED length of stay for behavioral health and substance abuse patients.

Appendix J

There are a number of community-based social services that could provide resources to patients and to the families of these patients, including the faith-based community. There simply is not an effective, efficient method for accessing these resources for Southcoast patients at the present time.

ED clinicians have identified the need for a better solution for behavioral health care coordination, and the teams working on behavioral health issues in the community are ready to engage in a shared effort to identify solutions. Southcoast uses a contractual intermediary to refer patients to inpatient behavioral health resources, so new protocols relating to the use of social services and other outpatient care settings will need to reflect the protocols of these intermediaries to assure that patients who require inpatient care receive it. Southcoast will ensure that the protocols also adhere to the Emergency Medical Treatment and Active Labor Act (EMTALA) and other applicable federal and state law and regulations. Southcoast will work closely with legal counsel to mitigate this risk, but will also continue ongoing initiatives to ensure EMTALA compliance. These include: Provider re-education; Use of a check list, with another person providing a double check; and individual provider counseling if EMTALA is found to be out of compliance.

Southcoast efforts achieve cost avoidance by redirecting behavioral health patients to outpatient and community-based resources rather than utilizing the ED for care, and improve efficiency by designing care pathways, workflows and care delivery protocols that leverage external resources and encourage the highest and best use of hospital resources. Behavioral health intersects with much other comorbidity, and addressing a patient's behavioral health needs can improve self-care and promote patient activation. In addition, the resources and pathway protocols developed will help to inform the targeting of behavioral health and case management services through the Southcoast ACO after the full implementation of AthenaClarity and the Epic software platforms. The cost savings yielded by this investment will justify future spending to continue the outreach and improvements (i.e. FTEs).

Appendix K

Southcoast's goal is not only to seek accreditation by a nationally recognized body, but to also, engage the physician practice care team in patient and family centeredness in a way that proactively and preventively manages health care needs for all populations. Early on in this process, with the deployment of Care Management within the physician practice, identification of patients in need of long-term care planning has contributed positively to the overall quality of care being delivered to our patients. While it's too early to quantify, the PCMH model has increased patient engagement, engaged the Care Team in providing patient and family centered care, increased collaboration of partnerships with the community and increased overall quality of care, all in an effort to meet the Triple Aim goals.

Appendix L

Alternative payment methods

In 2012, Southcoast Health System created the Southcoast Accountable Care Organization in order to apply for the Medicare Shared Savings Program (MSSP). This program has a two-prong approach in that a participating organization must achieve a certain level of quality reporting/performance before it can share in any Total Medical Expense savings. Southcoast is in its second year of the MSSP, and has just received CMS data that it can use to reduce unnecessary costs and develop care plans for patients with the highest comorbidity. In addition, in 2014 Southcoast was accepted for the CMS Bundled Payment Initiative (BPI) which also focuses on driving down the cost of service provided within specific DRGs, and then surplus sharing beyond the target. This program will begin in 2015, after Southcoast has had the opportunity to review its costs and target price data. In addition, Southcoast has also entered into a surplus sharing arrangement with a Medicaid Managed Care Organization (MCO) which also focuses on the Triple AIM goals of access, affordability, and quality. This will also provide critical infrastructure to help defray the added expense of clinicians and analysts. All three of these new contracts--the MSSP, BPI, and MCO--illustrate that Southcoast is seriously trying to control health care costs of our populations.

Transparency and data availability

Southcoast has paid careful attention to our standing in terms of prices and quality results. At this time, Southcoast is placed in the middle of the array of health care acute providers in Massachusetts. Given the high proportion of Medicare and Medicaid beneficiaries in our region, Southcoast has performed well at maintaining market-competitive pricing while mitigating the deficits associated with the governmental rates that are less than the cost of care. Given our pricing position in the marketplace, our physicians are of the opinion that the Southcoast Hospitals are a fair partner in risk arrangements. In fact, Southcoast has decreased rates in several outpatient areas to remain even more competitive with freestanding locations.

Additionally, Southcoast ranked highly in terms of quality results as demonstrated by the awards received from reputable Healthgrades. Most of these awards have been received over multiple years, and are not a one-time occurrence:

Southcoast has three services that are on the 100 Best U.S. Hospitals List: Cardiac Care; Cardiac Surgery, Prostatectomy

Southcoast has been ranked in the Top 5% of U.S. Hospitals in six different areas of care: Bariatric Surgery; Coronary Interventional; Prostate Surgery; Pulmonary Care; Stroke Care; and Women's Health.

Southcoast is ranked in the Top 10% of U.S. Hospitals for Patient Safety.

Several commercial payors have also deemed several specific services offered by Southcoast as centers of excellence. They include bariatric surgery, spinal surgery, and a Baby Friendly Hospital (obstetrics) by the World Health Organization.

The Southcoast website has links to all the various public reports regarding our quality results.

For example, in the BC AQC contract, if a deficit had to be repaid, then BC would first take the withhold monies from current claims, followed by use of our SPN reserve account, and then use of the quality monies earned. So in essence, a deficit would have to be larger than three layers of protection.

Historical claims data are reviewed. Southcoast requires specific contract clauses to address situations such as changes in severity, changes in unit cost due to negotiations with other providers, changes in subscriber composition, and/or changes in the growth of medical costs. At this time, Southcoast does not believe our risk to be significant under current contracts.

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010 **Note: Southcoast does not separate revenues into HMO and PPO categories.**

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based		Budget (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 107,588,979	X	$ 1,902,928	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$ 16,061,681	X	X	X	X
Harvard Pilgrim Health Care	$ 40,739,766	X	$ 206,089	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$ 3,167,239	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$ 11,462,856	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$ 7,404,670	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$ 26,486,037	X	X	X	X
Total Commercial	$ 148,328,746	X	$ 2,109,017	X	X	X	X	X	X	X	$ 64,582,483	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$ 19,857,504	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$ 49,733,068	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 2,095,593	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 71,686,165	X	X	X	X
MassHealth	$ 37,029,545	X	$ 673,788	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	$ 13,487,589	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$ 3,812,503	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$ 19,602,029	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$ 36,902,121	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$ 229,133,604	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	$ 19,739,599	X	X	X	X
GRAND TOTAL	$ 185,358,290	X	$ 2,782,804	X	X	X	X	X	X	X	$ 422,043,972	X	X	X	X

2011 **Note: Southcoast does not separate revenues into HMO and PPO categories.**

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 94,502,290	X	$ 1,567,854	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	$ 22,418,577	X	$ 10,000	X	$ 40,000	X	X	X	X	X	X
Harvard Pilgrim Health Care	$ 54,317,084	X	$ 274,287	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$ 2,550,546	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$ 12,657,268	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$ 7,517,272	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$ 27,423,991	X	X	X	X
Total Commercial	$ 148,819,373	X	$ 1,842,141	X	$ 22,418,577	X	$10,000	X	$40,000	X	$ 50,149,077	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$ 21,576,243	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$ 50,903,070	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 5,348,588	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 77,827,901	X	X	X	X
MassHealth	$ 36,224,637	X	$ 1,023,485	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	$ 16,287,486	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$ 2,657,420	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$ 21,844,442	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$ 40,789,348	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$ 240,546,436	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	$ 22,052,060	X	X	X	X
GRAND TOTAL	$ 185,044,010	X	$ 2,865,626	X	$ 22,418,577	X	$ 10,000	X	$ 40,000	X	$ 431,364,821	X	X	X	X

2012 **Note: Southcoast does not separate revenues into HMO and PPO categories.**

	P4P Contracts				Risk Contracts										
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus / (Deficit) Revenue		Quality Incentive Revenue		FFS Arrangements		Other Revenue		
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 87,639,392	X	$ 1,429,113	X	X	X	X	X	$ 847,858	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	$ 20,791,972	X	$ 10,000	X	$ 40,000	X	X	X	X	X	X
Harvard Pilgrim Health Care	$ 58,412,633	X	$ 294,768	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$ 2,968,977	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$ 13,928,622	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$ 7,253,310	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$ 27,405,180	X	X	X	X
Total Commercial	$ 146,052,026	X	$ 1,723,881	X	$ 20,791,972	X	$ 10,000	X	$ 887,858	X	$ 51,556,089	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$ 21,471,030	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$ 45,934,721	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 10,562,855	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 77,968,605	X	X	X	X
MassHealth	$ 34,355,491	X	$ 1,617,684	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	$ 15,229,759	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$ 3,401,949	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$ 24,514,650	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$ 43,146,358	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$ 254,601,820	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	$ 21,555,762	X	X	X	X
GRAND TOTAL	$ 180,407,517	X	$ 3,341,565	X	$ 20,791,972	X	$ 10,000	X	$ 887,858	X	$ 448,828,634	X	X	X	X

2013 **Note: Southcoast does not separate revenues into HMO and PPO categories.**

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 83,462,036	X	$ 1,411,876	X	X	X	X	X	$ 550,824	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	$ 21,105,346	X	$ 10,000	X	$ 40,000	X	X	X	X	X	X
Harvard Pilgrim Health Care	$ 57,449,851	X	$ 336,638	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$ 3,385,716	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$ 12,388,820	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$ 7,968,085	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$ 34,360,996	X	X	X	X
Total Commercial	$ 140,911,887	X	$ 1,748,514	X	$ 21,105,346	X	$ 10,000	X	$ 590,824	X	$ 58,103,617	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$ 18,481,884	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$ 49,328,754	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 12,844,278	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$ 80,654,916	X	X	X	X
MassHealth	$ 38,641,858	X	$ 40,000	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	$ 15,728,500	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$ 3,645,277	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$ 30,867,924	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$ 50,241,701	X	X	X	X
Medicare	$ 254,753,296	X	$ 359,272	X	X	X	X	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	$ 22,752,585	X	X	X	X
GRAND TOTAL	$ 434,307,040	X	$ 2,147,786	X	$ 21,105,346	X	$ 10,000	X	$ 590,824	X	$ 211,752,820	X	X	X	X

AGO Hospital Exhibit 2

2010

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total	$11,033,944	$3,379,389			$40,974,752	-$4,077,455			$510,187	-$718,303			$52,518,883	-$1,416,369		
Invasive													$0	$0		
Medical													$0	$0		
Cardiac Surgery	$3,999,651	$418,492			$8,126,415	-$2,674,856			$69,454	-$219,432			$12,195,520	-$2,475,796		
Dental	$92,982	$34,039			$121,011	$16,954			$0	$0			$213,993	$50,993		
Dermatology	$129,954	$64,000			$961,439	-$24,873			$18,585	-$14,981			$1,109,978	$24,146		
Endocinology	$1,156,598	$385,308			$5,217,505	-$223,014			$46,197	-$133,575			$6,420,300	$28,719		
Gastroenterology	$6,913,444	$1,934,536			$20,791,276	-$2,041,725			$308,559	-$702,606			$28,013,279	-$809,795		
General Medicine	$1,204,100	$445,132			$3,058,715	-$35,554			$60,758	-$100,760			$4,323,573	$308,818		
General Surgery	$19,858,619	$5,275,637			$29,289,475	-$2,658,564			$451,421	-$505,643			$49,599,515	$2,111,430		
Gynecology	$3,753,387	$718,435			$2,363,086	$133,161			$6,481	-$20,473			$6,122,954	$831,123		
Hematology	$816,879	$283,094			$1,992,269	-$175,928			$18,020	-$56,978			$2,827,168	$50,188		
Infectious Disease	$4,023,487	$1,629,259			$15,482,359	-$359,370			$172,864	-$277,220			$19,678,710	$992,669		
Neonatology	$1,998,239	$71,632			$4,942,458	-$757,017			$873	-$2,761			$6,941,570	-$688,146		
Nephrology	$1,276,190	$350,617			$8,855,044	-$415,006			$54,471	-$34,965			$10,185,705	-$99,354		
Neurology	$2,074,960	$821,015			$9,507,190	-$338,802			$188,179	-$119,035			$11,770,329	$363,178		
Neurosurgery	$822,040	$313,550			$2,027,642	-$216,938			$194,009	$33,583			$3,043,691	$130,195		
Normal Newborns	$1,888,653	$218,880			$3,894,558	$1,677,562			$2,646	-$8,366			$5,785,857	$1,888,076		
Obstetrics	$10,880,811	$1,561,516			$11,989,923	-$302,294			$39,684	-$41,345			$22,910,418	$1,217,877		
Oncology	$1,479,037	$641,463			$3,875,795	-$492,763			$5,087	-$16,083			$5,359,919	$132,617		
Ophthalmology	$33,563	$11,657			$152,685	$11,014			$1,192	-$3,590			$187,440	$19,081		
Orthopedics	$10,163,986	$2,571,055			$23,694,676	-$2,928,253			$1,504,119	$343,377			$35,362,781	-$13,821		
Otolaryngology	$745,486	$175,369			$1,278,131	-$105,427			$37,454	-$9,440			$2,061,071	$60,502		
Psychiatry	$2,681,843	-$115,998			$6,742,586	-$2,458,734			$407,564	-$763,933			$9,831,993	-$3,338,665		
Pulmonary	$7,590,211	$2,313,962			$37,758,623	-$1,636,378			$313,317	-$335,177			$45,662,151	$342,407		
Rehab	$629,491	-$217,291			$5,631,674	-$55,745			$188,198	-$30,793			$6,449,363	-$303,829		
Rheumatology	$96,368	$20,443			$717,042	-$81,880			$13,266	$2,130			$826,676	-$59,307		
Transplant Surgery	$0	$0			$0	$0			$0	$0			$0	$0		
Trauma	$23,388	-$791			$581,573	$124,900			$65,493	$20,528			$670,454	$144,637		
Urology	$2,761,197	$580,169			$3,988,352	-$171,826			$48,125	-$19,602			$6,797,674	$388,741		
Vascular Surgery	$1,239,796	$347,248			$5,025,647	-$1,345,032			$18,491	-$31,217			$6,283,934	-$1,029,001		
Other Inpatient	$802,516	-$154,124			$178,629	-$39,053			$19,966	-$3,834			$1,001,111	-$197,011		
Imaging			$18,991,242	$8,113,527			$11,197,809	$838,933			$ 907,774	$ 178,390			$ 31,096,825	$ 9,130,850
Other Treatments			$0	$0			$0	$0			$ -	$ -			$ -	$ -
Laboratory			$16,995,779	$5,572,674			$12,857,462	$392,934			$ 321,194	$ (326,627)			$ 30,174,435	$ 5,638,981
Ambulatory Surgery			$27,320,749	$4,593,039			$23,520,544	-$5,547,476			$ 1,733,461	$ (150,337)			$ 52,574,754	$ (1,104,774)
Therapies			$4,305,449	$151,595			$3,821,533	-$1,117,372			$ 833,163	$ 60,760			$ 8,960,145	$ (905,017)
Office Visits			$0	$0			$0	$0			$ -	$ -			$ -	$ -
Observation			$6,458,646	$169,795			$7,243,678	-$5,230,878			$ 406,290	$ (360,097)			$ 14,108,614	$ (5,421,180)
Other Outpatient			$37,015,205	$7,310,539			$59,322,587	-$10,750,181			$12,776,510	$ (1,075,784)			$ 109,114,302	$ (4,515,426)
GRAND TOTAL	**$100,170,820**	**$24,077,693**	**$111,087,070**	**$25,911,169**	**$259,220,530**	**-$21,652,896**	**$117,963,613**	**-$21,414,040**	**$4,764,660**	**-$3,770,494**	**$16,978,392**	**-$1,673,695**	**$364,156,010**	**-$1,345,697**	**$ 246,029,075**	**$ 2,823,434**

2011

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total	$14,291,413	$4,757,807			$44,869,186	-$4,330,813			$1,200,938	-$216,613			$60,361,537	$210,381		
Invasive													$0	$0		
Medical													$0	$0		
Cardiac Surgery	$4,003,874	$534,375			$7,227,756	-$2,794,072			$151,192	-$95,340			$11,382,822	-$2,355,037		
Dental	$50,800	$13,360			$167,883	-$9,467			$12,071	$1,783			$230,754	$5,676		
Dermatology	$166,516	$51,758			$986,925	-$56,953			$91,897	$24,700			$1,245,338	$19,505		
Endocinology	$1,449,265	$531,002			$5,822,205	-$506,332			$134,361	-$62,715			$7,405,831	-$38,045		
Gastroenterology	$8,429,617	$2,870,392			$24,073,054	-$1,157,424			$682,729	-$357,706			$33,185,400	$1,355,262		
General Medicine	$1,145,671	$337,984			$3,460,067	-$292,671			$159,307	-$65,626			$4,765,045	-$20,313		
General Surgery	$20,122,439	$6,276,775			$30,088,595	-$2,147,434			$855,825	-$192,907			$51,066,859	$3,936,434		
Gynecology	$3,341,420	$736,553			$2,455,025	$252,958			$33,403	-$16,718			$5,829,848	$972,793		
Hematology	$568,779	$65,812			$2,298,277	-$170,829			$20,026	-$1,428			$2,887,082	-$106,445		
Infectious Disease	$4,295,542	$1,567,845			$18,122,595	-$809,434			$650,406	-$103,556			$23,068,543	$654,855		
Neonatology	$1,840,111	$144,787			$5,328,179	-$1,468,279			$269	-$170			$7,168,559	-$1,323,662		
Nephrology	$1,345,888	$525,651			$9,327,484	-$683,778			$102,167	-$18,128			$10,775,539	-$176,255		
Neurology	$3,060,225	$1,461,046			$10,516,801	-$136,679			$354,176	-$13,067			$13,931,202	$1,311,300		
Neurosurgery	$1,269,511	$473,646			$2,326,684	-$392,733			$192,202	-$20,372			$3,788,397	$60,541		
Normal Newborns	$1,840,866	$285,895			$4,594,826	$2,232,997			$5,684	-$3,584			$6,441,376	$2,515,308		
Obstetrics	$10,104,848	$1,284,800			$12,528,926	-$545,237			$60,557	-$24,870			$22,694,331	$714,693		
Oncology	$1,037,266	$410,432			$3,668,802	-$287,674			$39,252	-$17,137			$4,745,320	$105,621		
Ophthalmology	$72,173	$35,448			$109,938	-$15,081			$14,879	$403			$196,990	$20,770		
Orthopedics	$11,335,550	$3,532,123			$25,233,747	-$3,198,111			$1,997,543	$760,501			$38,566,840	$1,094,513		
Otolaryngology	$678,751	$291,022			$1,829,220	-$137,206			$81,319	$11,374			$2,589,290	$165,190		
Psychiatry	$3,210,036	-$347,879			$7,691,684	-$2,867,877			$746,798	-$422,023			$11,648,518	-$3,637,779		
Pulmonary	$8,087,123	$2,645,562			$42,367,382	-$3,694,143			$627,004	-$184,772			$51,081,509	-$1,233,353		
Rehab	$1,061,278	-$268,700			$5,830,849	$35,801			$362,137	-$173,265			$7,254,264	-$406,164		
Rheumatology	$186,243	$51,407			$912,866	-$130,511			$25,996	-$2,118			$1,125,105	-$81,222		
Transplant Surgery	$0	$0			$0	$0			$0	$0			$0	$0		
Trauma	$72,265	$32,238			$578,357	-$35,594			$232,242	$96,982			$882,864	$93,626		
Urology	$2,923,981	$807,856			$4,542,443	-$13,759			$86,995	-$37,725			$7,553,419	$756,372		
Vascular Surgery	$1,629,491	$419,090			$5,013,072	-$1,742,196			$80,562	-$10,641			$6,723,125	-$1,333,747		
Other Inpatient	$744,174	-$221,606			$201,556	-$54,100			$24,114	-$7,181			$969,844	-$282,887		
Imaging			$17,866,731	$8,182,420			$11,184,264	$1,214,275			$692,526	$192,057			$29,743,521	$9,588,752
Other Treatments															$0	$0
Laboratory			$18,402,229	$6,221,505			$13,858,132	$216,459			$261,828	-$453,628			$32,522,189	$5,984,336
Ambulatory Surgery			$26,807,432	$5,906,411			$21,796,965	-$4,344,914			$1,491,571	-$220,240			$50,095,968	$1,341,257
Therapies			$4,440,419	$270,809			$4,349,696	-$1,105,740			$811,251	-$27,708			$9,601,366	-$862,639
Office Visits															$0	$0
Observation			$6,023,023	$203,066			$6,175,185	-$4,961,152			$285,974	-$309,448			$12,484,182	-$5,067,534
Other Outpatient			$37,946,027	$7,965,711			$58,619,771	-$11,041,180			$11,164,459	-$3,965,067			$107,730,257	-$7,040,536
GRAND TOTAL	**$108,365,116**	**$29,306,481**	**$111,485,861**	**$28,749,922**	**$282,174,384**	**-$25,156,631**	**$115,984,013**	**-$20,022,252**	**$9,026,051**	**-$1,151,919**	**$14,707,609**	**-$4,784,034**	**$399,565,551**	**$2,997,931**	**$242,177,483**	**$3,943,636**

2012

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total	$13,001,537	$4,311,612			$42,464,129	-$4,582,939			$696,549	-$814,161			$56,162,215	-$1,085,488		
Invasive													$0	$0		
Medical													$0	$0		
Cardiac Surgery	$3,913,756	$953,565			$6,780,480	-$1,470,163			$76,441	-$27,344			$10,770,677	-$543,942		
Dental	$27,960	$11,704			$155,926	-$26,330			$5,197	-$8,702			$189,083	-$23,328		
Dermatology	$221,967	$97,924			$920,136	$42,502			$23,216	-$17,509			$1,165,319	$122,917		
Endocinology	$1,242,903	$411,749			$6,115,037	-$159,892			$101,236	-$133,669			$7,459,176	$118,188		
Gastroenterology	$8,218,717	$2,949,569			$24,601,529	-$557,045			$509,309	-$637,752			$33,329,555	$1,754,772		
General Medicine	$1,211,303	$431,041			$3,535,757	$20,299			$82,526	-$103,601			$4,829,586	$347,739		
General Surgery	$18,681,454	$6,103,900			$30,994,327	-$3,546,878			$625,407	-$616,650			$50,301,188	$1,940,372		
Gynecology	$2,812,124	$513,974			$2,338,507	$37,083			$36,296	-$29,878			$5,186,927	$521,179		
Hematology	$618,513	$237,161			$2,423,745	-$34,250			$39,670	-$29,133			$3,081,928	$173,778		
Infectious Disease	$5,732,962	$1,684,997			$21,758,797	-$4,170,841			$413,367	-$610,855			$27,905,126	-$3,096,699		
Neonatology	$2,133,885	$408,098			$5,597,911	-$1,293,276			$16,847	-$28,207			$7,748,643	-$913,385		
Nephrology	$1,645,886	$577,105			$9,907,772	-$21,935			$85,865	-$109,457			$11,639,523	$445,713		
Neurology	$2,772,126	$1,258,857			$11,424,705	-$389,078			$311,179	-$113,852			$14,508,010	$755,927		
Neurosurgery	$708,134	$107,865			$1,734,458	-$939,794			$58,904	-$30,515			$2,501,496	-$862,444		
Normal Newborns	$2,004,545	$371,866			$4,714,945	$2,305,095			$2,446	-$4,096			$6,721,936	$2,672,865		
Obstetrics	$11,455,286	$1,885,098			$12,374,478	-$740,297			$31,792	-$32,948			$23,861,556	$1,111,853		
Oncology	$1,141,173	$345,151			$3,618,491	-$1,383,943			$69,978	-$115,980			$4,829,642	-$1,154,772		
Ophthalmology	$40,222	$5,701			$142,849	-$16,033			$3,723	-$6,233			$186,794	-$16,565		
Orthopedics	$10,608,923	$3,320,423			$24,965,033	-$915,273			$1,875,861	$592,938			$37,449,817	$2,998,088		
Otolaryngology	$574,009	$239,947			$1,478,120	-$17,412			$20,489	-$11,971			$2,072,618	$210,564		
Psychiatry	$3,529,209	$511,976			$8,491,574	-$2,020,038			$558,858	-$850,662			$12,579,641	-$2,358,724		
Pulmonary	$6,935,569	$2,808,414			$40,735,498	-$664,839			$412,577	-$429,591			$48,083,644	$1,713,984		
Rehab	$633,528	-$141,422			$6,254,899	-$387,820			$70,154	-$2,764			$6,958,581	-$532,006		
Rheumatology	$89,899	$35,448			$863,458	$48,018			$21,439	$6,164			$974,796	$89,630		
Transplant Surgery	$0	$0			$0	$0			$0	$0			$0	$0		
Trauma	$66,053	$43,009			$694,021	$156,214			$62,332	$18,497			$822,406	$217,720		
Urology	$2,275,633	$753,128			$4,299,772	-$23,637			$45,979	-$72,607			$6,621,384	$656,884		
Vascular Surgery	$1,511,745	$296,564			$5,486,858	-$1,661,084			$50,233	-$84,107			$7,048,836	-$1,448,627		
Other Inpatient	$713,811	-$145,454			$268,385	-$19,562			$21,446	-$4,533			$1,003,642	-$169,549		
Imaging			$15,411,613	$5,924,395			$12,127,930	$1,362,269			$943,621	$357,672			$28,483,164	$7,644,336
Other Treatments			$0	$0			$0	$0			$0	$0			$0	$0
Laboratory			$18,201,136	$6,319,974			$13,806,624	$388,004			$407,255	-$205,845			$32,415,015	$6,502,133
Ambulatory Surgery			$27,369,075	$4,592,390			$23,784,446	-$7,187,895			$1,917,361	$36,384			$53,070,882	-$2,559,121
Therapies			$4,819,130	$377,290			$5,145,209	-$835,782			$1,063,323	$129,762			$11,027,662	-$328,730
Office Visits			$0	$0			$0	$0			$0	$0			$0	$0
Observation			$8,329,203	$820,668			$10,728,477	-$7,407,625			$612,210	-$408,599			$19,669,890	-$6,995,556
Other Outpatient			$39,356,632	$8,788,579			$60,741,888	-$14,153,159			$13,508,664	$814,556			$113,607,184	-$4,550,024
GRAND TOTAL	**$104,522,832**	**$30,388,970**	**$113,486,789**	**$26,823,296**	**$285,141,597**	**-$22,433,148**	**$126,334,574**	**-$27,834,188**	**$6,329,316**	**-$4,309,178**	**$18,452,434**	**$723,930**	**$395,993,745**	**$3,646,644**	**$258,273,797**	**-$286,962**

2013

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total	$12,090,696	$3,853,499			$40,127,296	-$7,589,480			$766,350	-$625,994			$52,984,342	-$4,361,975		
Invasive													$0	$0		
Medical													$0	$0		
Cardiac Surgery	$4,505,333	$996,299			$8,407,321	-$2,748,787			$142,534	-$207,567			$13,055,188	-$1,960,055		
Dental	$67,189	$29,105			$115,399	-$12,294			$3,693	-$5,208			$186,281	$11,603		
Dermatology	$208,338	-$40,811			$863,369	-$422,087			$17,357	-$17,496			$1,089,064	-$480,394		
Endocinology	$1,347,524	$445,953			$5,377,175	-$540,211			$47,679	-$73,384			$6,772,378	-$167,642		
Gastroenterology	$7,649,961	$2,449,125			$25,517,362	-$2,382,931			$498,810	-$601,899			$33,666,133	-$535,705		
General Medicine	$1,150,951	$230,048			$3,766,837	-$582,451			$132,148	-$77,511			$5,049,936	-$429,914		
General Surgery	$17,912,285	$5,260,238			$31,267,787	-$6,163,003			$650,885	-$466,148			$49,830,957	-$1,368,913		
Gynecology	$2,253,850	$400,372			$1,776,770	-$106,077			$17,115	-$24,134			$4,047,735	$270,161		
Hematology	$600,224	$228,926			$2,471,838	-$232,935			$51,600	-$72,761			$3,123,662	-$76,770		
Infectious Disease	$5,702,395	$1,392,385			$25,465,525	-$6,986,259			$616,176	-$720,592			$31,784,096	-$6,314,466		
Neonatology	$2,621,886	$506,048			$6,096,960	-$1,022,757			$0	$0			$8,718,846	-$516,709		
Nephrology	$1,423,741	$497,090			$9,936,793	-$1,054,636			$111,517	-$54,969			$11,472,051	-$612,515		
Neurology	$2,709,335	$1,244,648			$11,391,902	-$562,444			$207,070	-$134,489			$14,308,307	$547,715		
Neurosurgery	$907,697	$85,208			$2,389,804	-$1,090,972			$121,399	-$49,816			$3,418,900	-$1,055,580		
Normal Newborns	$2,053,218	$384,207			$5,050,439	$2,637,817			$11,343	-$8,407			$7,115,000	$3,013,617		
Obstetrics	$11,384,443	$1,389,134			$12,165,965	-$1,411,507			$62,616	-$28,452			$23,613,024	-$50,825		
Oncology	$989,001	$363,370			$3,773,121	-$1,339,464			$15,157	-$32,752			$4,777,279	-$1,008,846		
Ophthalmology	$72,970	$20,651			$213,507	$5,693			$23,995	-$4,206			$310,472	$22,138		
Orthopedics	$9,302,374	$2,885,542			$22,963,770	-$3,140,046			$2,034,434	$497,624			$34,300,578	$243,120		
Otolaryngology	$467,714	$123,008			$1,373,465	-$146,299			$33,327	-$15,664			$1,874,506	-$38,955		
Psychiatry	$3,417,598	$126,852			$8,313,857	-$2,557,400			$568,660	-$764,168			$12,300,115	-$3,194,716		
Pulmonary	$7,560,985	$3,202,895			$40,688,350	-$2,431,342			$457,072	-$248,065			$48,706,407	$523,488		
Rehab	$645,407	-$85,350			$7,472,332	$139,520			$224,496	$55,839			$8,342,235	$110,009		
Rheumatology	$160,244	$45,247			$642,782	-$5,305			$4,656	-$6,565			$807,682	$33,377		
Transplant Surgery	$0	$0			$0	$0			$0	$0			$0	$0		
Trauma	$48,370	$32,309			$580,999	$89,184			$89,957	$27,441			$719,326	$148,934		
Urology	$2,513,860	$576,341			$3,637,970	-$1,134,054			$54,101	-$93,845			$6,205,931	-$651,558		
Vascular Surgery	$1,240,553	$305,661			$4,888,253	-$1,644,496			$12,113	-$17,081			$6,140,919	-$1,355,916		
Other Inpatient	$665,045	-$147,716			$252,537	-$258,795			$21,319	-$4,532			$938,901	-$411,043		
Imaging			$15,067,942	$5,203,858			$12,959,769	$1,757,039			$1,039,908	$361,547			$29,067,619	$7,322,444
Other Treatments			$0	$0			$0	$0			$0	$0			$0	$0
Laboratory			$17,157,680	$4,687,005			$13,469,808	-$208,814			$482,779	-$383,393			$31,110,267	$4,094,798
Ambulatory Surgery			$28,193,272	$3,653,320			$29,104,641	-$8,484,408			$2,027,185	$142,967			$59,325,098	-$4,688,121
Therapies			$4,680,317	$215,484			$5,703,132	-$772,003			$1,341,735	$198,125			$11,725,184	-$358,394
Office Visits			$0	$0			$0	$0			$0	$0			$0	$0
Observation			$8,794,252	$699,714			$14,297,842	-$9,595,184			$860,818	-$548,184			$23,952,912	-$9,443,654
Other Outpatient			$40,115,139	$7,079,758			$66,578,515	-$11,506,309			$12,378,849	$1,551,314			$119,072,503	-$2,875,237
GRAND TOTAL	**$101,673,187**	**$26,800,284**	**$114,008,602**	**$21,539,139**	**$286,989,485**	**-$42,693,818**	**$142,113,707**	**-$28,809,679**	**$6,997,579**	**-$3,774,801**	**$18,131,274**	**$1,322,376**	**$395,660,251**	**-$19,668,335**	**$274,253,583**	**-$5,948,164**

ATTESTATION

SOUTHCOAST HOSPITALS GROUP, INC.

I, Keith A. Hovan, being the duly authorized President and CEO of Southcoast Health System and Southcoast Hospitals Group Inc. (the "Company"), having been duly sworn, do hereby attest that I am legally authorized and empowered to represent the Company for the purposes of the foregoing testimony, and that the foregoing testimony is provided under the pains and penalties of perjury and is true and accurate to the best of my knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand as President and CEO of the Company this 5th day of September, 2014.

Keith A. Hovan
President and CEO
Southcoast Health System and Southcoast Hospitals Group

COMMONWEALTH OF MASSACHUSETTS)

) :ss: New Bedford

COUNTY OF BRISTOL)

The foregoing attestation was acknowledged before me this 5th day of September, 2014, by Keith A. Hovan, as President and CEO of Southcoast Health System and Southcoast Hosptials Group, Inc., as his free act and deed.

Notary Public

My Commission Expires: 4/2/21

KIMBERLY M. COON
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES APRIL 2, 2021