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.

(1) The Nurse Staffing Ballot initiative, Question 1 on the ballot in November, if passed will cost over $1 billion and close a number of beds. The combined impact of additional staff and closed beds will make it impossible to meet the inflation benchmark. We do not believe this will be a one or two year impact in growth. Recruiting and retaining 25% more nurses will likely create significant inflationary pressure fueled by the wealthy systems that are closer to the required ratios and have historically paid higher wages. Community hospitals will close more beds, and have more pressure for wage inflation, likely causing community hospitals to curtail services or close beds, moving patients from low cost care to higher cost care, further exacerbating inflation.
(2) Wage inflation will cause shortages of skilled labor, adding pressure on wages, which will reduce margins and create pressure on price.
(3) The continued spiral of the wealthy systems investing in their academic facilities, strengthening their brand, advertising their expertise; and drawing more patients from lower cost hospitals. The cost difference from a low-cost provider to a high cost provider is much greater than a mere 3.1% inflationary increase. The cost growth benchmark can work against the smaller, less powerful providers, keeping them under funded, if the insurance companies use the benchmark as an arbitrary measure with each individual contract. This use of the benchmark locks in place the continued movement of primary and secondary care into larger, higher cost tertiary systems.

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

(1) Drug cost inflation. Massachusetts should work with CMS to find an acceptable means of establishing a Medicaid Drug formulary for drugs included in Medicaid benefits. A commission should review all high cost drugs to determine quality of life benefit cost and limit the formulary based on cost and value. Hopefully the insurance plans would follow.
(2) Wage Inflation. The state is going to have to alter the benchmark based on realistic wage inflation if we have a return to the inflation of previous decades.
(3) Wealthy system growth at the expense of lower cost systems. This is a difficult problem that state has worked at diligently but without a solution. First, the lower paid hospitals, which have limited negotiating power, must be paid within a given range of their competitors to sustain high value access in their current market, much less grow.

Second, the State must develop regulations related to the physician organizations that are supported by wealthy providers. The wealthy providers continue to siphon money from their hospitals to support physician groups that do not have the same mission or regulations related to caring for patients in the community regardless of their ability to pay. Groups of physicians now significantly control where patients are referred, by managing leakage from their group. Additionally, some of these systems either allow their doctors to schedule Medicaid patients differently with less convenient appointments so that they limit their percentage within the practice, or they locate their offices in areas with few Medicaid patients. The state has little regulatory policing authority in this area, and must establish appropriate authority over not-for-profit sponsored physician groups, to ensure that the group is meeting community needs.

While much has been written and studied regarding how the big facilities have high prices and high market share, little has been studied, or shared publically about the price variation among large non-profit physician groups, whether their patient mix reflects the community within 10 miles of their office, or how they manage leakage within their networks. This has a hidden and costly impact on health cost, which should be studied.

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.

(1) Increase our insurance payments to reasonable rates relative to our geographic competition so that we have the ability to survive as a safety-net provider. If we do not succeed in increasing the insurance payments, we will fall behind our competitors in attracting talent and be unable to maintain a stable workforce. The cumulative impact of this is significant, and causes the public to choose higher cost systems, under the perception that they are higher value.
(2) Signature is committed to being successful in reducing total medical expense through reducing waste in the health system, and sustaining those changes through multiple forms of global budget risk. Signature works within global budgets for Medicare Advantage, Blue Cross, Tufts Commercial, Medicaid and the CMS Medicare bundle program. The waste we are targeting includes gaps in care, over utilization of tests, over utilization of emergency and inpatient care, and over use of post-acute care.
(3) As a result of success in reducing volume within the hospital, Signature is aimed internally at managing efficiently through increasing safety, quality and reducing cost per unit.

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.

Not applicable

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):

Not applicable

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.

Not applicable

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?

Not applicable

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 do not have true urgent care. We currently have by-appointment, for SMG patient's only, same day sick visits at Liberty Street. This, and some after hours, weekend hours is our main strategies to avoid ED admissions.

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.

Signature is concerned that the growth in alternative sites of care will, over time, increase the cost of care. Urgent care centers, telemedicine options and retail health care are not being designed as medical homes. Although, some patients may prefer having options available to them after hours just offering the emergency room does not seem to meet the needs of customer. Access is of course a reasonable request and can, if managed correctly provide exceptional longitudinal care. While on the surface increased access may seem like a great way to save, by reducing unnecessary trips to the ED, the visits to these alternative sites, are often not for significant patient emergencies. It would be incorrect to compare an urgent care visit to the cost of an average ED visit, and calculate the savings, as the average ED patient will be sicker than the average urgent care patient. In fact, urgent care patients self-select this option when they are not as sick, and if they are too sick, they are sent to the ED and have both the urgent care visit cost and the ED cost. Since these alternative sites are not being established as medical homes, they do not do as good a job of screening patients for cancer, or managing chronic illnesses. Sometimes, the only time a medical home physician may see some patients is when they are willing to see their PCP for a cold or minor ailment. The medical home physician would review the patient's screening needs, problem list, as well as treat for the reason for the visit. The long-term impact of fragmenting ambulatory primary care into "urgent" and chronic care may have a higher cost than any short-term savings.

The state needs to get ahead of the increasing trend for telemedicine and the potential impact this might have on the provision of access to the less fortunate in the state. For example, will retail giants like Amazon provide telemedicine only to those that can afford to pay, reducing margins for physicians who have a higher panel of Medicaid patients, by siphoning off profitable short visits? Will telemedicine providers provide depression screening, pre-diabetic screening, and counseling for medical adherence, and support for accessing medications the patient can afford? It is not likely that these additional services provided by a medical home PCP will be included in the short telemedicine call. And will the telemedicine providers over-use antibiotics for common colds, further reducing the efficacy of typical antibiotics?

The growth in alternative sites in MA is a double-edge sword. Patients have more access to less costly care than the ED, but at the same time if the infrastructure is not there for interconnectivity between EMR's, the healthcare that is delivered is fractured. Ideally the system would be able to interchange information about the visit at an urgent care center with the PCP's office seamlessly. Furthermore, given the new payment models of value-based payments, this will lead to some uncontrollable spend for the patient's PCP office. Again, if an ED visit was avoided, this may still be a preferable situation.

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?

First, I would suggest the state consider establishing policies and regulations that, based on behavioral economics have a higher expected return. The Obama administration established a Social and Behavioral Science Team (SBST) to assist agencies in developing effective policies and programs. The state should develop a similar SBST to support all agencies in developing policies and gaining synergy across policy to address social needs, including social influences of health.

Second, I would establish an agency to coordinate policy between local and state police, mental health, education, housing and the courts with a common goal of reducing the cost of caring for people with mental health diagnosis.

Third, in terms of investment, I would focus on the 5 percent of the population that have chronic illness, and behavioral health needs. These citizens may need additional support targeted to their special circumstance, and flexibility should be provided within the government structure to provide better service. In addition to working with employers, the state should take a comprehensive approach to metabolic disease, including taxing foods that contribute to problem and using that money to support lowering the cost of healthier options.

Fourth, the state should focus policy and incentives on the population that has one or more chronic illness, but does not currently have significant health burden. The majority of this population works and plans should include outreach to employers with incentives to change their health plan design, or if they do not offer insurance to provide benefits that support long term life style changes and wellness.

Lastly, we would recommend flexibility in the use of funding provided by the state in population management to a system of care, whose principal players are the health care system of the patient, as well as the community agencies necessary to address the social determinants of health. Furthermore, the state should invest heavily in other infrastructures that contribute to

social determinants of health, including education systems, public housing, and economic development. These investments should be targeted at specific needy areas of the state in order to maximize return on investment potential.

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. *Please note that our process does not include breaking out the written vs telephone and in-person inquires.*

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	**15**	
	Q2	**8**	
	Q3	**9**	
	Q4	**15**	
CY2017	**Q1**	**8**	
	Q2	**17**	
	Q3	**10**	
	Q4	**8**	
CY2018	**Q1**	**13**	
	Q2	**13**	
	TOTAL:	**116**	

   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.

   We use a new tool called Patient Estimates which gathers information from our charge description master (CDM), payor contracts, claims data and eligibility response data to give an "estimate" of the service. Currently, we can't determine accuracy of the estimate. Since it's an

online tool, if we have all the information entered in the system, the turnaround time is within minutes. We are still working out the reporting capabilities of this system.

What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

The Common barrier we encounter in timely response to the consumer inquiry is not knowing the CPT code or diagnosis code of the service the consumer is looking for an estimate for. In that case we use Price Transparency Request Form (see attached policy and procedure).

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.

   Signature Healthcare Brockton Hospital is not able to provide the requested information with complete confidence in the data's accuracy at this time. We recently conducted a review of the Hospital and Medical Group's data reporting and recording systems. It was at this time, we discovered a delay in the accessibility of data, as well as discrepancies in the data. Both accessibility and discrepancies in data underscored the Hospital's need for a decision support system. We chose to purchase and implement a new decision support system, and this system is being implemented in three phases, with each phase building on the previous; so that users can easily acclimate to the system, understand the power of information, and give sufficient time to ensure its accuracy. Therefore, we have provided the margin data is provided at the total provider level. We have attached the Center for Health Information and Analysis Acute Hospital Financial Performance Trends for CHA for FYs 2013-2017, which can also be accessed at http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2017-annual-report/five-year-trend/brocktn.pdf.

   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.

   As indicated above in question 3(a), Signature Healthcare Brockton Hospital is not able to provide the requested information with complete confidence in the data's accuracy at this time. We recently conducted a review of the Hospital and Medical Group's data reporting and recording systems. It was at this time, we discovered a delay in the accessibility of data, as well as discrepancies in the data. Both accessibility and discrepancies in data underscored the Hospital's need for a decision support system. We chose to purchase and implement a new decision support system, and this system is being implemented in three phases, with each phase

building on the previous; so that users can easily acclimate to the system, understand the power of information, and give sufficient time to ensure its accuracy.

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		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	$19.3	$2.0	$.8	$.1	$8.7	-	-	-	$1.7	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.7	-	$.1	-	-	-	$2.5	$1.8			
Harvard Pilgrim Health Care	$10.3	-	$.1	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$2.2	-			
HPI	-	-	-	-	-	-	-	-	-	-	$5.3	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.0	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.1	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$1.5	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$7.0			
Total Commercial	$29.6	$2.0	$.9	$.1	$11.4	-	$.1	-	$1.7	-	$17.1	$8.8			
Network Health	-	-	-	-	-	-	-	-	-	-	$8.2	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$9.3	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$15.7	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$2.5	$.6			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$35.8	$.6			
MassHealth	-	$23.7	-	$1.8	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$4.5	-	-$.1	-	-	-	$1.5	$.0			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$1.5	$1.9			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$6.3	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Commercial Medicare Subtotal	-	-	-	-	$4.5	-	-$.1	-	-	-	$10.7	$1.9			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$67.3			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.2			
GRAND TOTAL	$29.6	$25.6	$.9	$1.9	$15.9	-	-$.1	-	$1.7	-	$63.6	$86.8			

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	$19.1	$1.6	$.6	$.0	$8.9		-	-	$.9	-	$.2	-			
Tufts Health Plan	-	-	-	-	$2.9	-	$.0	-	-	-	$2.8	$1.7			
Harvard Pilgrim Health Care	$11.2	-	$.2	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.7	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.1	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.8	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$2.3	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.6	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$8.1			
Total Commercial	$30.3	$1.6	$.7	$.0	$11.8	-	$.0	-	$.9	-	$19.7	$9.8			
Network Health	-	-	-	-	-	-	-	-	-	-	$9.3				
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$10.6	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$16.6				
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$4.9	$.1			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$41.3	$.1			
MassHealth	-	$27.0	-	$.8	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$5.6	-	$1.1	-	-	-	$1.4	$.0			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$1.6	$2.1			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$7.4	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$2.5	-			
Commercial Medicare Subtotal	-	-	-	-	$5.6	-	$1.1	-	-	-	$12.9	$2.1			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$74.5			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.1			
GRAND TOTAL	$30.3	$28.6	$.7	$.9	$17.5	-	$1.2	-	$.9	-	$73.9	$94.6			

2016	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$8.8	$8.5	$.3	$.3	$14.3	-	-	-	$.4	-	$.4	$.2			
Tufts Health Plan	-	-	-	-	$4.5	-	$.1	-	-	-	-	$3.3			
Harvard Pilgrim Health Care	$11.9	-	$.0	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.4	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.4	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	$3.6			
Unicare	-	-	-	-	-	-	-	-	-	-	$2.3	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$2.4	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.9	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$8.3			
Total Commercial	$20.7	$8.5	$.4	$.3	$18.8	$.0	$.1	$.0	$.4	$.0	$14.8	$15.4			
Tufts - Network Health	-	-	-	-	-	-	-	-	-	-	$10.0	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$12.7	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$16.2	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$4.4	$.4			
Total Managed Medicaid	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$43.2	$.4			
MassHealth	-	$25.7	-	$1.0	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$7.4	-	$.3	-	-	-	$.0	-			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$3.8	-			
Senior Whole Health	-	-	-	-	$6.4	-	-	-	-	-	-	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$3.0	$.5			
Commercial Medicare Subtotal	$.0	$.0	$.0	$.0	$13.8	$.0	$.3	$.0	$.0	$.0	$6.8	$.5			
Medicare	-	-	-	-	-	$17.5	-	$3.0	-	-	-	$54.8			
Other	-	-	-	-	-	-	-	-	-	-	-	$7.5			
GRAND TOTAL	$20.7	$34.2	$.4	$1.3	$32.6	$17.5	$.4	$3.0	$.4	$.0	$64.9	$78.7			

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	$.5	$11.5	$.0	$.4	$11.0	-	-	-	$.8	-	$5.0	$.3			
Tufts Health Plan	-	-	-	-	$6.0	-	$.1	-	-	-	-	$1.1			
Harvard Pilgrim Health Care	$9.4	-	$.0	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.0	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.3	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	$3.2			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.9	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$1.1	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.7	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$6.0			
Total Commercial	$9.9	$11.5	$.1	$.4	$17.1	$.0	$.1	$.0	$.8	$.0	$17.0	$10.8			
Tufts - Network Health	-	-	-	-	-	-	-	-	-	-	$12.9	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$13.6	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$19.5	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$5.8	$.3			
Total Managed Medicaid	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$51.8	$.3			
MassHealth	-	$28.3	-	$.8	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$9.4	-	-$.7	-	-	-	$.0	-			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$3.3	-			
Senior Whole Health	-	-	-	-	$6.4	-	-	-	-	-	-	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$4.5	$.1			
Commercial Medicare Subtotal	$.0	$.0	$.0	$.0	$15.7	$.0	-$.7	$.0	$.0	$.0	$7.8	$.1			
Medicare	-	-	-	-	-	$18.5	-	$3.6	-	-	-	$58.5			
Other	-	-	-	-	-	-	-	-	-	-	-	$7.6			
GRAND TOTAL	$9.9	$39.8	$.1	$1.2	$32.8	$18.5	-$.7	$3.6	$.8	$.0	$76.6	$77.3			