Acton Medical
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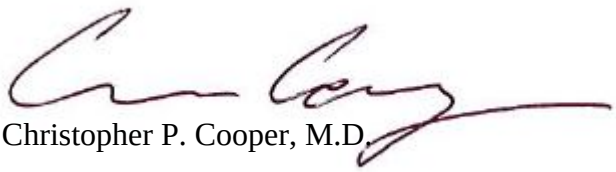
September 10, 2015

Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Attn: Lois H. Johnson

I, Christopher P. Cooper, M.D., Medical Director of Acton Medical Associates, P.C., am authorized to represent Acton Medical Associates, P.C. for the purposes of this testimony in response to inquiries from the Health Policy Commission, the Attorney General's Office, and the Center for Health Information and Analysis, and I have signed under the pains and penalties of perjury.



Christopher P. Cooper, M.D.

Medical Director and Chief Executive Officer

Acton Medical Associates, P.C.

Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

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

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

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 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 in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

    Acton Medical Associates, P.C. (hereinafter Acton Medical) has experienced the following trends in CY 2014 and year-to-date 2015.
    - Decrease in incentive revenue associated with Medicare initiatives such as Meaningful Use.
    - Increase in payroll and payroll related costs primarily due to the additional staffing requirements of referral processing, system implementation and application, data analysis and quality measurement reporting.
    - Increase in information technology costs including networking, wireless technology, IT security, hardware costs, outside maintenance and support contracts, and other applications.
    - Increase in medical supply costs including the cost of immunizations, laboratory reagents, and other supplies.
    - Increase in utility costs due to increased rates.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    Acton Medical has continued to enhance the following programs.
    - Employing triage nurses that manage patient care, avoiding unnecessary office visits.
    - Providing diagnostic services such as x-ray and ultrasound that are typically reimbursed at lower rates than at hospitals.
    - Providing in-house clinical services such as anticoagulation management, allergy clinics and vaccination clinics that would be more costly if provided in a hospital setting.
    - Employing various care coordinators such as a social worker and quality assurance nurses to ensure that patients receive appropriate care in a timely manner. This team also establishes registries of patients with chronic disease, allowing them to proactively outreach and manage the care of these patients.
    - Actively managing patient referrals to low-cost, high-quality providers in Acton Medical's network.
    - Utilizing a transitional care management program, which includes daily notification of discharges from our local hospital, patient outreach, scheduling of follow up appointments, and coordination of care by mulitple specialties, avoiding unneccssary hospital readmissions.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

Acton Medical has significant experience managing care and participating in alternative payment contracts. These contracts include full risk, non-risk and quality based incentive payments. Our managed care programs are intertwined with our integrated and Coordination of Care programs and are used to improve and augment the care of all patients, as well as reduce overall healthcare costs. We plan to continue to participate and expand patient membership under these contracts. Acton Medical does not enter into Shared Savings or other alternative payment contracts when total medical expense or quality outcomes are used to determine payment unless the patient is required to select a primary care physician (PCP) to directly manage their preventive care and referrals to specialists.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

Acton Medical encourages consideration for mandating PCP selections for all patients, regardless of insurer or benefit structures. Patients that self-refer often unnecessarily select higher-cost providers. We also recommend further review of medical malpractice reforms. It is difficult to quantify how often providers defensively order diagnostic services, prescribe medications or refer patients to specialists that are believed to be unnecessary simply to avoid the possibility of a malpractice claim. Finally, it is our recommendation that the health care cost growth benchmark of 3.6% exclude infrastructure expenditures necessary to implement quality improvement and cost containment initiatives. Investments in these programs should not be hindered by short-term goals in recognition of the potential long term cost containment benefit.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

Acton Medical continues to enter into risk contracts with HMOs that require patients to make a PCP selection. We believe that care management under these contracts has improved the quality of services and patient outcomes as well as helped to reduce healthcare costs. Our managed care systems are PCP-centric and rely on our PCPs' ability to proactively work with patients on the coordination of their care. Products that do not require PCP selection limit our ability to manage patient care and, therefore, carry risks that are beyond our control. We strongly feel that primary care involvement in patient care and appropriate referral patterns both improve quality and reduce costs. As such, Acton Medical does not enter into risk contracts or other alternative payment

contracts unless the patient is required to select a PCP. This could be addressed by requiring PCP selection for all risk and alternative payment plans.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

    1) Spending on post-acute care

    Our practice has partnered with a local hospital to implement a transitional care management program to ensure that we are notified daily of patients that are discharged after a hospitalization. Discharge summaries and all consultations are reviewed so that optimal follow up care is provided. Our nurses then contact patients within 48 hours of discharge to review the following: How they are feeling, discharge planning, discharge diagnosis and medications, need for coordination of care by multiple disciplines and community service agencies and scheduling follow up appointments. This information is presented to the primary care provider for review which provides the PCP an opportunity to identify patients who may need to be evaluated sooner than normal. We also have a social worker available for coordination of care of social services. We are currently working to expand this program by establishing a relationship with another hospital in an effort to reach more of our patient population upon discharge from that facility. We also collaborate with insurance companies so that we are aware of the programs that the insurance company offers for disease management. The transitional care management program also provides an opportunity for our nurses to assess and address barriers to care.

    2) Reducing avoidable 30 day readmissions

    As described above, our practice performs outreach to patients that have been discharged after a hospitalization. In addition to receiving a discharge list from the local hospital, we receive daily admission and discharge reports from some insurance companies which help us to identify our patients that have been admitted and/or discharged from hospitals outside of the local hospital.

    3) Reducing avoidable emergency department (ED) use

    Our practice is structured to minimize unnecessary emergency room utilization by our patients. We provide urgent, same day appointments for patients as well as urgent access to our social worker. The office is open 7 days a week with 24 hour triage advice available. While somewhat more difficult to measure, we believe our approach to well visits and the establishment of a primary care physician-patient relationship helps reduce these utilizations as well. Our pediatric department participates in the MCPAP program which provides urgent psychiatric consultative services. Additionally, our practice receives a daily ED visit report from the local hospital. Our nurses then outreach to all Acton Medical patients that have been discharged from the ED to review any need for follow up care.

4) Providing focused care for high-risk/high-cost patients

Acton Medical has implemented a diabetes management program to help reduce complications of diabetes. Our quality assurance nurses work in collaboration with our diabetic nurse practitioners. Some of the initiatives include performing outreach to all diabetic patients that have gaps in care, pre-visit planning for all diabetics that are scheduled with the diabetic nurse practitioner in order to provide a more meaningful visit that is patient centered, and coordinating care with specialists to reduce the cost of care. Most recently, our practice has added a registered dietician to the care team.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

Acton Medical continues to identify opportunities to establish relationships with other area hospitals so that we can receive medical record information upon admission and discharge to and from the inpatient facility. This will provide an opportunity to perform coordination of care to more of our patients in a timely manner in order to reduce readmissions. Acton Medical plans to expand our chronic disease management to include additional diagnoses for management of our high-risk/high-cost patients.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
   a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

   It is Acton Medical's belief that many acceptable factors contribute to the determination of prices by providers. These factors include, but are not limited to, the complexity of the service, availability of specialty services, and investments in research, teaching, and new technology innovation.

   b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

   Acton Medical believes that the overall cost of care is impacted more by the differentials in rates paid by payers to providers instead of the prices determined by providers. As stated in previous testimony, Acton Medical's approach to negotiating our risk contracts has been to request network competitive rates, since it is our belief that our integrated care systems and our commitment to care coordination and management will always

result in lower costs, PMPM, than that of most other groups. Recently, however, we are finding that many risk contract proposals are moving away from "network" rates and are, instead, adopting an approach which sets budgets and rates against the groups past performance. This model of establishing rates may account for the rate variation that is suggested in this question since this is a fairly arbitrary number and does not attempt to establish or reconcile a "market" rate for these services. Acton Medical strongly believes that this type of model does not recognize the achievements of groups, such as Acton Medical, which have long histories of effectively managing patient care while controlling costs. This model also makes it more difficult to sustain quality improvement and care management programs, since reimbursement does not recognize these efforts as value-added services over time. With the exception of the adoption of the above mentioned model, it is our belief that rate variations for payers are also a function of each group's ability to leverage its delivery systems, care integration programs, its membership, the size of the organization, the ancillary services it provides, and many other market factors. Acton Medical will rely on the Health Policy Commission to determine the overall impact of price variation on the Massachusetts' health care delivery system.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

       We continue to have a social worker on staff as part of our Patient-Centered Medical Home program, who provides on-site services to patients. She works with patients to connect them with community resources such as elder care, visiting nurse services, family and individual counseling, transportation services, and disability applications. The social worker also provides on-site emergency counseling. She works with the providers to integrate the behavioral needs of our patients into part of their ongoing care plan. She is a regular participant in clinical meetings and shares a growing network of mental health providers and resources she has vetted with the providers at Acton Medical. She meets regularly with area mental health providers, both new and established to maintain and enhance this network.

    b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

Via our social work program, we will continue to enhance our behavioral health care. We are continuously assessing our patients' needs and trying to determine how we can best meet them. Our practice is structured to minimize unnecessary emergency room utilization by all of our patients, including those with behavioral health issues. We provide urgent, same day appointments for patients as well as urgent access to our social worker. The office is open 7 days a week with 24 hour triage advice available. While somewhat more difficult to measure, we believe our approach to well visits and the establishment of a primary care physician-patient relationship helps reduce these utilizations as well. Our pediatric department participates in the MCPAP program which provides urgent psychiatric consultative services. We also utilize several programs that provide urgent and, often times, in home mental health assessments.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

   Acton Medical has achieved level 3 PCMH recognition from NCQA with a 100% of our PCP's recognized. Our group focuses on managing the care of the whole patient through prevention, follow-up for screening tests, and nurse triage. We have several quality programs in place that continue to evolve, including in-house diabetes support groups and monitoring of HEDIS measures. Acton Medical would not participate in an ACO unless the model would require patients to select a primary care physician to directly manage their preventive care and referrals to specialists.

Exhibit C: Instructions and AGO Questions for Written Testimony

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

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1				
	Q2				
	Q3				
	Q4				
CY2015	Q1				
	Q2				

Acton Medical, upon request, will direct insured patients to the member service number on the back of their card if they have questions regarding their coverage. Uninsured patients, upon request, are provided with our office visit charges. Patients typically inquire with our billing department regarding the cost of a physical, immunization, labs and ultrasound. Acton Medical does not track the number or type of inquiries for patients who are requesting price information.

2. Please submit a summary table showing for each year 2011 to 2014 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 Provider Exhibit 1** with all applicable fields completed. 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.

See Exhibit 1 attached

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of any technical barriers to making or receiving referrals and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

    a. Infectious disease is the only specialty service offered by Acton Medical Associates. A small percentage of incoming referrals of non-Acton Medical patients are received via fax and processed through the Allscripts PM system. Internal referrals are not required; however an order is entered by the member's primary care physician for a consultation with the infectious disease specialist.

    b. If a patient requires a referral, the primary care physicians place an order in our EMR system. When a patient initiates a referral request by phone, a task is generated in our EMR system and forwarded to the member's primary care physician for review. Once approved, the referral is processed with the member's insurance company and a referral letter is generated in our EMR system which is automatically faxed to the specialist. In addition, effective October 1, 2014, Acton Medical Associates began the process of sending e-referrals to the specialists associated with Emerson Hospital in compliance with Meaningful Use 2 requirements.

    c. Acton Medical Associates physicians refer patients to Emerson Hospital knowing the specialty care there is more cost effective. If specialty care cannot be provided at Emerson Hospital, members are directed to a qualified specialist outside of this referral circle. In such cases, these referrals are subjected to a secondary review and approval process by a designated medical director to determine the clinical appropriateness for the referral.

    d. The Referral Department checks the member's insurance eligibility prior to issuing a referral. The staff will access the appropriate insurance website to confirm that the specialist is participating with the member's insurance product. The Referral Department will inform the patient if the specialist is not in their insurance network and will work with the patient to find a specialist that contracts with their insurance

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide

2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services
6. **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.

7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **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.

9. **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.

10. **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.
11. **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.

2011 In Millions

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	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
Blue Cross Blue Shield	X	X	0.331	X	X	X	X	X	X	X	3.117	2.997	X	X	X
Tufts Health Plan	X	X	X	X	0.700	X	0.105	X	X	X	X	0.780	0.037	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	1.890	X	0.043	X	3.000	X	0.034	X	X
Fallon Community Health Plan	X	X	X	X	1.104	X	(0.073)	X	X	X	X	X	0.034	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.247	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.791	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.623	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.576	X	X	0.062
Total Commercial	-	-	0.331	-	1.804	-	1.922	-	0.043	-	6.117	6.014	0.104	-	0.062
		x													
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mass Health	-	-	-	-	-	-	-	-	-	-	-	0.257	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.169	X	0.493	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.169	-	0.493	-	-	-	-	-	-	-	-
Medicare	-	-	-	0.019	-	-	-	-	-	-	-	1.577	-	-	-
Other															
GRAND TOTAL	-	-	0.331	0.019	1.973	-	2.415	-	0.043	-	6.117	7.848	0.104	-	0.062

2012 In Millions

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	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
Blue Cross Blue Shield	X	X	0.229	X	X	X	X	X	X	X	2.577	3.078	X	X	X
Tufts Health Plan	X	X	X	X	0.960	X	0.816	X	0.081	X	X	1.120	0.038	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	2.187	X	0.091	X	3.252	X	0.034	X	X
Fallon Community Health Plan	X	X	X	X	1.184	X	0.254	X	X	X	X	X	0.033	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.281	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.815	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.555	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.781	X	X	0.281
Total Commercial	-	-	0.229	-	2.144	-	3.257	-	0.172	-	5.829	6.630	0.105	-	0.281
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mass Health	-	-	-	-	-	-	-	-	-	-	-	0.378	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.299	X	2.215	X	0.015	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.299	-	2.215	-	0.015	-	-	-	-	-	-
Medicare	-	-	-	0.311	-	-	-	-	-	-	-	1.654	-	-	-
Other															
GRAND TOTAL	-	-	0.229	0.311	2.443	-	5.472	-	0.187	-	5.829	8.662	0.105	-	0.281

2013 In Millions Updated with final risk settlements and year end adjustments

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	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
Blue Cross Blue Shield	X	X	0.340	X	X	X	X	X	X	X	2.810	3.646	X	X	X
Tufts Health Plan	X	X	X	X	0.869	X	0.965	X	0.038	X	X	1.272	0.034	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	1.964	X	-	X	3.127	X	0.032	X	X
Fallon Community Health Plan	X	X	X	X	1.096	X	0.129	X	X	X	X	X	0.033	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.304	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.968	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.619	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.435	X	X	0.269
Total Commercial	-	-	0.340	-	1.965	-	3.058	-	0.038	-	5.937	7.244	0.099	-	0.269
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MassHealth	-	-	-	-	-	-	-	-	-	-	-	0.414	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.252	X	1.682	X	0.027	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.252	-	1.682	-	0.027	-	-	-	-	-	-
Medicare	-	-	-	0.239	-	-	-	-	-	-	-	1.775	-	-	-
Other															
GRAND TOTAL	-	-	0.340	0.239	2.217	-	4.740	-	0.065	-	5.937	9.433	0.099	-	0.269

2014 In Millions With preliminary risk settlements

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	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
Blue Cross Blue Shield	X	X	0.373	X	X	X	X	X	X	X	2.659	3.552	X	X	X
Tufts Health Plan	X	X	X	X	0.797	X	0.998	X	0.044	X	X	1.462	0.097	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	1.433	X	0.041	X	3.165	X	0.032	X	X
Fallon Community Health Plan	X	X	X	X	1.107	X	0.155	X	X	X	X	X	0.032	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.223	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	1.011	X	X	X
Aetna	X	X	X	0.035	X	X	X	X	X	X	X	0.650	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.480	X	X	0.472
Total Commercial	-	-	0.373	0.035	1.904	-	2.586	-	0.085	-	5.824	7.378	0.161	-	0.472
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MassHealth	-	-	-	-	-	-	-	-	-	-	-	0.497	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.137	X	1.182	X	0.004	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.137	-	1.182	-	0.004	-	-	-	-	-	-
Medicare	-	-	-	0.179	-	-	-	-	-	-	-	1.922	-	-	-
Other															
GRAND TOTAL	-	-	0.373	0.214	2.041	-	3.768	-	0.089	-	5.824	9.797	0.161	-	0.472