MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, 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. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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, 2015, 2016, and/or 2017 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 templates, 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@mass.gov or (617) 979-1400.

HPC Contact Information

For any inquiries regarding HPC questions, please contact HPC-Testimony@mass.gov or (617) 979-1400.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@mass.gov or (617) 963-2030.

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

Similar to issues identified in past pre-filed testimony, BIDCO's top areas of concern in meeting the Commonwealth's health care cost growth benchmark include: (1) areas of cost growth that are out of the direct control of BIDCO, namely the increasingly high cost of pharmaceuticals and persistent provider price variation, (2) altering consumer attitudes to favor high-value, lower-priced health care options, and (3) ensuring appropriate allocation of administrative resources between payer and provider to decrease duplication as provider organizations assume more risk.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?

First, BIDCO encourages policymakers to continue prioritizing initiatives that incentivize purchasers — whether they are beneficiaries, employers or other consumers of health care services — in favoring high-value, lower-cost networks and providers. Particular recommendations are outlined in the *Special Commission on Provider Price Variation Report* (March 2017). For example, increasing price differentials among tiers may be a helpful tool that could drive consumers toward high-value and lower-cost plans and that, in turn, would encourage patients to receive care in the most clinically-appropriate settings. BIDCO also supports increasing the premiums between limited- and tiered network plans and broader commercial plans. Such innovative product designs are most impactful when paired with the ability to relieve insurance constraints on limited- and tiered-network plans, as this would help increase adoption and consumer selection of such products. Second, since there remains insufficient progress in addressing provider price variation, market-based solutions committed to upholding the values of "Triple Aim" should continue to play a key role in addressing this perplexing market phenomenon. Since the regulatory model in Massachusetts focuses on limiting total growth in health care spending, it tends to lock-in unwarranted price variation. Therefore, market-based competition is necessary to address unwarranted price variation. Without competition, the underlying dysfunction in the Massachusetts market will continue, high-priced providers will continue to extract higher payments, and inequity in the system will be maintained, leading to further destabilization of the remaining providers. In a market with significant unwarranted price variation, true competition from a high-value health system will provide the real possibility of a meaningful preferred health care solution for insurers, employers, and consumers.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

BIDCO engages in a number of projects and programs to support the reduction of health care expenditures given its role as an Accountable Care Organization. However, two primary priorities guide our work: (1) BIDCO provides the network critical analytical and clinical support to create and manage programs to address patient care gaps and achieve better health care outcomes, and (2) BIDCO continues to focus on moving more of its membership into value-based payment arrangements.

Data-directed management of total medical expense (TME)

BIDCO recognizes that the ability to retain and understand the utilization patterns of its membership has the potential to greatly influence the reduction of health expenditures. To achieve this, BIDCO creates data-driven reports based on real-time EHR data from its providers and lagged claims data from payors, which are reviewed at various BIDCO settings, including: (1) quarterly BIDCO Quality and TME Committee meetings that ultimately report to the BIDCO Board of Managers; (2) monthly PCP Advisory meetings, which are gatherings of BIDCO PCP leaders in the network; (3) monthly Pod meetings, which are gatherings of geographically aligned PCPs; and (4) bi-monthly risk unit meetings, which are gatherings of geographically aligned PCPs and their risk-sharing hospital. It is through this process whereby BIDCO staff, including its Performance Improvement Facilitators, engage providers and help them better understand how to turn the data into actionable practice changes to address any gaps or deficiencies, including identifying gaps revealing that patients are being treated in less-than-optimal settings from a clinical or cost-effectiveness perspective.

Additionally, BIDCO built into its data repository with Arcadia Healthcare Solutions the ability to provide real-time referral information to physicians and practices. This includes the ability to collect admit, discharge and transfer information from member hospitals along with data from hospital inpatient systems, including scheduling, lab, radiology and ambulatory data. With this added capability, a patient's physician is notified when a patient is admitted for a hospital impatient stay or to a skilled nursing home or is discharged from the hospital. This functionality will significantly help bridge the current IT divide between hospitals and physicians and better equip practitioners in the BIDCO network to timely intervene when a patient is seeking care outside of the community setting when it is not clinically necessary.

Value-Based Payment Arrangements

BIDCO exists today expressly to provide physician groups and hospitals the infrastructure to contract, share risk, and build population health management systems together, with the goal of providing the highest quality care in the most cost-efficient way. As such, BIDCO focuses on establishing arrangements with payers that support the transition to alternative payment models. This year, as in past years, BIDCO is engaging in new arrangements to meet this objective. For example, BIDCO is in its first performance year of the MassHealth ACO Program serving more than 35,000 beneficiaries. This is the first BIDCO-wide APM in a Medicaid product. BIDCO is also preparing to begin participating in a value-based arrangement in Blue Cross Blue Shield's PPO risk contract, thereby increasing BIDCO's participation in value-based contracts by approximately 45,000 members. As commercial payers, MassHealth and Medicare introduce new models and demonstrations, BIDCO will continue to evaluate them and determine how they may contribute to BIDCO's objective of increasing participation in alternative payment models.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such

alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond normal weekday business hours. Information requested in question (a) below may be provided in the form of a link to an online directory or as an appended directory.*

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.

This question is not applicable because BIDCO does not own or operate any alternative care sites.

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through a joint venture with another organization (information from non-owned affiliates should not be included):

Number of unique patient visits	N/A
Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	N/A
Percentage of patient visits where the patient is referred to a more intensive setting of care	N/A

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.

This question is not applicable because BIDCO does not own or operate any alternative care sites.

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?

This question is not applicable because BIDCO does not own or operate any alternative care sites.

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).

BIDCO provides its network of clinicians the requisite data needed to support activities that expand access and reduce unnecessary hospital utilization, as described in response to 1.c above. Given BIDCO's unique organizational structure, where our providers and hospitals all maintain their own independent corporate functions, we capitalize off their expertise and their programs that support to these objectives. For example, several BIDCO provider groups have instituted an emergency department (ED) utilization program. Specifically, a Beth Israel Deaconess Health Care community physician group has a telephonic program where designated practice contacts call every patient who visited an ED to schedule a follow-up visit with the patient's PCP, and to educate the patient on appropriate reasons to visit ED as well as alternative site of care, if an ED visit is not warranted. To the extent that BIDCO is able, it will coordinate with its network to ensure there is adequate support for the practice's initiatives. Additionally, BIDCO has a preferred skilled nursing facility (SNF) program focused on 30-day ED and hospital readmissions for Medicare risk patients and a Self-Management Action Plan (SMAP) for patients with certain chronic illnesses to ensure these patients have a management plan to avoid inappropriate utilization. BIDCO is also currently evaluating the establishment of its own behavioral health telemedicine program and instituting an embedded and telephonic transitions of care program for MassHealth ACO patients.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.

If managed appropriately and if operated in a manner where the practice site and the clinicians are held to certain standards, then there is great potential in the value that alternative care sites can bring to consumers. It also has the potential to address excessive health care cost growth in the Commonwealth if managed effectively. For example, if the site's clinical information systems are interoperable with the primary care clinician's EHR, the primary care clinician would have the full care record for the patient thereby increasing the potential to reduce unnecessary or duplicative services. Concomitant with the infrastructure needed to optimize the efficient performance of these sites, the consumer or patient must also be educated on how to maximize the benefit of these services. For example, consumers should understand that these sites not only provide tremendous convenience, but the value from the convenience may be quickly vitiated if the patient is nonetheless transferred to an ED. Consumers should also understand that alternative sites should not be used as a substitute for primary care delivered by a primary care clinician. Nonetheless, there is still much opportunity to shape consumer habits and clinician culture since the rapid growth and proliferation of these sites is relatively recent. It will be important to act swiftly before attitudes become entrenched and difficult to alter.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

☒ Legal barriers related to data-sharing

☒ Structural/technological barriers to data-sharing
☒ Lack of resources or capacity of your organization or community organizations
☒ Organizational/cultural barriers
☒ Other: (1) Present organizational capacity limitations that prevent an organization's ability to meaningfully connect with a high volume of community organizations, and (2) Lack of aligned financial incentives (i.e., benefit design needs to better incorporate the activities clinicians and community providers supply)

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?

Integrating services addressing health-related social needs within the existing health care delivery system is an extensive and critical undertaking. The Commonwealth's MassHealth ACO and Community Partner programs are facilitating the evolution of how to better connect the two related, but often separate, industries. BIDCO's participation in the MassHealth ACO continues to bring to light the sometimes overwhelming complexities in truly integrating social determinants of health into the traditional, clinical health care setting. This kind of transition is likely to take time; therefore, at the outset BIDCO recommends that policymakers and other officials provide the necessary flexibilities in order to successfully align systems. For example, not all systems will be capable of linking with each other right away, and some organizations may not have electronic systems at all. To manage the population effectively, those technological linkages are fundamental, but experience proves that systems integration is a tedious process that will undoubtedly be met with unexpected delays and setbacks. Therefore, any policies pertaining to the exchange of data electronically must have reasonable implementation timetables and should also be paired with reporting requirements that account for an entity's progress in aligning systems.

In that vein, additional resources are needed in order to meet the growing focus on addressing social determinants of health, and it is presently one of the most critical barriers both health care providers and community organizations face as they work to integrate social services with the health care delivery system. BIDCO is concerned that there are insufficient staff and insufficient workforce training opportunities available to optimally support the management of the population. Therefore, additional certificate programs and apprenticeship programs for community health workers, community resource specialists, and other similar fields are necessary to ensure sufficient access for consumers without an untimely delay. Specifically, training and certificate programs will be necessary in all facets of social welfare, including but not limited to housing, nutrition, food insecurity, and transportation.

AGO Pre-Filed Testimony Questions

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 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.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	0	0
	Q2	0	0
	Q3	0	0
	Q4	0	0
CY2017	**Q1**	0	0
	Q2	0	0
	Q3	0	0
	Q4	0	0
CY2018	**Q1**	0	0
	Q2	0	0
	TOTAL:	0	0

   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 analysis.

   This question is not applicable because BIDCO has not received any consumer price inquiries.

   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?

   This question is not applicable because BIDCO has not received consumer price inquires.

3. For hospitals and provider organizations corporately affiliated with hospitals:

   a) For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may

be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

This question is not applicable because BIDCO does not maintain or manage this information for its member hospitals. BIDCO recommends reviewing its member hospitals' Pre-filed Testimony submissions for a relevant response.

b) For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

This question is not applicable because BIDCO does not maintain or manage this information for its member hospitals. BIDCO recommends reviewing its member hospitals' Pre-filed Testimony submissions for a relevant response.

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.

2014	Risk Contracts	
	Claims-Based Revenue/Budget Surplus/(Deficit)/Quality Incentive Revenue	
	HMO	PPO
Blue Cross Blue Shield	$97.5M	
Tufts Health Plan	$30.9M	
Harvard Pilgrim Health Care	$37.1M	
Fallon Community Health Plan		
CIGNA		
United Healthcare		
Aetna		
Other Commercial		
Total Commercial	$165.5M	
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	$0.84M	
Commercial Medicare Subtotal	$0.84M	
Medicare	$162.8M	
Other		
GRAND TOTAL	$329.1M	

2015	Risk Contracts	
	Claims-Based Revenue/Budget Surplus/(Deficit)/Quality Incentive Revenue	
	HMO	PPO
Blue Cross Blue Shield	$105.2M	
Tufts Health Plan	$29.7M	
Harvard Pilgrim Health Care	$42.1M	
Fallon Community Health Plan		
CIGNA		
United Healthcare		
Aetna		
Other Commercial		
Total Commercial	$177.0M	
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	$3.8M	
Commercial Medicare Subtotal	$3.8M	
Medicare	$241.8M	
Other		
GRAND TOTAL	$422.6M	

2016	Risk Contracts	
	Claims-Based Revenue/Budget Surplus/(Deficit)/Quality Incentive Revenue	
	HMO	PPO
Blue Cross Blue Shield	$127.1M	
Tufts Health Plan	$51.7M	
Harvard Pilgrim Health Care	$156.7M	
Fallon Community Health Plan		
CIGNA		
United Healthcare		
Aetna		
Other Commercial		
Total Commercial	$335.5M	
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	$13.9M	
Blue Cross Senior Options	$20.7M	
Other Comm Medicare	$8.0M	
Commercial Medicare Subtotal	$42.6M	

Medicare		
Other		
GRAND TOTAL	$378.1M	

2017	Risk Contracts	
	Claims-Based Revenue/Budget Surplus/(Deficit)/Quality Incentive Revenue	
	HMO	PPO
Blue Cross Blue Shield	$123.1M	
Tufts Health Plan	$47.8M	
Harvard Pilgrim Health Care	$143.3M	
Fallon Community Health Plan		
CIGNA		
United Healthcare		
Aetna		
Other Commercial		
Total Commercial	$314.2M	
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	$15.4M	
Blue Cross Senior Options	$20.0M	
Other Comm Medicare	$9.6M	
Commercial Medicare Subtotal	$45.0M	
Medicare	$295.4M	
Other		
GRAND TOTAL	$654.6M	

Please note that as of 8/31/2018, BIDCO has not received all the Payor settlements and quality results