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?

With its founding by Circle Health and Tufts Medical Center in 2014, Wellforce set out to be a force for change in health care. A force to prove that more care belongs in the community. A force to support the physician-patient relationship. And a force to show that high-quality care doesn't have to be high cost. Over the past 5 years, Wellforce has continued to build a health system driven by the clinical-patient relationship and rooted in the communities we serve.

Wellforce continues to create value in the healthcare system by building upon a foundational tenet to pursue risk contracts where our physicians are supported and directly accountable for driving down total medical expense. Wellforce has also relentlessly pursued operational efficiencies and synergies we could not have achieved as single entities. We have improved the quality and connectedness of care, saved millions of dollars and we have brought more services closer to our patients.

Wellforce members are working together to control the cost of healthcare. By sharing best practices, using our purchasing power, integrating technologies and improving processes we have extracted more than $20 million of unnecessary costs out of the system. Clinical programs executed by the Wellforce Care Plan ACO, Home Health Foundation, urgent care and telehealth services enhance our ability to help families receive the right care in the right setting.

Wellforce was founded on the principle that care should be delivered when and where the patient needs it. We agreed we would not be constrained by the historical market philosophy perpetuated by our competitors that Boston has to be the hub of care. In just a few short years, Wellforce has proven complex, high-quality care in the community is not just a possibility but a reality. Below are some examples of how we have increased care in local communities:

Connected CardioVascular Care

A 100-member multi-disciplinary team of CardioVascular experts has created an enhanced and consistent cardiovascular experience across Wellforce. The group selected Heart Failure and Atrial Fibrillation as the first projects, creating standardized patient education materials and a nurse navigator program; improving patient outcomes across the system.

Intensive Commitment to Complex Care Close to Home

Lowell General Hospital and Tufts Medical Center began an ICU partnership more than five years ago. The results have included a higher case mix at Lowell General, greater value and, most importantly, more patients have stayed close to home and family. The intensivist team at Tufts Medical Center is now working with MelroseWakefield Hospital staff to recreate these results in Melrose.

Neurosurgery in Melrose

Through a partnership between Wellforce members Tufts Medical Center and MelroseWakefield Healthcare, north suburban area residents now have access to comprehensive spine and cranial care. Tufts Medical Center neurosurgeons provide consultations and surgeries at MelroseWakefield Hospital. The programs are attracting new patients into the MWHC system, increasing case mix, lowering costs and maximizing convenience for patients.

Home Care Services

In 2018, Home Health Foundation, a leader of home health and hospice care in the Merrimack Valley region, joined Wellforce. The demand or connecting services that will prevent ED and inpatient hospital admissions and connect post-discharge services is increasing across our network. Technological advancements mean more care can be delivered safely, conveniently and efficiently in the home. Home health and hospice services allow Wellforce clinicians to stay connected with an aging population and those with chronic conditions, decreasing readmissions and enhancing their quality of life. With this addition to Wellforce, we have expanded our reach along the continuum of care and added value with a focus on exceptional patient care.

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

1. **Support High Value Providers:** Supporting high value providers will be critical to meet the challenge of keeping healthcare cost growth at or below the benchmark; it will also be critical in ensuring lower income communities have access to high quality healthcare providers.
2. **Create Equity**: Government and payers can work to create greater equity in the distribution of healthcare resources throughout our communities. The inequitable distribution of healthcare dollars across communities in Massachusetts not only disadvantages providers in lower income cities and towns, it exacerbates the disparities that exist for these communities around health, access to care and financial ability to afford care to stay well.
3. **Align incentives to improve quality and lower costs:** The growth of capitated or population based payment contracts (built on an equitable payment model) should be encouraged over growth of fee for services insurance products and payer/provider contracts.
4. **Enhance Primary Care and Behavioral Health:** Enhancing payments for primary care and behavioral health services will help address the increasing demand and growing responsibilities of providing these services. Increasing payment for primary care and behavioral health will also help attract clinicians into these fields and help address the some of the dire need for services.
5. **Constrain pharmaceutical price growth:** Pharmaceutical spending growth is an element that consistently strains the budgets for every Wellforce entity. Wellforce has a pharmacy team supporting our hospitals and providers to reduce drug expenses, standardize care and align our pharmacy relationships, however this continues to be an area of cost growth far beyond our reach to constrain in any meaningful way.

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.

Wellforce entities have made significant investments in primary care to improve the health of our communities, enhance quality of care and increase access to services, while also reducing total medical expenses. Through the Wellforce Care Plan Medicaid ACO, Wellforce, in partnership with Fallon Health, has made significant investments in population health and primary care. One such investment includes regional care teams, consisting of RNs, Social Workers and Community Health Workers. These care teams manage the care of our most complex patients. Our MCO partner, Fallon Health, provides care coordination activities such as referrals for transportation and other services, which is very helpful to the primary care offices.

Some additional examples of the focused strategies and investments we have made in primary care for adults and children are:

- Creating greater access for our patients with extended hours weekday (until 8pm) and weekend appointments available.
- Deploying care management teams including social work, nursing and community health workers for Wellforce/Fallon Mass Health ACO and Next Gen Medicare ACO.
- Nurse transition teams are making post discharge calls to all primary care patients discharged from Tufts MC

- Pharmacists are embedded in some practices to support clinicians

- Point of care testing for diabetic patients that identifies allows to receive immediate follow-up care
- Assignment of a Physician Assistant team member to groups of physicians, with dedicated administrative time, to manage our chronic opioid patients in addition to supporting primary care
- Providing staffing flexibility and providing administrative support to help employed physicians manage their panels and support their practice administration

- Practice engagement in improvement assessments focused on: responsibility delegation/sharing, team building, decreasing ED utilization, improving Social Determinants of Health screening, understanding and addressing high need areas

- A number of practices are working towards Social Determinants of Health Screening for 100% of patients annually and using this data to assist their patients

- Supporting our large and small community physician practices to enhance practice sustainability, provider satisfaction and reduce burnout. Programs for physicians include leadership support and training, on-going education opportunities, including focused trainings building physicians skills in the following areas: leadership, negotiations, financial stewardship, resilience and change management

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.
The behavioral health and psychiatric needs of our patients cover a very wide spectrum, varying from highly acute, multi-symptom medical and behavioral complexities requiring inpatient admissions, to lesser diagnosis requiring consistent pharmacological management or lower intensity interventions or early intervention services. Supporting a network of clinicians to address this varying need can be incredibly challenging and resource intensive. As a nation we must continue to make progress in how we treat behavioral health. Within our communities Wellforce members have taken a number of steps to enhance the provision of the various services needed to address the growing behavioral health needs of our patients. Below are a number of those measures:

- Tufts MC primary care practices have an embedded Medical Addiction Therapy program, an Addiction Psychiatrist is on hand in clinics weekly consulting on patients with addiction disorders.
- A Physician Assistant is made available to help clinicians manage chronic opioid patients in addition to supporting primary care patients in the practice
- Many practices have social workers embedded in their practices specifically to help assist with the acute decompensation of patients and assist with psychiatry referrals.
- Many of our pediatric practice has embedded social workers providing onsite behavioral health support.
- The Tufts MC pediatric clinic also added an addiction psychiatrist and dedicated social workers and development needs specialists who speak multiple languages and have numerous cultural competencies to serve the needs of a dynamic urban population

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?

The transition from fee for service care to value based care requires investment in infrastructure to support practice transformation. That investment includes recruiting and maintaining a multidisciplinary team, developing reporting and analytic capacity, following patients through the continuum of care and expanding home based advanced care. This infrastructure investment requires dedicated funding to build and sustain. Payment mechanisms that fund this infrastructure enable practices and provider organizations to step away from fee for service and develop programs to manage their patient population. The following would be effective in strengthening and supporting primary care and behavioral health services:

- Additional funding for care management teams to support patients regardless of their insurer
- Reimbursement to allow physicians to care for patients outside of the office visit structure
- Increase amount and duration of mental health benefits for all patients
- Robust payment for telehealth and other strategies that could help keep patients out of the hospital or physician's office

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?

Uniformly across Wellforce our providers state that the single biggest change to most improve access to primary care and behavioral health care would be to increase reimbursement rates.

The other area of greatest concern at Wellforce is the sustainability of the programs developed through the ACO models, specifically the Medicaid ACO. The steeply declining DSRIP budget makes it difficult to sustain important member support programs and we would view an ongoing administrative payment (per member, per month funding) as a more workable and essential incentive.

Update, educate and integrate the behavioral health and substance use disorder privacy regulations. Across Wellforce clinicians continue to be frustrated by the myriad of privacy regulations that prohibit information sharing that could greatly improve patient care. Or worse, they are frustrated by the misunderstanding or misconceptions that providers across the care continuum perpetuate fear of violating privacy laws over better, more informed na d collaborative patient care management.

The current system of isolating behavioral health and substance use disorder care results in a total lack of communication with the rest of the patient care and support system. This makes collaboration of patient care planning, medicine reconciliation, and active problem solving difficult. In order to provide "whole person health", the behavioral health plan needs to be incorporated in with the medical and social care plans.

Primary care practices across Wellforce are engaging in a transformation to innovate, meet the dynamic needs of their patient panels and address a growing burden of administrivia. They are building integrated team based population health care models that provide high quality care, reduce total medical expense, educate patients and their families, address prevention, track, analyze and address gaps in care and social supports, deliver cost effective pharmacotherapy and provide robust behavioral health care services. This requires funding which cannot be generated by practice revenue alone.

Additional efforts that would accelerate enhancements would be the following:

- Move away from fee for service payment structures and toward alternative payments that drive value and align population health management
- Support funding increases and innovations for psychiatry, social work and addiction therapy management to work alongside primary care clinicians
- Address physician burnout by decreasing administrative burden (eliminate prior authorizations and peer-to-peer referral hurdles, standardize and limit quality measures, remove billing and coding rules to decrease documentation burden)

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	Minor Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Minor Contributing Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Major 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	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	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	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	Low
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Low
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	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	Medium

Area of Administrative Complexity	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

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: **Establishment of a universal methodology and rules set for risk adjustment and claims payment methodologies common among all payers.**

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**	18	N/A
	Q2	25	N/A
	Q3	32	240-360*
	Q4	44	240-360*
CY2018	**Q1**	57	240-360*
	Q2	78	240-360*
	Q3	71	240-360*
	Q4	119	240-360*
CY2019	**Q1**	182	240-360*
	Q2	189	240-360*
	TOTAL:	**815**	**1,920-2,880***

Totals based on a daily average of 4-6 inquiries.

    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.
    Financial Coordinators at Tufts MC work closely with the clinical teams in identifying every procedure/service that will be performed during the patient. This info is taken along with the patient's diagnosis, age, and sex in order to create the most accurate estimate. It is their goal to provide estimates within 24hours of the original request if all request info is readily available. After the

visit, we compare the estimated charges to the actual charges to check for accuracy and/or discrepancy in pricing.
Lowell General Hospital provides patient pricing estimates, but has not yet developed a tracking tool to capture the number and type of requests.

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

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

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

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

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.

2. Please include POS payments under HMO.

3. Please include Indemnity payments under PPO.

4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.

5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.

6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.

7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).

8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.

10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.

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

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					36,266,837	40,058,922	6,128,921		2,474,586						1,132,188
Tufts Health Plan					17,909,186		2,996,830		149,305						214,678
Harvard Pilgrim Health Care					21,363,593		(265,460)		195,511						495,945
Fallon Community Health Plan					3,524,180				84,343						179,537
CIGNA											2,271,210				
United Healthcare											15,793,066				
Aetna											5,113,115				
Other Commercial											12,557,222				
Total Commercial	-	-	-	-	79,063,796	40,058,922	8,860,291	-	2,903,745	-	35,734,613	-	-	-	2,022,348
Network Health											24,440,795				
Neighborhood Health Plan											26,106,257				
BMC HealthNet, Inc.											4,660,115				
Health New England															
Fallon Community Health Plan											706,637				
Other Managed Medicaid											1,493,348				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	57,407,152	-	-	-	-
MassHealth	26,277,439		477,538												
Tufts Medicare Preferred					2,840,200		4,369,898								9,996,604
Blue Cross Senior Options											2,972,689				
Other Comm Medicare											27,524,568				
Commercial Medicare Subtotal	-	-	-	-	2,840,200	-	4,369,898	-	-	-	30,497,257	-	-	-	9,996,604
Medicare											##########				1,106,195
Other											28,225,076				
GRAND TOTAL	26,277,439	-	477,538	-	81,903,996	40,058,922	########	-	2,903,745	-	##########	-	-	-	13,125,147

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					35,136,057	37,921,363	825,982		5,337,628						1,092,174
Tufts Health Plan					19,019,851		1,201,395		149,810						355,431
Harvard Pilgrim Health Care					17,411,879		2,030,194		334,777						606,678
Fallon Community Health Plan					3,511,999		54,380		153,642						376,076
CIGNA											2,892,644				
United Healthcare											15,125,278				
Aetna											5,175,568				
Other Commercial											14,408,129				
Total Commercial	-	-	-	-	75,079,786	37,921,363	4,111,951	-	5,975,857	-	37,601,619	-	-	-	2,430,359
Network Health											27,710,054				
Neighborhood Health Plan											25,262,009				
BMC HealthNet, Inc.											5,413,697				
Health New England															
Fallon Community Health Plan											1,886,627				
Other Managed Medicaid											1,380,257				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	61,652,644	-	-	-	-
MassHealth	30,339,055		450,000												
Tufts Medicare Preferred					1,948,949		4,438,964								10,109,863
Blue Cross Senior Options											1,399,944				
Other Comm Medicare											30,267,884				
Commercial Medicare Subtotal	-	-	-	-	1,948,949	-	4,438,964	-	-	-	31,667,828	-	-	-	10,109,863
Medicare											112,708,860				1,652,176
Other											35,678,411				
GRAND TOTAL	30,339,055	-	450,000	-	77,028,735	37,921,363	8,550,915	-	5,975,857	-	279,309,362	-	-	-	14,192,398	453,767,685

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					32,848,214	37,190,277	7,522,188		4,393,063						1,188,583
Tufts Health Plan					17,016,554		4,056,165		140,445						356,237
Harvard Pilgrim Health Care					16,034,818		(503,698)		372,092						573,448
Fallon Community Health Plan					4,500,794		225,000		98,965						245,049
CIGNA											4,014,363				
United Healthcare											14,203,268				
Aetna											5,613,061				
Other Commercial											16,087,282				
Total Commercial	-	-	-	-	70,400,379	37,190,277	11,299,655	-	5,004,565	-	39,917,974	-	-	-	2,363,316
Network Health											28,677,493				
Neighborhood Health Plan											12,006,377				
BMC HealthNet, Inc.											4,463,818				
Health New England															
Fallon Community Health Plan											23,438,389				
Other Managed Medicaid											4,706,041				5,285,000
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	73,292,118	-	-	-	5,285,000
MassHealth	27,233,957		352,484												
Tufts Medicare Preferred							2,975,646				1,921,026				10,186,260
Blue Cross Senior Options											1,479,029				
Other Comm Medicare											33,048,071				
Commercial Medicare Subtotal	-	-	-	-	-	-	2,975,646	-	-	-	36,448,126	-	-	-	10,186,260
Medicare											110,707,732				761,960
Other											35,513,086				
GRAND TOTAL	27,233,957	-	352,484	-	70,400,379	37,190,277	14,275,301	-	5,004,565	-	295,879,037	-	-	-	18,596,536

468,932,538

Tufts Medical Center

2016

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	HPIP	Notes:
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue									
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both			
BCBSMA	35,974,869	63,024,465	1,810,287	3,171,446												103,981,067	4.791%	
Tufts					50,751,692		-				-					50,751,692		do not distinguish HMO v. PPO, reported all as HMO
HPHC	51,724,770		188,564													51,913,334	0.38%	do not distinguish HMO v. PPO, reported all as HMO
Fallon												4,945,029				4,945,029		no delineation by product, reprt as PPO
CIGNA												6,166,409				6,166,409		no delineation by product, reprt as PPO
United												16,755,590				16,755,590		no delineation by product, reprt as PPO
Aetna												8,655,392				8,655,392		no delineation by product, reprt as PPO
Other Commercial												24,449,091				24,449,091		no delineation by product, reprt as PPO (include urn-transf
Total Commercial	87,699,639	63,024,465	1,998,851	3,171,446	50,751,692	-	-	-	-	-	-	60,971,510	-	-	-			
																-		
Network Health											25,207,428					25,207,428		do not distinguish HMO v. PPO, reported all as HMO
NHP											31,211,082					31,211,082		do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											12,045,114					12,045,114		do not distinguish HMO v. PPO, reported all as HMO
Fallon											447,046					447,046		do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											68,910,670							
																-		
Mass Health		53,067,542		865,802										1,500,000		55,433,344		classified all as PPO
																-		
Tufts Medicare Preferred					14,431,259		-									14,431,259		do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											6,284,431					6,284,431		do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											21,065,385					21,065,385		do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					14,431,259						27,349,817							
																-		
Medicare												164,072,537				164,072,537		classified all as PPO
																-		
All Other Payors												37,307,772			2,550,000	39,857,772		includes Comm Conn + GIC + Wcomp+ OOState Mediciaid ·
GRAND TOTAL	87,699,639	116,092,007	1,998,851	4,037,248	65,182,951	-	-	-	-	-	96,260,486	262,351,820	-	1,500,000	2,550,000	637,673,003		

Tufts Medical Center

2017

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	HPIP %	Notes:
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue									
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both			
BCBSMA	40,929,338	71,970,471	1,797,407	3,160,575												117,857,791	4.207%	
Tufts					55,762,545		-				-					55,762,545		do not distinguish HMO v. PPO, reported all as HMO
HPHC	48,588,529		246,779													48,835,308	0.53%	do not distinguish HMO v. PPO, reported all as HMO
Fallon												4,508,480				4,508,480		no delineation by product, reprt as PPO
CIGNA												5,774,216				5,774,216		no delineation by product, reprt as PPO
United												17,197,073				17,197,073		no delineation by product, reprt as PPO
Aetna												8,345,972				8,345,972		no delineation by product, reprt as PPO
Other Commercial												21,274,646				21,274,646		no delineation by product, reprt as PPO
Total Commercial	89,517,867	71,970,471	2,044,186	3,160,575	55,762,545	-	-	-	-	-	-	57,100,388	-	-	-	-		
																-		
Network Health											30,283,180					30,283,180		do not distinguish HMO v. PPO, reported all as HMO
NHP											30,924,292					30,924,292		do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											13,904,742					13,904,742		do not distinguish HMO v. PPO, reported all as HMO
Fallon											1,501,399					1,501,399		do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											76,613,613							
																-		
Mass Health		55,694,299		2,516,353										1,500,000		59,710,652		classified all as PPO
																-		
Tufts Medicare Preferred					13,783,082		-									13,783,082		do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											5,778,000					5,778,000		do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											24,575,195					24,575,195		do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					13,783,082						30,353,194							
																-		
Medicare												169,908,788				169,908,788		classified all as PPO
																-		
All Other Payors												40,214,676			3,370,146	43,584,822		includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	89,517,867	127,664,770	2,044,186	5,676,928	69,545,627	-	-	-	-	-	106,966,808	267,223,852	-	1,500,000	3,370,146	673,510,184		

Tufts Medical Center, FY 2018
AGO Provider Exhibit 1

2018	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			Notes:
	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	45,743,873	78,071,135	1,351,578	2,315,052												
Tufts Health Plan					62,981,199											do not distinguish HMO v. PPO, reported all as HMO
Harvard Pilgrim Health Care	52,557,749		236,253													do not distinguish HMO v. PPO, reported all as HMO
Fallon Community Health Plan												3,489,258				no delineation by product, reprt as PPO
CIGNA												8,433,378				no delineation by product, reprt as PPO
United Healthcare												14,039,718				no delineation by product, reprt as PPO
Aetna												10,052,572				no delineation by product, reprt as PPO
Other Commercial												23,238,124				no delineation by product, reprt as PPO
Total Commercial	98,301,622	78,071,135	1,587,831	2,315,052	62,981,199	-	-	-	-	-	-	59,253,050	-	-	-	
Network Health											31,857,855					do not distinguish HMO v. PPO, reported all as HMO, includes MC Plan + ACO Referral biz
Neighborhood Health Plan											12,953,334					do not distinguish HMO v. PPO, reported all as HMO, includes MC Plan + ACO Referral biz
BMC HealthNet, Inc.											21,024,361					do not distinguish HMO v. PPO, reported all as HMO, includes MC Plan + ACO Referral biz
Health New England																do not distinguish HMO v. PPO, reported all as HMO, includes MC Plan + ACO Referral biz
Fallon Community Health Plan					19,633,485						1,593,212					do not distinguish HMO v. PPO, reported all as HMO, includes MC Plan + ACO Referral biz
Other Managed Medicaid											8,875,817					includes Caid PCC Program
Total Managed Medicaid	-	-	-	-	19,633,485	-	-	-	-	-	76,304,579	-	-	-	-	
MassHealth		48,776,200		1,097,102											5,315,000	do not distinguish HMO v. PPO, reported all as HMO, incl Psych + Pedi High CMI + Caid Safety Net Hosp
Tufts Medicare Preferred					16,095,578											do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											6,288,381					
Other Comm Medicare											34,428,932					all other Medicare Mgd biz, no psych
Commercial Medicare Subtotal	-	-	-	-	16,095,578	-	-	-	-	-	40,717,313	-	-	-	-	classified all as PPO
Medicare												186,305,896				includes Mcre + Mcre Psych + PIP
Other												41,768,025				includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	98,301,622	126,847,335	1,587,831	3,412,154	98,710,262	-	-	-	-	-	117,021,892	287,326,971	-	-	5,315,000	