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?

Effective <u>vendor agreements</u> for items most used in delivering care. Drug costs, linen's, food, cleaning companies, routine maintenance and emergency repairs and maintenance must be handled by vendors with efficient operations offering quality services and reasonable pricing.

Effective recruiting, training and retention of necessary direct care staff. Success in these areas reduces overtime, and turnover costs.

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

For inpatient behavioral health care, the current system for court ordered medications can be lengthy and filled with repeated delays. Changes of current practices and procedures could speed up hearings being held and speed up medications being ordered and given to the patients. This would reduce the duration of expensive inpatient care.

Price controls on manufactures for medications necessary to stabilize patients experiencing severe psychotic episodes.

Greater access to community based resources for patients stepping down from inpatient care. Currently, discharges are often delayed until a community based provider is found that will accept a patient with an extensive psychiatric history.

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.

Primary Care Physicians are identified for inpatient admissions and contact is made for input into treatment and care.

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.

New outpatient levels of service have been added, and existing outpatient capacity levels have been increased each year to reduce the need for inpatient care and to reduce the length of stay in inpatient care.

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?

Currently, agencies that accept hospital step downs are the same agencies that accept patients to prevent hospitalization. Payers could improve the timeliness of hospital step-downs by contracting agencies and establishing a network that only accept step-downs. Many step down patients are prioritized behind "prevention of hospitalization" patients with current 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?

Increased efforts in making more stable housing available faster would decrease the need for behavioral health inpatient hospitalizations and the need for extended inpatient stays. Currently patients become stable in the hospital setting, but a discharge to a shelter environment would eliminate all gains and poses a threat to the health of the patient.

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	Major Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Not a Significant Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Not a Significant Factor
New, relatively less healthy patients entering your patient pool	Major Contributing Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant 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	High
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	High
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
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	High

Area of Administrative Complexity	Priority Level
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	High
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	High
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	High
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	High
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	High
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: Click here to enter text.

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.

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. **See Attachments**

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**		
	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.
    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?
    Click here to enter text.

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

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											467,086	x			
Tufts Health Plan											163,409	x			
Harvard Pilgrim Health Care											479,712	x			
Fallon Community Health Plan											0	x			
CIGNA											184,315	x			
United Healthcare											0	x			
Aetna											225,442	x			
Other Commercial											6,432,462	x			
Total Commercial											7,952,426	x			
Network Health											3,250,466	x			
Neighborhood Health Plan											3,025,843	x			
BMC HealthNet, Inc.											2,296,232	x			
Health New England											0	x			
Fallon Community Health Plan											290,646	x			
Other Managed Medicaid - MBHP, etc											7,492,922	x			
Total Managed Medicaid											16,356,109	x			
MassHealth											2,836,052	x			
Tufts Medicare Preferred												x			
Blue Cross Senior Options												x			
Other Comm Medicare												x			
Commercial Medicare Subtotal												x			
Medicare											10,388,806	x			
Other												x			
GRAND TOTAL											37,533,393	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											655,251	x			
Tufts Health Plan											174,162	x			
Harvard Pilgrim Health Care											846,918	x			
Fallon Community Health Plan											0	x			
CIGNA											212,823	x			
United Healthcare											383,045	x			
Aetna											6,159	x			
Other Commercial											1,657,635	x			
Total Commercial											3,935,993	x			
Network Health											3,191,207	x			
Neighborhood Health Plan											3,795,230	x			
BMC HealthNet, Inc.											2,588,945	x			
Health New England											0	x			
Fallon Community Health Plan											401,782	x			
Other Managed Medicaid											9,824,579	x			
Total Managed Medicaid											19,801,743	x			
MassHealth											2,501,332	x			
Tufts Medicare Preferred												x			
Blue Cross Senior Options												x			
Other Comm Medicare											1,751,557	x			
Commercial Medicare Subtotal											1,751,557	x			
Medicare											8,682,321	x			
Other												x			
GRAND TOTAL											36,672,946	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											793,944	x			
Tufts Health Plan											258,924	x			
Harvard Pilgrim Health Care											1,153,145	x			
Fallon Community Health Plan											0	x			
CIGNA											211,236	x			
United Healthcare											895,024	x			
Aetna											0	x			
Other Commercial											1,232,659	x			
Total Commercial											4,544,932	x			
Network Health											3,831,777	x			
Neighborhood Health Plan											3,646,712	x			
BMC HealthNet, Inc.											2,856,335	x			
Health New England											0	x			
Fallon Community Health Plan											379,520	x			
Other Managed Medicaid											9,571,290	x			
Total Managed Medicaid											20,285,634	x			
MassHealth											2,764,341	x			
Tufts Medicare Preferred												x			
Blue Cross Senior Options												x			
Other Comm Medicare											2,732,332	x			
Commercial Medicare Subtotal												x			
Medicare											11,338,806	x			
Other												x			
GRAND TOTAL											41,666,044	x			

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											851,415	x			
Tufts Health Plan											197,902	x			
Harvard Pilgrim Health Care											535,266	x			
Fallon Community Health Plan											0	x			
CIGNA											228,047	x			
United Healthcare											452,035	x			
Aetna											0	x			
Other Commercial											3,095,074	x			
Total Commercial											5,359,738	x			
Network Health											4,232,798	x			
Neighborhood Health Plan											355,267	x			
BMC HealthNet, Inc.											570,642	x			
Health New England											0	x			
Fallon Community Health Plan											309,339	x			
Other Managed Medicaid											14,328,317	x			
Total Managed Medicaid											19,796,363	x			
MassHealth											3,838,329	x			
Tufts Medicare Preferred												x			
Blue Cross Senior Options												x			
Other Comm Medicare											3,192,779	x			
Commercial Medicare Subtotal											3,192,779	x			
Medicare											10,176,531	x			
Other												x			
GRAND TOTAL											42,363,740	x			

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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											893,471				
Tufts Health Plan											59,934				
Harvard Pilgrim Health Care											388,016				
Fallon Community Health Plan											0				
CIGNA											321,098				
United Healthcare											0				
Aetna											7,645				
Other Commercial											1,433,770				
Total Commercial											3,103,934				
Network Health											2,211,890				
Neighborhood Health Plan											2,716,099				
BMC HealthNet, Inc.											1,921,303				
Health New England											0				
Fallon Community Health Plan											95,963				
Other Managed Medicaid											6,981,593				
Total Managed Medicaid											13,926,848				
MassHealth											918,488				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											593,027				
Commercial Medicare Subtotal											593,027				
Medicare											6,405,130				
Other											4,005				
GRAND TOTAL											24,951,432				

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											954,417				
Tufts Health Plan											76,232				
Harvard Pilgrim Health Care											447,096				
Fallon Community Health Plan											2,432,954				
CIGNA											365,591				
United Healthcare											0				
Aetna											69,611				
Other Commercial											4,310,971				
Total Commercial											8,656,872				
Network Health											2,758,837				
Neighborhood Health Plan											0				
BMC HealthNet, Inc.											469,186				
Health New England											0				
Fallon Community Health Plan											905,056				
Other Managed Medicaid									23,999	0	6,703,427				
Total Managed Medicaid									23,999	0	10,836,506				
MassHealth											713,103				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											581,036				
Commercial Medicare Subtotal											581,036				
Medicare											6,190,341				
Other											-499,759				
GRAND TOTAL									23,999	0	26,478,099				

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											1,140,090				
Tufts Health Plan											471,100				
Harvard Pilgrim Health Care											480,042				
Fallon Community Health Plan											261,042				
CIGNA											170,869				
United Healthcare											0				
Aetna											128,855				
Other Commercial											2,216,751				
Total Commercial											4,868,749				
Network Health											2,983,101				
Neighborhood Health Plan											2,850,219				
BMC HealthNet, Inc.											2,773,894				
Health New England											0				
Fallon Community Health Plan											84,246				
Other Managed Medicaid									145,866	0	6,862,838				
Total Managed Medicaid									145,866		15,554,298				
MassHealth											834,328				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											1,425,014				
Commercial Medicare Subtotal											1,425,014				
Medicare											7,496,621				
Other											-150,533				
GRAND TOTAL									145,866		30,028,477				

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											1,678,987				
Tufts Health Plan											327,016				
Harvard Pilgrim Health Care											570,792				
Fallon Community Health Plan											184,612				
CIGNA											242,607				
United Healthcare											0				
Aetna											120,293				
Other Commercial											1,814,979				
Total Commercial											4,939,286				
Network Health											2,833,471				
Neighborhood Health Plan											876,123				
BMC HealthNet, Inc.											5,460,803				
Health New England											0				
Fallon Community Health Plan											648,566				
Other Managed Medicaid											8,727,378				
Total Managed Medicaid											18,546,341				
MassHealth											587,949				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											1,914,271				
Commercial Medicare Subtotal											1,914,271				
Medicare											8,209,161				
Other											74,554				
GRAND TOTAL											34,271,562				

AGO Provider Exhibit 2

Hospital 1 **Please note: hospital does not track margin by payer**

Service Category	Commercial				Medicare				Medicaid				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns																				
Cardiology Total																				
Invasive																				
Medical																				
Cardiac Surgery																				
Dental																				
Dermatology																				
Endocinology																				
Gastroenterology																				
General Medicine																				
General Surgery																				
Gynecology																				
Hematology																				
Infectious Disease																				
Neonatology																				
Nephrology																				
Neurology																				
Neurosurgery																				
Normal Newborns																				
Obstetrics																				
Oncology																				
Ophthalmology																				
Orthopedics																				
Otolaryngology																				
Psychiatry																	$35m	$3m	$6.5m	$.5m
Pulmonary																				
Rehab																				
Rheumatology																				
Transplant Surgery																				
Trauma																				
Urology																				
Vascular Surgery																				
Other Inpatient																				
Imaging																				
Other Treatments																				
Laboratory																				
Ambulatory Surgery																				
Therapies																				
Office Visits																				
Observation																				
Other Outpatient																				
GRAND TOTAL																	$35m	$3m	$6.5m	$.5m

AGO Provider Exhibit 2

Hospital 2 **Please note: hospital does not track margin by payer**

Service Category	Commercial				Medicare				Medicaid				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns																				
Cardiology Total																				
Invasive																				
Medical																				
Cardiac Surgery																				
Dental																				
Dermatology																				
Endocinology																				
Gastroenterology																				
General Medicine																				
General Surgery																				
Gynecology																				
Hematology																				
Infectious Disease																				
Neonatology																				
Nephrology																				
Neurology																				
Neurosurgery																				
Normal Newborns																				
Obstetrics																				
Oncology																				
Ophthalmology																				
Orthopedics																				
Otolaryngology																				
Psychiatry																	$25m	$4m	$9m	$1.4m
Pulmonary																				
Rehab																				
Rheumatology																				
Transplant Surgery																				
Trauma																				
Urology																				
Vascular Surgery																				
Other Inpatient																				
Imaging																				
Other Treatments																				
Laboratory																				
Ambulatory Surgery																				
Therapies																				
Office Visits																				
Observation																				
Other Outpatient																				
GRAND TOTAL																	$25m	$4m	$9m	$1.4m