Berkshire
Medical Center
BERKSHIRE HEALTH SYSTEMS

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September 16, 2015

Via E-Mail: HPC-Testimony@state.ma.us

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

Dear Mr. Seltz,

On behalf of Berkshire Medical Center, Inc., I submit the following written testimony in response to the questions of the HPC in Exhibit B and questions of the AGO in Exhibit C of the Health Policy Commission's request dated August 6, 2015.

Sincerely,

Darlene Rodowicz
Chief Financial Officer

Written Testimony of Berkshire Medical Center, Inc.

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%.

Summary Statement. As is more fully discussed throughout this testimony, and was noted in previous testimony, in recent years, Berkshire Medical Center ("BMC") and its parent organization, Berkshire Health Systems ("BHS" and together, "BHS/BMC"), have found themselves increasingly in the role of principal provider, supporter and coordinator of health and wellness services for all of Berkshire County, an area the size of Rhode Island with a population significantly smaller than the City of Springfield alone. Especially in an environment of growing demographic and health status challenges, the new BHS/BMC role carries planning, financial and resource burdens that are unreimbursed and far beyond traditional undertakings by acute care hospitals. Despite those substantially expanded obligations, BHS/BMC has been able to offer its commercial payers contract rates that during the past several years include increases at or below the Medical CPI. In addition, BMC and other BHS affiliates engage in regular, successful efforts to implement the principals of IHI's Triple Aim and ABIM's Choosing Wisely campaign in existing work and continue to invest in community wellness programs for the community.

1.

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.

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?

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?

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

Discussion. As discussed in previous testimony, BHS/BMC finds itself providing, within lawful limits, resources and support to other unrelated components of the Berkshire County health services network for the sole purpose of assuring the continued presence of those providers in the area market place. Berkshire County continues to be an area in which private physician practices lack the resources to recruit, ramp up and retain

new physicians and other practitioners. In FY2015, a BHS/BMC was asked to hire the only remaining independent OB/GYN physicians as well as physicians from the largest independent surgical group in the region in order to prevent those physicians from ceasing practice or leaving the area. Both groups were in financial distress as a result of the market size and trends in utilization and sought out BHS/BMC to step in to stabilize the service for the community.

In FY2014 and 2015, BHS/BMCBHS/BMC was called upon by Governor, Executive Office of Health & Human Services and other state and federal officials—as well as BHS/BMC's own charitable mission—to provide healthcare services relief to meet the needs of the northern Berkshire community following the abrupt closure of North Adams Regional Hospital and Northern Berkshire Healthcare (NBH) on March 28, 2014. In addition to its effect of hospital services in the region, the closure would have shuttered two hospital-sponsored physician groups, as well as home care and hospice services, in northern Berkshire County, severely impacting thousands of lives. BHS/BMC without any opportunity to conduct the most rudimentary due diligence, BHS/BMC immediately hired the physicians, other providers and support staff of the family practice and obstetrics/gynecology groups that had been sponsored by NBH. The family practice group was one of just three primary care groups in the northern Berkshire region while the ob/gyn group was the only group providing obstetrics services to the community. Similarly hurried efforts were necessary to keep home care and hospice services available in the northern tier, including for patients then actively dependent upon those services. Along with the support for the physician groups and home care and hospice, BHS/BMCBHS/BMC, with less than a week's notice , restructured some of its key operations and mobilized other resources to meet the hospital and hospital-related needs of the northern Berkshire communities. The hospital closure required BHS/BMCBHS/BMC to redesign staffing models to meet the increased volume demand in order to continue providing safe and appropriate care. Some staffing demands required the use of contract labor and locums tenens supplements, a practice that BHS/BMCBHS/BMC has tried to minimize during normal operations. During FY2015, BHS/BMC also re-established in northern Berkshire County many hospital-based outpatient services that were abruptly stopped as a result of the hospital closure. Essential services including emergency services, outpatient imaging, endoscopy screening, mammography, and some outpatient surgery has been returned to the former North Adams Regional Hospital campus.

BHS/BMCBHS/BMC continues to actively engage in workforce development, as noted in last year's report. During FY2013, 2014 and 2015, BHS/BMCBHS/BMC, in partnership with the Chicopee-based Elms College, continued to fund the ASN to BSN nursing program for its nurses on the BHS/BMC campus. In 2015, BHS/BMCBHS/BMC launched, also in partnership with the Elms College, the first class of advance practice nursing students. Ten nurses are enrolled in this program. BHS/BMC believes that there will be an increasing shift in the model of care and an ongoing shortage of primary care physicians. While this investment should benefit BHS/BMC in the long run, the costs of this program are being borne currently by BHS/BMC.

A. Trends in the Market

   BHS/BMC continue to see pressure on its operating performance as growth in expenses continue to outpace increases in revenue. For the past several years, BHS/BMC has accepted in its commercial payer contracts increases that are at or below the Medical CPI. BHS/BMC are very dependent on

government payers, programs that have only permitted increases at or below the Medical CPI as well. In FY 2015, approximately 71% of BMC's net revenue came from government payers while another 1.6% was from the health safety net or self-pay, leaving just 27% of the net revenue from commercial payers. Berkshire County has a very limited participation in the HMO market given the size of the county and division of that market between a variety of payers. According to the Massachusetts Division of Insurance report of HMO membership as of March 31, 2015, Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. had 9,318 covered lives (2.1% of its total lives), about 4,600 of whom are BHS/BMC employees and their dependents enrolled in its self-insured program; Health New England had 11,420 covered lives(7.7% of its total lives), about 800 of whom are BHS/BMC employees and their dependents enrolled in its self-insured program; and Tufts Associates HMO, Inc. had 1,821covered lives(.6% of its total lives).

BHS/BMC continues its efforts to control costs while maintaining high quality performance. BHS/BMC has embedded Six Sigma/Lean techniques across the organization with an emphasis on using staffing-to-demand tools. These tools, along with Solucient benchmarking tools, have allowed BHS/BMC to effectively develop annual operating budgets and manage FTEs when vacancies occur. These tools are used at the department level with clear targets at or below the median benchmark. While building its annual operating budget, BHS/BMC disregards extraordinary or likely temporary income items, such as the current rural floor adjustment, in order to enforce greater discipline in budgeting and expense reduction and more predictable and sustainable financial performance. This approach has proven beneficial to the financial stability of BHS/BMC during times of volatility. Fiscal year 2015 will be a year in which BHS will achieve, on a consolidated basis, only a .1% operating margin. BHS/BMC continues to be vulnerable to changes in its medical staff, payer mix, community demographics, staffing shortages and the overall transition of sites and modalities of care.

BHS/BMC remains committed to STEEEP principles articulated by the Institute of Medicine (care that is safe, timely, effective, efficient, equitable and patient-centered). BHS/BMC remains committed to providing high quality care with an attention to efficiency and value. In FY2014 BMC was recognized as a Truven 100 Top Hospital, an award that considers quality, patient safety and cost of care. In FY2015 BHS/BMC was once again recognized by Healthgrades with the Distinguished Hospital Award for Clinical Excellence and Delta CareChex as a Top 100 Hospital in the Nation for Overall Hospital Care.

Total Medical Expense (TME) for Berkshire County, as calculated by commercial payers, has not been shared with BHS/BMC, in part because commercial payers claim to be unable to do so lawfully. The most recent information available to BHS/BMC is from 2009 and includes aggregate data from the four western counties of Massachusetts. BHS/BMC believes that the CMS Medicare Spending Per Beneficiary (MSPB) is a reliable measure for BHS/BMC to use as an indicator of costs compared to other Massachusetts hospitals and the hospitals in the nation.

The MSPB episode is defined as all claims with start date falling between 3 days prior to an inpatient PPS hospital admission (index admission) through 30 days post-hospital discharge.

The MSPB Measure Performance Rate is the ratio of a hospital's payment-standardized, risk-adjusted MSPB Amount to the median MSPB Amount across all hospitals. An MSPB Measure Performance Rate

of less than one indicates that a hospital's MSPB Amount is less expensive than the national median spending amount. The table below summarizes BMC's performance over the four most recent measurement periods. The most recent MSPB report reflects an increase in BMC's index with the change occurring in the post-discharge component, specifically skilled nursing facilities.

	Measurement Period				Spend/Episode	
	May 11-Dec 11	**Jan 12-Dec 12**	**May 13-Dec 13**	**Jan 14-Dec 14**	**May 13-Dec 13**	**Jan14-Dec14**
BMC	**1.03**	**1.00**	**0.99**	**1.02**	**$ 19,439.20**	**$ 20,433.95**
Massachusetts	**1.04**	**1.03**	**1.02**	**1.01**	**$ 20,008.29**	**$ 20,315.21**
United States	**0.98**	**0.98**	**0.98**	**0.98**	**$ 19,253.48**	**$ 19,679.19**

BHS/BMC has adopted the Choose Wisely principles promulgated by the ABIM Foundation. As a primary target, BHS/BMC has focused on eliminating unnecessary imaging and laboratory testing. Health New England is the only commercial insurance plan engaged with BHS/BMC that offers a shared savings arrangement, so that succeeding in initiatives such as Choose Wisely represents a gain for payers but a financial loss for BHS/BMC,.

Beginning in FY2015, BHS/BMC has been working with its medical staff to explore and develop a Berkshire County Physician Hospital Organization (PHO) that would provide a vehicle to develop alternative payment models with payers, as well as coordinated quality improvement initiatives. BHS/BMC is also exercising restraint in its charge increases at or below the Medicare market basket increase and the Massachusetts gross state product.

As discussed in last year's report, BHS/BMC works with other community providers to improve transitions in care between hospital, home and skilled nursing facilities. Using data in the MSPB report and with a goal of further reducing unnecessary admissions and readmissions, BHS/BMC analyzed its data to identify which physician practices and skilled nursing facilities had the highest incidence of readmissions. BHS/BMC has developed a standing working group to understand the causes of these readmissions and improve care transitions to reduce the readmission rate and improve outcomes for the patient. Efforts to reduce the post-acute care costs include launching a county-wide patient centered medical home initiative, implementing a BOOST program (Better Outcomes by Optimizing Safe Transitions) on some BMC nursing units, embedding home care nurses in physician practices, introducing behavioral health telemedicine and focusing on reducing post-hospitalization syndrome.

BHS/BMC will continue to exercise restraint in its delivery approach to help the Commonwealth meet the cost growth benchmark for the coming year. BHS/BMC has received funding from the Prevention Wellness Trust Fund and the CHART grant. The CHART grant has assisted in the development of a "medical neighborhood" known locally as the "Neighborhood for Health" to provide services that will improve the health and well-being of the residents of northern Berkshire County. The Neighborhood for

Health will provide supportive services such as diabetes education, a congestive heart failure clinic, and behavioral health day program (in partnership with the Brien Center, an independent behavioral health and substance abuse outpatient service provider) and acute outpatient alcohol detox services on the former NARH campus. Many of these services are currently either poorly reimbursed or not reimbursable at all, but are believed to have a positive impact on patients and their ability to remain home and reduce readmissions while improving the wellness of the community.

BHS/BMC will continue to expand its Canyon Ranch Institute Life Enhancement Program (CRI LEP) as described in last year's report. Since last year BMC has engaged community members for four distinct group programs with approximately 20 members each. BHS/BMC has expanded this program to southern Berkshire county and will expand the program to northern Berkshire county in 2016. The CRI LEP helps community members prevent, identify, and address chronic diseases and disease risk. The support team members receive from one another has been positive with the groups continuing to reconnect long after the formal program has ended.

There continue to be many recommended systematic or policy changes that would assist BHS/BMC to operate more efficiently without reducing quality. These include:

- Recognition that there are healthcare organizations like BHS/BMC that, because of the nature of the communities for which they are responsible, have burdens that go well beyond those of a traditional hospital or health system.
- Recognition that the total cost of care or total medical expense in an area such as Berkshire County may include factors beyond the cost of a typical episode of care.
- Financial performance measures and payment measures that represent the reimbursement at the Health System level instead of the disjointed hospital only or physician only payment rates.
- True transparency in claims data and other appropriate information between providers, insurers and regulators to assure that such data and information can serve as a truly accurate and useful tool for comparison and improvement.
- Development of uniform definitions, quality reporting measures, claims submission and determination processes among insurers in order to eliminate a substantial amount of non-productive overhead cost of providers.

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

BHS/BMC has been working with the medical staff during 2015 to develop a Berkshire County PHO. While still in the development stages, it is believed that the size of our community will require a partnership with a larger PHO to share administrative, analytical and information technology services. The PHO will always need to be concerned and protect itself from the higher probability of large variations given the small size of the population it will serve. Recognition of the higher risk in small markets and some protection from these risks would be beneficial to the development of these alternative payment models.

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.**

BHS/BMC work with other community providers to improve care transitions between hospital, home and skilled nursing facilities. Using data in the MSPB report and with a goal of further reducing unnecessary admissions and readmissions, BHS/BMC analyzed its data to identify which physician practices and skilled nursing facilities had the highest incidence of readmissions. BHS/BMC has developed a standing working group to understand the causes of these readmissions and improve care transitions to reduce the readmission rate and improve outcomes for the patient. Efforts to reduce the post-acute care costs include launching a county wide patient centered medical home initiative, implementing a BOOST program (Better Outcomes by Optimizing Safe Transitions) on some BMC nursing units, embedding home care nurses in physician practices, introducing behavioral health telemedicine and focusing on reducing post-hospitalization syndrome. BHS/BMC also opened a walk –in clinic and an urgent care clinic in FY2015 to provide alternative, lower cost settings of care for patients in need of lower level emergency care or access to services when their own primary care practice cannot see them or if they do not have a primary care physician.
BHS/BMC is also working with Hospice Care in the Berkshires, Inc., an associated, local non-profit hospice service, to provide a palliative care program for patients suffering from chronic diseases allowing patients to be more engaged in their clinical care and overall treatment.

    b. **Please describe your organization's specific plans over the next 12 months to address each of these four areas.**
BHS/BMC will continue to develop programs using its own data to reduce readmissions and complications. BHS/BMC plans to develop programs under the PHO that will focus on unnecessary emergency department utilization and diagnostic testing.

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? Providers generally calculate the total cost of services that they provide and determine the total revenue necessary to cover those costs. Spread across the range of services and service volumes that vary from provider to provider, with payment arrangements and amounts that vary**

from provider to provider, the total revenue requirement—when allocated to specific prices for specific services—will necessarily vary from provider to provider.

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.

Discussion

BHS/BMC has been unable to obtain the data used to develop these payment indexes from the payers and has been unable to verify the data or the methodology used. However, BHS/BMC does believe that publishing one component of the payment for an episode of care or service based upon the provider number without including the other components of the payment associated with the care or service can be misleading to the reader of the reports. While some of the reports indicate that BHS/BMC may receive higher than average or average payments for hospital services, other reports indicate that the physician component of the service is paid near the bottom of the range. Since TME is not shared at the county or regional level, BHS/BMC does not know where it stands at the aggregate level, even if the extraordinary components of BHS/BMC's TME are disregarded.

BHS/BMC has over the last several years accepted increases in its contracted rates from payers that have been at or below the Medical CPI.

BHS/BMC also believes that global budgets may vary by geographic regions based upon the demographics and social well-being of the community it serves. BHS/BMC believes the fixed cost of providing services to a community or region that is less densely populated is higher on a per unit of service basis than that same program in a more densely populated area. The needs of the community or region will need to be balanced over time with the cost of providing these services in these less populated areas.

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.

   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.

Discussion

BHS/BMC has had a long tradition of collaborating with the Brien Center, a non-profit outpatient and transitional care behavioral health and substance abuse provider. BHS/BMC provide the medical staff for the Brien Center which has provided patients with care management that bridges the transitions between inpatient and outpatient care. As of September 1, 2015, BHS/BMC, in conjunction with the HPC through the CHART grant, established a "Neighborhood for Health" for northern Berkshire county residents. This program recognizes that many patients have comorbid behavioral health and chronic medical conditions. Patients are able to access behavioral health, outpatient acute detox services, and behavioral health day treatment programs at the neighborhood while they can also access a congestive heart failure clinic, diabetes education, nutritional counseling and community health worker services. The goal of the program is to avoid readmissions and allow patients to remain healthy at home.

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?**

As noted in the previous responses, BHS/BMC has begun work with its medical staff to develop a PHO. While work continues on the development of a PHO it is believed that many of the capabilities needed to successfully run and administer a PHO will need to be acquired from a larger PHO. These services include but are not limited to analytics and information system platforms.

Exhibit C: Instructions and AGO Questions for Written Testimony

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

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

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	206	0	206	
	Q2	208	0	208	
	Q3	207	0	207	
	Q4	201	0	201	
CY2015	Q1	215	0	215	
	Q2	216	0	216	

BHS/BMC returns all patient calls and provides estimates of the charges related to services being questioned. The patients are informed to call their insurance companies to get an estimate of their out of pocket exposure including copays and deductibles associated with the services in question.

Inquiries have been placed for the following services: MRI, cat scan, nuclear medicine, diagnostic imaging, ultrasound, stress tests, echocardiograms, laboratory, outpatient surgery, sleep studies, inpatient stays, partial hospitalization services, ECT, physical therapy, occupational therapy, speech therapy and audiology.

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 <u>AGO Hospital Exhibit 1</u> 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**.
See attached excel spreadsheet.

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.

8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	35,629,716	22,356,319	1,178,774	742,781											
Tufts Health Plan											8,384,154				
Harvard Pilgrim Health Care											1,326,994				
Fallon Community Health Plan															
CIGNA											3,960,124				
United Healthcare											9,620,707				
Aetna															
Other Commercial											42,680,367				
Total Commercial	35,629,716	22,356,319	1,178,774	742,781							65,972,344				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.											18,454,503				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											1,754,487				
Total Managed Medicaid											20,208,990				
MassHealth	14,810,333		48,389												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	123,168,546		45,767												
Other											17,747,168				
GRAND TOTAL	173,608,595	22,356,319	1,272,930	742,781							103,928,503				

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	33,972,912	22,869,807	1,231,591	848,102											
Tufts Health Plan											10,082,218				
Harvard Pilgrim Health Care											1,897,505				
Fallon Community Health Plan											2,281,629				
CIGNA											5,356,185				
United Healthcare											10,222,319				
Aetna											4,524,286				
Other Commercial											37,913,815				
Total Commercial	33,972,912	22,869,807	1,231,591	848,102							72,277,957				
Network Health															
Neighborhood Health Plan											169,564				
BMC HealthNet, Inc.											22,636,878				
Health New England					1,006,790		146,179								
Fallon Community Health Plan															
Other Managed Medicaid											4,074,351				
Total Managed Medicaid					1,006,790		146,179				26,880,793				
MassHealth	14,566,864		435,705										415,102		
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	130,011,965		100,687												
Other											19,486,233				
GRAND TOTAL	178,551,741	22,869,807	1,767,983	848,102	1,006,790		146,179				118,644,983		415,102		

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	31,664,165	20,967,086	1,126,432	724,526											
Tufts Health Plan											9,675,189				
Harvard Pilgrim Health Care											1,347,587				
Fallon Community Health Plan											2,474,508				
CIGNA											5,413,537				
United Healthcare											11,384,765				
Aetna											5,215,018				
Other Commercial											39,116,529				
Total Commercial	31,664,165	20,967,086	1,126,432	724,526							74,627,133				
Network Health											1,085,018				
Neighborhood Health Plan											207,497				
BMC HealthNet, Inc.											23,778,140				
Health New England					730,910		72,039								
Fallon Community Health Plan															
Other Managed Medicaid											4,438,590				
Total Managed Medicaid					730,910		72,039				29,509,245				
MassHealth	14,689,387		742,524												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	147,025,918		77,527												
Other											21,805,282				
GRAND TOTAL	193,379,470	20,967,086	1,946,483	724,526	730,910		72,039				125,941,661				

-1.015E-07

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	32,141,762	20,889,506	1,139,699	745,424											
Tufts Health Plan											8,458,107				
Harvard Pilgrim Health Care											1,891,759				
Fallon Community Health Plan											3,244,976				
CIGNA											5,125,103				
United Healthcare											10,078,842				
Aetna											5,823,548				
Other Commercial											37,580,807				
Total Commercial	32,141,762	20,889,506	1,139,699	745,424							72,203,142				
Network Health											1,719,918				
Neighborhood Health Plan											317,941				
BMC HealthNet, Inc.											22,473,726				
Health New England					1,429,376		109,328								
Fallon Community Health Plan															
Other Managed Medicaid											4,149,923				
Total Managed Medicaid					1,429,376		109,328				28,661,507				
MassHealth	14,933,592		702,442												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	152,621,238														
Other											23,124,723				
GRAND TOTAL	199,696,592	20,889,506	1,842,142	745,424	1,429,376		109,328				123,989,372				

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	37,425,618	22,577,023	1,869,621	1,134,532											
Tufts Health Plan											10,245,948				
Harvard Pilgrim Health Care											2,203,688				
Fallon Community Health Plan											4,895,264				
CIGNA											6,084,868				
United Healthcare											9,445,781				
Aetna											6,921,578				
Other Commercial											38,833,344				
Total Commercial	37,425,618	22,577,023	1,869,621	1,134,532							78,630,470				
Network Health											2,998,781				
Neighborhood Health Plan											1,835,886				
BMC HealthNet, Inc.											25,289,315				
Health New England					2,148,404										
Fallon Community Health Plan															
Other Managed Medicaid											5,429,418				
Total Managed Medicaid					2,148,404						35,553,399				
MassHealth	17,282,207		593,988												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare					480,411										
Commercial Medicare Subtotal					480,411										
Medicare	168,310,747														
Other											17,164,426				
GRAND TOTAL	223,018,572	22,577,023	2,463,609	1,134,532	2,628,816						131,348,295				