MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 25, 2019, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit the Suffolk University website. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be available via livestream and video will be available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing page on the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

On or before the close of business on **September 20, 2019**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

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

HPC Contact Information

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

AGO Contact Information

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

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:
Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

    a. What are your organization's top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

The Highland Healthcare Associates IPA (Highland) is a not-for-profit independent physician organization with 320 physician members dedicated to raising the quality of patient care, preserving the physician-patient relationship and sustaining the private practice of medicine. Approximately 90% of our physicians practice in a private, independent practice (i.e. are not employed by a hospital or health system). The care provided in the offices of our independent primary care and specialist physicians is inherently lower cost than many of our competitors, as there are no associated facility charges.

Highland is run by physicians, for physicians and their patients. The Board of Directors, our governing body, and our Medical Directors, are all practicing physicians. Our dedicated and experienced staff are backed by a collaborative environment, where we encourage physicians to contribute to ideas to advance performance and care in our community. For 30 years, we've been committed to enhancing quality, cost efficiency and patient experience.

Highland is an enthusiastic member of New England Quality Care Alliance and Wellforce. Approximately 50,000 patients have selected Highland primary care physicians (Internal Medicine, Family and Pediatrics) for their care and the care of their families. We aim to keep community level care right where it belongs – in our local community. We strongly believe in referring to "high value" providers, those that provide high quality, lower cost care and communicate effectively with the referring physician for optimal coordination of patient care. This is why we are proud to be affiliated with Tufts Medical Center and Floating Hospital for Children for advanced care patient needs -- Tufts-Floating is that high value tertiary provider. In partnership with these organizations, we work tirelessly to improve care delivery, while also respecting and supporting private practice. While Highland seeks to work collaboratively with hospitals and healthcare systems, our primary allegiance is to the Highland physicians and their patients.

Independently and in collaboration with NEQCA, there are several programs we offer to improve the quality and efficiency of patient care. And, as a clinically and financially integrated organization, Highland differentially shares quality and risk funds with our

physician members based on defined performance measures. Strategic priorities and the programs to support these include:

1. **Clinical Management - focusing on high cost, high utilization patients; elimination of unnecessary and low-yield procedures; cost-effective pharmaceutical choices; and moving services from hospital facilities to the ambulatory setting whenever medically appropriate.**
2. **Quality Improvement - Quality registries within and outside the practice-based EMRs for patient outreach purposes (e.g. cancer screens, diabetes care).**
3. **Prevention and Wellness - We focus on making certain that our patients have the necessary care necessary to prevent illness, rather than to simply respond to episodic patient needs.**
4. **High Value Providers – We encourage the use of high value providers for referral needs when there are not pre-existing specialty care relationships, access issues or other extenuating patient circumstances.**
5. **Administrative Burden – We strive to reduce administrative complexity to enable our providers to focus on what's most important, taking care of their patients.**

Additionally, we are part of a network that aggressively pursues risk-based payer contracts that incent providers to improve the quality and efficiency of patient care, over fee-for service contracts that incent quantity of services.

Highland has a performance improvement infrastructure that includes:

1. **Medical Director Support - PCP and Specialist Medical Directors engage directly with their Highland physician colleagues. Each Medical Director is also the lead on one or more organizational strategic initiatives. Our medical leadership collaborates with staff and each other to discuss challenges and continuously plan for quality and efficiency improvements.**
2. **Staff Support - Our Performance Improvement team is led by a Manager who is highly experienced in Performance Improvement and Clinical Care. Her team works in concert with NEQCA performance team staff.**
3. **Hands-on Engagement and Education – There are required meetings and webinars for Physicians and their Practice Managers throughout the year. The topics relate directly to our organizational initiatives to improve quality and patient experience, and to reduce costs.**

   For example, in June of this year, David Seltz, Health Policy Commission Executive Director, spoke at our Annual Physician Membership Meeting. The CME Program titled "The Imperative to Control Healthcare Spending: A Broader Context" was well received by the approximately 200 physicians that attended. Two weeks later, we presented the video of David Seltz's talk to approximately 100 practice staff at our

Annual Practice Manager Meeting. A brainstorming session at each table followed, whereby the participants shared ideas on how their practices could help with the imperative to bend the cost curve.

4. **Referral Program - Through our referral program, we encourage that community level specialty care stays in the community, rather than to be directed to more expensive tertiary providers. When tertiary level care is necessary for optimal outcome, a Medical Director engages in a discussion with the PCP regarding the use of high value tertiary providers, absent a pre-existing patient-physician relationship.**

5. **Active Panel Review and On-going Education - We provide regular reports and patient lists to our physicians to assist them with quality and efficiency improvement and to identify patients in need of services. We maintain performance improvement program content on our website and expect all physicians to register for and regularly visit the site.**

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

Highland believes that private practice physicians and other high value providers are best positioned to support the Commonwealth in its goals to reduce unnecessary medical expenditures and bend the cost curve.

In its push toward greater cost transparency, the Commonwealth seeks to promote a free market for health care, where physicians, hospitals, and providers of ancillary services like MRI compete on quality and price. However, the reality is just the opposite. Quality data are somewhat available, though perhaps difficult for patients to interpret. Cost information is largely shrouded in mystery, determined by health plan negotiated contracts and affected by myriad complexities hidden from the view of patients and providers. A patient who is paying out of pocket because they have not yet met their deductible may be able to compare charges between competing providers but may not know to factor in such variables as facility fees. A patient who has largely met their deductible may find that even their health plan has difficulty figuring out how much a given service may cost them at various institutions. Patients who have met their deductible in full, or have none, have little or no incentive at all to choose a cost-effective provider.

The situation is reminiscent of what took place with pharmaceutical costs 25 years ago. When generic drugs first became available, and the co-pays were insignificantly different for generics versus brand-name drugs, patients typically insisted on getting the brand name medications. As soon as the co-pays reflected the actual price disparity between brand name and generic drugs, patients phoned by the hundreds to request being switched to generics. Thus co-pays and tiering ought to reflect the true cost of choosing a given provider, taking into account the contracted fee schedules and any associated facility charges.

Furthermore, a specialist physician's access to patients has nothing whatsoever to do with the doctor's accessibility, skill or cost-effectiveness. Rather, it is increasingly dependent on only one variable – what healthcare system is negotiating the contracts on behalf of the physician, and thus considers him or her "in network."

Physicians that are employed by high cost systems are powerless to do anything but refer patients to high cost providers and services within these systems. Performance on financial risk contracts does not directly impact the compensation of salaried physicians, and employed primary care physicians are typically insulated from the negative impact on total medical expenditure of their system's expensive sites of service and facility fees. However, private practice physicians derive an essential portion of their overall compensation from the quality and financial risk incentives in our risk-based contracts. Many private practice physicians could simply not meet their increasing overhead expenses without these performance-based funds. Simply put, performance on a risk budget directly affects the ability of private practice physicians to "keep the lights on" and earn reasonable compensation but this does not necessarily have the same impact on physicians employed by large, expensive systems.

Moreover, the larger expensive systems have been advantaged over smaller, more efficient systems. With their higher payment rates, significant margins and extensive financial resources, the more advantaged providers build costly satellite locations in the community and conduct expensive advertising campaigns that directly target and draw patients to their more expensive sites of service. The high value providers that are paid lower rates simply don't have the margin to compete in this marketing reality.

Imagine the scenario of being a private practice primary care physician that is striving to direct specialty care to high value providers, while their patients are pressuring them for a referral to a well-advertised, more costly setting – this flawed and untenable situation in an era where we are trying to deliver more cost efficient care occurs routinely in our practices. While private practice providers and "high value" systems are best positioned to help the Commonwealth achieve its goals, these providers have become the most disadvantaged in today's highly consolidated and expensive health care environment.

Furthermore, some hospital-owned health care corporations are actively attempting to push private practice doctors into employment to reduce or eliminate the competition of less expensive private services. For specialists, this can be done by pressuring employed primary care physicians to refer only to specialists who are employed by the system. Those specialists are then required to perform most or all of their procedures at hospital-owned facilities which have higher negotiated fees and associated facility fees as well. Independent specialists will then find that their practices are no longer financially viable; they either close their doors or acquiesce to employment. In Highland's service area, an outpatient colonoscopy is available in a private endoscopy suite for about $450. The cost of the same service at a local hospital-owned outpatient center is $1750, perhaps even more at certain academic medical centers. Yet local hospital-employed physicians are instructed not to send patients to the free-standing facility. As physician employment

increases, the viability of the freestanding facility will be threatened. Then there will be no alternative to the higher cost facilities.

To support the goals of the Commonwealth, payers and employers alike need to align benefit design and patient cost-sharing with use of "high value" providers, and independent private practices should be given a level playing field to compete with hospital-employed practices. There should be co-pays for facility fees as well as for outpatient provider fees. The patients should be aware of these co-pays before they book their appointments. Referrals to cost-effective physicians should not be restricted based upon contracting network.

Pharmaceutical costs and direct advertising to consumers also create significant challenges for private practice physicians and Provider Organizations as we strive to provide cost efficient care.

The need for accessible mental health and substance abuse (MH/SA) services for patients with both public and private insurance alike is growing. The short supply and inadequacy of true rehabilitative services creates the revolving door phenomenon, adding more cost to our healthcare system. Inadequacy of MH/SA treatment options also result in costly, otherwise avoidable emergency room visits and inpatient services, and exacerbates other medical conditions.

The Commonwealth has made commendable efforts over the past few years to increase price and cost transparency for providers and patients alike. For physicians, improved transparency helps with our understanding of the financial implications of our ordering decisions. For patients, transparency helps with their understanding of their financial responsibilities. We continue to hear frustrations from our physicians and patients alike regarding available transparency resources and tools. Insurers have the entirety of information on cost, benefit design and patient cost-sharing – supplying cost information should be the insurers' responsibility.

Other suggestions include:

- **More closely normalize payments to hospitals to decrease the significant differences in payment to one hospital vs. another for the very same inpatient or outpatient service.**
- **Largely reduce or eliminate unnecessary facility charges for physician services rendered in hospital settings. Employed physicians are expected to refer their patients to hospital clinics where facility charges are included for specialty care.**
- **Healthcare employers offer their employees financial incentives to use their facilities, even when their facilities are more expensive. Eliminate these perverse incentives that raise costs. Align benefit structure with "high value" providers. Note that for plans without reasonable cost sharing, patients are generally not concerned with whether their MRI is done at a tertiary hospital or at a lower cost ambulatory facility, for example; when reasonable cost sharing is in place, the patient is more conscious of costs. Encourage patients to truly use "high value" providers and improve cost transparency through payer resources to empower patients to make cost conscious decisions.**

- **Continue efforts to reduce administrative burden, so the physician's time is more devoted to taking care of patients rather than on administrative tasks that have been identified as "low value"**

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.

Highland has been highly focused on private practice primary care growth over the past 4 years. We differentiate Highland in the marketplace through:

- **Allowing physicians to select and maintain their own certified EMR, with remote access to staff for quality improvement and care management purposes, rather than requiring any specific EMR product(s) to be used by our member physicians.**
- **Allowing physicians to maintain their local (community hospital and community physician) referral patterns, rather than requiring use of any specific community hospital(s).**
- **Offering a culture, including specific business support resources, to assist those who wish to remain in private practice.**
- **Unlike some other organizations, we allocate 100% of contractual quality funds to PCPs, rather than sharing with specialists or maintaining a portion to operate our organization. The quality measures are relevant only to office-based primary care and should belong to the PCPs that do the work.**
- **In conjunction with NEQCA, we offer resources to our PCP practices to reduce administrative burden and to assist the practices in their efforts to improve the quality and efficiency of care.**

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

- **Our NEQCA network offers Behavioral Health support to help locate and coordinate services for commercial patients.**

- **Our Wellforce ACO offers behavioral health supports and services to Medicaid patients.**
- **While very early on the process, our Pediatric practices recognize the importance of imbedding behavioral health into their practices; two such practices have implemented this model.**

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?

Incentivize physicians to provide services in their offices, rather than to refer to more costly settings, including:

- **Increase payments to physicians for after hour services to reduce unnecessary emergency room visits.**
- **Offer reasonable reimbursement and payment policies for in office IV therapy.**
- **Offer reasonable reimbursement and payment policies for telephonic consults.**
- **Offer reasonable credentialing, reimbursement and payment policies for behavioral health imbedded in the primary care practice.**

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?

No additional comments beyond what has already been covered.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Minor Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Major Contributing Factor

Factors	Level of Contribution
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	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	Low
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	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	Medium

Area of Administrative Complexity	Priority Level
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Medium
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	High
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	High
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	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. 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.

    This question is not applicable to Highland. As an IPA, rather than a provider of services, we do not receive inquiries from patients.

Health Care Service Price Inquiries Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	Q3		
	Q4		
CY2019	**Q1**		
	Q2		
	TOTAL:		

    b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.

    N/A

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?

N/A

Click here to enter text.

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

   a. For each year **2016 to present**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

   b. For **2018 only**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.

11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2015	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$8,620,644		$2,913,622		$865,419						
Tufts Health Plan					$6,159,933		$417,512		$108,840				$1,046,196		
Harvard Pilgrim Health Care					$7,058,840	$356,669	$131,673		$235,921						
Fallon Community Health Plan									$47,708				$77,880		
CIGNA															
United Healthcare															
Aetna			$37,004												
Other Commercial (Minuteman)			$30,487												
Total Commercial			$67,491		$21,839,418	$356,669	$3,462,807		$1,257,888				$1,124,076		
Network Health													$62,498		
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid													$62,498		
MassHealth															
Tufts Medicare Preferred					$173,102										
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal					$173,102										
Medicare					$4,059,533		$26,793								
Other															
GRAND TOTAL			$67,491		$26,072,053	$356,669	$3,489,600		$1,257,888				$1,186,573		

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					$8,485,092		$3,222,379		$1,227,646						
Tufts Health Plan					$7,467,237		$447,263		$114,822				$893,825		
Harvard Pilgrim Health Care					$8,025,523		$362,916		$383,005						
Fallon Community Health Plan									$57,965				$122,952		
CIGNA															
United Healthcare															
Aetna			$43,513												
Other Commercial (Minuteman)			$77,591												
Total Commercial			$121,104		$23,977,852		$4,032,558		$1,783,438				$1,016,777		
Network Health													$55,251		
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid													$55,251		
MassHealth															
Tufts Medicare Preferred					$239,229		$120,396						$6,041		
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal					$239,229		$120,396						$6,041		
Medicare					$4,201,838		$97,256								
Other															
GRAND TOTAL			$121,104		$28,418,919		$4,250,210		$1,783,438				$1,078,069		

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					$8,066,137	$8,914,069	$2,050,231		$1,423,358						
Tufts Health Plan					$5,685,408		$409,688		$173,700				$836,204		
Harvard Pilgrim Health Care					$6,832,492		($234,329)		$425,159						
Fallon Community Health Plan									$32,790				$114,706		
CIGNA															
United Healthcare															
Aetna			$37,946												
Other Commercial (Minuteman)			$76,348												
Total Commercial			$114,294		$20,584,037	$8,914,069	$2,225,590		$2,055,007				$950,910		
Network Health													$63,965		
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid													$63,965		
MassHealth															
Tufts Medicare Preferred					$227,873		$233,225						$6,492		
Blue Cross Senior Options					$660										
Other Comm Medicare															
Commercial Medicare Subtotal					$228,532		$233,225						$6,492		
Medicare					$3,820,204										
Other															
GRAND TOTAL			$114,294		$24,632,773	$8,914,069	$2,458,815		$2,055,007				$1,021,367		

AGO Provider Exhibit 1

2018	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$7,834,010	$8,667,706									
Tufts Health Plan					$5,541,844										
Harvard Pilgrim Health Care					$5,695,196										
Fallon Community Health Plan													$100,042		
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial					$19,071,050	$8,667,706							$100,042		
Network Health													$71,268		
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid					$487,009										
Total Managed Medicaid					$487,009								$71,268		
MassHealth															
Tufts Medicare Preferred					$264,148								$6,704		
Blue Cross Senior Options					$12,483										
Other Comm Medicare															
Commercial Medicare Subtotal					$276,631								$6,704		
Medicare					$3,740,771										
Other															
GRAND TOTAL					$23,575,461	$8,667,706							$178,014		

NOTES for Pre-filed testimony spreadsheet:

1. Tufts Commercial and Tufts Group Insurance Commission (GIC) are combined on the spreadsheet.
   - Note that the Tufts HMO claims-based revenue may include a small amount of GIC PPO due to the way in which our data reporting tool captured the claims.

2. 2017 Quality - NEQCA paid to Highand per an all Payer quality model. For Highland this totaled $1,848,517 for two payers - HMO Blue and HPHC.
   - Total 2017 amounts were pro-rated between HMO Blue (77%) and HPHC (23%) based on 2015-2016 quality payment percentage allocations.

3. The 2018 contract year has not been settled with the payers.

4. Payer withhold returns are captured in claims, where applicable.

5. Highland does not have access to claims data for Fallon, Aetna, Minuteman or Network Health.

6. With the exception of BCBS beginning in 2017, Highland does not have access to PPO claims.
   - 2015 HPHC PPO Claims - These are the GIC insured claims prior to the GIC switching from PPO to POS products for their insureds.

7. Medicare data is limited to the NEQCA ACO. Not all Highland PCPs participate.

8. Medicaid data is limited to the Wellforce ACO. Not all Highland PCPs participate.

9. Network Health - includes Medicaid and Connector products.