September 11, 2015

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

We are in receipt of your letter dated August 6, 2015 identifying Emerson Hospital as a witness for the annual public hearings concerning health care cost trends in the Commonwealth. We are pleased to participate in this important process and wish to support the efforts of the HPC and the AGO in its efforts to identify ways to deliver healthcare in a more affordable, effective and accountable manner.

To this end, we respectfully submit the attached written testimony in response to the questions of the HPC in Exhibit B and questions of the AGO in Exhibit C.

Please do not hesitate to contact me if there are any questions or if more information is needed. I can be reached at cschuster@emersonhosp.org or at 978-287-3111.

Thank you.

Sincerely,

Christine Schuster
President and CEO

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

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

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

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

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

Annual Change:	**2014**	**Jun 2015**
Revenue (NPSR)	1.6%	3.9%
Expense	1.4%	5.2%

The above chart shows Emerson Hospital growth trend for revenues and expenses for 2014 and year-to-date 2015. Emerson Hospital performed better than benchmark growth in 2014 for revenue and operating expenses. Year-to-date 2015, Emerson Hospital is slightly above the benchmark for revenue (which is the cost applicable to the purchasers of healthcare). However the cumulative average of both years of revenue growth is below the Commonwealth's benchmark growth. Year-to-date 2015 Emerson Hospital is above the benchmark for expenses, but the average of both years of expenses also remains below the benchmark. Inpatient utilization, defined as inpatient discharges, declined in 2014 but has increased year-to-date 2015 primarily attributable to medical and psychiatric inpatient volume. Outpatient care grew 2% in 2014 and 0.4% year-to-date 2015, particularly related to laboratory testing and physical therapy. While the number of inpatient medical discharges has declined since 2013, the intensity of service continues to increase. Medicare case mix increased from 1.39 in 2014 to 1.42 year-to-date 2015 while commercial payer case mix increased from .74 in 2014 to 1.03 year-to-date 2015.

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

The hospital has undertaken numerous initiatives in the past couple of years to minimize the growth in healthcare expenditures. The results of these actions have contributed to the aforementioned growth rates that are at or below the benchmark targets. These initiatives include:

- Implemented processes to flex staffing levels to actual volume.
- Replacement hires for non-clinical positions are hired at 37.5 hours per week instead of 40.
- Maintained our ongoing relationship with outside experts on identifying opportunities to minimize costs and maximize efficiencies.

- In conjunction with the Emerson Hospital physicians, enhanced our electronic health record that allows for the flow of patient information across the continuum of care.
- Upgraded the majority of our mammography machines to 3-D tomosynthesis resulting in a significant decline in the need for patients to have repeat imaging.
- Active member of an ACO focusing on carefully managing patient care and associated costs.
- Streamlined additional clinical pathways.
- Supporting Patent Centered Medical Home implementation for many of our primary care practices.
- Implemented a Care Transitions Collaborative comprising area SNFs, home care, pharmacies and senior centers to manage transition of care among them and the hospital.
- Expanded our community Integrative Health & Wellness Center focused on educational classes.
- Implemented a Rehab documentation system to more efficiently manage our Physical Rehab patients.
- Expanded the capacity to treat locally the Physical Rehab patients.
- Implemented a low-dose CT screening program for early detection of lung cancer
- Received a CHART II grant that will be used for initiatives to reduce re-admissions
- Conducted a Community Health Needs Assessment

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?

i. Continue to work with the community physicians to share utilization information through a health information exchange.
ii. Collaborate with the physician-hospital organization to evaluate PHO structure and function and align performance measures.
iii. Implement the CHART II grant to reduce 30-day readmissions among high risk patients.
iv. Continue cost control efforts through Self-Insurance program for employee health insurance.
v. Continue to expand community-based Health and Wellness Center.

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

Emerson Hospital recognizes and supports the healthcare imperative to operate more efficiently without reducing the quality of care delivered to its patients. To that end, we consistently explore opportunities to achieve efficiencies particularly within the realms of care transitions, preventive care and wellness programs. As Emerson evaluates the

health needs of the communities it serves the aforementioned have been identified as opportunities to partner with community stakeholders to reduce cost and increase efficiency.

Care transitions, or more specifically, ensuring the safe and effective discharge of patients to skilled nursing facilities, rehabilitation centers or even home, are fraught with challenges and complexities which can adversely impact patient care. For example, access to pharmacies, patient teaching and in-home support can often be lacking for a significant portion of Emerson patients. Surrounding these processes with the necessary resources for patient education and assistance (e.g., expanded reimbursement for home care visits) would result in a reduction in unnecessary readmissions and emergency room level of care.

Similarly, in the arenas of preventive care and wellness programs, Emerson is committed to the delivery of services to mitigate the need for higher levels of care. Through patient education and preventive services delivered in collaboration with Emerson physician practices, patient risk is diminished and outcomes improved.

To the extent that policy changes within the Act could support through resource allocation, care transitions, preventive care and wellness programs, efficiency would be improved and a positive impact to health care cost metrics realized.

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

   Emerson's obstacles are consistent with many other health care providers. Disparate technology platforms create barriers to the coordination of care due to the lack of interoperability between IT systems. Further, fee for service payment models continue to be the dominant method of payment, which creates barriers to implementing alternative payment models. Care regularly needs to be coordinated between providers that are under differing payment arrangements resulting in a misalignment of incentives. Employed physicians, independent physicians, hospitals, rehab providers and long-term care providers are often working under a different set of incentives and payment models resulting in inefficient and uncoordinated care. Finally, payers continue to not be fully able to administer alternative payment models in that their legacy IT platforms are geared toward fee for service payment mechanisms. As a final point on barriers to adopting alternative payment mechanisms, we believe the Center for Healthcare Quality and Payment Reform pamphlet entitled "Ten Barriers to Health Care Payment Reform" provides an excellent overview of the challenges faced by providers in moving away from fee-for-service 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.
b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

At Emerson Hospital, there is a focused effort to address the 4 key opportunities of spending on post-acute care, reducing avoidable 30-day readmissions, reducing avoidable emergency department use and providing focused care for high risk/cost patients.

During the past 12 months, the following efforts have been put in place:

1. **Spending on Post Acute Care:**

   Current Practice:
   The RN Care managers and social workers assess very medical surgical and CCU patient to understand their current living situation and community services and strive to ensure that patients will have safe transitions to the next level of care, attempting to return the patient to their current living environment if that is the safest plan. We follow Medicare Discharge Planning Conditions of Participation and ensure active participation by patient and family/caregiver. We include the interdisciplinary team to ensure that the team is in agreement with the transition plan and develop a plan which will ensure a safe transition and prevent readmission. We include community partners while developing the plan so they are also an active participant. We also ensure that communication to the next provider occurs prior to discharge and that the appropriate discharge information is sent at time of discharge.

   Plans over the next 12 months:
   Emerson Hospital is involved in the CHART Program with the HPC. We will formally begin our program on October 1, 2015. The tactics described above will be continued over the next 2 years. We will focus on ensuring that high risk patients (those with HF, COPD, Cancer, End Stage Renal Disease, MI, pneumonia, stroke, Diabetes Mellitus, or those patients who are readmits within the last 30 days or > two times in the past 6 months, patients admitted from SNF or home care within the past 60 days, or admitted from hospice within the past 6 months) are assessed upon admission and throughout the hospital stay for transition planning and put in place those post acute needs that will ensure both quality of care, safety, decreased readmissions at appropriate cost for the patient.

2. **Reducing Avoidable 30 day readmissions:**

   Current practice:
   The RN care managers and social workers perform a more detailed assessment for those patients who are readmitted within 30 days of discharge. A worksheet is used to prompt the discussion which includes asking patient and/or caregiver to describe in their own words why they came back to the hospital as well as other questions which address understanding of education about their illness and discharge teaching, follow up appointments, medications and understanding and

access to medications. The care manager will also reach out to current agencies/post acute care providers to understand the plan in the community and causes of failed discharge. This assessment is reviewed with the attending physician, nursing and other disciplines as appropriate and all disciplines are expected to review the index discharge and understand causes of the readmission. Based on the outcomes or that, the team will work to make changes to the care plan and transition plan for the patient to assist in preventing further readmissions.
The data is captured in an excel spreadsheet and any trends are reviewed by the Readmission Committee.

Plans over the next 12 months:
This practice will continue over the next 12 months as described above with some additional educational efforts to the nursing staff and hospitalists as we are finding not enough time spent reviewing the readmitted patients in daily rounds. Therefore, we are updating to readmission sheet for outcome monitoring and encouraging the interdisciplinary team to take more time to review causes of readmissions and utilize the outcome sheet so we can have better outcomes and trending. The trends will then be used to change practice as needed.

3. **Reducing Avoidable Emergency Department (ED) use:**

Current Practice:
Increased ED care management staffing to 12 hour shifts Monday through Friday. Increased care management presence in ED on weekends and open posting for 12 hour weekend care manager. The role of the care manager in the ED is to ensure that patients are admitted that have medical need for admission and ensuring appropriate level of care. They are also responsible for ensuring that patients who do not need admission are discharged to a safe and effective transition plan actively including the patient and caregiver in the plan. There has also been a SNF transition team that meets monthly with the hospital and ED staff to ensure decreased readmission opportunities and decreased use of the ED. Also discussing improved opportunity for collaboration with the SNF on off hours and weekends to transfer patients from the ED to the SNF. Because our readmission rate is higher for SNF patients, we are working to look at opportunities to identify why the patients are being sent to the ED and what can be done sooner to prevent the patient needing ED care. We have instituted that all SNFs in the area utilize Interact Tools.
The ED care managers and staff are also working with Emerson Home Care to look at patients that are sent to the ED and opportunities to decrease ED usage by sooner interventions in the home or physician office. This is a work in progress.

Plans over the next 12 months:
Working on development of care plans at discharge for high risk for readmission patients. These patients will then be flagged as having a care plan so that if they do return to the ED, a plan is in place to prevent readmission to the hospital if able.

The care manager will begin follow up phone calls for all high risk patients at discharge with the goal of ensuring that the patient has the services they need to stay safe in the community and prevent ED and hospital usage.
Also, looking to have more standardized discharge teaching and materials for patient at discharge to understand their discharge instructions. For example, over the past year, a heart failure education program and Heart Failure Zones education page is given to the patient. We are planning on developing more of these for our high risk diagnoses over this year. We are currently working with our QIO (Healthcentrix Advisors) to institute 'Lung Talk' education video for patients and RN so that there is a standardized education process for COPD and other lung diseases. This is also inclusive of SNF and home care liaisons as part of the team.

4. Providing Focused Care for High Risk/Cost Patients

Current Practice/Plan Over the Next 12 Months:
As described above, we have been focusing on high risk patients which include HF, COPD, Cancer, End Stage Renal Disease, MI, pneumonia, stroke, Diabetes Mellitus, or those patients who are readmits within the last 30 days or > two times in the past 6 months, patients admitted from SNF or home care within the past 60 days, or admitted from hospice within the past 6 months. These patients are identified as being at high risk for readmission and use of healthcare dollars. Over the past year, we have worked to develop various strategies that we will continue to implement over the next 12-24 months. They include the following:

- Triggers developed in MediTech so that if any of the high risk criteria are found, the patient is flagged as a high risk patient to the care managers and nursing units.
- Care managers perform an in depth assessment of current services and living situation and develops an initial discharge plan updated daily with the patient and interdisciplinary team.
- Performing bedside rounds daily with the hospitalist, RN, care manager and pharmacist to discuss care plan, medications, discharge plan and goals for the day with the patient and caregiver. This is currently taking place on one of our medical-surgical units with the goal of instituting on other medical-surgical units for high risk patients. On units not performing bedside rounds, the interdisciplinary team and hospitalist reviews high risk patients in a team meeting.
- Patients who may qualify for palliative care or hospice will have a consultation with the liaison for that service. This has been instituted this year. We have a monthly Palliative care meeting and review statistics of referrals as well as opportunities to increase appropriate referrals. Also review readmission data and opportunities to have had palliative care/hospice. The liaison is also meeting with appropriate high risk patients to understand their goals of care.
- In the upcoming year, Emerson Hospital will work with Honoring Choices and become a Community Partner. We are also working with the Care Transitions Collaborative to have other members become Community Partners as well so that we can understand and

increase conversations with patients around goals of care, advance care directives, and MOLST (when appropriate) to ensure that the patient goals are met.

- Instituted a partnership with Minuteman Services to have a Transitions Social Worker who is available to partner with high risk patients post discharge who are in need of psychosocial interventions in the community to assist in optimizing care management and prevent readmissions to the hospital. This was just implemented over the last few months.
- Instituted a new role of an Aftercare Social Worker in psychiatric services who is available to meet with high risk psychiatric patients and follow them post discharge to assist in optimizing care management and prevent readmissions to the hospital. This was just implemented over the last month.
- We will begin calling high risk patients within 48 hours of discharge this month utilizing a script. The purpose of this call is to ensure that the patient is safe, has their medications, understands discharge instructions, has follow up appointment, and any other questions are answered. The care manager will then make appropriate referrals as needed such as earlier PCP if issues, pharmacy follow up if medication questions, etc.
- We have begun (Sept) making follow up PCP appointments with all high risk patients to be seen within 5-7 days of discharge.

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?

        The reason for variation in price across providers is frequently tied to the real and/or perceived value of any given provider. In any free market economy, the price a service provider can receive is largely driven by consumer demand, the supply of those services and real and/or perceived differences in quality or service. We see this in healthcare in Massachusetts where many academic medical centers are perceived as more desirable places to receive care in the minds of many consumers. This may be tied to brand and reputation as well as the higher level of actual value these centers can provide in terms of types of technology, innovative procedures and treatment, and available cutting edge care. These centers also make investments in teaching and research that community hospitals do not. These activities are critical to training tomorrow's physicians and other healthcare providers. Frequently**,** these investments**,** as well as the development of new clinical innovations and state-of-the-art information technology**,** create a higher cost and higher value organization.

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.

In a true free market economy, the customers make the ultimate decision on which products or services succeed or fail. When presented with two products or services that offer similar benefits, customers vote with their purchases and decide which product or service will survive. However**,** in healthcare this equation is often skewed. Customers of healthcare are largely immune to the true price of a service because of the way health insurance is structured. Truly price sensitive consumers—those with high deductibles and co-pays or self-pay---will make decisions regarding where they received healthcare on an entirely different set of criteria than those consumers in health plans with low out-of-pocket expenses. Consumers who have high out-of-pocket expenses or who have to pay more to go out of network will give greater consideration to the prices charged for services. Consumers with low out of pocket expenses will tend to go to hospitals with the better brand and reputation, often strongly influenced by the referring physician's preference. Although high deductible health plans present challenges to hospitals in terms of the collectability of these balances, Emerson believes that structures that incent patients to seek out the best value will result in lower cost and higher quality and service over the long-term.

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.

Emerson Hospital has engaged with regional partners to integrate and coordinate medical and behavioral health services in several ways. The Behavioral Health department has prioritized outreach to physician practices to establish effective two-way communication regarding the care of patients to enable smooth and reliable discharge plans and to help to ensure adequate compliance with aftercare arrangements. Additionally, we have established connections with regional providers to smooth referral and triage of patient to and from Emerson Hospital. 2.) The Hospital has secured a CHART II grant from the HPC to allow us to identify and track high-risk BH and medical patients and to actively engage them to avoid both unnecessary ED visits and readmissions. We are able to connect with these patients prior to discharge and to follow them in the community. This arrangement allows us to identify problems with re-integration to the community setting

rapidly and to address those difficulties before they result in an ED visit or a re-admission.

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 will continue to strengthen our cross collaboration with community providers via continued regular communication comprehensive information sharing. In addition, our implementation of the CHART II initiative will allow us to reduce both unnecessary ED visits and re-admissions (target is a 20% reduction)

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?

   PCMH-We have 16 out of 20 practices at level 3 NCQA, with the goal of recertifying using 2014 standards by the end of 2016.

   ACO-WE have participated with Partners Health Care in the Medicare Pioneer ACO for the past several years. Our infrastructure includes care managers, medical directors, and monthly pod meetings.

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	113	0	113	MRI/CT/PETCT/LAB/SDC/INPT/MATERNITY/NM
	Q2	144	3	147	MRI/CT/PETCT/LAB/SDC/INPT/MATERNITY/NM
	Q3	107	0	93	MRI/CT/PETCT/LAB/SDC/INPT/MATERNITY/NM
	Q4	148	0	142	MRI/CT/PETCT/LAB/SDC/INPT/MATERNITY/NM
CY2015	Q1	149	0	145	MRI/CT/PETCT/LAB/SDC/INPT/MATERNITY/NM
	Q2	158	1	125	MRI/CT/PETCT/LAB/SDC/INPT/MATERNITY/NM

Accounts that were not resolved were due to us returning patients call to get more information or to update with the estimated cost and patients not returning our calls. We do not leave estimate of voicemail unless the patient instructs us to.

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **AGO Hospital Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

   See attached

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 (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	26.4	29.8	1.4	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	6.8	7.7	0.4	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.6	7.5	0.3	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	3.8	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	4.7	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	8.3	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	5.1	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	8.8	x	x	x
Total Commercial	39.8	45	2.1	x	x	x	x	x	x	x	x	30.7	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.1	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	1	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.2	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	x	x	x	x	x	x	x	x	x	x	x	2.3	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.3	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.5	x	0.3	x	x	x	3.3	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	0.6	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.5	x	x	x	x	x	3.9	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	39.2	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.4	x	x	x
GRAND TOTAL	39.8	45.0	2.1	x	x	4.5	x	0.3	x	x	x	80.8	x	x	x

2011(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	26.9	30.3	1.3	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	6.0	6.7	0.3	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.8	7.6	0.3	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	3.1	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	4.6	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	8.4	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.5	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	6.4	x	x	x
Total Commercial	39.7	44.6	1.9	x	x	x	x	x	x	x	x	27	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.5	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	1.6	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.3	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	x	x	x	x	x	x	x	x	x	x	x	3.4	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.3	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.9	x	0.2	x	x	x	3.5	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	1.1	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.9	x	x	x	x	x	4.6	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	37.9	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.2	x	x	x
GRAND TOTAL	39.7	44.6	1.9	x	x	4.9	x	0.2	x	x	x	77.4	x	x	x

2012 (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	24.8	28.0	1.1	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	5.9	6.7	0.3	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.7	7.6	0.3	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	2.8	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	5.6	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	9.2	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.5	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	5.7	x	x	x
Total Commercial	37.4	42.3	1.7	x	x	x	x	x	x	x	x	27.8	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.5	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	3.6	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.3	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	x	x	x	x	x	x	x	x	x	x	x	5.4	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.6	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.7	x	0.2	x	x	x	4.7	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	1.1	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.7	x	x	x	x	x	5.8	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	40.4	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.4	x	x	x
GRAND TOTAL	37.4	42.3	1.7	x	x	4.7	x	0.2	x	x	x	84.4	x	x	x

2013 (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	25.2	28.0	1.2	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	6.4	7.1	0.3	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	7.7	8.5	0.4	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	2.9	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	6.3	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	9.3	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.4	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	7.5	x	x	x
Total Commercial	39.3	43.6	1.9	x	x	x	x	x	x	x	x	30.4	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.6	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	2.2	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.4	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	x	x	x	x	x	x	x	x	x	x	x	4.2	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.8	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	5.5	x	x	x	x	x	3.5	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	1.3	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	5.5	x	x	x	x	x	4.8	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	39.2	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.5	x	x	x
GRAND TOTAL	39.3	43.6	1.9	x	x	5.5	x	N/A	x	x	x	83.9	x	x	x

2014 (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	26.7	30.1	1.0	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	5.8	6.6	0.2	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.8	7.7	0.3	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	3.2	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	6.0	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	9.2	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.5	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	6.8	x	x	x
Total Commercial	39.3	44.4	1.5	x	x	x	x	x	x	x	x	29.7	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	2.0	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	2.5	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.6	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	x	x	x	x	x	x	x	x	x	x	x	5.1	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	3.5	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.5	x	x	x	x	x	3.6	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	1.5	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.5	x	x	x	x	x	5.1	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	36.6	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.4	x	x	x
GRAND TOTAL	39.3	44.4	1.5	x	x	4.5	x	N/A	x	x	x	82.4	x	x	x