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

Boston Children's Hospital
Until every child is well™

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

September 19, 2018

David Seltz
Executive Director
Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Dear Mr. Seltz,

Attached, please find the testimony of Boston Children's Hospital, signed under pains and penalties of perjury, in response to questions provided by the Health Policy Commission and the Office of the Attorney General.

As the Chief Executive Officer of Boston Children's Hospital, I am legally authorized and empowered to represent the organization for the purposes of this testimony.

If you have any questions, please contact Joshua Greenberg, Vice President of Government Relations, at (617) 919-3055.

Sincerely,

Sandra L. Fenwick
Chief Executive Officer
Boston Children's Hospital

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.

1. Historic and consistent Medicaid underpayment
2. Rising prescription drug costs and the financial impact of drug shortages
3. Potential impact of mandated nurse staff ratios in all hospitals at all times

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

1. Historic and consistent Medicaid underpayment

In Massachusetts, MassHealth, the state Medicaid program, also includes the Children's Health Insurance Program (CHIP) and serves approximately two-fifths of the Commonwealth's children. The Medicaid program accounts for a significant portion of the state budget, but is also one of the main revenue sources for the state thanks to federal contributions to the program via the Federal Medical Assistance Percentage (FMAP).

We appreciate that as a public payor MassHealth faces unique challenges especially during economic downturns. Historically, MassHealth's preferred budget management tool has been to cut provider rates. As a result, MassHealth's widely recognized provider underpayment for care creates substantial distortions in the health care delivery system, requiring increasing levels of cross-subsidization by providers, a cost largely borne by employers and the public at large. The cross-subsidization occurs within providers (higher margin services supporting lower margin services), between providers (high Medicaid payor mix providers have disproportionate need to cost shift relative to low burden providers), and among payors (commercial plans relying on Medicaid to "wrap around" coverage, especially for residents with complex needs.) These problems are exacerbated by Medicaid's payment structure/methodology being beholden to state budget dynamics (e.g. rates are unpredictable, and specific payment decisions often result from "backing into a budget number").

Boston Children's Hospital is deeply committed to partnering with the MassHealth program and providing care to pediatric MassHealth members. MassHealth (Medicaid and CHIP) currently accounts for over 33% of the Boston Children's payor mix (and over 37% of our Massachusetts payor mix), one of the highest percentages in the state.

As the state's only acute freestanding children's hospital, we have limited options for cross-subsidization and experience additional challenges in supporting our mission. Medicare reimburses providers in a more adequate and predictable fashion than Medicaid and includes support for other missions, such as graduate medical education. But for Boston Children's, unlike hospitals that primarily serve adults, Medicare is a statistically insignificant portion of our payor mix. This leaves commercial (local and out of state) and international payors as our only option to cross-subsidize our Medicaid losses. Until such time as adequate and predictable payments for MassHealth services can be developed, high volume Medicaid hospitals will continue to struggle with subsidizing these financial losses, and will be challenged in making longer term investments in care delivery transformation. If decision makers in the Commonwealth are able to stabilize Medicaid provider rates to more closely match the costs of providing care, then commercial rates will decrease over time as a result.

Boston Children's Hospital would like to see policy makers spend more time addressing how we might create a sustainable, reasonably financed, and predictable child health system in Massachusetts with a strong focus on the MassHealth program. In addition, the realities of Medicaid underpayment may prove especially challenging for providers like Boston Children's who have expertise in and a deep commitment to providing care to children with medical complexity (CMC), some of the Commonwealth's most vulnerable children. While children are generally healthy, and the population of CMC is small, CMC are often covered by MassHealth either as their primary insurance or as secondary insurance. CMC have extensive, interdependent needs, and rely upon extensive networks of hospital, specialist and community-based providers for care. They account for a disproportionate share of medical spending in the pediatric population and are at substantial risk for poor outcomes if timely access to care is unavailable or impeded. That is why we strongly support the Massachusetts Health Policy Commission (HPC) conducting an analysis of the CMC population in Massachusetts, in an effort to move the state towards a more sustainable, reasonably financed and predictable child health system.

2. Rising prescription drug costs and the financial impact of drug shortages

The August 2018 Center for Health Information and Analysis (CHIA) study on prescription drug use and spending identifies pharmacy spending as a major component of total health expenditures in Massachusetts, representing over 18% of commercial spending in 2015 and 2016. The increasing role that pharmacy costs are playing in the state budget as well as family budgets represents a call to action for both the HPC and the state legislature.

While we appreciate the HPC's thoughtful approach to evaluating the pharmaceutical practices of "white and brown bagging", more can and should be done by the HPC moving forward to conduct reports and provide policy recommendations that examine prescription drug pricing in a transparent manner. Specific areas of concern that Boston Children's is monitoring relative to prescription drugs are the financial and operational impacts of prescription drug shortages. In addition, drug prices continue to rise for medications used to manage chronic conditions often seen in pediatrics; examples of these medications include Epi-Pens and insulin. Finally, we are increasingly concerned about inconsistent authorization and payment policies for emerging high cost therapies such as Kymriah, which is used to treat pediatric leukemia, and Luxturna, which is a treatment for children and adults with inherited vision loss that can result in blindness.

3. Potential impact of mandated nurse staff ratios in all hospitals at all times

Boston Children's Hospital has taken an institutional position in opposition to question one on the November 2018 statewide ballot relative to proposed mandated nurse staffing ratios. It is disappointing that the HPC has failed to look at the potential financial and operational impacts of this ballot question to the health system. As the state agency charged with implementing this question if passed, along with being responsible for monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery, the HPC should play a critical role in providing a transparent, independent, policy analysis on this question which could have substantial cost implications for the Commonwealth.

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 top strategic priority of Boston Children's to improve care and better manage expenditures is the implementation of our Medicaid ACO in partnership with the Tufts Health Public Plan (THPP). The Boston Children's Hospital ACO has three strategic priorities for the Delivery System Reform Incentive Payment (DSRIP) opportunity to improve the outcomes and population health of our nearly 90,000 pediatric covered lives in our MassHealth (Medicaid + CHIP) ACO while reducing the total cost of care. Those three strategic priorities are centered on improving pediatric complex care management, investments in expansion of access to behavioral health services, and the assessment and development of targeted interventions related to social determinants of health.

1. Complex Care

Boston Children's estimates, based on the work of the Children's Hospital Association nationally, that approximately 5-6% of all the Boston Children's Hospital ACO population are children with medical complexity (CMC), or conditions frequently impacting two or more body systems, and likely to result in serious lifetime impairments. Our primary care network maintains specialized programs for CMC and uses a coordinated approach to the identification and care of children with developmental delays and chronic and congenital conditions. The Rainbow Program,

based at Children's Hospital Primary Care at Longwood (CHPCL), and a similar Kids and Adolescents with Special Abilities (KASA) program at Boston Children's at Martha Eliot in Jamaica Plain, coordinate integrated, multi-disciplinary care for children with complex medical needs, most of whom are covered by MassHealth. Extensive work by the Children's Hospital Association to determine potential cost savings through a Center for Medicare and Medicaid Services (CMS) Innovation center (CMMI) grant suggests significant opportunities to both improve quality and reduce costs. Our own experience in risk-based Medicaid contracts similarly demonstrated our most significant total medical expense impact was in the RCII (children with a formal disability determination) population. One the goals of our ACO work with CMC is to reduce unnecessary hospital utilization which is also mentioned in subsequent areas of this written testimony.

2. Behavioral Health

Limited access to mental health providers, particularly those who serve children and youth, has been identified as a key factor that contributes to high prevalence of undiagnosed or untreated conditions among both children and their parents. An estimated 14% of the Boston Children's Hospital ACO population has a behavioral health condition. The Boston Children's community health needs assessment identified behavioral health, including substance use disorder, as a key health-related concern for children and families in Boston Children's priority local (Boston) neighborhoods. The primary care providers in our Pediatric Physician's Organization at Children's (PPOC) have identified numerous behavioral health needs among its patient population, including anxiety, depression, and eating disorders.

As noted in past years' responses, and further articulated in our answer to Question 2 (Section 2.E.4 below), we have tried to tackle these problems by working "upstream" to identify problems early, develop community capacity to shorten the time to intervention and support improved coordination, and to enhance the opportunities for specialized pediatric consultations and more intensive service with our Department of Psychiatry.

Boston Children's is one of the lead organizations for the state's Children's Mental Health Campaign (CMHC), a coalition of families, advocates, health care providers, educators, and consumers from across Massachusetts dedicated to comprehensive reform of the children's mental health system. Behavioral health needs that have been identified by the CMHC include psychiatric "boarding," when a child in mental health crisis requires inpatient psychiatric care, but there are no clinically appropriate resources, leading to prolonged stays in hospital Emergency Departments (EDs) or medical units; barriers that prevent children with mental and behavioral health problems from having a successful school experience; and unhealthy substance use by youth.

3. Social Determinants

The Boston Children's Hospital community needs assessments have traditionally focused on the local neighborhoods surrounding Boston Children's as required by state and federal regulation. The Boston Children's Hospital ACO and THPP anticipate identifying and serving similar needs across the state. Historically, the Boston Children's community health needs assessment has identified poverty, education, access to affordable housing, neighborhood safety, and food security as key individual and community concerns. For example, the number of homeless individuals in Boston steadily increased between 2009 and 2013, and there was a 25% increase in the reported numbers of homeless families between 2013 and 2015. Boston Children's-based primary care practices focus on care for children living in poverty, and the PPOC serves many families with social needs that contribute to poorly-controlled illness and affect the family's ability to keep the child healthy. In addition to the salient health and health-related social characteristics, our needs assessment and other evaluation activities have identified early childhood education and health services as key for this population of pediatric patients. Concerns for this critical "zero to five" developmental stage include gaps in access to screening, early intervention and early education services, and additional programs that support the parents of young children in identifying delays and promoting healthy child development.

Over the past year, we have had extensive opportunities to enhance our concrete responses (beyond the investments we are making through our ACO) through the $53M in funding to community based organizations made available as a result of our Determination of Need application. These investments have been carefully developed with strong community input, and touch many of the areas outlined above in very substantial ways. More information is available here.

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.

N/A

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):

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.

N/A

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?

N/A

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).

1. **Boston Children's at Martha Eliot, Children's Hospital Primary Care at Longwood (CHPCL) & the Pediatric Physicians Organization of Children's (PPOC)**

   Boston Children's has a deep commitment to helping families raise healthy, happy children; timely access to primary care is central to this. These efforts improve continuity and have been shown to reduce emergency department utilization. At the Boston Children's at Martha Eliot and Children's Hospital Primary Care at Longwood (CHPCL) appointments are available on evenings, weekends and some holidays. Our primary care providers at CHPCL can be reached 24 hours a day for medical advice as well. As mentioned previously in question 1c, as part of the Boston Children's ACO, we are working to reduce unnecessary hospital utilization for CMC who are enrolled in our ACO. We look forward to providing updates on these efforts in the future.

   The PPOC is made up of more than 400 physicians, nurse practitioners and physician assistants devoted exclusively to pediatric primary care, in close collaboration with subspecialists at Boston Children's. The PPOC has over 90 locations throughout Massachusetts and collectively cares for more than 350,000 children. The mission of the PPOC is to enhance our member pediatricians' ability to deliver the highest quality of care to the children and families they serve and improve professional satisfaction and operational effectiveness of our members. Many of our practice sites maintain appointments during evening and weekend hours.

2. Partnership with Atrius Health

As a different example of supporting community based primary care and subspecialty physicians, Boston Children's has served as the principal pediatric subspecialty partner with Atrius Health. We work collaboratively in the following domains to improve integration, with the end goal of enhancing quality performance and managing total medical expenditures:

- Clinical Integration: improving how Atrius Health pediatricians and Boston Children's subspecialists work together to ensure that roles and responsibilities are understood in order to maximize the value of each visit and ensure that care gaps are closed. These approaches also serve to reduce unnecessary testing, improve pre- and post- visit communication/coordination, and improve patient experience. We have worked on specific integration pathways in a number of specialties including neurology and gastroenterology.

- Technical Integration: Development of two-way web portals that allow clinicians at both institutions to view the medical records of shared patients. Among other benefits, this bidirectional access enhances patient experience through improved clinician awareness and drives value by minimizing duplication of services.

- Visiting Subspecialist Rounds and an Annual Continuing Medical Education (CME) Event: Atrius Health's access to Boston Children's clinical experts through visiting rounds and an annual CME event allows Atrius Health clinicians to better diagnose, treat, and refer patients.

3. Telemedicine

Boston Children's continues to advocate for the successful passage of comprehensive telemedicine policy that would codify a definition of telemedicine, address the issue of coverage parity and solve for administrative burdens of adoption via proxy credentialing. In the absence of the adoption of comprehensive telemedicine policy, our efforts to expand access to telemedicine services have been limited. Boston Children's is currently offering, or hopes to offer soon, the services below through digital models that allow timely and appropriate access to care and can help reduce unnecessary hospital utilization.

Live (synchronous) video visits between a Boston Children's specialist or primary care physician and their patient allows for both scheduled and on-demand appointments (e.g. scheduled surgical follow-up, evaluation of urgent flu-like symptoms). This will have the impact of 1) reducing length of stay and allowing for earlier discharges, 2) improving adherence to treatment plans, 3) enhancing access to sub-specialty care, 4) increasing provider effectiveness, and 5) improving provider-patient experience ratings.

Live video and "store and forward" (asynchronous) consults between a Boston Children's specialist and a community-based provider (e.g. Boston Children's pediatric Intensivist connecting directly to a community hospital Intensivist to provide treatment recommendations, preventing unnecessary patient transport and keeping care in local hospitals; a community-based pediatrician sending an asynchronous dermatology consult to a Boston Children's dermatologist to reduce duplication of visits and extend clinical expertise to distant communities). The goal of these efforts is to reduce unnecessary transfers and admissions, decrease length of stay, and increasing patient satisfaction by enabling them to remain in the local community setting.

Additional virtual health initiatives such as:

- Non-Emergency Medical Transportation services to decrease no-show rates to time-critical appointments and reduce unnecessary emergency room visits and hospital utilization.

- eVisits (asynchronous, protocolized questionnaire visits) to help triage acute or routine visits and decrease the number and frequency of higher cost visits that can be safely managed remotely.

- Automated care management (proactive, automated care for chronic patients) to proactively manage higher risk patients by having pre-identified check points during a patient's care journey.

- Hospital-at-home services to facilitate early discharge for complex care patients and equip these patients with medical devices in their home which interact directly with their care team (e.g. continuous sending of vitals, connecting to physician via video in emergent situations)

4. Behavioral Health

Prevention of unnecessary emergency department (ED) "boarding" due to psychiatric conditions and timely access to behavioral health care remains a top priority for Boston Children's, with the goal of maintaining low- to moderate-acuity patients in primary care with consultation to the primary care provider. Although Boston Children's does not have alternative care sites, we are working to ensure that patients have access to behavioral health specialty consultation when they need it with a focus on increased access to subspecialty care.

As noted in prior submissions, we have been working aggressively to co-locate behavioral health clinicians in our primary care sites, and now have this service available for the majority of our primary care patients. This has enabled warm handoffs, better coordination between medical and behavioral health, and an enhanced ability to locate and refer to additional community-based services for longer-term interventions.

"Urgent" outpatient appointments with a Child and Adolescent Psychiatrist are being used to support patients with Boston Children's or PPOC pediatricians who require in-person consultation, particularly to avoid ED utilization. Similarly, urgent care "bridge" appointments are available to discharge patients in a timely way from the ED in order to avoid boarding or avoidable admissions.

With a grant from the HPC, the PPOC has continued and expanded its capacity for remote consultation utilizing telepsychiatry for patients in three large pediatric practices. Our Department of Psychiatry provides immediate consultative support for specific patient questions, and is continuing to enhance this effort through our ACO.

On September 6, 2018, the Boston Children's Department of Psychiatry added a satellite clinic located on the Boston Children's Waltham campus. This site will provide psychopharmacology and therapy as part of the Boston Children's continuum of behavioral health care.

Finally, Boston Children's is a member of the executive committee of the Children's Mental Health Campaign (CMHC), which is working to develop policy solutions to address access to mental health services, psychiatric boarding and substance use prevention.

5. Pediatric Community of Care

As the largest pediatric referral center in the region, Boston Children's maintains a Community of Care (CoC) network of community hospital relationships and satellite/physician office locations. Through the CoC network, Boston Children's is able to extend its geographic coverage and support the delivery of and access to pediatric care for patients in their local communities. Today, the CoC network includes formal relationships with seven community hospitals in eastern Massachusetts where Boston Children's physicians provide clinical oversight and on-site physician coverage of emergency department, pediatric inpatient and/or neonatal services ranging from Level I – Level III nurseries. Some of Boston Children's community hospital relationships also include service arrangements for ambulatory surgical and/or specialty consultations/visits as well as remote services for interpretations (e.g. EEG, EKG, cardiac echo). Boston Children's CoC network also includes four satellite and three physician office locations. Satellite locations include Lexington, North Dartmouth, Peabody and Waltham. Physician office locations include Milford, Norwood and Weymouth.

Beyond its CoC network, Boston Children's and its physician foundations maintain a mix of formal and informal relationships and service arrangements with other pediatric specialists who are generally based at the other smaller pediatric programs in Boston and the region. These arrangements include management and provision of a specific service, recruitment of shared faculty, on-site sub-specialty care and consultative services, temporary support, education and training and referrals for care that is not otherwise available locally.

Additionally, Boston Children's maintains transfer agreements with 54 hospitals and other organizations within Massachusetts and the other New England states. Finally, as part of its community mission, Boston Children's provides financial and technical assistance to ten community health centers in Boston: Bowdoin Street Health Center, Brookside Community Health Center, The Dimock Center, Charles River Community Health, Mattapan Community Health Center, South Cove Community Health Center, South End Community Health Center, Southern Jamaica Plain Health Center, Upham's Corner Health Center and Whittier Street Health Center.

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.

Currently, there are two pediatric-focused urgent care centers in Massachusetts: PM Pediatrics in Dedham and American Family Care (AFC) Kids Well in Newton. Other urgent care centers, such as CVS Minute Clinics and Partners Healthcare urgent care sites, provide pediatric care in addition to adult and elder care services. Given that there is not a strong presence of pediatric-focused urgent care or alternative care sites we will refer the recommendations and statements made by the American Academy of Pediatrics (AAP) relative to these care sites.

The AAP notes that urgent care facilities can provide a safe, effective adjunct to, but not a replacement for, the medical home or ED. The AAP recommends that if urgent care facilities are to be used as a resource for pediatric urgent care, they should first solicit help from the pediatric professional community to define expectations and levels of plans for pediatric consultation. Pediatricians who are prepared to assist in the stabilization and management of critically ill and injured children should be accessible. Pediatricians should be certain that freestanding urgent care centers are prepared to stabilize and transfer critically ill and injured children before they are recommended to their patients and families for after-hours use.

The following represents a sample of the AAP Urgent Care Facility Emergency Preparedness Recommendations:

1. Administrators at freestanding urgent care facilities should ensure that their staff is capable of providing resuscitation, stabilization, timely triage, and appropriate transfer of all pediatric patients.

2. Urgent care facilities that provide care for children must be staffed by physicians, nurses, and ancillary health care professionals with the certification, experience, and skills necessary for pediatric basic and advanced life support during all hours of operation.

3. Triage, transfer, and transport agreements should be prearranged with definitive care facilities that are capable of providing the appropriate level of care based on the acuity of illness or injury of the child.

4. Mechanisms for notifying the primary care physician or another on-call health care professional about the treatment given to ensure appropriate follow-up with the child's

medical home should be in place and should be compliant with the regulations of the Health Insurance Portability and Accountability Act (HIPAA). If a primary care physician is not identified, efforts should be made to refer the patient to a pediatrician able to promote a medical home environment.

5. Administrators at urgent care facilities must ensure that there is an organized and structured quality-improvement program to monitor and improve care for ill or injured children.

6. Freestanding urgent care facilities should have a policy for disaster preparedness and participate in their community disaster plan.

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: Historic underinvestment in children

Eradication of poverty is the number one strategy that policy makers and experts could undertake to lower health care costs and improve social determinants of health. Pediatric providers have long known that poverty is the major driver of pediatric population health outcomes, because children in the United States are disproportionately poor. In addition, pediatric providers have long understood the connection between health related social needs and health outcomes because it is required in caring for children. Caring for children means interacting with the various systems responsible for the child, systems such as parents/caregivers, schools and the child welfare system to name a few.

In a 2017 report by the Lucile Packard Foundation for Children's Health and the Children's Hospital Association "The New Importance of Children' in America", a grim economic picture is painted for the future of our country due to historic and longstanding disparities in investments into our youngest members of society.

From an operational and infrastructure perspective, we have faced significant challenges, particularly with ACO community partners around the utilization of two-way data sharing as a critical component to the success of partnerships between health care providers, families and

community-based organizations. To that end we recommend that the state create policy and systems changes that will enable bi-directional data sharing between health care providers and community-based organizations to collaborate in a secure manner. We have also heard that community-based organizations need additional support and investments to build secure data systems to enable real-time, protected information sharing.

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

To begin to address the social needs of children, significant investments must be made into child and family serving community-based organizations and public health agencies in the Commonwealth.

As an example, through the Commonwealth's Determination of Need/Community Health Initiative (DoN/CHI) commitment, Boston Children's has an opportunity to build on our 150 year history of partnering with the community to make a significant impact on the health of children and families in Boston and throughout Massachusetts over the next ten years. We will distribute $53 million in funds from the DoN/CHI program via our newly-formed Boston Children's Collaboration for Community Health. In August of this year, after soliciting proposals and undertaking a rigorous multi-step review process, we announced the first community organizations to receive a portion of these funds. This round of funding was focused on the following strategic issue areas, which were identified in close collaboration with the local communities through a year-long community engagement process: Zero to Five Child Health and Development; Family Housing Stability and Economic Opportunity; and Community Physical Activity, Recreation and Food Access. Grants were awarded for a total of $11 million to be distributed over the next three years to a total of 30 organizations who are working strategically in these three issue areas. Future funding opportunities to be announced this fall will support additional efforts in child mental health and youth support systems, community trauma response, and health equity initiatives.

We look forward to sharing updates from our funded partners in the months and years ahead, including their efforts to:

- Improve access to programs and resources for parents with children ages 0-5
- Utilize strategies to stabilize housing and promote economic opportunities for families
- Strengthen community access to healthy food and physical activities

One of our major learnings as a result of the DON planning process is that child health investments in the Commonwealth tend to be ad hoc without a clear sense of long term sustainability. We propose that funding opportunities such as DSRIP, health care assessments and other health care systems investments be required to include a minimum level of child-focused investment allocations congruent with the pediatric population in Massachusetts. This may seem like a significant mandate; however there is now a growing body of research that has documented the range of childhood services that can successfully put children and families on the path toward lifelong health and well-being, especially those at greatest risk of poor outcomes. When we make collective decisions to invest in our children, the effects last a

lifetime and can deliver significant returns on investment for the larger society as well as the individual child and their family.

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.

   Below please find the Boston Children's estimated health care service price inquiries data, which reflects inquiries from both inside and outside of Massachusetts. Please note, all inquiries, regardless of entry point (e.g. phone call to Customer Service, Online request via Web, etc.) go through the same centralized process for review. This process has been evolving over time to better respond to patient and family needs and, as a result of changes in how we field and track inquiries and provide estimates, our year over year comparison may not be perfectly consistent. However, we believe the data is directionally accurate, without material change.

   Also of note, our online web-portal is one of the most frequently accessed methods for price inquiries and for the purposes of this required written testimony, we have documented web requests below along with written inquiries.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	156	34
	Q2	178	29
	Q3	275	52
	Q4	261	52
CY2017	**Q1**	292	45
	Q2	285	44
	Q3	227	44
	Q4	261	30
CY2018	**Q1**	289	10
	Q2	282	32
	TOTAL:	**2506**	**372**

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.

Boston Children's records the creation of the estimate using functionality within our registration and billing system, Epic, via a program called Smart Texts. The Smart Texts are generated with date and time stamps, which enables Boston Children's to monitor time between request and response; 98% of our requests are responded to within 24 hours.

Of note, an April 2017 publication "Massachusetts Hospitals Score Poorly on Price Transparency…Again," by Pioneer Health, surveyed Massachusetts hospitals and found Boston Children's was able to generate estimates for an MRI within 35 minutes, the second fastest time found in the survey. In addition, the estimates provided by Boston Children's were found to be accurate and estimates were available via both phone and an online portal accessible on our website.

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?

Creating an estimate based on patient reported needs is challenging. To generate an estimate, we require the procedure codes to build up the total charge. However, procedure codes may

vary based on actual services rendered, and become more complex with complex procedures. Obtaining appropriate codes may be difficult, but working with internal coders and physician offices can help reduce these barriers. Helping patients understand how the macro-health care payment environment works is very important as price transparency continues to challenge us to be as consumer-centric as possible.

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.

Boston Children's Hospital				
AGO Questions for Written Testimony				
FY15-FY17 (based on Strata)				
	FY2015	**FY2016**	**FY2017**	
(A) Commercial Business:				
Operating Margin - Financials	25.4%	25.0%	23.3%	
% Total Expenses	38.0%	38.7%	39.6%	
(B) Government Business:				
Operating Margin - Financials	-44.2%	-52.0%	-52.7%	
% Total Expenses	22.8%	22.1%	21.8%	
(C) All Other Business:				
Operating Margin - Financials	-8.9%	-7.5%	-6.4%	
% Total Expenses	39.2%	39.2%	38.6%	
Total Business:				
Operating Margin - Financials	2.6%	2.6%	2.1%	
% Total Expenses	100.0%	100.0%	100.0%	
(A) Commercial includes all other payers not listed in (B) and (C) below.				
(B) Government includes BMC, HSN, MA Medicaid, Medicaid Out of State, Medicare, MBHP, Network Health, and NHP.				
(C) All other includes International, and Self Pay, research, and other operating.				
Includes one time expenses.				

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.

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 Total Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-	-	-	-	-	-	-	-	-	-	38,997,500	-	-	-
Blue Cross Blue Shield	-	-	-	-	103,015,818	216,399,162	-	-	-	-	-	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	-	51,332,052	-	-	-
Fallon Community Health Plan	8,230,138	763,713	-	-	-	-	-	-	-	-	-	-	-	-	-
Harvard Pilgrim Health Care	72,268,620	43,517,780	-	-	-	-	-	-	-	-	-	-	-	-	-
Health New England	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	7,755,293	-	-	-	-
Tufts Health Plan	32,902,903	24,370,733	-	-	-	-	-	-	-	-	-	-	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	39,671,799	-	-	-
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	117,134,998	-	-	-
Total Commercial	***113,401,661***	***68,652,226***	**-**	**-**	***103,015,818***	***216,399,162***	**-**	**-**	**-**	**-**	***7,755,293***	***247,136,348***	**-**	**-**	**-**
MassHealth MCO	-	-	-	-	-	-	-	-	-	-	-	90,735,177	-	-	-
MassHealth SCO/PACE/OneCare	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other MassHealth	-	-	-	1,514,879	-	-	-	-	-	-	-	70,577,138	-	-	-
Total MassHealth	**-**	**-**	**-**	***1,514,879***	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***161,312,315***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	10,646,972	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***10,646,972***	**-**	**-**	**-**
Other Government		-		-		-		-		-		60,542,652			-
Other		-		-		-		-		-		2,412,952			-
GRAND TOTAL		***182,053,888***		***1,514,879***		***319,414,980***		**-**		**-**		***489,806,533***			**-**

2014 Out-Of-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	19,421,002	-	-	-
Blue Cross Blue Shield	-	-			20,910,832	94,040,737					-	-	-	-	-
CIGNA	-	-			-	-					-	24,951,256	-	-	-
Fallon Community Health Plan	373,096	11,887			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	10,255,220	10,239,521			-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			-	-					166,630	-	-	-	-
Tufts Health Plan	3,122,731	944,288			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	21,242,716	-	-	-
Other Commercial	-	-			-	-					-	101,765,206	-	-	-
Total Commercial	***13,751,047***	***11,195,696***	**-**	**-**	***20,910,832***	***94,040,737***	**-**	**-**	**-**	**-**	***166,630***	***167,380,180***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	653,116	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-			-	-					-	2,275,807	-	-	-
Total MassHealth	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***2,928,923***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	3,189,728	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***3,189,728***	**-**	**-**	**-**
Other Government		-				-						47,982,741			-
Other		-				-						779,390			-
GRAND TOTAL		***24,946,743***		**-**		***114,951,569***		**-**		**-**		***222,427,591***			**-**

2014 In-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	19,576,499	-	-	-
Blue Cross Blue Shield	-	-			82,104,986	122,358,425					-	-	-	-	-
CIGNA	-	-			-	-					-	26,380,795	-	-	-
Fallon Community Health Plan	7,857,042	751,826			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	62,013,400	33,278,260		-	-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			-	-					7,588,663	-	-	-	-
Tufts Health Plan	29,780,172	23,426,445			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	18,429,083	-	-	-
Other Commercial	-	-			-	-					-	15,369,792	-	-	-
Total Commercial	***99,650,614***	***57,456,530***	**-**	**-**	***82,104,986***	***122,358,425***	**-**	**-**	**-**	**-**	***7,588,663***	***79,756,169***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	90,082,061	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-		1,514,879	-	-					-	68,301,331	-	-	-
Total MassHealth	**-**	**-**	**-**	***1,514,879***	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***158,383,392***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	7,457,244	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***7,457,244***	**-**	**-**	**-**
Other Government		-				-						12,559,911			-
Other		-				-						1,633,562			-
GRAND TOTAL		***157,107,144***		***1,514,879***		***204,463,411***		**-**		**-**		***267,378,941***			**-**

2015 Total Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-	-	-	-	-	-	-	-	-	-	43,102,323	-	-	-
Blue Cross Blue Shield	-	-	-	-	104,507,778	211,699,642	-	-	-	-	-	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	-	50,979,517	-	-	-
Fallon Community Health Plan	9,829,025	289,656	-	-	-	-	-	-	-	-	-	-	-	-	-
Harvard Pilgrim Health Care	63,487,317	47,797,862	-	511,647	-	-	-	-	-	-	-	-	-	-	-
Health New England	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	9,906,522	-	-	-	-
Tufts Health Plan	26,466,295	24,759,822	-	-	-	-	-	-	-	-	-	-	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	46,164,509	-	-	-
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	141,926,524	-	-	-
Total Commercial	***99,782,637***	***72,847,340***	***-***	***511,647***	***104,507,778***	***211,699,642***	***-***	***-***	***-***	***-***	***9,906,522***	***282,172,874***	***-***	***-***	***-***
MassHealth MCO	-	-	-	-	-	-	-	-	-	-	-	76,764,965	-	-	-
MassHealth SCO/PACE/OneCare	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other MassHealth	-	-	-	-	-	-	-	-	-	-	-	83,254,246	-	-	-
Total MassHealth	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***160,019,211***	***-***	***-***	***-***
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	11,226,234	-	-	-
Total Medicare	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***11,226,234***	***-***	***-***	***-***
Other Government		-		-		-		-		-		65,837,996			-
Other		-		-		-		-		-		2,309,671			-
GRAND TOTAL		***172,629,977***		***511,647***		***316,207,420***		***-***		***-***		***531,472,508***			***-***

2015 Out-of-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	21,451,674	-	-	-
Blue Cross Blue Shield	-	-			20,209,625	84,598,731					-	-	-	-	-
CIGNA	-	-			-	-					-	25,836,201	-	-	-
Fallon Community Health Plan	534,937	16,616			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	6,208,664	9,392,305			-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			-	-					155,546	-	-	-	-
Tufts Health Plan	1,793,262	953,769			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	25,873,611	-	-	-
Other Commercial	-	-			-	-					-	125,302,841	-	-	-
Total Commercial	***8,536,863***	***10,362,690***	**-**	**-**	***20,209,625***	***84,598,731***	**-**	**-**	**-**	**-**	***155,546***	***198,464,326***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	780,448	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-			-	-					-	1,129,840	-	-	-
Total MassHealth	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***1,910,287***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	2,360,364	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***2,360,364***	**-**	**-**	**-**
Other Government		-				-						49,284,667			-
Other		-				-						541,850			-
GRAND TOTAL		***18,899,553***		**-**		***104,808,355***		**-**		**-**		***252,717,041***			**-**

2015 In-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	21,650,649	-	-	-
Blue Cross Blue Shield	-	-			84,298,153	127,100,911					-	-	-	-	-
CIGNA	-	-			-	-					-	25,143,316	-	-	-
Fallon Community Health Plan	9,294,088	273,039			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	57,278,653	38,405,558		511,647	-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			-	-					9,750,976	-	-	-	-
Tufts Health Plan	24,673,033	23,806,054			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	20,290,899	-	-	-
Other Commercial	-	-			-	-					-	16,623,683	-	-	-
Total Commercial	***91,245,774***	***62,484,651***	***-***	***511,647***	***84,298,153***	***127,100,911***	***-***	***-***	***-***	***-***	***9,750,976***	***83,708,547***	***-***	***-***	***-***
MassHealth MCO	-	-			-	-					-	75,984,517	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-		-	-	-					-	82,124,406	-	-	-
Total MassHealth	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***158,108,923***	***-***	***-***	***-***
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	8,865,870	-	-	-
Total Medicare	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***8,865,870***	***-***	***-***	***-***
Other Government		-				-						16,553,329			-
Other		-				-						1,767,821			-
GRAND TOTAL		***153,730,425***		***511,647***		***211,399,064***		***-***		***-***		***278,755,467***			***-***

2016 Total Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-	-	-	-	-	-	-	-	-	-	45,854,445	-	-	-
Blue Cross Blue Shield	-	-	-	-	109,230,285	254,197,767	-	-	-	-	-	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	-	58,529,268	-	-	-
Fallon Community Health Plan	9,470,458	459,396	-	-	-	-	-	-	-	-	-	-	-	-	-
Harvard Pilgrim Health Care	79,343,719	44,080,084	-	687,473	-	-	-	-	-	-	-	-	-	-	-
Health New England	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Neighborhood Health Plan	-	-	-	-	10,310,248	-	-	-	-	-	180,361	-	-	-	-
Tufts Health Plan	25,340,949	31,043,515	-	-	-	-	-	-	-	-	-	-	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	52,608,882	-	-	-
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	168,359,189	-	-	-
Total Commercial	***114,155,125***	***75,582,995***	***-***	***687,473***	***119,540,533***	***254,197,767***	***-***	***-***	***-***	***-***	***180,361***	***325,351,784***	***-***	***-***	***-***
MassHealth MCO	-	-	-	-	-	-	-	-	-	-	-	65,702,033	-	-	-
MassHealth SCO/PACE/OneCare	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other MassHealth	-	-	-	327,255	-	-	-	-	-	-	-	94,406,403	-	-	-
Total MassHealth	***-***	***-***	***-***	***327,255***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***160,108,436***	***-***	***-***	***-***
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	10,118,258	-	-	-
Total Medicare	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***10,118,258***	***-***	***-***	***-***
Other Government		-		-		-		-		-		75,670,761			-
Other		-		-		-		-		-		2,240,227			-
GRAND TOTAL		***189,738,121***		***1,014,728***		***373,738,300***		***-***		***-***		***573,669,827***			***-***

2016 Out-of-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	23,828,251	-	-	-
Blue Cross Blue Shield	-	-			27,907,069	104,708,859					-	-	-	-	-
CIGNA	-	-			-	-					-	30,608,239	-	-	-
Fallon Community Health Plan	310,055	3,732			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	9,470,968	8,866,339			-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			-	-					180,361	-	-	-	-
Tufts Health Plan	1,069,973	3,170,502			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	29,463,027	-	-	-
Other Commercial	-	-			-	-					-	151,608,816	-	-	-
Total Commercial	***10,850,997***	***12,040,573***	**-**	**-**	***27,907,069***	***104,708,859***	**-**	**-**	**-**	**-**	***180,361***	***235,508,334***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	599,183	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-			-	-					-	2,355,522	-	-	-
Total MassHealth	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***2,954,705***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	2,848,889	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***2,848,889***	**-**	**-**	**-**
Other Government		-				-						55,933,515			-
Other		-				-						286,622			-
GRAND TOTAL		***22,891,570***		**-**		***132,615,928***		**-**		**-**		***297,712,425***			**-**

2016 In-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	22,026,193	-	-	-
Blue Cross Blue Shield	-	-			81,323,217	149,488,907					-	-	-	-	-
CIGNA	-	-			-	-					-	27,921,028	-	-	-
Fallon Community Health Plan	9,160,402	455,664			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	69,872,751	35,213,745		687,473	-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			10,310,248	-					-	-	-	-	-
Tufts Health Plan	24,270,976	27,873,013			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	23,145,855	-	-	-
Other Commercial	-	-			-	-					-	16,750,374	-	-	-
Total Commercial	***103,304,128***	***63,542,422***	**-**	***687,473***	***91,633,465***	***149,488,907***	**-**	**-**	**-**	**-**	**-**	***89,843,450***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	65,102,850	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-		327,255	-	-					-	92,050,881	-	-	-
Total MassHealth	**-**	**-**	**-**	***327,255***	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***157,153,731***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	7,269,369	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***7,269,369***	**-**	**-**	**-**
Other Government		-				-						19,737,246			-
Other		-				-						1,953,605			-
GRAND TOTAL		***166,846,551***		***1,014,728***		***241,122,372***		**-**		**-**		***275,957,402***			**-**

2017 Total Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-	-	-	-	-	-	-	-	-	-	50,616,114	-	-	-
Blue Cross Blue Shield	-	-	-	-	119,315,758	255,946,429	-	-	-	-	-	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	-	70,736,909	-	-	-
Fallon Community Health Plan	13,192,623	1,228,898	-	-	-	-	-	-	-	-	-	-	-	-	-
Harvard Pilgrim Health Care	75,161,852	49,156,231	-	317,682	-	-	-	-	-	-	-	-	-	-	-
Health New England	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Neighborhood Health Plan	-	-	-	-	16,325,263	-	-	-	-	-	373,742	-	-	-	-
Tufts Health Plan	26,058,513	29,257,445	-	-	-	-	-	-	-	-	-	-	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	55,990,791	-	-	-
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	160,951,145	-	-	-
Total Commercial	***114,412,987***	***79,642,573***	***-***	***317,682***	***135,641,022***	***255,946,429***	***-***	***-***	***-***	***-***	***373,742***	***338,294,959***	***-***	***-***	***-***
MassHealth MCO	-	-	-	-	-	-	-	-	-	-	-	71,098,602	-	-	-
MassHealth SCO/PACE/OneCare	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other MassHealth	-	-	-	491,850	-	-	-	-	-	-	-	111,954,184	-	-	-
Total MassHealth	***-***	***-***	***-***	***491,850***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***183,052,786***	***-***	***-***	***-***
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	9,123,006	-	-	-
Total Medicare	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***-***	***9,123,006***	***-***	***-***	***-***
Other Government		-		-		-		-		-		67,171,797			-
Other		-		-		-		-		-		2,404,141			-
GRAND TOTAL		***194,055,560***		***809,532***		***391,587,451***		***-***		***-***		***600,420,431***			***-***

2017 Out-of-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	23,712,742	-	-	-
Blue Cross Blue Shield	-	-			29,194,439	103,287,509					-	-	-	-	-
CIGNA	-	-			-	-					-	37,677,593	-	-	-
Fallon Community Health Plan	343,454	5,911			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	8,692,813	10,490,948			-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			-	-					373,742	-	-	-	-
Tufts Health Plan	1,149,181	2,785,601			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	31,317,593	-	-	-
Other Commercial	-	-			-	-					-	143,011,096	-	-	-
Total Commercial	***10,185,448***	***13,282,460***	**-**	**-**	***29,194,439***	***103,287,509***	**-**	**-**	**-**	**-**	***373,742***	***235,719,025***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	175,370	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-			-	-					-	543,554	-	-	-
Total MassHealth	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***718,925***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	2,887,061	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***2,887,061***	**-**	**-**	**-**
Other Government		-				-						49,848,954			-
Other		-				-						373,598			-
GRAND TOTAL		***23,467,908***		**-**		***132,481,948***		**-**		**-**		***289,921,305***			**-**

2017 In-State Volume	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	overall		HMO	PPO	HMO	PPO	overall		HMO	PPO	HMO	PPO	Both
Aetna	-	-			-	-					-	26,903,372	-	-	-
Blue Cross Blue Shield	-	-			90,121,319	152,658,920					-	-	-	-	-
CIGNA	-	-			-	-					-	33,059,316	-	-	-
Fallon Community Health Plan	12,849,169	1,222,987			-	-					-	-	-	-	-
Harvard Pilgrim Health Care	66,469,038	38,665,282		317,682	-	-					-	-	-	-	-
Health New England	-	-			-	-					-	-	-	-	-
Neighborhood Health Plan	-	-			16,325,263	-					-	-	-	-	-
Tufts Health Plan	24,909,332	26,471,844			-	-					-	-	-	-	-
United Healthcare	-	-			-	-					-	24,673,198	-	-	-
Other Commercial	-	-			-	-					-	17,940,049	-	-	-
Total Commercial	***104,227,539***	***66,360,113***	**-**	***317,682***	***106,446,582***	***152,658,920***	**-**	**-**	**-**	**-**	**-**	***102,575,934***	**-**	**-**	**-**
MassHealth MCO	-	-			-	-					-	70,923,232	-	-	-
MassHealth SCO/PACE/OneCare	-	-			-	-					-	-	-	-	-
Other MassHealth	-	-		491,850	-	-					-	111,410,630	-	-	-
Total MassHealth	**-**	**-**	**-**	***491,850***	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***182,333,861***	**-**	**-**	**-**
Commercial Medicare	-	-			-	-					-	-	-	-	-
Traditional Medicare	-	-			-	-					-	6,235,945	-	-	-
Total Medicare	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	***6,235,945***	**-**	**-**	**-**
Other Government		-				-						17,322,843			-
Other		-				-						2,030,543			-
GRAND TOTAL		***170,587,652***		***809,532***		***259,105,503***		**-**		**-**		***310,499,126***			**-**