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.

The healthcare cost benchmark has served as a strong marker for the industry in identifying a shared goal for cost containment. Wellforce was founded by hospitals and providers who strongly believe in the drive to value and in delivering the highest quality of care in the most efficient way. Setting aside the continuous growth in pharmaceutical costs that is outpacing all other healthcare cost growth; Wellforce sees a number of issues ahead that will greatly challenge the state's ability to meet the benchmark. Top among those challenges will be the potential implementation of mandated nurse staffing ratio. Should the mandated nurse staffing ratio become law the conservative cost estimate across the Wellforce system is $44 million dollars annually. The projected costs of implementation are over $1billion per year without delivering any proven benefit to healthcare quality. We are deeply concerned about the impact this staffing mandate will have on our ability to continue to support services that are already under reimbursed, such as behavioral health. Should we be required to immediately meet rigid staffing ratios or face significant financial penalties, it will require a diversion of scarce resources away from initiatives that improving access to care, enhancing clinical protocols, addressing social determinants of health and improving the health and experience of our patients and improving the job satisfaction of our clinicians.

The second issue that will pose a major challenge to the holding to the benchmark is the possible approval and creation of the Beth Israel Lahey health system. As the HPC's own analysis showed, the cost increases associated with the creation and growth of this system will not only increase the healthcare cost burden in Massachusetts, it will exacerbate the healthcare pricing disparities and inequities across communities. Worse, while this mega merger will increase healthcare costs, it will quite likely jeopardize access to healthcare services in our most vulnerable communities.

Wellforce is built around a belief that communities should have access to outstanding, high quality, complex healthcare services at an affordable price. We believe these services can and will be delivered in a number of settings and that it is our responsibility to create and care for patients in the most appropriate setting; often that means choosing not to send a patient to an academic medical center for care, but rather in providing that patient with access to care from academic medical center specialists in their local a community setting or by sending our patients for follow-up care in an ambulatory care center that is not on the hospital license. If more of the healthcare insurers and providers do not drive care to lower cost settings, or if consumers do not pursue greater value for their healthcare dollars, the state will be challenged in meeting the healthcare cost containment benchmark. We also firmly believe that the growth in

PPO products and the shrinking commitment of many providers and insurers to true risk contracts will hinder our ability to drive to value and reduce healthcare spending.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
Top among the changes that we believe will have the most impact in healthcare is behavioral health integration and reimbursement. Even in ACO models behavioral health is treated as a "carved out" service, resulting in fragmented care planning, less than optimal outcomes for patients and frustration for caregivers. Changing regulations and payer practices to ensure behavioral health diagnosis and treatment can be shared, as necessary, throughout a patient's care team and enhancing reimbursement levels for behavioral healthcare services will have a significant positive impact in outcomes for patients in need of behavioral health services and in increasing access to and availability of these services. Wellforce has consistently advocated for greater transparency around healthcare payment rates and reimbursement, this is an area where insurers and providers should be required to provide much more transparency, particularly with global payment arrangements and risk contracts. Understanding how physicians are accountable or the amount of risk that is actually borne by physicians in risk arrangements will help shed light on how insurers', providers' and physicians' incentives are aligned or misaligned with the state's goals for driving value and accountability in healthcare.

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.
Wellforce recognizes that the key to better, more affordable healthcare lies in ensuring patients' get the right care, at the right place, at the right time and at the right cost. We are committed to providing a value-based model of care to all patients, actively managing utilization and moving care to the most appropriate care setting so that we are part of the solution to the healthcare cost problem. Our providers have been early adopters of risk arrangements and have over 370,000 lives in value-based contracts, The Wellforce model is aligned to drive patient care to the most appropriate setting, operating under an appropriately sized inpatient chassis impelled by our "Distributed Academic Medical Center model, we have built a system and culture which pushes care away from more expensive Boston hospitals into the community. The success of this model is demonstrated by the acuity in all our settings. Tufts Medical Center has the highest acuity in Boston because it pushes secondary and tertiary care to its community partners. While it is too early to measure results of this approach for MelroseWakefield Healthcare (one of our newer partners), Lowell General has seen a significant increase in its acuity from those cases. At Wellforce, our drive isn't to fill more and more inpatient hospital beds, rather we are focused on building healthy communities, by providing access to a wide range of healthcare services across the care continuum. Evidence of this model can be found throughout our system entities and in partnerships outside our system, for example Tufts Medical Center's pediatricians staff five pediatric specialty clinics in Chelmsford, Westford, Lawrence, Woburn and Brockton. Tufts Medical Center PO pediatricians and neonatologists also staff pediatric inpatient units and Special Care Nurseries in community hospitals, supporting local clinicians and enabling pediatric patients to receive care in their own communities. For adult patients, Tufts Medical Center PO specialists—including neurosurgeons, vascular surgeons, thoracic surgeons, gyn-onc surgeons, cardiologists and pulmonologists—consult with patients in community

clinics and perform surgeries in community hospitals to support the Wellforce mission of keeping care local. Providers across the Wellforce system are innovating and collaborating, one such program in development over the past year, the Wellforce-Wide Initiative in Cardiovascular Care has engaged providers in fostering best practices in caring for patients with atrial fibrillation and heart failure. Wellforce has convened working groups with medical, clinical, quality and administrative expertise that are pursuing innovative initiatives aimed at improving the delivery of care across the Wellforce network and supporting clinical integration and population management.

The Wellforce Care Plan was created to meet the opportunity and challenge laid out by the Baker Administration to embrace a new way of caring for our Medicaid population. Utilizing the infrastructure and expertise of the Lowell General PHO, Lowell Community Health Center, New England Quality Care Alliance and Fallon Health we are managing – and changing- the lives of over 50,000 MassHealth members come from as we harness the advantages and collaborations of real-time data and information sharing and weaving together clinical and social services. We view the Medicaid ACO as an extension of our commitment to population health, an area where our physician organizations have deep experience, having developed techniques that help reduce total medical expense including referral management, strategies to reduce emergency room utilization and care management models that integrate primary care and behavioral health.

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.

Wellforce currently has six urgent care centers that are corporately owned and operated by our Wellforce member health systems, Circle Health/Lowell General Hospital and Melrose Wakefield Healthcare. In addition to our owned assets, we have an established non-owned clinical affiliation with Health Express Walk-in Urgent Medical Care, which has six urgent care centers, and are in advanced discussions regarding a clinical affiliation with another established urgent care center in the market. Please see below for our alternative care locations:

Site Name	Location	Ownership/Affiliation Status
Circle Health Urgent Care – Billerica	199 Boston Road, North	Corporately owned and

	Billerica, MA 01862	operated
Circle Health Urgent Care – Westford	198 Littleton Road, Westford, MA 01886	Corporately owned and operated
Circle Health Urgent Care – Dracut (opening September 17, 2018)	9 Loon Road, Dracut, MA 01826	Corporately owned and operated
Lowell General Hospital Urgent Care	1230 Bridge Street, Lowell, MA 01850	Corporately owned and operated
Hallmark Health Urgent Care – Medford	170 Governors Avenue, Medford, MA 02155	Corporately owned and operated
Hallmark Health Urgent Care – Reading	30 New Crossing Road, Reading, MA 01867	Corporately owned and operated
Health Express – Abington	170 Bedford Street, Abington , MA 02351	Non-owned affiliate clinical affiliate
Health Express – Kingston	182 Summer Street, Kingston, MA 02364	Non-owned affiliate clinical affiliate
Health Express – Pembroke	117 Old Church Street, Pembroke, MA 02359	Non-owned affiliate clinical affiliate
Health Express – Plymouth	59 Long Pond Road, Plymouth, MA 02360	Non-owned affiliate clinical affiliate
Health Express – Quincy	119 Parkingway, Quincy, MA 02619	Non-owned affiliate clinical affiliate
Health Express - Weymouth	330 Washington Street, Weymouth, MA 02188	Non-owned affiliate clinical affiliate

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):

FY2017 total visit volume	49,101
Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	Commercial: 54% Medicare: 11% Mass Health/Medicaid: 17% Self-Pay: 3% Other: 15%
Percentage of patient visits where the patient is referred to a more intensive setting of care	3.1%

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.

Wellforce's overall clinical staffing model for our alternative care sites is designed to provide patients with the highest quality of care at a lower cost. All of our alternative care sites are staffed with Advance Care Providers (Nurse Practitioner or Physician Assistant) with clinical oversight provided by our Emergency Medicine physicians both on-site and via video at our sites. These providers are supported by registered nurses, medical assistants, and non-clinical administrative staff. The medical assistants in these sites are also certified radiology or lab technicians. By utilizing Advance Care Providers and having our radiology or lab technicians cross trained as medical assistants, we are able to control costs in our alternative care sites. However, it is our non-clinical administrative staff that differentiates our alternative care sites from others in the market by acting as patient navigators, as well. Patient navigators are tasked to provide patients with guidance through our organization for any follow up care needs that fall outside of or following the alternative care setting. Patients who need a primary care provider (PCP) will be connected, as needed, with one of our many high-quality PCPs within the organization.

We are currently in the process of developing a direct scheduling option in select primary care practices that will allow patients to schedule an appointment with one of our PCPs after their visit at the alternative care site. For specialty care follow up, patient navigators are able to help patients obtain any necessary referrals and connect patients with a specialist, as needed, within the organization.

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?

Our core method of sharing medical records of a patient's visit at one our alternative care sites with their primary care provider (PCP) is through fax. However, we do offer interoperable electronic health record capabilities with our employed primary care practices. A majority of our providers are able to document during the patient visit at the alternative care site, which allows them to send the medical records to the patient's PCP shortly after their visit. If there is a more urgent need for the patient to follow up with their PCP, the staff at the alternative care site may send a note or call the patient's PCP to notify them that they need to follow up with the patient.

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).

Wellforce is developing an integrated suite of convenient care services to help meet the changing expectations and needs of our patient population. **"Wellforce Express Care"** will include 3 options/channels of care for our patients:

1. **Wellforce Express Care On-Line** – patients will effectively have the option of "no-travel" telemed visits for their low acuity ("lights") urgent care needs. We are currently evaluating technology partners and expect to launch our first pilot in late 2018/early 2019.

2. **Wellforce Express Care Walk-In** – in parallel, we will be working with select Primary Care Providers in the Wellforce System to create a true walk-in patient experience in the patient's PCPs office setting. Many PCPs offer same-day office visits but very few offer designated walk-in hours/visits for their current patients. We are benchmarking with systems across the country to evaluate and test which models will best meet the true "walk-in experience" for our patients while still being economically viable and operationally seamless for very busy PCP offices.

3. **Wellforce Express Urgent Care** – and finally, like most systems, we will also continue to offer more traditional brick/mortar Urgent Care sites either through expansion of our current owned assets or through carefully selected Urgent Care partners in the market. As noted earlier, Wellforce has a pending agreement with an independent Urgent Care provider who is interested in being strategically aligned with our developing Wellforce Express Care suite of services.

By offering our patients choices to fit their needs and busy lifestyles, we think we may have an opportunity to have a positive influence on the total cost of patient care – keeping the care connected to their PCP will be critical to ensure we are able to avoid duplication, meet patient needs for convenient urgent and light-urgent care needs and avoid the use of higher cost care settings for low acuity (but still urgent) care needs.

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.

With an estimated 150-160 urgent care (including retail clinics) sites available to patients in our Wellforce markets, we don't believe that simply adding more stand-alone urgent care sites is the optimum way to help improve patient access, lower the overall cost of care or improve overall care quality. Patients are demanding choice and control for their family's care which is why we are launching a full suite of services and options (including the markets first truly integrated "no-travel" virtual urgent care experience) – most importantly, we intend to build the program being mindful of both changing patient need as well integrating the care experience with the patient's primary care provider. As we've learned, retail seems to be learning health care faster than health care is learning retail… and this is why we are very focused on the changing needs and expectations of our patient population. We believe we can bring the retail health experience to the physician setting while providing our patients the choice of care setting for their urgent and light-urgent care needs.

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: lack of interoperability with Community Providers

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

Hospitals are bound by regulatory standards that prohibit data sharing. Community agencies are also, in many cases, unable to share data without bi-directional and program specific release forms. This is a huge problem as hospitals/partial programs often will not talk with community providers about patients they service, citing privacy regulations in HIPAA. High Risk patients are not being handed off to the next/ higher level of care. This is disrupts the Community Partner program. Simultaneously, the Department of Mental Health has promulgated regulations that state providers need to discuss cases with outpatient providers. We cannot be responsible for care or costs of care if we cannot get the information needed. According to the DMH and Medicaid, this is a federal issue, which it may be, but providers cannot be responsible if necessary information is inaccessible.

The ability to address health care needs using mobile applications, online learning, and virtual health in conjunction with provider visits in the home would promote cost savings and sustainability.

Providing resources for Community Partners to better engage, manage and be more integrated with providers' EMRs would be very helpful.

Most importantly, increasing available behavioral health services within our local communities would have an enormously positive impact on our members' lives. There are simply not enough access to behavioral health resources within our community and expecting a patient to travel from Lowell to Arlington for services in unrealistic.

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.

   Wellforce does not engage with patients directly; however each of our hospitals and our physician organizations support price transparency and helping consumers make more value based decisions about their healthcare.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**		
	Q2		
	Q3		
	Q4		
CY2017	**Q1**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	TOTAL:		

   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.
   Required Question: 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?
   Required Question: Click here to enter text.

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

a) For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.
Required Question: Click here to enter text.

b) For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

Wellforce is unable to provide this information in a standardized format that will accurately capture the cost and profitability or loss across services lines for these entities.

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.

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					36,266,837	40,058,922	6,128,921		2,474,586						1,132,188
Tufts Health Plan					17,909,186		2,996,830		149,305						214,678
Harvard Pilgrim Health Care					21,363,593		(265,460)		195,511						495,945
Fallon Community Health Plan					3,524,180				84,343						179,537
CIGNA											2,271,210				
United Healthcare											15,793,066				
Aetna											5,113,115				
Other Commercial											12,557,222				
Total Commercial	-	-	-	-	79,063,796	40,058,922	8,860,291	-	2,903,745	-	35,734,613	-	-	-	2,022,348
Network Health											24,440,795				
Neighborhood Health Plan											26,106,257				
BMC HealthNet, Inc.											4,660,115				
Health New England															
Fallon Community Health Plan											706,637				
Other Managed Medicaid											1,493,348				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	57,407,152	-	-	-	-
MassHealth	26,277,439		477,538												
Tufts Medicare Preferred					2,840,200		4,369,898								9,996,604
Blue Cross Senior Options											2,972,689				
Other Comm Medicare											27,524,568				
Commercial Medicare Subtotal	-	-	-	-	2,840,200	-	4,369,898	-	-	-	30,497,257	-	-	-	9,996,604
Medicare											114,292,242				1,106,195
Other											28,225,076				
GRAND TOTAL	26,277,439	-	477,538	-	81,903,996	40,058,922	########	-	2,903,745	-	266,156,339	-	-	-	13,125,147

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					#########	#########	825,982		5,337,628						1,092,174	
Tufts Health Plan					#########		1,201,395		149,810						355,431	
Harvard Pilgrim Health Care					#########		2,030,194		334,777						606,678	
Fallon Community Health Plan					3,511,999		54,380		153,642						376,076	
CIGNA											2,892,644					
United Healthcare											15,125,278					
Aetna											5,175,568					
Other Commercial											14,408,129					
Total Commercial	-	-	-	-	#########	#########	4,111,951	-	5,975,857	-	37,601,619	-	-	-	2,430,359	
Network Health											27,710,054					
Neighborhood Health Plan											25,262,009					
BMC HealthNet, Inc.											5,413,697					
Health New England																
Fallon Community Health Plan											1,886,627					
Other Managed Medicaid											1,380,257					
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	61,652,644	-	-	-	-	
MassHealth	#########		450,000													
Tufts Medicare Preferred					1,948,949		4,438,964								#########	
Blue Cross Senior Options											1,399,944					
Other Comm Medicare											30,267,884					
Commercial Medicare Subtotal	-	-	-	-	1,948,949	-	4,438,964	-	-	-	31,667,828	-	-	-	#########	
Medicare											112,708,860				1,652,176	
Other											35,678,411					
GRAND TOTAL	#########	-	450,000	-	#########	#########	8,550,915	-	5,975,857	-	279,309,362	-	-	-	#########	453,767,685

Tufts Medical Center

2016

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	HPIP	Notes:
	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			
BCBSMA	35,974,869	63,024,465	1,810,287	3,171,446												103,981,067	4.791%	
Tufts					50,751,692		-				-					50,751,692		do not distinguish HMO v. PPO, reported all as HMO
HPHC	51,724,770		188,564													51,913,334	0.38%	do not distinguish HMO v. PPO, reported all as HMO
Fallon												4,945,029				4,945,029		no delineation by product, reprt as PPO
CIGNA												6,166,409				6,166,409		no delineation by product, reprt as PPO
United												16,755,590				16,755,590		no delineation by product, reprt as PPO
Aetna												8,655,392				8,655,392		no delineation by product, reprt as PPO
Other Commercial												24,449,091				24,449,091		no delineation by product, reprt as PPO (include urn-trans
Total Commercial	87,699,639	63,024,465	1,998,851	3,171,446	50,751,692	-	-	-	-	-	-	60,971,510	-	-	-			
																-		
Network Health											25,207,428					25,207,428		do not distinguish HMO v. PPO, reported all as HMO
NHP											31,211,082					31,211,082		do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											12,045,114					12,045,114		do not distinguish HMO v. PPO, reported all as HMO
Fallon											447,046					447,046		do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											68,910,670							
																-		
Mass Health		53,067,542		865,802										1,500,000		55,433,344		classified all as PPO
																-		
Tufts Medicare Preferred					14,431,259		-									14,431,259		do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											6,284,431					6,284,431		do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											21,065,385					21,065,385		do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					14,431,259						27,349,817							
																-		
Medicare												164,072,537				164,072,537		classified all as PPO
																-		
All Other Payors												37,307,772			2,550,000	39,857,772		includes Comm Conn + GIC + Wcomp+ OOState Mediciaid ·
GRAND TOTAL	87,699,639	116,092,007	1,998,851	4,037,248	65,182,951	-	-	-	-	-	96,260,486	262,351,820	-	1,500,000	2,550,000	637,673,003		

Tufts Medical Center

2017

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	HPIP %	Notes:
	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			
BCBSMA	40,929,338	71,970,471	1,797,407	3,160,575												117,857,791	4.207%	
Tufts					55,762,545		-				-					55,762,545		do not distinguish HMO v. PPO, reported all as HMO
HPHC	48,588,529		246,779													48,835,308	0.53%	do not distinguish HMO v. PPO, reported all as HMO
Fallon												4,508,480				4,508,480		no delineation by product, reprt as PPO
CIGNA												5,774,216				5,774,216		no delineation by product, reprt as PPO
United												17,197,073				17,197,073		no delineation by product, reprt as PPO
Aetna												8,345,972				8,345,972		no delineation by product, reprt as PPO
Other Commercial												21,274,646				21,274,646		no delineation by product, reprt as PPO
Total Commercial	89,517,867	71,970,471	2,044,186	3,160,575	55,762,545	-	-	-	-	-	-	57,100,388	-	-	-	-		
																-		
Network Health											30,283,180					30,283,180		do not distinguish HMO v. PPO, reported all as HMO
NHP											30,924,292					30,924,292		do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											13,904,742					13,904,742		do not distinguish HMO v. PPO, reported all as HMO
Fallon											1,501,399					1,501,399		do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											76,613,613							
																-		
Mass Health		55,694,299		2,516,353										1,500,000		59,710,652		classified all as PPO
																-		
Tufts Medicare Preferred					13,783,082		-									13,783,082		do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											5,778,000					5,778,000		do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											24,575,195					24,575,195		do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					13,783,082						30,353,194							
																-		
Medicare												169,908,788				169,908,788		classified all as PPO
																-		
All Other Payors												40,214,676			3,370,146	43,584,822		includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	89,517,867	127,664,770	2,044,186	5,676,928	69,545,627	-	-	-	-	-	106,966,808	267,223,852	-	1,500,000	3,370,146	673,510,184		