Baystate Health

September 14, 2016

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

Subject: Testimony for Public Hearing Concerning Health Care Cost Trends

Dear Mr. Seltz,

In response to your July 19, 2016 letter, we have prepared this letter, associated template, and Exhibit 1 (collectively "Written Testimony"). We appreciate the extension for the submission of this Written Testimony until September 16, 2016. However, the deadline for submitting the Written Testimony was short and some of the requested information was not readily available. Accordingly, the Written Testimony submitted has been prepared based on reasonable inquiry and is true and correct to the best of our knowledge, information and reasonable belief.

Your letter is directed to Baystate Health, Inc. (BH) an integrated health care delivery system, which includes Baystate Medical Center, Inc., Baystate Medical Practices, Inc., Baystate Mary Lane Hospital Corporation, Baystate Franklin Medical Center, Inc., Baystate Wing Hospital, Inc., and Baystate Noble Hospital, Inc. BH is also associated with Baycare Health Partners, Inc. which is a physician hospital organization and includes an accountable care organization. In some responses, when appropriate, we have included information about these related organizations.

In closing, I am legally authorized and empowered to represent BH for the purposes of the Written Testimony. I hereby certify under the pains and penalties of perjury that, under my direction, BH has made a diligent effort to respond to the questions submitted to it, and that, to the best of my knowledge, information and reasonable belief, the Written Testimony is true and correct.

Sincerely,

MKeroack MD

Mark A. Keroack, MD, MPH
President & CEO
Baystate Health

Enclosures:
- Associated template
- Exhibit 1

Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. **Strategies to Address Health Care Cost Growth.**
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 has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
    a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

First, factors outside the control of health care providers make it difficult to meet the health care cost growth benchmark. The most glaring example is pharmacy expense growth that significantly exceeds other expense categories. When expensive new pharmaceutical agents, like Solvaldi which is used for the treatment of hepatitis C, are introduced and become the standard of care, providers have no choice but to prescribe them. In our commercial risk contract with Blue Cross Blue Shield of Massachusetts (BCBSMA), for example, the most significant percent increase in total medical expense (TME) was due to pharmacy expenses, which increased by 34% in 2014 compared to 2013; excluding pharmacy expenses, our TME decreased by 1.1% across all other expense categories. Similarly, in our commercial risk contract with Health New England (HNE), pharmacy expenses grew by 35% during the same time period; excluding pharmacy expenses, our TME decreased by 2.9% across all other expense categories. That said, a recent analysis of CHIA data revealed that the TME of our PHO, Baycare Health Partners, Inc. (Baycare), is lower than the plan-wide average of Fallon Health Plan, BCBSMA, HNE, Tufts Health Plan, and BMC HealthNet.

Second, increased utilization—rather than unit price increases—appears to be driving higher costs. For the past several years, Baystate Health (Baystate) has been in the process of transitioning from a volume-based to a value-based system of health care delivery. In 2012, through Baycare, we created an accountable care organization (ACO), Pioneer Valley Accountable Care (PVAC), which has implemented numerous population health initiatives to advance the triple aim of reducing costs, improving quality, and enhancing the patient experience. These include patient-centered medical homes, an engaged provider network, committed physician leadership, payer partnerships, a robust clinical integration program, practice-based care management, advanced use of health information technology, and sophisticated data warehouse and analytic capabilities. In spite of these initiatives, PVAC experienced an increase in its PMPM expenses of 10.75% between 2015 and the first quarter of 2016. This increase is largely due to increased inpatient utilization. For all medical and surgical admissions combined to hospitals and skilled nursing facilities (SNFs) between December 2014 and April 2016, PVAC's PMPM expense increased by 43%. Its admissions per 1,000 members increased by 51% during that time while the average paid per stay decreased by 17%–indicating that utilization as opposed to prices is driving the overall increase.

Third, until the health care system fully transitions from a volume-based to value-based system of health care delivery, it will be impossible to fully align incentives across providers to realize the promise of the triple aim. For example, the reimbursement system, even under agreements with downside risk,

remains largely fee-for-service (FFS), which encourages primary care physicians (PCPs) to focus their attention on generating as many relative value units as possible whereas a value-based reimbursement system across payers could enable the PCPs' focus to shift to better managing a larger panel of patients using e-care (which is not currently reimbursed in the FFS system), additional advanced practice professionals, and other cost-effective services. This would enable primary care practices to optimize their use of care teams that include physician extenders/advanced practice professionals, such as nurse practitioners and health coaches, to institute electronic visits, and to expand use of patient portals – all of which would facilitate having open access and enhance patients' experience and engagement. The care teams and e-care would be able to provide much of the routine, less complex care thereby allowing the PCPs to focus more time for the care of the complex patient within the practice and encouraging them to have more complex patients on their panels. Similarly, hospitals throughout the Commonwealth are focusing on clinical documentation improvement initiatives to help augment their revenue in an environment of severe downward pressure on FFS reimbursement. While appropriate and justified from a clinical perspective, and rational, and indeed necessary, from a business perspective, these efforts may conflict with incentives in value-based arrangements and contribute to increases in TME.

Finally, another area of concern is the benchmark does not effectively take into consideration the comparison performance of other provider groups within the given Health Plans' average which are 2 key elements that should be considered. Provider organizations that have been early adopters of alternative payment methodologies that focus on the triple aim goals or those that have historically received lower reimbursement levels are disadvantaged by the current approach. A clear example of our concern was highlighted during HPC's recent review of Baycare's CHIA data where the HSA TME (Health Status Adjusted Total Medical Expense) for the Tufts Health Commercial Plan showed a year over year increase of 7.25% which was due primarily to higher pharmacy costs and increased inpatient utilization. However, upon additional review and comparison even with these 2 factors causing the increase, Baycare's HSA TME was still more than 12% lower than the Plan's average HSA TME for the entire state.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

Please see above response in 1a

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Does NOT Plan to Implement in the Next 12 Months

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Does NOT Plan to Implement in the Next 12 Months

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other: Specialty Pharmacy in 2014

Currently Implementing

viii. Other: Retail Pharmacy strategy

Currently Implementing

ix. Other: Participate in the HRSA/OPA 340B drug pricing program for outpatient drug therapy

Currently Implementing

3. **Strategies to Integrate Behavioral Health Care.**

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

1) In the primary care setting, Baystate Medical Center's Springfield-based Health Centers have partnered for many years with a number of community mental health providers, most notably Behavioral Health Network (BHN) and Gandara, to provide co-located behavioral health services for primary care patients with behavioral health needs. In addition, since 2013, Baystate Behavioral Health has been in the process of implementing fully Integrated Behavioral Health Services (IBH) for the more than fifteen community-based primary care practices operated by Baystate Medical Practices throughout the Pioneer Valley. Baystate's IBH model consists of an on-site licensed mental health clinician functioning as a fully integrated member of the primary care team; a designated psychiatrist who is available for consultation via telephone, secure EMR messaging; face-to-face patient visits; and a centrally located IBH Care Coordinator who manages referrals to community-based behavioral health providers to support resources for patients who need longer term services. The IBH psychiatrist, clinician and care coordinator work as a team with primary care to address patients' behavioral health needs, with the ultimate aim of supporting the overall health of the population cared for by each practice. In addition to Baystate's IBH program, we serve as the Western Mass. site for the Massachusetts Child Psychiatry Access Project (MCPAP), providing same-day telephonic child psychiatry consultation to pediatricians in the western four counties of the Commonwealth. MCPAP also offers education and training for pediatrician offices; face-to-face consultations with a licensed social worker and/or a psychiatrist; and care coordination for referrals to community providers.

2) In the Specialty Care arena, the primary focus of Baystate Behavioral Health's Adult and Child Outpatient Services is to provide collaborative mental health services for Baystate's medical specialty practices. Licensed social workers and psychologists partner with specialty practices to provide behavioral health treatment to their patients with psychiatric co-morbidities, backed up by psychiatrists and advanced practice nurses who can provide psychopharmacological care as

needed. Adult Outpatient Behavioral Health has established collaborative partnerships with Baystate Gastroenterology, Infectious Disease, Pain Management, Adult Weight Management, Bariatric Surgery, Neurology, and with OB/GYN to identify and treat women with post-partum depression. Child/Adolescent Outpatient Behavioral Health has established collaborative partnerships with Baystate Pediatric Pulmonary, Pediatric Neurology, Pediatric Sleep Center, Adolescent Medicine's Comprehensive Eating Disorders Program, Pediatric Gastroenterology, Pediatric Endocrinology, Pediatric Cardiology, Pediatric Genetics and Pediatric Hemoncology, not to mention General Pediatrics. In addition to providing psychological evaluations and psychotherapy treatment for children and adolescents with both complex medical and psychiatric illnesses, we also support medical specialty practices working with young people who struggle with self-care regimens required by their medical condition, such as diabetes, sleep apnea, cystic fibrosis and irritable bowel syndrome.

3) For hospital-based services, Baystate's Psychiatry Consultation Service has operated for many years as a dedicated team of psychiatrists and clinical nurse specialists providing rapidly available psychiatry consultation for medical inpatients who are identified has having co-morbid psychiatric illness. In January 2016, Behavioral Health Services initiated the Behavioral Resource Team (BRT). This team encompasses the existing Constant Companion pool, and also includes the addition of new Behavioral Resource Nurses who are available to consult with the med/surg nursing care team to intervene directly with behaviorally challenging patients; provide teaching to floor nurses; and assist with optimal usage of Constant Companion resources. In the Emergency Department, Behavioral Health has partnered with nursing and physician leadership to develop enhanced behavioral health services for psychiatric crisis patients, including behavioral health specialty nurses and mental health counselors; medication reconciliation for psych crisis patients on holding status while awaiting placement; development of behavioral health care plans for patients on holding status; and enhanced psychiatry consultation to start psychopharmacological treatment for patients on holding status.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

1) Challenge: The traditional separation of behavioral and physical health service delivery systems can result in "siloed thinking" among providers.

Baystate Strategy: Hospital leadership has addressed this directly, with the CEO explicitly charging all medical specialties to consider how integrated behavioral healthcare can advance the total care provided to their patients. In the primary care setting, IBH clinicians are sent to the UMass Integrated Primary Care Certificate Program to help us develop an effective shared approach to providing IBH in primary care. Regular supervision with the IBH medical director and clinical supervisor reinforces the clinicians in this new model of care. For PCPs, new practices receive three sessions of orientation with IBH clinicians and psychiatrists prior to initiating IBH. Monthly IBH-Primary Care team meetings thereafter are a forum for learning from successes and exploring strategies to address challenges. On a daily basis, IBH clinicians participate in any team "huddles" that occur in the practice. Baystate's fully integrated medical record assures an open flow of clinical information between IBH and PCPs. On the inpatient side, behavioral health leadership works in close partnership with med/surg and Emergency Department leaders to develop shared understanding of the challenges related to caring for med/surg patients with behavioral health concerns as well as shared strategies to meeting those challenges.

2) Challenge: Current fee for service payment models don't support the kind of flexible, informal and brief patient contacts, nor the collateral and team interventions, that must be part of truly integrated behavioral health services in primary care.

Baystate Strategy: Senior leadership has dedicated strategic dollars to support development of an IBH model that includes dedicated time for non-billable collateral and team-based services. In addition, IBH is maximizing its ability to ensure that all appropriate payments for services are in fact received, without compromising the non-billable time needed for non-traditional IBH services. EOHHS Grant funds have supported aggressive data analysis to help us demonstrate the value IBH services bring to the health outcomes and overall healthcare costs for primary care patients.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

i. **Policy:** Baystate Health, Inc. and affiliated hospitals (Baystate) have a common community benefit mission: "To reduce health disparities, promote community wellness, and improve access to care for vulnerable populations." To help bridge health care and community health, Baystate is adopting its first-ever "Community Benefit and Social Impact Policy" to operationalize this mission and meet the requirements of the Patient Protection and Affordable Care Act (ACA) requirements. A central provision of this policy creates opportunities for anchor institution community partnerships (AICP) to address social determinants of health. AICP-sponsored enterprises involve community non-profits firmly rooted in their locales and may take many forms including: supporting local businesses, developing high quality educational services, creating mechanisms for local hiring and contracting, or catalyzing community economic development through direct capital investment.

ii. **Practice:** (Baystate has established the "Better Together Grant (BTG) Program" as a structure that brings together health care and community-based non-profit organizations across Baystate hospitals' service areas to shape future health care and human services. The aim is to develop powerful community-clinical relationships and approaches that target the social determinants of health. These new relationships and collaborative approaches seek to change the structural determinants and conditions in which people are born, grow, live, work and age. In particular, BTG funding is intended to address social determinants of health identified in the triennial community health needs assessment process. BTG funding instigates change in structural determinants and conditions, thus making it easier for people live healthy and for communities to be healthier places to live in.

iii. **Delivery System Transformation:** Baystate Medical Center and Health New England are developing new models for more collaborative provider and health plan efforts to reduce longstanding disparities faced by historically underserved populations through coverage

expansions and provisions to help bridge health care. For instance, BeHealthy case mangers (community health workers) deliver home and community-based services (including referral, support services, and case management services) to reduce patient emergency room visits and inpatient hospitalizations. This approach integrates Community Health Workers into primary care teams. These Community Health Workers will assess patients' needs using the protocol, develop individualized patient plans based on the identified needs, and then help connect patients to community and social services.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

i. **Staff Capacity and Diversity:** The lack of understanding among the public, professionals, and policy makers of the nature and full extent of social determinants on individual, community, and population health. Additionally, the lack of diversity in interprofessional and interdisciplinary teams (especially among health professionals) makes it more difficult for such teams to understand and fully appreciate the ways in which ethnic and cultural diversity can impact and sometimes magnify the effects of social and health habits.

ii. **Data Challenges:** There is a need for more evidence as to which interventions make a measurable difference regarding individual, community, and population health, as well as a need for data systems to collect and disseminate data to support that research. The availability of data regarding social determinants of health, including metrics for measuring population health, is far from ideal. The methodology for measuring far upstream is underdeveloped. Although the value of primary and preventative care is increasingly recognized, the absence of a coordinated approach to health data, together with the limitations of current data sets and methods, makes it difficult to quantify community needs or justify funding interventions.

iii. **Health Equity Challenge:** The lack of ultimate accountability for health disparities at any specific level of society undermines the effectiveness of any social determinants of health intervention. This, coupled with prioritized spending to address diseases after they have arisen, rather than before they develop, exacerbates the impact of the social determinants of health and makes them more difficult to address. Resources, when available, often reside in public and private institutions far removed from the particular communities that need them.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

Our primary care providers have been in risk contracts (through our PHO) for over eight years, and the providers get regular feedback on the total cost of care for these patients. This has created an environment where they are very conscious of value-based care, and they utilize and

refer for services in the appropriate settings balancing the individual needs of the patient, the quality of the service, and the cost of care. Additionally, as there is increased awareness about the social determinants of health, the care management staff and providers regularly partner with community support agencies and social services to ensure patients receive a full spectrum of care and support.

In the post-acute care arena, there has been ongoing work to develop a high value network for post-acute facilities. Community facilities are evaluated for quality of care, length of stay, as well as communication. This information is regularly utilized by the hospital case management staff that helps patients determine where they will go after discharge.

We have as a point of strategy tried multiple things to keep patients in the communities we serve from driving past their community hospitals to BMC. Most of these revolve around enhancing specialty care in the regions. They include:

- Putting a single leader over all our hospitals to optimize the system rather than any one component.
- Investments in facilities, like surgery at Baystate Franklin Medical Center, cancer at Mary Lane, ED at Wing.
- Dozens of specialists from BMC traveling each week to hold sessions and do cases at regional hospitals. These include adult medicine, surgery and pediatrics
- Hiring on site specialists in hard to recruit areas like orthopedics, urology, neurology, pulmonary and cardiology.
- Telehealth strategies around neurology and several other new areas.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   38T

   ii. If no, why not?
   This is not a feature that is available at the point of care within our EHR.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   38T

   ii. If no, why not?
   This is not a feature that is available at the point of care within our EHR.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
Baystate has funded, established and participates in the Pioneer Valley Information Exchange (PVIX), an IHE-standards conforming Health Information Exchange (HIE). This private regional HIE is used to connect affiliated and non-affiliated healthcare organizations across the western Massachusetts community to exchange Clinical Care Documents. The HIE also delivers lab orders and results between Baystate Reference Labs and community-based non-employed provider groups that utilize these lab services. Additionally, Baystate provides access to both employed and private provider groups for both hospital- and office-based patient care.

ii. If no, why not?
38T

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

First, effective January 1, 2016, our ACO, Pioneer Valley Accountable Care (PVAC) is one of 18 ACOs nationally that are participating in the Next Generation ACO (NGACO) Model, recently launched by the Centers for Medicare & Medicaid Services (CMS) Innovation Center. NGACO is a population-based payment initiative with downside risk for health care organizations and clinicians who are experienced in coordinating care for patients across care settings. Approximately 35,000 Medicare beneficiaries are attributed to PVAC. Previously, between 2013 and 2015, PVAC participated in CMS' Medicare Shared Savings Program.

Second, through Baycare, our PHO, we participate in multiple commercial risk contracts with downside risk—and have done so for several years. Baycare has had an Alternative Quality Contract with BCBSMA since 2010, a commercial risk agreement with Health New England (HNE) since 2011, a Medicare Advantage risk agreement with HNE since 2012, and a commercial risk agreement with UniCare (GIC) since 2016. The participants have demonstrated consistently strong performance in these agreements, all of which include robust quality incentive programs. Currently, Baycare value-based agreements encompass about 150,000 covered lives. For several years, Baycare and PVAC have been actively moving toward converting the majority of their contracts to value-based/ outcomes-based contracts, and the PHO is in active discussions with additional payers. In addition, Baystate accepts full risk for approximately 67,000 BeHealthy (managed Medicaid) members through our wholly-owned subsidiary, HNE. Further, for the past 18 months, Baystate and Baycare have been actively engaged with EOHHS to redesign the MassHealth program. We are committed to and engaged in this process and remain very interested in participating in the full rollout of an alternative payment contract for PCC and managed Medicaid members as additional details of the program are released.

Third, Baystate participates in multiple bundled payment programs, which are payment arrangements that include financial and performance accountability. Through the Bundled Payments for Care Improvement Initiative (BPCI) run by the Center for Medicare and Medicaid Innovation (CMMI), current bundle initiatives include Model 2 total joint replacement (hip & knee replacement-

DRGs 469, 470) and Model 2 CABG (DRGs 231-236). The total joint and CABG bundle will be completing performance year 3 in 2016 and we are pursuing continuation for two more years (2017 and 2018). Additionally, Baystate Medical Center entered into its 3rd Model 2 BPCI bundle for colorectal surgery (performance year 1for DRGs 329, 330 & 331). Baystate has been developing three commercial bundles with HNE: obstetrics, total joint- hip and total joint knee).

Participation in the BPCI demonstration has been a huge success for Baystate Medical Center. There were significant reductions in 90-day costs for both total joint replacement and CABG. Additionally, there were significant decreases in hospital expenditures, increasing the operating margin associated with performing CABG procedures. More importantly, indices of quality and patient safety were maintained or improved while increasing engagement with patients and their families. Partnerships with post-acute providers have been strengthened with data sharing, regular educational offerings, and improved coordination of care for patients. Further, on January 1, 2016, PVAC launched an internal end stage renal disease bundle, in which the participating nephrologists are responsible for the TME of the bundle patients.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

First, as noted earlier, the majority of the current health care reimbursement system remains fee-for-service (FFS), which rewards providers based on the number of office visits, tests or procedures they perform. Because payment is tied to consumption, FFS directly contradicts APMs whose incentives are not aligned to the providers' practice patterns. FFS also creates fragmentation, with providers incented to "compete" with one another, rather than work together for better outcomes. Because providers are rewarded this way, they lack a strong motivation to steer people toward the highest-quality, most cost-effective care. While the movement away from FFS and toward value-based care continues to gain acceptance, it is still in its testing phase. To change the payment model and shift from FFS to a value based model, much more investment is needed to change the current health care infrastructure, culture and operational practices. These new payment models are by no means systematic. For most, they are difficult to implement and scale, requiring more collaboration with other vested health care providers and adoption by multiple payers. Further, staffing models have been designed to support the FFS model with face-to-face care. Transitioning to population-based care requires a different care team model with new skills and staffing ratios to manage populations and track and coordinate care when patients are not in the office.

Second, multi-faceted financial barriers to implementing APMs remain daunting: Continuing disproportionate cost pressures on Baystate Health—a recognized early adopter of APMs--are challenging the organization's ability to allocate appropriate resources to evolution of models of care. The infrastructure (whether human capital, enabling technology, or other resources) to support population health management will continue to be costly. Ultimately, we hope our risk contracting, APM contracting, and ACO activities will be self-supporting, but we encourage payers (whether public or private) to provide adequate infrastructure payments and support to their contracted providers to assist in the implementation. While there are strong indications that Baystate Health will be included in the next Medicaid waiver program, the organization's longstanding position as the only high-proportion Medicaid provider in the state without participation in the Medicaid waiver or other special state funding provisions for care for underserved populations has become an insurmountable financial challenge, and raises questions about our ability to continue to move progressively away from FFS models. At the same time, providers face the unfunded mandate of compliance with numerous regulations such as those required for Risk Bearing Provider

Organizations under Chapter 224. Further, the need (and likely government mandate) to build reserves over time is a significant barrier. As more risk shifts from insurance companies to providers, careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves. All of the above are exacerbated by federal mandates, such as MACRA, which will require significant investments in infrastructure to comply with the plethora of reporting requirements. It remains unclear whether it will be possible to generate a positive return on these investments.

Third, APM design continues to place most of the burden on primary care providers while specialists control much of the total medical spend. Until specialists can be more fully engaged in and integrated into APMs, it will be difficult to realize APMs' full potential. We have strived for many years, with limited success, to encourage specialists to be active participants in APMs, and in 2016, specialty engagement is one of our ACO's top five strategies for success. Efforts to date include specialist participation in various bundled payment initiatives and participation in risk contracting, but actionable performance measures for specialists remain elusive. We applaud the GIC's efforts to assemble and release quality and efficiency measures for specialists, and we encourage the GIC to make such data available on a public website as we believe transparency of performance data will drive behavior change and narrow unintended variations in practice patterns.

c. Are behavioral health services included in your APM contracts with payers?
Yes
   i. If no, why not?

Behavioral health services are carved out of the risk arrangement for only one of our commercial risk agreements—namely with Unicare (GIC). This is our first experience with incorporating downside risk into an indemnity product—both for our PHO and the health plan—so we felt it would be prudent to gain more experience before putting the providers at risk for behavioral health services.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Public and private quality measures reporting are important drivers for ensuring quality and patient safety surveillance and improvement. Measurement and reporting to the private and public payers allows for external benchmark comparisons. This promotes organizational accountability and fosters transparency of hospital performance to patients, providers, and payers. There are many challenges with quality measures reporting. Measure sets are not harmonized among payers (public and private sector) contributing to duplication of work. There is a significant resource burden around measure collection, abstraction and reporting. Most measures are not automated and require a professionally trained clinician to manually review records to capture the specified elements. Baystate Medical Center addresses these challenges through advocacy. For example, during the annual updates to the CMS proposed

Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) programs, CMS will accept comments on the proposed rules. During this comment period, organizations like Baystate Health can provide feedback around any proposed changes. The MassHealth Acute Hospital P4P Program Quality Measures Program also offers a comment period to hospitals around quality measure changes.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

Most electronic health records (EHRs) and IT platforms are disparate and lack connectivity in a way that promotes electronic data sharing. Better alignment and improved efficiencies would be achieved if data could be shared electronically with standard specifications. Most data sources are not connected in a way that provides easy transmission and accuracy of the quality measures. Strengthening infrastructure and data systems for public reporting and using electronic data collection are essential going forward.

Nationally, there is a push to collaborate more with key stakeholder forums around alignment and reporting of quality measures. For example, the National Quality Forum recently launched a measures application partnership, which plays a pivotal role in the measure selection, as well as identifying the next generation of measures, and aligning measures. Quality measures need to shift and capture measurement from the individual/provider level, the facility, and the population.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

a. We would advocate for transparency requirements to be placed on pharmaceutical companies with respect to pricing decisions. All across the country, not just here in the Commonwealth, there is a large growth in the cost of prescription drugs as a percentage of total medical spend. This growth is driven by escalating prices in all segments of the pharmaceutical industry – generic, name brand and specialty. We believe that requiring pharmaceutical manufacturers to explain the rationale for drug prices will bring additional accountability and lead to smaller price increases. Also, pharmaceutical companies, as significant players in the overall cost of health care, ought to be subject to the requirements of Chapter 224 and participate in these hearings.

b. To enable the integration of behavioral health care, we would support regulatory and payment reforms to enforce reasonable standards regarding access to care for behavioral health, requiring health systems to monitor access to care standards and provide performance based incentive payments to systems that are able to ensure timely access for patients who screen positive for common and high impact mental health issues (ie depression, substance abuse, trauma-related mental health problems for children, etc). This will encourage primary care screening, warm handoffs, good care coordination (all elements of integrated care). Similarly, we would advocate that more robust behavioral health quality measures be incorporated with associated value based payments in risk contracts; for instance, tracking the percentage of patients who have poorly controlled chronic diseases (such as diabetes, asthma, COPD, CAD) and patients who are high utilizers of healthcare

services, who receive an annual mental health screening in the primary care setting, who are provided a full behavioral health assessment if they screen positively, and who receive appropriate behavioral health follow-up when it is indicated by the assessment.

c. Action to reduce inequalities in health resulting from social, cultural and economic determinants requires a comprehensive approach involving strategies inside and outside the health sector. The important role of social, cultural and economic factors that determine health and socioeconomic inequalities in health often lie beyond the responsibility of the health care sector. While our understanding of the exact nature and extent of the problem of socioeconomic inequalities in health, as well as the most effective strategies to deal with them, is still imperfect, there is sufficient evidence to make a start. The Health Policy Commission in collaboration with the Governor's Office should prioritize reducing socioeconomic inequalities in health and provide a comprehensive set of policy solutions that build on existing services or recommend better ways to invest existing resources and redirect funding to give stronger emphasis to reducing those inequalities. More specifically, building healthy communities should be a central concern of social and economic policy, where "community development" provides a strong basis for health development. This implies broader community development initiatives that are likely, among other things, to make it easier for people to live healthy lives and for communities to promote health of people.

d. There are several changes that would support and encourage the use of high value providers:
1- Moving away from FFS and volume based care, and coverage of care coordination, telephone and e-visits, and other forms of indirect patient care would allow providers to thoughtfully utilize available resources.
2-Accessbile information on cost and quality of services available. For example, reliable data regarding consultants and their use of high-cost testing and procedures.
3-Support of enhanced primary care models; good chronic disease management has clearly been shown to require intervention by a multidisciplinary team including health educators, behavioral health, social work, and other resources that address the social determinants of health. These important resources are currently underfunded and supported.
4-Interoperability of EHRs and support for information sharing. Information exchanges exist, but there are barriers to getting provider organizations to join, including cost as well as concerns about use of shared information for competitive reasons. Policies that encourage and financially support participation are sorely needed.

e. First, we have previously noted the inherent challenges in further adopting APMs when providers still have one foot firmly planted in the FFS world and the other in the value-based world. Until a critical mass of patients are covered by APM agreements, it will not make financial or operational sense for providers to change their workflows fully to align with a value-based delivery system. We acknowledge that the Commonwealth of Massachusetts recognizes this challenge and, for several years, has been encouraging commercial payers to transition away from FFS toward APMs. It is not enough, however, for a payer simply to roll out its own flavor of APM within its provider network. Rather, payers should be encouraged to offer APMs of similar design to ease the administrative burden of implementation on the providers who are being asked to assume considerably more risk under these APMs—much as the Group Insurance Commission did in mandating that the commercial carriers adopt a uniform provider tiering methodology in its Clinical Performance Improvement Initiative. To succeed in risk contracts or APMs, providers require the agreements to have a consistent design, (e.g., similar budget constructs, quality and efficiency measures, care protocols, risk mitigation programs). If payers could be encouraged to provide adequate infrastructure payments and support to their contracted providers to assist in APM implementation, APM adoption would accelerate.

Second, we encourage removal of the significant financial barriers that are impeding APM adoption. We address three such barriers below.

- To reiterate, Baystate Health's position as the only high-proportion Medicaid provider in the state without participation in the Medicaid waiver or other special state funding provisions for care for underserved populations, materially hampers our ability to move more aggressively away from FFS models. In addition, the recent mandate that limits MassHealth reimbursement to MCOs and Acute Care Hospitals to 105% of the MassHealth FFS rates will ultimately discourage hospital participation in APM models. Acute Care Hospitals will not be interested in participating in APMs and taking on risk because the current level of reimbursement by MassHealth MCOs generates a deficit of approximately 20%, so this mandate will only widen the existing gap.

- Further, consideration should be given to the unfunded mandates providers face in complying with regulations such as the Risk Bearing Provider Organization (RBPO) and Registration of Provider Organizations (RPO) regulations. The Massachusetts Hospital Association and others have clearly documented where these regulations require duplication of effort—both with requirements of other state agencies and health plans. Clearly the requirement that provider organizations implement an Internal Appeals Process for health plan members involved in APMs with downside risk will be confusing to their members and duplicative of a core function that already exists today in each health plan. Amending the regulations to reduce these administrative burdens would free up resources that could be directed to APM adoption.

- Perhaps the greatest barrier is the need to build reserves over time. Many risk-bearing entities, such as our PHO, are structured as taxable entities, and existing tax laws make it considerably more difficult for them to build reserves to the same extent and as rapidly as their not-for-profit counterparts. In other words, assuming 40% of their profits are taxed, taxable RBPOs need to generate two-thirds greater profits to accumulate the same reserves as a tax-exempt entity. Regulations governing provider reserves should reflect this hurdle, perhaps allowing for lower reserve thresholds or longer time periods for reserve accumulation for taxable RBPOs. As more risk shifts from insurance companies to providers, careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves.

f. To promote alignment of quality measurement and reporting, organizations need to advocate through public comment forums. A focused call to action to evaluate the quantity and quality of all measures continues to be a priority. Additionally, there are just too many quality and accountability measures with a need to reduce the actual number of measures organizations and physician groups are tracking. Reducing the number of measures and aligning measures with improvement strategies to actually improve care would minimize the burden and inefficiencies while promoting improvement and organizational learning.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **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.

   Note: In our submitted AGO Provider Exhibit 1, Medicare excludes the Medicare Shared Savings program we participate in under Baycare since we cannot determine what portion of the Medicare patients/revenues were covered under that program and we did not have any payback or extra payments as a result of the program.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

   Baystate Health Hospitals and Baystate Medical Practices provides prospective patients with estimations of charges and estimations of anticipated out of pocket expenditures upon request. Inquiries are directed towards our Patient Billing Services team and then completed. Baystate personnel may connect with ordering providers in order to clearly understand what services the patient is expected to have in order to prove an estimation. Baystate Health Hospitals and Baystate Medical Practices also provides patient information titled "Help Understanding Your Insurance Coverage" which are available at our check in locations and explain co-pays, deductibles, co-insurance and provide Baystate resource contact numbers for assistance with their estimations and Financial Counseling.

   Baystate Medical Center has contracted/partnered with a software company in order to improve the estimation process. Baystate Health Hospitals have also implemented a Pre-Registration process which involves Baystate staff reaching out to scheduled patients typically 3 days in advance and educating and informing patients on their estimated co-pay and/or deductible amount based upon their specific insurance plan and providing payment options.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

   Patient inquiries are completed by Baystate Health Hospitals and Baystate Medical Practices within 2 business days of receiving all the information necessary to develop a price and out of pocket estimation. The software which Baystate Health utilizes provides reporting of estimated patient deductible, co-pay and/or co-insurance and compares to actual deducible, co-pay and/or co-insurance and is currently being analyzed. Initial review of estimations outside an acceptable range indicates that deductibles are challenging due to a few factors: the timing of the estimation as compared to the services not yet adjudicated by the carrier as well as the issue that one managed care plan returns the patient's annual deductible each time electronically, and not the patient actual current deductible. Another significant factor is that what services are expected to be performed are not always the actual services depending on each patient's specific condition at the time of services. An example of this would be an MRI with contrast is originally scheduled but an MRI without contrast is provided, therefore changing the price. In circumstances where patients question differences in estimated price and actual price, examination of factors leading to that difference takes place,

and is followed by explanation to the patient and a re-assessment of the formulas and tools that led to the estimate.

c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

Health Insurance organizations have evolved to provide very specific benefits to companies or individuals which create increased challenges with estimating the patient's out of pocket obligations. In addition to the deductible challenge noted above, we have an insurance company which will waive co-pays if patient has a cancer diagnosis as an example. This is challenging to program within software prior to the patient being seen and diagnosed. An additional common example is surrounding a "screening" type test/procedure (colonoscopy is one example) scheduled that does not have a patient co-pay, co-insurance or deductible but results in an actual diagnostic test (not screening as originally anticipated) which can often invoke a co-pay, deductible, or co-insurance.

Note: The Baystate Health Hospitals noted in the above responses include Baystate Medical Center, Baystate Franklin Medical Center, and Baystate Mary Lane Hospital, and do not currently include Baystate Wing Hospital nor Baystate Noble Hospital as we continue to integrate standardized Baystate Health software in those newly acquired locations.

Exhibit 1 AGO Questions to Providers

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. 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 reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
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.

2012

	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	$62,045,403	$85,751,998	$1,934,282	$2,292,474	$0	$0	$0	$0	$0	$0	$351,342	$745,918	$0	$0	$0
Tufts Health Plan	$20,820,107	$3,408,159	$131,819	$0	$0	$0	$0	$0	$0	$0	$76,868	$27,379	$0	$0	$0
Harvard Pilgrim Health Care	$4,729,010	$5,853,873	$4,463	$0	$0	$0	$0	$0	$0	$0	$55,121	$12,939	$0	$0	$0
Fallon Community Health Plan	$13,422,166	$0	$16,480	$0	$0	$0	$0	$0	$0	$0	$49,803	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,906,404	$9,392,130	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,785,365	$1,534,389	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,690,835	$5,334,932	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$64,506,225	$35,497,527	$5,213,030	$0	$0	$0	$74,966,529	$15,435,728	$0	$0	$0
Total Commercial	$101,016,686	$95,014,030	$2,087,044	$2,292,474	$64,506,225	$35,497,527	$5,213,030	$0	$0	$0	$116,882,266	$32,483,415			
Network Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,442,640	$0	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,381,767	$0	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$108,853,572	$0	$0	$0	$0
Health New England	$0	$0	$0	$0	$9,049,821	$0	$1,112,515	$0	$0	$0	$293,925	$0	$0	$0	$0
Fallon Community Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,291,582	$629,094	$0	$0	$0
Other Managed Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,173,814	$2,806,774	$0	$0	$0
Total Managed Medicaid	$0	$0	$0	$0	$9,049,821	$0	$1,112,515	$0	$0	$0	$132,437,301	$3,435,868	$0	$0	$0
MassHealth	$80,836,503	$0	$2,971,138	$0	$0	$0	$0	$0	$0	$0	$1,681,093	$0	$0	$0	$0
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,734,781	$0	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$14,242,231	$10,371,546	$481,101	$0	$0	$0	$1,880,137	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$14,848,561	$0	$671,106	$0	$0	$0	$27,431,148	$109,653	$70,820	$0	$0
Commercial Medicare Subtotal	$0	$0	$0	$0	$29,090,792	$10,371,546	$1,152,207	$0	$0	$0	$34,046,065	$109,653	$70,820	$0	$0
Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$355,972,160	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,049,934	$0	$0	$0	$0
GRAND TOTAL	$181,853,189	$95,014,030	$5,058,182	$2,292,474	$102,646,838	$45,869,073	$7,477,752	$0	$0	$0	$673,068,819	$36,028,936	$70,820	$0	$0

2013

	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	$63,037,271	$83,502,388	$2,175,607	$2,738,296	$0	$0	$393,828	$0	$0	$0	$806,207	$503,420	$0	$0	$0
Tufts Health Plan	$22,125,532	$2,846,717	$72,593	$0	$0	$0	$0	$0	$0	$0	$150,981	$16,964	$0	$0	$0
Harvard Pilgrim Health Care	$5,028,288	$4,959,189	$12,808	$0	$0	$0	$0	$0	$0	$0	$37,916	$12,280	$0	$0	$0
Fallon Community Health Plan	$13,653,095	$0	$24,855	$0	$0	$0	$0	$0	$0	$0	$59,672	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,069,505	$8,871,387	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,820,858	$963,556	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,769,138	$4,103,432	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$57,839,732	$42,244,958	$1,230,266	$0	$0	$0	$76,804,820	$16,061,686	$0	$0	$0
Total Commercial	$103,844,186	$91,308,293	$2,285,864	$2,738,296	$57,839,732	$42,244,958	$1,624,094	$0	$0	$0	$124,519,098	$30,532,725	$0	$0	$0
Network Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,371,407	$0	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,228,932	$0	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$108,087,235	$0	$0	$0	$0
Health New England	$0	$0	$0	$0	$18,341,229	$0	$1,341,210	$0	$0	$0	$603,996	$0	$0	$0	$0
Fallon Community Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$973,207	$740,439	$0	$0	$0
Other Managed Medicaid	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,563,591	$2,821,878	$0	$0	$0
Total Managed Medicaid	$0	$0	$0	$0	$18,341,229	$0	$1,341,210	$0	$0	$0	$130,828,368	$3,562,317	$0	$0	$0
MassHealth	$71,374,935	$0	$3,521,652	$0	$0	$0	$0	$0	$0	$0	$1,366,599	$0	$0	$0	$0
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,981,485	$0	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$12,594,177	$10,862,985	$73,801	$0	$0	$0	$2,301,544	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$18,709,636	$0	$0	$0	$0	$0	$36,231,549	$198,570	-$26,188	$0	$0
Commercial Medicare Subtotal	$0	$0	$0	$0	$31,303,813	$10,862,985	$73,801	$0	$0	$0	$43,514,578	$198,570	-$26,188	$0	$0
Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$376,128,088	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,179,457	$0	$0	$0	$0
GRAND TOTAL	$175,219,121	$91,308,293	$5,807,516	$2,738,296	$107,484,774	$53,107,943	$3,039,105	$0	$0	$0	$706,536,188	$34,293,613	-$26,188	$0	$0

2014

	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	$62,145,318	$89,054,217	$2,148,733	$2,859,922	$0	$0	$196,659	$0	$0	$0	$719,670	$470,820	$0	$0	$0
Tufts Health Plan	$21,188,128	$2,628,490	$44,382	$0	$0	$0	$0	$0	$0	$0	$111,365	$14,584	$0	$0	$0
Harvard Pilgrim Health Care	$5,728,175	$5,239,449	$11,625	$0	$0	$0	$0	$0	$0	$0	$19,778	$3,682	$0	$0	$0
Fallon Community Health Plan	$15,982,864	$0	$35,463	$0	$0	$0	$0	$0	$0	$0	$38,895	$0	$0	$0	$0
CIGNA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,765,265	$8,219,232	$0	$0	$0
United Healthcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,747,375	$679,553	$0	$0	$0
Aetna	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,290,599	$2,549,947	$0	$0	$0
Other Commercial	$0	$0	$0	$0	$61,772,018	$45,636,505	$2,615,488	$0	$0	$0	$76,094,285	$13,030,161	$0	$0	$0
Total Commercial	$105,044,485	$96,922,156	$2,240,204	$2,859,922	$61,772,018	$45,636,505	$2,812,147	$0	$0	$0	$127,787,232	$24,967,978	$0	$0	$0
Network Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,761,763	$0	$0	$0	$0
Neighborhood Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,001,318	$0	$0	$0	$0
BMC HealthNet, Inc.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$122,297,479	$0	$0	$0	$0
Health New England	$0	$0	$0	$0	$22,147,332	$0	$221,629	$0	$0	$0	$647,785	$0	$0	$0	$0
Fallon Community Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$813,536	$850,921	$0	$0	$0
Other Managed Medicaid	$49,572	$80,713	$0	$0	$0	$0	$0	$0	$0	$0	$9,573,762	$2,785,880	$0	$0	$0
Total Managed Medicaid	$49,572	$80,713	$0	$0	$22,147,332	$0	$221,629	$0	$0	$0	$149,095,643	$3,636,801	$0	$0	$0
MassHealth	$80,420,397	$0	$1,940,490	$0	$0	$0	$0	$0	$0	$0	$1,396,000	$0	$0	$0	$0
Tufts Medicare Preferred	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,693,374	$29,016	$0	$0	$0
Blue Cross Senior Options	$0	$0	$0	$0	$11,662,209	$11,284,121	$472,022	$0	$0	$0	$320,913	$0	$0	$0	$0
Other Comm Medicare	$0	$0	$0	$0	$20,365,680	$0	$386,569	$0	$0	$0	$62,760,306	$202,695	$63,357	$0	$0
Commercial Medicare Subtotal	$0	$0	$0	$0	$32,027,889	$11,284,121	$858,591	$0	$0	$0	$68,774,593	$231,711	$63,357	$0	$0
Medicare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$388,709,236	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$33,251,145	$0	$0	$0	$0
														$0	
GRAND TOTAL	$185,514,454	$97,002,869	$4,180,694	$2,859,922	$115,947,240	$56,920,625	$3,892,367	$0	$0	$0	$769,013,848	$28,836,490	$63,357	$0	$0

2015

	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	62,262,698	95,614,817	2,295,643	3,291,355	-	-	-	-	-	-	636,440	177,809	-	-	-
Tufts Health Plan	22,002,607	1,889,850	-	-	-	-	-	-	-	-	113,468	45,991	-	-	-
Harvard Pilgrim Health Care	9,466,036	5,163,458	13,459	-	-	-	-	-	-	-	56,689	14,705	-	-	-
Fallon Community Health Plan	14,460,669	-	24,787	-	-	-	-	-	-	-	68,121	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	22,920,303	9,997,444	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	13,704,288	650,128	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	14,381,966	4,555,703	-	-	-
Other Commercial	-	-	-	-	60,000,321	60,095,866	1,250,489	-	-	-	88,146,822	13,154,542	-	-	-
Total Commercial	108,192,010	102,668,125	2,333,889	3,291,355	60,000,321	60,095,866	1,250,489	-	-	-	140,028,096	28,596,323	-	-	-
Network Health	-	-	-	-	-	-	-	-	-	-	10,916,696	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	11,477,277	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	34,756,296	-	-	-	-
Health New England	-	-	-	-	97,351,700	-	461,402	-	-	-	13,430,951	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	3,474,715	436,350	-	-	-
Other Managed Medicaid	911,303	1,108,192	-	-	-	-	-	-	-	-	9,454,373	1,507,611	-	-	-
Total Managed Medicaid	911,303	1,108,192	-	-	97,351,700	-	461,402	-	-	-	83,510,307	1,943,960	-	-	-
MassHealth	102,035,980	-	1,638,911	-	-	-	-	-	-	-	506,784	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	6,833,057	702,404	-	-	-
Blue Cross Senior Options	-	-	-	-	13,302,979	15,244,281	560,000	-	-	-	319,593	-	-	-	-
Other Comm Medicare	-	-	-	-	27,389,815	-	367,640	-	-	-	90,513,582	506,966	-	-	-
Commercial Medicare Subtotal	-	-	-	-	40,692,793	15,244,281	927,640	-	-	-	97,666,232	1,209,370	-	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	440,133,111	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	32,745,807	-	-	-	-
GRAND TOTAL	211,139,293	103,776,317	3,972,800	3,291,355	198,044,815	75,340,147	2,639,531	-	-	-	794,590,337	31,749,653	-	-	-