MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

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

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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

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

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

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, and/or 2017 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

HPC Contact Information

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

AGO Contact Information

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

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

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

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

Mercy's top areas of concern in supporting the state's ability to meet the 3.1% cost growth benchmark relate to policy decisions that affect the role that high-value community hospitals, like Mercy Medical Center, have in helping to support high quality lower cost healthcare. Commercial health insurance provider price inequity is the most significant area of concern for Mercy. As a matter of health equity, and to stabilize high value community hospitals, like Mercy, a structural remedy for commercial insurance price inequities must be addressed. The commercial health insurance system has failed to address wide rate disparities. Some community hospitals are paid more than 30% b*elow* the statewide average and a third of what the highest paid hospitals receive, for the same services. Without policymaker action, this problem will continue to erode our community hospitals and further negatively impact communities and patients. Without policymaker action, local access to care is threatened and costs will increase if care that can be delivered high value community hospitals is concentrated at higher cost providers.

A second significant area of concern for Mercy is behavioral health payment policy and specifically the inequity that exists in Medicaid Behavioral Health Disproportionate Share Hospital "DSH" payments. For many years, the Massachusetts Medicaid payment system has recognized the role of DSH hospitals. This policy recognition is seen in several payment areas, including Medicaid acute care DSH funding. Unfortunately, inpatient behavioral health services are excluded from the Medicaid acute care DSH payment calculation. Mercy, and its behavioral health campus Providence Behavioral Health Hospital, is one of the largest providers of Medicaid inpatient behavioral health care in Massachusetts. The lack of Behavioral Health DSH funding has a destabilizing impact on the ability of Mercy/Providence to deliver this care.

A third area of significant concern for Mercy is the mandated nurse staffing ballot initiative. If passed, this ballot initiative would have a significantly negative impact on the Massachusetts healthcare delivery system and even more negative impact on behavioral health services. A recently released study by the Massachusetts Association of Behavioral Health Systems found that mandated nurse staffing ratios could lead to the loss of more than 1,000 inpatient behavioral health beds, increase emergency room boarding for mental health patients, and decreased access to recovery services across the Commonwealth. As one of the largest providers of inpatient behavioral health care in Massachusetts, this initiative will have a particularly destabilizing impact on Mercy Medical Center / Providence Behavioral Health Hospital and the patients and communities we serve.

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

Policies that destabilize high value community hospitals and the behavioral health delivery system are Mercy's top areas of concerns in supporting the state's ability to meet the 3.1% cost growth benchmark.

Commercial Health Insurance price Inequity: a structural solution to the commercial price inequity issue is necessary. A commercial insurance rate floor would offer the most stabilizing impact and provide support for cost effective providers.

Behavioral Health DSH: Increased financial investment in the Medicaid behavioral health system are necessary. The Massachusetts FY15 Budget contained an appropriation to fund behavioral health DSH payments that were directed to providers most in need of support. This policy and funding should be reauthorized.

MassHealth ACO payment methodology – Network Variance Factor: Payment methodologies must provide appropriate incentives for cost efficient ACOs. The current Network Variance Factor methodology creates challenges for Medicaid ACOs by reducing capitated rates for more efficient ACOs. Adequate Medicaid ACO capitated rates for cost effective providers are necessary to sustain the Medicaid ACO program and support cost effective providers.

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.

Complex Care Management: Identifying patients with complex care profiles to assure that appropriate care treatment plans are developed and followed in order to the appropriate care interventions. Specific interventions include Mercy Health ACO and participation in eh SHIFT grant (focused on Substance Use Disorder patients in the Emergency Department).

Workforce Management: Focus on benchmarking to measure performance against other similar-sized hospitals and developing a best-practice productivity approach.

Care Coordination: Multidisciplinary daily rounding is a key component of the enhanced care coordination program focused on providing the highest quality care at the right time in the appropriate setting.

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	**N/A**

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

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

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).

Mercy Medical Center is a member of Trinity Health Of New England (TH Of NE). Mercy and TH Of NE continue to pursue strategies to increase access to alternative care in lower cost ambulatory centers. Riverbend Medical Group, Western Massachusetts largest medical group is owned by TH Of NE and is affiliated with Mercy Medical Center. Riverbend provides weekend primary care walk-in capability, on-line scheduling for existing patients to expedite the time to be seen and offers extended hours for its primary care patients in select locations and days. TH Of NE will soon pilot a virtual primary care visit that will allow patients to email Riverbend providers their primary care health concerns. The providers will triage the patients request and provide the appropriate level of treatment. Another strategy is the continued focus on providing appropriate levels of care especially as it relates to emergency room patients. Mercy Medical Center strives to provide care in its emergency room that will, when clinically appropriate, result in a discharge rather than a higher cost admission. This is especially true of our orthopedic emergency room visits since an orthopedic call coverage program was established to treat patients in the ER, discharge them and then schedule them for surgery if appropriate or discharged to physical therapy for treatment.

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.

The growth of alternative care sites helps Mercy Medical Center and TH Of NE achieve the triple aim of providing high value, high quality and high patient satisfaction. The alternative site growth decreases the total cost of care for our patients since they are typically cheaper and less complex to operate compared to hospitals. This lower cost is a tremendous boost to any of our shared risk arrangements and more specifically to our patients with higher deductibles. Alternative care sites can provide better timely access to

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high quality services in a lower cost setting. This is true for urgent cares which can treat the majority of visits that are seen in costlier emergency rooms. Since alternative care sites are typically much smaller and therefore less costly to build than hospitals, it is easier to locate them closer to where patients need care. The convenience of having these services in the community improves the access to and appropriate use of these services.

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: Click here to enter text.

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

The greatest challenge in addressing social determinants of health (SDOH) is the lack of resources to do so, either in staffing or the resources and community capacity to address the patient's need. Housing is the most glaring example of this. Many patients are homeless, at-risk of homelessness or living in substandard housing. Once this area is identified by either the provider and/or community health worker, the process to obtain housing could take weeks or even years. There is no priorization for individuals who are in need of housing and are recommended from a healthcare system. Consideration of such a priority would put an undue burden on a healthcare system and result in individuals seeking healthcare in order to acquire housing, however, we know that the mere intervention of suitable housing can generate successful health outcomes without even one healthcare intervention. Our current ACO has permanently housed three individuals since the beginning of the ACO work at Mercy (March 2018) and it was mostly done through the skill and connections of a talented community health worker. These are not reimbursable costs under a traditional payment model. Our recommendation is to consider the value of addressing the SDOH as identified through the CDC's five key areas, (Economic Stability, Education, Social and Community Context, Health and Healthcare, Neighborhood Build Environment) and design payment models, flexible spending resources, and electronic medical records that can identify and track these areas that contribute to the health of the individuals.

Most of the SDOH areas are large systemic challenges and fall well beyond the scope and service ability of the healthcare system. Partnering with community providers and addressing issues as in a policy and systemic model is the only way to provide long term

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success on an intervention, whether it be increased transportation assistance, housing, better culinary programs for school children and/or employment. Healthcare anchor institutions should be at the table with community partners and utilize their employer strength to assist non-profits and community establishments in getting the attention the SDOH should warrant.

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.

~~1.~~ **Please see attached Mercy 2018 Cost Trends Testimony AGO Provider Exhibit 1**

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		**88**
	TOTAL:		**88**

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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.

A ~~Required Questi~~transition in leadership (March 2016) and this manual tracking was inadvertently omitted. A more robust tool for patient estimates was implemented in May 2018, which allows automated tracking and reporting. We do not expect there will be a gap in reporting moving forward.

~~on: Click here to enter text.~~

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?

~~Requ~~A transition in leadership (March 2016) and this manual tracking was inadvertently omitted. A more robust tool for patient estimates was implemented in May 2018, which allows automated tracking and reporting. We do not expect there will be a gap in reporting moving forward.~~~~ired~~ ~~Question: Click here to enter text.~~

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

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3.

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.

~~Requ~~**Mercy is unable to complete the table as requested. Currently, Mercy's accounting systems cannot accurately validate payer/service line operating margin data.** ~~**ired 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.~~ **Mercy is unable to complete the table as requested. Currently, Mercy's accounting systems cannot accurately validate payer/service line operating margin data.**

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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.

2017	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	25,671,737		514,693												
Tufts Health Plan	2,501,767														
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
CIGNA											4,669,726				
United Healthcare															
other commervcial											41,857,552				
Total commercial	28,173,504	0	514,693	0	0	0	0	0	0	0	46,527,278	0	0	0	0
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.											11,177,943				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											35,138,956				
Total Managed Medicaid	0	0	0	0	0	0	0	0	0	0	46,316,899	0	0	0	0
MassHealth	15,347,815		375,297										3,067,101		
Tufts Medicare Preferred					17,310,613		0		-108,107						
Blue Cross Senior Options											4,996,883				
Other Comm Medicare					23,303,889										
Commercial Medicare Subtotal	0	0	0	0	40,614,502	0	0	0		0	4,996,883	0	0	0	0
Medicare											96,497,958				
Other													4,620,822		
GRAND TOTAL	43,521,319	0	889,990	0	40,614,502	0	0	0	0	0	194,339,017	0	7,687,923	0	287,052,752

0

2016									Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	23,528,487		451,762												
Tufts Health Plan	2,635,314														
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
CIGNA											4,762,850				
United Healthcare															
other commervcial											41,762,845				
Total commercial	26,163,801	0	451,762	0	0	0	0	0	0	0	46,525,695	0	0	0	0
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.											9,711,516				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											34,341,102				
Total Managed Medicaid	0	0	0	0	0	0	0	0	0	0	44,052,618	0	0	0	0
MassHealth	13,179,132		445,007												
Tufts Medicare Preferred					18,443,410		-1,948,334				4,463,372				
Blue Cross Senior Options															
Other Comm Medicare					19,673,631										
Commercial Medicare Subtotal	0	0	0	0	38,117,041	0	-1,948,334	0	0	0	4,463,372	0	0	0	0
Medicare											87,018,451				
Other													4,837,394		
GRAND TOTAL	39,342,933	0	896,769	0	38,117,041	0	-1,948,334	0	0	0	182,060,136	0	4,837,394	0	263,305,938

Payer	Mercy IP	Mercy OP	Mercy total	SPECFIC recon to F/S	#REF! GENERAL	MMC FINAL	PBH IP	PBH OP	PBH total	SPECFIC	#REF! GENERAL	PBH total		MCC/PBH		#REF!
BC ELECT PPO	1,947,190	2,991,442	4,938,632		#REF!	#REF!	88,425	834	89,259		#REF!	#REF!	BC ELECT PPO	#REF!	Blue Cross Blue Shield	#REF!
BC INDEMNITY	474,529	1,258,423	1,732,952		#REF!	#REF!	509,292	94,941	604,233		#REF!	#REF!	BC INDEMNITY	#REF!	Blue Cross Blue Shield	#REF!
BC OUT OF STATE	3,160,508	3,119,535	6,280,042		#REF!	#REF!	232,881	5,114	237,996		#REF!	#REF!	BC OUT OF STATE	#REF!	Blue Cross Blue Shield	#REF!
BLUE CARE 65	2,990,101	1,633,940	4,624,042		#REF!	#REF!	183,850	0	183,850		#REF!	#REF!	BLUE CARE 65	#REF!	Other Comm Medicare	#REF!
BLUE HMO	3,528,544	5,337,601	8,866,145		#REF!	#REF!	116,788	8,439	125,227		#REF!	#REF!	BLUE HMO	#REF!	Blue Cross Blue Shield	#REF!
CIGNA	1,341,334	2,886,836	4,228,170		#REF!	#REF!	312,341	42,239	354,579		#REF!	#REF!	CIGNA	#REF!	CIGNA	#REF!
COM'L INSURANCE	2,375,779	5,188,691	7,564,470		#REF!	#REF!	743,610	3,667	747,278		#REF!	#REF!	COM'L INSURANCE	#REF!	Other Commercial	#REF!
COMMONWEALTH CARE	393,876	611,631	1,005,507		#REF!	#REF!	11,473	116,914	128,388		#REF!	#REF!	COMMONWEALTH CARE	#REF!	***OTHER ARRAGMNENT***	***#REF!***
DMH	0	0	0		#REF!	#REF!	0	0	0		#REF!	#REF!	DMH	#REF!		
DPH	0	0	0		#REF!	#REF!	245,240	319,046	564,286		#REF!	#REF!	DPH	#REF!	***Other***	***#REF!***
HEALTH NET	6,673,443	6,026,261	12,699,704		#REF!	#REF!	0	0	0		#REF!	#REF!	HEALTH NET	#REF!	BMC HealthNet, Inc.	#REF!
HEALTH NEW ENG	8,196,359	13,309,179	21,505,538	#REF!	#REF!	#REF!	943,125	25,304	968,429		#REF!	#REF!	HEALTH NEW ENG	#REF!	Other Commercial	#REF!
HEALTH SAFETY NET	304,326	520,855	825,180	#REF!	#REF!	#REF!	230,169	0	230,169	#REF!	#REF!	#REF!	HEALTH SAFETY NET	#REF!	***Other***	#REF!
MBHP	0	0	0		#REF!	#REF!	5,850,735	1,492,817	7,343,552		#REF!	#REF!	MBHP	#REF!	Other Managed Medicaid	#REF!
MEDICAID/OTHER GOV'T	6,265,505	6,112,826	12,378,331	#REF!	#REF!	#REF!	1,829,196	1,022,616	2,851,812		#REF!	#REF!	MEDICAID/OTHER GOV'T	#REF!	***MassHealth***	16,078,391
MEDICARE	43,484,370	29,815,496	73,299,865	#REF!	#REF!	#REF!	1,757,898	105,397	1,863,295	#REF!	#REF!	#REF!	MEDICARE	#REF!	***Medicare***	#REF!
MEDICARE PSYCH	0	389	389		#REF!	#REF!	5,189,224	0	5,189,224		#REF!	#REF!	MEDICARE PSYCH	#REF!	***Medicare***	***#REF!***
MEDICARE REHAB	6,033,270	507,050	6,540,321		#REF!	#REF!	0	0	0		#REF!	#REF!	MEDICARE REHAB	#REF!	***Medicare***	***#REF!***
OTH GOVT/VETERANS SVCS	251,293	399,458	650,751		#REF!	#REF!	41,822	6,823	48,645		#REF!	#REF!	OTH GOVT/VETERANS SVCS	#REF!	***Other***	***#REF!***
OTHER HMO/PPO	3,663,112	4,949,941	8,613,053		#REF!	#REF!	715,912	38,907	754,819		#REF!	#REF!	OTHER HMO/PPO	#REF!	Other Commercial	#REF!
OTHER MANAGED MEDICAID	6,936,461	8,137,183	15,073,644		#REF!	#REF!	4,412,320	3,103,970	7,516,290		#REF!	#REF!	OTHER MANAGED MEDICAID	#REF!	Other Managed Medicaid	#REF!
OTHER MANAGED MEDICARE	8,584,796	7,500,935	16,085,731		#REF!	#REF!	1,004,232	0	1,004,232		#REF!	#REF!	OTHER MANAGED MEDICARE	#REF!	Other Comm Medicare	#REF!
SELF	956,848	4,698,353	5,655,200		#REF!	#REF!	668,018	128,429	796,447		#REF!	#REF!	SELF	#REF!		***#REF!***
TUFTS	946,907	1,976,503	2,923,410		#REF!	#REF!	81,452	2,737	84,189		#REF!	#REF!	TUFTS	#REF!	Tufts Health Plan	3,020,476
TUFTS MEDICARE PRE	7,210,308	6,748,194	13,958,502		#REF!	#REF!	94,104	144	94,248		#REF!	#REF!	TUFTS MEDICARE PRE	#REF!	Tufts Health Plan	#REF!
WORK COMP	544,553	1,010,556	1,555,109		#REF!	#REF!	0	0	0		#REF!	#REF!	WORK COMP	#REF!	Other	#REF!
Total	116,263,411	114,741,277	231,004,689	#REF!	#REF!	#REF!	25,173,684	6,518,341	31,780,449		#REF!	#REF!		#REF!		
							Accrual		13594.15831	gen						

2015	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	22,540,374		451,762												
Tufts Health Plan	3,020,476														
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
United Healthcare											4,613,082				
other commercial											41,698,670				
Total commercial	25,560,850	0	451,762	0	0	0	0	0	0	0	46,311,752	0	0	0	0
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.											12,737,252				
Fallon Community Health Plan															
Other Managed Medicaid											30,725,361				
Total Managed Medicaid	0	0	0	0	0	0	0	0	0	0	43,462,613	0	0	0	0
MassHealth	15,576,450		501,941												
Tufts Medicare Preferred					14,227,164		-128,404								
Blue Cross Senior Options											4,830,809				
Other Comm Medicare					17,188,026										
Commercial Medicare Subtotal	0	0	0	0	31,415,190	0	-128,404	0	0	0	4,830,809	0	0	0	0
Medicare											89,147,008				
Other													3,973,880		
GRAND TOTAL	41,137,300	0	953,702	0	31,415,190	0	-128,404	0	0	0	183,752,182	0	3,973,880	0	261,103,852

0

GRAND TOTAL