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
# CleanSlate Centers

## 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?
**CleanSlate is an integrated behavioral health addiction medicine practice that takes into account our patients' whole health needs. To that end, every patient is assessed not only for their substance use disorder but also for their behavioral health and physical health needs and referred to care with primary care and behavioral health specialists. By supporting patients across the spectrum of their health care needs and engaging them in preventive care (naloxone distribution, counseling), we believe we are supporting reduced emergency room visits and in-patient stays for addiction-related physical illnesses. Moreover, we screen and treat for Hepatitis C, to reduce patients' burdens on finding care elsewhere, including in emergency rooms or hospital stays for unattended Hep C-related physical illness.**

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?
**Permitting and paying for substance use disorder treatment, both the medical and behavioral health visits, via telemedicine would allow patients to obtain treatment when transportation, work schedules and other practical or physical barriers might prevent them from obtaining care otherwise.**

## 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.
**CleanSlate's (CS) clinical model and numerous initiatives dramatically improve access to and quality of care as well as decreases the total cost of care by providing both preventative medicine and treatment to those with substance use disorder(s).**

**Additionally, our patient's primary care health management is paramount on initial evaluations and physicals and remains an ongoing focus throughout their treatment course. All patients are screened for primary care needs during their physicals and routinely encouraged to engage with primary care providers with whom we work in our communities. Our program is organized to best attend to patient convenience, each patient's unique needs and to the unique needs of our provider partners in the community. Specific examples of these different initiatives are as follows:**

**CS accepts walk-in's, makes same-day appointments, has extended hours, and rapidly initiates life-saving treatment in all its centers as it's critical to provide care when a person is ready. Combined with our expertise in managing patients with wide-ranging acuity (severity of disease), CS reduces utilization of powerful drivers of high cost rescue care including ER, inpatient detox, and inpatient psych/medical stays.**

**CS has long been a leader in the provision of rapid access to high quality care for pregnant women. Our pregnant patients have high retention in care, resulting in full term healthy deliveries. This avoids very costly NICU and prolonged neonatal inpatient stays. CS providers work closely with obstetricians and support holistic supportive management of neonatal withdrawal syndrome (NWS). CS providers also provide continuous counseling to our pregnant patients decreasing risky behaviors and educating them about NSW, which demystifies this temporary and highly manageable condition. Armed with the knowledge that recovery has bestowed great health to their newborns and that NWS is manageable, new moms can confidently bond with their babies.**

**Furthermore, CS has programs with many hospitals and emergency rooms local to our sites to support initiation of medication-assisted treatment and to make real-time warm handoffs for immediate and direct entrance into CS program.**

**CS provides drug and alcohol counseling and care coordination in all our MA sites to ensure patient care and social support needs are comprehensively met. We work with an extensive network of primary care providers, obstetricians, and community supports directly facilitating and arranging care, transportation, and assistance with housing, food and employment. We also arrange for higher levels of care as needed. Every medical visit also includes screening for patient access to primary care and higher intensity behavioral health services.**

**All initial evaluations and re-joins to our program include infectious disease (HIV, Hepatitis C, and Hepatitis B) and medical screening to ensure that acute needs are addressed and, in the case of Hepatitis C, to offer direct treatment. Infectious disease serology is repeated once at 6 months and annually according to USPTF recommendations.**

**CS directly provides integrated curative treatment of chronic Hepatitis C that has also been proven to improve our patients' retention in care and decrease their illicit drug use per tox screens. Directly integrating Hepatitis C treatment into our addiction treatment visits has resulted in very high compliance with medication regimens, further decreasing cost of care by ensuring that maximum benefit is delivered to patients receiving them.**

**Shortly, in 2019, CS will also offer Hepatitis B and Hepatitis A Vaccine in accordance with clinical guidelines for the care of those with Hepatitis C and IV drug use.**

**All CleanSlate's clinical guidelines are based upon continuous review of clinical evidence.**

**CleanSlate provides the highest quality care as demonstrated with BSAS licensing. In 2020, CleanSlate will also become CARF accredited.**

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.
**Since inception, CS has utilized behavioral health techniques including motivational interviewing and cognitive behavioral therapy in all medical visits in addition to requiring concurrent engagement in recovery activities such as therapy and/or 12-step programming. For years CS has provided groups, care coordination and licensed drug and alcohol counseling in all our MA sites and across the nation.**

**In 2019, CS added Licensed Clinical Social Workers to provide therapy and to support expansion of our behavioral health workforce to become a fully integrated medical-behavioral health care provider and provide the full spectrum of addiction treatment and care on site to our patients. As with Hepatitis C, directly integrating behavioral health care dramatically improves access to needed treatment thereby decreasing reliance on emergency and high acuity 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?
**CleanSlate has identified the following five payer strategies as that would be most beneficial to our organization to support behavioral health care:**
**Bundled payments for all services, not just for select services; Value-based payment options; Collaboration of performance metrics based on both payor and provider data; Help in identifying members that are not getting appropriate care and redirecting those members to providers who have proven to provider high quality, appropriate cost options; Incentivizing providers to he both medical and behavioral health services by investing in them and offering to provide incentives for expanding both scope of care and service areas.**

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?
**Expansion of telemedicine (and paying for same) would be very helpful in providing behavioral health and addiction medicine services, given the shortage of providers across both fields and the transportation barriers facing our more rural patients. One policy in support of increased access could be to allow well supervised but less credentialed behavioral health providers to provide and bill for these services. Additionally, addressing driver's license revocation and remediation fees would reduce transportation barriers due to these penalties. And, finally, clarity around**

**which provider types and under what circumstances, providers can provide reimbursable behavioral health services would support more providers engaging in this type of care and facilitate patients accessing it when and where they need it.**

## 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 | Not a Significant Factor |
| Aging of your patients | Not a Significant Factor |
| New or improved EHRs that have increased your ability to document diagnostic information | Minor Contributing Factor |
| Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information) | Minor 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) | Not a Significant Factor |
| Other, please describe:<br>Click here to enter text. | Level of Contribution |

☐ 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 | Medium |

| Area of Administrative Complexity | Priority Level |
|---|---|
| **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 | Medium |
| **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 | High |
| **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 | Medium |
| **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 | Medium |
| **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. **Please see that attached AGO Provider Exhibit 1 CleanSlate. The data presented was pulled from our old revenue database which does not consistently distinguish between lines of service for all health plans. For example, it was difficult to distinguish which Fallon Community Health Plan claims were for the commercial plan or for the Medicaid managed care plan. Similarly, we could not consistently distinguish between PPO and HMO revenue. We are in the process of transitioning to a new revenue database that will be able to parse the data more specifically, going forward.**

3. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   **We do not collect this data.**

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

| Health Care Service Price Inquiries<br>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.

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

**These questions are not applicable to CleanSlate.**

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**

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**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 | X | X | X | X | $30M | X | ($0.50) | X | $0.50 | X | X | $40M | X | X | $10M |
| Tufts Health Plan | $15M | $7M | $0.3M | 0 | X | X | X | X | X | X | X | X | $0.25M | X | X |
| Harvard Pilgrim Health Care | | | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | | | | | |
| CIGNA | | | | | | | | | | | | | | | |
| United Healthcare | | | | | | | | | | | | | | | |
| Aetna | | | | | | | | | | | | | | | |
| Other Commercial | | | | | | | | | | | | | | | |
| ***Total Commercial*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | | | | | |
| Neighborhood Health Plan | | | | | | | | | | | | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | | | | | |
| Health New England | | | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | | | | | |
| Other Managed Medicaid | | | | | | | | | | | | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| ***MassHealth*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | | | | | |
| Blue Cross Senior Options | | | | | | | | | | | | | | | |
| Other Comm Medicare | | | | | | | | | | | | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| ***Other*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | | | | | | | | | | | | | | | |

| 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 | | | | | | | | | | | | | | | |
| Tufts Health Plan | | | | | | | | | | | | | | | |
| Harvard Pilgrim Health Care | | | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | | | | | |
| CIGNA | | | | | | | | | | | | | | | |
| United Healthcare | | | | | | | | | | | | | | | |
| Aetna | | | | | | | | | | | | | | | |
| Other Commercial | | | | | | | | | | | | | | | |
| ***Total Commercial*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | | | | | |
| Neighborhood Health Plan | | | | | | | | | | | | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | | | | | |
| Health New England | | | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | | | | | |
| Other Managed Medicaid | | | | | | | | | | | | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| ***MassHealth*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | | | | | |
| Blue Cross Senior Options | | | | | | | | | | | | | | | |
| Other Comm Medicare | | | | | | | | | | | | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| ***Other*** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | | | | | | | | | | | | | | | |

| 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 | | | | | | | | | | | 4,057,921 | | | | |
| Tufts Health Plan | | | | | | | | | | | 7,420,095 | | | | |
| Harvard Pilgrim Health Care | | | | | | | | | | | 4,860 | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 34,540 | | | | |
| CIGNA | | | | | | | | | | | 733,586 | | | | |
| United Healthcare | | | | | | | | | | | 65,740 | | | | |
| Aetna | | | | | | | | | | | 268,730 | | | | |
| Other Commercial | | | | | | | | | | | 26,698,415 | | | | |
| ***Total Commercial*** | | | | | | | | | | | 39,283,887 | | | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | - | | | | |
| Neighborhood Health Plan | | | | | | | | | | | 27,060 | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | 1,148,830 | | | | |
| Health New England | | | | | | | | | | | 6,656,950 | | | | |
| Fallon Community Health Plan | | | | | | | | | | | - | | | | |
| Other Managed Medicaid | | | | | | | | | | | 1,032,810 | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | 8,865,650 | | | | |
| | | | | | | | | | | | | | | | |
| ***MassHealth*** | | | | | | | | | | | 7,398,232 | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | 85,350 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | - | | | | |
| Other Comm Medicare | | | | | | | | | | | 67,290 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | 152,640 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | 9,552,921 | | | | |
| | | | | | | | | | | | | | | | |
| ***Other*** | | | | | | | | | | | - | | | | |
| | | | | | | | | | | | | | | | |

# AGO Provider Exhibit 1

**CleanSlate Centers**

Post Dates from 1/1/18-12/31/18

**This data was pulled from our old revenue database which does not consistently distinguish between lines of service for all health plans. For example, it was difficult to distinguish which Fallon Community Health Plan claims were for the commercial plan or for the Medicaid managed care plan. Similarly, we could not consistently distinguish between PPO and HMO revenue. We are in the process of transitioning to a new revenue database that will be able to parse the data more specifically, going forward.**

| 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 | | | | | | | | | | | 4,408,038 | | | | |
| Tufts Health Plan | | | | | | | | | | | 8,440,983 | | | | |
| Harvard Pilgrim Health Care | | | | | | | | | | | 18,050 | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 2,669,640 | | | | |
| CIGNA | | | | | | | | | | | 1,023,462 | | | | |
| United Healthcare | | | | | | | | | | | 36,890 | | | | |
| Aetna | | | | | | | | | | | 326,400 | | | | |
| Other Commercial | | | | | | | | | | | 25,156,295 | | | | |
| ***Total Commercial*** | | | | | | | | | | | 42,079,759 | | | | |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | - | | | | |
| Neighborhood Health Plan | | | | | | | | | | | 29,290 | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | 1,566,030 | | | | |
| Health New England | | | | | | | | | | | 4,437,124 | | | | |
| Fallon Community Health Plan | | | | | | | | | | | - | | | | |
| Other Managed Medicaid | | | | | | | | | | | 21,640 | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | 6,054,084 | | | | |
| | | | | | | | | | | | | | | | |
| ***MassHealth*** | | | | | | | | | | | 13,139,475 | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | 72,730 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | - | | | | |
| Other Comm Medicare | | | | | | | | | | | 101,534 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | 174,264 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | 10,039,940 | | | | |
| | | | | | | | | | | | | | | | |
| ***Other*** | | | | | | | | | | | - | | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | | | | | | | | | | | 71,487,521 | | | | |