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?

Reliant Medical Group's cost containment efforts are focused in three main areas:

First, Reliant seeks to reduce the growth in prescription drug spending, particularly for high-cost specialty drugs. We have tools embedded in our electronic medical record that provide prescribers with clinical protocols, guidelines, and formularies for drugs. We also have initiatives underway to provide education and information to prescribers on the cost effectiveness of clinically appropriate and therapeutically equivalent treatment alternatives and sites of service, and to monitor prescribing practices among our clinicians so that we can design interventions as appropriate. Reliant's Office of Population Health works closely with our patients to assure appropriate medication adherence and compliance, particularly for highly complex individuals. Finally, we have hired clinical pharmacists that provide consultation and medication reconciliation for complex patients, perform prior authorization reviews for high-cost drugs, and conduct academic detailing on appropriate prescribing, particularly for opioids and other pain medications.

Second, Reliant is focused on improving treatment for patients with substance use disorders and other behavioral health conditions. We are in the process of implementing a new model of behavioral health care, which will include standardized screening protocols to help us better identify and track patient needs. We are deploying embedded behavioral health clinicians to all our primary care practices so that we can arrange for care for our patients as soon as a substance use or behavioral health need is identified. Reliant also is engaging with targeted behavioral health providers and substance use treatment facilities in the community so that we can provide coordinated referrals for evidence-based treatments for specialized conditions that Reliant may not have the capacity of expertise to appropriately manage. Finally, we are developing a medication-assisted treatment program that will allow us to provide chronic care management to substance use disorder patients in recovery.

Third, Reliant is increasingly concerned about rising hospital unit costs for inpatient services. Consistent with the Health Policy Commission's research, we have found that the hospitals who care for Reliant's patients have sharply increased the use of higher-complexity Diagnosis-Reliant Group (DRG) codes, and reimbursement for an increasing number of hospital discharges incorporates an outlier payment. Reliant is working with the payers in Massachusetts to encourage more comprehensive auditing of inpatient

claims to assure that hospital billing is appropriate and supported by the clinical documentation. We also continue to find opportunities to divert patients from hospital settings to lower-cost sites of care.

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

With regard to escalating pharmacy costs, Reliant Medical Group supports federal and state regulatory controls on drug pricing, potentially including limits on annual price increases and an approval process for the pricing of new drugs based on clinical effectiveness. We also support regulatory limits on direct-to-consumer advertising, and we are encouraged by early efforts by CMS and others in the industry to reform the way providers are reimbursed for office-administered oncology drugs.

With substance use disorders, there are several areas where policy changes may help improve care for patients and reduce medical expenses. Federal law continues to limit clinical information sharing for patients with substance abuse histories and disorders. While Reliant recognizes patient concerns around maintaining the confidentiality of this information, confidentiality requirements in this area hinder efforts to effectively manage substance abuse disorders across provider settings. Moreover, we believe that HIPAA standards assure an appropriate level of privacy for patients while still permitting information exchange between treating providers. Reliant also believes that the Commonwealth can play a role in developing industry standards for measuring quality and outcomes in behavioral health services, and by promoting transparency of results for those behavioral health providers licensed in Massachusetts. Finally, Reliant encourages all payers – including the Commonwealth through MassHealth and the GIC – to promote greater integration of physical and behavioral health services through the elimination of behavioral health carve-outs.

With regard to inpatient hospital costs, we encourage the Health Policy Commission and the Attorney General to use their investigatory authority to assure that hospital billing practices are appropriate and compliant. Public payers, including MassHealth and the GIC, should promote more comprehensive auditing and claims editing practices with hospitals to address potential overpayment issues.

Finally, while Reliant recognizes the strides that Massachusetts has made in promoting value-based payment, we continue to be frustrated by the persistence of fee-for-service payment in much of the health care industry. We encourage the Commonwealth to expand upon existing payment reform efforts in MassHealth and other state programs, and we believe that state government can play a role in standardizing alternative payment and risk adjustment methodologies to assure consistency and actuarial stability in the commercial market.

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.

   At Reliant Medical Group, we believe that primary care is at the core of our efforts to provide high quality, evidence based, affordable care to our patients. While Reliant is a multi-specialty group that also offers a number of ancillary services to the community, our organization is structured to assure that we can provide excellent clinical care to patients with a Reliant primary care provider.

   In 2015, Reliant embarked on an ambitious care transformation initiative to develop an integrated, team-based model of care in our primary care practices. As part of this effort we also relocated many of our primary care practices to new, modern buildings. As excited as have been to move into new buildings, we are most enthusiastic about bringing into these new facilities more efficient processes and procedures that have enhanced the way we deliver care to our patients.

   To learn as much as we could about the process and facility changes that we sought to pursue as part of this care transformation effort, we constructed two modular experiential clinical settings, which we called "model cells." In these model cells, several providers worked with patients to test new ways of doing things. We looked at everything from how patients check in, to the kinds of services we provide right in the exam room, to how our clinicians and staff communicate with each other.

   Most importantly, we used the model cells to learn how to further refine our team approach to healthcare. Specifically, we developed an enhanced team care model where physician-led teams of various caregivers – including advanced practitioners, nurses, medical assistants, and others – all share in the care of patients. While we are still early in this transformation, it appears that these efforts have helped us to improve patient access, more effectively coordinate care, improve efficiency, and reduce clinician and staff burnout.

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.

   As noted above, Reliant is focused on improving treatment for patients with substance use disorders and other behavioral health conditions. We are in the process of implementing a new model of behavioral health care, which will include standardized screening protocols to help us better identify and track patient needs. We are deploying embedded behavioral health clinicians to all our primary care practices so that we can arrange for care for our patients as soon as a substance use or behavioral health need is

identified. Reliant also is engaging with targeted behavioral health providers and substance use treatment facilities in the community so that we can provide coordinated referrals for evidence-based treatments for specialized conditions that Reliant may not have the capacity of expertise to appropriately manage. Finally, we are developing a medication-assisted treatment program that will allow us to provide chronic care management to substance use disorder patients in recovery.

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?

Reliant Medical Group believes that the best way to support the delivery of high-quality primary care and behavioral health services is through value-based contracting arrangements where we assume financial risk for the total cost of care of our patient population. Reliant has operated under these arrangements since the 1970s because traditional fee-for-service payment does not adequately reimburse providers for these services. By contrast, value-based care arrangements assure that providers can take the time and invest the resources needed to keep patients as healthy as possible, reducing medical costs over the long term and improving patient wellbeing. None of the investments Reliant has made in primary care transformation and behavioral health integration would have been possible if we operated in a purely fee-for-service environment. Reliant continues to work with the payers in our market to move more of our patient volume into value-based arrangements.

Within fee-for-service payment models, Reliant remains concerned that reimbursement for behavioral health services is unacceptably low, particularly for those payers that utilize carve-out vendors. We believe that low remibursement limits the availability of providers available to patients, particularly those with complex or specialized needs.

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?

As noted above, while Reliant recognizes the strides that Massachusetts has made in promoting value-based payment, we continue to be frustrated by the persistence of fee-for-service payment in much of the health care industry. We encourage the Commonwealth to expand upon existing payment reform efforts in MassHealth and other state programs, and we believe that state government can play a role in standardizing alternative payment and risk adjustment methodologies to assure consistency and actuarial stability in the commercial market.

Reliant encourages all payers – including the Commonwealth through MassHealth and the GIC – to consider payment improvements for behavioral health providers, and to

promote greater integration of physical and behavioral health services through the elimination of behavioral health carve-outs.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

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

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Major Contributing Factor
Aging of your patients	Major Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Not a Significant Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Not a Significant Factor
New, relatively less healthy patients entering your patient pool	Minor Contributing Factor
Relatively healthier patients leaving your patient pool	Minor Contributing 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	Medium

Area of Administrative Complexity	Priority Level
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Low
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	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	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	High
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Low
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	High
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

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

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in

commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.**

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

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

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

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

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	32
	Q2	0	18
	Q3	0	24
	Q4	0	26
CY2018	**Q1**	0	44
	Q2	0	65
	Q3	0	25
	Q4	0	5
CY2019	**Q1**	0	31
	Q2	0	13
	TOTAL:	0	283

    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.

    Reliant Medical Group patients can request information on Reliant's fees either by speaking to staff at our clinical sites, or by calling our centralized Revenue Operations staff, and information can be provided to the patient immediately.

    If a patient is seeking specific allowance or contracted rate information to determine their out of pocket costs under a deductible or coinsurance, the staff at our clinical sites will

refer the individual to our centralized Revenue Operations staff. There, the staff utilizes multiple methods to obtain plan allowance and contracted rate information, including Recondo SurePay Health estimates for radiology services and the Experian/MPV software platform for all other services. In many cases, we can provide the information to the patient immediately while they are on the phone, though we respond to all information requests within one business day.

Our key challenge in providing plan allowance and contracted rate information is that the information is only accurate at the moment it is obtained. For example, if a patient has claims pending adjudication with their insurer that could accrue to their deductible or coinsurance prior to receiving services at Reliant, the estimate we give will be inaccurate. We communicate this limitation to our patients, and we provide them with contract information for the insurer if they need any more specific information.

c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

Reliant Medical Group receives very few consumer inquiries for price information, and we are consistently able to respond within one business day, if not immediately. As noted above, timing can affect the accuracy of the information we are able to provide to patients. We encourage patients to contact their insurer to understand their deductible and coinsurance responsibilities, as well as their current accruals for out of pocket expenditures within the benefit plan year.

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.

Not applicable; Reliant Medical Group does not have a corporate affiliation with a hospital.

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.

Not applicable; Reliant Medical Group does not have a corporate affiliation with a hospital.

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 Arrangements		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					114,430,964		2,170,312		3,667,974				
BCBSMA PPO										25,051,217			
Tufts FI					21,860,707		950,496		Combined				
Tufts SI					Combined				3,796,817				
Tufts PPO (incl. CareLink)				312,824						4,456,615			
HPHC FI					35,040,304		163,182		1,213,742				
HPHC SI									6,249,933				
HPHC PPO (incl. Passport & Independence)										8,063,887			
NHP Comm													
Fallon					115,208,184		820,296		16,331,866	417,063			
Aetna										5,005,891			
Other Commercial (Any remaining payors not listed above - lump together)									34,442,992	9,028,883			
Total Commercial	-	-	-	312,824	286,540,159	-	4,104,286	-	65,703,324	52,023,556			
Fallon Medicaid					22,101,827				3,288,056	Combined			
Total Managed Medicaid													
Medicaid FFS									9,193,359	Combined			
Tufts Medicare Preferred			Combined	357,889	175,072,374		95,460		225,055				
Medicare Advantage									6,448,011	Combined			
Commercial Medicare Subtotal													
Medicare FFS									Combined	21,826,093			
GRAND TOTAL	-	-	-	670,713	483,714,360	-	4,199,746	-	84,857,806	73,849,648			

Sources of Information:

Net Collection Analysis was used for FFS Arrangements
All Product Analysis was used to obtain Net Cap Revenue and Quality Incentives
PVV was used as a cross check of Net Cap Revenue
DME, Optics, SEE and Scope Subsidiary revenues were dropped into Commercial Other

Reconciliation to GL - Total Capitation Revenue			
	Cap	P4P Cap	Total
Per Above	483,714,360	4,199,746	487,914,106
Surplus Return	1,800,992	(1,800,992)	-
	485,515,352	2,398,754	487,914,106
Per GL	485,488,321	2,484,277	487,972,598
Difference Pass	27,031	(85,523)	(58,492)

Risk:			
Commercial	290,644,445	44.9%	
Medicare	175,167,834	27.1%	
Medicaid	22,101,827	3.4%	75.4%
Non-Risk:			
Commercial	118,039,704	18.2%	
Medicare	28,857,048	4.5%	
Medicaid	12,481,416	1.9%	24.6%
	647,292,273	100.0%	100.0%

2016	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Net Cap Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					#########				1,417,073		3,574,026	28,149,019			
Tufts Health Plan				188,071	19,978,527				1,051,944		3,338,630	5,049,082			
Harvard Pilgrim Health Care					46,391,202				86,269		8,168,333	7,992,871			
Fallon Community Health Plan					99,875,005				527,440		15,573,011	212,812			
CIGNA											3,291				
United Healthcare											4,116,337	133,479			
Aetna												5,320,843			
Other Commercial											25,413,075	11,933,851			
Total Commercial	0	0	0	188,071	#########	0	0	0	3,082,726	0	60,186,703	58,791,957	0	0	0
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan					21,814,184				138,788		4,927,493				
Other Managed Medicaid															
Total Managed Medicaid	0	0	0	0	21,814,184	0	0	0	138,788	0	4,927,493	0	0	0	0
MassHealth											12,824,645				
Tufts Medicare Preferred				101,873	#########				221,595						
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal	0	0	0	101,873	#########	0	0	0	221,595	0	0	0	0	0	0
Medicare											13,999,334	15,700,414			
Other															
GRAND TOTAL	0	0	0	289,944	#########	0	0	0	3,443,109	0	91,938,175	74,492,371	0	0	0

2017	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Net Cap 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					#########				2,131,775		3,425,085	29,826,683			
Tufts Health Plan				174,335	25,150,304				1,247,406		3,331,071	4,690,116			
Harvard Pilgrim Health Care					42,843,640				261,549		5,416,664	7,718,349			
Fallon Community Health Plan				390,374	91,541,546				489,056		12,508,604	215,158			
CIGNA											3,222				
United Healthcare											4,463,078	59,180			
Aetna												4,990,799			
Other Commercial											12,838,571	16,174,748			
Total Commercial	0	0	0	564,709	#########	0	0	0	4,129,786	0	41,986,295	63,675,033	0	0	0
Network Health															
Neighborhood Health Plan											1,904,663				
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan					28,544,058				183,548		5,743,062				
Other Managed Medicaid											2,418,847				
Total Managed Medicaid	0	0	0	0	28,544,058	0	0	0	183,548	0	10,066,572	0	0	0	0
MassHealth											6,567,710				
Tufts Medicare Preferred				0	#########				220,989		273,127				
Blue Cross Senior Options											803,868				
Other Comm Medicare											18,632,611	672,209			
Commercial Medicare Subtotal	0	0	0	0	#########	0	0	0	220,989	0	19,709,606	672,209	0	0	0
Medicare											0	9,464,579			
Other											13,047,737				
GRAND TOTAL	0	0	0	564,709	#########	0	0	0	4,534,323	0	91,377,920	73,811,821	0	0	0

** Note: Reliant reports capitation payments received for risk contracts under this column.

AGO Provider Exhibit 1

2018	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Net Cap 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					139,092,925				2,614,870		4,011,568	31,525,721			
Tufts Health Plan				(28,899)	26,564,767				1,111,324		3,667,531	4,552,263			
Harvard Pilgrim Health Care					41,691,461				161,494		5,178,946	7,982,946			
Fallon Community Health Plan					70,073,721				700,100		17,949,774	272,024			
CIGNA											2,349				
United Healthcare											4,386,188	66,007			
Aetna												5,435,614			
Other Commercial											13,423,121	17,157,626			
Total Commercial	-	-	-	(28,899)	277,422,874	-	-	-	4,587,788	-	48,619,477	66,992,201	-	-	-
Network Health															
Neighborhood Health Plan											292,264				
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan					45,405,581				13,491		5,538,107				
Other Managed Medicaid											2,894,563				
Total Managed Medicaid	-	-	-	-	45,405,581	-	-	-	13,491	-	8,724,934	-	-	-	-
MassHealth											3,194,921				
Tufts Medicare Preferred					162,085,414				144,291		396,339				
Blue Cross Senior Options											65,806	781,188			
Other Comm Medicare											20,006,331	862,191			
Commercial Medicare Subtotal	-	-	-	-	162,085,414	-	-	-	144,291	-	20,468,476	1,643,379	-	-	-
Medicare												10,273,674			
Other											11,588,262				
GRAND TOTAL	0	0	0	-28,899	484,913,869	0	0	0	4,745,570	0	92,596,070	78,909,254	0	0	0

** Note: Reliant reports capitation payments received for risk contracts under this column.