Acton Medical
ASSOCIATES, PC

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September 8, 2014

Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Attn: Lois H. Johnson

I, Christopher P. Cooper, M.D., Medical Director of Acton Medical Associates, P.C., am authorized to represent Acton Medical Associates, P.C for the purposes of this testimony in response to inquiries from the Health Policy Commission, the Attorney General's Office, and the Center for Health Information and Analysis, and I have signed under the pains and penalties of perjury.

Christopher P. Cooper, M.D.

Medical Director and Chief Executive Officer

Acton Medical Associates, P.C.

Dated: September 8, 2014

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 Tuesday, October 7. 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 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, 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.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk 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 Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses 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 begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement 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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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 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 between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      a. Acton Medical Associates, P.C. (hereinafter Acton Medical) has experienced the following trends from CY 2010 through year-to-date 2014.
      • Increase in payroll and payroll related costs primarily due to the additional staffing requirements of referral processing, system implementation and application, data analysis and quality measurement reporting.
      • Increase in information technology costs including networking, wireless technology, IT security, hardware costs and other applications.
      • Increase in the cost of medical malpractice insurance.
      • Increase in system application costs and incentive revenue from Medicare based programs relating to Meaningful Use and PQRS.
      • Increase in payroll costs and consulting costs associated with the requirements of HIPAA compliance.
      • Increase in quality incentive component of risk contracts.
   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      Acton Medical has continued to enhance the following programs.
      • Employing triage nurses that manage patient care, avoiding unnecessary office visits.
      • Providing diagnostic services such as x-ray and ultrasound that are typically reimbursed at lower rates than at hospitals.
      • Providing in-house clinical services such as anticoagulation management, allergy clinics and vaccination clinics that would be more costly if provided in a hospital setting.
      • Employing various care coordinators such as a social worker and quality assurance nurses to ensure that patients receive appropriate care in a timely manner. This team also establishes registries of patients with chronic disease, allowing them to proactively outreach and manage the care of these patients.
      • Actively managing patient referrals to low-cost, high-quality providers in Acton Medical's network.
   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of

technology and error reduction) to ensure the Commonwealth will meet the benchmark?

We have restructured the quality assurance department to add workflows that focus on the following quality initiatives to improve care for our patients:

- Population health management to monitor preventive care measures for our total population.
- Partnering with a local hospital to provide transitional care management for patients within 48 hours of discharge with the goal of preventing readmission.
- Participating in Meaningful Use 2 and utilizing certified electronic health record technology to monitor our performance of quality patient care.
- Reporting PQRS quality measures to ensure that patients get the right care at the right time.
- Managing diabetic registries and performing pre-visit preparation for our diabetic population.
- Utilizing huddle sheets for support staff and providers to communicate and prepare for patient visits.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Acton Medical encourages consideration for mandating PCP selections for all patients, regardless of insurer or benefit structures. Patients that self-refer often unnecessarily select higher-cost providers.

Acton Medical recommends further review of medical malpractice reforms. It is difficult to quantify how often providers defensively order diagnostic services, prescribe medications or refer patients to specialists that are believed to be unnecessary simply to avoid the possibility of a malpractice claim.

Finally, it is our recommendation that the health care cost growth benchmark of 3.6% exclude infrastructure expenditures necessary to implement quality improvement and cost containment initiatives. Investments in these programs should not be hindered by short-term goals in recognition of the potential long term cost containment benefit.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
SUMMARY:
   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
   Acton Medical has significant experience in managing care including full risk contracts and some non-risk contracts. We believe that care management under these contracts has improved the quality of services and patient outcomes as well as helped reduce healthcare costs. We have not measured the effects in terms of

healthcare cost, service quality, or patient outcomes, as the care management programs we have in place as a Patient-Centered Medical Home are made available to all of our patients, regardless of their insurance coverage. We strongly feel that primary care involvement in patient care and appropriate referral patterns both improve quality and reduce costs.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).
Acton Medical has not conducted analysis relating to the implementation of APMs, as the care management programs we have in place as a Patient-Centered Medical Home are made available to all of our patients, regardless of their insurance coverage or reimbursement method.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
As stated above, Acton Medical's care management programs are used to improve and augment the care of all our patients. Acton Medical cannot easily calculate the effects of APMs as they relate to specific populations. However, we have outlined the costs associated with bearing risk, coordination of care, and quality programs in the attachment Acton Medical – AGO Exhibit 2.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
SUMMARY:

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?
Health status risk adjustment measures do not sufficiently account for changes in patient population acuity. These adjustments are dependent on coding rather than actual care provided. Current coding allows for the same condition to be coded in more than one way. One code may lead to a health status adjustment that is lower or higher despite there being no clinical difference. Particularly for patients with chronic conditions, this can lead to inaccurate risk adjustment measures. Health status measures for children with chronic health conditions have historically been inaccurate. They are typically measured as being "healthier" and their health care costs underestimated. Those with behavioral health issues face similar challenges.

b. How do the health status risk adjustment measures used by different payers compare?
Health status calculations are very complex and each payer has its own proprietary formula. All payers reporting health status risk adjustments appear to be using DxCG scores and age/sex factors to calculate risk adjustments, but the number of diagnoses codes allowed for these calculations, as well as the variation of the other adjustment factors, frustrate our attempts to confirm or anticipate these factors using our internal population data.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?
All of Acton Medical's risks contracts include health status adjustments, to varying degrees, which directly impact the financial outcomes of these contracts. As such, Acton Medical has hired consultants to train our medical and support staff in DxCG coding and documentation. In addition, we have expanded our Quality Assurance department and have hired an experienced QA nurse to manage the various quality initiatives.

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
SUMMARY:
ANSWER: Acton Medical agrees that timely, reliable and actionable data and information are critical for high-quality care and cost containment. It is hoped that the adoption of Health Information Exchanges will greatly improve the flow of information between providers, hospitals and pharmacies. Real-time, up-to-date records, or even universal records, would reduce duplicative and/or unnecessary diagnostic procedures, improve care coordination, and help to avoid medical errors. In addition, improving access to claims data for use in population management and quality initiatives is greatly needed. Specifically, claims data formats should be consistent for all payers, and the lag-time for accessing these data should be decreased to no more than 30 days. Managing these disparate systems is costly and unwieldy.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY:
   a. Which attribution methodologies most accurately account for patients you care for?
   Acton Medical is a primary care provider group, as such, we believe that the most accurate attribution occurs when the patient is required to select a PCP. When PCP selection is not required, we believe that attribution methodologies which review historical claims data to identify preventive care visits with primary care providers may also accurately attribute members.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
   Acton Medical does not enter into risk contracts or other alternative payment contracts when total medical expense or quality outcomes are used to determine payment unless the patient is required to select a PCP. Acton Medical encourages consideration for mandating PCP selections for all patients, regardless of insurer or payment structures. We feel that the PCP should be empowered to

manage referrals and direct patients to the least-cost, high-quality services appropriate to the complexity to the patient's condition.

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY:
   ANSWER: Challenges include:
   - Staying current with payer definitions of quality measures as there is variation among the payers.
   - Understanding the measures in order to implement workflows to support meeting the measures.
   - Reviewing monthly reports from the payers for accuracy and then supplying supporting documentation for patients who are identified as not meeting the measure due to the limitations of claims reporting from the payers.
   - Reports from payers vary in how they are formatted and structured.
   - When payers send paper reports to individual providers rather than electronic reports to the quality manager, it makes it difficult to track and manage the reports in a timely manner.
   - Some payers do not provide reports for every quality measure that is expected to be managed.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
   SUMMARY:
   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
      Acton Medical does not currently track inpatient trends across all payers, but receive inpatient activity reports for our risk contracts. Rather, we encourage our physicians to refer to AMCs only when clinical appropriate.
   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.
      Acton Medical's primary referral circle is Emerson Hospital, a low-cost community hospital. If a patient requests a referral outside of the Emerson circle, the referral must first be reviewed and approved by the primary care physican, and then it is subjected to a secondary review and approval process by a designated medical director to determine the clinical appropriateness for the referral. If clinically appropriate, the referral is approved. If not, the care is redirected to Emerson Hospital.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
   SUMMARY:
   a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.
      We have partnered with a local hospital to implement a transitional care management program to ensure that we are notified daily of patients that are discharged after a hospitalization. Our nurses then contact patients within 48 hours of discharge to review the following: How they are feeling, discharge planning, discharge diagnosis and medications, need for coordination of care by multiple disciplines and community service agencies and scheduling follow up appointments. This information is presented to the primary care provider for review which provides the PCP an opportunity to identify patients who may need to be evaluated sooner than normal. We also have a social worker available for coordination of care of social services.
   b. How does your organization ensure optimal use of post-acute care?
      • As mentioned above, we have partnered with a local hospital to provide transitional care to our patients and additional hospitals may be added in the future.
      • Discharge summaries and all consultations are reviewed so that optimal follow up care is provided.
      • We have also started to collaborate with insurance companies so that we are aware of the programs that the insurance company offers for disease management.
      • The transitional care management program also provides an opportunity for our nurses to assess and address barriers to care.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
   SUMMARY:

Health Care Service Price Inquiries			
Year	**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In**	**Average (approximate) Response Time**

			Person	to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: Acton Medical, upon request, will direct insured patients to the member service number on the back of their card if they have questions regarding their coverage. Uninsured patients, upon request, are provided with our office visit charges. Patients typically inquire with our billing dept regarding the cost of a physical, immunization, labs and ultrasound. Acton Medical does not track the number or type of inquiries for patients who are requesting price information.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
    SUMMARY:
    ANSWER: Acton Medical has not conducted analyses regarding the effects of tiered and limited network products on our organization. At our request, Acton Medical is designated as a single-tiered practice with all of our health plans. We choose not to contract with risk plans if the limited network does not include our hospital of affiliation, Emerson Hospital. Acton Medical has a busy, full practice that does not seem to have been affected by tier placement.

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 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.
    SUMMARY:
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
       We have hired a social worker as part of our Patient-Centered Medical Home program, who provides on-site services to patients. She works with patients to connect them with community resources such as elder care, visiting nurse services, family and individual counseling, transportation services, and disability applications. The social worker also provides on-site emergency counseling. She works with the providers to integrate the behavioral needs of our patient into part of their ongoing care plan.
    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

Our practice is structured to minimize unnecessary emergency room utilization by all of our patients, including those with behavioral health issues. We provide urgent, same day appointments for patients as well as urgent access to our social worker. The office is open 7 days a week with 24 hour triage advice available. While somewhat more difficult to measure, we believe our approach to well visits and the establishment of a primary care physician-patient relationship helps reduce these utilizations as well. Our pediatric department participates in the MCPAP program which provides urgent psychiatric consultative services.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
   There is a need for more mental health providers in the community to provide both counseling and medication management, as there can be a long wait for a patient to see a provider. Coordination of care between primary care providers, therapists, and psychiatrists is limited due to additional privacy concerns regarding this type of care. We have found some providers who are able to provide more urgent care as well as communicate clinical diagnoses and care plans. With the help of our social worker, we continue to work on strengthening these relationships and establishing new ones.
d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.
   Because of the nature and classification of behavioral health data, Acton Medical Associates ability to report this data is limited.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY:
    a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
       Acton Medical achieved level 3 recognition from PCMH with a 100% of the PCP's recognized.
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
       100% of Acton Medical's patients receive care from recognized PCP's.
    c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.
       We have not conducted any specific analysis on the impact of PCMH on outcomes, quality, and cost of care.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY:
    ANSWER: Acton Medical's commentary is expressed in the answers provided above.

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 submit a summary table showing for each year 2010 to 2013 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. Please attempt to provide complete answers. 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.

   Completed in Attachment AGO Provider Exhibit 1

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2. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Acton Medical's risk management programs are intertwined with our integrated and coordination of care programs, which are used to improve and augment the care of all of our patients. Acton Medical cannot easily calculate the costs for services as they relate to a specific insurance or reimbursement model except as noted below:

- Risk Management Costs: Acton Medical employs an analyst whose main responsibility is to gather, analyze, audit and report on our risk members' claims activity and to provide analytic support during risk contract negotiations.
- Staffing Costs: Acton Medical employs a variety of staff members that directly contribute to the overall coordination of care of our entire patient population. These services are available to all patients, regardless of insurance. As such, these costs cannot be attributed to risk members only.
- Line of Credit: As a for-profit organization, Acton Medical cannot accumulate or maintain reserves against our risk contracts without suffering significant tax burdens. Approximately 14 years ago, Acton Medical secured a line of credit using its assets as collateral for the purpose of establishing a contingency plan against significant risk contract deficits or possible negative cash flows generated at the time of contract termination (claims run-out).

- Stop-Loss Coverage: Stop-loss coverage is provided for all risk contracts.
- Contractual Deficit Protection: Acton Medical has several risk contracts with risk corridors. These corridors limit Acton Medical's exposure to significant deficits or surpluses.

Based on the protections and programs outlined above, Acton Medical does not consider itself to bear significant downside risk associated with its risk contracts.

Per member per month costs completed in attachment Acton Medical - AGO Exhibit 2

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3. Please explain and submit supporting documents that show the process by which (a) your physicians refer patients to providers within your provider organization and outside of your provider organization; and (b) your physicians receive referrals from within your provider organization and outside of your provider organization. Please include a description of how you use your electronic health record and care management systems to make or receive referrals, 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.

Acton Medical Associates is a primary care practice. A small percentage of incoming referrals are received for infectious disease and travel medicine.
Acton Medical physicians' primary referral circle is Emerson Hospital. If specialty care cannot be provided at Emerson, members are directed to a qualified specialist outside of this referral circle. In such cases, these referrals are subjected to a secondary review and approval process by a designated medical director to determine the clinical appropriateness for the referral.
Referrals are processed according to the insurers' requirements. Referral letters are generated in our EMR and automatically faxed to the specialist.

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4. Please explain and submit supporting documents that describe how, if at all, information on cost and quality is made available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care. Include in your response any type of information on costs or quality made available to your physicians through electronic health management, care management, disease management, large case-management or other clinical management programs.

Acton Medical Associates has an established review and approval process for referrals outside of our local network. This local network and its costs are well known to AMA and our physicians. So, while direct costs are not known at the time of referral, deviations from the norm are easily identified. We also participate in insurance company mandated reviews for imaging studies. These reviews and approvals are based on the cost of the procedures. Prior to approval, studies are directed to lower cost centers. All referrals are done based on

the desire to provide the best care to our patients but AMA does not generally have specific quality measures that are available at the point of referral.

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide

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
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services
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.

2010 In Millions

	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	X	X	0.304	X	X	X	X	X	X	X	3.324	2.700	X	X	X
Tufts Health Plan	X	X	X	X	0.702	X	0.671	X	X	X	X	0.858	0.036	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	1.680	X	0.117	X	2.410	X	0.034	X	X
Fallon Community Health Plan	X	X	X	X	1.148	X	0.858	X	X	X	X	X	0.045	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.253	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.812	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.640	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.900	X	X	0.151
Total Commercial	-	-	0.304	-	1.850	-	3.209	-	0.117	-	5.734	6.163	0.115	-	0.151
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mass Health	-	-	-	-	-	-	-	-	-	-	-	0.283	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.295	X	0.778	X	0.019	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.295	-	0.778	-	0.019	-	-	-	-	-	-
Medicare	-	-	-	0.012	-	-	-	-	-	-	-	1.270	-	-	-
Other															
GRAND TOTAL	-	-	0.304	0.012	2.145	-	3.987	-	0.136	-	5.734	7.716	0.115	-	0.151

2011 In Millions

	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	X	X	0.331	X	X	X	X	X	X	X	3.117	2.997	X	X	X
Tufts Health Plan	X	X	X	X	0.700	X	0.105	X	X	X	X	0.780	0.037	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	1.890	X	0.043	X	3.000	X	0.034	X	X
Fallon Community Health Plan	X	X	X	X	1.104	X	(0.073)	X	X	X	X	X	0.034	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.247	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.791	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.623	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.576	X	X	0.062
Total Commercial	-	-	0.331	-	1.804	-	1.922	-	0.043	-	6.117	6.014	0.104	-	0.062
		x													
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mass Health	-	-	-	-	-	-	-	-	-	-	-	0.257	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.169	X	0.493	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.169	-	0.493	-	-	-	-	-	-	-	-
Medicare	-	-	-	0.019	-	-	-	-	-	-	-	1.577	-	-	-
Other															
GRAND TOTAL	-	-	0.331	0.019	1.973	-	2.415	-	0.043	-	6.117	7.848	0.104	-	0.062

2012 In Millions Updated with final risk settlements and year end adjustments

	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	X	X	0.229	X	X	X	X	X	X	X	2.577	3.078	X	X	X
Tufts Health Plan	X	X	X	X	0.960	X	0.816	X	0.081	X	X	1.120	0.038	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	2.187	X	0.091	X	3.252	X	0.034	X	X
Fallon Community Health Plan	X	X	X	X	1.184	X	0.254	X	X	X	X	X	0.033	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.281	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.815	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.555	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.781	X	X	0.281
Total Commercial	-	-	0.229	-	2.144	-	3.257	-	0.172	-	5.829	6.630	0.105	-	0.281
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mass Health	-	-	-	-	-	-	-	-	-	-	-	0.378	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.299	X	2.215	X	0.015	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.299	-	2.215	-	0.015	-	-	-	-	-	-
Medicare	-	-	-	0.311	-	-	-	-	-	-	-	1.654	-	-	-
Other															
GRAND TOTAL	-	-	0.229	0.311	2.443	-	5.472	-	0.187	-	5.829	8.662	0.105	-	0.281

2013 In Millions With preliminary risk settlements

	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	X	X	0.340	X	X	X	X	X	X	X	2.810	3.646	X	X	X
Tufts Health Plan	X	X	X	X	0.869	X	0.965	X	-	X	X	1.272	0.034	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	1.764	X	-	X	3.127	X	0.032	X	X
Fallon Community Health Plan	X	X	X	X	1.096	X	0.129	X	X	X	X	X	0.033	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	0.304	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	0.968	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	0.619	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	0.515	X	X	0.269
Total Commercial	-	-	0.340	-	1.965	-	2.858	-	-	-	5.937	7.324	0.099	-	0.269
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MassHealth	-	-	-	-	-	-	-	-	-	-	-	0.414	-	-	-
Tufts Medicare Preferred	X	X	X	X	0.252	X	1.682	X	-	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	-	-	-	-	0.252	-	1.682	-	-	-	-	-	-	-	-
Medicare	-	-	-	0.239	-	-	-	-	-	-	-	1.775	-	-	-
Other															
GRAND TOTAL	-	-	0.340	0.239	2.217	-	4.540	-	-	-	5.937	9.513	0.099	-	0.269

Acton Medical Associates, PC
Exhibit C Question 2

Commercial Risk Contracts	2013 Member Months
Tufts	25300
Fallon	12643
HPHC	31865
	69808

Cost associated with bearing risk and coordination of care:	2013 Allocation	Risk PMM
Stop-loss broker	$55,000	$0.79
Stop-loss premium expense	$730,394	$10.46
Salary of financial analyst	83,766	$1.20
Payroll costs of triage nurses	1,285,440	$18.41
Salary of quality assurance manager (partial year)	31,271	$0.45
Payroll costs of utilization review staff	149,166	$2.14
Payroll costs of referral processing	224,952	$3.22
Payroll costs of registration outreach	95,514	$1.37
Payroll costs of mental health coordination (LICSW)	63,188	$0.91
Payroll costs of diabetes education (NP)	95,183	$1.36
Payroll costs of EMR support staff	335,526	$4.81
Coumadin clinic nurse salary	60,911	$0.87
Allergy clinic salary (NP)	32,546	$0.47
Nurse educator salary	36,012	$0.52
EMR maintenance and support (support contract)	$231,500	$3.32
Total	$3,510,370	$50.29

* All payroll costs have been adjusted to included the approximate cost of benefits