MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 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 (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines 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.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 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 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, 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 25, 2019, 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 the Suffolk University website. 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 available via livestream and video will be 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 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 page on 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 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 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.**

On or before the close of business on **September 20, 2019**, 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.

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 or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced 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 strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

Acton Medical is committee to lowering overall TME by pursuing the following initiatives, strategies and activities:

- **We have staff dedicated to managing transitional care for hospital discharges from hospitals and SNFs. This program will ensure that patients are receiving appropriate and timely follow-up care, discharge instructions are understood and being followed, prescriptions are filled and medications are taken per instructions, and specialty and rehabilitation referrals are generated. This should result in a reduction of hospital readmissions thereby reducing TME.**
- **We have expanded our support staff by adding an additional FTE Licensed Independent Clinical Social Worker, 2 FTE nurse practitioners, and 0.5 Registered Nutritionist. These support staff will reduce unnecessary visits to emergency facilities, provide support for patients with newly diagnosed illnesses, and reduce the need for specialty services.**
- **Our practice recently completed a conversion of our imaging PACS system to join our community hospital's system. Although this will increase the costs to our practice, patients and overall TME will be reduced by eliminating the need for duplicative studies since the hospital and community specialists will have access to these images.**
- **Our Quality Assurance department has been expanded to include all patients regardless of insurance. Although we are not compensated for most of these services, we feel that it is important that all patients received reminders for recommended screenings and to follow-up on care needs to reduce preventable diseases and manage chronic conditions.**

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

Acton Medical believes that the following changes would result in reduced health care expenditures:

- Primary care physicians should receive adequate compensation for providing telemedicine services. Massachusetts is one of the few remaining states that does not mandate reimbursement for these services.

- Patients, regardless of insurance, should be mandated to choose a primary care physician and to coordinate their primary, specialty, and tertiary care with that PCP.

These patients would then receive necessary preventive services, recommended health screenings, timely vaccinations, and prescription reconciliations and management.

- Massachusetts and the federal government should consider ways to reduce the administrative burdens for physicians, which we believe would result in expanded services for patients. Burn-out and fatigue reduces physicians ability to provide timely services to patients.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

- **Acton Medical is committed to a patient centered medical home philosophy and has consistently maintained annual accreditation.**
- **Acton Medical has a rigorous quality department that is dedicated to several initiatives with the goal of improving quality of care and reducing health care costs. Some of these initiatives include:**
  - **Pre-visit planning for diabetic patients to prevent gaps in care**
  - **Controlling High Blood Pressure in patients with hypertension**
  - **Transitional Care Management to avoid readmission**
  - **Behavioral Health screenings**
- **Nurse Practitioners are available to see patients on a same-day basis, increasing access to patients who need urgent appointments. NP's also provide support to patients by providing advice and test results over the phone, reducing the total cost of care by avoiding unnecessary appointments.**

b. Please describe your organization's top strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

- **Behavioral Health Screenings (PHQ9 or PHQ2) are administered at all physical appointments.**
- **Transitions of care after mental health-related hospitalizations are closely monitored by the social workers, allowing for smoother follow up after hospitalization, and ensuring appropriate follow up with mental health providers and primary care physicians.**
- **An additional Social Worker was hired in 2019. Social workers provide much needed support to patients who require therapy, social services, elder care in the home, or transition to hospice. Social work support is**

vital in improving healthcare quality and cost, by assessing a patient's immediate and long-term needs, and best preparing for future needs with appropriate support and services.

- **Maternal Depression screenings are administered at all well visit appointments to parents of children ages 2 weeks and 2 months.**

c. Payers may also provide incentives or other supports to provider organizations to deliver high-functioning, high-quality, and efficient primary care and to improve behavioral health access and quality. What are the top contract features or payer strategies that are or would be most beneficial to or most effective for your organization in order to strengthen and support primary and behavioral health care?

- **Providing claims data would be helpful in our efforts to achieve seamless coordination of care, since we are a primary care practice that relies on quality and cost information to guide referrals to specialist.**
- **Reimbursement for primary care services should be increased, since adequate payment for services allows patients and providers the time and resources to focus on preventive care. Preventive medicine allows for early and appropriate treatment of health conditions that could later be life-threatening. For example, diagnosing and treating high blood pressure early avoids later complications of untreated high blood pressure, such as heart attack, stroke, and kidney disease.**
- **Quality initiatives should be generously reimbursed, since they are administrative and technical undertakings that can be expensive but worthwhile for patients.**
- **Telemedicine should be reimbursed, allowing patients to have easier access to their providers.**

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

- **There should be incentives at a state level to encourage medical residents in training to enter primary care. For example, the University of Massachusetts Medical School Learning Contract allowed medical students to have a reduced educational cost, if they practiced primary care in Massachusetts for a set period of time.**
- **Tuition reimbursement, loan repayment, and competitive salaries are incentives that could be enacted at a state level, to encourage residents to practice primary care in Massachusetts.**

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications.

Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Minor Contributing Factor
Aging of your patients	Major Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Major Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	Not a Significant Factor

☐ Not applicable; neither risk scores nor acuity have increased for my patients in recent years.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	Low
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Low
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	High

Area of Administrative Complexity	Priority Level
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Low
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Low
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Low
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Low
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Low
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Low
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

5. STRATEGIES TO SUPPORT ADOPTION AND EXPANSION OF ALTERNATIVE PAYMENT METHODS:

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.**

- ☐ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☒ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☐ Encouraging non-Massachusetts based payers to expand APMs in Massachusetts
- ☐ Identifying strategies and/or creating tools for overcoming problems related to small patient volume
- ☒ Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)
- ☐ Aligning payment models across payers and products
- ☐ Enhancing provider technological infrastructure
- ☒ Other, please describe: **stopgap**

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 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.
   Please see Excel document included in submission.
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 Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	Not Recorded	N/A
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	Q3		
	Q4		
CY2019	**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.
   Acton Medical, upon request, will direct insured patients to the member service number on the back of their card if they have questions regarding their coverage. Uninsured patients, upon request, are provided with our office visit charges. Patients typically inquire with our billing department regarding the cost of a physical, immunization, labs and ultrasound. Acton Medical does not track the number or type of inquiries for patients who are requesting price information.

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?
No barriers are present.

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

Not corporately affiliated.

a. For each year **2016 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.

b. For **2018 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.

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.

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			373,457						388,054		2,168,718	2,876,720			
Tufts Health Plan					734,766		670,202					1,144,143	92,776		
Harvard Pilgrim Health Care					46,017		(175,998)		35,485			2,719,817	31,858		
Fallon Community Health Plan					745,856		186,231					18,349	32,210		
CIGNA												164,039			
United Healthcare												955,185	824		
Aetna												638,922	47,815		
Other Commercial												78,951			12,109
Total Commercial	0	0	373456.7	0	1526639	0	680434.85	0	423539.34	0	2168718	8596126	205482.82	0	12109
Network Health															
Neighborhood Health Plan												62			
BMC HealthNet, Inc.															
Health New England												45			
Fallon Community Health Plan												3,797			
Other Managed Medicaid												5,249			
Total Managed Medicaid	0	0	0	0	0	0	0	0	0	0	0	9153	0	0	0
MassHealth	0	0	0	0	0	0	0	0	0	0	0	372,734	0	0	0
Tufts Medicare Preferred					299,109		667,097						567,986		
Blue Cross Senior Options															
Other Comm Medicare												6,695			
Commercial Medicare Subtotal	-	-	-	-	299,109	-	667,097	-	-	-	-	6,695	567,986	-	-
Medicare	0	0	0		0	0	0	0	0	0	0	1,744,315	76060	0	0
Other												331,594			
GRAND TOTAL	-	-	373,457	-	1,825,748	-	1,347,532	-	423,539	-	2,168,718	11,060,617	849,529	-	12,109

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	-	-		-	-	-	-	-	-	-	2,058,542	2,937,568	18,252	-	-
Tufts Health Plan	-	-	-	-	667,020	-	654,605	-	13,450	-	-	1,158,101	86,073	-	-
Harvard Pilgrim Health Care	-	-	-	-	42,015	-		-	33,059	-	-	2,644,246	30,025	-	-
Fallon Community Health Plan	-	-	-	-	699,821	-	154,000	-				19	30,017		
CIGNA												174,122			
United Healthcare												984,476	232		
Aetna												585,919	40,825		
Other Commercial							21,037					69,654			8,731
Total Commercial	-	-	-	-	1,408,856	-	829,642	-	46,509	-	2,058,542	8,554,105	205,424	-	8,731
Network Health												2,860			
Neighborhood Health Plan												490			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan												342			
Other Managed Medicaid															
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	3,692	-	-	-
MassHealth												382,767			
Tufts Medicare Preferred					269,270		293,563						600,932		
Blue Cross Senior Options															
Other Comm Medicare												3,541			
Commercial Medicare Subtotal	-	-	-	-	269,270	-	293,563	-	-	-	-	3,541	600,932	-	-
Medicare												1,709,943	3,697		
Other												326,811			
GRAND TOTAL	-	-	-	-	1,678,126	-	1,123,205	-	46,509	-	2,058,542	10,980,859	810,053	-	8,731

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											1,938,991	2,919,047	318,209		
Tufts Health Plan					643,266		1,001,997		13,450			1,129,888	85,881		
Harvard Pilgrim Health Care					50,104		(39,872)		30,265			2,502,676	25,086		
Fallon Community Health Plan					901,479		155,171					23,771	34,892		
CIGNA												168,501			
United Healthcare												1,101,947			
Aetna												679,998	42,624		
Other Commercial												76,837			8,932
Total Commercial	-	-	-	-	1,594,849	-	1,117,296	-	43,715	-	1,938,991	8,602,665	506,692	-	8,932
Network Health												5,335			
Neighborhood Health Plan												848			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan												685			
Other Managed Medicaid												1,910			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	8,778	-	-	-
MassHealth												364,693			
Tufts Medicare Preferred					260,142		152,926						671,156		
Blue Cross Senior Options															
Other Comm Medicare												3			
Commercial Medicare Subtotal	-	-	-	-	260,142	-	152,926	-	-	-	-	3	671,156	-	
Medicare										455		1,847,510	534		
Other												386,186			
GRAND TOTAL	-	-	-	-	1,854,991	-	1,270,222	-	43,715	455	1,938,991	11,209,835	1,178,382	-	8,932

AGO Provider Exhibit 1

2018	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											2,116,780	3,212,550	325,831		
Tufts Health Plan					641,149		242,729					1,294,224	88,687		
Harvard Pilgrim Health Care					66,839				39,523			2,348,802	22,389		
Fallon Community Health Plan					787,690							32,136	29,204		
CIGNA												211,252			
United Healthcare												1,227,642			
Aetna												789,073	31,293		
Other Commercial												86,980			10,314
Total Commercial	-	-	-	-	1,495,678	-	242,729	-	39,523	-	2,116,780	9,202,659	497,404	-	10,314
Network Health												3,740			
Neighborhood Health Plan												1,403			
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan												390			
Other Managed Medicaid												2,186			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	7,719	-	-	-
MassHealth												397,382			
Tufts Medicare Preferred					267,249		443,242						705,242		
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal	-	-	-	-	267,249	-	443,242	-	-	-	-	-	705,242	-	-
Medicare												1,961,945			
Other												527,195			
GRAND TOTAL	-	-	-	-	1,762,927	-	685,971	-	39,523	-	2,116,780	12,096,900	1,202,646	-	10,314