Baystate Health

September 17, 2015

Mr. David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

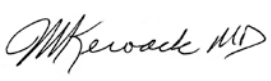
Subject: Testimony for Public Hearing Concerning Health Care Cost Trends

In response to your August 6, 2015 letter, we have prepared this letter, associated template, and exhibit (collectively "Written Testimony"). The deadline for submitting the Written Testimony was short and some of the requested information was not readily available. Accordingly, the Written Testimony submitted has been prepared based on reasonable inquiry and is true and correct to the best of our knowledge, information and reasonable belief.

Your letter is directed to Baystate Health, Inc. (BH) an integrated health care delivery system, which includes Baystate Medical Center, Inc., Baystate Medical Practices, Inc., Baystate Mary Lane Hospital Corporation, Baystate Franklin Medical Center, Inc., Baystate Wing Hospital, Inc., and Baystate Noble Hospital, Inc. BH is also associated with Baycare Health Partners, Inc. which is a physician hospital organization and includes an accountable care organization. In some responses, when appropriate, we have included information about these related organizations.

In closing, I am legally authorized and empowered to represent BH for the purposes of the Written Testimony. I hereby certify under the pains and penalties of perjury that, under my direction, BH has made a diligent effort to respond to the questions submitted to it, and that, to the best of my knowledge, information and reasonable belief, the Written Testimony is true and correct.

Sincerely,



Mark A. Keroack, MD, MPH
President & CEO
Baystate Health

Enclosures:
- Associated template
- Exhibit

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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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.

   Baystate Medical Center, Inc. (BMC) experienced an increase in inpatient discharges between our FY2013 and FY2014 of 2.4%, and the current year to date discharges through July 2015 have increased 4.2% compared to the same period in FY2014. These increases are primarily due to healthcare coverage expansion. This growth has put continued pressure on our expense base. From FY2013 to FY2014, our expenses grew at an annual rate of approximately 6.2% with our most recent FY2015 year to date growth of about 9.2%. However, after adjusting for patient volumes (inpatient and outpatient), patient acuity, and the significant expansion of our contract/specialty pharmacy program, the annual growth in expenses is less than 1%.

   Net patient service revenues grew 6.3% between FY2013 and FY2014 and about 8.2% for the most recent FY2015 year to date compared to the same period in FY2014. These increases are due to the increases in patient volumes and the expansion of our contract/specialty pharmacy program with little if any increase in payment rates.

   Due to time constraints, we have only provided information on BMC, the flagship hospital of our system.

   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?

   BMC expense growth, after adjusting for patient volumes and patient acuity, is less than 1%, which is well below the c. 224 health care cost growth benchmark. We believe there needs to be an adjustment to hospital expense growth for changes in patient volume and patient acuity. As reflected in this answer and our answer to question 1.c., below, Baystate Health has many efforts ongoing to address health care costs.

   Baystate Health is committed to the continual development and application of a comprehensive model for system wide continuous improvement in the areas of

staff engagement, quality outcomes, patient satisfaction and cost reduction. We have a long history of continuous improvement and cost control based on scientific methods. We continue this tradition with the aggressive development of a model for process improvement that engages leadership and staff at all levels toward a common set of organizational goals and objectives. Cost containment and reduction are expected as key outcomes in conjunction with improved quality and patient satisfaction. We are developing leadership and staff capabilities around the utilization of proven models of teamwork, waste elimination and value enhancement.

Since at least 2010, Baystate Health has been on a population health journey to move away from fee-for-service, volume-based care toward a value-based delivery system. In 2010, through its physician-hospital organization, Baycare Health Partners (Baycare), Baystate Health launched a multiyear commercial risk contracting pilot with eight primary care practices, including the Baystate Medical Practices, who were culturally ready to embrace value-based contracts. Our initial scope was the commercial managed care population of two of our major payers: Health New England (HNE) and Blue Cross Blue Shield of Massachusetts (through its Alternative Quality Contract). We recognized, however, the need for a critical mass of patients who were receiving value-based care to truly gain the clinicians' attention. With the introduction of the Medicare Shared Savings Program (MSSP), we realized that not only had we purposefully assembled the critical building blocks that constitute an accountable care organization (ACO), but also that the MSSP offered us this critical mass. Baycare, therefore, established an ACO subsidiary, Pioneer Valley Accountable Care (PVAC) as the vehicle through which the pilot practices and their specialty and hospital referral network could participate in the MSSP, and PVAC has participated in the MSSP since January 2013.

Since its inception, Baycare has been actively moving toward converting the majority of its members' clinical revenue to outcomes-based contracts. We are close and estimate that nearly half is outcomes-based today. Our commercial risk contracting pilot served as the foundation for our population management journey. We tried to have the following critical population health building blocks in place or in process before executing our risk agreements and launching our MSSP participation because we see them as core competencies for successful value-based contract performance:

- Patient-centered medical homes throughout our service area;
- An engaged, high-value provider network;
- A preferred post-acute network;
- Committed physician leadership;
- Payer partnerships;
- Practice-based care management;
- A robust clinical integration program;
- Advanced use of health information technology;

- Sophisticated data warehouse and analytic capabilities; and
- Select bundled payment models.

The participants have demonstrated consistently strong performance in the commercial risk contracts generating outcomes-based surpluses annually since 2011. The Commonwealth sets the target growth rate for total per person medical spending in the state. Annually, we performed under these budgets in both risk contracts thus lowering the overall increase in total medical expenditures below statewide expectations. We have generated strong quality scores and savings to CMS in our first two performance years of the MSSP (although we did not meet the minimum savings rate and therefore did not share in the savings).

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?

We always intended to take the lessons learned in the pilot and expand our risk contracts to these health plans' other product lines and to other payers, which is happening right now with the addition of risk agreements with HNE, for its Medicare Advantage product, with UniCare GIC, and with shared savings agreements with Cigna and Tufts. We are in active discussions with other commercial health plans for outcomes-based agreements. In addition to commercial payers, it is likely that our agreement with HNE for BeHealthy, its managed Medicaid line of business, will transition to a risk agreement.

Further, PVAC has applied to participate in Track 3 of the MSSP or in the Next Generation ACO Model effective January 1, 2016. Both of these programs are two-sided risk models. We are confident that our applications will be approved, and the addition of downside risk will provide a strong incentive for our providers to more fully implement the building blocks listed above.

Baystate Health firmly believes that the continuation of the efforts described above throughout 2016 supports the Commonwealth's ability to achieve its health care cost growth benchmark.

To provide more detail about one of our core building blocks, BMC is participating in the innovative new payment Bundle Payments for Care Improvement initiative CMMI program. Under the initiative, BMC has entered enter into payment arrangements that includes financial and performance accountability. Monthly statistics are collected for these patient populations regarding discharge setting disposition, post-acute length of stay and acute stay encounters for a 90 day post-acute period. These data reveal best practice as reflected in patient return to function and time to total care discharge. CMS

provides BMC with claims data for the 90 day bundle; this data is used for improvement and benchmarking. BMC is in performance year 3 for total joint and coronary artery bypass surgery (CABG) and performance year 1 for colorectal surgery. BMC has submitted the application for the new outpatient bundle (Oncology Care Model) for oncology patients requiring chemotherapy. HNE has worked with BMC in implementing similar bundle models for the commercial population. In addition, an end stage renal disease bundle will go live through PVAC on January 1, 2016.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

BMC is one of the largest providers of Medicaid services in the Commonwealth, with approximately 28% of inpatients cared for by the program. Despite being a relatively low cost teaching hospital, reimbursement rates by Medicaid cover only 78% of costs, resulting in system losses in the program of over $40M per year. BMC is one of two large Medicaid providers (along with UMass Memorial Medical Center (UMMMC)) excluded from the Delivery System Transformation Waivers (1115 Waivers) from CMS. UMMMC receives approximately $40M per year in alternative state support, leaving BMC as the only hospital in the top 8 Medicaid providers with no state support. The flawed allocation formula for DSTI moneys provides 4 times as much support per Medicaid beneficiary in Greater Boston than in Western Massachusetts. We believe that such moneys should truly reward efforts at delivery system transformation (e.g., medical homes, care coordination, bundled care projects, risk contracts) that Baystate Health has already undertaken.

Baystate Health is also the owner of the largest health plan in Western Massachusetts, HNE, with over 200,000 covered lives in commercial, Medicare and Medicaid lines of business. The covered Medicaid population has grown rapidly over the last year from under 20,000 to nearly 80,000, related to the cancellation by BMC Health Net of our provider contract and auto-assignment of patients wishing to remain with Baystate Health providers. The rapid growth in pharmaceutical prices has added to losses at HNE, which are absorbed by the Baystate Health system. In addition, the recent controversial provisions for risk adjustment in the exchange and small group market have confused severity of illness with intensity of medical services in the Eastern part of the state, benefitting the most wealthy insurer in the Commonwealth and threatening to enhance its already market dominant position.

Despite broadening the definition of an appropriate inpatient stay under the two-midnight rule, CMS continues to exclude time spent under observation from the three-day requirement for skilled nursing facility (SNF) stays. Inpatient stays do not begin until a physician writes an order for patient admission; thus any time spent in observation preceding an admission will not count toward the length of

stay requirement. This policy along with observation status generally, has been the subject of recent media scrutiny. Further clarifications and policy changes are needed.

Medicare created a 3-day inpatient hospitalization requirement for the Medicare Part A eligibility of the post-acute care SNF Benefit. The practice of Medicine when this rule was adopted is very different today. CMS approved a new 3-day waiver for Pioneer Accountable Care Organizations in April 2014 and expanded this waiver to the hospitals participating in the CMMI bundle alternative payment models as long as the skilled facility has a 3 star CMS rating on Nursing Home Compare. Broadening the waiver or eliminating it all together can direct patients to the appropriate level of care based upon clinical assessment, thus avoiding costly and unnecessary hospitalizations.

Additionally, public and private quality measures reporting are important drivers for ensuring quality and patient safety surveillance and improvement. Measurement and reporting to the private and public payers allows for external benchmark comparisons. This promotes organizational accountability and fosters transparency of hospital performance to patients, providers, and payers. However**,** there are many challenges with quality measures reporting. There is a significant resource burden around measure collection, abstraction and reporting. Most measures are not automated and require a professionally trained clinician to manually review records to capture the specified elements. Measure sets are not harmonized among payers (public and private sector) contributing to duplicity of work. An example of this disconnect is around electronic measure submission requirements, specifically the clinical quality measures (eCQMs) as part of the Hospital Inpatient Quality Reporting Program (IQR) and thee Medicare EHR Incentive Program or the Hospital IQR Program.

Finally, in the CMS readmission penalty program, socioeconomic status is not included in the risk adjustment methodology. This can impact a hospital's performance negatively if the catchment area is urban with a greater percent of patients with social economic hardships.

2. **What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?**

The majority of the current healthcare payment model continues to be a fee-for-service based system, which rewards providers based on the number of office visits, tests or procedures they perform. Because payment is tied to consumption, fee-for-service directly contradicts alternative payment models like bundles as the incentives are not aligned to the providers' practice patterns. Fee-for-service also creates fragmentation, with providers incented to "compete" with one another, rather than work together for better outcomes. Because providers are rewarded this way, they lack a strong motivation to steer people toward the highest-quality, most cost-effective care. While the movement

away from fee-for-service and toward value-based care continues to gain acceptance, it is still in its testing phase. To change the payment model and shift from fee-for –service to a value based model, much more investment is needed to change the current healthcare infrastructure, culture and operational practices. These new payment models are by no means systematic. For most, they are difficult to implement and scale, requiring more collaboration with other vested healthcare providers.

Another barrier is around data analytics and the challenges with varying EHR platforms, and software applications that cannot be integrated to share the same data sources. Measuring the performance of these alternative payment models requires additional human and IT resources which are genuinely not an added operational budget item in these pilots. This creates an added burden to the hospital systems; testing innovation is slower based on how much band width is available to design, implement, evaluate and spread for increased adoption.

Because traditional payment models in primary care have been fee for service, staffing models have been built to support a fee for service model with face to face care. Transitioning to population based care requires a different care team model with new skills and staffing ratios to manage populations and track and coordinate care when patients are not in the office.

Additional financial barriers include the following:

- *Funding/Infrastructure Support*: The infrastructure (whether human capital, enabling technology, or other resources) to support population health management will continue to be costly. Ultimately, we hope our risk contracting, alternative payment contracting, and ACO activities will be self-supporting, but we encourage payers (whether public or private) to provide adequate infrastructure payments and support to their contracted providers to assist in the implementation. Baystate Health's position as the only high-proportion Medicaid provider in the state without participation in the Medicaid waiver, or other special state funding provisions for care for underserved populations, has become a major financial challenge, and raises questions about our ability to continue to move progressively away from fee-for-service models.

- *Reserves*: Further, we anticipate the need (and likely government mandate) to build reserves over time. As more risk shifts from insurance companies to providers, careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves.

Further, we encourage widespread adoption of the benefit enhancements envisioned for CMS' Next Generation ACO Model as they will remove barriers to adopting alternate payment models and lead to better, more affordable care. Specifically:

- *3-day SNF rule*: A 3-day SNF waiver will enable providers to reduce unnecessary hospital expenditures and improve care integration, quality assurance, and patient

safety. Potentially avoidable hospital admissions often occur as a required entry path to a SNF for patients not needing hospitalization. The waiver supports the right acuity and location of care while avoiding the cost and potential harms of unnecessary inpatient stays. It will allow frail elders with significant social stressors who need respite or skilled nursing care at a level higher than can be provided safely at home to obtain it directly. The waiver will enable patients to transition to a SNF as soon as their medical condition warrants it without financial implications. This improves their experience of care and promotes patient safety. In addition, the waiver will promote our care integration efforts with our post-acute providers.

- *Post-discharge home visits*: Patients are susceptible to harm (such as medication errors and poor communication), waste (such as duplicate testing), avoidable readmissions, and dissatisfaction during times of transition. Reimbursement for post-discharge home visits will help providers remedy these pitfalls. Appropriate and better care in the home environment likely will decrease unnecessary ER visits and readmissions, thus saving costs, while addressing patient engagement, disease management education, safety and medical equipment availability, appropriate utilization, and medication reconciliation and administration. Clinical interaction within the home facilitates addressing challenges within each patient's social and living context. The clinician will address basic, critical issues such as ensuring equipment is functional and the patient and family understand how and why to use it. The home visit allows for root cause recognition and action plan development on specific adherence issues and educational gaps. It will improve patient safety as home visits allow for the most accurate and actionable medication reconciliation. The visits allow for previously unrecognized medical, housing, and social issues within the patient's home to be evaluated and acted upon.

- *Telehealth*: Telehealth will foster e-care, and therefore has the potential to improve access, lower health care costs, and improve the quality of care. Telemedicine allows providers to reach out to a larger number of patients in a more efficient manner, contributing toward the goals of expanding access to care and better managing an entire population's health. Transportation and the cost and inconvenience of coming to a physician office is a significant burden for many patients, which keeps them from obtaining routine and preventative care and can result in patients' health decompensating to the point of costly and unnecessary hospitalizations and emergency room use. Keeping patients local at community hospitals for e-consults not only reduces family travel, but often offers earlier access to specialists than would otherwise be the case. Supporting telemedicine can help patients manage their chronic and acute conditions to stay healthy and meet their personal health goals – thereby reducing the cost of care, improving quality, and enhancing the patient experience.

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.**

   As we anticipate entering into a Medicare ACO model with downside risk in 2016, our ACO has included these four areas among the priorities that will be our initial focus. Its activities are summarized below.

   - *Spending on post-acute care*: In 2013, we implemented our preferred post-acute network. The SNFs' performance on a variety of quality and efficiency metrics informed the network's composition. Through its further implementation, our goal is to reduce the length of stay of our attributed Medicare beneficiaries to Medicare Advantage levels and reduce the variation of the average per diem costs in the SNFs to which they are admitted.

     Our ACO has close partnerships with our post-acute network, conducting bimonthly transitional care quality improvement meetings with every post-acute provider that focus on improving communication and transitions across episodes of care. Readmission root cause analyses identify improvement opportunities, which inform practice modifications at the hospital, SNF, VNA, and community practice levels. We have standardized transition communication processes including: clinical notifications to PVAC care managers 48 hours prior to discharge, SNF physician discharge summaries, and SNF discharge packet content sent to the PVAC practice upon discharge.

     In addition, PVAC is working with PatientPing, a corporation that provides software services that allow us to share information with other health care entities involved in the care of our patients and allow real-time tracking and management of patients during SNF and VNA encounters. Paired with our care management activities, PatientPing allows PVAC to manage post-acute stays and initiate care management activities upon real-time transition notifications.

   PVAC is also implementing a pilot to reduce unnecessary rehab/SNF admissions. Its goal is to increase the percentage of patients who are discharged home with VNA services, where appropriate, instead of to SNFs. A standardized tool is used to help identify patients whom it would be appropriate to discharge home with VNA services or to a SNF with the intent of making the home with VNA option a more facile choice/process than it is today.

- *Acute care (i.e., reducing avoidable 30-day readmissions and avoidable emergency department (ED) use)*: Reducing avoidable admissions will contribute to lowering the total cost of care and will ensure that patients receive the right care at the right location at the right time. We define avoidable admissions as an admission to a hospital for certain acute illnesses or worsening chronic conditions that might have been avoided with the delivery of high-quality outpatient treatment and disease management.

  We are contemplating identifying patients with potentially avoidable admissions through a variety of methods, such as electronic flagging, electronic alerting of registered patients to evaluating provider and ED case manager, designated provider for ED evaluation of eligible patients, medical management/clinical practice guidelines for specific diagnoses, standardized referral process to VNA, and an electronic communications platform across the continuum of providers and care venues. The ED at BMC has developed specific protocols for the management of cellulitis, deep venous thrombosis and atrial fibrillation that allow direct discharge to home with VNA care, avoiding hospital admission. This is part of a strategy to be the ED of choice for our medical home primary care providers.

  Informed by the AHRQ's Ambulatory Care Sensitive Conditions, we likely will prioritize areas including: grand mal status and other epileptic convulsions, chronic obstructive pulmonary diseases, asthma, heart failure and pulmonary edema, hypertension, angina, and diabetes. We are in the process of developing appropriate performance indicators that will be measured and reported regularly.

  Finally, improved coordination and transitions of care, as demonstrated in the PCMH standards, supports reducing readmissions and avoidable ED visits. The Baystate Health standard is to contact patients within 48 hours of discharge to promote a safe transition to home. This includes review of medications, plan of care, services, and patient understanding of what to do in an emergency. At this time a follow-up appointment is confirmed within 7 days of discharge.

- *Providing focused care for high-risk/high-cost patients*: Our ACO has a practice-based care management program, which in addition to focusing care on the top of the pyramid, is our most intense patient engagement strategy. Patients with complex health care needs work with nurse care managers who, as part of the health care team, develop individual care plans and work with the patient to better manage their care and engage them in shared decision-making. Care management also provides ongoing patient education and health risk assessments between visits. Our embedded nurse care managers and care coordinators work directly with patients on health outcomes, processes, and transitions of care, which take into account the patients' needs, preferences, values and priorities. Clinical information is disseminated to patients in a manner and format they can understand and readily use to assist with health management skills, and it includes a standardized library of patient education materials.

Our care managers identify high risk patients through several means including transitions of care, provider referrals, and predictive modeling algorithms. Care managers use comprehensive medical and psychosocial screening and assessment tools for high-risk patients and patients with chronic conditions, which allow them to develop individual care plans that address immediate and long-term needs. Care managers perform a whole person assessment and collaboratively develop individual care plans in concert with the patient/ family and PCP. Key patient-specific clinical goals and timeframes and appropriate cultural and community resources necessary to enhance patient self-management are identified and incorporated into the personalized care plans. Barriers to care and strategies to address them are critical components of the plans. Our ability to create individual care plans respects patient diversity and addresses ethnic and cultural needs. Care managers monitor the effectiveness and necessity of established care plans and goals and modify them as needed to ensure patients' specific needs are being met.

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

See above as these efforts are ongoing.

BMC will continue to participate in the alternative payment Bundle Payments for Care Improvement initiative CMMI program. BMC is in performance year 3 for total joint and coronary artery bypass surgery (CABG) and performance year 1 for colorectal surgery (July 2015 implemented). BMC has submitted the application for the new outpatient bundle (Oncology Care Model) for oncology patients requiring chemotherapy. HNE has worked with BMC in implementing similar bundle models for the commercial population.

Reducing avoidable re-hospitalizations has been a clinical quality and patient safety organizational goal since 2010 with the focus of reducing avoidable re-hospitalizations in select high risk populations. Targeted populations for implementation of the STAAR framework include: heart failure, acute myocardial infarction, pneumonia and COPD. BMC has been the leader in developing and sustaining the Western MA Cross Continuum Partnership. BMC has been a mentor hospital for transitions of care, working with the Institute of Healthcare Improvement (IHI) as an intensive pilot site for studying the concept of spread and sustainable improvement. Overall readmission indices have been below expected for the organization. The organization has active hospital based and cross continuum improvement teams.

BMC has been recognized as a Charter Hospital in the Premier QUEST project and has achieved Top Performance in terms of Effectiveness, Mortality and Cost for three consecutive years (2010, 2011 and 2012). BMC staff plays leadership roles in the development and evaluation of this national project. Quality

effectiveness measures are near the top decile of all hospitals nationally. BMC has not received any Medicare penalties.

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?**

      We do not have detailed data on prices paid to other providers, and thus do not engage in pricing analyses. Given that limitation, we can state generally that prices may vary for numerous reasons, including quality and acuity which are key acceptable factors in pricing variances.

      The burden of losses incurred by government program underpayments is not uniform across providers in Massachusetts, which can also result in overall price variances. Payments from commercial insurers must subsidize underpayments by government payment programs—particularly when those underpayments are not offset by other means (the Medicaid waiver, for example).

      Other factors that should be recognized in price variations include the cost of educating the next generation of physicians, the cost of educating the next generation of nurses and allied health professionals, case and service mix not fully recognized by DRG grouping and related weights, technology when supported by patient volumes, Level 1 Trauma Center, and Level III NICU.

      Price variation can also be caused by the market power of larger insurers and managed care organizations which, due to their size, can dictate prices.

   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.**

      Baystate Health's hospital and physician practices are low-cost providers, as shown by CHIA reports. Our goal is to keep care local and in appropriate settings to assist in controlling the overall cost of care. Care provided in the local (Western Massachusetts) region is more cost-effective and at the same level of quality, compared to when patients travel to other areas for such care. When

patients travel to other areas of the state for care that could be provided locally at the same level of quality but at a lower price, it raises the overall cost of care and negatively affects the financial health and sustainability of community and lower-cost providers.

Of course, the overall cost of care is also affected by the socio- economic conditions of the communities that the providers serve. This can result in care being provided in more ED and inpatient settings, which affects the overall cost of care. Baystate Health provides access at its hospitals, health centers and physician practices to a very large Medicaid population with large health care disparities. However, Medicaid recipients in Boston receive four times the funding support, per capita, that Medicaid recipients do elsewhere in Massachusetts. More equitable reimbursement to like organizations across the state for care provided to these populations will more equitably support achievement of the aim of better cost containment among all health providers.

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.**

    In 2015, PVAC, our ACO, implemented a behavioral health pilot with two of its participating community practices. Working with representatives from Behavioral Health Network (BHN), clinicians have been embedded in these practices on a regularly scheduled basis allowing patients to remain in the practice for behavioral health care. Services being provided include depression screening follow-up, therapy sessions, and consult services. Two other participating practices have their own, but similar, behavioral health integration efforts underway. These efforts have demonstrated improved compliance with the practice-generated plan of care and assisted the patients in reconciling and improving their medication adherence. As a result, we anticipate healthier care at a lower cost.

    Over the past 12 months Baystate Health's Department of Psychiatry and Department of Primary Care and Clinical Integration have collaborated in the continued implementation of integrated behavioral health (IBH) services in

Baystate Health's ten community primary care practices. Starting with two practices in mid-2013, and with the support of Baystate Health strategic funding, we are currently providing IBH consulting psychiatry in all ten practices and on-site IBH clinicians in five primary care practices from Greenfield to the Connecticut border. In the past 12 months, Baystate's three Community Health Centers in Springfield have further developed their collaboration with BHN, a community mental health center in Springfield whose department of Healthcare and Community Outreach provides on-site IBH clinicians. In August, Baystate Psychiatry, Primary Care and Community Health Centers collaborated with BHN to submit a Letter of Interest (LOI) to the Blue Cross Blue Shield Foundation's "Fostering Effective Integration of Behavioral Health and Primary Care" grant. Our LOI was selected as a finalist, and earlier this month we submitted a full application for three years of $200,000/year funding to support an Integrated Care for Chronic Pain project at two sites, Greenfield Family Medicine (with IBH services provided by Baystate Psychiatry) and Springfield's Mason Square Neighborhood Health Center (with IBH services provided by BHN). Both of these communities have been significantly impacted by the Commonwealth's opioid abuse epidemic. Awards will be announced in December.

Within the hospital, Baystate Health has had a long-standing contractual agreement with BHN's community Emergency Services Program (ESP) to provide crisis evaluations and placement services for crisis patients in the BMC Emergency Department. Baystate Health's regional hospitals in Greenfield, Ware, Palmer and Westfield have similar agreements with their local ESPs. In the past 12 months BMC has collaborated with BHN in the placement of a full-time Care Coordinator in the ED who provides focused assistance with placement for these patients. Baystate meets quarterly with BHN to discuss approaches to improving care for psychiatric crisis patients and providing alternatives to ED services. Within the past year, BHN has opened the "Living Room," a peer- and clinician-staffed alternative 24-hour support setting for individuals in crisis. The Living Room has successfully diverted dozens of patients who would have otherwise sought services in the ED. Baystate Psychiatry has also collaborated with BHN to provide medical direction and psychiatry coverage for BHN's new "Village for Youth," a Community Based Acute Treatment (CBAT) setting scheduled to open this month in Springfield. This diversionary short-term residential setting for 12- to 18-year-olds in crisis will provide an alternative to ED and inpatient care. Over the past year, Baystate Behavioral Health and the BMC Emergency Department have developed a proposal that includes 7-day week psychiatry staffing (APRNs and/or MDs) and dedicated specialty behavioral health nursing staff in the ED. The proposal has achieved preliminary support from senior leadership and will be presented for final funding approval later this month. By bringing Enhanced Emergency Psychiatry Services to the ED, we will start psychopharmacological and psychiatric nursing care while patients are awaiting placement, promoting more rapid stabilization of symptoms; more rapid placement in inpatient psychiatric care; and for some, an ability to divert to non-inpatient levels of care and support.

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.

Over the next 12 months we plan to continue the implementation of IBH services in Baystate Community Primary Care practices. On-site IBH clinical staffing is scheduled to start in the Belchertown and Ware practices within the next month, and planning is in place for IBH rollout in the remaining three Community Primary Care practices in East Longmeadow, West Springfield and Springfield's Northern Edge. If our BCBSMA Fostering Effective Integration Grant is funded, we will implement our Integrated Care for Chronic Pain project at the primary care sites in Greenfield and Springfield's Mason Square. Baystate's newly acquired regional hospitals in Palmer and Westfield both have associated primary care practices. Over the next year we will begin planning for a model of IBH services in these practices, too.

Over the next 12 months we expect to implement our Enhanced Emergency Psychiatry Services (EEPS) in the BMC ED. Pending funding approval from Baystate's Clinical Strategic Planning Committee later this month, EEPS will include the hire of 1.4 FTEs of APRN coverage, 7-days/week in the ED, and 0.4 FTE of Adult and Child Psychiatrist coverage, 5-days/week. Even without this funding, the EEPS implementation will include continued hiring of specialty psychiatric nursing staff and collaboration with BHN Crisis to reach out to community settings (e.g., schools, group homes, community agencies, Department of Children and Families) to provide education about alternatives to the hospital Emergency Department for adults and children in psychiatric crisis.

Baystate Behavioral Health will also continue its collaboration with the medical/surgical inpatient units to improve the care for med/surg patients with behavioral health disorders or disruptive behaviors. In recent years this work has produced an algorithm for use by med/surg nursing staff to guide care of behaviorally challenging patients. The Director of Behavioral Health and Director of Medical Nursing and Transplant Services are co-chairing an ad hoc committee charged with developing a proposal to bring enhanced psychiatric services to the care of these patients, too. An expected component of this proposal will be a full-time psychiatric CNS who will round on all behaviorally challenging med/surg inpatients, providing collaborative input to the Psychiatry Consultation Service and education to med/surg nursing staff on the development of integrated behavioral health/med-surg care plans to provide optimal care for these individuals.

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?

See answers to Questions 1.b and 1.c above

In addition, seventeen (17) primary care practices within the Baystate Medical Practices are recognized by the National Committee for Quality Assurance (NCQA) as Level 2 or Level 3 Patient Centered Medical Homes (PCMH). The plan is to expand the PCMH model to the Wing and Noble primary care practices. To achieve status as a PCMH, practice transformation includes enhanced access and continuity, developing team based care, managing populations, care management, self-care support and care planning, tracking and coordinating care, and performance measurement and quality improvement.

In 2010, we launched the risk contracting pilot described above with eight primary care practices who were culturally ready to embrace value-based contracts, including the Baystate Medical Practices. Five of the eight (with 21 sites) have achieved and maintain NCQA PCMH recognition. We conduct monthly performance meetings at each participating PCMH practice at which we review un-blinded quality, utilization, and efficiency performance. We identify opportunities for performance improvement, review actionable data down to the individual physician or patient level, and share best practices. We believe that the experience gained in implementing the critical elements of the PCMH model has prepared us well for value-based delivery; these elements include: physician-directed care teams, better coordinated care, enhanced access, care management, and the availability of actionable data.

Our ACO, PVAC has been operational since 2012. Our infrastructure and experience in both commercial risk contracting and the MSSP are readily transferrable to a Medicare ACO model with two-sided risk. PVAC has been working aggressively to improve the health and care of our assigned beneficiaries at an affordable, sustainable cost. We have implemented several population health capabilities, described earlier, which have generated strong quality scores and cost savings. We believe we have the appropriate building blocks in place to be a successful ACO. The addition of downside risk will provide a strong incentive for our providers to more fully implement these building blocks.

7. **Since 2014, Baystate Health (Baystate) has completed a number of material changes, including acquiring two community hospitals—Wing Memorial Hospital (Wing) and Noble Hospital (Noble); additionally, its corporately affiliated insurer, Health New England (HNE), leased a major physician group, Valley Medical Group (VMG). Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.**

    a. **How have costs (e.g., prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes?**

Baystate has committed to a regional model for specialty care, in which key specialty groups (e.g., cardiology, GI, oncology, general surgery) travel from the Springfield campus to community hospitals in the North, East and West, allowing those hospitals to retain more care in lower cost settings, and reserving Springfield beds for more complex patients. This has led to successful retention of patients in Franklin County (Baystate Franklin Medical Center). The model is in earlier phases of implementation in the Eastern and Western regions.

With respect to Baystate Wing Hospital, formerly Wing Memorial Hospital (Wing), the acquisition of Wing by Baystate Health was effective September 1, 2014. Accordingly it is too early to determine, specifically, how costs, referral patterns, quality, and access to care have changed, noting, however, that Wing prices have not been materially changed since the completion of this transaction. In regard to referral patterns, a marked change in inpatient referrals has occurred with the primary shift in Wing inpatient referrals from UMMMC to Baystate Health. This is beneficial to the Wing patient population for a couple of reasons: First, the majority of Wing's patients, who primarily reside in or around Palmer, MA, live considerably closer to BMC than to UMMMC. Second, the cost to provide patient care is notably cheaper at BMC than at UMMMC. In addition, it is expected that the Wing transaction will result in a lower cost, higher quality, more patient-centered care model that is more beneficial for the Wing patient population and the community at large.

Noble Hospital, recently acquired on July 1, 2015, is new to the system and thus it is too early to determine how costs, referral patterns, quality, and access to care have changed.

With respect to the practice lease of VMG by HNE, which was effective January 1, 2015, it is also too early to determine how costs, referral patterns, quality, and access to care have changed. The alliance was sought by VMG to enable its providers to assume greater levels of upside and downside risk for both commercial and Medicare patients. HNE provides a source of capital to the group and shares either gains and losses with the group. It is important to note that VMG retains complete medical autonomy, including complete independence about how and to whom it makes referrals. HNE expects that over time the transaction will have beneficial results including creating an integrated care alliance that is good for patients and the community, encouraging participation between the health plan and the medical practice, giving providers predictable incomes and appropriate incentives, minimizing administrative burdens and costs and promoting efficiency, and promoting a population health, coordinated risk-sharing model.

b. With regard to Baystate's acquisition of Wing, Baystate stated in its notice of material change (MCN) that the geographic proximity of Wing to the Baystate system would enable Wing to better assess and address community needs. Baystate also stated that it intended to invest in Wing's operations and help meet Wing's needs for additional physicians and services, particularly primary care. What progress has been made toward these plans?

In just a few short months, the Baystate/Wing partnership has been instrumental in addressing numerous provider needs within the Wing "community". Through the assistance of Baystate Health, Wing has been able to recruit and fill three (3) primary care vacancies, noting that this has been an issue for Wing for at least one to two years. It is expected that this expanded PCP presence in the region will help to keep patients out of the more costly regional Emergency Departments, while helping to drive care to the appropriate lower cost, patient-centered setting. In addition, high demand regional services such as inpatient/outpatient Psychiatry and Orthopedic surgery have been reassessed within the region and additional providers have been recruited to support the growing demand in Wing's catchment area. With Baystate Health oversight and assistance, Wing has also identified GI as an area of need in the region, and, through Baystate Health's recruitment efforts, increased GI services will be offered starting in early Fiscal Year 2016.

c. With regard to Baystate's acquisition of Noble, Baystate stated in its MCN that it will commit to investing in Noble and working to ensure patients can receive care locally. Which services have Baystate and Noble identified as needing investment and support based upon local needs?

Baystate Health is engaged with Noble in the following initiatives to support and expand local care:

- working together to recruit a surgeon
- bringing in two general surgeons for clinic time
- looking to expand inpatient rehabilitation services
- participating in daily phone rounds with all Baystate Health hospitals to better coordinate and place local behavioral health patients
- planning thoracic, vascular and colorectal clinics
- planning for an Emergency Department Information System (EDIS) to increase patient throughput and improve patient satisfaction scores
- working to improve and expand the oncology program and to lower costs

- planning the installation of an electronic health records system in every primary care physician office to better streamline and coordinate care and to improve patient satisfaction
- working on numerous facility upgrades including new boilers and chilling tower

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital 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	34	0	34	Various Surgical Procedures, CT Scans, MRI, Ultrasound, Sleep Study, Physical Therapy
	Q2	38	0	38	Daystay Surgical Procedures, Diagnostic Radiology, Birth of Child
	Q3	41	0	41	Physical Therapy, Daystay Surgical Procedures, Diagnostic Radiology, Cardiac Stress Testing, Birth of Child
	Q4	37	0	37	Various Surgical Procedures, Cardiac Stress Testing, Infusions, Colonoscopy, CT Scans, MRI, Ultrasound, Sleep Study
CY2015	Q1	53	0	53	Pulmonary Rehab, Colonoscopy, Physical Therapy, Genetic Testing, Various Surgical Procedures, Ultrasound, Cardiac Testing, Radiology Testing, Mammography,
	Q2	72	0	72	Pulmonary Rehab, Colonoscopy, Physical Therapy, Genetic Testing, Various Surgical Procedures, Ultrasound, Cardiac Testing, Radiology Testing, Mammography, MRI, Birth of a Child

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 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.

A significant portion of Baystate Health's payer contracts and revenue stream are involved in alternative payment contracts that track quality and/or efficiency measures and have either upside/downside risk or shared savings elements as Baystate Health transforms to a reimbursement methodology that focuses on value rather than volume.

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of any technical barriers to making or receiving referrals and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

   (a) Patient referrals to and from providers within our provider organization, are made by phone, CIS (Electronic Health Record) consult request, and fax.
   Outside of our provider organization, referrals are made by phone, fax, and the Specialist Appointment Request -BMP Line, located on Baystate Health's web site. Referral Services receives some new patient urgent referrals by phone, and a limited number of providers with E-clinical works can submit an electronic referral request. Referral Services is utilized by both those providers within and outside our organization.

   Information about referring to Baystate Health is located on our Web Site.

   (b) In addition to the more traditional referral process, Baystate Health's EHR provides a Consult Request mechanism for internal, provider-to-provider referrals. Components of this include a Consultation Request structured template that leads the referring provider through the various elements deemed essential to the receiving provider. This document can be forwarded to clinical & clerical staff as well as directly to the requested consultant. In addition, the EHR's Message Center offers a similar template that offers efficiencies to both the providers and the staff that facilitate scheduling.
   The aforementioned Consultation Request document can be used to refer patients outside of the provider organization, though only by a manual process at this time. Baystate Health is a participating member of the Pioneer Valley Information Exchange (PVIX), a regional health information exchange that is developing an eReferral platform to facilitate the initiation, documentation and tracking of these key clinical activities.

One difference in how we sometimes receive referrals from or make referrals to other provider organizations as opposed to our provider organization also relates to technology. When checking for the next available appointment with a specialist, provider offices within the same group have access to each other's schedules and can easily check for the next available appointment, but a phone call often has to be made to check availability of a specialist outside of the same provider group.

(c) We currently do not receive requests for this type of information from referring provider offices. Patients have requested estimates of what the patient responsibility for specific services will be, which we provide to them.

(d) When referring patients for services, patient insurance information is obtained and verified as to whether or not the patient's insurance plan is in-network or out-of-network for the provider or service that they are requesting. The patient is informed of that determination. We then work with the patient and the insurer to make the appropriate approved referral. We follow the specific insurance plan rules regarding referrals and/or prior authorizations prior to services.

A list of insurance carriers that we accept and information about co-pays and deductibles are available on Baystate Health's Web Site.

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.

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	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	76,483,085	87,319,051	1,688,663	1,841,237	-	-	-	-	-	-	279,198	627,600	-	-	-
Tufts Health Plan	18,587,423	3,370,722	2,960	-	-	-	-	-	-	-	60,806	19,381	-	-	-
Harvard Pilgrim Health Care	5,842,790	5,347,447	-	-	-	-	-	-	-	-	26,552	1,570	-	-	-
Fallon Community Health Plan	14,341,569	-	8,346	-	-	-	-	-	-	-	46,105	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	12,126,459	10,893,977	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	12,695,006	1,506,119	-	-	-
Aetna	-	-	2,819	-	-	-	-	-	-	-	8,017,859	7,356,026	-	-	-
Other Commercial	-	-	-	-	68,191,471	27,051,126	1,529,144	-	-	-	75,466,140	17,094,539	-	-	-
Total Commercial	115,254,867	96,037,221	1,702,788	1,841,237	68,191,471	27,051,126	1,529,144	-	-	-	108,718,125	37,499,212	-	-	-
Network Health	-	-	-	-	-	-	-	-	-	-	3,016,189	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	13,925,803	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	106,315,051	-	-	-	-
Health New England	-	-	-	-	9,021,103	-	-	-	-	-	118,022	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	1,338,281	686,011	-	-	-
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	5,134,389	1,844,462	-	-	-
Total Managed Medicaid	-	-	-	-	9,021,103	-	-	-	-	-	129,847,734	2,530,472	-	-	-
MassHealth	74,729,698	-	2,007,473	-	-	-	-	-	-	-	1,797,753	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	5,055,383	-	-	-	-
Blue Cross Senior Options	-	-	-	-	19,502,760	10,093,679	407,275	-	-	-	2,248,042	-	-	-	-
Other Comm Medicare	-	-	-	-	10,414,099	-	-	-	-	-	20,060,326	97,035	-	-	-
Commercial Medicare Subtotal	-	-	-	-	29,916,859	10,093,679	407,275	-	-	-	27,363,752	97,035	-	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	294,365,781	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	29,404,629	-	-	-	-
GRAND TOTAL	189,984,564	96,037,221	3,710,261	1,841,237	107,129,433	37,144,806	1,936,419	-	-	-	591,497,774	40,126,720	-	-	-

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	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	62,045,403	85,751,998	1,934,282	2,292,474	-	-	-	-	-	-	351,342	745,918	-	-	-
Tufts Health Plan	20,820,107	3,408,159	131,819	-	-	-	-	-	-	-	76,868	27,379	-	-	-
Harvard Pilgrim Health Care	4,729,010	5,853,873	4,463	-	-	-	-	-	-	-	55,121	12,939	-	-	-
Fallon Community Health Plan	13,422,166	-	16,480	-	-	-	-	-	-	-	49,803	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	16,906,404	9,392,130	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	13,785,365	1,534,389	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	10,690,835	5,334,932	-	-	-
Other Commercial	-	-	-	-	64,506,225	35,497,527	5,213,030	-	-	-	74,966,529	15,435,728	-	-	-
Total Commercial	101,016,686	95,014,030	2,087,044	2,292,474	64,506,225	35,497,527	5,213,030	-	-	-	116,882,266	32,483,415			
Network Health	-	-	-	-	-	-	-	-	-	-	4,442,640	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	11,381,767	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	108,853,572	-	-	-	-
Health New England	-	-	-	-	9,049,821	-	1,112,515	-	-	-	293,925	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	1,291,582	629,094	-	-	-
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	6,173,814	2,806,774	-	-	-
Total Managed Medicaid	-	-	-	-	9,049,821	-	1,112,515	-	-	-	132,437,301	3,435,868	-	-	-
MassHealth	80,836,503	-	2,971,138	-	-	-	-	-	-	-	1,681,093	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	4,734,781	-	-	-	-
Blue Cross Senior Options	-	-	-	-	14,242,231	10,371,546	481,101	-	-	-	1,880,137	-	-	-	-
Other Comm Medicare	-	-	-	-	14,848,561	-	671,106	-	-	-	26,760,042	109,653	70,820	-	-
Commercial Medicare Subtotal	-	-	-	-	29,090,792	10,371,546	1,152,207	-	-	-	33,374,959	109,653	70,820	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	355,972,160	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	32,049,934	-	-	-	-
GRAND TOTAL	181,853,189	95,014,030	5,058,182	2,292,474	102,646,838	45,869,073	7,477,752	-	-	-	672,397,714	36,028,936	70,820	-	-

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	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	63,037,271	83,502,388	2,175,607	2,738,296	-	-	393,828	-	-	-	806,207	503,420	-	-	-
Tufts Health Plan	22,125,532	2,846,717	72,593	-	-	-	-	-	-	-	150,981	16,964	-	-	-
Harvard Pilgrim Health Care	5,028,288	4,959,189	12,808	-	-	-	-	-	-	-	37,916	12,280	-	-	-
Fallon Community Health Plan	13,653,095	-	24,855	-	-	-	-	-	-	-	59,672	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	21,069,505	8,871,387	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	13,820,858	963,556	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	11,769,138	4,103,432	-	-	-
Other Commercial	-	-	-	-	57,839,732	42,244,958	1,230,266	-	-	-	76,804,820	16,061,686	-	-	-
Total Commercial	103,844,186	91,308,293	2,285,864	2,738,296	57,839,732	42,244,958	1,624,094	-	-	-	124,519,098	30,532,725			
Network Health	-	-	-	-	-	-	-	-	-	-	4,371,407	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	11,228,932	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	108,087,235	-	-	-	-
Health New England	-	-	-	-	18,341,229	-	1,341,210	-	-	-	603,996	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	973,207	740,439	-	-	-
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	5,563,591	2,821,878	-	-	-
Total Managed Medicaid	-	-	-	-	18,341,229	-	1,341,210	-	-	-	130,828,368	3,562,317	-	-	-
MassHealth	71,374,935	-	3,521,652	-	-	-	-	-	-	-	1,366,599	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	4,981,485	-	-	-	-
Blue Cross Senior Options	-	-	-	-	12,594,177	10,862,985	73,801	-	-	-	2,301,544	-	-	-	-
Other Comm Medicare	-	-	-	-	18,709,636	-	-	-	-	-	36,231,549	198,570	(26,188)	-	-
Commercial Medicare Subtotal	-	-	-	-	31,303,813	10,862,985	73,801	-	-	-	43,514,578	198,570	(26,188)	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	376,128,088	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	30,179,457	-	-	-	-
GRAND TOTAL	175,219,121	91,308,293	5,807,516	2,738,296	107,484,774	53,107,943	3,039,105	-	-	-	706,536,188	34,293,613	(26,188)	-	-

2014

	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	62,145,318	89,054,217	2,148,733	2,859,922	-	-	196,659	-	-	-	719,670	470,820	-	-	-
Tufts Health Plan	21,188,128	2,628,490	44,382	-	-	-	-	-	-	-	111,365	14,584	-	-	-
Harvard Pilgrim Health Care	5,728,175	5,239,449	11,625	-	-	-	-	-	-	-	19,778	3,682	-	-	-
Fallon Community Health Plan	15,982,864	-	35,463	-	-	-	-	-	-	-	38,895	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	21,765,265	8,219,232	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	14,747,375	679,553	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	14,290,599	2,549,947	-	-	-
Other Commercial	-	-	-	-	61,772,018	45,636,505	2,615,488	-	-	-	76,094,285	13,030,161	-	-	-
Total Commercial	105,044,485	96,922,156	2,240,204	2,859,922	61,772,018	45,636,505	2,812,147	-	-	-	127,787,232	24,967,978			
Network Health	-	-	-	-	-	-	-	-	-	-	5,761,763	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	10,001,318	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	122,297,479	-	-	-	-
Health New England	-	-	-	-	22,147,332	-	221,629	-	-	-	647,785	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	813,536	850,921	-	-	-
Other Managed Medicaid	49,572	80,713	-	-	-	-	-	-	-	-	9,573,762	2,785,880	-	-	-
Total Managed Medicaid	49,572	80,713	-	-	22,147,332	-	221,629	-	-	-	149,095,643	3,636,801	-	-	-
MassHealth	80,420,397	-	1,940,490	-	-	-	-	-	-	-	1,396,000	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	5,693,374	29,016	-	-	-
Blue Cross Senior Options	-	-	-	-	11,662,209	11,284,121	472,022	-	-	-	320,913	-	-	-	-
Other Comm Medicare	-	-	-	-	20,365,680	-	386,569	-	-	-	62,760,306	202,695	63,357	-	-
Commercial Medicare Subtotal	-	-	-	-	32,027,889	11,284,121	858,591	-	-	-	68,774,593	231,711	63,357	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	388,709,236	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	33,251,145	-	-	-	-
GRAND TOTAL	185,514,454	97,002,869	4,180,694	2,859,922	115,947,240	56,920,625	3,892,367	-	-	-	769,013,848	28,836,490	63,357	-	-