COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS. SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO. 2018-3703

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff,

v.

BETH ISRAEL LAHEY HEALTH, INC.,

Defendant.

ASSURANCE OF DISCONTINUANCE
PURSUANT TO M.G.L. CHAPTERS 93A, § 5 and 93, § 9

I. INTRODUCTION

1. Certain health care providers and provider organizations, including Lahey Health System, Inc., CareGroup, Inc., and their component parts, subsidiaries, and affiliates (e.g., Beth Israel Deaconess Medical Center, Inc., New England Baptist Hospital ("NEBH"), and Mount Auburn Hospital); Seacoast Regional Health Systems, Inc.; Lahey Clinical Performance Network, LLC; Lahey Clinical Performance Accountable Care Organization, LLC; and Beth Israel Deaconess Care Organization, and including all the closing entities as listed on Exhibit A (the "Transaction Parties") plan to come together under common corporate membership and control under a new corporate entity, Beth Israel Lahey Health, Inc. (the "Proposed Transaction").

2. The Commonwealth of Massachusetts, through the Massachusetts Office of the Attorney General ("AGO"), has conducted an investigation into the Proposed Transaction. The AGO's investigation raised concerns that the effect of the Proposed Transaction (a) may be substantially to lessen competition in the sale of health care services in certain geographic areas of the Commonwealth; (b) may increase total health care costs in the Commonwealth; and (c) may have an adverse effect on access to health care services, particularly for vulnerable populations.

3. In addition, the Massachusetts Health Policy Commission ("HPC") issued a Report of its Cost and Market Impact Review of the Proposed Transaction that, examining factors identified in M.G.L. c. 6D, § 13(d), concluded that the Proposed Transaction could lead to significant price increases and could negatively affect access to high quality care, particularly for underserved populations. Based on these findings, the HPC referred its report to the AGO.

4. Based on the AGO's investigation and the HPC's findings with regard to the factors in M.G.L. c. 6D, § 13(d), the AGO expressed concerns that the Proposed Transaction may constitute or may result in unfair methods of competition or unfair or deceptive acts or practices which may violate M.G.L. c. 93A, § 1 et. seq. and M.G.L. c. 93, § 4.

5. Beth Israel Lahey Health, Inc., on behalf of itself and the Transaction Parties, disputes the HPC's findings and asserts that the Proposed Transaction will increase competition, and improve care quality and care access to all populations by the introduction of a high quality, accessible, and lower-cost market option. Nevertheless, in the interests of resolving the differences between the Parties to this Assurance of Discontinuance ("Assurance"), Beth Israel Lahey Health, Inc., on behalf of itself and the Transaction Parties, has agreed to the measures set forth in this Assurance to mitigate these concerns.

6. The AGO accepts and files this Assurance with the Court pursuant to M.G.L. c. 93A, § 5 and M.G.L. c. 93, § 9.

II. PARTIES

7. The Commonwealth of Massachusetts is represented by the AGO.

8. Beth Israel Lahey Health, Inc. is a Massachusetts Chapter 180 nonprofit charitable corporation formed on November 27, 2018. It has a principal place of business in Massachusetts. Beth Israel Lahey Health, Inc. represents and warrants that, upon the Closing Date, it shall have the power, authority and obligation to assure its compliance, and that of each of the Transaction Parties and their Corporate Affiliates, subsidiaries, subdivisions, officers, directors, trustees, partners, agents, servants, employees and/or successors with the provisions of this Assurance.

III. JURISDICTION AND VENUE

9. This Court has jurisdiction over the subject matter and over the Parties hereto.

IV. DEFINITIONS

10. "Access Period" means the eight (8) year period following the Closing Date.

11. "Alternative Payment Methods" means any transfer of funds from a payer to BILH pursuant to a contract for a Commercial Health Insurance Product or a Managed Medicare Health Insurance Product that is not captured by Commercial Unit Price payments as defined in Paragraph 75 or by Managed Medicare Percent of Unit Price payments as defined in Paragraph 83, including but not limited to risk payments (e.g., per-member-per-month reimbursement), quality payments, and infrastructure payments.

12. "AGO" means the Massachusetts Office of the Attorney General.

13. "Baseline Revenue" shall be defined as in Paragraph 77(g)(ii).

14. “Baseline Set of Services” shall be defined as in Paragraph 77(b).

15. “BILH” means Beth Israel Lahey Health, Inc., including its Corporate Affiliates, subsidiaries, subdivisions, officers, directors, trustees, partners, agents, servants, employees and/or successors.

16. “BILH Facility” means any licensed health care facility that is owned, operated, or controlled by BILH, including any BILH Hospital.

17. “BILH Hospital” means any Massachusetts licensed hospital that is owned, operated, or controlled by BILH and shall include all facilities and sites that operate under the license of such hospital.

18. “BILH Primary Care Practice” means any primary care practice staffed by health care providers employed by or jointly contracting with BILH.

19. “BILH Providers” means all health care providers that are owned or controlled by (e.g., through corporate membership or employment), under direct financial management of, or that jointly contract with BILH. The term “BILH Provider” and each reference to a named BILH Provider shall include all of its subdivisions, officers, directors, trustees, partners, agents, servants and/or employees (including its employed physicians and other health care professionals) and all of the physicians and other health care professionals who are members of, are affiliated with and/or participate in such BILH Provider for Payer contracting.

20. “Bridge Clinic” means a transitional outpatient addiction clinic that provides substance use disorder treatment to patients leaving the emergency department or patients discharged from inpatient care until the patient is placed in a community care setting.

21. “Centers for Medicare & Medicaid Services’ Medicare Rate Schedules” means any fee schedule or payment system produced by the Centers for Medicare & Medicaid Services

("CMS") on which BILH and a Covered Managed Medicare Payer base any of their negotiated payments for a Managed Medicare Health Insurance Product. This includes, but is not limited to, the Centers for Medicare & Medicaid Services' Acute Inpatient Prospective Payment System ("PPS"), Hospital Outpatient PPS, Physician Fee Schedule, Clinical Laboratory Fee Schedule and Ambulatory Fee Schedule.

22. "Centralized Bed Management Program" means Lahey's centralized inpatient psychiatry and detoxification bed management and bed placement system wherein a centralized system or department monitors a behavioral health patient's progress through a facility's emergency department and coordinates the placement of such behavioral health patients in the inpatient unit best suited to their needs based on clinical presentation and geographic location.

23. "CHC Affiliate" means Bowdoin Street Health Center, Inc.; Fenway Community Health Center, Inc.; South Cove Community Health Center, Inc.; Dimock Community Health Center, Inc.; Charles River Community Health, Inc.; or Outer Cape Health Services, Inc.; *provided*, however, that if any of the listed entities terminates or does not continue its affiliation with BILH at any point after the Filing Date it shall not thereafter be considered a CHC Affiliate under this Assurance.

24. "CHIA" means the Center for Health Information and Analysis established by M.G.L. c. 12C, § 2.

25. "CIN" or "Clinically-Integrated Network" means the entity, however named, that jointly negotiates contracts with Payers on behalf of BILH health care facilities and providers and contractual affiliates, and any CIN successor entity.

26. "Closing Date" means the date upon which Beth Israel Lahey Health, Inc. becomes the sole member of any or all of those entities listed as First Tier Affiliates in Exhibit A.

27. "Community Benefits" means community health investments and charity care provided and reported pursuant to the AGO's Community Benefits Guidelines.

28. "Community Health Center" means a non-profit, community-based organization that provides comprehensive primary and preventive health care and social services to medically underserved individuals and families (see Section 330 of the Public Health Service Act).

29. "Commercial Health Insurance Product" means any of the various health insurance plans or products and/or health benefit plan designs offered or administered by any Payer and not funded by Medicare, or Medicaid, including but not limited to tiered network plans, limited network plans, self-insured health plans, indemnity plans, preferred provider organization plans ("PPO"), health maintenance organization plans ("HMO") and point of service plans ("POS").

30. "Commercial Unit Price" shall be defined as in Paragraph 75.

31. "Commercial Unit Price Rate of Increase" shall be defined as in Paragraph 77(a).

32. "Contract Year" means a 12-month period during which a Payer Contract between BILH or any Corporate Affiliate of BILH and a Covered Commercial Payer or Covered Managed Medicare Payer is in effect. The first Contract Year under a Payer Contract shall begin the day that the contract's reimbursement rates go into effect; subsequent Contract Years shall begin 12 months after the previous Contract Year began.

33. "Contractually-Affiliated Provider" means a provider who is not a BILH Corporate Affiliate but who contracts with one or more Payers through BILH.

34. “Corporate Affiliate” means, as to any named organization or entity, any corporation, limited liability company, limited partnership or other organization or entity that directly or indirectly controls, is controlled by, or is under common control with the named organization or entity, where “control” means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the entity whether through ownership of voting securities, membership interests, the power to elect or appoint directors, trustees or managers or otherwise. As used in this Assurance, unless otherwise specifically indicated, the term “Corporate Affiliate” shall include all of its subsidiaries, subdivisions, corporate members, successors, stockholders, officers, directors, trustees, partners, agents, servants and/or employees.

35. “Covered BILH Providers” means all BILH Providers excluding the Joint Contracting Safety Net Affiliates.

36. “Covered Commercial Payer” shall be defined as in Paragraph 78.

37. “Covered Managed Medicare Payer” shall be defined as in Paragraph 88.

38. “Department” shall be defined as in Paragraph 104.

39. “Filing Date” means the date this Assurance is filed with the clerk of the Suffolk Superior Court.

40. “First Tier Affiliate” means any entity of which Beth Israel Lahey Health, Inc. will be the sole corporate member.

41. “Gateway Municipality” shall have the meaning set forth in M.G.L. c. 23A, § 3A.

42. “Health Care Cost Growth Benchmark” shall be as established by the HPC, pursuant to the requirements of M.G.L. c. 6D, § 9.

43. "Health Care System" means an organization that includes at least one hospital and at least one group of physicians that provides a wide range of care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management.

44. "HPC" means the Massachusetts Health Policy Commission established by M.G.L. c. 6D, § 2.

45. "IMPACT Model" means Lahey's current model of primary care – behavioral health integration, also known as the "Collaborative Care" model. The IMPACT Model involves introducing primary care patients who are identified through screenings and direct referrals to an embedded behavioral health clinician. The clinician works collaboratively with the PCP, supported by a consulting psychiatrist, to deliver treatment, coordinate care and patient contact, and facilitate referral to more intensive treatment when necessary.

46. "Joint Contracting Safety Net Affiliate" means Lawrence General Hospital, Cambridge Health Alliance, and any other Safety Net Hospital that may enter into an agreement with BILH pursuant to which BILH contracts with Payers on its behalf; *provided*, however, that if any such entity terminates or does not continue its affiliation with BILH at any point after the Filing Date it shall not thereafter be considered a Joint Contracting Safety Net Affiliate under this Assurance.

47. "Lahey" means Lahey Health System, Inc. and all of its successors, subsidiaries, Corporate Affiliates, subdivisions, officers, directors, trustees, partners, agents, servants and/or employees.

48. "Managed Medicare Health Insurance Product" means a managed care health insurance plan made available by a Payer only to Medicare-eligible enrollees under Title XVIII of the Social Security Act.

49. "Managed Medicare Payment Constraint" shall be defined as in Paragraph 85.

50. "Managed Medicare Percent of Unit Price" shall be defined as in Paragraph 83.

51. "MassHealth" means the health coverage programs administered by the Massachusetts Executive Office of Health and Human Services to benefit low- and moderate-income people in the Commonwealth, including the Medicaid program under Title XIX of the Social Security Act and the State Children's Health Insurance program under Title XXI of the Social Security Act.

52. "MassHealth ACO" means Accountable Care Organization health programs offered through MassHealth.

53. "MAT" or "Medication Assisted Treatment" means the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose.

54. "Monitor" means the independent third party who will monitor BILH's compliance with this Assurance throughout the Monitoring Period.

55. "Monitoring Period" means the ten (10) year period following the Closing Date.

56. "Net Patient Service Revenue" means the revenue a hospital would expect to collect for services provided less contractual allowances, as contained in the hospital's financial statements and as reported by the hospital to CHIA.

57. "Parties" means collectively the Commonwealth and Beth Israel Lahey Health, Inc.

58. "Payer" means any organization or entity that contracts with health care providers and other health care organizations to provide or arrange for the provision of health care services to any person or group of persons and that is responsible for payment to such providers and other health care organizations of all or part of any expense for such health care services, including but not limited to commercial insurance companies, health maintenance organizations, preferred provider organizations, union trust funds, multiple employer trusts and self-insured health plans.

59. "Payer Contract" means a contract between BILH and a Payer pursuant to which BILH agrees to provide or arrange for the provision of health care services to enrollees of the Payer's Commercial Health Insurance Products and/or the Payer's Managed Medicare Insurance Products.

60. "PCP" means a primary care provider.

61. "Price Constraint Period" means the seven (7) year period following the Closing Date.

62. "Projected Revenue" shall be defined as in Paragraph 77(c).

63. "Safety Net Affiliate" means Lawrence General Hospital; Cambridge Health Alliance; or Signature Healthcare Brockton Hospital; *provided*, however, that each of these entities is considered a "Safety Net Affiliate" based on its contractual and/or clinical affiliation with a Transaction Party as of the Filing Date, and if any such entity terminates or does not continue its affiliation with BILH at any point after the Filing Date, it shall not thereafter be considered a "Safety Net Affiliate" under this Assurance.

64. "Safety Net Hospital" means any hospital with a Medicaid payer mix greater than 20%, as reported by CHIA for the prior fiscal year.

65. "Service Line" means each of the following categories of health care services and/or levels of care: (i) ambulatory surgery; (ii) high tech imaging (e.g., MRI, PET); (iii) clinical/pathology lab; (iv) physical or occupational therapy; (v) specialist office visits (non-behavioral health); (vi) primary care office visits; (vii) behavioral health office visits; (viii) behavioral health inpatient; (ix) behavioral health residential; and (x) emergency services.

66. "System-wide Price Constraint" shall be defined as in Paragraph 76.

67. "Total Projected Revenue" shall be defined as in Paragraph 77(d).

68. "Transaction Parties" shall be defined as in Paragraph 1.

69. "Uniform Price Change" shall be defined as in Paragraph 77(g)(i).

70. "Vertically Integrated" shall be defined as in Paragraph 78(c)(i).

V. ASSURANCES

71. Beth Israel Lahey Health, Inc., on behalf of itself and the Transaction Parties, agrees to the following Assurances to address the AGO's concerns:

A. 7-Year Price Constraint

i. Constraint on the Growth of Commercial Unit Price Payments

72. To mitigate the growth of health care costs in the Commonwealth, any Commercial Unit Price [as defined in Paragraph 75] payments made by Covered Commercial Payers [as defined in Paragraph 78] to Covered BILH Providers shall be subject to the 7-year price constraint, described below.

73. For any Contract Year of a Payer Contract executed on or after the Filing Date, with rates first going into effect within the Price Constraint Period, or of an existing Payer Contract that is extended or renewed during the Price Constraint Period, the Commercial Unit Price Rate of Increase [as defined in Paragraph 77(a)] for Covered BILH Providers, calculated

on an annual aggregated basis across all Covered BILH Providers, agreed to in any Payer Contract with any Covered Commercial Payer shall not be greater than the System-wide Price Constraint [as defined in Paragraph 76].

74. BILH's compliance with the System-wide Price Constraint with respect to its Commercial Unit Prices shall be measured at the time that BILH enters into a Payer Contract with a Covered Commercial Payer. BILH shall be in compliance with the System-wide Price Constraint if the Commercial Unit Price Rate of Increase, calculated on an annual aggregated basis across all Covered BILH Providers, is not greater than the System-wide Price Constraint for each Contract Year of that Payer Contract's term that begins during the Price Constraint Period.[1]

a. For the purposes of calculating the Commercial Unit Price Rate of Increase, any extensions or renewals of existing Payer Contracts with Covered Commercial Payers with rates first going into effect during the Price Constraint Period shall be treated as new Payer Contracts.

75. "Commercial Unit Price" means the negotiated rate of reimbursement to be paid to BILH or any Covered BILH Provider in exchange for providing a specified health care service to an enrollee, as is paid in one of the Covered Commercial Payer's "fee-for-service"[2] Commercial Health Insurance Products, including but not limited to rates of reimbursement for physician fees, professional fees and/or facility fees.

76. The System-wide Price Constraint for any Contract Year beginning during the Price Constraint Period shall be set at the percentage number of the Health Care Cost Growth

[1] The operation of the System-wide Price Constraint is described in more detail in Paragraph 77 and examples of its operation are provided in Exhibits B, C1, C2 & D.
[2] E.g., any payments for services made on a unit basis, including but not limited to Diagnosis-Related Group payments and per diem payments.

Benchmark ("HCCGB") in the calendar year the Payer Contract in effect for those Contract Years is signed, minus 0.1%,[3] subject to the following conditions:

a. In a given calendar year, should the System-wide Price Constraint be calculated at a lower percentage than it would be if calculated in 2018 (i.e., 3.0%), then the System-wide Price Constraint shall be set at 3.0% for that calendar year.

b. If a significant change in market conditions occurs, BILH may petition the AGO to reopen the System-wide Price Constraint for revision. Examples of significant changes in market conditions include, but are not limited to, the following:

i. The 12-month trailing average in the year-over-year change in the Consumer Price Index for All Urban Consumers – Northeast Region (the "CPI Average") rises by an amount greater than 1.5 percentage points above the System-wide Price Constraint during the Price Constraint Period. (E.g., if the System-wide Price Constraint is 3.0% in a given year, should the CPI Average be greater than 4.5%, this provision would be triggered.)

ii. Changes in law or new law that significantly raise the costs of providing care for Massachusetts health care providers.

77. The Commercial Unit Price Rate of Increase shall be calculated as described in this Paragraph 77.

a. The Commercial Unit Price Rate of Increase shall be the percentage change in Total Projected Revenue[4] [as defined in Paragraph 77(d)] that would be paid, in the

[3] For example, if a Payer Contract in effect from January 1, 2019 through December 31, 2021, were to be signed in 2018, the System-wide Price Constraint would be 3.0%, calculated by subtracting 0.1% from 3.1%, and that 3.0% would serve as the System-wide Price Constraint when measuring the Commercial Unit Price Rate of Increase for each of the 2019, 2020 and 2021 Contract Years.

[4] The Total Projected Revenue in a future Contract Year will be determined by using the actual utilization of medical services at Covered BILH Providers in the baseline year. The purpose of calculating the Total Projected

aggregate, to the Covered BILH Providers from one Contract Year to the immediately following (next) Contract Year for a pre-defined "market basket" of health care services, the Baseline Set of Services [as defined in Paragraph 77(b)].

b. The Baseline Set of Services shall be the volume of each and every health care service provided by Covered BILH Providers to a Covered Commercial Payer's enrollees (excluding enrollees in a Covered Commercial Payer's Managed Medicare or Managed Medicaid plans) in the most recently completed Contract Year (e.g., if BILH is negotiating a new Payer Contract in 2019 that will take effect on January 1, 2020, the most recently completed contract year would be 2018), or in a recent trailing twelve-month period if the use of such recent trailing twelve-month period is agreed upon by BILH and the Covered Commercial Payer.

c. To calculate the Projected Revenue for a given service in each Contract Year, the negotiated Commercial Unit Price for that service in that Contract Year is applied to the volume of that service in the Baseline Set of Services (e.g., if the Baseline Set of Services were those provided in the 2018 Contract Year, to calculate the Projected Revenue for a given service for the 2019 Contract Year, the negotiated Commercial Unit Price for that service for 2019 would be applied to the volume of that service provided in the 2018 Contract Year; if the Baseline Set of Services were those provided in a recent trailing twelve-month period, to calculate the Projected Revenue for a given service for the 2019 Contract Year, the negotiated Commercial Unit Price for that service for 2019 would be applied to the volume of that service provided in that twelve-month period).

Revenue for different future Contract Years while holding utilization constant is to measure the percentage change in unit price.

d. The Total Projected Revenue for each Contract Year shall be the sum of the Projected Revenue amounts for all services included in the Baseline Set of Services for that Contract Year.

e. To calculate the Commercial Unit Price Rate of Increase for a Contract Year, the Total Projected Revenue for that Contract Year is compared to the Total Projected Revenue for the immediately-preceding Contract Year (i.e., the Commercial Unit Price Rate of Increase for Contract Year 2020 would be the percentage by which the Total Projected Revenue for Contract Year 2020 exceeds the Total Projected Revenue for Contract Year 2019).

f. A simplified example of how the Commercial Unit Price Rate of Increase would be calculated at the time a Payer Contract is agreed to by BILH and a Covered Commercial Payer is given in Exhibit B.

g. It is the intent of the Parties that the mechanism described herein be sufficiently flexible as to ensure the accurate calculation of the Commercial Unit Price Rate of Increase for various contract structures by requiring that the Baseline Set of Services be 'repriced' under the new contract using underlying unit prices. However, the AGO recognizes that using underlying unit prices in this calculation may be unnecessary for some contracts or parts of some contracts. Where applicable, the Projected Revenue amounts used in the calculation of the Total Projected Revenue, and subsequently the Commercial Unit Price Rate of Increase, may be calculated using an alternative method described below in Paragraphs 77(g)(i)-(vi) which shall be deemed an acceptable method of demonstrating compliance with the System-wide Price Constraint:

i. For Payer Contracts or parts of Payer Contracts in which BILH and a Covered Commercial Payer negotiate percentage price changes for

categories of health care services (e.g., laboratory; high-end imaging; inpatient services) in which all services in such category receive the same negotiated percentage price change, which shall be defined as a Uniform Price Change, it is possible to calculate the Projected Revenue for each of those categories by applying those Uniform Price Changes to a Baseline Revenue [as defined in Paragraph 77(g)(ii)] without examining the utilization and unit price of each of the services contained in the Baseline Set of Services, using the method described below.

ii. For purposes of this calculation, the Baseline Revenue for each applicable category of services shall be (a) the revenue that was paid to BILH for that category of services in the most recently completed Contract Year, provided that each such revenue amount used by BILH for this purpose is acceptable to the Covered Commercial Payer (e.g., if BILH is negotiating a new Payer Contract in 2019 that will take effect on January 1, 2020, the most recently completed Contract Year would be 2018. Thus, the Baseline Revenue for each category of services will be the revenue paid to BILH by that Payer for that category of services in 2018), or (b) the revenue that was paid to BILH for that category of services in a recent trailing twelve-month period, provided that each such revenue amount during such recent trailing twelve-month period used by BILH for this purpose is acceptable to the Covered Commercial Payer.

iii. If using a Baseline Revenue from the most recently completed Contract Year, the Projected Revenue for a given category of services with a Uniform Price Change in the Contract Year immediately following the baseline year (i.e., the year before a new contract comes into effect) will be calculated by multiplying

the Baseline Revenue for that category by 1 plus the Uniform Price Change for that category for the immediately following Contract Year (e.g., for a new Payer Contract taking effect on January 1, 2020, the Baseline Revenue for a given category of services is that of 2018, and the Projected Revenue for that category in the 2019 Contract Year will be calculated by applying the Uniform Price Changes in the 2019 Contract Year to the 2018 Baseline Revenue).

1. To calculate the Projected Revenue for that category of services in subsequent Contract Years (i.e., years included in the new contract), the Projected Revenue in the immediately preceding Contract Year will become the Baseline Revenue for that category of services (e.g., for a new Payer Contract taking effect on January 1, 2020, when calculating the Projected Revenue for a given category of services for 2020, the Projected Revenue for 2019 will become the Baseline Revenue for that category of services).

iv. If using a Baseline Revenue from a recent twelve-month trailing period, the Projected Revenue for a given category of services with a Uniform Price Change in the first Contract Year of a new contract will be calculated by multiplying the Baseline Revenue for that category by 1 plus the Uniform Price Change for that category for the first Contract Year of that new contract. To calculate the Projected Revenue for that category in subsequent Contract Years, the Projected Revenue in the immediately preceding Contract Year will become the Baseline Revenue for that category of services.

v. The Total Projected Revenue for each Contract Year shall be the sum of the Projected Revenue amounts for all categories of services with

Uniform Price Changes for that Contract Year, in addition to, if applicable, any Projected Revenue amounts for services calculated using the unit prices and utilization method.

vi. To calculate the Commercial Unit Price Rate of Increase for a Contract Year, the Total Projected Revenue for that Contract Year is compared to the Total Projected Revenue for the immediately preceding Contract Year (e.g., the Commercial Unit Price Rate of Increase for Contract Year 2020 would be the percentage by which the Total Projected Revenue for Contract Year 2020 exceeds the Total Projected Revenue for Contract Year 2019).

1. Simplified examples of how the Commercial Unit Price Rate of Increase would be calculated using the method described in Paragraphs 77(g)(i)-(vi) are provided in Exhibits C1 and C2.

h. Consistent with and as part of the Monitoring obligations in Paragraphs 140-154, the basis of any of the calculations described in Paragraph 77(a)-(f) and/or 77(g)(i)-(vi), including the underlying data for and calculations of the Baseline Revenue and Commercial Unit Prices and/or other methods of obtaining payment from a Covered Payer for such services or category of services, shall be made available to the AGO and the Monitor upon request in order to verify the Projected Revenue amounts and the Total Projected Revenue.

78. A Covered Commercial Payer means a Payer described by the following descriptors and conditions:

a. Subject to the limitations set forth in Paragraph 78(c) and Paragraph 78(d) below, the following named Payers and their subdivisions, subsidiaries, successors, assigns and/or affiliates that issue health insurance policies for Massachusetts residents: (i) Harvard

Pilgrim Health Care, Inc.; (ii) Tufts Health Plan, Inc.; (iii) Blue Cross and Blue Shield of Massachusetts, Inc.; (iv) Fallon Community Health Plan, Inc.; (v) UnitedHealthcare, Inc.; (vi) Cigna Corporation; and (vii) Aetna Health, Inc.

b. Additional Payers, as necessary, so that the volume of payments pursuant to Commercial Health Insurance Products to Covered BILH Providers that the System-wide Price Constraint applies to collectively account for at least 90% of such commercial payments to the Covered BILH Providers (when excluding the payments made by the Payers identified in Paragraph 78(c) and Paragraph 78(d)).

c. A Payer shall not be included in the definition of Covered Commercial Payer (even if it otherwise meets the definition of Covered Commercial Payer in Paragraph 78(a) or Paragraph 78(b)) if it is or becomes Vertically Integrated[5] [as defined in Paragraph 78(c)(i)] with a Health Care System (other than BILH) that (i) provides health care services at locations in Essex, Middlesex, Suffolk, Norfolk, Bristol or Plymouth Counties, and (ii) has 20% or more statewide market share of acute care hospital revenue by Net Patient Service Revenue as calculated by CHIA.

i. "Vertically Integrated" means a relationship between a Payer and a Health Care System where a Health Care System controls, is controlled by, or is under common control with a Payer, whether by corporate membership, equity ownership, or otherwise. A payer is not "Vertically Integrated" with a Health Care System if it merely shares control over any entity (including a Payer entity) with that Health Care System. (E.g., if Payer A and Health Care System B create Joint Venture Payer C,

[5] This section does not imply that any future proposed vertical transactions are or may be consistent with antitrust, consumer protection, or other laws, and the Attorney General specifically retains all rights and authority to challenge, as appropriate, any such proposed vertical transaction as in violation of applicable law.

Payer A is not Vertically Integrated with Health Care System B, but Joint Venture Payer C would be Vertically Integrated with Heath Care System B.)

d. If a Payer that meets the definition of Covered Commercial Payer (i) is or becomes a participant in a broad joint venture or similar relationship with a Health Care System, such that the Payer and Health Care System are financially integrated for major lines of business (which would include, but not be limited to, an arrangement where a significant portion of the insurance risk for a major line of business is transferred to the Health Care System or an arrangement where a Health Care System provides a substantial portion of all of the health care services provided to a Payer's members), and (ii) such Health Care System is located in Essex, Middlesex, Suffolk, Norfolk, Bristol or Plymouth Counties, then BILH may petition the AGO to exclude such a Payer from the definition of Covered Commercial Payer.

e. If a Covered Commercial Payer completes a transaction that upon its completion would result in its removal from the definition of Covered Commercial Payer under either Paragraph 78(c) or Paragraph 78(d) while a Payer Contract is in effect between the Covered Commercial Payer and BILH, it shall remain a Covered Commercial Payer for the life of that Payer Contract unless both the affected Payer and BILH agree to reopen their Payer Contract.

ii. <u>Addition of a New Health Care Provider to BILH</u>

79. If a health care provider becomes a Covered BILH Provider during the Price Constraint Period (a "New BILH Provider"), when including that New BILH Provider in the calculation of the Commercial Unit Price Rate of Increase upon its joining a Payer Contract negotiated by BILH, the Commercial Unit Prices or Baseline Revenue amounts used to calculate the "Total Projected Revenue in the immediately-preceding Contract Year" shall be those from

the last Contract Year, or a recent trailing twelve-month period if the use of such recent trailing twelve-month period is agreed upon by BILH and the Covered Commercial Payer, covered by the Payer Contract for a Commercial Health Insurance Product between the New BILH Provider and a Covered Commercial Payer prior to the New BILH Provider joining BILH. If no such previous Payer Contracts exist, a weighted average of the Commercial Unit Prices or Baseline Revenue amounts paid to comparable Covered BILH Providers under existing contracts with Covered Commercial Payers shall be used to calculate the "Total Projected Revenue in the immediately-preceding Contract Year" for that New Covered BILH Provider.

iii. Departure of a Health Care Provider from BILH

80. If a health care provider departs BILH during the Price Constraint Period (a "Departing BILH Provider"), it shall be excluded from the calculation of the Commercial Unit Price Rate of Increase when BILH negotiates a new Payer Contract after the date of departure. Such a departure will not impact compliance with the System-wide Price Constraint under an existing Payer Contract.

iv. Changes in Unit Price That Do Not Occur at the Beginning of a Contract Year

81. If BILH and a Covered Commercial Payer agree to a change in Unit Price or a Uniform Price change that occurs during a Contract Year, when calculating the Total Projected Revenue (for the purpose of calculating the Commercial Unit Price Rate of Increase), the different Unit Prices or Uniform Price Changes shall be averaged in a weighted manner based upon the percentage of the Contract Year each Unit Price or Uniform Price Change covers. An example of this calculation is provided in Exhibit D.

v. Functional Constraint on Commercial Alternative Payment Methods

82. For any Contract Year of a Payer Contract executed on or after the Filing Date, with rates first going into effect within the Price Constraint Period, BILH and a Covered Commercial Payer are free to enter into an agreement that provides payment for a Commercial Health Insurance Product to BILH or a Covered BILH Provider through one or more Alternative Payment Methods provided that:

a. Any Commercial Unit Price rates used in the calculation of payments to BILH shall be subject to the System-wide Price Constraint, as required in Paragraph 73.

b. BILH, throughout any negotiation with a Covered Commercial Payer, shall make available the option for any or all lives and/or services covered by said Payer under a Commercial Health Insurance Product to be paid pursuant to a Commercial Unit Price agreement at a rate of increase no-greater-than the System-wide Price Constraint in effect.

i. BILH and the Covered Commercial Payer are in no way further constrained in negotiating Alternative Payment Methods for Commercial Health Insurance Products and may agree to any Alternative Payment Method for any or all lives and/or services that both parties find mutually preferable to a price-constrained Commercial Unit Price arrangement for such lives and/or services.

ii. If BILH and a Covered Commercial Payer are unable to negotiate an Alternative Payment Method for a Commercial Health Insurance Product for which the Payer finds the cost and terms acceptable, the Payer may choose to exercise the standing option of a Commercial Unit Price arrangement covering such lives and/or services.

iii. It is the intent of the Parties that the option described herein preserves the ability of BILH and a Covered Commercial Payer to innovate and develop mutually advantageous arrangements that improve quality and reduce healthcare spending in the Commonwealth while ensuring that any agreed-upon Alternative Payment Method remains functionally constrained by the Payer's option to apply the Commercial Unit Price System-wide Price Constraint, as described in Paragraph 73.

vi. <u>Constraint on Managed Medicare Unit Price Payments</u>

83. "Managed Medicare Percent of Unit Price" means the negotiated rate of reimbursement to be paid to BILH or any Covered BILH Provider in exchange for providing a specified health care service to an enrollee of a Covered Managed Medicare Payer's [as defined in Paragraph 88] Managed Medicare Health Insurance Product, expressed as a percentage of the Centers for Medicare & Medicaid Services' Medicare Rate Schedules.

84. For any Contract Year of a Payer Contract executed on or after the Filing Date, with rates first going into effect within the Price Constraint Period, or of an existing Payer Contract that is extended or renewed during the Price Constraint Period, the Managed Medicare Percent of Unit Price paid to Covered BILH Providers, agreed to in any Payer Contract with any Covered Managed Medicare Payer, shall not be greater than the Managed Medicare Payment Constraint [as defined in Paragraph 85].

a. The Managed Medicare Payment Constraint shall not apply to a Managed Medicare Percent of Unit Price agreed upon by BILH and a Covered Managed Medicare Payer as a part of a Payer Contract that provides payment to BILH through an Alternative Payment

Method. The requirements of Paragraph 89 will apply to such a Managed Medicare Alternative Payment Method.

85. The Managed Medicare Payment Constraint shall be set at the relevant Managed Medicare Percent of Unit Price paid to BILH or a Covered BILH Provider in the most recently completed Contract Year, regardless of any changes made by the government to the underlying Centers for Medicare and Medicaid Services' Medicare Rate Schedules.[6]

a. If BILH and a Covered Managed Medicare Payer agree that it is mutually advantageous to set a higher Managed Medicare Percent of Unit Price in a new Payer Contract, then BILH may petition the AGO to set such new Managed Medicare Percent of Unit Price as the Managed Medicare Payment Constraint for such Covered Managed Medicare Payer.

86. BILH's compliance with the Managed Medicare Payment Constraint with respect to its Managed Medicare Percent of Unit Price shall be measured at the time that BILH enters into a Payer Contract with a Covered Managed Medicare Payer.

87. If a health care provider becomes a Covered BILH Provider during the Price Constraint Period (a "New BILH Provider"), the Managed Medicare Percent of Unit Price for that New BILH Provider under a new Payer Contract with a Covered Managed Medicare Payer shall be that from the last Contract Year, or a recent trailing twelve-month period if the use of such recent trailing twelve-month period is agreed upon by BILH and the Covered Managed Medicare Payer, covered by the Payer Contract for a Managed Medicare Health Insurance Product between the New BILH Provider and a Covered Managed Medicare Payer prior to the

[6] For example, if BILH is negotiating a new Payer Contract with a Covered Managed Medicare Payer for a Managed Medicare Health Insurance Product that will take effect on January 1, 2020, and in the most recently completed Contract Year, 2018, a BILH hospital received 100% of the CMS Acute Inpatient PPS for acute inpatient services from that Covered Managed Medicare Payer, the Managed Medicare Payment Constraint for that hospital will be set at 100% of the CMS Acute Inpatient PPS for acute inpatient services, and that is the maximum rate that will be applied under the new Payer Contract.

New BILH Provider joining BILH. If no such previous Payer Contract exists, a weighted average of the Managed Medicare Percent of Unit Prices paid to comparable Covered BILH Providers under existing contracts with Covered Managed Medicare Payers shall be used to calculate the Managed Medicare Percent of Unit Price for that new Covered BILH Provider.

88. A Covered Managed Medicare Payer means any Payer that contracts with BILH for any BILH Providers to provide services to that Payer's Managed Medicare enrollees.

vii. <u>Constraint on Managed Medicare Alternative Payment Methods</u>

89. For any Contract Year of a Payer Contract executed on or after the Filing Date, with rates first going into effect within the Price Constraint Period, BILH and a Covered Managed Medicare Payer are free to enter into a Payer Contract that provides payment for a Managed Medicare Health Insurance Product to BILH through one or more Alternative Payment Methods provided that:

a. BILH, throughout any negotiation with a Covered Managed Medicare Payer, shall make available the option for any or all lives and/or services covered by said Payer under a Managed Medicare Health Insurance Product to be paid pursuant to a Managed Medicare Percent of Unit Price agreement at a rate no greater than the Managed Medicare Payment Constraint in effect.

i. BILH and the Covered Managed Medicare Payer are in no way further constrained in negotiating Alternative Payment Methods for Managed Medicare Health Insurance Products and may agree to any such contract that both parties find mutually preferable to a price-constrained Managed Medicare Percent of Unit Price arrangement for such lives and/or services.

ii. If BILH and a Covered Managed Medicare Payer are unable to negotiate an Alternative Payment Method for Managed Medicare Health Insurance Products for which the Payer finds the cost and terms acceptable, the Payer may choose to exercise the standing option of a Managed Medicare Percent of Unit Price arrangement covering such lives and/or services.

iii. It is the intent of the Parties that the option described herein preserves the ability of BILH and a Covered Managed Medicare Payer to innovate and develop mutually advantageous arrangements that improve quality and reduce healthcare spending in the Commonwealth while ensuring that any agreed-upon Alternative Payment Method remains functionally constrained by the Payer's option to apply the Managed Medicare Payment Constraint, as described in Paragraph 85.

B. Access to Health Care Services

90. Unless otherwise indicated, the obligations set forth in this Section B shall apply throughout the Access Period.

91. BILH shall maintain access for the communities served by BILH Hospitals to substantially similar clinical services as before the Closing Date.

i. <u>Access Related to MassHealth</u>

92. BILH Facilities participating in MassHealth as of the Filing Date shall maintain their participation in MassHealth indefinitely.

93. All health care providers employed by BILH who participate in MassHealth as of the Filing Date shall continue to participate in MassHealth so long as they are qualified to do so.

94. BILH shall make a good faith effort to have all physicians and other licensed providers who are employed by BILH, and all other BILH Providers, apply to participate in MassHealth (if they are eligible for such participation) within three (3) years of the Filing Date.

95. Consistent with M.G.L. ch. 151B, § 4(10) and 130 CMR 450.202, BILH shall be prohibited indefinitely from capping the number of MassHealth patients it collectively serves.

96. To increase the percentage of MassHealth patients in its payer mix, BILH shall create, implement and adequately fund a new program of marketing and advertising that targets underserved populations in specific geographies throughout Eastern Massachusetts and highlights and promotes access to BILH Providers for MassHealth patients. BILH, with input from the AGO, shall determine the scope and scale of such a program, as well as its geographic and demographic priorities.

97. As part of its efforts to serve MassHealth patients, NEBH shall create, implement and adequately fund a marketing, advertising and outreach program, including but not limited to the development of a multi-channel, micro-targeted campaign with a mix of transit advertising, print and digital advertising, and targeted outreach to housing developments (all utilizing multilingual messaging), focusing on the Boston neighborhoods of Mission Hill, Roxbury, Dorchester, and Mattapan.

ii. <u>Commitments to Community-Based Health Care Providers & Underserved Populations</u>

98. Consistent with the Transaction Parties' historical clinical and financial support for CHC Affiliates and Safety Net Affiliates, BILH shall fund and distribute at least $40.96 Million in the aggregate to CHC Affiliates and Safety Net Affiliates during the Access Period, *provided*, however, that up to $1 Million of such funds may be expended in the time period between the Filing Date and Closing Date. The distributions shall be made on a timely and

reasonably consistent annual basis and shall not at any point fall below $4.096 Million over any two-year period during the Access Period.

99. BILH shall also fund and distribute at least $8.8 Million in additional direct financial support to CHC Affiliates and Safety Net Affiliates during the Access Period. The distribution of this $8.8 Million shall (i) begin as soon as possible and, in any event, no later than two (2) years after the Closing Date, and (ii) continue on a timely and reasonably consistent basis throughout the Access Period and in accordance with planning processes described in Paragraphs 106(a) and 112(b). BILH shall not fund this $8.8 Million from a reduction in other historical spending used to benefit underserved populations.

100. BILH's financial obligations under Paragraphs 98-99 relative to any CHC Affiliate or Safety Net Affiliate are subject to the renewal and/or continuation of an affiliation with BILH; *provided*, however, that BILH's aggregate financial obligations under Paragraphs 98-99 shall not change even if a CHC Affiliate or Safety Net Affiliate does not continue an affiliation with BILH.

101. In addition to the financial obligations described in Paragraphs 98-99, BILH shall also fund and distribute at least $5 Million in strategic investments during the Access Period to expand access to needed health care services for communities of color and low-income communities, including, but not limited to, by establishing new collaborative relationships with Community Health Centers located in Gateway Municipalities and other underserved areas. This $5 Million shall not come from a reduction in other historical spending used by BILH to benefit underserved populations.

102. The new investments described in Paragraphs 99, 101 and 119 of this Assurance shall supplement (and shall not supplant) the level of Community Benefits spending by each

BILH Hospital as of the Filing Date. Nothing in this Assurance, however, precludes any BILH Hospital from reporting the investments described herein as Community Benefits, provided they qualify as such pursuant to the AGO's Community Benefits Guidelines.

103. For a period of one year after the Closing Date, BILH shall not employ any PCP who as of the Filing Date is employed by or jointly contracted with (i) a Safety Net Hospital, or (ii) a Community Health Center, *provided*, however, that this "no hire" provision shall not apply:

a. to a PCP who is employed by or jointly contracted with a hospital which is contractually affiliated with or owned by a Health Care System that has 10% or more statewide commercial market share by Net Patient Service Revenue, as calculated by CHIA for the prior fiscal year; or

b. to any PCP with whom BILH has a non-disclosure agreement, letter of intent, or executed agreement already in place as of the Closing Date, *provided further*, however, that for any employment arrangement that would otherwise violate this provision but for this "in process" exception, BILH will provide the AGO and the HPC with evidence that negotiations over terms were already underway as of the Filing Date.

104. During the Access Period, except with the assent of the hospital, BILH shall not solicit, or cause the solicitation, for employment any Department that is part of a Safety Net Hospital. For purposes of this paragraph, a "Department" shall mean all or a substantial majority of hospital medical staff in a clinical department or division, such that the departure of such a group of medical staff members would render the hospital incapable of continuing to provide that clinical service, including specialty and sub-specialty services.

iii. <u>Affiliation and Collaboration</u>

105. BILH shall make good faith efforts to continue and renew affiliation agreements with the CHC Affiliates on substantially similar terms to those in place as of the Filing Date and

in accordance with its financial obligations in Paragraphs 98-99. If a CHC Affiliate chooses to discontinue its affiliation with BILH, any obligation of BILH towards that CHC Affiliate under this Assurance, including financial obligations under Paragraphs 98-99, shall cease and any funds that BILH would have used to meet its financial obligations to that CHC Affiliate shall be reallocated towards BILH's other obligations under Paragraphs 98 or 99.

106. Within one (1) year of the Closing Date, and continuing throughout the Access Period:

a. BILH shall engage in a collaborative process with each CHC Affiliate to establish goals and priorities for BILH's investments in Community Health Centers, including new investments made pursuant to Paragraph 99; and

b. BILH shall ensure meaningful participation of personnel from the CHC Affiliates in regional clinical needs assessments and other relevant BILH business planning in the CHC Affiliates' service areas.

107. Within two (2) years of the Closing Date, and continuing throughout the Access Period, BILH shall explore opportunities to expand clinical and financial support to additional Community Health Centers within the primary service areas of BILH Hospitals and hospitals who are Contractually-Affiliated Providers in Essex and Middlesex Counties.

108. BILH shall make good faith efforts to continue and renew affiliation agreements with the Safety Net Affiliates on substantially similar terms to those in place as of the Filing Date and in accordance with its financial obligations in Paragraphs 98-99. However, if a Safety Net Affiliate chooses to discontinue its affiliation with BILH, any obligation of BILH towards that Safety Net Affiliate under this Assurance, including financial obligations under Paragraphs 98-99, shall cease. Further, any funds that BILH would have used to meet its financial

obligations to that Safety Net Affiliate shall be reallocated towards BILH's other obligations under Paragraphs 92-122, including to programs and services addressing access for at-risk, underserved, uninsured and MassHealth patient populations and to Safety Net Hospitals that become contractually or clinically affiliated with BILH after the Filing Date. While such funds may be directed to sustaining or expanding BILH's participation in MassHealth ACO programs, they shall not be used to offset any losses from BILH's participation in the MassHealth program itself.

109. BILH shall, in accordance with ongoing affiliation agreements, maintain the clinical programs that the Transaction Parties are supporting at Safety Net Affiliates as of the Filing Date, *provided*, however, that if in accordance with BILH's obligations set forth in Paragraphs 112(a) and 112(b), BILH and a Safety Net Affiliate agree to end or reduce a clinical program existing as of the Filing Date in favor of a different clinical program, such discontinuance or reduction shall not constitute a violation of this Paragraph 109 as long as the historical levels of financial support to the Safety Net Affiliates pursuant to Paragraph 98 are maintained.

110. BILH shall assist Safety Net Affiliates with the recruitment of PCPs and specialists, and with efforts to increase the number of PCPs and specialists affiliated with the Safety Net Affiliates, based on shared programmatic priorities, as agreed to by those entities.

111. BILH shall make the BILH brand and logo available to the Safety Net Affiliates for the purpose of overall hospital co-branding in signage, marketing, communications, and advertisement, as well as for targeted co-branding of clinical programs that have a sufficient degree of clinical integration with BILH (e.g., Signature Healthcare's Greene Cancer Care Center's affiliation with Beth Israel Deaconess Medical Center ("BIDMC")). Such co-branding

shall follow clear and consistent guidelines developed by the BILH marketing and clinical teams, *provided*, however, that BILH shall also maintain flexibility to meet the needs of Safety Net Affiliates that choose to maintain co-branding with a specific legacy institution (e.g., BIDMC) rather than BILH.

112. Within one (1) year of the Closing Date, and continuing throughout the Access Period:

a. BILH shall establish a model for joint system and regional planning for the relevant regions within which each Safety Net Affiliate operates. This model shall ensure meaningful participation of personnel from the Safety Net Affiliates in (i) regional clinical needs assessments; (ii) planning for clinical service expansion or closure; (iii) opening, expanding, or closing facilities; and (iv) other relevant business planning in the Safety Net Affiliates' respective geographic regions.

b. BILH shall determine with each Safety Net Affiliate a set of mutually agreed-upon priorities for investment, including new investments pursuant to Paragraph 99, in concert with ongoing affiliation agreements, except in such cases where mutually agreed-upon priorities have been previously defined with a Safety Net Affiliate.

c. BILH shall ensure meaningful participation of personnel from the Safety Net Affiliates in community health needs assessments and program planning related to BILH's provision of Community Benefits in furtherance of its charitable mission in the relevant service areas of each Safety Net Affiliate; *provided*, however, that each Safety Net Affiliate is expected to maintain its own distinct Community Benefits program.

iv. Joint Contracting Safety Net Affiliates

113. BILH shall not require, encourage or otherwise affirmatively incent physicians in risk-sharing arrangements with Joint Contracting Safety Net Affiliates to move into a risk-sharing arrangement with any BILH Hospital.

114. BILH shall treat all referrals by CIN physicians to any CIN network hospitals (including the Joint Contracting Safety Net Affiliates) or CIN network physicians as "in-system" or "retained" (i.e., not leakage).

115. BILH shall not take any actions to discourage or dis-incentivize CIN physicians (regardless of their affiliation) from referring patients to the Joint Contracting Safety Net Affiliates, including but not limited to actions that discourage such referral through BILH's design and implementation of metrics measuring "leakage" or systems incentivizing referrals.

116. BILH shall ensure that at least one member of the CIN Board of Managers shall be a representative from a Joint Contracting Safety Net Affiliate.

117. BILH shall ensure that, when negotiating and implementing reimbursement rates, Joint Contracting Safety Net Affiliates and BILH Hospitals with a Statewide Relative Price of less than 0.85 as defined and calculated by CHIA, receive a rate increase no less than the Commercial Unit Price Rate of Increase for each Covered Commercial Payer as defined in paragraph 77(a).

118. BILH shall offer Joint Contracting Safety Net Affiliates the option to participate in all CIN shared risk contracts.

v. Access to Behavioral Health Care

119. BILH shall create and fund through an investment of at least $16.9 Million a comprehensive and integrated continuum of behavioral health services with multiple entry points that enhances access to mental health and substance use disorder treatment for patients across

Eastern Massachusetts. BILH shall prioritize the initiatives set forth in Paragraphs 120-122 within that continuum. This $16.9 Million shall not come from a reduction in other historical spending used by BILH to benefit underserved populations.

120. BILH shall extend the IMPACT Model to all BILH Primary Care Practices, including completion of the hiring of additional behavioral health clinicians, consulting psychiatrists, and program supervisors necessary for the implementation of the IMPACT Model. BILH shall undertake this expansion as soon as reasonably practicable after the Closing Date and, in any event, pursuant to the following timetable:

a. Within three (3) years of the Closing Date, BILH shall extend the IMPACT Model to 50% of BILH Primary Care Practices where BILH employs the PCPs.

b. Within five (5) years of the Closing Date and continuing through the remainder of the Access Period, BILH shall extend the IMPACT Model to 100% of BILH Primary Care Practices.

c. In addition to the actions described above, within two (2) years of the Closing Date, BILH will perform a study of the feasibility of expanding the IMPACT Model to the CHC Affiliates.

121. BILH shall, within three (3) years of the Closing Date and continuing for the remainder of the Access Period, extend the Centralized Bed Management Program to all BILH Hospitals and other BILH Facilities that provide inpatient behavioral health treatment.

122. BILH shall, within two (2) years of the Closing Date and continuing for the remainder of the Access Period, invest in initiatives to enhance access to MAT for patients with opioid use disorders, including (i) expansion of Bridge Clinics to additional BILH Hospitals and (ii) expansion of same-day admission programs for MAT patients.

vi. Governance Commitments

123. BILH shall maintain and abide by governing documents, including Beth Israel Lahey Health, Inc.'s Bylaws and Articles of Organization, that reflect in the organization's charitable purposes (i) a core commitment to meeting the health care, including behavioral health, needs of at-risk, underserved, uninsured and government payer patient populations throughout the Commonwealth and (ii) a core commitment to diversity and geographic representation from within the service areas of the Safety Net Affiliates.

124. BILH shall include within the membership of Beth Israel Lahey Health, Inc.'s Board of Trustees a community healthcare leader and/or advocate who is experienced in addressing healthcare access for at-risk, underserved, uninsured and government payer patient populations in the Commonwealth.

125. BILH shall incorporate into its governance structure, including Beth Israel Lahey Health, Inc.'s Board of Trustees and each First Tier Affiliate's Board of Trustees, a commitment to (i) membership diversity, including but not limited to racial, gender and socioeconomic diversity and (ii) geographic representation from within the BILH (or First Tier Affiliate, as applicable) service area.

C. Reporting Requirements

126. Unless otherwise stated, all reports, data and information subject to and contained in the reporting requirements in this Section C, shall be due within sixty (60) days following the Closing Date and then annually thereafter on or before January 15 of each year for the prior fiscal year ending September 30. The AGO and BILH, by mutual agreement, may revise the initial reports of data and information required to be provided within sixty (60) days after the Closing Date.

127. BILH shall produce the data required in Paragraphs 129, 132 and 135 in a format mutually agreed upon with the AGO.

128. Throughout the Monitoring Period, BILH shall provide the AGO copies of any reports that it provides to the Department of Public Health ("DPH") as a condition of the approval of the Determination of Need Application: NEWCO-17082413-TO, as amended on October 10, 2018, including but not limited to the reports required by Conditions 1, 2, 4, and 5. Such copies shall be provided to the AGO when BILH provides DPH with the report.

129. Throughout the Monitoring Period, BILH shall annually report to the AGO the following information and data:

a. Analyses with supporting financial data detailing BILH's targeted cost savings, if any, as a result of the elimination of redundant operations; the cost savings actually achieved during the annual reporting period; and the total cost savings achieved in relation to the target.

b. Analyses with supporting financial data detailing BILH's targeted cost savings, if any, as a result of improved efficiencies related to patient care; the cost savings actually achieved during the annual reporting period; and the total cost savings achieved in relation to the target.

c. Analyses with supporting financial data detailing BILH's targeted cost savings, if any, due to shifting community-appropriate care to higher value sites of care; the cost savings actually achieved during the annual reporting period; and the total cost savings achieved in relation to the target.

d. Information sufficient to identify the elimination of any existing clinical services or the creation of new clinical services during the annual reporting period and in total, including the locations impacted.

e. Information sufficient to identify any clinical, administrative, financial, or other operations that have been consolidated during the annual reporting period and in total, including the locations impacted.

130. Within eighteen (18) months of the Filing Date, BILH shall submit a report to the AGO detailing its plan to have all BILH Providers apply to participate in MassHealth, pursuant to its obligations in Paragraph 94.

131. The information provided to the AGO pursuant to Paragraphs 128-130 shall be considered public records subject to the Massachusetts Public Records Law, M.G.L. c. 66, § 10, and the AGO shall have the authority to share it with any person or entity, including the HPC.

132. Throughout the Monitoring Period, BILH shall annually report to the AGO the following additional information and data:

a. For all BILH Facilities, (i) the total number of patient encounters within each Service Line, and (ii) for each such patient encounter: the relevant Service Line; the Facility name; the payer category (i.e., Medicaid, Medicare or commercial); and the patient's zip code.

b. For all PCPs at BILH Primary Care Practices, the total number of patients covered by risk contracts, broken down by payer.

c. For BILH patients covered by risk contracts, (i) the total number of patient encounters with any BILH Provider, and (ii) the total number of patient encounters that are not with a BILH Provider, broken down by payer category (i.e., Medicaid, Medicare or commercial).

d. A list of all physicians who, during the prior year, became employed by

BILH or began jointly contracting with BILH. For each such physician, the list shall identify: the physician's first and last name; practice name; practice location; provider identification number; specialty; date of affiliation; and the physician's previous employer and previous joint contracting affiliate, if different than the employer.

e. BILH annual revenue by payer, divided into categories for fee-for-service revenue, risk settlement revenue, and any other supplemental or quality payments, both in total and per member per month where applicable.

133. BILH shall make good faith efforts to answer any reasonable inquiries from the AGO concerning the reports provided under Paragraph 132. The AGO may make reasonable requests for additional information and data as necessary to clarify information provided under Paragraph 132.

134. The AGO and BILH, by mutual agreement, may revise the required reports of data and information under Paragraph 132.

135. For the four-year period beginning one (1) year after the Closing Date, BILH shall provide an annual report to the AGO detailing the employment or joint contracting of any PCP who, immediately prior to affiliating with BILH, was employed by or jointly contracted with a Safety Net Hospital prior to the PCP joining BILH. The report should include details such as the PCP's first and last name; practice name; practice location; provider identification number; date of affiliation with BILH; and the identification of the PCP's prior affiliation.

136. The AGO shall have the authority to share all data or information reported by BILH under Paragraphs 132 and 135 with the HPC for the purposes of evaluating, assessing and monitoring the impact of the creation of BILH on the cost and access to health care services in the Commonwealth. The AGO and the HPC shall, to the extent provided by law, protect the

confidentiality of any data or information provided under Paragraphs 132 and 135 and identified by BILH as confidential, consistent with applicable law, including laws governing public records.

137. BILH, upon prior notice from the AGO, shall waive any confidentiality obligations owed to it on the part of any third party, including any payers, who may have records of BILH that the AGO deems relevant to its assessment of the impact of the creation of BILH on the cost of and access to health care services.

138. Nothing in this Assurance is to be construed as a waiver by BILH of any rights it may have to assert that information it provides pursuant to Paragraphs 132 and 135 is not subject to public disclosure under applicable law. BILH may assert in good faith at any time that any submission of information to the AGO, whether by BILH or the Monitor as set forth below, in connection with this Assurance, is subject to exemption from disclosure under any applicable public records law, including but not limited to M.G.L. c. 66 and its implementing regulations. Upon such an assertion by BILH, the AGO will assess whether the information in question is subject to exemption from disclosure.

139. Pursuant to its authority under M.G.L. c. 12, § 11N, the AGO may require BILH (along with other payers and providers) to produce certain information related to the AGO's monitoring of trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market.

VI. THIRD PARTY MONITORING OF ASSURANCE COMPLIANCE

140. Within forty-five (45) days of the Filing Date, BILH shall propose to the AGO a Monitor with (i) experience related to the operations and finances of large health care

institutions, and (ii) sufficient independence from BILH to ensure effective and impartial performance of the Monitor's duties as described in this Assurance. BILH shall provide the AGO with the proposed Monitor's name, resume or CV, and contact information, and shall respond to any follow up inquiries from the AGO concerning the proposed Monitor's qualifications.

141. If the AGO, in its sole discretion, determines that the proposed Monitor is not qualified, or if it is otherwise not satisfied with BILH's proposed candidate, BILH shall propose alternate candidates pursuant to the process described in Paragraph 140. This selection process shall continue until a Monitor acceptable to both BILH and the AGO is chosen, provided that BILH and the AGO shall use best efforts to complete the selection process within ninety (90) days of the Filing Date.

142. Upon approval of the Monitor by the AGO, BILH shall retain the Monitor to perform the duties set forth in this Assurance and on terms consistent with this Assurance. The terms of the engagement shall be subject to AGO approval. BILH shall designate the AGO a third-party beneficiary to its engagement agreement with the Monitor.

143. The Monitor shall, upon approval of the AGO, have the power and authority to retain individuals or firms, including outside experts, to assist in fulfilling the Monitor's responsibilities and duties. Any such individuals shall have sufficient independence from BILH to ensure effective and impartial performance of the Monitor's duties as described in this Assurance.

144. The Monitor, in consultation with the AGO and following input from BILH, shall develop a proposed scope of work and associated budget within ninety (90) days after the Closing Date and thereafter on an annual basis no later than ninety (90) days after the

anniversary of the Closing Date. The AGO shall have the authority to review and approve such proposal.

145. BILH is solely responsible for payment of all fees and expenses of the Monitor, the Monitor's staff, and reasonably required outside experts approved by the AGO in performing the duties set forth in this Assurance. BILH shall compensate the Monitor, and any individuals or firms hired to assist the Monitor as described in Paragraph 143, (i) on reasonable and customary terms commensurate with the individual's or firm's experience and responsibilities and (ii) consistent with the Monitor's scope of work.

146. Throughout the Monitoring Period, the Monitor shall have the authority and responsibility to monitor BILH's compliance with all terms of this Assurance.

147. The Monitor shall have the power and authority to obtain all relevant documents and information from BILH, including meeting with or interviewing current (and, as necessary, former) BILH employees, executives, and officers, and any other relevant third party, concerning BILH's compliance with this Assurance.

148. BILH shall cooperate with and facilitate the work of the Monitor, including using its best efforts to provide the Monitor with access to BILH's third-party vendors, agents and consultants.

149. BILH waives any confidentiality obligations owed to it on the part of any third party who may have records of BILH or other information that may be relevant to the Monitor's work pursuant to this Assurance.

150. The AGO may request, and the Monitor shall share, any documents or information related to the Monitor's work, including confidential information obtained from

BILH. The AGO will notify BILH of any such contact with the Monitor either prior to or within five (5) days of any such contact.

151. The AGO may contact the Monitor at any time during the Monitoring Period to discuss BILH's compliance with this Assurance, including concerns that BILH is not complying with this Assurance.

152. At BILH's expense, the Monitor shall prepare an annual report as to BILH's compliance with this Assurance throughout the Monitoring Period. The Monitor's report:

a. Shall be delivered to the AGO and BILH on or before January 15 of each year for the prior fiscal year ending September 30;

b. Shall be considered a public record under the Massachusetts Public Records Law, although BILH reserves the right to request that the AGO assess whether a portion or portions of the annual report should be redacted or withheld by the AGO as exempt from disclosure under the Massachusetts Public Records Law;

c. Shall not contain information reasonably asserted by BILH to be confidential;

d. Shall include a description of any instance in which the Monitor believes that BILH was or is not in compliance with this Assurance and a detailed explanation as to why the Monitor has formulated this conclusion;

e. Shall include, but shall not be limited to, the following:

i. An assessment of whether BILH is in compliance with the System-wide Price Constraint as to each of the Covered Payers;

ii. An assessment of, and information and data sufficient to show, BILH's compliance with its Assurances concerning MassHealth-related access in Paragraphs 92-97 and hiring and solicitation in Paragraph 103-104;

iii. Financial data and descriptions reflecting BILH's financial investments during the annual reporting period in the CHC Affiliates and Safety Net Affiliates, as required in Paragraph 98-99;

iv. An assessment of, and information sufficient to show, BILH's compliance with its non-financial commitments to the CHC Affiliates, Safety Net Affiliates, and the Joint Contracting Safety Net Affiliates, as set forth in Paragraphs 105-118;

v. Financial data concerning BILH's community investments during the reporting period as required in Paragraph 101 and a detailed explanation of how the investments have been used in communities of color and for low-income and other underserved populations;

vi. Financial data concerning BILH's investments during the reporting period to improve access to behavioral health as required in Paragraph 119 and a detailed explanation of how the investments have been used;

vii. An assessment of BILH's compliance with the governance provisions, as set forth in Paragraphs 123-125;

viii. An assessment of BILH's compliance with obligations relating to access to behavioral health services, as set forth in Paragraph 120-122; and

ix. An assessment of any concerns presented to the Monitor by the AGO regarding BILH's compliance with this Assurance.

153. At the AGO's sole discretion, the Monitor shall meet with the AGO within sixty (60) calendar days after providing the AGO its annual monitoring report to discuss the findings in the report.

154. If during the Monitoring Period (i) the Monitor becomes unable to perform his or her obligations or (ii) if the AGO, in its sole discretion, determines that the Monitor cannot fulfill its obligations to monitor BILH's compliance with this Assurance to the satisfaction of the AGO and notifies BILH of such determination, BILH shall within thirty (30) calendar days of such event propose to the AGO a new Monitor in accordance with the process described in Paragraphs 140-141.

VII. GENERAL PROVISIONS

155. This Assurance represents the entire agreement between the AGO and BILH concerning the matters addressed herein. It supersedes any prior agreement, understandings, or stipulations between the Parties regarding the subject matter hereof.

156. This Assurance shall be binding on BILH and its successors, as well as their agents, servants, employees, trustees and assigns. If BILH has fulfilled its obligations under this Assurance for the five (5) year period following the Closing Date, BILH may present evidence to the AGO that the financial commitments in Paragraphs 98, 99, 101 and 119 of this Assurance are unsustainable and have resulted in BILH incurring significant and sustained losses. Further, BILH may petition the AGO to amend BILH's obligations under this Assurance for the remainder of the applicable time period, which request shall be subject to the sole discretion of the AGO.

157. This Assurance shall be governed by and interpreted in accordance with the laws of the Commonwealth of Massachusetts. This Assurance confers no standing or other legal rights on any party other than the AGO and BILH.

158. This Assurance shall be filed in the Superior Court of Suffolk County. The Superior Court of Suffolk County has and shall retain jurisdiction over this Assurance.

159. This Assurance shall not relieve BILH of any obligation to comply with all applicable federal, state, and local laws and regulations.

160. Nothing contained in this Assurance, including but not limited to the reporting requirements in Paragraphs 128-139 set forth above and the monitoring provisions in Paragraphs 140-154, shall be construed to limit in any way whatsoever the AGO's authority under any provision of law to investigate any matter, to obtain any documents and information through subpoena, civil investigative demand or any other lawful process, or to bring any action the AGO deems appropriate under any provision of law.

161. By virtue of the provisions of M.G.L. c. 93A, § 5, any violation of the terms of this Assurance by BILH, its agents, servants, employees, successors, and assigns after the date of this Assurance shall constitute prima facie evidence of a violation of M.G.L. c. 93A, § 2, in any civil action or proceeding commenced by the AGO.

162. BILH shall comply with all reasonable inquiries and requests from the AGO regarding the implementation of the terms contained within this Assurance.

163. BILH hereby accepts the terms and conditions of this Assurance and waives any right to challenge it in any action or proceeding.

164. Exhibits A, B, C1, C2 and D are incorporated herein and are fully part of this Assurance and binding upon the Parties.

165. The titles in this Assurance have no independent legal significance and are used merely for the convenience of the Parties.

166. This Assurance may be executed in counterparts.

167. This Assurance shall be effective upon the Filing Date. In the event BILH notifies the AGO that the Proposed Transaction will not occur and has been abandoned, this Assurance shall terminate and the rights and obligations of the Parties hereto shall thereafter be null and void.

168. Any notices or communications required to be transmitted between the AGO and BILH pursuant to this Assurance shall be provided in writing by first-class mail, postage prepaid, and by electronic mail to the Parties as follows, unless otherwise agreed in writing.

If to the Office of the Attorney General:

William Matlack
Chief, Antitrust Division
Eric Gold
Chief, Health Care Division
Office of the Attorney General
One Ashburton Place, 18th Floor
Boston, MA 02108
william.matlack@mass.gov
eric.gold@mass.gov

If to BILH :

Kevin Tabb, MD
President and Chief Executive Officer
Beth Israel Lahey Health, Inc.
109 Brookline Avenue, Suite 300
Boston, MA 02215-3903
ktabb@bidmc.harvard.edu

Jamie Katz, JD
General Counsel
Beth Israel Lahey Health, Inc.
109 Brookline Avenue, Suite 300
Boston, MA 02215-3903
jwkatz@bidmc.harvard.edu

169. The undersigned represent that s/he is duly authorized to execute this Assurance on behalf of BILH and to bind BILH to all applicable provisions of this Assurance, and that on behalf of BILH s/he voluntarily enters this Assurance.

By: _____
Kevin Tabb, MD
President & CEO

Date: 11-28-2018

By: _____
Ann-Ellen Hornidge, JD
Chair

Date:

168. Any notices or communications required to be transmitted between the AGO and BILH pursuant to this Assurance shall be provided in writing by first-class mail, postage prepaid, and by electronic mail to the Parties as follows, unless otherwise agreed in writing.

If to the Office of the Attorney General:

William Matlack
Chief, Antitrust Division
Eric Gold
Chief, Health Care Division
Office of the Attorney General
One Ashburton Place, 18th Floor
Boston, MA 02108
william.matlack@mass.gov
eric.gold@mass.gov

If to BILH :

Kevin Tabb, MD
President and Chief Executive Officer
Beth Israel Lahey Health, Inc.
109 Brookline Avenue, Suite 300
Boston, MA 02215-3903
ktabb@bidmc.harvard.edu

Jamie Katz, JD
General Counsel
Beth Israel Lahey Health, Inc.
109 Brookline Avenue, Suite 300
Boston, MA 02215-3903
jwkatz@bidmc.harvard.edu

169. The undersigned represent that s/he is duly authorized to execute this Assurance on behalf of BILH and to bind BILH to all applicable provisions of this Assurance, and that on behalf of BILH s/he voluntarily enters this Assurance.

By: _____
Kevin Tabb, MD
President & CEO

Date:

By: Ann-Ellen Hornidge
Ann-Ellen Hornidge, JD
Chair

Date: 11/28/2018

COMMONWEALTH OF MASSACHUSETTS
ATTORNEY GENERAL MAURA HEALEY

By: _____

Mary A. Beckman, Chief, Health Care and Fair Competition Bureau (BBO# 565655)
William T. Matlack, Chief, Antitrust Division (BBO# 552109)
Eric M. Gold, Chief, Health Care Division (BBO# 660393)

Date: 11-28-2018

Exhibit A
Closing Entities

Closing Entities	Post-Closing Status
Beth Israel Lahey Health, Inc.	System Parent
Anna Jaques Hospital (1)	First Tier Affiliate
Beth Israel Deaconess Medical Center, Inc. ("BIDMC")(2)	First Tier Affiliate
Beth Israel Deaconess – Milton	First Tier Affiliate
Beth Israel Deaconess – Needham	First Tier Affiliate
Beth Israel Deaconess – Plymouth	First Tier Affiliate
Lahey Clinic Foundation, Inc. (3)	First Tier Affiliate
Mount Auburn Hospital	First Tier Affiliate
New England Baptist Hospital	First Tier Affiliate
Northeast Hospital Corporation	First Tier Affiliate
Northeast Behavioral Health Corporation	First Tier Affiliate
Winchester Hospital	First Tier Affiliate

Notes:

(1) Seacoast Regional Health Systems, Inc. will merge into Anna Jaques Hospital

(2) CareGroup, Inc. will merge into BIDMC

(3) Lahey Health System, Inc. will merge into Lahey Clinic Foundation, Inc., which is currently and will remain the sole member of Lahey Clinic, Inc. and Lahey Clinic Hospital, Inc.

Exhibit B: Calculation of the Commercial Unit Price Rate of Increase in the first Contract Year of a new Payer Contract

The following example illustrates the calculation of the Commercial Unit Price Rate of Increase for the BILH system with a single Covered Commercial Payer X[1]. The example contract is negotiated in 2019 and will take effect on January 1, 2020. The most recently completed Contract Year was 2018. 2020 therefore represents the first year of a new Payer Contract.

Covered BILH Provider (examples)	Baseline Set of Services (2018)		2019 Commercial Unit Price	2019 Projected Revenue	2020 Commercial Unit Price	2020 Projected Revenue
	All services provided by Covered BILH providers to Covered Payer X's enrollees in 2018 (examples)	2018 utilization (# of services) for Baseline Set of Services	2019 negotiated unit price for each service	2019 unit prices applied to Baseline Set of Services	2020 negotiated unit price for each service	2020 unit prices applied to Baseline Set of Services
BIDMC	MS-DRG 231: Coronary Artery Bypass with PTCA with MCC	100	$40,000	$4,000,000	$41,000	$4,100,000
	CPT 77431: Radiation Treatment Management; Complete Course of Therapy; 1-2 Fractions	900	$4,000	$3,600,000	$4,100	$3,690,000
BID Plymouth	MS-DRG 775: Vaginal Delivery without CC	200	$5,000	$1,000,000	$5,100	$1,020,000
	MS-DRG 193: Simple Pneumonia and Pleurisy with MCC	300	$6,000	$1,800,000	$6,100	$1,830,000
Lahey Burlington	CPT 99214: Office or Other Outpatient Visit for Established Patient (Neurology Consultation)	5,000	$150	$750,000	$155	$775,000
	MS-DRG 296: Cardiac Arrest, Unexplained with MCC	500	$14,000	$7,000,000	$14,300	$7,150,000
Primary Care Group	CPT 99214: Office or Other Outpatient Visit for Established Patient	5,000	$150	$750,000	$155	$775,000
Total Projected Revenue	-	-	-	**$18,900,000**	-	**$19,340,000**

$$\textbf{2020 Commercial Unit Price Rate of Increase} = \frac{2020\ \text{TPR} - 2019\ \text{TPR}}{2019\ \text{TPR}} \times 100 = \frac{\$19{,}340{,}000 - \$18{,}900{,}000}{\$18{,}900{,}000} \times 100 = \mathbf{2.3\%}$$

[1] This Exhibit is intended to illustrate the calculation by using a short list of example services provided by Covered BILH Providers to the enrollees of Covered Commercial Payer X. The System-wide Price Constraint is applied in this manner to all such services unless the methodology in Exhibit C1 and/or C2 is used for some or all services.

Exhibit C1: Alternative calculation of the Commercial Unit Price Rate of Increase with Baseline Revenue of most recently completed Contract Year

The following example illustrates the calculation of the Commercial Unit Price Rate of Increase for the BILH system with a single Covered Commercial Payer X[2]. The example contract is negotiated in 2019 and will take effect on January 1, 2020. The most recently completed Contract Year was 2018. 2020 therefore represents the first year of a new Payer Contract.

Payer: Covered Commercial Payer X Baseline Period: 2018 Contract Year (1/1/2018 - 12/31/2018)						
Covered BILH Provider (examples)	Category of Services	2018 Baseline Revenue	2019 Uniform Price Increase	2019 Projected Revenue	2020 Uniform Price Increase	2020 Projected Revenue
BIDMC	Laboratory[3]	$12,000,000	0.0%	$12,000,000	0.0%	$12,000,000
	High-End Imaging (MR, CT)[3]	$30,000,000	-5.0%	$28,500,000	-5.0%	$27,075,000
	All Other Hospital Services[4]	$350,000,000	2.8%	$359,800,000	3.5%	$372,393,000
Winchester Hospital	Laboratory	$1,000,000	0.0%	$1,000,000	0.0%	$1,000,000
	High-End Imaging (MR, CT)	$3,500,000	-5.0%	$3,325,000	-5.0%	$3,158,750
	All Other Hospital Services	$28,000,000	4.0%	$29,120,000	3%	$29,993,600
BILH Physicians	Primary Care E & M Codes	$40,000,000	5.0%	$42,000,000	5.0%	$44,100,000
	All Other Professional Billing	$640,000,000	2.4%	$655,360,000	2.40%	$671,088,640
Total Projected Revenue	-	**$1,104,500,000**	-	**$1,131,105,000**	-	**$1,160,808,990**

$$\textbf{2020 Commercial Unit Price Rate of Increase} = \frac{\text{2020 TPR} - \text{2019 TPR}}{\text{2019 TPR}} \times 100 = \frac{\$1{,}160{,}808{,}990 - \$1{,}131{,}105{,}000}{\$1{,}131{,}105{,}000} \times 100 = \mathbf{2.6\%}$$

[2] This Exhibit is intended to illustrate the calculation by using example categories of services provided by Covered BILH Providers to the enrollees of Covered Commercial Payer X. The System-wide Price Constraint may be applied in this manner to all such services, where applicable.
[3] Specific categories of clinical services listed only where the unit price increase from Covered Commercial Payer X varies from the uniform unit price increase.
[4] All other services listed on one line to reflect that the unit price increase is applied uniformly for all services other than those specifically listed.

Exhibit C2: Alternative calculation of the Commercial Unit Price Rate of Increase with Baseline Revenue of trailing twelve-month period

The following example illustrates the calculation of the Commercial Unit Price Rate of Increase for the BILH system with a single Covered Commercial Payer X[5]. The example contract is negotiated in 2019 and will take effect on January 1, 2020. The most recently completed Contract Year was 2018. 2020 therefore represents the first year of a new Payer Contract. The most recent 12-months of revenue data available to both BILH and Payer X, and agreed upon by Payer X, is 8/1/2018 – 7/31/2019. In addition, the revenue amounts used by BILH for all categories of trailing 12-month Baseline Revenue must be acceptable to the Payer.

Payer: Covered Commercial Payer X Baseline Period: Trailing twelve months (8/1/2018 – 7/31/2019)						
Covered BILH Provider (examples)	Category of Services	Trailing 12-month Baseline Revenue	2020 Uniform Price Increase	2020 Projected Revenue	2021 Uniform Price Increase	2021 Projected Revenue
BIDMC	Laboratory[6]	$12,000,000	0.0%	$12,000,000	0.0%	$12,000,000
	High-End Imaging (MR, CT)[6]	$30,000,000	-5.0%	$28,500,000	-5.0%	$27,075,000
	All Other Hospital Services[7]	$350,000,000	2.8%	$359,800,000	3.5%	$372,393,000
Winchester Hospital	Laboratory	$1,000,000	0.0%	$1,000,000	0.0%	$1,000,000
	High-End Imaging (MR, CT)	$3,500,000	-5.0%	$3,325,000	-5.0%	$3,158,750
	All Other Hospital Services	$28,000,000	4.0%	$29,120,000	3%	$29,993,600
BILH Physicians	Primary Care E & M Codes	$40,000,000	5.0%	$42,000,000	5.0%	$44,100,000
	All Other Professional Billing	$640,000,000	2.4%	$655,360,000	2.40%	$671,088,640
Total Projected Revenue	-	**$1,104,500,000**	-	**$1,131,105,000**	-	**$1,160,808,990**

[5] This Exhibit is intended to illustrate the calculation by using example categories of services provided by Covered BILH Providers to the enrollees of Covered Commercial Payer X. The System-wide Price Constraint may be applied in this manner to all such services, where applicable.
[6] Specific categories of clinical services listed only where the unit price increase from Covered Commercial Payer X varies from the uniform unit price increase.
[7] All other services listed on one line to reflect that the unit price increase is applied uniformly for all services other than those specifically listed.

Calculation of the Unit Price Rate of Increase:

$$\textbf{2020 Commercial Unit Price Rate of Increase} = \frac{2020\ \text{TPR} - 2019\ \text{TPR}}{2019\ \text{TPR}} \times 100 = \frac{\$1{,}131{,}105{,}000 - \$1{,}104{,}500{,}000}{\$1{,}104{,}500{,}000} \times 100 = \mathbf{2.4}\%$$

$$\textbf{2021 Commercial Unit Price Rate of Increase} = \frac{2021\ \text{TPR} - 2020\ \text{TPR}}{2020\ \text{TPR}} \times 100 = \frac{\$1{,}160{,}808{,}990 - \$1{,}131{,}105{,}000}{\$1{,}131{,}105{,}000} \times 100 = \mathbf{2.6}\%$$

Exhibit D: Calculation of Total Projected Revenue for changes in Commercial Unit Price that do not occur at the beginning of a Contract Year.

The following example illustrates the calculation of the Total Projected Revenue for the BILH system from a single Covered Commercial Payer X, for a Contract Year, 2020, in which the change in Commercial Unit Price does not occur at the beginning of that year. The example contract is negotiated in 2019 and will take effect on January 1, 2020. The negotiated Commercial Unit Price increase occurs on October 1, 2020. The most recently completed Contract Year was 2018. 2020 Total Projected Revenue A & 2020 Total Projected Revenue B are calculated using the Baseline Set of Services or Baseline Revenue, as illustrated in Exhibits B, C1 and C2. The combined 2020 Total Projected Revenue will then be used to calculate the Commercial Unit Price Rate of Increase for 2020.

Covered BILH Provider	2020 Projected Revenue A Jan - Sept rates applied to Baseline Set of Services or Uniform Price Increases applied to Baseline Revenue	2020 Projected Revenue B Oct - Dec rates applied to Baseline Set of Services or Uniform Price Increases applied to Baseline Revenue	2020 Total Projected Revenue (.75 x TPR A) + (.25 x TPR B)
BIDMC	$10,000,000	$10,300,000	$10,075,000
BID Plymouth	$9,000,000	$9,135,000	$9,033,750
Lahey Burlington	$180,000	$187,200	$181,800
NEBH	$20,000,000	$20,400,000	$20,100,000
Primary Care Group XYZ	$240,000	$246,000	$241,500
Total Projected Revenue	$39,420,000	$40,268,200	$39,632,050