PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

David F. Torchiana, MD
President and Chief Executive Officer

Submitted Electronically via HPC-Testimony@state.ma.us

September 2, 2016

Dear Mr. David Seltz:

Enclosed you will find written testimony for the Partners HealthCare as requested for the upcoming cost trend hearings.

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

Please direct any follow-up questions to Joseph Alviani, Vice President of Government Affairs at Partners HealthCare (jdalviani@partners.org 617-278-1041).

Sincerely,

David Torchiana

David F. Torchiana, MD

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)

Partners strongly supports the state's goal to reduce healthcare cost growth. Partners supports the main mechanism chosen by the state to achieve this goal, namely shared risk contracting, which holds providers accountable for the total cost of care for a defined population. We support this approach because we think it provides the best opportunity to reduce cost growth while ensuring the quality of care for our patients.

Our top two areas of concern are: 1) the pace and complexity of payment policy changes, and 2) the limited ability for providers to address key drivers of their own cost structure. Taken together, we are concerned that these issues, if not addressed, may create significant barriers for patients seeking high quality and safe healthcare services in the future.

Pace and complexity of payment policy changes: Federal changes to the Medicare program are having a profound impact on providers. Some, such as the Pioneer ACO program and the hospital value-based purchasing program, have been in place for several years, but continue to be refined even as providers work to manage under the new payment mechanisms. Others, like the new Medicare physician payment program called "MACRA," have not yet begun, but promise significant disruption, new administrative costs, and will result in Medicare payment increases to physicians well short of inflation, where they have been for more than a decade.

At the state level, plans for Medicaid payment reform are now firmly established. The planned changes promise a major change in operations for those groups who will provide the bulk of healthcare for the poor in Massachusetts over the next 5 years. While the state has promised funding for the infrastructure needed to help providers succeed under these new payment models, providers still expect to receive rate increases of less than inflation from Medicaid.

Finally, despite recent increases in insurance premiums greater than inflation, provider commercial rate increases have been below inflation. Nearly all providers are now managing under commercial risk-based contracts that financially punish those providers whose total medical expense (TME) increases are above the network average, regardless of whether or not that average is above or below the state benchmark of 3.6 percent.

In summary, all three sources of provider payments (i.e., Medicare, Medicaid, and commercial) are increasing at a rate of less than inflation. This constraint on revenues is having the desired impact.

Providers are working diligently to re-engineer their processes and cut expenses, as well as make the necessary investments. Nonetheless, these revenue contractions cannot be sustained indefinitely without having an undesirable impact on the delivery of healthcare services.

The limited ability for providers to address the direct drivers of their input costs: There are four major cost drivers for providers: 1) wage pressure that pushes up costs at the rate of wage inflation, 2) new technology, especially pharmaceuticals, 3) increased regulatory and administrative requirements, and 4) cross-subsidies to necessary clinical services that cannot be supported on their own (i.e., behavioral health).

Cost driver #1 - Providers can suppress wage growth for a period of time, but healthcare wage growth at general wage inflation seems to be a reasonable expectation, keeping in mind both collective bargaining pressures and the shared desire to be nationally competitive for talent. Redesign of care delivery has some potential to increase efficiency and decrease the need for some services, thereby reducing the healthcare workforce and associated costs. Healthcare providers in Massachusetts are working hard at this, but there are limits to the speed and the extent of these changes.

Cost driver #2 - Recently more than 50 percent of the increase in overall healthcare costs has come from the cost of pharmaceutical agents. This cost pressure is part of a more general phenomenon of new treatments and services being introduced into the healthcare marketplace. Given the reasonable expectation that wages are likely to go up at somewhere close to inflation, anything new that is provided as a service, such as new treatments for cancer, will come at an incremental cost above inflation. Some innovations actually reduce the costs of care, but whether the implementation and optimization of these innovative care models can keep pace with the introduction of those new services that increase the costs of care is unclear.

Cost driver #3 – Increased regulatory and administrative requirements continue to be a major cost factor in the healthcare sector. Providers must allocate the necessary resources to comply with existing and new requirements, some of which are redundant and outdated, and provide limited value to patient care.

Cost driver #4 – All providers cross-subsidize the delivery of underpaid services by relying on revenue from other services that generate a margin. It has been a natural focus of policy makers to target cuts at higher margin services. As these cuts are enacted, the unintended consequence is the reduction in resources available for underpaid, but necessary, services. Examples of such services are mental health care, care for burn victims, care for those infected with HIV, care for substance use disorder, etc.

Partners will continue to do all it can to reduce the increase in costs in healthcare and we share the goal of limiting cost growth to general inflation. As this description makes clear, numerous stakeholders in the healthcare arena impact the cost of providing healthcare. For providers to succeed they will need help with wage pressure, the costs of their supplies, especially pharmaceuticals, regulatory relief, and increased funding for underpaid services.

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)

By far the biggest opportunity is to allow providers greater flexibility to provide only the care that patients need instead of forcing providers to deliver services defined by what is paid for. The fee-

for-service system is inflationary because every paid service needs to be (by necessity) precisely defined, but that definition fits an average or archetypal patient and not the specific needs of an individual patient. For example, there are over 100 reasons for a physician to order a CT scan of the spine, but every CT scan performed follows one of a limited number of protocols in order to satisfy payment requirements. The majority of CT scans for the spine are performed to answer simple questions that typically only require a short 2-minute process, instead of the standard 15-minute process that most payment requirements dictate. This same situation applies to numerous areas of healthcare – specialists are not paid without a face-to-face visit but about 20 percent of specialist visits could do not require an in person meeting and could be replaced with "virtual visits." A specified number of home visits are required to meet certain regulatory requirements even if additional visits are not beneficial to a specific patient. The list of such opportunities is long, but changing each individual requirement is a large and time consuming task.

A simpler way forward, is to change the payment system. Put providers at risk and then remove the regulatory and payment requirements set up by the fee-for-service system. A good example for how this works is the waiver of the Medicare three-day rule under the Pioneer ACO. The three-day rule requires patients to spend three days in the hospital before Medicare will pay for a stay in a skilled nursing facility. This forces many elderly adults to be hospitalized much longer than necessary. Under the Pioneer ACO waiver of this rule, Partners has avoided over 200 hospitalizations of Medicare beneficiaries, resulting in better care and lower costs. Providers in Massachusetts are well along the path of adopting accountability for costs of care, but there has been very little movement to reduce the payment requirements that constrain providers' options for delivering care that meet patient needs, nor has there been a reduction in the highly inefficient administrative processes required by payers. Processes that add many millions of dollars of unproductive expenses to the costs of delivering care.

A second policy problem facing this state is the duplication of risk-based capital. Providers taking on financial risk are required to backstop that risk with capital, and yet there has been no change in the requirements on insurance companies to meet their own risk requirements. So as insurers' risk has decreased, there has been no decrease in their own risk-based capital. This duplication of risk-based capital is wasteful.

Finally, we recommend both the HPC and the Center for Health Information Analysis (CHIA) use only final total medical expenditure (TME) data when determining whether or not a provider met the cost growth benchmark for the purposes of public reporting and requiring performance improvement plans. At the provider level there is significant variation between preliminary TME data and final TME data. For example, for 2013 Partners' physician group had a reported preliminary TME trend of 4.3 percent for its Blue Cross Blue Shield patients. A year later, that number was revised to a final TME trend of 0.7 percent. Issuing a report or requiring a performance improvement plan based on preliminary data leads to incomplete and misleading conclusions that do not serve our mutual public policy objectives. Furthermore, we suggest that the HPC and CHIA consider using a more comprehensive measure of a provider's overall performance by calculating a weighted average TME trend for the top three major payers, as well as examine a multi-year trend.

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)
      Currently Implementing
   ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends
      Currently Implementing
   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: Insert Text Here
   viii. Other: Insert Text Here
   ix. Other: Insert Text Here

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)

Partners has been pursuing a multi-part strategy for several years. One set of tactics involves enhancing detection and treatment services within primary care settings. These tactics include (but are not limited to): 1) universal screening, 2) rapid access phone triage and e-consult services, 3) embedded mental health services (referred to as the "IMPACT" model), and 4) mental health services dedicated to special populations, such as the severely ill and cancer patients. In all of these areas we are providing a range of mental health services including for the most common conditions, such as depression, anxiety, and substance use disorder.

A second set of tactics addresses substance use disorder for any patient hospitalized within our system (regardless of whether or not their primary care physician is within Partners). This set of services includes: 1) narcotic prescribing guidelines, 2) recovery coaches, and 3) treatment services.

A third set of tactics attempts to address the shortage of mental health beds in Massachusetts by transitioning existing bed capacity to mental health specific services. This is a key part of our plan for renovations of North Shore Medical Center.

Finally, Partners is experimenting with new models of care including the planned release and testing of an internet-based cognitive behavioral treatment (CBT) program.

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)

Both primary care services and behavioral health services cost more to deliver than providers receive in reimbursements. In addition, there is little or no return on investment in behavioral health integration from risk-based contracts due to the latency period for the investments to produce returns and the inadequate risk adjustment for mental health conditions. Therefore, all integration efforts are cross-subsidized by other services. Given the budget pressures, there is a limit to the amount of cross-subsidization that providers can provide. Payments to providers that cover the true costs of providing these services would be the single most important policy change that would enable the adoption of behavioral health integration.

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)

1. *Assessment of social determinants from both an individual patient and a community level*

    a. *Assessment of individual patients' social determinants:*

        i. *Epic - The adoption of our new electronic medical record system, Epic, provides us with opportunities to collect information about the social determinants of health. Aligned with the Institute of Medicine's recommended Social and Behavioral Domains and Measures for Electronic Health Records, Partners is exploring best practices on the inclusion of additional data elements listed below:*

- *Physical activity (exercise)*
- *Alcohol & drug use*
- *Nutrition (diet)*
- *Hunger (food insecurity)*
- *Access to transportation*
- *Exposure to crime & violence*
- *Access to safe & affordable housing*
- *Employment status*
- *Social capital/social support*
- *Citizenship*
- *Refugee status*
- *Access to affordable food*
- *Income*

        ii. *CMS Accountable Health Communities grant application – Partners has applied to participate in the CMS randomized controlled trial to conduct systematic screening for health-related social needs in our Medicaid and Medicare patients and to provide awareness of community resources in response to those needs. In advance of our participation in this program, many of our primary care practices are already participating in the Health Leads program.*

iii. *iCMP – Partners' integrated care management program (iCMP) is the practice-based strategy in which we manage high-risk patients via care teams embedded into our primary care practices. The focus is on the subset of patients who are chronically ill, medically or psychosocially complex, and who would benefit from enhanced care management linked to customized interventions. These patients are typically high utilizers of resources and have multiple medical conditions, with behavioral health or substance use disorders complicating those medical conditions. They also often lack socioeconomic resources to manage illnesses. Enrollees are assigned a Care Team leader (nurse or social worker) who is embedded in the practice. They also have access to a care team that includes other mental health specialists, pharmacy supports, and community resource specialists. All members of the care team have access to an internally built multi-statewide database of community organizations that can be accessed to connect patients with resources in their communities that will better facilitate their care.*

Once the Care Team leader has engaged with the patient, they begin the process of assessing the patient's status and needs through a process that encompasses the patient's social determinants of health. The iCMP assessment tool is used to develop a baseline on the patient's functional status, psychosocial and behavioral health issues, advance care interests, home environment, function, fall risk, medication, nutrition, community resources, and lifestyle risk factors. Bringing Medicaid patients into this program as part of the Medicaid ACO and Medicaid Pilot means that we are serving a patient population for whom the social determinants are more important than ever in determining health outcomes. In recognition of that, community health workers are being added to these care teams as a strategy to address social determinants in the home and community environments more explicitly.

b. *Community level assessments:*

Community Health Needs Assessments (CHNAs) define health in the broadest sense and recognize that factors at multiple levels impact a community's health – from lifestyle behaviors (e.g. diet and exercise), to clinical care (e.g. access to medical services), to social and economic factors (e.g. employment opportunities), to the physical environment (e.g. open space). Our hospitals' CHNAs look at data at all these levels with considerable focus on the social determinants of health, due to their significant influence on the health and long-term health outcomes of communities. We understand that social and economic factors have the greatest impact on the health of individuals, and this understanding informs the development of our system community health programming.

2. *Support for community organizations that directly impact the social determinants*

Partners HealthCare and its hospitals work with many community organizations to make measurable and sustainable improvements in the health status of underserved populations.

a. *Community Health Centers – Partners' deep commitment to the community can be seen through its relationship with many community health centers, meeting the unique needs of the communities they serve. Brigham and Women's and Massachusetts General Hospital operate a total of five community health centers and have a strong affiliation with a sixth. Partners provides funding to federally qualified health centers to support patient services and community members to address issues such as insurance coverage, food insecurity, housing, leadership and job training, obesity, and substance abuse prevention. Please see attachment #1 for details about our support of community health centers.*

b. *Community-based organizations – Through initiatives that include access to health care, prevention, and workforce development, Partners and its hospitals are making a difference in the communities in which we live and work through its support of community organizations. Please see attachment #1 for details about our support for community-based organizations.*

3. *Community programs directly aimed at addressing the social determinants*

Partners community health improvement programs work to address the social determinants of health and issues of health equity through hospital-based and community programs. We provide detailed information on our community health improvement programs and commitments in our annual filing to the Attorney General as part of our community benefit reporting. Examples include support for community health worker and patient navigator services; medical interpreters and immigrant and refugee programs; domestic violence abuse, prevention, and trauma care programs; prenatal and pregnancy support; children, youth, and adolescent health programs; services for the homeless; food insecurity; community coalitions; and workforce development programs. Please see the attachment #1 and this web link for complete information: http://www.cbsys.ago.state.ma.us/cbpublic/public/browse_reports.aspx?section=0

c. 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)

1) *Poverty: Poverty drives many of the social determinants of health, and is a complex challenge that requires the work of multiple stakeholders across a range of areas – education, training and employment, public safety, urban planning and development, and many others. This is not a problem that the healthcare system can fix alone; hospitals can be a contributor to this work, in partnership with other sectors.*

2) *Gap between patient/community needs and public/private reimbursement: Many of the services required to address social determinants are non-reimbursable ones, requiring the healthcare system to invest its own resources. There are competing priorities within a healthcare system, and delivering high quality patient care is by definition the top priority.*

3) *Data collection: Collecting patient level data on social determinants has its challenge. The validity of this data is often questionable, and while we do have an electronic medical record – Epic – that provides a single tool by which to collect this data across our entire system, there are challenges in making sure this data is collected consistently, is easily understood by those asking*

and answering the questions, and is part of a standardized workflow. Even when we can ensure valid and consistent data collection, it must be actionable, and many community organizations and resources are scarce and at capacity. Emergency and permanent housing, shelter beds, and transportation services are all areas in which providers have insufficient access to resources for patients.

Additionally, there is a lack of a shared understanding and metrics of what the state views as the highest health priorities. As the National Academy of Medicine Report Vital Signs highlighted, we have a lot of measures of health and healthcare, but we do not have consensus on a limited set of priorities that all stakeholders (government, providers, payers, foundations, local communities) can all work on together. The Vital Signs report proposes a set of indicators that the state could use as a starting point. Having a parsimonious set of health indicators published annually would serve to focus efforts on the healthcare outcomes that matter most to our citizens.

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.

We define value as the best outcomes delivered at the lowest cost. Optimized value includes the best outcomes, the most efficient process for the patient, and the most efficient process for the team of people caring for the patient. We think the referring physician is in the best position to decide the optimal specialty service provider for their patient, but because of the complexity of sub specialized care, we provide all physicians with resource guides, detailed descriptions of what conditions our specialists treat, phone access lines, and a physician gateway internet portal for physicians outside the Partners system. To make the process more efficient for patients we are installing a single EHR (now 85% complete) throughout our system that allows our patients to fill orders or specialty consults at the location most convenient for them. The patients care team can now see the same records, test results, phone notes, and scheduled appointments.

In an important sense, the highest value referral is a referral that is avoided, while still ensuring that the clinical question is answered. Partners has avoided over 5,000 referrals in the past 2 years by setting up the infrastructure and incentives for our primary care physicians to ask questions of specialists without the need for a referral. We expect this program to more than double in volume in the next year. We have developed the capacity to monitor variation in practice patterns and disseminate this information to providers. Finally, we are collecting large amounts of patient reported outcomes (PROs) data and using this data to help insure that care is optimized for all patients regardless of where within our organization the patient is seen.

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.
39T

ii. If no, why not?

As noted in prior response, we have established programs that enable our referring physicians to get high value care wherever the patient is seen within our system. We are not aware of performance metrics of individual physicians that can provide accurate indicators of value so we do not include them. The available data on cost and quality for an individual specialist does not include information relevant to the specific circumstances of the individual patient (geographic preferences, disease sub-type or severity, etc.) and so are of little benefit to a referring clinician. Furthermore, we have assessed the validity of available claims-based metrics and have identified systematic inaccuracies. We do endorse and are actively building systems for assessing patient reported outcomes (PROs) and are working to incorporate this information into our quality improvement efforts to insure that our patients get the best possible outcomes from whichever Partners provider they are referred to.

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.
    39T

    ii. If no, why not?

    As noted above, the available claims-based data is both inaccurate and rarely includes the types of detailed information required to make an optimal referral.

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.

    The Partners' Epic-based system provides one-click access to information on any individual patient who has information contained in any other Epic-based system. Partners also participates in the MA HIway allowing the exchange of data between any Partners' provider and any other provider in Massachusetts who also participates.

    ii. If no, why not?
    39T

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)

Partners has entered into APMs with both Medicare through the Pioneer ACO and all of our major commercial contracts. All of our HMO contracts are risk based and we have also entered into PPO risk-based contracts. While we have pursued bundled payments, local commercial payers have expressed limited interest and we have not yet been eligible for federal programs. While we are pursuing PCMH adoption as part of our transformation path, this is not included (or supported) in any of our current contracts.

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)

The challenges we noted in last year's submissions remain relevant today. We continue to explore bundled payments but have not been able to take part in any of the Medicare initiatives either because we are not included in one of the selected regions or technicalities in the program rules render us ineligible. To the extent we have agreement with private payers to develop new APMs, we are constrained by system and data limitations facing both payers and providers. We also continue to explore risk for PPO lives, but have not yet seen progress in the development of a comparable model to the one for the HMO population. The creation of fair performance benchmarks and contract models that recognize progress remain ongoing challenges.

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

The inclusion of behavior health services in risk-based contracts often depends on whether the payer has carved out behavioral health services to a behavioral health plan. If the payer does not carve out these services, our risk-based contracts with these payers include behavioral health services. In cases where payers carve out these services, we've entered into a pay-for-performance arrangement with one behavioral health plan. Beyond this, we haven't encountered similar interest from other behavioral health plans.

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.

The lack of quality measure reporting alignment is an area that Partners has worked to improve over the years. Our key approaches have been to work with payers to align measures; to invest in an electronic health record that will foster more efficient data capture and reporting; and to simplify the measures we ask our clinicians to focus on by using an internal performance incentive program. In general, for a single measure, one must abstract clinical data from the patient's record, submit the data properly (usually via a web portal), validate the payer's calculated performance results, and analyze trends for quality improvement. Measure alignment reduces the resources necessary to

accomplish each of these aspects of monitoring quality healthcare. Further, trying to focus on too many measures dilutes the ability to focus on each measure. This is related both to the amount of financial incentive per measure and the administrative or technical bandwidth to available.

For inpatient care, Partners has worked to promote alignment of the quality measures required by payers, by negotiating the use of performance rates as published by the Centers for Medicare and Medicaid Services' on the Hospital Compare website. This has allowed both Partners and the payer to validate performance in a way that uses fewer resources than when each payer had varying sources for assessing performance. Over the years, though we have achieved alignment, the base volume of measures is still more than 100 unique metrics, and payers, such as MassHealth, may still tweak metrics to gather information regarding their populations of interest. At present, reporting data related to the quality of care, requires staff with a level of education, training and experience that allows for clinical judgment of the data. Partners, like most providers, is steadily moving toward electronic health record quality measurement, data capture and reporting. However, quality data reporting at this time continues to require manual validation and significant manual abstraction from the electronic record. EHRs cannot always keep pace with the change in quality measure specifications. Aligning and consolidating quality data reporting is critical to managing the costs of collecting quality data and ensuring it is captured accurately.

In the ambulatory space, Partners has also worked to promote alignment of measures required by payers, primarily to keep providers focused on the most clinically meaningful measures of quality. With most measures of quality at the clinic level currently derived from claims, the burden of measure proliferation is one that requires analytic power to validate and analyze performance, more so than the burden of data abstraction and reporting. In addition to aligning measures, we have used our internal performance framework to reduce the ambulatory quality slate to 12 measures related to chronic disease measurement, cancer screening, and behavioral health for our clinicians to focus on. In doing so, we shield providers from an unwieldy and interminable list of measures, some of which are considered flawed and inaccurately reflect quality of patient care.

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).

Alignment among payers, for quality measure specifications (all payer populations), performance period, reporting frequency and reporting vehicles/interfaces, would be helpful. We support the rationalization of the lists of measures to a smaller group of core measures that matter to clinicians and patients. Thus, we would support an effort be led by clinicians and patients. This will involve, to a large extent, moving completely away from claims data and turning to EHR data. Payers must be willing to accept the agreed upon measures as well as regulatory agencies and measure approvers (e.g., NQF and NCQA. Further, the development of new formats for EHR data collection is essential to truly capture clinical quality appropriately, and choosing legacy measures based on their availability does not achieve what is sought by measure alignment. A better strategy might be to focus on putting the infrastructure in place to enable EHR data collection across provider systems as well as the creation of EHR-based specifications. Supporting development of electronic clinical quality measures (eCQMs) and certified clinical registries may be a large part of the solution. Electronic standards and definitions should be mandatory prerequisites of new measures, as these standards will guide us toward not only standardized measure, but actually better measures to improve patient care. It may be that not all provider and EHR systems can achieve these immediately, but they should be encouraged to attain this goal over time.

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.

Strategies to Address Pharmaceutical Spending:

Partners has a number of committees that have been formed to address pharmaceutical spending that includes an Inpatient Pharmaceutical and Therapeutics committee (P&T) and more recently, an Ambulatory Pharmaceutical and Therapeutics committee to address drug spending and processes in the Outpatient setting. In addition to these groups, Partners has also established a specialty pharmacy committee, that works in conjunction with the P&T groups, to proactively manage the impact of new and existing high-cost drugs that are being introduced into the market. The committee has developed a number of key tactics to minimize the impact of these high-cost drugs including: establishing guidelines for appropriate use; educating providers on guidelines; monitoring prescribing patterns and intervening where needed; identifying and mitigating the impact of high-cost drugs; and developing an ambulatory formulary and preferred drug lists.

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. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

   See attached table.

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.

      When Chapter 224 came into law in January of 2014, Partners began using a manual process to provide estimates to patients upon request. This process involved the following steps:

      1. *The patient request comes in through Customer Service, Registration, Admitting or Physician Practices.*
      2. *The staff member who receives the patient request will utilize the provided script and complete an electronic intake form with the patient's information.*
      3. *The staff member will then email this information to the appropriate Patient Access Patient Estimate mailbox for the entity that will be providing the services. These mailboxes are managed by the local Financial Counseling staff.*
      4. *Financial Counseling staff calculates the estimate using the patient estimate worksheet.*
      5. *To calculate the estimate, insurance benefits are verified using NEHEN. Tables that were created by Contracting reflecting cost information for commonly requested procedures are used. The data is then plugged into the estimate worksheet.*
      6. *The estimate is provided to the patient via the external estimate letter, which details the estimate and payment options.*

      Epic, our new electronic medical record and practice management system, has patient estimate functionality available. However, the hospital/practice must be live on Epic for at least 6 months in order to effectively use the tool. Beginning in late 2015 we began using this functionality to replace the manual process at entities live on Epic. Currently the financial counselors at Mass General, Brigham and Women's, Brigham and Women's Faulkner, and Newton Wellesley are using this functionality. We continue to use the intake form so Customer Service, the department, or a practice can attain information from the patient and forward it along to the email address for the appropriate entity to complete the estimate. After that step everything else is done in Epic. The other Partners entities will continue to use the manual spreadsheets until 6 months after Epic has been implemented.

In addition to expanding the Epic estimate functionality to other entities, we will also begin training departments and practices on how to calculate their own estimates. Our patient engagement vision involves providing estimates to all patients for all elective services at time of scheduling, regardless of whether or not requested by the patient. We are also considering integrating the ability for patients to create their own estimates via the online patient portal, PatientGateway. By implementing the Epic patient estimate functionality across the enterprise we can increase patient engagement and overall satisfaction. It is expected that all hospitals will be using this functionality by early 2018.

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.

When the financial counselors receive the estimate requests via the email box for their entity, they enter them into Epic. There are 2 reports established that show progress on the estimates: estimates in process and finalized estimates. This allows the managers to ensure that we are meeting the 48-hour timeframe for providing estimates.

We are also building a report in Epic that pulls in the actual charges for the procedure as well as the estimate so that a comparison can be done. We will continue to refine this report as needed. Prior to this report, all comparisons are being done manually by each hospital.

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?

At this time, we have not encountered any major barriers to successfully providing patients with estimates within the 48-hour timeline. We have solid processes in place to help triage and route the requests throughout our system. The mailboxes utilized by the financial counselors are managed locally and multiple people have access to them in the event that there is an issue. We also have a coding email box that is managed by the Partners coding team in the event that there is a coding-related question. In addition, since going live with Epic we have a support structure in place to ensure that if there are system-related questions, or issues, those are dealt with by the Partners eCare team responsible for Epic implementation.

However, one challenge we experience is that the care a patient receives may change during the course of his/her treatment based on the clinical decision making of the physician. If the patient is sicker than initially anticipated, the initial estimate may not be accurate. We try to explain this to patients but it is not clear that they fully understand the impact. In addition, we are only as accurate as the payer systems are updated. If the insurer does not have up-to-date, accurate information about the patient's deductible status or benefit structure, we may not be able to give the patient the most accurate estimate.

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	$ 112.23	$ -	$ 11.69	$ -	$ 232.52	$ 244.97	$ 2.63	$ -	$ 2.01	$ -	$ 333.10	$ 860.73	$ 1.54	$ -	$ -
Tufts Health Plan	$ 34.22	$ -	$ 3.26	$ -	$ 65.51	$ 5.66	$ (0.40)	$ -	$ 0.27	$ -	$ 130.70	$ 190.62	$ 2.90	$ -	$ -
Harvard Pilgrim Health Care	$ 41.58	$ -	$ 4.18	$ -	$ 88.35	$ 5.42	$ 0.79	$ -	$ 1.10	$ -	$ 275.30	$ 202.62	$ 1.66	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 31.24	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 129.11	$ 3.79	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 211.47	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 182.10	$ 27.37	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 398.11	$ -	$ -	$ -
Total Commercial	$ 188.03	$ -	$ 19.13	$ -	$ 386.38	$ 256.05	$ 3.02	$ -	$ 3.38	$ -	$ 1,081.55	$ 1,894.71	$ 6.10	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 57.77	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 78.56	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5.50	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 141.83	$ -	$ -	$ -	$ -
MassHealth	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 213.45	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 9.76	$ -	$ -	$ -	$ -	$ -	$ 69.70	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16.37	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11.36	$ 32.28	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 9.76	$ -	$ -	$ -	$ -	$ -	$ 97.43	$ 32.28	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ 141.99	$ -	$ 5.40	$ -	$ -	$ -	$ 1,221.07	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 343.70	$ -	$ -	$ -
GRAND TOTAL	$ 188.03	$ -	$ 19.13	$ -	$ 396.14	$ 398.04	$ 3.02	$ 5.40	$ 3.38	$ -	$ 1,534.26	$ 3,491.76	$ 6.10	$ -	$ -

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.

[6] Claims-based revenue for P4P contracts with United Healthcare are included in FFS Arrangements Revenue, due to a limited ability to isolate the data.

[7] Change from 2015 submission – Revenue under Risk Contracts has been restated with updated information, and may have impacted the revenue reported as FFS Arrangements for the same payer(s).

[8] Change from 2015 submission – Tufts Medicare Preferred previously reported under FFS Arrangements, is now properly reported in the Claims-Based Revenue under Risk Contracts.

[9] Change from 2015 submission – Revenue from prior year submission may be restated due to new information.

[10] Other revenue such as infrastructure could be overstated due to revenue collected by affiliated entities, not legally owned by PHS.

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	$ -	$ -	$ -	$ -	$ 294.64	$ 285.82	$ (2.45)	$ -	$ 2.11	$ -	$ 299.39	$ 912.62	$ 4.37	$ -	$ -
Tufts Health Plan	$ -	$ -	$ -	$ -	$ 93.29	$ 5.23	$ (3.09)	$ -	$ 0.90	$ -	$ 143.03	$ 203.12	$ 4.37	$ -	$ -
Harvard Pilgrim Health Care	$ -	$ -	$ -	$ -	$ 98.85	$ 5.40	$ (0.67)	$ -	$ 1.18	$ -	$ 299.09	$ 222.40	$ 2.50	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 35.62	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 139.82	$ 5.35	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 208.19	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 195.70	$ 29.48	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ 5.73	$ -	$ (0.16)	$ -	$ -	$ -	$ 25.99	$ 380.31	$ -	$ -	$ -
Total Commercial	$ -	$ -	$ -	$ -	$ 492.51	$ 296.45	$ (6.37)	$ -	$ 4.19	$ -	$ 1,138.64	$ 1,961.47	$ 11.04	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 70.34	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ 6.97	$ -	$ (1.16)	$ -	$ -	$ -	$ 76.02	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11.00	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ 6.97	$ -	$ (1.16)	$ -	$ -	$ -	$ 157.36	$ -	$ -	$ -	$ -
MassHealth	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 221.89	$ -	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 13.60	$ -	$ -	$ -	$ -	$ -	$ 63.54	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18.92	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15.42	$ 39.21	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 13.60	$ -	$ -	$ -	$ -	$ -	$ 97.88	$ 39.21	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ 184.78	$ -	$ 1.80	$ -	$ -	$ -	$ 1,217.60	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 354.48	$ -	$ -	$ -
GRAND TOTAL	$ -	$ -	$ -	$ -	$ 513.08	$ 481.23	$ (7.53)	$ 1.80	$ 4.19	$ -	$ 1,615.77	$ 3,572.76	$ 11.04	$ -	$ -

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.

[6] Claims-based revenue for P4P contracts with United Healthcare are included in FFS Arrangements Revenue, due to a limited ability to isolate the data.

[7] Change from 2015 submission – Revenue under Risk Contracts has been restated with updated information, and may have impacted the revenue reported as FFS Arrangements for the same payer(s).

[8] Change from 2015 submission – Tufts Medicare Preferred previously reported under FFS Arrangements, is now properly reported in the Claims-Based Revenue under Risk Contracts.

[9] Change from 2015 submission – Revenue from prior year submission may be restated due to new information.

[10] Other revenue such as infrastructure could be overstated due to revenue collected by affiliated entities, not legally owned by PHS.

2014

	P4P Contracts		
	Claims-Based Revenue		Incentive-Ba
	HMO	PPO	HMO
Blue Cross Blue Shield	$ -	$ -	$ -
Tufts Health Plan	$ -	$ -	$ -
Harvard Pilgrim Health Care	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -
Aetna	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -
Total Commercial	$ -	$ -	$ -
Network Health	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -
Health New England	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -
MassHealth	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -
Medicare	$ -	$ -	$ -
Other	$ -	$ -	$ -
GRAND TOTAL	$ -	$ -	$ -

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific informati

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessme

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other sn

[5] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employ

[6] Claims-based revenue for P4P contracts with Unicare (Other Commercial) and United Healthcare are included

[7] Change from 2015 submission – Revenue under Risk Contracts has been restated with updated information, a

[8] Change from 2015 submission – Tufts Medicare Preferred previously reported under FFS Arrangements, is nov

[9] Change from 2015 submission – Revenue from prior year submission may be restated due to new information

[10] Other revenue such as infrastructure could be overstated due to revenue collected by affiliated entities, not le

			Risk Contracts		
sed Revenue	Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		
PPO	HMO	PPO	HMO	PPO	
$ -	$ 292.37	$ 302.10	$ (11.38)	$ -	
$ -	$ 89.02	$ 5.22	$ (1.59)	$ -	
$ -	$ 90.30	$ 5.00	$ (1.63)	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ 21.08	$ -	$ (0.21)	$ -	
$ -	$ 492.77	$ 312.32	$ (14.81)	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ 49.98	$ -	$ (1.55)	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ 49.98	$ -	$ (1.55)	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ 13.01	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ -	$ -	$ -	$ -	
$ -	$ 13.01	$ -	$ -	$ -	
$ -	$ -	$ 247.47	$ -	$ 9.91	
$ -	$ -	$ -	$ -	$ -	
$ -	$ 555.76	$ 559.79	$ (16.36)	$ 9.91	

ion for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available.

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naller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in tota

yees/dependents for whom PHS is 100% at risk through self-insured employer account.

in FFS Arrangements Revenue, due to a limited ability to isolate the data.

nd may have impacted the revenue reported as FFS Arrangements for the same payer(s).

v properly reported in the Claims-Based Revenue under Risk Contracts.

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gally owned by PHS.

Quality Incentive Revenue		FFS Arrangements		
HMO	PPO	HMO	PPO	HMO
$ 1.31	$ -	$ 296.64	$ 925.01	$ 4.01
$ 0.62	$ -	$ 141.33	$ 210.51	$ 4.12
$ 1.18	$ -	$ 298.50	$ 228.62	$ 2.39
$ -	$ -	$ 43.10	$ -	$ -
$ -	$ -	$ 136.87	$ 12.92	$ -
$ -	$ -	$ -	$ 219.88	$ -
$ -	$ -	$ 191.53	$ 30.77	$ -
$ -	$ -	$ 63.44	$ 363.43	$ -
$ 3.11	$ -	$ 1,171.41	$ 1,991.14	$ 10.52
$ -	$ -	$ 27.90	$ 27.90	$ -
$ 0.66	$ -	$ 101.73	$ 84.41	$ -
$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ 24.78	$ 24.78	$ -
$ 0.66	$ -	$ 154.41	$ 137.09	$ -
$ -	$ -	$ 240.66	$ -	$ -
$ -	$ -	$ 64.04	$ 77.06	$ -
$ -	$ -	$ 20.10	$ 20.10	$ -
$ -	$ -	$ 6.81	$ 66.51	$ -
$ -	$ -	$ 90.95	$ 163.67	$ -
$ -	$ -	$ -	$ 1,201.97	$ -
$ -	$ -	$ -	$ 309.75	$ -
$ 3.77	$ -	$ 1,657.43	$ 3,803.62	$ 10.52

al it is accurate.

Other Revenue

PPO	Both
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -
$ -	$ -

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	$ -	$ -	$ -	$ -	$ 284.18	$ 417.22	Not settled yet	$ -	Not settled yet	$ -	$ 301.43	$ 860.28	$ 3.79	$ -	$ -
Tufts Health Plan	$ -	$ -	$ -	$ -	$ 79.31	$ 5.80	Not settled yet	$ -	Not settled yet	$ -	$ 137.42	$ 228.00	$ 4.07	$ -	$ -
Harvard Pilgrim Health Care	$ -	$ -	$ -	$ -	$ 85.32	$ 5.20	Not settled yet	$ -	Not settled yet	$ -	$ 314.27	$ 232.60	$ 2.03	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 45.10	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 84.69	$ 58.26	$ -	$ -	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 213.01	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 186.74	$ 32.91	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ 1.42	$ 33.26	$ -	$ (1.12)	$ -	Not settled yet	$ -	$ 57.05	$ 325.16	$ -	$ -	$ -
Total Commercial	$ -	$ -	$ -	$ 1.42	$ 482.07	$ 428.22	$ (1.12)	$ -	$ -	$ -	$ 1,126.70	$ 1,950.22	$ 9.89	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15.93	$ -	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ 66.28	$ -	$ (4.11)	$ -	$ -	$ -	$ 145.39	$ -	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 34.36	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26.84	$ 0.20	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ 66.28	$ -	$ (4.11)	$ -	$ -	$ -	$ 222.52	$ 0.20	$ -	$ -	$ -
MassHealth	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 253.14	$ 11.99	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 13.25	$ -	$ -	$ -	$ -	$ -	$ 53.71	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25.95	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 86.65	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 13.25	$ -	$ -	$ -	$ -	$ -	$ 79.66	$ 86.65	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ 275.59	$ -	$ 3.30	$ -	$ -	$ 0.14	$ 1,238.94	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 318.35	$ -	$ -	$ -
GRAND TOTAL	$ -	$ -	$ -	$ 1.42	$ 561.60	$ 703.81	$ (5.23)	$ 3.30	$ -	$ -	$ 1,682.16	$ 3,606.35	$ 9.89	$ -	$ -

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.

[6] Claims-based revenue for P4P contracts with Unicare (Other Commercial) and United Healthcare are included in FFS Arrangements Revenue, due to a limited ability to isolate the data.

[7] 2015 Unicare Risk Contract Settlement is included in Other Commercial P4P Contracts Incentive-Based Revenue, but Unicare Claims-Based Revenue is included in FFS Arrangements due to a limited ability to isolate the data.

[8] Change from 2015 submission – Revenue under Risk Contracts has been restated with updated information, and may have impacted the revenue reported as FFS Arrangements for the same payer(s).

[9] Change from 2015 submission – Tufts Medicare Preferred previously reported under FFS Arrangements, is now properly reported in the Claims-Based Revenue under Risk Contracts.

[10] Other revenue such as infrastructure could be overstated due to revenue collected by affiliated entities, not legally owned by PHS.

***Attachment* #1 - HPC 2016 Cost Trends Testimony**
Additional Responses to HPC Question #4

1) Support for community organizations that directly impact the social determinants

Community Health Center Support, Examples
Partners Healthcare provides grant funding to health centers in East Boston for job training programs and pediatric obesity. The *Let's Get Movin*' program provides children and families in the diverse low-income communities of East Boston, Chelsea, Revere and Winthrop with the physical activity programs, education, and the medical care necessary to make healthy decisions to prevent and decrease obesity. The *Education and Training Institute (ETI)* program provides entry-level skills to professional development, training and advancement courses, and seminars in such a way as to recognize the complex lives and needs of community members and entry-level health center employees.

We offer hunger assistance grants to our 20 licensed and affiliated health centers. Health centers can use the grant funding to meet the needs of food insecure patients. Some examples of how the funding is used include: to purchase grocery store gift cards to be distributed to families in need of emergency food access and to provide holiday food baskets for families experiencing hunger. We provide additional grant funding to health centers with on-site food pantries. This allows the health centers to supplement their food pantries with food and necessities not available through other sources.

We provide annual grant support to the *Young at Arts* program at South Boston Community Health Center, as part of its Institute for a Healthier Community program, a resource for teens 12-18 to explore health, art, and community service. The *Youth Ambassador* program engages youth in positive activities and empowers youth leadership skills by developing partnerships with different sectors in the community and strengthening relationships with adults from these sectors. A second goal is to change norms about how adults perceive young people and include them in the life of the community. Through workshops and activities, the program offers youth the opportunity to learn about the dangers of substance abuse and train them to become peer educators on the subjects of substance abuse prevention and teen health.

Community-Based Organization Support, Examples
Partners provides funding for four *Mass in Motion* communities – Chelsea, Revere, Lynn, and Salem – to support community coalition work, host events, and raise awareness about healthy eating and active living. In the last year, our funding has helped communities in Lynn and Salem to establish city-wide Complete Streets policies. In Chelsea, funding supports the continued addition of healthier items to the school menu and to continue the Walking School Bus program. In Revere, this year's funding supported the development of a dog park, the opening of three Urban Trails, and the beginning implementation of a Complete Streets Policy. In Chelsea and Revere, this work is done in partnership with our licensed health centers in those communities.

As part of Partners commitment to building tomorrow's health care workforce, we have developed a partnership with *Camp Harbor View* to engage campers' curiosity about science, introduce them to the educational connections between school and health careers and promote

healthy choices and behaviors. Camp Harbor View, located on Long Island in Boston Harbor, was created by Mayor Thomas M. Menino and Jack Connors, is run by the Boys and Girls Club of Boston, and funded through the Camp Harbor View Foundation, a nonprofit organization. Each summer, Partners organizes two Health Career Education days to introduce campers to the idea of working in the medical field. Some Leaders in Training (LITs) interested in careers in health care also take part in two-week internships at hospitals and health centers affiliated with Partners HealthCare. These internships offer older teenagers a chance to see what a future in health care might look like, and equip them with the knowledge to seek out that path.

2) Support for community organizations that directly impact the social determinants

Community Health Workers (CHW) bridge the gap between communities and health and social services by facilitating communication between patients and providers, educating patients, serving as advocates, and helping patients navigate the healthcare system. CHWs provide culturally competent support, coordinate services and referrals and follow up, and help patients access health insurance and other supportive programs. CHWs make home visits, help patients with transportation, accompany patients to appointments as needed, and educate and support patients with wellness and disease management activities.

Medical Interpreters and Immigrant and Refugee Programs provide language support to improve patient/provider communication, health outcomes, and patient safety and provide a continuum of care across multiple settings to ensure the wellbeing of refugees, asylees and immigrants.

Domestic Violence, Abuse Prevention and Trauma Care Programs are a part of Partners long standing commitment to improve the health, wellbeing, and safety of those experiencing abuse from an intimate partner. Programs at our hospitals offer a free and confidential advocacy support services to hospital and health center patients, employees, and community members, which includes safety planning, individual counseling and support, information about the health effects of domestic violence, support groups, medical advocacy, and connects survivors with community resources (health care, housing, shelter, lawyers, and others), and legal and court advocacy. Some of our programs conduct research on various issues facing clients and provide consultation for providers as well as prevention and education programs.

Patient Navigators provide appointment reminders, patient education, clinical communication, language support, appointment preparation, emotional support, scheduling assistance, address barriers, and support patient motivation in access to care.

Prenatal Outreach and Pregnancy Support provides education and referrals to patients during pregnancy and postpartum. Programs encourage family involvement and seeks to improve birth outcomes by addressing social and medical needs of pregnant women.

- *Perinatal Case Manager Program* for over 20 years has provided a direct response to the high infant mortality and low birth weight rates in certain Boston neighborhoods. The program seeks to prevent infant deaths and poor birth outcomes by addressing the social and medical needs of pregnant women. Case managers function like CHWs, coordinating health care for pregnant women, educating them about healthy behaviors, and supporting patients in accessing

services. Case managers provide financial and transportation support and assist patients in overcoming barriers to health care and services. The program provides technical assistance and training for case managers at six of our hospital licensed and affiliated health centers: Brookside Community Health Center, Martha Eliot Health Center, Mattapan Community Health Center, Southern Jamaica Plain Health Center, South End Community Health Center, and Whittier Street Health Center. By working together with hospital providers, case managers ensure culturally responsive care for pregnant women throughout their perinatal period.

Children, Youth and Adolescent Health Programs. Some examples of our programs in this area include:

- *Racial Healing and Reconciliation Team* at Southern Jamaica Plain Health Center works with youth in a racial healing and reconciliation process to address the impact of racism on the social determinants of health with a focus on employment, workforce development and education.

- *Pediatric Asthma Program* provides pediatric and adolescent patient navigation, education, home visits, referrals to services, and collaboration within the MGH Chelsea health center and with outside agencies.

- *Charlestown Family Support Circle* provides home visits, accompaniment to court and school meetings, and coordinating referrals and services.

Health Services for the Homeless and Food Security, with Boston Health Care for the Homeless Program, delivers direct care in 2 hospital clinics and over 60 shelters sites in Boston. Our sites also screen patients for food insecurity and connect those in need with food resources such as SNAP, WIC, food pantries, and local organizations.

Some examples of our coalition work include:

- *Healthy Chelsea* is a coalition comprised community leaders, organizations, and residents that work to identify the social and environmental factors influencing Chelsea's high obesity prevalence and to develop and implement an action plan.

- *Charlestown Substance Abuse Coalition* (CSAC) works to increase access to and resources for successful treatment and recovery from substance use disorders. The coalition has nearly 50 active members representing 12 community sectors. Its *Turn It Around* youth group raised awareness of substance use through community events and through social media. In 2015, the Charlestown Navigator worked with 96 people in recovery or struggling with addiction to connect them with needed resources. CSAC recently expanded its prevention curriculum into Charlestown High School, the Boys & Girls Clubs, and the Stay-in-Shape afterschool program, reaching 400 students. CSAC created the Charlestown Trauma working group in 2015 and partnered with Boston Public Health Commission to host regular community NARCAN trainings.

- *Chelsea Substance Use Disorder (SUD) Leadership Team* works to increase access to and resources for successful treatment and recovery from SUDs. The program brings together SUDs, Healthy Eating & Active Living, and Family Violence into one 'Healthy Communities' structure, which will help facilitate collaboration with Chelsea Public Schools and community organizations.

- *Revere Cares: Alcohol, Tobacco, and Other Drugs (ATOD) Initiative* is an award winning coalition with 350 members dedicated to preventing alcohol and drug abuse among Revere youth. Coalition members represent a variety of sectors, including parents, youth, government officials, educators, health professionals, first responders and law enforcement. The Coalition oversees two major initiatives, the ATOD, and Revere on the Move Initiatives. Revere CARES' ATOD initiative has expanded in recent years to include opioid overdose prevention.

Workforce Development: Partners Workforce Development has been organized around pipelines representing different constituent groups: youth, low-income community residents, incumbent workers, and community health clinicians. The primary goals of the workforce development programs at both the system level and at our anchor institutions are to build a skilled, diverse workforce and to improve the health of communities by providing good jobs with good benefits and opportunities for advancement. Educational attainment is a primary focus as both a means to create a more skilled workforce and as a pathway to economic self-sufficiency. Examples include:

- *Partners in Career and Workforce Development (PCWD)* addresses the Boston health care industry's need for a highly skilled diverse workforce, incumbent employees' interests in career advancement, and the Boston community's desire to provide stable careers with growth potential and family-sustaining wages to low-income residents. Launched in 2003, PCWD is jointly operated by Partners Human Resources and Community Health. Through collaboration with Project Hope, a multi-service community-based agency located in Roxbury, PCWD provides low-income and low-skilled community residents with training, internships, career counseling/case management and job placement services which offer family-sustaining, generous benefits, and opportunities for advancement within Partners HealthCare affiliates. Offered 3 times per year, the rigorous, 8-week program focuses on working in a health care environment, medical terminology, HIPAA, developing customer service skills, resume writing, effective workplace communication, as well as interviewing skills. Partners collaborates with Jewish Vocational Service (JVS) and other training providers for some of the program's curriculum, mock interviews, and other training content. Upon completion of classroom instruction and internships, PCWD graduates are placed in a variety of positions, including but not limited to, patient

service coordinators, unit coordinators, operating room assistants, and laboratory aides. Since inception, 535 participants have graduated from the program.

- *Youth pipeline's* primary focus is to prepare and connect area youth to post-secondary educational opportunities. Both Brigham and Women's and Mass General have well-developed programs, serving about 350 youth each year, that provide exposure to the health care field as well as mentorship, work experience and college readiness programming, application support, and scholarships. For youth program participants, there are opportunities to continue working at the institutions during and after college.

- *Next generation of leaders in community health pipeline*: Established in 2011 by the Kraft family, the Kraft Center for Community Health supports community health centers in their efforts to recruit, retain and develop primary care physicians and nurses committed to practice in community health. The community health workforce is critical to providing access to care for vulnerable and underserved patients and the Kraft Center' mission is to prepare the next generation of leaders in community health. The Kraft Center carries out its work in close collaboration with the Mass. League of Community Health Centers.