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.

BIDMC maintains its committed focus on leading efforts to reduce medical expense trends and looks forward to making more significant progress toward Massachusetts' stated goals of reducing health care spending with the formation of Beth Israel Lahey Health.

There are 3 key areas that continue to present challenges and will continue to be areas of focus - high cost of pharmaceuticals, wage pressure and costs of new technology.

Continued Growth in Cost of Pharmaceuticals. The inflation rate for pharmaceuticals for our organization, even with cost control mechanisms and strategies in place, is approximately 7%. Contributing to these high costs are sole-source drugs, highly specialized biologic therapies, and drug shortages. While pharmaceutical advances have greatly benefitted our patients, BIDMC believes that improved transparency of clinical and cost effectiveness would help identify areas of excessive and unjustified prices and increase the accountability of manufacturers and pharmacy benefit managers.

Wage Pressure. The single largest obligation of our annual operating budget is the funding of our workforce,which guides BIDMC's decisions regarding compensation and benefit structure. The Massachusetts nurse staffing ballot initiative, if passed, has the potential to dramatically increase the hospital's workforce expenditure commitment.

It is a core value of our Medical Center to provide opportunities for our workforce to advance or evolve their career at BIDMC. BIDMC works hard to be an employer of choice by, among other things, providing career advancement programs, such as the BIDMC Pipeline Program, which provides employee education and job training at BIDMC for little-to-no-cost to the participant. These efforts aim to keep valuable employees with high value benefits that provide a high return on investment and are less costly than increasing wages to the levels paid by the dominant market players.

Cost of New Technology and Clinical Advances. As a provider attempting to remain at the forefront of current and innovative treatment and medical care, there are significant costs to market access that must be assumed in order to improve access to care and transform the delivery of medicine. Maintaining the ability to provide leading edge technology often requires significant space renovation and equipment overhaul. In addition to sizeable costs associated with making

the space available for new technology, the new technology itself is expensive. One example of such new therapy is TAVR, or transcatheter aortic valve replacement, a highly costly procedure which can dramatically improve the lives of high risk patients who are unlikely to survive a heart valve replacement.

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

BIDMC continues to challenge policymakers to create incentives in the health care marketplace that favor consumer investment in high-value, low-cost networks and providers. As we have noted in previous HPC Cost Trends Pre-Filed Testimony, unjustified and dramatic variation in prices paid to like providers continues to have a significant impact on the healthy functioning of the health care market in Massachusetts, both for low-cost community providers, and for providers of similar size and capability who provide precisely the same services and fulfill the same mission at dramatically different prices within the market. The current marketplace climate under unjustified price variation perpetuates the destabilization of competition among health care providers, including community hospitals serving disproportionate numbers of low income patients, and some academic medical centers, leading to dysfunction in the Massachusetts health care market, and overall inequity in the health care system. BIDMC believes that market-based forces, like the competitive pressure on the dominant health system created by the proposed Beth Israel Lahey Health transaction, can effectively address unwarranted price variation and have the potential to significantly impact market dysfunction harmful to consumers in the Commonwealth, particularly in communities where access to care has eroded or disappeared.

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.

The proposed formation of Beth Israel Lahey Health is our main strategic priority to help reduce health care expenditures. Beth Israel Lahey Health has planned specific initiatives to improve access to care and population health, and to achieve efficiencies that cannot be realized by the Parties on their own, which will benefit the citizens of the Commonwealth.

In reiterating what we have stated in our previous HPC submissions, Beth Israel Lahey Health will create a forward-thinking, transformative, and geographically distributed health care delivery network to provide enhanced access to high-value care for patients in Eastern Massachusetts, meet the needs of purchasers seeking to reduce medical expenditures, and advance progress toward Massachusetts' stated goals of reducing health care spending and promoting adoption of alternative payment methodologies ("APMs").

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.

BIDMC owns and operates two licensed Urgent Care Centers (UCC) in the community, BID Urgent Care-Chestnut Hill, located at 200 Boylston Street, Chestnut Hill, MA (opened in 2014) and BID Urgent Care–Chelsea, located at 1000 Broadway Street, Chelsea, MA (opened in late August 2017).

Our UCCs provide low cost, high quality services primarily to residents of Boston, Newton and Chelsea and their nearby surrounding communities. We care for all patients from a variety of health care settings, health care systems and unaffiliated patients (not affiliated with any specific health care system or without a PCP of record) on a walk -in or scheduled appointment basis, during hours of operation.

The UCCs extended hours of operation (shown below) enhance access to care. The hours of operation are:

BID Urgent Care – Chestnut Hill:
Monday – Friday: 9 a.m. to 9 p.m.
Weekends and some Holidays: 9 a.m. to 7 p.m.

BID Urgent Care – Chelsea:
Monday – Friday: 11 a.m. to 7 p.m.
Weekends and most Holidays: 9 a.m. to 5 p.m.

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	Chestnut Hill =18,392 Chelsea= 6,248 (ramp up phase)
Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	Urgent Care Sites / CHMOB / Chelsea Commercial 65.75% 47.33% Medicaid 12.61% 25.70% Medicare 18.94% 24.62% Self-Pay 2.22% 1.64% Other (Auto Liab / Workers Comp) 0.48% 0.71% 100.00% 100.00%
Percentage of patient visits where the patient is referred to	Chestnut Hill: 4.5% transferred to a more intensive setting

a more intensive setting of care	Chelsea: 9.1% transferred to a more intensive setting

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.

BIDMC UCCs are staffed by ED physicians, Nurses and Techs/Medical Assistants. We believe this staffing model is a key differentiator because the ED physician's training allows for a more refined assessment of the patient's condition, reduces the need to move a number of patients to an ED, and allows the UCC to appropriately care for a broader range of patients (within the UCC licensing guidelines). An ED visit is avoided with this heightened ability to assess, diagnose and treat, and care is provided in the less costly urgent care setting.

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?

A primary care provider (PCP) within the BID system (BIDMC and its owned affiliates) receives the UCC visit summary and an alert to direct the PCP to check the patient's full chart. In situations where the patient's PCP is not a provider within the BID system, the patient receives a copy of the UCC visit summary and is instructed to share the summary with their PCP. In order for BIDMC to facilitate providing a UCC visit summary via secure email to the patient's PCP, it is BIDMC's standard operating practice to request PCP contact information and patient authorization at the time of a UCC visit. Upon receipt of both the PCP's contact information and proper patient authorization, the UCC visit summary is provided to the PCP in a timely manner. Often, patients choose not to provide the information, are unable to recall the name of their PCP at the time, or do not have a PCP of record. Failure to provide this information is clearly a barrier to sharing real-time information with other health care providers.

If BIDMC notices an increased frequency of UCC usage by an out-of-system physician, we outreach to that practice to obtain additional contact information such as a fax number or secure patient file transfer instructions to facilitate expedited transfer of patient information.

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).

At several of BIDMC's primary care practices, we currently offer extended office hours, particularly for those sites not in close proximity to BIDMC's UCCs, which enhances access for patients. Our UCCs also provide additional back-up for PCP offices caring for patients who require a higher level of care than what may be appropriately provided at PCP's offices, avoiding a more costly ED visit. To assist with access and fully integrate with and support our primary care network, our Urgent Care sites also will see new patients and perform a quick assessment / intake during their visit, and then refer new patients to one of our PCPs with the work-up already begun.

This intake will be available for the PCPs to view in our Online Medical Record so they can use the foundational information for further follow up in primary care.

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.

BIDMC has found our Urgent Care sites to be beneficial for patients, providers, and ultimately the Commonwealth in terms of enhanced clinical quality and lower health care costs. With lower cost of care, comparatively lower patient co-pays in the urgent care setting, and enhanced clinical staffing, more appropriate care may be provided in the lower cost UCC setting. An added benefit for BIDMC system patients is our staff's efforts to ensure that "preventive care gaps" are identified in medical records and appropriate steps are taken to close the preventive care gap. For example, BIDMC staff schedule requests for screening exams, such as mammography, GI endoscopy, or Hemoglobin A1c, when a need is demonstrated in the records. Staff then inform the PCP that the preventive care gap was addressed. BIDMC's ability to identify and correct preventive care gaps enhances care management with an end goal of potentially avoiding more costly care.

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: Lack of capacity and resources at the implementation level to provide viable solutions.

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

Through BIDCO, BIDMC participates in the MassHealth ACO with the intent of integrating social determinants of health into the traditional, clinical health care setting. BIDMC and BIDCO also participate in Boston's Social Determination of Health Collaborative alongside other academic medical centers and MassHealth ACOs. BIDMC has identified three critical challenges that limit our ability to leverage existing community resources to assist our patients in addressing their social determinant of health needs.

Regulatory Clarification. The Commonwealth should enhance and improve the current policies related to the transfer and sharing of certain patient information with community resources and

partners. Such data transparency is necessary for a collaborative response to addressing social determinants of health needs.

Vendor Interoperability for Referral Platforms. The Commonwealth should promote community resource collaboration by developing and improving the interoperability of referral platforms used by various community resources. Increased interoperability will allow for better referral case-management and communication between community resources, partner organizations, and healthcare providers. The ability for healthcare providers to see what referrals were already made for specific social determinant of health needs can facilitate collaboration and benefit patients and their advocates by allowing them to manage and access their referrals through a centralized platform. Improved interoperability would also reduce duplicative efforts and redundant referrals to community resources.

Insufficient Community Resources. For certain social determinants of health, such as housing, inadequate capacity renders awareness and recognition insufficient at mitigating the issue. For example, partnering organizations for housing face challenges to having any real impact as there is simply no affordable housing available to offer to those in need. Without adequate capacity to address social determinant of health needs, the needs will prevail. Therefore, the Commonwealth should invest in identifying the adequacy of community resources and when inadequate, create concrete, innovative solutions to address these insufficiencies.

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**	-----	-----
	Q2	7	-----
	Q3	10	-----
	Q4	17	-----
CY2017	**Q1**	76	-----
	Q2	159	-----
	Q3	181	-----
	Q4	278	-----
CY2018	**Q1**	300	-----
	Q2	190	-----
	TOTAL:	1218	-----

   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.

   At BIDMC, there were a few requests for price information when Chapter 224 first went into effect. As our process continues to become more robust, the request volume continues to rise. Today, all incoming estimate requests are logged and tracked for timeliness of completed response. The completion goal is two business days.

The results of the monitoring show that the majority of requests are completed in the same day unless additional information is needed from a provider or scheduling office. When additional information is needed, the request is acknowledged within one business day with an explanation of the need to obtain additional information in order to complete the estimate request. Where a request is for an identified patient with a scheduled date of service, the billed charges are reviewed quarterly to check the accuracy of the estimate provided and explanations for the discrepancies researched. For example, additional services or lab testing added during a scheduled procedure or additional time in the O.R could result in higher charges than the estimate. Future estimates for the same services/procedures can then be fine-tuned to include additional services that may be involved. Many requests for estimates are from individuals who are 'shopping around' and may not actually come to our institutions for services. For these cases, a look-back QA process of the specific service is not feasible.

The vast majority of estimate requests come to us in writing, through a specific e-mail address we have set up, with specific staff to answer the requests. The requests come directly from either an existing patient, potential patient, routed through a provider's office or through our clinic staff. There are a few minor requests that come to us in person or by phone, so numbers are not tracked separately. Upon receipt of a phone request, we request that the caller provides us with a written or email request to ensure we are providing a complete response.

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?

The main barrier encountered for accuracy and timeliness of response to consumer is lack of specificity in the request for pricing. When a specific request is unclear, we need to request for additional information, such as the patient's medical record number, date of birth, and/or the name of the ordering provider, to check for scheduled visits and procedures and, if necessary, reach out to the provider's office for more specific information (e.g CPT codes) to provide a better estimate. In the case of a requestor who is not yet a registered patient or who does not yet have an ordering provider, we work directly with the requestor to elicit more specific information about the nature of the planned service in order to provide the estimate. It can occasionally take time to get responses from provider offices, and we follow up daily until we have the information needed to complete the estimate and respond to the requestor.

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

a) For each <u>year 2015 to present</u>, 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.

A relatively small differential in payment rates exists between HMO and PPO patients for only some of our payors, therefore, BIDMC has not recognized any material difference in margins between these two types of patients. Additionally, BIDMC currently does not have any contracts that incorporate a "per member per month budget" against the cost of claims, therefore, settlement through this type of reimbursement does not affect our revenue or margins.

Please refer to attached **AGO Provider Exhibit 1** for additional information.

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.

Please refer to attached **AGO Provider Exhibit 2** for additional information.

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.

BIDMC 2014	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 98.10	$ 136.72			
Tufts Health Plan											$ 29.10	$ 46.70			
Harvard Pilgrim Health Care											$ 142.70	$ 17.40			
Fallon Community Health Plan											$ 5.20				
CIGNA											$ 8.80				
United Healthcare											$ 9.00				
Aetna											$ 18.20				
Other Commercial											$ 49.88				
Total Commercial											$ 360.98	$ 200.82			
Network Health											$ 35.20				
Neighborhood Health Plan											$ 37.80				
BMC HealthNet, Inc.											$ 11.70				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid											$ 84.70	$ -			
MassHealth											$ 49.30				
Tufts Medicare Preferred											$ 32.80				
Blue Cross Senior Options											$ 12.20				
Other Comm Medicare											$ 13.60				
Commercial Medicare Subtotal											$ 58.60	$ -			
Medicare											$ 332.00				
Other											$ 27.10				
GRAND TOTAL											$ 912.68	$ 200.82			

BIDMC 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											$ 106.90	$ 149.50			
Tufts Health Plan											$ 27.20	$ 49.00			
Harvard Pilgrim Health Care											$ 152.00	$ 21.10			
Fallon Community Health Plan											$ 5.20				
CIGNA											$ 10.30				
United Healthcare											$ 9.10				
Aetna											$ 20.00				
Other Commercial											$ 55.77				
Total Commercial											$ 386.47	$ 219.60			
Network Health											$ 34.30				
Neighborhood Health Plan											$ 49.10				
BMC HealthNet, Inc.											$ 12.60				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid											$ 96.00	$ -			
MassHealth											$ 59.00				
Tufts Medicare Preferred											$ 34.30				
Blue Cross Senior Options											$ 16.40				
Other Comm Medicare											$ 16.80				
Commercial Medicare Subtotal											$ 67.50	$ -			
Medicare											$ 342.60				
Other											$ 27.63				
GRAND TOTAL											$ 979.20	$ 219.60			

BIDMC 2016	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											$ 102.50	$ 157.08			
Tufts Health Plan											$ 24.80	$ 51.70			
Harvard Pilgrim Health Care											$ 160.50	$ 24.30			
Fallon Community Health Plan											$ 5.40				
CIGNA											$ 11.70				
United Healthcare											$ 8.20				
Aetna											$ 23.90				
Other Commercial											$ 52.15				
Total Commercial											$ 389.15	$ 233.08			
Network Health											$ 42.40				
Neighborhood Health Plan											$ 66.50				
BMC HealthNet, Inc.											$ 15.90				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid											$ 124.80	$ -			
MassHealth											$ 54.00				
Tufts Medicare Preferred											$ 33.80				
Blue Cross Senior Options											$ 15.70				
Other Comm Medicare											$ 22.14				
Commercial Medicare Subtotal											$ 71.64	$ -			
Medicare											$ 379.00				
Other											$ 28.30				
GRAND TOTAL											$1,046.89	$ 233.08			

BIDMC 2017	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											$ 97.00	$ 158.44			
Tufts Health Plan											$ 27.78	$ 49.07			
Harvard Pilgrim Health Care											$ 156.75	$ 28.18			
Fallon Community Health Plan											$ 6.50				
CIGNA											$ 14.02				
United Healthcare											$ 13.36				
Aetna											$ 23.77				
Other Commercial											$ 57.95				
Total Commercial											$ 397.14	$ 235.69			
Network Health											$ 51.28				
Neighborhood Health Plan											$ 60.79				
BMC HealthNet, Inc.											$ 18.28				
Health New England											$ -				
Fallon Community Health Plan											$ -				
Other Managed Medicaid											$ -				
Total Managed Medicaid											$ 130.35	$ -			
MassHealth											$ 56.98				
Tufts Medicare Preferred											$ 34.79				
Blue Cross Senior Options											$ 14.34				
Other Comm Medicare											$ 24.91				
Commercial Medicare Subtotal											$ 74.05	$ -			
Medicare											$ 420.38				
Other											$ 21.24				
GRAND TOTAL											$1,100.13	$ 235.69			

BIDMC 2017

Service Category	Commercial				Medicare				Medicaid				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns																	$ -	$ -	$ -	$ -
Cardiology Total	$ 21.90	$ 4.50	$ 23.93	$ 5.11	$ 50.28	$ (5.79)	$ 20.77	$ (4.60)	$ 6.13	$ (1.00)	$ 2.48	$ (2.32)	$ 0.31	$ (1.84)	$ 0.31	$ (0.18)	$ 78.62	$ (4.12)	$ 47.49	$ (1.99)
Invasive																	$ -	$ -	$ -	$ -
Medical																	$ -	$ -	$ -	$ -
Cardiac Surgery	$ 21.40	$ 5.50	$ 0.24	$ (0.02)	$ 28.05	$ 1.31	$ 0.21	$ (0.10)	$ 5.09	$ (0.25)			$ 0.11	$ (0.79)			$ 54.64	$ 5.76	$ 0.45	$ (0.11)
Dental																	$ -	$ -	$ -	$ -
Dermatology			$ 3.82	$ 1.25			$ 2.69	$ 0.29			$ 1.12	$ 0.34					$ -	$ -	$ 7.63	$ 1.88
Endocinology			$ 3.36	$ 0.90			$ 1.77	$ (0.37)			$ 1.07	$ 0.31					$ -	$ -	$ 6.21	$ 0.84
Gastroenterology	$ 11.24	$ 3.83	$ 42.40	$ 11.47	$ 6.30	$ (0.52)	$ 13.59	$ (1.56)	$ 5.11	$ (0.11)	$ 7.96	$ (1.47)	$ 0.28	$ (0.33)	$ 0.90	$ (0.34)	$ 22.93	$ 2.87	$ 64.83	$ 8.10
General Medicine	$ 55.47	$ 16.00	$ 39.16	$ 6.99	$ 91.54	$ (2.52)	$ 14.45	$ (5.21)	$ 23.15	$ (5.08)	$ 16.01	$ (0.93)	$ 0.70	$ (1.89)	$ 0.87	$ (0.58)	$ 170.85	$ 6.50	$ 70.49	$ 0.27
General Surgery	$ 8.44	$ 3.29	$ 6.27	$ 2.01	$ 5.72	$ (0.54)	$ 2.86	$ 0.55	$ 2.03	$ (0.46)	$ 1.05	$ (0.64)	$ 0.46	$ (0.08)	$ 0.10	$ (0.02)	$ 16.66	$ 2.22	$ 10.29	$ 1.90
Gynecology					$ 2.92	$ 0.35	$ 2.65	$ (0.54)									$ 2.92	$ 0.35	$ 2.65	$ (0.54)
Hematology	$ 25.87	$ 7.83	$ 38.22	$ 5.19	$ 19.62	$ (7.21)	$ 34.08	$ (6.64)	$ 9.15	$ (0.62)	$ 8.49	$ (4.65)	$ 1.25	$ (0.50)	$ 0.61	$ (0.59)	$ 55.89	$ (0.50)	$ 81.40	$ (6.68)
Infectious Disease			$ 0.83	$ (0.27)			$ 0.45	$ (0.42)			$ 0.51	$ (0.32)			$ 0.04	$ (0.06)	$ -	$ -	$ 1.83	$ (1.07)
Neonatology	$ 27.30	$ 3.78	$ 0.34	$ (0.03)					$ 12.81	$ (1.99)	$ 1.34	$ 0.12	$ 0.28	$ (0.63)			$ 40.39	$ 1.16	$ 1.68	$ 0.10
Nephrology	$ 1.42	$ 0.69	$ 1.85	$ 0.36	$ 1.75	$ (0.18)	$ 2.39	$ (0.51)	$ 0.44	$ (0.28)	$ 0.63	$ (0.06)	$ 0.02	$ (0.04)	$ 0.10	$ (0.07)	$ 3.62	$ 0.19	$ 4.97	$ (0.28)
Neurology	$ 9.37	$ 2.09	$ 13.98	$ 4.22	$ 12.96	$ (1.25)	$ 7.44	$ (0.77)	$ 2.98	$ (0.96)	$ 3.10	$ (0.72)	$ 0.15	$ (0.86)	$ 0.48	$ (0.09)	$ 25.46	$ (0.98)	$ 25.00	$ 2.64
Neurosurgery	$ 15.18	$ 2.03	$ 4.45	$ 1.32	$ 14.35	$ (0.19)	$ 2.61	$ (0.19)	$ 5.13	$ (2.20)	$ 0.68	$ (0.66)	$ 1.59	$ (0.65)	$ 0.26	$ (0.05)	$ 36.25	$ (1.01)	$ 8.00	$ 0.42
Normal Newborns																	$ -	$ -	$ -	$ -
Obstetrics	$ 47.07	$ 9.96	$ 25.89	$ 5.31					$ 12.60	$ (2.66)	$ 9.06	$ (3.05)	$ 0.38	$ (0.45)	$ 0.45	$ (0.48)	$ 60.05	$ 6.86	$ 35.39	$ 1.79
Oncology	$ 2.66	$ 0.78	$ 5.94	$ 1.46	$ 3.00	$ (0.11)	$ 2.02	$ (0.50)	$ 0.45	$ 0.07	$ 0.91	$ (0.57)	$ 0.03	$ (0.12)			$ 6.14	$ 0.63	$ 8.87	$ 0.39
Ophthalmology			$ 3.29	$ 0.64			$ 3.87	$ (0.13)			$ 1.30	$ 0.02					$ -	$ -	$ 8.46	$ 0.53
Orthopedics	$ 22.62	$ 5.64	$ 16.65	$ 6.10	$ 27.82	$ 4.10	$ 5.20	$ (0.11)	$ 4.93	$ (1.48)	$ 3.57	$ (0.22)	$ 1.97	$ (0.70)	$ 1.59	$ (0.16)	$ 57.33	$ 7.56	$ 27.01	$ 5.60
Otolaryngology			$ 3.59	$ 2.09			$ 0.71	$ 0.13			$ 0.33	$ 0.01					$ -	$ -	$ 4.63	$ 2.23
Psychiatry	$ 3.03	$ (2.35)	$ 0.60	$ (0.22)	$ 3.85	$ (4.42)	$ 0.52	$ (0.29)	$ 1.62	$ (3.52)	$ 0.47	$ (0.23)	$ 0.04	$ (0.33)	$ 0.12	$ (0.07)	$ 8.55	$ (10.62)	$ 1.71	$ (0.81)
Pulmonary	$ 5.89	$ 0.96	$ 1.34	$ (0.14)	$ 10.59	$ (3.41)	$ 1.03	$ (0.68)	$ 4.17	$ (0.14)	$ 0.62	$ (0.01)	$ 0.34	$ (0.41)	$ 0.12	$ 0.00	$ 20.99	$ (3.00)	$ 3.11	$ (0.83)
Rehab																	$ -	$ -	$ -	$ -
Rheumatology			$ 4.26	$ 0.75			$ 3.25	$ 0.24			$ 1.25	$ (0.23)			$ 0.10	$ (0.05)	$ -	$ -	$ 8.85	$ 0.71
Transplant Surgery	$ 7.59	$ 0.75	$ 0.62	$ 0.21	$ 6.77	$ (5.03)	$ 0.56	$ (0.11)	$ 3.76	$ (0.43)	$ 0.13	$ (0.08)	$ 0.98	$ (0.63)			$ 19.09	$ (5.35)	$ 1.31	$ 0.03
Trauma	$ 8.59	$ 1.86	$ 1.95	$ 0.51	$ 13.07	$ 0.49	$ 0.34	$ (0.12)	$ 4.14	$ (0.43)	$ 0.32	$ (0.30)	$ 2.38	$ (0.74)	$ 0.16	$ (0.06)	$ 28.17	$ 1.18	$ 2.76	$ 0.03
Urology	$ 4.67	$ 1.37	$ 6.06	$ 2.04	$ 3.46	$ 0.54	$ 3.96	$ 0.05	$ 0.73	$ (0.08)	$ 0.84	$ (0.34)	$ 0.07	$ (0.00)			$ 8.92	$ 1.82	$ 10.86	$ 1.75
Vascular Surgery	$ 6.49	$ 0.54	$ 1.72	$ 0.44	$ 16.92	$ (0.82)	$ 1.95	$ (0.46)	$ 0.99	$ (0.54)	$ 0.35	$ 0.24	$ 0.10	$ (0.23)			$ 24.50	$ (1.05)	$ 4.01	$ 0.22
Other Inpatient	$ 20.78	$ 6.00			$ 18.65	$ 3.38			$ 4.66	$ (0.57)			$ 0.24	$ (0.27)			$ 44.33	$ 8.54		
Imaging			$ 3.26	$ (0.20)			$ 2.90	$ (1.86)			$ 0.59	$ (0.62)							$ 6.75	$ (2.68)
Other Treatments			$ 11.40	$ 5.55			$ 7.83	$ 1.06			$ 1.94	$ (0.16)							$ 21.18	$ 6.45
Laboratory																			$ -	$ -
Ambulatory Surgery																			$ -	$ -
Therapies																			$ -	$ -
Office Visits																			$ -	$ -
Observation																			$ -	$ -
Other Outpatient			$ 40.46	$ 8.29			$ 16.71	$ (3.59)			$ 11.14	$ (5.54)			$ 3.38	$ (1.54)			$ 71.70	$ (2.39)
GRAND TOTAL	**$ 326.95**	**$ 75.03**	**$ 305.87**	**$ 71.32**	$ 337.62	$ (21.81)	$ 156.81	$ (26.42)	**$ 110.07**	**$ (22.74)**	**$ 77.27**	**$ (22.08)**	$ 11.67	$ (11.49)	$ 9.58	$ (4.35)	**$ 786.31**	**$ 18.99**	**$ 549.52**	**$ 18.48**

Defined by Admitting Physician Divisions