



September 11, 2015

[Via Email: HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us)

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

To whom it may concern:

This e-mail is in response to the letter we received from David Seltz, Executive Director, Health Policy Commission, dated August 6, 2015, requesting that we provide certain information to the Health Policy Commission. We have attached our responses in the attached files.

I am legally authorized and empowered to represent Sturdy Memorial Hospital for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Please direct any questions to this filing to me. My phone number is (508) 236-8155.

Sincerely,

A handwritten signature in blue ink that reads 'Joseph Casey'.

Joseph Casey
CFO

Sturdy Memorial Hospital

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine 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.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

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: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** 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**.

We encourage you to refer to and build upon your organization's 2013 or 2014 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.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and 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 other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.

- a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

The table below summarizes revenue, utilization, and expense for seven months of calendar year 2015 (annualized) compared to a full year of calendar year 2014. Expenses for 2015 were also adjusted for any anticipated year-end entries to make them comparable to CY 2014.

	CY 2014	CY 2015 (annualized)	Incr (Dcr)	Inc (Dcr) percentage
Net Revenue	\$158,884,341	\$159,771,219	\$886,878	0.56%
Free Care	\$2,462,196	\$3,031,149	\$568,953	18.77%
Patient Days	27,899	30,144	2245	7.45%
Discharges	6,714	6,977	263	3.77%
ALOS	4.16	4.32	.17	3.82%
Observations	2,120	2,158	38	1.77%
Births	713	636	-77	-12.11%
ER visits	52,181	51,489	-692	-1.34%
Oncology visits	7,231	7,095	-136	-1.91%
OR cases	9,020	8,467	-553	-6.53%
Total Expense	\$149,494,494	\$155,555,640	\$6,061,146	3.9%

Volume year over year shows an increase in inpatient discharges and days and a decrease in births and the outpatient statistics as detailed in the table above. Both inpatient and outpatient volume typically fluctuates a few percentage points each year with no identifiable reason. The OR case volume decrease in CY 15 was impacted by the vacancy of one of our GI surgeons which is now filled. Births in this area of the state have been trending lower which is likely contributing to the decline. The severe winter had a negative impact on the Emergency Room volume as well as our clinics because of travel restrictions/difficulties. This also adversely affected ALOS as we were not always able to discharge patients on time because of the weather. The increase in patient days was primarily in the Medicare population.

Comparing annualized CY 2015 to CY 2014, net revenue is up approximately .6% while expenses increased 3.9%. The hospital payer mix is currently 64% governmental (Medicare, Medicaid and state subsidized). Reimbursements from the government payers are substantially below commercial rates and annual rate increases do not keep pace with

inflation. Commercial payers are generally tied to (at or below) an inflation factor which has been running between 2% and 2.5% in the past 3 years. The high percentage of government payer mix puts downward pressure on net revenue growth while expenses continue to increase. Approximately 66% of Sturdy’s expenses are for wages and benefits. Salaries and wages increased at a higher rate than inflation as a result of enhanced nursing rate increases for retention and recruitment purposes. The hospital maintains a fully funded defined benefit pension for its employees. The mortality assumption was changed as of October 1, 2014, as a result of a recommendation by the Society of Actuaries, which increased our annual pension expense by an additional \$1,526,000, which is equal to 1% of total operating expenses.

- b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

The following actions have been undertaken to contribute to cost reduction:

- Orthopedic initiative to improve clinical care of hip/knee replacement patients as follows:
 - Standardized pre-operative classes for all hip/knee patients.
 - Enhanced the pain management protocol to prevent over sedation.
 - Early ambulation and increased physical therapy in the inpatient setting.

Results from the orthopedic initiative detailed in the table below demonstrate a decreased length of stay in the hospital of approximately ½ day and a drop in patients discharged to SNF (rather than discharged home) from the 68.8% baseline to 50.7% or less in each of the 3 FY 15 quarters. This would support lower acute hospital costs and lower skilled nursing facility costs

	FY 13 (baseline)	FY 14	Q1 FY15	Q2 FY15	Q3 FY15
Hospital ALOS	3.5	3.2	3.0	3.0	3.1
% disch to SNF	68.8%	63.9%	50.7%	29.7%	49.2%

- Reduced readmissions by assigning a nurse case manager to meet with high risk patients (COPD and CHF) in the hospital setting and then follow the patient post discharge to identify any gaps in medication and dietary adherence, as well as follow-up with PCP.
- Oncology nurse navigator (see answer to Question 3(a))
- The hospital has given up rate increases to third party payers which directly lead to lower premium costs. Commercial reimbursement increases for FY 16 are 1%.
- The hospital has a value analysis committee that throughout the year reviews all new supplies, including those that replace existing supplies. The committee is staffed with a wide range of clinical, operational and fiscal representatives. Supplies are tested in pilot groups and reviewed for both clinical performance and

pricing impact prior to purchasing for general use. This program has resulted in substantial saving that annually exceeds \$100,000.

- Reduced staffing in the billing office .9 ftes or 4% as a result of continued efficiencies from additional conversion to electronic billing and payment systems. Nursing aides were reduced approximately 4.0 ftes which savings was used to fund additional RN staff to better meet patient clinical needs without increasing costs.
- Built an initial screening tool for nurses to identify palliative care candidates with the goal of reducing hospital readmissions. Recently contracted with Hope Hospice to facilitate palliative care transitions (see program description to 1(c) below).

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

- The following initiatives are planned which will result in reduced costs, primarily from a reduction in hospital readmissions:
 - Institute a post-acute care team (PACT) that includes community providers such as skilled nursing facilities (SNF) and home care agencies, to improve transitions of care by doing the following: partner with skilled nursing facilities (SNFs), community and home health care agencies to develop and implement strategies for improved patient transitions back to the community with appropriate resource and support systems in place.
 - Develop standardized care plans and order sets that more fully integrate the Gold Standards for COPD patient care management.
 - Partner with Hope Hospice to provide an on-site patient liaison to facilitate appropriate access to hospice and palliative care services.
 - Plan to provide on-site pharmacy which will allow patients to obtain prescriptions at discharge and receive enhanced education regarding medications
 - Staff a nurse case manager in the Emergency Room to appropriately review patient admissions that may be avoidable, and facilitate support services including home health, rehabilitation, and hospice for those patients deemed appropriate to safely transition back to the community.
- Enter into an AQC contract with Blue Cross Blue Shield of Massachusetts which will provide economic incentives for physicians and the hospital that may result in better care coordination and lower costs.
- Partner with UMass Medical Center to join their Medicare shared savings ACO. This will provide data enabling us to identify high risk patients and develop plans for specifically managing health care for those patient populations

- d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
- Fee for Service Medicare has a rule that requires beneficiaries to spend seventy-two hours in an acute hospital in order to be able to access the skilled nursing benefit. We would recommend the rule be removed.
 - Facilitate the exchange of health care information for physicians, hospitals, skilled nursing providers, home care and other strategic health care providers. Currently the state information highway is not facilitating this sharing of data in any meaningful way. A time line should be established for the state to implement a health information exchange that forces IS vendors to participate in a way that is transparent to health care providers.
 - MassHealth should pay for hospital based nurse practitioner and physician assistant services (Medicare and commercial insurers already do this). Physician extenders are less costly than physicians and should be encouraged.
 - Consolidation of reporting requirements so that hospitals are not reporting the same information to multiple sources, such as Board of Pharmacy, DPH, Board of Medicine. Consider creating a central repository of such information and allow these agencies to access what they require.
 - Enhance availability of behavior health services which will reduce hospital admissions as well as the length of stay in the inpatient and emergency room settings. We currently struggle with available psychiatric beds for patients requiring placement, as well as availability of outpatient behavioral health services for those transitioning out into the community.
 - Revise the guardianship process for patients deemed incompetent, to expedite the transition of care to the most appropriate, least costly setting.
 - Standardize the forms and pre authorization routines that payers require. It appears that the pre-authorization process is sometimes used to discourage utilization of necessary services and/or avoid payment.
 - Improve timeliness of available clinical outcomes and fiscal data, much of which lags by two to four years. The current lag time in availability and reporting has two downsides. For one it frequently hampers our ability to make meaningful quality improvement changes. Secondly, for measures, such as readmissions, and other measures associated with financial penalties, having reimbursement reduced two to four years after the measurement period risks eliminating financial resources that might be used to address the performance measure in the current period.
2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
- The hospital, and network of physicians in the Attleboro area, is relatively small which makes the assumption any global budget or shared risk strategies risky.
 - The data that we have received from the insurance companies, that would be necessary to manage and succeed in these alternative payment arrangements, does not translate very well to actionable items. Our experience is that the information provided by the insurance companies is not readily available in real time and is limited in providing strategies and guidance in managing and reducing costs.

- Nurse case manager shortages are currently slowing our ability to implement cost savings strategies outlined in 1(c) above.
 - Medicare Advantage rates are based on historical county costs which has resulted in disproportionate expansion in counties that have had higher historic rates. Bristol county has historically lower Medicare costs per beneficiary which makes it more difficult to build a viable financial savings model. It is possible that strategies to increase Medicare Advantage capitation payments for patient “risk scores” might produce a viable financial model, but it is unlikely to produce any real cost savings (it simply gives the illusion of savings by increasing the existing patient health status score).
 - The dual eligible (Medicare and Medicaid) under 65 state initiative is not available to Bristol county residents which likely resulted from the lower Bristol county based Medicare rates noted above.
 - We approached Commercial payers to develop an orthopedic bundled rate but were turned down. Apparently their systems could not accommodate such an initiative. It did not fit with their claims payment system
 - Lack of evidence that the investment in capitation type agreements can actually be covered by cost savings. For example, Medicare Advantage is actually costing the federal government more than the fee for service model.
 - The hospital is located in Attleboro Massachusetts which borders Rhode Island. Rhode Island hospital is the closest trauma hospital to residents in our community. It appears that the contracted rates that some of the key payers have with the providers in Rhode Island are higher than what they would be with similar hospitals in Massachusetts which would make our TME costs higher than other Massachusetts hospitals that do not border Rhode Island(or possibly other states)
3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
- a. Please describe your organization’s efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts. We have already commented on much of this in questions 1(b) and 1(c). The following additional information is provided:
- The hospital piloted an initiative aimed at MassHealth patients with excessively high emergency room utilization. This effort was partially funded by an Infrastructure and Capacity Building Grant. Based on utilization for the 12 months ended March 2014, 30 patients were selected for the target group (17 patients were in the group from the previous year). During the initial visit with their PCP, participants were educated about the program and asked to sign a contract with their PCP that included calling the PCP prior to visiting Emergency Room and coming to the PCP office instead of going to the Emergency Room if appropriate. Participants also received an introductory call from a case manager within 3 days of signing-on to the program. The case manager continued to work with the participants throughout the program term. ER utilization for the group dropped from an average of 16.3 visits per month to 9.9 per visits per month. The savings from the decreased ER utilization did not offset the cost of the program.

It's possible several of the patients in the program changed their behavior permanently so that there would be continued savings to MassHealth even after the program terminated.

- We share data on frequency of emergency room visits with our primary care physicians provided by certain payers. This peer comparison data has been helpful in identify outliers and in educating physicians to decrease unnecessary emergency room utilization.
- In FY 2014 the hospital implemented a nurse navigator program in Oncology to coordinate care for cancer patients with the purpose of better outcomes for these compromised, high risk patients. The patient navigation process begins at the time of diagnosis. All newly diagnosed cancer patients are screened for psychosocial distress, and physical and functional impairments. The nurse navigator addresses and obtains orders for the appropriate referrals to support services. The nurse navigator guides the patient and family though the healthcare system, helping to overcome any barriers for patients and their families. The navigation process includes consistently tracking quality care indicators and evaluating patient outcomes. The Cancer Program has also achieved STAR certification, which coordinates a variety of rehab and symptom management services, as part of the treatment and post-treatment options, aimed toward improving the quality of life for cancer survivors across the continuum of care.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

The specifics of our plans have been detailed in our many of the answers given in questions previous to this. Details of the following additional plans are provided:

- Approximately 35% of U.S. adults are obese putting them at higher risk of disease and complication than the general population. Frequently these patients also have chronic illnesses such as COPD, CHF and Diabetes. We plan to implement a comprehensive Bariatric Weight Management Program in the next 12 months which will provide nutritional services and psychiatric consultations to participants. This program will be integrated with services that we currently provide, which will result in an overall, comprehensive wellness program that includes diabetic teaching, medically supervised cardiac and pulmonary rehab services as well as other Wellness fitness programs provided both the hospital and/or outside community resources. In addition, we plan to partner with a hospital to provide surgical services to those patients who would benefit from bariatric procedure options. The goals would be to provide pre and post bariatric surgical care locally, at Sturdy, to facilitate treatment and better monitor outcomes.
- The hospital is in discussion to partner with an urgent care provider (and /or plans to open one or more urgent care centers on its own) which would likely result in a reduction in emergency room visits. This will not result in any immediate cost savings, in fact in the near term it will increase cost to the system. Staffing in the Emergency Room, and capacity, is unlikely to decrease until a significant amount of volume reduction occurs.

- We are recruiting staff at Sturdy Memorial Associates, a sister company of the hospital, to expand physician office hours through the use of extenders on the weekends to decrease unnecessary emergency room utilization.
4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
- a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?
- Examples of acceptable reasons for prices to vary:
- Payer mix. Providers that care for more patients with governmental insurance require higher commercial rates to offset the lower rates received from the government. Alternatively, the state could create a payment system to reimburse providers that care for more MassHealth patients a higher rate of payment. To some extent, this already exists. Super DSH hospitals receive supplemental payments to help make them whole. DSH hospitals receive a small payment enhancement, however, that payment does not make up enough of the reimbursement shortfall. A better solution for the state would be creating a sliding reimbursement scale for MassHealth and pay the hospitals that see more MassHealth a higher reimbursement rate and those hospitals that see fewer MassHealth patients, a lower reimbursement rate.
 - Hospital size would likely affect efficiency and therefore the cost of care provided. There are certain fixed costs to providing any service and as volume grows, those fixed costs can be spread over more volume. That said, smaller hospitals may be more nimble and may be able to adapt to a changing environment more efficiently.
 - Seasonality, hospitals, like Nantucket Hospital have to maintain facilities (beds, etc.) to meet the demands of a summer population that drops substantially in the other nine months of the year.
 - Location. The wage index used by Medicare to adjust hospital wages is flawed. This results in significantly different payments to hospitals competing for personnel in the same job markets. The wage index formula has been under review for several years.
 - Quality, although measurement of quality is still a work in progress.
 - Location of services provided. Hospitals maintain many services twenty-four hours per day. Hospitals are normally reimbursed one standard amount for those services when in fact the cost to provide a CT at 2:00 am is actually higher than one provided between 7:00am and 5:00pm. Free standing MRI and CT centers do not have to provide for emergency services outside of their normal working hours.

- The contract pricing that the payers negotiate. TME may be negatively impacted for Hospitals on the borders of the state if the payer does not contract with (or has less favorable contract with) the hospitals in the neighboring state.

Examples of unacceptable reasons for prices to vary:

- Hospitals/other providers that continually make poor business decisions resulting in increased prices to compensate for those poor decisions. Examples might be excessive capital spending on inpatient beds in an environment of shrinking hospital admissions.
- Prices that generally reflect wasteful spending by providers.
- Hospitals that negotiate prices from payers that are too low to maintain the long-term viability of the hospital.

- b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

Three of the biggest hospitals, Massachusetts General and Brigham and Women's, and Children's Hospital combined control about 1/3 of the commercial acute hospital market in Eastern Massachusetts as measured by commercial payments to providers. Those hospitals are reimbursed significantly higher than most of the other hospitals in the state. Therefore, their prices have a significant impact on healthcare costs and the future growth in health care costs. The physician groups affiliated with those hospitals also have payments that are significantly higher than most other physician groups making it easier to attract and retain physicians. If lower cost community hospitals can't recruit and retain sufficient numbers of physicians, patients who can travel, may migrate out of the lower cost community settings.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
 - a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

We currently contract with the state's Crisis Team and McLean Hospital to assess, consult and facilitate placements of mental health patients that are borders in our Emergency Care Center. In addition, we contract with Arbour Fuller for in-patient consultative services, utilizing a psychiatric nurse practitioner to consult on patients identified as appropriate for behavioral health screening and intervention. This consultative service allows us to facilitate and ensure appropriate placement and/or

access to available outpatient services in transitioning out to the community. In collaboration with Arbour-Fuller, we also submitted a grant proposal to BCBSMA Foundation around behavioral health integration into Medical Homes.

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- b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

While we did not receive the aforementioned BCBSMA Foundation grant, we will still be pursuing options for a Behavioral Health Integration Model with our SMA Medical Home Group Practices (outlined below) that would ideally meet the Level 5 Close Collaboration integrated services measures.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

Sturdy Memorial Associates, an affiliated multi-specialty group practice, employs 33 primary care physicians in 8 locations in the hospital's service area. All primary care practices have received designation as patient centered medical homes from NCQA. The hospital supports SMA through the integration of the electronic medical record (EMR). The hospital and physician group both utilize EMR which run on different software platforms. The hospital has provided for a significant amount of data exchange which contributes to improved coordination of care. For example, inpatient discharge summaries and emergency room summaries are electronically sent from the hospital to the physician's office to ensure proper follow-up. As noted earlier, appointments are made with PCPs for all inpatients discharged from the hospital. Emergency Room physicians also have access to the SMA EMR. The EMR also facilitates the care coordination of patients seen in outpatient departments and clinics, such as cardiac rehab.

Many of the answers to the above questions involve initiatives to improve patient care and cost efficiencies. I won't repeat them here but would add that many of the strategies we have taken generally require increased financial resources, which the hospital has provided. For example, adding nurse case management services to the hospital emergency department adds cost to the hospital, and potentially reduces admissions to the hospital, but potentially lowers the overall cost of health care to the system.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	28	0	28	See below
	Q2	26	1	28	
	Q3	33	1	34	
	Q4	36	0	36	
CY2015	Q1	34	0	34	
	Q2	47	1	48	

During the six quarters reported above, the inquiries for the following services were made:

- 8 CT Scans
- 4 Echo-cardiograms
- 34 Lab tests
- 18 MRIs
- 11 ultrasounds
- 18 x-rays
- 8 mammograms
- 4 colonoscopies
- 4 minor surgery

Other including, various surgeries (knee replacement, knee arthroscopy, hammer toe, hernia repair, hysteroscopy, bone density, colonoscopy, pain clinic, cataract, endoscopy, sleep study,

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **AGO Hospital 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.

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Exhibit 1 AGO Questions to Hospitals

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. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **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.
6. **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.
7. **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.
8. **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).
9. **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.
10. **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.
11. **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.
12. **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.

2011

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield											\$ 18,424,181	\$ 17,034,549			
Tufts Health Plan											\$ 10,112,523				
Harvard Pilgrim Health Care											\$ 12,577,943				
Fallon Community Health Plan											\$ 1,106,890				
CIGNA											\$ 1,098,809				
United Healthcare											\$ 7,500,426				
Aetna											\$ 2,043,586				
Other Commercial											\$ 8,823,651				
Total Commercial	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 61,688,009	\$ 17,034,549	\$ -	\$ -	\$ -
Network Health											\$ 203,327				
Neighborhood Health Plan											\$ 1,790,903				
BMC HealthNet, Inc.											\$ 3,894,131				
Health New England											\$ -				
Fallon Community Health Plan											\$ -				
Other Managed Medicaid											\$ 41,255				
Total Managed Medicaid	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,929,616	\$ -	\$ -	\$ -	\$ -
MassHealth	\$ 6,837,162		\$ 407,932												
Tufts Medicare Preferred											\$ 494,116				
Blue Cross Senior Options											\$ 199,648	\$ 115,301			
Other Comm Medicare											\$ 1,909,372				
Commercial Medicare Subtotal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,603,136	\$ 115,301	\$ -	\$ -	\$ -
Medicare												\$ 44,997,293			
Other											\$ 6,555,605				
GRAND TOTAL	\$ 6,837,162	\$ -	\$ 407,932	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 76,776,366	\$ 62,147,143	\$ -	\$ -	\$ -

Note: The hospital does not split HMO and PPO registrations and therefore cannot provide that net-revenue split. We also included any pay for performance money from Medicare FFS in the claims payments because that is how we receive them. We considered the MassHealth RFA a A24 P4P contract. Medicare is classified as PPO.

2012

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield											\$ 18,598,884	\$ 17,366,514			
Tufts Health Plan					\$ 10,671,743		\$ (171,850)								
Harvard Pilgrim Health Care											\$ 12,516,461				
Fallon Community Health Plan											\$ 1,480,824				
CIGNA											\$ 1,201,842				
United Healthcare											\$ 7,987,428				
Aetna											\$ 2,413,050				
Other Commercial											\$ 8,754,309				
Total Commercial	\$ -	\$ -	\$ -	\$ -	\$ 10,671,743	\$ -	\$ (171,850)	\$ -	\$ -	\$ -	\$ 52,952,798	\$ 17,366,514	\$ -	\$ -	\$ -
Network Health											\$ 675,310				
Neighborhood Health Plan											\$ 1,976,552				
BMC HealthNet, Inc.											\$ 4,139,910				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											\$ 115,488				
Total Managed Medicaid	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 6,907,260	\$ -	\$ -	\$ -	\$ -
MassHealth	\$ 6,649,525		\$ 354,373												
Tufts Medicare Preferred											\$ 496,706				
Blue Cross Senior Options											\$ 207,273	\$ 82,609			
Other Comm Medicare											\$ 2,642,002				
Commercial Medicare Subtotal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,345,981	\$ 82,609	\$ -	\$ -	\$ -
Medicare												\$ 49,114,710			
Other											\$ 6,337,955				
GRAND TOTAL	\$ 6,649,525	\$ -	\$ 354,373	\$ -	\$ 10,671,743	\$ -	\$ (171,850)	\$ -	\$ -	\$ -	\$ 69,543,994	\$ 66,563,833	\$ -	\$ -	\$ -

\$ 153,611,618
 \$ 153,429,095
 \$ (182,523)

2013

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield											\$ 17,528,789	\$ 16,979,591			
Tufts Health Plan					\$ 10,379,712		\$(400,985)								
Harvard Pilgrim Health Care											\$ 11,513,346				
Fallon Community Health Plan											\$ 1,340,501				
CIGNA											\$ 1,397,975				
United Healthcare											\$ 8,047,477				
Aetna											\$ 2,386,915				
Other Commercial											\$ 8,641,680				
Total Commercial	\$ -	\$ -	\$ -	\$ -	\$ 10,379,712	\$ -	\$(400,985)	\$ -	\$ -	\$ -	\$ 50,856,683	\$ 16,979,591	\$ -	\$ -	\$ -
Network Health											\$ 1,490,320				
Neighborhood Health Plan											\$ 2,712,694				
BMC HealthNet, Inc.											\$ 3,910,852				
Health New England											\$ 17,387				
Fallon Community Health Plan															
Other Managed Medicaid											\$ 48,145				
Total Managed Medicaid	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,179,398	\$ -	\$ -	\$ -	\$ -
MassHealth	\$ 6,425,564		\$ 137,845												
Tufts Medicare Preferred											\$ 520,792				
Blue Cross Senior Options											\$ 128,988	\$ 267,230			
Other Comm Medicare											\$ 2,720,072				
Commercial Medicare Subtotal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,369,852	\$ 267,230	\$ -	\$ -	\$ -
Medicare												\$ 52,715,729			
Other											\$ 6,832,296				
GRAND TOTAL	\$ 6,425,564	\$ -	\$ 137,845	\$ -	\$ 10,379,712	\$ -	\$(400,985)	\$ -	\$ -	\$ -	\$ 69,238,229	\$ 69,962,550	\$ -	\$ -	\$ -

\$ 2,014

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield											\$ 16,567,898	\$ 17,290,359			
Tufts Health Plan					\$ 10,053,113		\$ (420,000)								
Harvard Pilgrim Health Care											\$ 10,651,106				
Fallon Community Health Plan											\$ 1,114,656				
CIGNA											\$ 1,192,293				
United Healthcare											\$ 7,718,606				
Aetna											\$ 2,357,035				
Other Commercial											\$ 7,064,892				
Total Commercial	\$ -	\$ -	\$ -	\$ -	\$ 10,053,113	\$ -	\$ (420,000)	\$ -	\$ -	\$ -	\$ 46,666,486	\$ 17,290,359	\$ -	\$ -	\$ -
Network Health											\$ 2,889,850				
Neighborhood Health Plan											\$ 3,583,335				
BMC HealthNet, Inc.											\$ 5,829,832				
Health New England											\$ 6,817				
Fallon Community Health Plan															
Other Managed Medicaid											\$ 217,990				
Total Managed Medicaid	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 12,527,824	\$ -	\$ -	\$ -	\$ -
MassHealth	\$ 7,318,891		\$ 1,019,461												
Tufts Medicare Preferred											\$ 408,400				
Blue Cross Senior Options											\$ 687,629				
Other Comm Medicare											\$ 3,190,793				
Commercial Medicare Subtotal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,286,822	\$ -	\$ -	\$ -	\$ -
Medicare												\$ 53,628,902			
Other											\$ 5,688,574				
GRAND TOTAL	\$ 7,318,891	\$ -	\$ 1,019,461	\$ -	\$ 10,053,113	\$ -	\$ (420,000)	\$ -	\$ -	\$ -	\$ 69,169,706	\$ 70,919,261	\$ -	\$ -	\$ -

\$ 158,060,432