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.

Statement that signatory is legally authorized to represent MACIPA, signed under pain of perjury

I, Barbara Spivak, MD, the President and Chairman of the Board of the Mount Auburn Cambridge Independent Practice Association, Inc. am legally authorized to represent MACIPA, signed under pains and penalties of perjury.

_____

Date: 9/14/18

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.

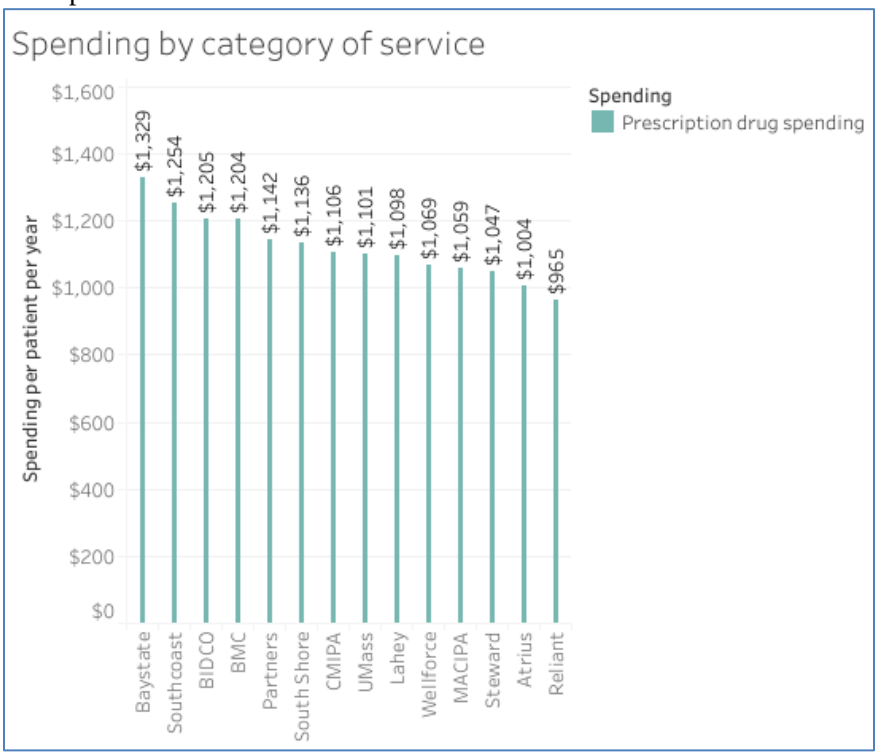
- MACIPA is very concerned on the state's ability to meet the benchmark if Massachusetts ballot question 1 on mandated nurse staffing ratios passes. We anticipate not only increased costs for the additional nurses that will be required at hospitals but for all the physician practices MACIPA represents as an expected shortage of nurses will increase wages for them. We would request that if the question passes HPC and CHIA immediately study the expected impact on THCE and adjust the benchmark accordingly. Physicians, hospitals, and insurers cannot be held responsible for the increase in costs voted on by the citizens of Massachusetts.

- Services rendered outside of the MACIPA/MAH network often are more expensive, lead to extra testing, and uncoordinated care between PCP and specialists. MACIPA provides our physicians with information on a regular basis showing which patients leave the network for services.

- MACIPA has established several programs that will reduce the growth and/or prevent more complex and expensive pharmaceutical treatments. Preventing diseases is paramount to improving the health of patients and keeping rising health costs under control. Chronic diseases, such as heart disease, cancer, and diabetes account for majority of the nation's health spending. By promoting preventive services, we hope to eliminate or reduce the need for pharmaceutical treatments that would occur if diseases/conditions progressed. Examples are below.
    - MACIPA has a full time Pharmacy Director. As a member of the MACIPA senior management team, he works with our physicians and their support staff to optimize the effectiveness, safety and cost of medication therapy for all patients. He also works with MACIPA's Medical Directors, Quality Staff and Care Management Department to develop new strategies to improve patient care. For patients with uncontrolled chronic conditions and gaps in care, the pharmacist works with physicians and other providers to recommend medications and dosing regimens tailored to each patient's clinical situation
    - MACIPA's Pharmacy and Therapeutic Committee manages an internal drug formulary. This committee meets quarterly and consists of the Pharmacy Director, physicians and members of our quality team. The mission of the committee is to utilize current medical literature, free of drug manufacturer bias, to promote the appropriate use of medications that are safe, efficacious and cost-effective. This process guides prescribing toward the most clinically appropriate, cost effective and evidence-based choices, with a focus on generics. These efforts results in lower net cost of medications for MACIPA patients,

their employers and health plans. In addition, the MACIPA's pharmacist is also a member of the Mount Auburn Hospital Pharmacy and Therapeutics Committee

Examples of success - Health Plan Performance



Reference: Massachusetts Health Policy Commission DataPoints, Issue 6: Provider Organization Performance Variation March 1, 2018. *https://www.mass.gov/service-details/hpc-datapoints-issue-6-provider-organization-performance-variation*

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

The increased enrollment into PPOs from HMOs has limited our ability to have a bigger impact on TME. We should encourage insurers to create larger differentials in the premium so employers will be more likely to purchase HMO plans. The provider community should work with the insurers to help achieve this by having a similar differential in their reimbursement rates.

The HPC could set minimum premium and provider payment differentials to encourage this market shift.

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.

Social determinants of health

The MACIPA Social Work Department identified a potentially underserved population: Caregivers of seniors with dementia. Currently, via PCP referrals, the social workers encounter caregivers who struggle to provide and sustain care for family members with cognitive loss. This population may not be connected with community resources, often being unaware of the resources and services which may be available to them. The strain on the caregiver can be enormous, and can precipitate crises, both physical and behavioral, for the family member with dementia and/or the caregivers themselves. Further, it is known that hospitalization causes disorientation and deterioration for dementia patients. This initiative will help to keep patients home and out of the hospital and SNFs. This will decrease overall health care costs and spending. The goal for the outreach program is as follows:

1. Assess for unmet needs
2. Address caregiver stress
3. Connect caregiver to community services
4. Check for and assist with Health Care Proxy and Advance Care Directives, if applicable
5. Result in avoiding unnecessary hospitalizations and SNF stays, resulting in decreased costs.

Use of Nurse Practitioner to make home visits on chronically ill, homebound patients.
MACIPA utilizes an Advanced Practice Nurse (APN) to make home visits on homebound, chronically ill patients. These patients have been identified by the primary care practices as having 1 or more chronic conditions that they are having difficulty managing. The APN sees the patients at least monthly, or more frequently if clinically indicated. The APN communicates directly with our Primary Care physicians and practice-based Case Managers to provide team-based, patient-centered care to these patients. Providing this care proactively in the patient's home results in lower ED visits and acute hospitalizations, while improving patients' satisfaction with their care.

MACIPA Metabolic Team
In order to improve the health outcomes and reduce long-term medical expenditures for some of our chronic disease patients, the MACIPA Metabolic Team was created. The MACIPA Metabolic Team is an initiative focused on systematically tracking diabetic and hypertension patients and providing support for practices to manage their diabetic and hypertensive populations. The team consists of the Chief Operating Officer, Quality Improvement Director, Pharmacy Director, Social Work Director, PCP/Endocrinologist, Health Coaches, Practice Facilitators. The team meets weekly to review treatment history and plan for those diabetic and hypertensive patients whose outcomes (i.e. A1c, Blood Pressures) are out of range, or are at risk for negative outcomes and also to address ad hoc requests from providers. The clinical team makes medication and clinical recommendations via direct consultation to the caregiver which includes evaluating if the patient would benefit from the MACIPA Health Coaching program. The team also supports and trains practices to better perform population management to ensure patients are getting appropriate visits and tests to manage their disease and prevent acute/chronic complications. Also, in collaboration with Mount Auburn Diabetes Center, the Metabolic Team is identifying and fast tracking complex diabetic patients who could benefit from an Endocrinology consultation. The Endocrine Center agreed to provide better access with reserved appointment slots where patients could meet both the endocrinologists and certified diabetes educator. In addition, the center will look to facilitate a partnership with an Ophthalmology group located within their building for same day to diabetic eye exams. The combined services provided by the MACIPA Metabolic Team and the Endocrine Center should lead to better care provided to the patients and improve health outcomes while reducing costs by avoiding acute and chronic complications for these patients.

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):

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

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).

We have been continuing to promote among the MACIPA practices and patients the use of the walk-in center at Mount Auburn Hospital when the practice sites are closed. We are also focusing on the integrated care we can provide as physicians in the walk-in center have access to most of our risk patients' records through our integrated use of our EPIC EMR.

We are also working with physicians to increase their office access. We review and share ED visit utilization, and share best practice information to increase same day availability both with PCPs and advanced practice providers. We do significant outreach to patients who have not had an office visit so that they establish a regular relationship with their primary care provider.

Our patients now have the ability to schedule their own appointments with their PCP office via the EMR. The patient portal also permits ongoing communication between patients and their providers.

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.

While the use of Urgent Care Centers is sometimes warranted and can provide an alternative to use hospital emergency departments there are some drawbacks as the state tries to improve overall TME. First and foremost we need to understand if the growth of UCCs is having a negative impact on PCPs. If they are taking away business this could increase the shortage of PCPs. There is also a lack of coordinated care if patients utilize an UCC other than our hospital walk in center.

We have already experienced the increase in fragmented care produced, sometimes resulting in the wrong treatment plans for patients that then need to be altered. Since UCCs generally do not get a full patient history nor have access to their medical records this is not a problem that can be overcome easily.

Also we are not aware of any quality standards that UCCs are held to similar to the multitude for PCPs. We are held to over 40 different ambulatory quality and patient experience measures by Medicare and the health plans and many more are publically reported. Similar measures should be developed and made publically available to understand if they are meeting the high standards all patients of the Commonwealth have become accustomed to. We have several examples of patients who are flagged for failing several required quality metrics due to treatment provided at several different UCCs.

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: Programs change too often, doesn't allowing for meaningful engagement

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

For individuals who are socially isolated and have a variety of physical, cognitive and mental impairments, annual recertification for public benefits such as Medicaid, SSDI & SNAP Benefits can be a challenging process. It would be a worthwhile intervention for MA to allocate funding to these agencies (SSA, DTA & Mass Health) for case management services that focus solely on assistance with the reevaluation processes. It would significantly decrease considerable confusion and stress for beneficiary recipients to have a point person at each agency who can support them through the annual recertification process. Adding CM services would address the importance of the social determinants of health and its impact on health outcomes by decreasing incidents of individuals losing access to their income, money for food and health insurance. Benefit lapses occur frequently due to missing annual recertifications. When basic benefits are no longer in place, individuals are less likely to prioritize their health.

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		
	Q3		
	Q4		
CY2017	**Q1**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	TOTAL:		

   MACIPA does not provide direct patient care and therefor has not received any inquiries

   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.
   N/A.

   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?

N/A

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.
   Required Question: Click here to enter text.

   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.
   Required Question: Click here to enter text.

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	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue[1]		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	X	X	X	X	$12.2M	X	$2.9M	X	$2.5M	X	X	X	$1.0M	X	X
Tufts Health Plan	X	X	X	X	$4.0M	X	$2.7M	X	X	X	X	X	$0.7M	X	X
Harvard Pilgrim Health Care	X	X	X	X	$16.0M	X	$4.0M	X	X	X	X	X	$0.6M	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	$0.01M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$32.2M	X	$9.6M	X	$2.5M	X	X	X	$2.3M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$6.2M	X	$2.0M	X	X	X	X	X	$1.4M	X	
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	$0.03M
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Commercial Medicare Subtotal	X	X	X	X	$6.2M	X	$2.0M	X	X	X	X	X	$1.4M	X	$0.03M
Medicare	X	X	X	X	$16.4M	X	$1.9M	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$54.8M	X	$13.5M	X	X	X	X	X	$3.7M	X	$0.03M

Notes:

1. Claims-Based Revenue as received through extracts from the plans, MACIPA does not bill or receive physician claims payments and MACIPA does not receive data for non-risk patients

2015	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue[1]		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	X	X	X	X	$12.5M		$2.2M	X	$1.8M	X	X	X	$.9M	X	X
Tufts Health Plan	X	X	X	X	$5.3M		$2.0M	X	X	X	X	X	$.7M	X	X
Harvard Pilgrim Health Care	X	X	X	X	$8.4M	$1.8M	$2.7M	$0.1M	$0.06M	X	X	X	$.6M	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	$0.01	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$26.2M	$1.8M	$6.9M	$0.1M	$1.8M	X	X	X	$2.2M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$6.4M		$(0.2M)	X	X	X	X	X	$1.4M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	$.05M
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.4M		$(0.2M)	X	X	X	X	X	$1.4M	X	$.05M
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$32.6M	$1.8M	$6.7M	$0.1M	$1.8M	X	X	X	$3.6M	X	$.05M

Notes:

1. Claims-Based Revenue as received through extracts from the plans, MACIPA does not bill or receive physician claims payments and MACIPA does not receive data for non-risk patients

2016	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue[1]		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	X	X	X	X	$11.3M	$10.9M	$0.9M	$0.01M	$1.4M	X	X	X	$.8M	$.2M	X
Tufts Health Plan	X	X	X	X	$6.4M	X	$2.4M	X	X	X	X	X	$.7M	X	X
Harvard Pilgrim Health Care	X	X	X	X	$8.3M	$1.5M	$3.0M	$0.1M	$.03M	$.01M	X	X	$0.6M	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	$.09M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$26M	$12.4M	$6.3M	$0.1M	$1.43M	$.01M	X	X	$2.2M	$.2M	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$6.0M	X	$1.8M	X	$.06M	X	X	X	$1.2M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	$.06M
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.0M	X	$1.8M	X	$.06M	X	X	X	$1.2M	X	$.06M
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$32M	$12.4M	$8.1M	$0.1M	$1.5M	$.01M	X	X	$3.4M	$.2M	$.06M

Notes:

1. Claims-Based Revenue as received through extracts from the plans, MACIPA does not bill or receive physician claims payments and MACIPA does not receive data for non-risk patients

2017	P4P Contracts					
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue[1]	
	HMO	PPO	HMO	PPO	HMO	PPO
Blue Cross Blue Shield	X	X	X	X	$10.4M	$10.6M
Tufts Health Plan	X	X	X	X	$5.4M	X
Harvard Pilgrim Health Care	X	X	X	X	$7.3M	$0.6M
Fallon Community Health Plan	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X
Aetna	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X
Total Commercial	X	X	X	X	$23.1M	$11.2M
Network Health	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X
Health New England	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$5.9M	X
Blue Cross Senior Options	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$5.9M	X
Medicare	X	X	X	X	$12.7M	X
Other	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	41.7M	$11.2M

Notes:

1. Claims-Based Revenue as received through extracts from the plans, MACIPA does not bill or receive
2. Not all values are final for 2017 and may change
3. Quality settlement has not occurred

Risk Contracts				FFS Arrangements		Other Revenue		
Budget Surplus/ (Deficit) Revenue[2]		Quality Incentive Revenue[3]						
HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
tbd	tbd	tbd	X	X	X	$.7M	$.4M	X
$3.7M	X	X	X	X	X	$.7M	X	X
$2.2M	$0.1M	tbd	tbd	X	X	$.6M	X	X
X	X	X	X	X	X	$.01M	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
$5.9M	$.01M	X	X	X	X	#2.0M	$.4M	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
$0.9M	X		X	X	X	$1.3M	X	X
X	X	X	X	X	X	X	X	$.04M
X	X	X	X	X	X	X	X	X
$0.9M	X		X	X	X	$1.3M	X	$.04M
$1.6M	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X
$8.3M	$.01M	X	X	X	X	$3.26M	$.4M	$.04M

: physician claims payments and MACIPA does not receive data for non-risk patients