# Health Policy Commission Questions - 2013

1. **Chapter 224 of the Acts of 20 12 (c.224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.**

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

   *Summary: Partners' population health management (PHM) initiative provides the greatest opportunity to lower costs, manage trend, coordinate care and improve outcomes. Partners PHM strategy includes two key components — Patient Centered Medical Homes (PCMH) and the integrated Care Management Program (iCMP).*

   Partners' population health management (PHM) initiative provides the best opportunity to lower costs, manage trend, coordinate care, and improve outcomes. PHM is an approach that invests in services and infrastructure to improve patient access, reduce fragmentation in care, help patients navigate the system, and provide information to patients so they can make better health care decisions. Phase I of Partners' PHM strategy includes two key components: Patient Centered Medical Homes (PCMH) and the integrated Care Management Program (iCMP).

   Partners is transforming all of its primary care practices to become PCMHs as part of a multi-year effort. PCMH is a team-based health care delivery model led by a personal physician working closely with nurse practitioners, behavioral health specialists, case managers, and other allied health professionals and supported by a comprehensive health information technology system.

   Partners is also implementing the integrated Care Management Program (iCMP) within all of its primary care practices. This program focuses on better care coordination and management of medically complex, vulnerable patients across the continuum to improve health, quality, and cost outcomes.

   Partners' PHM initiative necessitates enhanced and strengthened relationships with community-based providers, including both hospitals and physicians. By keeping patients within a coordinated system that shares a common strategy and a robust health IT platform, caregivers can track the quality of care more effectively and focus on the cost of that care by eliminating repetitive procedures, such as tests and imaging that can happen when a patient sees a disconnected number of providers. By investing in primary care and doing a better job of coordinating care through its PHM initiative, Partners can keep patients healthier and out of the hospital – ultimately reducing costs in the health care system.

**b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?**

*Summary: Partners' integrated care management program (iCMP) provides one of the greatest opportunities to improve the quality and efficiency of care. iCMP focuses on the 5 percent of the patient population that generates nearly 50 percent of medical costs.*

Partners' integrated care management program (iCMP) provides one of the greatest opportunities to improve the quality and efficiency of care. It is well documented that 5 percent of the population generates nearly 50 percent of medical costs. iCMP is designed to focus specifically on those high-cost and high-risk patients who have complex and often multiple conditions by providing them with robust care management. Each patient enrolled in the program is monitored by a nurse care manager associated with the patient's primary care physician, along with a team of caregivers, including social workers and community resource specialists. The nurse care manager proactively identifies and addresses issues, such as medications and appointment compliance, which may have an impact on patient health and cost.

Over the last 12 months, Partners has identified patients who may benefit from high risk patient management by using data from its electronic health records and claims data from payers. Partners has hired 80 nurse care managers, 16 social workers, 3 pharmacists, and 8 community resource specialists who collectively have begun management of more than 8,000 medically complex patients across the system.

(See question #1.c for a discussion of challenges.)

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

While Partners is committed and will continue to make progress in reducing the growth in health care costs, it does so in the face of serious challenges. Removing these challenges would greatly speed the pace of progress towards lowering health care costs. These challenges include:

- Ability to pursue new partnerships with community hospitals and community physicians
- Reimbursement models with non-aligned incentives (e.g., global budgets based on underlying fee for service payments; and services such as nurse care managers not adequately reimbursed)
- Public payer shortfalls
- Duplicative reporting requirements
- Complex billing policies
- Lack of access to real-time patient claims data
- Labor costs
- Heightened demand for high-cost technology and interventions

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

Through its population health management initiative, Partners is focused on lowering medical costs and overall trend. Partners has also renegotiated existing contracts with three major commercial payers and has every expectation that the payers will pass those savings on to consumers and businesses in the form of lower premiums. (See question #2 for more details.)

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

Over the past 3 years Partners has saved over $300 million in expenses across the system. Partners achieved these savings through a variety of efforts including improvements in its clinical care processes and productivity and administrative expenses. This allowed Partners to reopen its existing contracts with the three major Massachusetts commercial payers — Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan — and agree to rate adjustments that will generate $345 million in total savings to be passed back to consumers over four years. Partners does not anticipate that its prices will increase by more than the rate of general inflation for the next several years, a level of increase needed to ensure high quality care and a talented workforce.

In the first full year of participation in the Medicare Pioneer ACO and commercial risk contracts, Partners has delivered encouraging results with regard to its medical trend. In 2012, Partners combined trend for its commercial risk-based contracts was -0.7% when health status adjusted. In the Medicare Pioneer ACO, Partners succeeded in beating its national benchmark on trend by 2.4% — resulting in $14.4 million in savings.

**3. C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?**

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

Partners' Patient Centered Medical Homes (PCMH) and integrated Care Management Program (iCMP) offer the greatest opportunities to integrate behavioral health services. (See question #1 for a description of these programs.) Partners is implementing a clinical model that improves the detection of behavioral health (BH) disorders and integrates the delivery of BH services within PCMH. PCMH will improve access to coordinated, evidence-based BH services, improve the management of BH disorders and co-morbid illness, and improve outcomes and reduce total medical expense. In addition, high-risk medically complex patients at risk of incurring high costs, receive evidenced-based behavioral health care and case management services through iCMP. In this program, care managers, BH providers, and patients collaborate in developing a coordinated treatment plan.

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

Key challenges include the successful design and launch of new technologies (e.g., telehealth-based services), hiring and training staff, and integrating new care protocols seamlessly into existing workflows. Another major challenge is reimbursement for behavioral health services provided within a primary care setting, which is not available due to regulatory constraints. Inadequate funding and reimbursement threaten access to BH providers and the expansion of integrated models of care. In addition, the BH carve out model, which results in separate budgets for mental and physical health creates a barrier that interferes with the integration of BH with general medical care. It should, therefore, be reconsidered, since an integrated budget that includes both BH and medical care would facilitate and enhance integration.

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

The following policy changes would promote integration:

- Alignment of financial incentives to promote the provision of integrated care
- Adequate funding for BH services would make it possible for patients to receive treatment at the most appropriate, cost-effective setting
- Funding for infrastructure necessary to implement integrated and innovative care models would facilitate expansion of existing programs
- Reimbursement for virtual visits using telehealth technologies could be used to improve access to specialty care
- Reimbursement for online patient directed therapy options, such as internet-based cognitive behavioral therapy significantly reduces depression and anxiety symptoms in a cost effective manner
- Support for partnerships with community hospitals and community physicians

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

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

Partners is redesigning how care teams work with patients and ensuring that these teams have the technology and tools necessary to provide high quality, coordinated, and cost effective care. Partners is actively managing particular patient populations to improve clinical outcomes through its PHM initiative. (See question #1 for details.) These include patients with chronic or complex illness, including behavioral health, long term care, and rehabilitative health needs, and those at high risk for becoming high cost, high utilizers, or having avoidable adverse clinical outcomes. Key areas of focus include palliative care, readmissions, and transitions in care. These efforts are supported by new payment models with each of the state's large commercial insurers and through the federal Pioneer ACO program. (See question #2 for details.)

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

Partners is committed and will continue to make real progress for its patients in reducing the trend in health care costs, it does so in the face of serious challenges. Removing these challenges would greatly speed the pace of progress towards lowering health care costs. These challenges include:

- Ability to pursue new partnerships with community hospitals and community physicians
- Reimbursement models with non-aligned incentives (e.g., global budgets based on underlying fee for service payments; and services such as nurse care managers not adequately reimbursed)
- Public payer shortfalls
- Duplicative reporting requirements
- Complex billing policies
- Lack of access to real-time patient claims data
- Labor costs
- Heightened demand for high-cost technology and interventions

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

Partners is making significant investments in transforming how care is delivered, specifically in the development of Partners' Patient Centered Medical Homes (PCMH) and the integrated Care Management Program (iCMP), which are more effectively supported by global payment models. Partners current reimbursement model is fee for service (and therefore rewards providers for volume), and where there is risk, there is shared savings with downside risk. Fee for service does not align with the way care is being delivered in the primary care setting. Each payer (government and private) has varying ability to transition from fee for service to global payments. Partners is eager to implement new programs that experiment with technology (virtual visits/real time consultations), reduce the overall cost of care, and increase patient satisfaction. Without the current model transitioning from fee for service to global payments, especially for primary care, it will be challenging for Partners to continue to make progress in redesigning care.

Partners also needs to strengthen its relationships with community-based providers in order to enhance its primary care capacity and ensure patients receive care in the most appropriate and lowest cost setting closest to home. Eliminating barriers to new provider relationships is important to promoting efficient and accountable care.

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

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

Partners acute hospitals use various unit cost metrics to track expenses depending on their type of work. At an institutional level, Partners primarily use the Cost per Case Mix Adjusted Discharge (CMAD) as a measurement of cost per unit trends over time. Other benchmarks include full-time employee (FTE) per CMAD and FTE per patient day.

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

Partners primarily use Action OI, an operational benchmarking system purchased through the University HealthSystem Consortium. ACTION OI benchmarks are derived from over 750 hospitals nationwide that supply data on a quarterly basis.

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

The budget process within the acute hospitals at Partners is the primary driver for reviewing expense growth. Performance throughout the year is measured against budget. The Finance Department routinely works with the other departments to ensure they understand significant changes in their expenses (compared to budget and/or the prior year), identify the key drivers of change (changes in volume, intensity, price per unit, etc.), and manage the impact of those drivers.

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

To comply with the new transparency requirement in Chapter 224, Partners is putting the necessary policies and procedures into place. Starting in January 1, 2014, each hospital will be able to provide patients with an estimate of their liability for inpatient services and the contracted amount for outpatient services. Patients will be asked to call the Admitting Department if they need an estimate.

Starting in 2015, Partners will be transitioning this function to its new information system – Epic. Although Epic implementation is well underway, it will take several years before it will be fully operational due to the complexity of the organization and the comprehensiveness of the Epic solution.

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

*Summary: Partners concurs with the Center for Health Information Analysis' (CHIA) finding that the growth in total medical expenditures (TME) has slowed in recent years. This is consistent with Partners experience. However, in future reports Partners urges CHIA to include important contextual about the volume of patients treated when presenting data on the amount of payments each provider received in a given year.*

Partners concurs with the Center for Health Information Analysis' (CHIA) finding that the growth in total medical expenditures (TME) has slowed in recent years. This is consistent with Partners experience and understanding of recent market trends. Recent studies suggest that this downward trend is not simply a result of the recession or an anomaly, but rather a result of fundamental changes to the health care system including, payment and delivery system reforms, shifting care to lower cost settings, and changes in benefit design.

Similarly, Partners is not surprised by the finding in the CHIA report that Partners received 28 percent of hospital and physician payments in 2011. Each year 1.5 million patients — about 25 percent of the state's population — choose to receive their care at Partners facilities. Additionally, Partners offers important services that many other providers choose not to offer, including mental health, substance abuse and rehabilitation services. The payments received by Partners are proportional to the number of patients treated at Partners practices and facilities. Partners urges CHIA to include such important contextual information in future reports.

# Attorney General Questions - 2013

**1. For each year 2009 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.**

See attachment A for an excel file of the following table.

| PHS Total Operating Margin FY 2009 - FY 2012 | | | | | |
|---|---|---|---|---|---|
| FY | Margin | Commercial | Government | Other | Total |
| 2009 | $ | 1,013.160 | (685.253) | (163.458) | 164.449 |
| | % | 23.4% | -36.9% | -11.4% | 2.2% |
| 2010 | $ | 1,092.993 | (766.951) | (131.522) | 194.520 |
| | % | 23.9% | -38.6% | -8.4% | 2.4% |
| 2011 | $ | 1,191.347 | (862.418) | (95.624) | 233.305 |
| | % | 25.2% | -40.9% | -5.8% | 2.8% |
| 2012 | $ | 1,280.407 | (931.995) | (157.503) | 190.909 |
| | % | 26.5% | -42.6% | -8.0% | 2.1% |
| **Note: Margin in $Ms** | | | | | |

* Medicaid and free care losses have been growing more rapidly in recent years than Medicare losses. Since 2009 Medicaid margins have declined from -44% to -74% and Free Care margins from -84% to -211%. Medicaid and Free Care contributed 41% of the margin losses from public payers in 2012, up from 32% in 2009.
** Nationally, in 2012 private payers paid hospitals 135% of their cost on average, an increase from 117% in 2001. (Avalere Health analysis of American Hospital Association Annual Survey data, 2013).

Partners facilities included in the Partners table are as follows:

- Acute care hospitals: Brigham and Women's, Brigham and Women's Faulkner, Martha's Vineyard, Massachusetts General, Nantucket Cottage, Newton Wellesley, North Shore Medical Center
- Non-Acute facilities: Partners Continuing Care and McLean
- Physician's Organizations: Brigham and Women's Physicians Organization, Massachusetts General Physicians Organization, Newton Wellesley Ambulatory Services, North Shore Physicians Group

Margin is calculated as follows: Revenue less Costs. The Margin was split into three categories "Government", "Commercial" & "Other":

- Government: Medicaid (managed & non-managed), Medicare (managed & non-managed) & Free Care
- Commercial: Non-Government Patient Care Related (Including Commonwealth Care)
- Other: Non-Patient Care Related

% Margin is calculated as follows: $\frac{\text{Margin}}{\text{Revenue}}$

2. **If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully-insured v. self-insured) on your opportunities for surpluses.**

   *Summary: Partners is a Medicare Pioneer ACO and has entered several commercial payer contracts that put the system at risk for its performance on managing total medical expense trend. Under the Medicare Pioneer ACO, Partners succeeded in beating its national benchmark on trend by 2.4% — resulting in $14.4 million in savings. In its commercial contracts combined, Partners experienced a negative trend of -0.7%, when health status adjusted.*

   Partners is a Medicare Pioneer ACO and has entered several commercial payer contracts that put the system at risk for its performance on managing total medical expense trend. These risk contracts provide incentives for Partners to redesign the way care is delivered to its patients, which it is doing primarily through development of Patient Centered Medical Homes (PCMH) and its integrated Care Management Program (iCMP). (See question #2 from the Health Policy Commission for a description of these programs.)

   After its first full year of participation in the Pioneer ACO initiative and risk contracts with the Commonwealth's three largest commercial insurers Partners has delivered encouraging results both with respect to quality and cost. In Medicare's Pioneer ACO, Partners performed exceptionally well in the program's quality measures. At the same time, Partners succeeded in beating its national benchmark on trend by 2.4% — resulting in $14.4 million in savings. In its commercial contracts combined, Partners experienced a negative trend of -0.7% for care delivered to its patients, when health status adjusted.

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

   *Summary: Partners uses two major sources of data to analyze performance in its risk contracts and project its risk. Partners receives claims data on its patients from the payers, and has the ability to extract clinical data from its electronic health records of its patients.*

   Partners uses two major sources of data to analyze performance in its risk contracts and project its risk. Partners receives claims data on its patients from the payers, and Partners has the ability to extract clinical data from its electronic health records of its patients. Depending on the performance measure being analyzed, Partners uses one or both of these sources to produce reports that approximate its year-end performance in its risk contracts. Reports are produced monthly, and a final settlement report is produced at the end of the contract year.

During the course of the measurement year, Partners uses its quarter-end reports to determine whether the network is in a surplus or deficit scenario, and books reserves at its entities to cover any projected losses. In addition, a cash retention on physician billing is taken by the payer for some of Partners network participants, which is then returned to Partners Community Healthcare, Inc. (PCHI). PCHI holds a portion of this cash until it is determined that any external losses are covered.

In order to better control cost, accept risk, and manage the care of its patients, Partners continues to invest in necessary infrastructure to support a variety of care management programs for the patients who see its primary care doctors (see answer to question #2 for more details).

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

   As part of its commercial risk arrangements, the payers calculate and share a PCHI network level DxCG risk score for the relevant measurement periods. The payers also provide Partners with claims data for those members covered under the risk arrangement. PCHI has the capability to run the DxCG software using these data feeds and generate risk scores at both the network and individual provider group level. Partners monitors changes in population severity to evaluate changes observed in medical expense. Partners also uses the software's clinical classification function to identify member sub populations with similar disease profiles to further refine its care management efforts.

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

   **See attachment B for excel spreadsheet.**

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

   **NOTE:** The following responses speak to growth for both periods FY10-11 and FY11-12. The percentage change and dollar value of growth is noted throughout the text.

   a.) Total operating expense for the Partners system increased 6% ($488M) FY10-11 and 7% ($542M) FY11-12, driven in part due to volume and case mix growth. Employee compensation and benefits increased slightly more than 5% (approx $235M) per year, driven by the opening of the Lunder (i.e., patient care facilities), the growth within the physician organizations due to the implementation of its population health management initiative, and a modest salary and wage

program. Supply and other expenses grew 8% ($150M) FY11-12, mainly driven by Lunder, increases in space-related expense at the Brigham and Women's Hospital (BWH) (i.e., Landsdowne, Mass Mental, and research space), BWH's program support to the Brigham and Women's Physician Organization, and the Huron Healthcare Consulting engagement that identified cost reduction and revenue cycle improvement opportunities.

b.) Depreciation grew 11% ($41M) FY10-11 and 5% ($21M) FY11-12 while interest expense grew 9% ($6.4M) FY10-11 and 26% ($21M) FY11-12 due to increased borrowing to support the capital needs and funding the pension plan across the system. A 14% ($129M) increase in research expense in FY10-11 across the hospitals was offset by the temporary funds from the American Recovery and Reinvestment Act of 2009. Also in FY12, Partners made a strategic decision related to a change in scope and direction for its system-wide patient administrative system and concluded that certain costs that had been capitalized no longer had future value. A one-time, non-cash impairment charge of $110M was recorded.

**7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.**

*Summary: Partners has numerous programs focusing the wellness of its patients, communities, and employees. For example, Partners is strengthening health centers – the cornerstone of care for more than 800,000 people in our state – through the Partnership for Community Health. This grant program is a 15 year, up to $90 million commitment.*

Wellness programs are critical to the long-term health of patients. Partners has numerous longstanding wellness programs, from a comprehensive hospital based smoking cessation program to annual ambulatory practice-based wellness visits. A majority of these activities are not reimbursed by payers, and Partners has committed internal funding to them.

Partners' work to improve community health focuses on three priority areas: access, economic and educational opportunities, and health and well-being through prevention. Together with its hospitals, health centers and local partners, Partners is making deep, long-term commitments to community health programs that are effective, measurable, and sustainable. For example, Partners is strengthening health centers – the cornerstone of care for more than 800,000 people in our state – through the Partnership for Community Health. This grant program is a 15 year, up to $90 million commitment. Partners is investing in young people with summer and school year jobs, college preparation courses, STEM curriculum, and college scholarships to enhance their educational experiences and career paths. And Partners is helping to make the healthy choice into the easy choice for children and families by supporting the state Department of Public Health's Mass in Motion – a program designed to engage whole communities in healthy nutrition and exercise options.

Partners is also committed to improving the health of its community, and that extends to its employees. Based on claims data for its employees, Partners has identified five key areas of opportunities: diabetes / obesity, healthy maternity, age-appropriate cancer screening, mental health / substance abuse, and tobacco cessation. The medical director for Partners employee population has convened groups across the system to develop programs in these areas.

PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

Submitted Electronically via

HPC-Testimony@state.ma.us

**Gary L. Gottlieb, M.D., M.B.A.**
*President and Chief Executive Officer*
*Partners HealthCare System, Inc.*

*Professor of Psychiatry*
*Harvard Medical School*

September 27, 2013

Dear Ms. Johnson and Ms. Aladro:

Massachusetts has a strong record of success in solving tough problems when all stakeholders work together. Partners HealthCare is committed to working with the Health Policy Commission and the Attorney General's Office to improve care for patients and their families, to reshape the health care system, and to make our state an even better place to live for all of our residents.

Enclosed you will find written testimony for Partners HealthCare as requested for the upcoming cost trend hearings on Oct 1-2, 2013. Please note that since Massachusetts General Hospital and Brigham and Women's Hospital are affiliates of Partners HealthCare System, their responses are identical to the responses submitted by Partners HealthCare. However, where appropriate, entity-specific data tables are provided.

By my signature below, I certify that I am legally authorized and empowered to represent Partners HealthCare for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Aimee Golbitz, Office of Government Affairs at Partners HealthCare (agolbitz@partners.org 617-823-3997).

Sincerely,

Gary L. Gottlieb, MD, MBA
President and CEO

Partners HealthCare System, Inc., Prudential Tower, Suite 1150, 800 Boylston Street, Boston, Massachusetts 02199-8001
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**Attachment A - Partners HealthCare**

| PHS Total Operating Margin FY 2009 - FY 2012 | | | | | |
|---|---|---|---|---|---|
| FY | Margin | Commercial | Government | Other | Total |
| 2009 | $ | 1,013.160 | (685.253) | (163.458) | 164.449 |
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| | % | 26.5% | -42.6% | -8.0% | 2.1% |
| **Note: Margin in $Ms** | | | | | |

# Exhibit 1 AGO Questions to Providers and Hospitals

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

**NOTES:**

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

**2009**

| | P4P Contracts | | | | Risk Contracts | | | | | | FFS Arrangements | | Other Revenue Arrangements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claims-Based Revenue | | Incentive-Based Revenue | | Claims-Based Revenue | | Budget Surplus / (Deficit) Revenue | | Quality Incentive Revenue | | | | | | |
| | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | Both |
| BCBSMA | $ 412,536,173 | | $ 35,582,282 | | | | | | | | $ 367,308,333 | $ 784,891,309 | $ 4,679,825 | | |
| Tufts | $ 132,935,597 | | $ 6,205,572 | | | | | | | | $ 92,950,420 | $ 94,942,464 | $ 570,333 | | |
| HPHC | $ 161,909,962 | | $ 11,585,377 | | | | | | | | $ 206,365,560 | $ 110,436,668 | $ 886,742 | | |
| Fallon | | | | | | | | | | | $ 24,547,715 | | | | |
| CIGNA | | | | | | | | | | | $ 96,134,301 | $ 1,726,423 | | | |
| United | | | | | | | | | | | | $ 141,664,932 | | | |
| Aetna | | | | | | | | | | | $ 125,327,583 | $ 34,045,873 | | | |
| Other Commercial | | | | | | | | | | | | $ 385,414,333 | | | |
| ***Total Commercial*** | $ 707,381,731 | | $ 53,373,231 | | | | | | | | $ 912,633,912 | $ 1,553,122,002 | $ 6,136,899 | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | $ 50,238,634 | | | | |
| NHP | | | | | | | | | | | $ 70,092,347 | | | | |
| BMC Healthnet | | | | | | | | | | | $ 6,344,018 | | | | |
| Fallon | | | | | | | | | | | | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | $ 126,675,000 | | | | |
| | | | | | | | | | | | | | | | |
| ***Mass Health*** | | | | | | | | | | | $ 225,125,182 | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | $ 79,121,522 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | $ 13,433,462 | | | | |
| Other Comm Medicare | | | | | | | | | | | $ 38,976,201 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | $ 131,531,186 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | $ 1,070,872,489 | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | $ 707,381,731 | | $ 53,373,231 | | | | | | | | $ 1,395,965,279 | $ 2,623,994,490 | $ 6,136,899 | | |

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
Other Commercial Primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS , One Health, and other smaller payers.
The HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate
Data include MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS
Payer line information for McLean, Spaulding Network, MVH, and NCH is not available. They represent ~8% of total PHS NPSR

**2010**

| | P4P Contracts | | | | Risk Contracts | | | | | | FFS Arrangements | | Other Revenue Arrangements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claims-Based Revenue | | Incentive-Based Revenue | | Claims-Based Revenue | | Budget Surplus / (Deficit) Revenue | | Quality Incentive Revenue | | | | | | |
| | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | Both |
| BCBSMA | $ 424,587,594 | | $ 45,524,517 | | | | | | | | $ 376,570,265 | $ 853,613,773 | $ 5,069,549 | | |
| Tufts | $ 132,005,692 | | $ 10,031,058 | | | | | | | | $ 107,092,961 | $ 126,731,169 | $ 587,192 | | |
| HPHC | $ 160,881,819 | | $ 14,346,350 | | | | | | | | $ 212,917,102 | $ 131,957,314 | $ 960,341 | | |
| Fallon | | | | | | | | | | | $ 27,816,654 | | | | |
| CIGNA | | | | | | | | | | | $ 90,848,918 | $ 5,067,830 | | | |
| United | | | | | | | | | | | | $ 166,625,061 | | | |
| Aetna | | | | | | | | | | | $ 147,099,956 | $ 27,475,035 | | | |
| Other Commercial | | | | | | | | | | | | $ 399,721,261 | | | |
| ***Total Commercial*** | $ 717,475,105 | | $ 69,901,925 | | | | | | | | $ 962,345,856 | $ 1,711,191,443 | $ 6,617,082 | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | $ 66,400,014 | | | | |
| NHP | | | | | | | | | | | $ 74,542,660 | | | | |
| BMC Healthnet | | | | | | | | | | | $ 5,644,049 | | | | |
| Fallon | | | | | | | | | | | | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | $ 146,586,724 | | | | |
| | | | | | | | | | | | | | | | |
| ***Mass Health*** | | | | | | | | | | | $ 222,623,839 | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | $ 77,976,194 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | $ 13,601,229 | | | | |
| Other Comm Medicare | | | | | | | | | | | $ 39,152,937 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | $ 130,730,360 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | $ 1,151,785,973 | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | $ 717,475,105 | | $ 69,901,925 | | | | | | | | $ 1,462,286,779 | $ 2,862,977,416 | $ 6,617,082 | | |

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
Other Commercial Primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS , One Health, and other smaller payers.
The HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate
Data include MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS
Payer line information for McLean, Spaulding Network, MVH, and NCH is not available. They represent ~8% of total PHS NPSR

**2011**

| | P4P Contracts | | | | Risk Contracts | | | | | | FFS Arrangements | | Other Revenue Arrangements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claims-Based Revenue | | Incentive-Based Revenue | | Claims-Based Revenue | | Budget (Deficit) | | Quality Incentive Revenue | | | | | | |
| | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | Both |
| BCBSMA | $ 448,222,202 | | $ 47,484,701 | | | | | | | | $ 324,274,556 | $ 904,357,168 | $ 4,666,282 | | |
| Tufts | $ 137,265,405 | | $ 12,654,603 | | | | | | | | $ 95,841,251 | $ 157,028,743 | $ 494,044 | | |
| HPHC | $ 166,641,127 | | $ 16,406,473 | | | | | | | | $ 209,722,136 | $ 172,658,417 | $ 829,071 | | |
| Fallon | | | | | | | | | | | $ 28,871,969 | | | | |
| CIGNA | | | | | | | | | | | $ 100,447,066 | $ 5,599,138 | | | |
| United | | | | | | | | | | | | $ 198,209,821 | | | |
| Aetna | | | | | | | | | | | $ 162,537,571 | $ 26,080,761 | | | |
| Other Commercial | | | | | | | | | | | | $ 419,493,284 | | | |
| ***Total Commercial*** | $ 752,128,734 | | $ 76,545,777 | | | | | | | | $ 921,694,548 | $ 1,883,427,333 | $ 5,989,397 | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | $ 81,656,996 | | | | |
| NHP | | | | | | | | | | | $ 85,858,079 | | | | |
| BMC Healthnet | | | | | | | | | | | $ 7,968,874 | | | | |
| Fallon | | | | | | | | | | | | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | $ 175,483,950 | | | | |
| | | | | | | | | | | | | | | | |
| ***Mass Health*** | | | | | | | | | | | $ 199,845,348 | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | $ 72,681,425 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | $ 13,810,081 | | | | |
| Other Comm Medicare | | | | | | | | | | | $ 18,656,837 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | $ 105,148,343 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | $ 1,249,747,510 | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | $ 752,128,734 | | $ 76,545,777 | | | | | | | | $ 1,402,172,190 | $ 3,133,174,843 | $ 5,989,397 | | |

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
Other Commercial Primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS , One Health, and other smaller payers.
The HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate
Data include MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS
Payer line information for McLean, Spaulding Network, MVH, and NCH is not available. They represent ~8% of total PHS NPSR

## Attachment B - Partners Health Care

**2012**

| | P4P Contracts | | | | Risk Contracts | | | | | | FFS Arrangements | | Other Revenue Arrangements | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claims-Based Revenue | | Incentive-Based Revenue | | Claims-Based Revenue | | Budget Surplus/ (Deficit) Revenue | | Quality Incentive Revenue | | | | | | |
| | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | HMO | PPO | Both |
| BCBSMA | $ 112,234,564 | | $ 11,692,162 | | $ 271,941,278 | | $ 2,628,689 | | 2012 not yet settled | | $ 293,675,254 | $ 1,105,698,770 | $ 2,877,349 | | |
| Tufts | $ 34,219,763 | | $ 3,260,239 | | $ 72,482,229 | | $ (282,009) | | 2012 not yet settled | | $ 123,614,701 | $ 196,279,371 | $ 433,286 | | |
| HPHC | $ 41,581,138 | | $ 4,180,762 | | $ 81,938,348 | | $ 793,187 | | 2012 not yet settled | | $ 281,712,620 | $ 208,038,009 | $ 762,045 | | |
| Fallon | | | | | | | | | | | $ 31,242,463 | | | | |
| CIGNA | | | | | | | | | | | $ 129,114,275 | $ 3,787,321 | | | |
| United | | | | | | | | | | | | $ 211,465,271 | | | |
| Aetna | | | | | | | | | | | $ 182,104,609 | $ 27,371,434 | | | |
| Other Commercial | | | | | | | | | | | | $ 430,393,988 | | | |
| ***Total Commercial*** | $ 188,035,465 | | $ 19,133,163 | | $ 426,361,856 | | $ 3,139,867 | | | | $ 1,041,463,922 | $ 2,183,034,164 | $ 4,072,681 | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | $ 57,770,940 | | | | |
| NHP | | | | | | | | | | | $ 78,559,128 | | | | |
| BMC Healthnet | | | | | | | | | | | $ 5,502,614 | | | | |
| Fallon | | | | | | | | | | | | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | $ 141,832,681 | | | | |
| | | | | | | | | | | | | | | | |
| ***Mass Health*** | | | | | | | | | | | $ 213,448,418 | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | $ 79,455,133 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | $ 16,371,342 | | | | |
| Other Comm Medicare | | | | | | | | | | | $ 11,364,546 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | $ 107,191,021 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | $ 184,943,252 | | $ 5,151,516 | | | | $ 1,178,117,914 | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | $ 188,035,465 | | $ 19,133,163 | | $ 426,361,856 | $ 184,943,252 | $ 3,139,867 | $ 5,151,516 | | | $ 1,503,936,042 | $ 3,361,152,078 | $ 4,072,681 | | |

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
Other Commercial Primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS , One Health, and other smaller payers.
The HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate
Data include MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS
Payer line information for McLean, Spaulding Network, MVH, and NCH is not available. They represent ~8% of total PHS NPSR