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.

South Shore Health System (SSHS) is committed to providing innovative, cost-effective, and high-quality services and programs that will ultimately improve health outcomes for individuals and families across the South Shore. SSHS has listened to the needs of the region and expanded beyond medical and surgical services to add specialty services that most community hospitals don't provide, thereby reducing the need for patients to travel to hospitals outside of the South Shore.

While we are committed to continuing to invest in the high-quality services that our community desires, it is not without focus on meeting the benchmark. However, there are factors that should be taken into consideration for our ability to achieve this goal, including:

1) **Consumer Acceptance:** SSHS is dedicated to providing high-quality, community-based care that allows our patients to stay in the community and not travel long-distances for services that we can provide. As an organization, we are also consistently looking for ways to keep this care as low-cost as possible to benefit our consumers and to meet the state benchmark.

   While actors in the health care system are aware of the benchmark and efforts to contain health care costs, consumers need to be educated and become an active participant in such efforts. As we move forward with new approaches to care, it is critical that all health entities have buy-in from their patients or we will not see the desired results. Patients have specific preferences and often, the cost of care can be higher if patients make decisions based on perception, rather than choosing care that is coordinated and cost-effective. Change and acceptance amongst patients can only come with significant outreach, communication and engagement.

2) **Pharmaceutical Drug Spending:** The most significant cost driver in health care is the skyrocketing costs of pharmaceutical drugs. The Health Policy Commission's "2017 Annual Health Care Cost Trends Report" found that prescription drug spending was one of the highest growth areas in 2016, with increases in spending of 6.1%. For health systems, there is limited control over this area of spending and that needs to be taken into consideration in review of the benchmark.

3) **Question 1:** The most immediate concern is related to the potential passage of Question 1, which would require SSHS to adopt rigid, one-size-fits-all Registered Nurse-to-patient ratios with no exceptions. The negative impact of implementation on our patients and their families cannot be ignored as they will experience tremendous barriers to care and longer wait times for key services. It will cost SSHS up to $33 million and approximately 200 new nurses will be required

to be in order to be in compliance. There is no way that this tremendous cost can be absorbed without the reduction or elimination of key programs and specialty services, resulting in the need for patients to go into Boston for the specialty care that SSHS can no longer provide. Businesses, individuals and families will also pay for Question 1 through higher insurance co-pays, premiums, deductibles and higher taxes. This is likely the single, largest direct threat to meeting the benchmark for every hospital across the state.

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

To address these concerns, SSHS recommends close review and analysis of:
1) Funding for Consumer Education and Engagement: There needs to be a statewide initiative, focusing on educating consumers on health care options. Separate from ongoing transparency efforts focused on pricing, consumers need to understand where they can receive care and how their decisions impact overall health care spending. With this effort, necessary policy, regulatory or statutory changes may be identified to streamline this work.
2) Pharmaceutical Drug Spending: It is apparent that the Commonwealth should take action to address the ongoing, significant increases in drug spending. Increased transparency of actual pharmaceutical costs should be considered, along with statutory changes requiring pharmaceutical companies to be held to similar cost benchmarks as health systems.
3) Data Sharing: The Commonwealth should closely examine the statutes and regulations pertaining to sharing of medical information. Across the state, more and more patients are presenting with physical and mental health issues and there are often barriers to sharing information that could help provide more comprehensive treatment.

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.

SSHS has taken a comprehensive, multi-faceted approach to treating patients in the most appropriate and cost-efficient settings, including:

1) **Moving Toward Mobile Integrated Health:** In July 2018, SSHS became the emergency medical services (EMS) provider for the city of Weymouth, providing the health system with a new and exciting opportunity for serving the residents of its home community. It also is a significant step toward preparing for the development and implementation of a mobile integrated health (MIH) program. SSHS is looking forward to working with the Department of Public Health (DPH) as it continues to roll-out the MIH program, which will provide SSHS with a more coordinated and streamlined approach to serving patients in the most appropriate setting to meet their needs.

2) **Serving Patients in the Most Appropriate Settings:** SSHS recognizes that not all emergency department (ED) visits are emergent and in order to provide our patients with high-quality, coordinated alternative settings for the level of care that they need, we will be adding urgent care centers within our system. By adding this resource to the health system and implementing a MIH program, SSHS will have enhanced opportunities for patients to avoid unnecessary trips to the ED.

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.
Required Answer: Click here to enter text.

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.
Required Answer: Click here to enter text.

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?
Required Answer: Click here to enter text.

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).

SSHS recognizes that not all emergency department (ED) visits are emergent and in order to provide our patients with high-quality, coordinated alternative settings for the level of care that they need, we will be adding urgent care centers within our system. By adding this resource to the health system and implementing a mobile integrated health (MIH) program, SSHS will have enhanced opportunities to avoid unnecessary trips to the ED.

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.

Alternative care sites, such as urgent care centers, have the opportunity to be a significant resource for patients across the state. As a health system focused on adding urgent care centers as a treatment option, we believe that this will provide increased timely access to care outside of the ED setting. It is our intent to fully integrate urgent care into our system, including ensuring that coordinated, appropriate follow-up is conducted.

While SSHS has been focused on adding urgent care to our system, other alternative care settings outside of our system continue to open within our service area, with limited governmental oversight and requirements or a focus on full coordination of patient care. All alternative care sites entering the market should be required to file a notice of material change and HPC should be afforded the opportunity to appropriately determine the potential full impact of new centers to the entire health care system.

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?

To the extent that policy and regulatory changes could support data sharing, it would enable providers to be better coordinated and establish and maintain critical relationships. Statewide investments, at the state and provider level, are necessary to ensure that there are integrated IT systems that enable data to be shared in a consistent and timely manner, and that support the right referral mechanisms, follow-up and enhanced communication.

Health care systems need to have access to the right data to be able to quantify if there is a problem and once a determination is made, resources are necessary to develop and implement a response. Organizations also need the internal capacity to establish relationships to build the infrastructure to support work on social determinants of health. With many competing priorities and state and federal requirements, it is challenging to identify available resources to do this work.

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	9	346
CY2017	**Q1**		
	Q2		
	Q3		
	Q4	8	638
CY2018	**Q1**		
	Q2	6	139
	TOTAL:	23	1,123

The information included in the above table is related to the hospital-based price inquiries. We have the ability produce this information on an annual basis, not quarterly.

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.

South Shore Health System (SSHS) has several mechanisms for providing consumers with health care pricing information. For all hospital based care, estimates are aggregated, using a payment estimation tool through Passport/Experian. Estimates are derived by comparing the consumer's health insurance product against the hospitals charge master and contracted rates for a specific episode of care description or CPT code.

Using the payment estimation tool allows multiple hospital areas to supply real time price inquires to consumers. The results of the inquiries are stored and archived within the estimation tool, allowing for tracking and referencing of given estimations. The estimation tool also supports SSHS's ability to print and supply the consumer with a written estimation of out of pocket expenses after insurance.

At times, complex surgical procedures with multiple CPT codes need additional support using a contract management tool called Harvest, to calculate the expected charges for a given procedure. These types of estimation are not frequent and can take up to the two working days allowed under Chapter 224.

The hospital supports a direct phone line for patient pricing inquiries. The pricing line information and hours of operation are available on the SSHS website. The quality and accuracy of price

inquiries is supported by the updating of contracted rates and hospital charge master within the third party systems.

SSHS has one primary physician practice which uses a fee schedule spreadsheet to support consumer price inquires for physician based care. They report minimal price inquiries annually. The registration and billing areas support consumer inquiries using the practices fee schedule. Inquiries can be responded to real time using the fee schedule spreadsheet. Any pricing inquiries for hospital based care would be secured through the hospital's payment estimation tools.

SSHS' Home Health Care and Hospice division also reviews insurance coverage and out of pocket amounts with consumers. Generally, consumers do not contact the division for pricing inquiries and are referred to these services via a medical provider.

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?

South Shore Health System is able to appropriately respond to all of the inquiries received from consumers. There may be barriers to supplying a real time estimation of cost depending on the information being supplied by the consumer. Consumers often call with minimal information, which affects the timeliness of an accurate response. In the event that the consumer does not have their insurance information, it can create delays in the provider's ability to provide an accurate and timely response to the consumer.

Another barrier to supplying timely pricing is a result of complex surgical procedure inquiries. These procedures may be done infrequently or are new to the organization. Securing an accurate response to an inquiry may involve multiple hospital areas and a manual calculation may be necessary.

To support consumer access, SSHS provides a direct line for patient pricing inquiries. Leveraging electronic payment estimation tools that combine hospital pricing and consumer insurance benefits, also supports our ability to provide real time pricing information.

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.

Please see attached.

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.

South Shore Hospital does not currently have cost accounting systems to respond in the level of detail requested. South Shore Health System is currently evaluating a new enterprise resource planning system that will include the capability to provide the information requested, however, the functionality is estimated to be available in fiscal year 2021.

Massachusetts Health Policy Commission
2018 Pre-Filed Testimony: AGO Question 3A
South Shore Health System/South Shore Hospital

The source for this information is the submitted DHCFP 403 Reports

FY2015	Commercial	Medicare	Medicaid	Other	Total
Net Patient Service Revenue	241,690,315	205,717,685	50,972,604	11,530,009	509,910,613
Operating Margin	64,510,128	(21,759,560)	(12,204,310)	(2,393,012)	28,153,246
Margin Percentage	27%	-11%	-24%	-21%	6%
Percentage of Business (Based on Gross Charges)	38%	46%	13%	3%	100%
FY2016					
Net Patient Service Revenue	258,333,760	217,096,716	57,545,377	12,173,387	545,149,240
Operating Margin	68,502,966	(32,214,796)	(11,169,520)	(4,638,041)	20,480,609
Margin Percentage	27%	-15%	-19%	-38%	4%
Percentage of Business (Based on Gross Charges)	38%	46%	13%	3%	100%
FY2017					
Net Patient Service Revenue	236,539,430	219,597,139	74,986,708	31,974,671	563,097,948
Operating Margin	47,331,238	(47,053,532)	(5,060,380)	172,343	(4,610,331)
Margin Percentage	20%	-21%	-7%	1%	-1%
Percentage of Business (Based on Gross Charges)	34%	45%	15%	6%	100%

Insurance Plans				
	Aetna	Medicare	Mass Health	Auto
	Blue Cross	Sr Whole Health	NHP	Workers Comp
	Cigna	Tufts Medicare	Network Health	Champus
	Fallon	Medicare Advantage	BMC	Connector Care
	Harvard Pilgrim		Tufts Network Hea	Health Safety Net
	HCVM			
	HPO			
	NHP			
	PHCS			
	Tufts			

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	44M	56.7M	1.3M	1.7M	X	X	X	X	X	X	2.4M	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	34.9M	X	X	X	X
Harvard Pilgrim Health Care	73M	X	1.5M	X	X	X	X	X	X	X	1.6M	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	3.3M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	3.7M	X	X	X	X
United Healthcare	7.5M	X	.060M	X	X	X	X	X	X	X	.6M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	6.1M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	30.3M	X	X	X	X
Total Commercial	124.5M	X	2.8M	X	X	X	X	X	X	X	82.9M	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	.1M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	.6M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Health New England	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	.002M	X	X	X	X
Other Managed Medicaid	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	1M	X	X	X	X
MassHealth	X	X	.5M	X	X	X	X	X	X	X	45.2M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	14.7M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	8.3M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	23.2M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	157.1M	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	6.2M	X	X	X	X
GRAND TOTAL	124.5M	56.7M	3.3M	1.7M	X	X	X	X	X	X	315.6M	X	X	X	X

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	41.6M	57M	1.2M	1.6M	14M	X	.045M	X	1.6M	X	2.6M	9.2M	X	X	X
Tufts Health Plan	X	X	X	X	X	X	.034M	X	X	X	38.1M	2.6M	X	X	X
Harvard Pilgrim Health Care	75.8M	X	3.8M	X	X	X	1.1M	X	X	X	6.7M	2.1M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	4.2M	.066M	X	X	X
CIGNA	9M	X	X	X	X	X	X	X	X	X	4.6M	.064M	X	X	X
United Healthcare	X	X	.1M	X	X	X	X	X	X	X	3.8M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	8.4M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	31.9M	.007M	X	X	X
Total Commercial	126.4M	57M	5.1M	1.6M	14M	X	1.2M	X	1.6M	X	100.2M	14M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	6.1M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	17.5M	.0001M	.3M	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	5.3M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	.002M	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	5.7M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	34.6M	.0001M	.3M	X	X
MassHealth	X	X	.7M	X	X	X	X	X	X	X	19.30	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	1.5M	X	(1.5M)	X	.005M	X	18.2M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	12.50	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	1.5M	X	(1.5M)	X	.005M	X	30.9M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	182.3M	5.2M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	11.2M	1.9M	X	X	X
GRAND TOTAL	126.4M	57M	5.8M	1.6M	15.5M	X	(.3M)	X	1.6M	X	378.5M	21.1M	.3M	X	X

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	44.6M	67.1M	1.2M	1.7M	10.4M	X	.4M	X	1.7M	X	3M	11.7M	X	X	X
Tufts Health Plan	X	X	X	.098M	X	X	.1M	X	X	X	38.2M	.7M	X	X	X
Harvard Pilgrim Health Care	78.2M	X	X	X	5.9M	X	(.8M)	X	.1M	X	1.8M	1.2M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	3.1M	.037M	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	7.9M	1.1M	X	X	X
United Healthcare	10.2M	X	.1M	X	X	X	X	X	X	X	3.5M	.006M	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	9M	.031M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	37M	.1M	X	X	X
Total Commercial	133M	67.1M	1.3M	1.8M	16.3M	X	(.3M)	X	1.8M	X	103.5M	14.9M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	7.1M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	23.3M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	5.7M	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	3.9M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	40M	X	X	X	X
MassHealth	X	X	.5M	X	X	X	X	X	X	X	18.9M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	1.6M	X	(2M)	X	.021M	X	19.2	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.3M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	14.9M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	1.6M	X	(2M)	X	.021M	X	34.4M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	188.4M	5.1M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	7.7M	.001M	X	X	X
GRAND TOTAL	133M	67.1M	1.8M	1.8M	17.9M	X	(2.3M)	X	1.8M	X	393M	20M	X	X	X

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	43.1M	67.5M	1.2M	1.8M	11.7M	X	(1.3M)	X	1.7M	X	4.7M	11.2M	X	X	X
Tufts Health Plan	X	X	X	X	X	X	.2M	X	X	X	37.4M	1M	X	X	X
Harvard Pilgrim Health Care	71.7M	X	5.4M	X	7.4M	X	X	X	X	X	2.2M	.8M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	3.8M	.021M	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	8.1M	1.2M	X	X	X
United Healthcare	10M	X	.4M	X	X	X	X	X	X	X	3M	1.3M	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	8.6M	.1M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	38.3	.062M	X	X	X
Total Commercial	124.8M	67.5M	7M	1.8M	19.1M	X	(1.1M)	X	1.7M	X	106M	15.7M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	4.2M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	23.1M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	4.7M	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	7.5M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	39.5M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	17.8M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	1.6M	X	.4M	X	.042M	X	17.8	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	20.1M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	1.6M	X	.4M	X	.042M	X	38.1M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	199.6M	5.3M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	6.2M	.003M	X	X	X
GRAND TOTAL	124.8M	67.5M	7M	1.8M	20.7M	X	(.7M)	X	1.7M	X	403.2M	21M	X	X	X