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?
      Click here to enter text.

Reduce emergency department use. As part of a larger effort to provide more efficient, timely and cost-effective care to patients, Dana-Farber established an acute care clinic in September 2018 to manage patients with cancer-related symptoms. The objective has been to change the site of care for patients who would otherwise be seen in the ED and discharged home as well as to decrease the frequency of hospitalization following ED evaluation by providing oncology subspecialized outpatient care.

The model for the clinic was informed by significant external research of similar clinics at other hospitals. It is overseen by medical oncologists and staffed by a multi-disciplinary team including oncology trained nurse practitioners and physician assistants. The clinic offers the same services that are generally available within Dana-Farber's outpatient clinics, including ultrasound, CT, MRI, x-rays, standard labs and ECG.

Since the inception of the clinic, over a 9-month period, Dana-Farber has seen 544 patients with the highest volume being in breast oncology followed by gastrointestinal and thoracic oncology. Some of the reported symptoms for patients have been nausea, fever/chills, and dehydration. 72% of these patients have been discharged home from the acute care clinic. A preliminary analysis has revealed a reduction in ED visits and it is proving to be effective in safely treating oncology patients for several cancer-related symptoms by changing the site of care.

Reduce practice variation. Cancer care has exponentially increased in complexity over the last decade. The introduction of genomics, proteomics and molecular-targeted therapies has dramatically increased the treatment options for most cancer conditions, resulting in a crowded field of treatment options for clinicians. As the speed of the evolution of cancer care increased, the concept of Dana-Farber pathways emerged in 2012 with the goal to provide optimal patient care and treatment and to disseminate these best practices throughout community settings. The identification of this treatment is based on the most up-to-date published evidence, lowest symptom burden, and that which is most cost-effective.

The output of this program is the construction of medical oncology and radiation oncology clinical pathways built into an electronic platform that provides decision support. The effort has continued to evolve and provides enhanced integration with EMRs. This new platform through data capture and analytics is a novel method for enhancing the delivery and ability to learn from the provision of cancer care. We will be able to better partner with our collaborating institutions

to more effectively manage our cancer population clinically, operationally and with financial sensitivity.

Dana-Farber's payers have been extremely supportive of this initiative and are working with us to understand factors affecting treatment choice and how this information can be used to identify patients at high risk, including identifying the need for symptom triage pathways, supportive care, care coordination, and other services.

Shared care model. Another effort Dana-Farber is pursuing is to reduce hospitalizations and provide shared care in a community setting for patients receiving hematopoietic cell transplantation (HCT), commonly known as bone marrow transplantation. HCT is the only potentially curative treatment for many advanced hematologic malignancies and is a highly technical procedure that is only available at select centers in the U.S. For this reason, many patients who undergo HCT live at great distances from their chosen HCT center. Moreover, after hospital discharge, the first 180 days post-HCT are critical. Patients must be watched closely for infections and/or the development of graft-versus-host disease (GVHD) and specialized anti-rejection medications must be tightly managed. For those who live far away, the need for close follow-up for such a long period can cause a great burden in terms of familial finances, impact on caregivers, and compromised quality of life.

Dana-Farber has partnered with the Patient-Centered Outcomes Research Institute (PCORI) to help patients who live far away from our Boston location. In the context of a large randomized clinical trial, we aim to assess the effectiveness of a Shared Care program which allows patients to receive the first half of their post-HCT care at our Boston location and the second half of their post-HCT care with a designated local oncologist who practices closer to where the patients live. Designated local care teams receive intensive training on HCT follow-up care through various mechanisms including a yearly educational symposium. Accrual to the study began in January 2018 and will continue until May 2021. It is expected that 324 patients who live greater than thirty minutes from Boston will participate. The study team follows patients using required data repository outcomes and patient-reported outcomes instruments.

We anticipate that in addition to improving patient and caregiver quality of life and satisfaction, the Shared Care model will potentially reduce the cost of care, as some care may be provided at a lower cost at the local health care facility, and patients will not need to spend as much money out of pocket travelling to our Boston location. This program is part of a greater effort to develop a sustainable and patient-centered long-term follow-up care model for patients and caregivers post-HCT.

Transferring care to the ambulatory setting. Dana-Farber has established an ambulatory HCT service, with our first patient having received reduced-intensity HCT in the outpatient setting in July 2019. Instead of spending an average of 8 days in the inpatient setting, patients who are eligible for an ambulatory HCT visit Dana-Farber's outpatient clinic daily for their chemotherapy and HCT, which we believe is equally as safe as HCTs performed in the inpatient setting. We estimate that in the first year, up to 45 patients may be eligible for this service, amounting to 360 inpatient days avoided. Beyond the benefit of reducing inpatient days, patients benefit from being able to sleep in their own housing.

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

A significant barrier to Dana-Farber's ability to reduce health care expenditures is managing prior authorization requirements for unscheduled clinical services such as imaging or administration of supportive care medications. This creates reimbursement risks for providers, increases administrative costs and introduces potentially unnecessary delays in delivering patient care. As a result, we recommend that health plans waive any prior authorization or referral requirements for established patients to utilize these critical clinical services during an unplanned, urgent visit to Dana-Farber. This is addressed further in section 4.

Dana-Farber also restates its support for passage of the telemedicine bill which would significantly improve our ability to enhance the shared care model.

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

As a specialty cancer hospital, this question is not applicable to Dana-Farber.

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.
Click here to enter text.

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.
Click here to enter text.

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?
Click here to enter text.

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?
Click here to enter text.

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	Level of Contribution
Aging of your patients	Level of Contribution
New or improved EHRs that have increased your ability to document diagnostic information	Level of Contribution
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Level of Contribution
New, relatively less healthy patients entering your patient pool	Level of Contribution
Relatively healthier patients leaving your patient pool	Level of Contribution
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Level of Contribution
Other, please describe: 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
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Priority Level
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	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	High
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	Priority Level
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Priority Level
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	Priority Level
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
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	Priority Level
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

Dana-Farber continues to be significantly affected by the growing burden of administrative costs associated with health plan utilization control requirements. Over the past few years, we have seen health plans continue to add and expand prior authorization requirements. We are currently considering the impact of the new MA Health drug authorization requirement, which includes over 60 drugs that are regularly utilized at Dana-Farber. Given the cost and complexity of services required to treat cancer, and the volume of new/innovative therapies and services we provide on a regular basis, extensive resources are expended at DFCI to ensure patients have appropriate health plan approvals in place to ensure coverage.

We recommend that the Health Policy Commission, in partnership with the Division of Insurance, convene a workgroup of stakeholders to evaluate prior authorization programs with the goal of increasing transparency and reducing unnecessary administrative burden. Specifically, the workgroup should consider and develop guidelines to address the following key issues:

- **Developing streamlined approval for treatment plans that follow established clinical pathways:**
    - Clinical pathways designed by an NCI-designated comprehensive cancer center are an evidence-based, consensus-driven approach to treating cancer. Instead of creating additional steps to authorize care for a patient's treatment on a defined pathway, adherence to the pathway should warrant approval in lieu of prior authorization.
- **Increasing transparency, improving accountability, and simplifying administrative steps of health plan prior authorization programs:**
    - The criteria by which prior authorization requests are evaluated should be clear and transparent, with up-to-date metrics available to all parties. Increasingly, utilization management vendors develop and manage these programs on behalf of health plans. The vendors have developed authorization processes that cannot reasonably be managed within a clinical setting. The vendors regularly deny approvals which are subsequently overturned after time-intensive peer-to-peer discussions with clinicians. Discrepancies between the health plan and vendor lead to unnecessary denials, placing additional burden on the provider to resolve in order to be paid.
    - Some health plans are very limited in utilizing technology-enabled tools to support their prior authorization programs. In these cases, requests are especially onerous and require many manual steps, including printing and faxing. Other health plans have developed web portals, which support a streamlined approach to entering prior authorization requests and typically provide more timely responses. We understand that the upcoming MA Health prior authorization process will be manual and further burdened by drug-specific forms and a separate signature from

the ordering physician (providers order treatments in the electronic health record including an electronic signature).
    - Obtaining health plan approval for a patient coming to Dana-Farber for treatment has become increasingly resource intensive as health plans have developed policies related to drug coverage based on site of service or step therapies which do not take into account the clinical and treatment complexities of cancer patients.
    - The performance/results of health plan prior authorization programs should be made available to providers and to the Health Policy Commission. These metrics could help identify which types of radiology, drug, and lab authorization programs add value, and which programs add administrative cost to the system without demonstrable benefit.
- **Health plan requests for medical records**
    - Health plans regularly request medical records for the same patient receiving the same service on different dates of service (e.g. for multiple courses of chemotherapy, which is typical for our patient population) requiring that we send the same information over and over again. This is administratively onerous and delays payment for care.
- **Ensuring appropriate expertise for review of specialty service authorizations:**
    - Many reviewers of authorization requests have general medical expertise but lack the necessary background to evaluate care for oncology cases that include highly complicated medical histories and treatment plans. As an example, specialized molecular and genetic pathology laboratory testing is rapidly evolving and authorization programs and reviewers are not updated regularly enough to result in an efficient or appropriate exchange between the vendor and provider seeking approval. This increases the administrative burden on specialty providers to provide the relevant evidence base, which may not yet be reflected in health plan guidelines and algorithms.
- **Health plan review of all diagnoses submitted on a claim.**
    - Oncology patients often receive many, many services on the same day. Consistent with hospital billing rules, all ambulatory services performed on a single day are billed on a single claim. There are many different diagnosis codes that are relevant to describe the clinical rationale for services rendered. Payers do not always read all the diagnosis codes, which leads to denials. This administrative burden delays payment for care and can impact a patient's out of pocket responsibility.
- **Understanding the impact on patients and consumers:**
    - Insurance denials and appeals can lead to significant stress and anxiety for patients with cancer. Payers and provider organizations must partner in an ongoing way to be certain that utilization management protocols do not interfere

with the core mission of providing timely, medically necessary care to our patients.

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.

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**	0	17
	Q2	0	15
	Q3	0	10
	Q4	0	10
CY2018	**Q1**	0	16
	Q2	0	7
	Q3	0	0
	Q4	0	8
CY2019	**Q1**	0	11
	Q2	0	4
	TOTAL:	0	98*

*Note: 7 of the 98 requests were ultimately cancelled. Reasons included that the requester was planning to obtain care at another facility, or the requester was interested in other information related to their insurance coverage, which was addressed during a discussion with our Financial Counselors.

    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.

Dana-Farber continues to evaluate and pursue improvements to our price estimates. Examples of such improvements include adjusting estimated charges for treatment regimens based on the patient's weight and height for dosing purposes, accounting for varied dose/cycles of treatment being requested, as well as adjusting the physician treatment request template to query if specific services are likely to be provided as part of the treatment plan, such as supportive agents, diagnostic radiology, and/or radiation therapy.

Dana-Farber tracks all Chapter 224 price estimate requests in a Price Estimate Request Tracker. This tracker includes the patient demographic and insurance information, the date of the request, a summary of the specific request, and the date a Financial Counselor provides a written estimate to the patient. A manager provides feedback to staff on a regular basis and reviews the tracker periodically to ensure estimates are presented within the targeted timeframe of 2 business days from receipt of the request. Forty-two percent (42%) of estimates from Q1 CY2017 through Q2 CY2019 were provided on the same day as the request was received. Eighty-five percent (85%) of estimates were completed within 2 business days. In instances where we were unable to provide an estimate within the targeted 2 business day timeframe, delays are often the result of staff not being able to reach the patient or provider for additional information regarding the request or complicated estimates that require input from other resources (e.g., clinical trial considerations, retail pharmacy).

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?

There are several barriers to effectively responding to patient inquiries. Patients or potential patients contacting us for price estimates are often ultimately looking for other types of information, such as his/her out of pocket expenses (e.g., outstanding balance based on the time of year or coverage for specific services). Dana-Farber's Financial Counselors explain verbally and in writing that the estimate provided does not represent the patient's actual personal financial responsibility, which often is the key information patients are seeking.

Additionally, while consumer inquiries regarding individual services such as high-tech radiology (e.g., MRI, PET/CT) often can be easily and accurately addressed at the time of inquiry by referencing Dana-Farber's charge schedule, there are complexities to producing an accurate and timely estimate for a course of treatment. Due to varied duration of oncology services, Dana-Farber typically produces treatment estimates based

on charges incurred for comparable patients who have previously received a similar regimen. Variations exist in the charges incurred among cancer patients based on the duration of treatment, the doses of medications prescribed, comorbidities, as well as side effects of treatment that require supportive care. As cancer treatments become increasingly personalized, these complexities all factor into our ability to accurately provide a comprehensive estimate of all services a patient might receive here at Dana-Farber. Dana-Farber does its best to educate patients about the estimate process and the information provided, and additionally shares information regarding any resources available for those who are under or uninsured, consistent with our Financial Assistance Policy.

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.

    The data requested on margin and payor mix, and the list of carriers/programs, are provided in excel format as Attachment B.

    Dana-Farber does not have any payor contracts that incorporate a per member per month budget. We do not look at revenue or margin based on HMO or PPO business. In general, there are very few payor contracts where there is a reimbursement impact based on HMO or PPO business and, in cases where there are, there is a very small difference between the two.

    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 DFCI	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											70,149,098	94,128,292			
Tufts Health Plan											27,011,304	15,818,910			
Harvard Pilgrim Health Care											56,277,719	28,910,407			
Fallon Community Health Plan											6,090,069	271,480			
CIGNA											3,471,123	8,831,499			
United Healthcare											14,619,935	12,293,776			
Aetna											22,523,235	3,379,572			
Other Commercial											47,983,650	10,647,527			
Total Commercial											248,126,133	174,281,463			
Network Health											4,200,136				
Neighborhood Health Plan											18,482,855				
BMC HealthNet, Inc.											241,130				
Health New England											98,053				
Fallon Community Health Plan											969,433				
Other Managed Medicaid											3,385,939				
Total Managed Medicaid											27,377,546	-			
MassHealth											12,918,798				
Tufts Medicare Preferred											11,724,014				
Blue Cross Senior Options											1,993,114	3,863,888			
Other Comm Medicare											6,671,623	1,518,628			
Commercial Medicare Subtotal											20,388,751	5,382,516			
Medicare													162,667,433		
Other												62,850,764			
GRAND TOTAL											308,811,228	242,514,743	162,667,433		

2015 DFCCN	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											4,736,693	1,434,750			
Tufts Health Plan											1,760,979	12,001			
Harvard Pilgrim Health Care											3,295,868				
Fallon Community Health Plan											182,086	412			
CIGNA											1,048,605	2,073			
United Healthcare											1,504,677				
Aetna											330,863	15,327			
Other Commercial											1,317,462				
Total Commercial											14,177,233	1,464,563			
Network Health											37,557				
Neighborhood Health Plan											892,896				
BMC HealthNet, Inc.											346,340				
Health New England											-				
Fallon Community Health Plan											-				
Other Managed Medicaid											393,067				
Total Managed Medicaid											1,669,860	-			
MassHealth											1,117,390				
Tufts Medicare Preferred											1,456,495	-			
Blue Cross Senior Options											275,958	370,587			
Other Comm Medicare											1,429,900	92,135			
Commercial Medicare Subtotal											3,162,353	462,722			
Medicare													15,914,256		
Other												385,951			
GRAND TOTAL											20,126,836	2,313,236	15,914,256		

2016 DFCI	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											76,211,937	109,218,733			
Tufts Health Plan											34,039,788	21,012,849			
Harvard Pilgrim Health Care											59,775,914	37,095,020			
Fallon Community Health Plan											10,992,844	458,172			
CIGNA											4,816,133	11,414,247			
United Healthcare											6,586,077	27,651,508			
Aetna											25,855,540	2,325,517			
Other Commercial											13,722,478	27,677,051			
Total Commercial											232,000,711	236,853,097			
Network Health											198,029				
Neighborhood Health Plan											31,566,305				
BMC HealthNet, Inc.											229,204				
Health New England											133,743				
Fallon Community Health Plan											1,448,942				
Other Managed Medicaid											5,973,045				
Total Managed Medicaid											39,549,268	-			
MassHealth											12,012,127				
Tufts Medicare Preferred											16,872,984				
Blue Cross Senior Options											951,688	5,080,411			
Other Comm Medicare											10,046,780	3,711,042			
Commercial Medicare Subtotal											27,871,452	8,791,453			
Medicare													204,092,219		
Other												92,936,526			
GRAND TOTAL											311,433,558	338,581,076	204,092,219		

2016 DFCCN	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											4,718,890	2,001,780			
Tufts Health Plan											1,735,637	14,625			
Harvard Pilgrim Health Care											2,590,971	-			
Fallon Community Health Plan											183,978	746			
CIGNA											563,225	-			
United Healthcare											1,611,767	-			
Aetna											271,806	42,594			
Other Commercial											1,402,943	-			
Total Commercial											13,079,217	2,059,745			
Network Health											6,276	-			
Neighborhood Health Plan											963,767	-			
BMC HealthNet, Inc.											491,892	-			
Health New England											-	-			
Fallon Community Health Plan											-	-			
Other Managed Medicaid											-	-			
Total Managed Medicaid											1,461,935	-			
MassHealth											1,276,899				
Tufts Medicare Preferred											1,684,077	-			
Blue Cross Senior Options											235,552	754,405			
Other Comm Medicare											632,423	612,656			
Commercial Medicare Subtotal											2,552,052	1,367,061			
Medicare													16,260,321		
Other												1,562,303			
GRAND TOTAL											18,370,103	4,989,109	16,260,321		

2017 DFCI	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											90,609,270	121,292,929			
Tufts Health Plan											34,443,131	18,986,311			
Harvard Pilgrim Health Care											60,247,604	43,708,554			
Fallon Community Health Plan											9,714,515	1,438,952			
CIGNA											6,337,594	11,716,951			
United Healthcare											9,828,719	30,629,061			
Aetna											32,747,814	3,962,811			
Other Commercial											20,773,307	26,599,020			
Total Commercial											264,701,954	258,334,589			
Network Health											-				
Neighborhood Health Plan											19,628,530				
BMC HealthNet, Inc.											440,079				
Health New England											79,719				
Fallon Community Health Plan											758,093				
Other Managed Medicaid											9,870,388				
Total Managed Medicaid											30,776,809	-			
MassHealth											19,372,152				
Tufts Medicare Preferred											16,527,896	116,610			
Blue Cross Senior Options											2,396,027	3,666,732			
Other Comm Medicare											12,289,482	7,392,614			
Commercial Medicare Subtotal											31,213,405	11,175,956			
Medicare													244,026,845		
Other												111,628,330			
GRAND TOTAL											346,064,320	381,138,875	244,026,845		

2017 DFCCN	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											2,696,653	2,742,209			
Tufts Health Plan											1,316,515	79,674			
Harvard Pilgrim Health Care											1,701,186	23,936			
Fallon Community Health Plan											227,534	22,308			
CIGNA											446,280	66,897			
United Healthcare											1,612,546	23,524			
Aetna											166,128	204,168			
Other Commercial											663,434	120,749			
Total Commercial											8,830,276	3,283,465			
Network Health											20,728	-			
Neighborhood Health Plan											494,164	-			
BMC HealthNet, Inc.											323,594	-			
Health New England											-	-			
Fallon Community Health Plan											-	-			
Other Managed Medicaid											573,209	-			
Total Managed Medicaid											1,411,695	-			
MassHealth											1,664,884				
Tufts Medicare Preferred											819,978	-			
Blue Cross Senior Options											575,707	471,022			
Other Comm Medicare											1,183,487	885,591			
Commercial Medicare Subtotal											2,579,172	1,356,613			
Medicare													14,972,522		
Other												1,180,198			
GRAND TOTAL											14,486,027	5,820,276	14,972,522		

2018 DFCI	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											104,898,231	135,364,766			
Tufts Health Plan											33,680,835	23,161,658			
Harvard Pilgrim Health Care											69,303,798	52,757,799			
Fallon Community Health Plan											9,303,557	1,070,247			
CIGNA											9,098,179	17,984,493			
United Healthcare											10,974,565	37,622,640			
Aetna											38,853,185	2,845,702			
Other Commercial											17,472,420	25,415,054			
Total Commercial											293,584,770	296,222,359			
Network Health											-				
Neighborhood Health Plan											2,774,009				
BMC HealthNet, Inc.											2,526,650				
Health New England											54,714				
Fallon Community Health Plan											620,209				
Other Managed Medicaid											32,459,794				
Total Managed Medicaid											38,435,376	-			
MassHealth											12,581,853				
Tufts Medicare Preferred											20,934,665	339,898			
Blue Cross Senior Options											2,219,390	5,151,066			
Other Comm Medicare											18,894,021	10,705,278			
Commercial Medicare Subtotal											42,048,076	16,196,242			
Medicare													271,166,761		
Other												98,779,704			
GRAND TOTAL											386,650,075	411,198,305	271,166,761		

2018 DFCCN	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											2,415,548	3,169,459			
Tufts Health Plan											1,408,969	97,786			
Harvard Pilgrim Health Care											927,322	55,557			
Fallon Community Health Plan											135,437	261			
CIGNA											491,017	18,345			
United Healthcare											1,592,054	64,247			
Aetna											347,084	19,581			
Other Commercial											282,797	246,546			
Total Commercial											7,600,228	3,671,782			
Network Health											-	-			
Neighborhood Health Plan											-	-			
BMC HealthNet, Inc.											234,982	-			
Health New England											-	-			
Fallon Community Health Plan											2,456	-			
Other Managed Medicaid											768,271	-			
Total Managed Medicaid											1,005,709	-			
MassHealth											2,099,226				
Tufts Medicare Preferred											1,313,407	-			
Blue Cross Senior Options											1,158,607	297,527			
Other Comm Medicare											2,118,896	990,885			
Commercial Medicare Subtotal											4,590,910	1,288,412			
Medicare													13,255,538		
Other												3,894,395			
GRAND TOTAL											15,296,073	8,854,589	13,255,538		

AGO Provider Exhibit 2
ADULT

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	29,426,043	7,923,607	529,740,126	154,724,627	15,504,375	(2,455,872)	313,905,093	(54,576,456)	1,805,087	(809,897)	39,492,867	(15,346,668)	3,522,761	283,075	82,914,772	22,333,777	50,258,266	4,940,913	966,052,858	##########
Ophthalmology																				
Orthopedics																				
Otolaryngology																				
Psychiatry																				
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																				

AGO Provider Exhibit 2
PEDI

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			30,640,960	3,126,822			1,611	(27,267)			9,719,275	(3,115,568)			12,342,171	73,307			52,704,017	57,294
Ophthalmology																				
Orthopedics																				
Otolaryngology																				
Psychiatry																				
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																				

Dana-Farber Cancer Institute
Margin Analysis & Payor Mix for AGO Subpoena
Calendar Year 2016-2018

	Total Margin %		
Payor Category	**CY16**	**CY17**	**CY18**
Commercial	23.6%	23.8%	28.1%
Medicare	-18.3%	-20.3%	-17.3%
Medicaid	-24.9%	-31.3%	-37.8%
All Other	12.7%	30.3%	23.0%

	% of Total Business		
Payor Category	**CY16**	**CY17**	**CY18**
Commercial	48.2%	45.2%	44.4%
Medicare	37.6%	40.7%	42.4%
Medicaid	7.3%	6.6%	6.9%
All Other	6.9%	7.5%	6.3%
Total	**100.0%**	**100.0%**	**100.0%**

Enc - Payor Plan Code	Enc - Payor Plan Code_Desc	Margin Mapping
100108	AETNA ASA	Commercial
100107	AETNA ASA GEHA	Commercial
100101	AETNA HMO POS	Commercial
100101	AETNA HMO POS EPO	Commercial
100105	AETNA STUDENT HEALTH - CHICKERING	Commercial
102601	AETNA TRANSPLANT	Commercial
	AETNA/USHC-HMO	Commercial
100102	AETNA INDEMNITY	Commercial
100104	AETNA PPO	Commercial
	AETNA/USHC-PPO	Commercial
	BLUE CARE ELECT	Commercial
11000118	BLUE CROSS ANTHEM NH HMO POS	Commercial
11000101	BLUE CROSS BLUE BENEFITS ADMINISTRATORS	Commercial
11000102	BLUE CROSS FEDERAL	Commercial
11000103	BLUE CROSS HMO POS	Commercial
11000115	BLUE CROSS MEDEX CHOICE SUPPLEMENT	Commercial
11000106	BLUE CROSS MEDEX SUPPLEMENT	Commercial
11000105	BLUE CROSS OOS AND MANAGED BLUE SUPPLEMENT	Commercial
	BLUE CROSS OUT OF AREA	Commercial
	BLUE CROSS OUT OF AREA HMO	Commercial
11000109	BLUE CROSS OUT OF STATE HMO POS	Commercial
11000104	BLUE CROSS INDEMNITY	Commercial
	BLUE CROSS OUT OF AREA PPO	Commercial
11000110	BLUE CROSS OUT OF STATE INDEMNITY	Commercial
11000112	BLUE CROSS OUT OF STATE PPO	Commercial
11000113	BLUE CROSS PPO	Commercial
11000113	BLUE CROSS PPO EPO	Commercial
	CIGNA	Commercial
101801	CIGNA BEHAVIORAL HEALTH	Commercial
100602	CIGNA HMO POS	Commercial
100609	CIGNA LOCAL PLUS IN-NON CONTRACT PLANS	Commercial
	CIGNA/HLTHS-HMO/POS	Commercial
100606	MVP HEALTH CARE	Commercial
100603	CIGNA INDEMNITY	Commercial
100604	CIGNA PPO	Commercial
	CIGNA/HEALTHSOURCE-PPO	Commercial
	FALLON	Commercial
100808	FALLON COMMUNITY CARE PLAN	Commercial
	FALLON COMMUNITY HEALTH PLAN	Commercial
100810	FALLON DIRECT CARE	Commercial
100805	FALLON SELECT CARE	Commercial
100802	FALLON STEWARD TIERED	Commercial
100804	FALLON PPO	Commercial
12000113	HARVARD PILGRIM ELEVATE OPTIONS	Commercial
12000111	HARVARD PILGRIM FOCUS	Commercial
12000101	HARVARD PILGRIM GIC PRIMARY CHOICE HMO	Commercial
12000114	HARVARD PILGRIM HEALTH PLANS INC HMO	Commercial
12000115	HARVARD PILGRIM HEALTH PLANS INC SELECT HMO	Commercial
12000103	HARVARD PILGRIM HMO POS	Commercial
12000110	HARVARD PILGRIM INDEPENDENCE GIC POS	Commercial
	HARVARD PILGRIM REFERRAL	Commercial
12000112	HARVARD PILGRIM SELECT OR ELEVATE	Commercial
12000106	HARVARD PILGRIM STUDENT RESOURCES	Commercial
12000102	HARVARD PILGRIM HEALTH PLANS INC PPO	Commercial
	HARVARD PILGRIM HEALTHCARE PPO	Commercial
12000108	HARVARD PILGRIM INDEPENDENCE GIC PPO	Commercial
	HARVARD PILGRIM JOINT OFFERING - NPPO	Commercial
12000105	HARVARD PILGRIM PPO	Commercial
12000107	HARVARD PILGRIM UNITED CHOICE AND OPTIONS PPO	Commercial
101602	UNITED HARVARD PILGRIM PASSPORT PPO	Commercial
100916	AMBETTER	Commercial
102102	ASSURANT HEALTH	Commercial
102203	BANKERS LIFE	Commercial
100305	BMC HEALTHNET COMMERCIAL	Commercial
	BOSTON HEALTHNET	Commercial
102113	CDPHP	Commercial
102205	CONSOLIDATED HEALTH PLANS	Commercial
102206	CORESOURCE	Commercial
103601	ELEMENT CARE	Commercial
100901	GENERIC COMMERCIAL	Commercial
100902	GENERIC HMO POS	Commercial
102201	GENERIC PHCS MULTIPLAN	Commercial
	GIC	Commercial
100605	GREAT WEST	Commercial
102209	GROUP HEALTH INC.	Commercial
102208	GROUP INSURANCE SERVICE CENTER	Commercial
102219	HEALTH NEW ENGLAND	Commercial
103103	HEALTH NEW ENGLAND COMMERCIAL	Commercial
103103	HEALTH NEW ENGLAND HMO	Commercial
102226	HEALTH PARTNERS	Commercial
102225	HEALTHY CT	Commercial
	HMO BLUE REFERRAL	Commercial
102212	LOOMIS CO	Commercial
102111	MAIL HANDLERS BENEFIT PLAN	Commercial
100915	MAINE COMMUNITY HEALTH OPTIONS	Commercial
102213	MERITAIN HEALTH	Commercial
100911	MINUTEMAN HEALTH	Commercial
102214	MUTUAL OF OMAHA	Commercial

Enc - Payor Plan Code	Enc - Payor Plan Code_Desc	Margin Mapping
100608	NATIONAL ASSOCIATION OF LETTER CARRIERS	Commercial
100907	NATIONAL MARROW DONOR PROGRAM	Commercial
102607	NATIONAL TRANSPLANT NETWORK HUMANA	Commercial
15000102	NEIGHBORHOOD HEALTH PLAN HMO	Commercial
100904	NEIGHBORHOOD HEALTH PLAN RI	Commercial
100914	NEIGHBORHOOD HEALTH PLAN RI EXCHANGE	Commercial
	NETWORK HEALTH	Commercial
101303	NETWORK HEALTH (TUFTS) MSP EXTEND	Commercial
100905	NEW HAMPSHIRE HEALTHY FAMILIES	Commercial
	NHP COMMERCIAL REFERRAL	Commercial
	ONE HEALTH	Commercial
	OTHER HMO	Commercial
	PAF PAYORS	Commercial
	PHCS	Commercial
102110	STARMARK	Commercial
	TAHP REFERRAL	Commercial
102223	ULTRA BENEFITS	Commercial
101504	UNICARE COMMUNITY CHOICE	Commercial
100906	WELL SENSE HEALTH PLAN	Commercial
100903	GENERIC PPO	Commercial
102219	HEALTH NEW ENGLAND PPO	Commercial
	HUMANA PPO	Commercial
101202	HUMANA PPO POS	Commercial
	TAHP PPO NEW CY05	Commercial
101501	UNICARE GIC INDEMNITY PLAN	Commercial
	TUFTS CIGNA ALLIANCE	Commercial
17000102	TUFTS HMO	Commercial
17000113	TUFTS NAVIGATOR POS	Commercial
17000105	TUFTS POS EPO	Commercial
101307	TUFTS PUBLIC PLANS DIRECT	Commercial
17000107	TUFTS SPIRIT OR SELECT	Commercial
17000108	TUFTS STEWARD DPO POS	Commercial
17000109	TUFTS STEWARD EPO	Commercial
	TUFTS STEWART COMMUNITY CHOICE	Commercial
	TUFTS TOTAL - REFERRAL	Commercial
17000110	TUFTS UNIFORMED SERVICES FAMILY HEALTH PLAN	Commercial
100601	CIGNA CARELINK PPO	Commercial
17000101	TUFTS CARELINK PPO	Commercial
17000112	TUFTS NAVIGATOR PPO	Commercial
17000106	TUFTS PPO	Commercial
	UNITED	Commercial
101613	UNITED COMMUNITY PLAN	Commercial
	UNITED HARVARD ALLIANCE	Commercial
101604	UNITED HEALTHCARE HMO	Commercial
101610	UNITED HEALTHCARE POS	Commercial
101611	UNITED HEALTHCARE UMR	Commercial
101615	UNITED OXFORD CHOICE PLUS	Commercial
101608	UNITED OXFORD HEALTH PLAN	Commercial
101608	UNITED OXFORD NON CHOICE PLUS	Commercial
101614	UNITED STUDENT RESOURCES	Commercial
101605	UNITED HEALTHCARE INDEMNITY	Commercial
101606	UNITED HEALTHCARE PPO	Commercial
100306	BMC HEALTHNET COMMUNITY ALLIANCE ACO	Medicaid
100303	BMC HEALTHNET MASSHEALTH CAREPLUS	Medicaid
100302	BMC HEALTHNET MASSHEALTH MCO	Medicaid
100307	BMC HEALTHNET MERCY ALLANCE ACO	Medicaid
100308	BMC HEALTHNET SIGNATURE ALLIANCE ACO	Medicaid
100309	BMC HEALTHNET SOUTHCOAST ALLIANCE ACO	Medicaid
100812	FALLON 365 CARE RELIANT ACO	Medicaid
100809	FALLON MASSHEALTH	Medicaid
100807	FALLON MASSHEALTH CAREPLUS	Medicaid
100813	FALLON WELLFORCE ACO	Medicaid
103106	HEALTH NEW ENGLAND BE HEALTHY PARTNERSHIP ACO	Medicaid
103104	HEALTH NEW ENGLAND MASSHEALTH	Medicaid
103101	HEALTH NEW ENGLAND MASSHEALTH CAREPLUS	Medicaid
300102	MASSHEALTH	Medicaid
300110	MASSHEALTH CAREPLUS	Medicaid
300111	MASSHEALTH CAREPLUS PCC	Medicaid
300109	MASSHEALTH DENTAL	Medicaid
300114	MASSHEALTH FAMILY ASSISTANCE	Medicaid
300115	MASSHEALTH FAMILY ASSISTANCE PCC	Medicaid
300105	MASSHEALTH LIMITED	Medicaid
300106	MASSHEALTH PCC	Medicaid
300107	MASSHEALTH PENDING	Medicaid
	MEDICAID	Medicaid
300107	MEDICAID PENDING	Medicaid
15000103	NEIGHBORHOOD HEALTH PLAN MASSHEALTH	Medicaid
15000105	NEIGHBORHOOD HEALTH PLAN MASSHEALTH CAREPLUS	Medicaid
	NEIGHBORHOOD- MERRIMACK VALLEY ACO	Medicaid
	NHP MASSHEALTH CARE PLUS	Medicaid
	NHP MEDICAID REFERRAL	Medicaid
101305	TUFTS (NETWORK HLTH) MASSHEALTH CAREPLUS TOGETHER	Medicaid
101302	TUFTS (NETWORK HLTH) MASSHEALTH TOGETHER	Medicaid
15000108	ALLWAYS HEALTH PARTNERS MY CARE FAMILY ACO	Medicaid
	BMC HEALTHNET - BOSTON ACO	Medicaid
	BMC HEALTHNET - MERCY HEALTH ACO	Medicaid
100403	CELTICARE MASSHEALTH CAREPLUS	Medicaid
100501	CHILDRENS MEDICAL SECURITY PLAN	Medicaid

Enc - Payor Plan Code	Enc - Payor Plan Code_Desc	Margin Mapping
	MASSHEALTH ACO	Medicaid
300118	MASSHEALTH COMMUNITY CARE COOPERATIVE C3 ACO	Medicaid
300116	MASSHEALTH PARTNERS HEALTHCARE CHOICE ACO	Medicaid
300117	MASSHEALTH STEWARD HEALTH CHOICE ACO	Medicaid
	Other Masshealth Care Plus plans	Medicaid
	Out of State Medicaid MCO	Medicaid
	TUFTS PUBLIC - CAMBRIDGEÂ ALLIANCE ACO	Medicaid
101308	TUFTS PUBLIC PLANS ATRIUS HEALTH ACO	Medicaid
101309	TUFTS PUBLIC PLANS BIDCO ACO	Medicaid
101311	TUFTS PUBLIC PLANS BOSTON CHILDRENS ACO	Medicaid
101310	TUFTS PUBLIC PLANS CHA ACO	Medicaid
101305	TUFTS PUBLIC PLANS MASSHEALTH CAREPLUS TOGETHER	Medicaid
101302	TUFTS PUBLIC PLANS MASSHEALTH TOGETHER MCO	Medicaid
	TUFTS PUBLICÂ - LAHEYÂ NETWORK ACO	Medicaid
	BLUCARE 65	Medicare
11000107	BLUE CROSS MEDICARE HMO BLUE REPLACEMENT	Medicare
11000111	BLUE CROSS OUT OF STATE MEDICARE REPLACEMENT	Medicare
11000108	BLUE CROSS MEDICARE PPO BLUE REPLACEMENT	Medicare
	MEDICARE	Medicare
200101	MEDICARE A	Medicare
200102	MEDICARE B	Medicare
200201	MEDICARE NHIC PRO	Medicare
200103	MEDICARE PART A & B	Medicare
200103	MEDICARE PART A B	Medicare
200105	MEDICARE RAILROAD	Medicare
200202	MEDICARE RAILROAD PROF	Medicare
100103	AETNA MEDICARE REPLACEMENT	Medicare
102114	CDPHP MEDICARE REPLACEMENT	Medicare
100610	CIGNA MVP MEDICARE REPLACEMENT	Medicare
100702	COMMONWEALTH CARE ALLIANCE ONE CARE	Medicare
100702	COMMONWEALTH CARE ALLIANCE ONE CARE MEDICARE REPLACEMENT	Medicare
100701	COMMONWEALTH CARE ALLIANCE SCO MEDICARE REPLACEMENT	Medicare
100701	COMMONWEALTH CARE ALLIANCE SENIOR CARE OPTIONS	Medicare
103602	ELDER SERVICE NEIGHBORHOOD PACE	Medicare
100803	FALLON MEDICARE REPLACEMENT	Medicare
	FALLON SENIOR REFERRED	Medicare
103604	GENERIC ELDER SERVICES	Medicare
101001	GENERIC MEDICARE REPLACEMENT	Medicare
100910	GENERIC MEDICARE SUPPLEMENT	Medicare
12000104	HARVARD PILGRIM MEDICARE ENHANCE SUPPLEMENT	Medicare
12000109	HARVARD PILGRIM STRIDE MEDICARE REPLACEMENT	Medicare
103105	HEALTH NEW ENGLAND MEDICARE POS REPLACEMENT	Medicare
101201	HUMANA HMO MEDICARE REPLACEMENT	Medicare
101203	HUMANA MEDICARE SUPPLEMENT	Medicare
16000702	MARTINS POINT GENERATIONS ADV HMO MEDICARE REPLACEMENT	Medicare
200106	MEDICARE CLINICAL TRIAL RESTRICTED USE	Medicare
	MEDICARE REPLACEMENT OTHER	Medicare
	ONE CARE	Medicare
101401	SENIOR WHOLE HEALTH MEDICARE REPLACEMENT	Medicare
16000504	TRICARE FOR LIFE MEDICARE SUPPLEMENT	Medicare
101304	TUFTS (NETWORK HLTH) ONE CARE UNIFY	Medicare
101601	UNITED EVC SCO COM MEDICARE REPLACEMENT	Medicare
101603	UNITED HEALTHCARE AARP MEDICARE SUPPLEMENT	Medicare
101607	UNITED HMO AARP MEDICARE REPLACEMENT	Medicare
	UNITED MEDICARE ADVANTAGE SECURE HORIZONS	Medicare
101601	UNITED SCO COMMUNITY MEDICARE REPLACEMENT	Medicare
100103	AETNA PPO MEDICARE REPLACEMENT	Medicare
11000111	BLUE CROSS OUT OF STATE PPO MEDICARE REPLACEMENT	Medicare
101612	UNITED PPO AARP MEDICARE REPLACEMENT	Medicare
101612	UNITED PPO MEDICARE REPLACEMENT	Medicare
17000114	TUFTS MEDICARE COMPLEMENT SUPPLEMENT	Medicare
17000103	TUFTS MEDICARE PREFERRED HMO REPLACEMENT	Medicare
17000104	TUFTS MEDICARE PREFERRED SUPPLEMENT	Medicare
101304	TUFTS PUBLIC PLANS ONE CARE UNIFY MEDICARE REPLACEMENT	Medicare
17000111	TUFTS SENIOR CARE OPTION MCARE REPLACEMENT	Medicare
	TUFTS MCARE ADVANTAGE PPO	Medicare
14000102	AETNA INTERNATIONAL	Other
14000117	AETNA INTERNATIONAL KUWAIT EMBASSY	Other
15000106	ALLWAYS HEALTH PARTNERS CONNECTORCARE	Other
15000102	ALLWAYS HEALTH PARTNERS HMO	Other
15000109	ALLWAYS HEALTH PARTNERS PHS RISK	Other
101104	BEACON HOSPICE	Other
14000104	BERMUDA FIRE & MARINE (BF&M)	Other
14000104	BERMUDA FIRE MARINE (BFM)	Other
14000105	BERMUDA GEHI	Other
14000106	BEST DOCTORS INC.	Other
100304	BMC HEALTHNET CONNECTORCARE	Other
14000107	BRITISH COLUMBIA HEALTH	Other
18000106	BROADSPIRE INSURANCE	Other
14000108	CANADIAN MEDICAL NETWORK	Other
102220	CAPITAL DISTRICT PHYSICIANS HEALTH PLAN	Other
101103	CARE DIMENSIONS	Other
18000107	CCMSI	Other
100402	CELTICARE COMMONWEALTH CHOICE - DIRECT	Other
100404	CELTICARE CONNECTORCARE	Other
101701	CENPATICO	Other
	CHAMPUS	Other
16000101	CHAMPVA	Other

Enc - Payor Plan Code	Enc - Payor Plan Code_Desc	Margin Mapping
14000101	CIGNA INTERNATIONAL	Other
102602	CIGNA TRANSPLANT	Other
18000110	CITY OF BOSTON	Other
18000132	CITY OF BOSTON FIRE DEPT	Other
14000109	COLONIAL MEDICAL	Other
18000114	COMMONWEALTH OF MASSACHUSETTS	Other
300201	CONNECTICUT MEDICAID	Other
18000115	COOK AND COMPANY INSURANCE	Other
1	EPIC Self Pay Default Payor Plan Code	Other
101105	EVERCARE HOSPICE	Other
	FALLON COMMONWEALTH CARE	Other
100808	FALLON CONNECTORCARE	Other
300202	FLORIDA MEDICAID	Other
16000204	GENERIC COUNTY JAIL	Other
102101	GENERIC COVENTRY	Other
101101	GENERIC HOSPICE	Other
14000110	GENERIC INTERNATIONAL COMMERCIAL	Other
14000209	GENERIC INTERNATIONAL EMBASSY	Other
300203	GENERIC MEDICAID OUT OF STATE	Other
16000301	GENERIC OTHER GOVERNMENT	Other
100913	GENERIC OUT OF STATE MEDICAID REPLACEMENT	Other
104201	GENERIC SPECIAL BILLING	Other
102605	GENERIC TRANSPLANT	Other
18000119	GENERIC WORKERS COMPENSATION	Other
14000119	GLOBAL BENEFITS GROUP	Other
14000118	GMMI	Other
102104	GOVERNMENT EMPLOYEE HEALTH ASSOCIATION	Other
	HCVM	Other
103102	HEALTH NEW ENGLAND CONNECTOR CARE	Other
13000103	HEALTH SAFETY NET EMERGENT BD	Other
13000104	HEALTH SAFETY NET FULL	Other
13000106	HEALTH SAFETY NET PARTIAL	Other
101106	HOPE HEALTH	Other
101102	HOSPICE OF THE GOOD SHEPHERD	Other
102606	INTERLINK TRANSPLANT	Other
	INTERNATIONAL	Other
102221	KAISER PERMANENTE	Other
14000201	KUWAIT HEALTH DIVISION	Other
14000202	KUWAIT MILITARY DIVISION	Other
14000116	KUWAIT OIL COMPANY	Other
18000120	LIBERTY MUTUAL INSURANCE	Other
102603	LIFE TRAC TRANSPLANT	Other
300204	MAINE MEDICAID	Other
16000302	MARTINS POINT	Other
16000701	MARTINS POINT USFHP	Other
	MEDICAID OUT OF STATE	Other
15000106	NEIGHBORHOOD HEALTH PLAN CONNECTORCARE	Other
300205	NEW HAMPSHIRE MEDICAID	Other
300206	NEW YORK MEDICAID	Other
15000201	NHP BEACON HEALTH OPTIONS	Other
	NHP COMMONWEALTH CARE	Other
	NHP CONNECTORCARE	Other
101108	OLD COLONY HOSPICE	Other
102604	OPTUM HEALTH TRANSPLANT	Other
	OTHER CONNECTORCARE PLAN	Other
	OTHER GOVERNMENT	Other
	OTHER-SPECIALIZED	Other
14000203	QATAR HEALTH DIVISION	Other
14000112	QUALITY HEALTH MANAGEMENT	Other
300207	RHODE ISLAND MEDICAID	Other
14000205	SAUDI ARABIA HEALTH DIVISION	Other
14000206	SAUDI ARABIA MILITARY DIVISION	Other
001	SELF PAY	Other
16000401	STATE MCI CORRECTIONAL CENTER	Other
16000201	SUFFOLK COUNTY - NASHUA STREET JAIL	Other
18000128	THE HARTFORD INSURANCE	Other
18000129	TRAVELERS INSURANCE	Other
16000501	TRICARE EAST REGION	Other
16000501	TRICARE NORTH REGION	Other
16000502	TRICARE SOUTH REGION	Other
16000503	TRICARE WEST REGION	Other
101306	TUFTS PUBLIC PLANS CONNECTORCARE DIRECT	Other
14000215	UNITED ARAB EMIRATES HAAD	Other
14000207	UNITED ARAB EMIRATES HEALTH DIVISION	Other
14000208	UNITED ARAB EMIRATES MILITARY DIVISION	Other
101613	UNITED COMMUNITY OUT OF STATE MEDICAID	Other
14000114	UNITED INTERNATIONAL	Other
18000130	US DEPARTMENT OF LABOR	Other
300208	VERMONT MEDICAID	Other
16000601	VETERANS ADMINISTRATION OF MA	Other
16000602	VETERANS ADMINISTRATION OF RI	Other
16000505	VETERANS CHOICE	Other
	WORKERS COMP	Other
18000131	ZURICH INSURANCE	Other
15000107	ALLWAYS HEALTH PARTNERS PPO	Other