Complete connected care℠

September 11, 2015

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz:

This letter and attached Exhibit B and C include Lowell General Hospital's response to the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, request for written testimony on health care cost trends. I certify that I am legally authorized and empowered to represent Lowell General Hospital for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please feel free to contact me directly at 978-937-6200 or Susan Green, Executive Vice President and Chief Financial Officer at 978-788-7143.

Sincerely,

Normand E. Deschene
Chief Executive Officer
Lowell General Hospital

Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

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

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

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

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

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

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

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

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

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

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

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends. (Time Period below reflects FY 14 and projected FY 15 based on YTD July 15 information)

Net revenue has slightly increased by 1% ($415,630M to $419,614M):

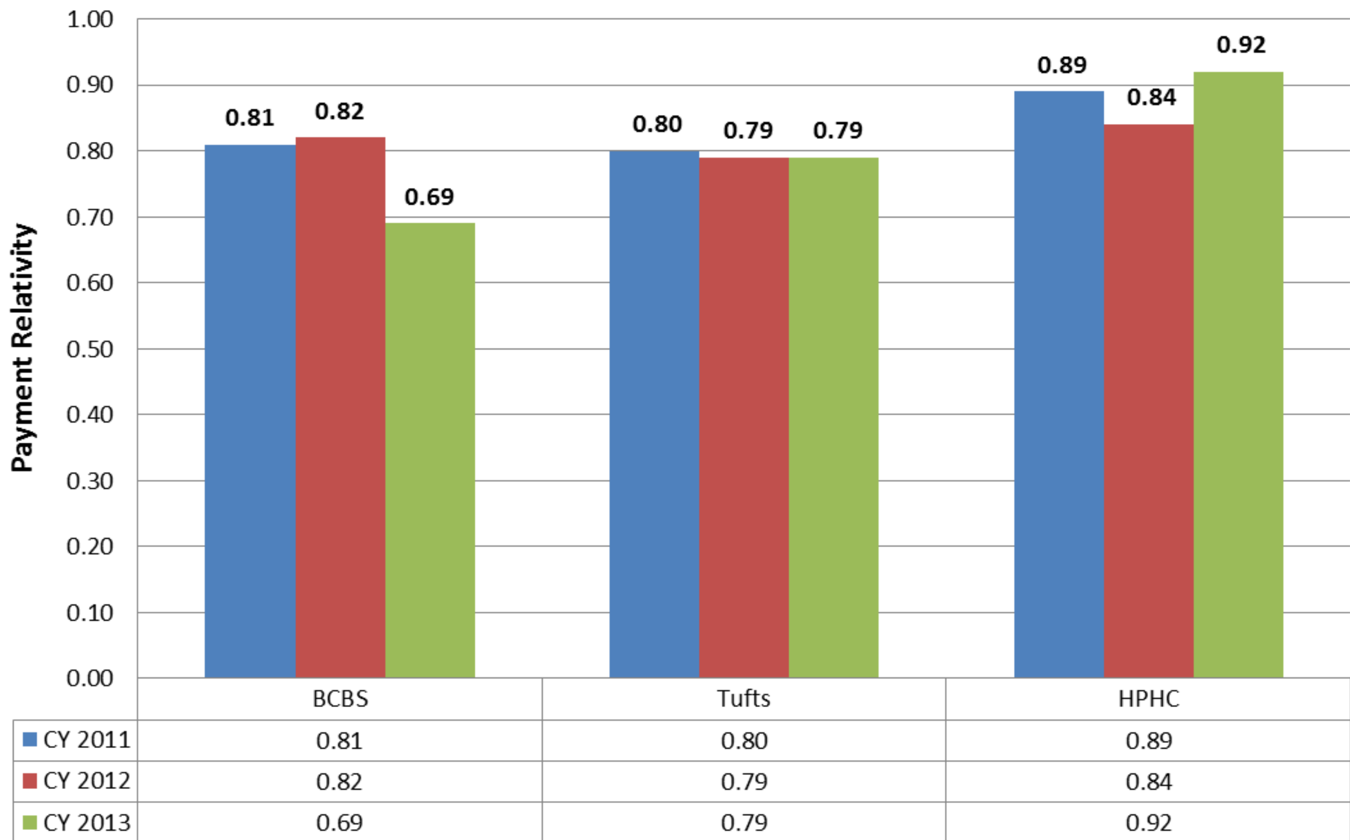
- Inpatient days have increased by 6.8% while inpatient discharges have increased by 1.2%. Average length of stay (ALOS) has increased by 5.5% to 4.04. Observation discharges have increased 2.8%.
- Emergency Department and surgical volumes have remained relatively flat (-0.3% and -0.02% respectively)
- Overall outpatient volume has increased by 3.7%
- Operating expenses have decreased by $1.8M or -0.4%
    -

Driving factors:

- Based on the relative price data, Lowell General Hospital continues to be paid significantly below the median for all commercial payers
- Observation days have increased due to payer incentives to treat potential inpatients as outpatients and CMS's issuance of the "two midnight rule".
- Higher deductible plans have influenced a patient's willingness to postpone elective ambulatory surgery
- Continued clinical staffing requirements and strategic monitoring of labor management to provide *Complete connected care*
- Continued efforts to decrease inappropriate Emergency Department utilization
- Strategic initiatives aimed at addressing behavioral health needs and the Community Medical Home (CHART Grant Phase 2 funded grants from the Health Policy Commission)

    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?

Lowell General Hospital provides comprehensive health care, including a Level 3 Trauma Center, cardiology, neurosurgery, orthopedics and level 2 special care nursery services. We provide these comprehensive services at the lowest payment quartile from commercial payers such as Blue Cross, Harvard Pilgrim Health Care and Tufts Health Plan as follows:



	BCBS	Tufts	HPHC
CY 2011	0.81	0.80	0.89
CY 2012	0.82	0.79	0.84
CY 2013	0.69	0.79	0.92

Every inpatient or outpatient case that remains at LGH or within the Circle Health system helps the Commonwealth achieve the benchmark cost. Redirection of care from almost every acute care hospital to Lowell General Hospital will save healthcare dollars. LGH plays a very important role in delivering low cost, high quality care to the residents of the fourth largest community in the Commonwealth. We are not part of the cost problem, and we should be studied as part of the solution. Our organization has been committed to transforming the care delivery model and the payment system since 2008. LGH has participated in alternative payment models or risk arrangements with Blue Cross Blue Shield, Harvard Pilgrim Health Care and Tufts Health Plan. LGH has participated in the Medicare Shared Savings Program since July 2013 and performed extremely well, with savings of more than $12.8M over the first performance period with 11,000 Medicare beneficiaries. Finally, LGH and our orthopedic surgeons commenced a Bundled Payment for Care Improvement (BPCI) arrangement effective July 2015 for total joints lower extremity. The orthopedic surgeons of LGH are very committed to keeping patients local by preventing transfers to higher cost facilities.

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?

Circle Health and LGH are fully committed to pursuing value-based risk contracting across the organization. Specifically, we anticipate renewal acceptance in to the Medicare Shared Savings Program's new 2016 contract term. We are considering adopting additional downside risk through the highest risk Track 3 to access the appropriate levers required to optimize performance under this program. Additionally, key stakeholders within Circle Health are working with MassHealth to assist in the development of a new framework focused on value based reimbursement for MassHealth patients. The system currently assumes material risk with all local commercial carriers and we look forward to expanding these alternative payment models to non-HMO lines of business.

LGH has collaborated with its orthopedic providers to assume risk under the Medicare (BPCI) orthopedic bundle beginning July 1, 2015

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

Circle Health strongly encourages the Commonwealth to work with health plans to adopt additional flexibility with member liability waivers to support and promote population health management activities specifically aimed at chronic disease conditions (e.g. diabetes, chronic obstructive pulmonary disease, and congestive heart failure) to mitigate barriers to ensure adherence to and compliance with disease-specific treatment programs, such as deductibles that may be cost-prohibitive to getting necessary testing or copays which may inhibit patient optimization of the health care system. Patients with the greatest need most often experience significant obstacles to optimizing the health care system.

In addition, LGH implores the HPC to consider more creative solutions for patient consent. As currently written, the requirements around patient consent create barriers against effective transitions of care across the care continuum.

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

While not a barrier, the transfer of insurance risk as provider risk under alternative payment methods is a growing challenge for systems that should not be required to assume such level of risk (e.g. escalating retail prescription costs increased specialty pharmacy cost). A very real barrier is the ability to access information to make informed decisions around what degree of risk should be borne by a provider system. We encourage HPC to work with the health plans to promote and create a standard attribution model across all payers and severity adjustment for non-HMO product lines. Alternative payment methods should also aim to be as consistent as possible on all quality measures. HPC should strongly encourage MassHealth to provide the same level of data and consistency required of the health plans.

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.

In 2014, the Lowell General Hospital and the Lowell General Physician Hospital Organization (LGPHO) embarked on a multi-phased, multifaceted Medical Home Initiative driven by the shift to value-based payment models. The goal of the initiative is to improve the patient experience and patient outcomes, as well as the need to provide care in the most appropriate setting through a centralized care team at the medical home. This Medical Home Initiative aims to provide care in the most appropriate setting, which will reduce avoidable 30-day readmissions and Emergency Department use. It will also provide focused care and connections to community resources to high risk/high cost patients, including those with behavioral health comorbidities.

To aid in the funding of this new model, the LGH applied for and was awarded two CHART Phase 2 grants. The first is targeted for developing the community Medical Home Initiative for patients with chronic, complex care needs. The second is a collaborative grant with Lahey Health Behavioral Services and Lahey Health System's community hospitals to improve access to services for patients with complex behavioral health needs through the medical home. In addition, in early 2015, LGH implemented a pilot program to improve the health and treatment compliance for patients with uncontrolled diabetes, as defined by patients with an HbA1c greater than 8, which was funded in part by a Harvard Pilgrim Quality Program grant. Further, LGH is collaborating with area skilled nursing facilities to improve care transitions from the acute to post-acute care settings through a preferred provider risk-sharing arrangement and has been invited to apply for a Collaborating Communities grant from Massachusetts eHealth Institute to support cross-setting care transitions.

In addition to the Medical Home Initiative and related programs, in 2015 Circle Health opened an Urgent Care Center in Westford to improve access to urgent but non-emergent care. Circle Health formed several Innovation Counsels to identify opportunities for improving the value of care provided by system providers through an integrated local delivery model. Incentive programs are developed annually to target opportunities to engage with providers for improving the delivery of health care, especially to the complex chronically ill populations.

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

Over the next 12 months, LGH will implement many of the initiatives that have been in the planning phase over the past 12 months. The Medical Home is hiring clinical staff and plans to begin developing care plans for patients with complex chronic illnesses, including behavioral health comorbidities. An outpatient location for patients in crisis or in need of detoxification will open its doors in 2016 to see patients with complex behavioral health needs who previously were high utilizers of the Emergency Department services. Community Health Workers will establish relationships with patients whose needs go beyond the clinical and pair them with social services

in their communities. Providers across the care continuum will have access to a single care plan for complex patients and utilize existing technology to coordinate care across care settings, helping prevent unnecessary Emergency Department visits, hospital readmissions, and extended stays in skilled nursing facilities.

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?

Acceptable reasons for price variation:

- **Variation due to patient acuity (case-mix, complexity of patients served)**
- **Variation in hospital input prices - labor costs due to geographic labor markets**
- **Variation due to quality processes and outcomes**
- **Variation due to provisions of teaching and research programs**
- **Designation as a critical access hospital**
- **Variation to correct historical and current price disparities**

Unacceptable reasons for price variation:

- **Market power: Negotiating leverage with payers due to provider size & scale**
- **Dominance in geographic submarket**
- **Historically high fee schedules which are baked into future pricing (resulting in perpetuation of price disparities)**
- **Perception that high cost equates to high quality**
- **Perception that better care is available in Boston**
- **Provision of specialized services**
- **Provider's branding and/or perceived reputation**
- **Provider's payer mix (mix of public/private/uninsured)**
- **Provider's occupancy rate**
- **Provider's profit margin**
- **Provider/system inefficiencies and unnecessary service duplication**

    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.

Price variation has arguably been the key determinant of the growth in Total Health Care Expenditures (THCE) in the Commonwealth as well as the key factor in creating the current landscape and market position of MA health care providers.

Over the past three years (CY10-CY13), acute hospital payments from commercial payers have been concentrated among higher-priced hospitals. Lowell General Hospital has consistently been categorized within the cohort of lower-priced hospitals. In CY13, 86% of total payments for inpatient services and 73% of total payments for outpatient services went to Massachusetts hospitals whose negotiated commercial contracts placed them in the top two Relative Price Quartiles. According to CHIA's report on Provider Price Variation in the MA Health Care Market (Feb. 2015), this distribution of payments between higher- and lower-priced providers has remained virtually unchanged over the last three years.

We believe the price disparity between these two groups has been the predominant reason that the higher-priced providers, especially those in the top Relative Price Quartile, have been able to retain and expand their dominant position in the market – by primarily relying on scale and price to grow and improve their organizations, rather than driven by quality and efficiency.

One measure of cost efficiency is the Adjusted Cost per Case-Mix Adjusted Discharge (CMAD). This metric provides a comparative benchmark of each provider's use of resources on a per discharge basis. (The measure calculates total inpatient hospital costs, excluding direct medical education and physician compensation costs, divided by total inpatient discharges adjusted for case-mix.) According to CHIA's report on Massachusetts Hospital Profiles (Jan. 2015), Lowell General Hospital's FY13 Adjusted Cost per CMAD was $8,873, which placed us in the lowest quartile for the cohort of the state's community hospitals. We are proud of our position as a low-cost provider, which is the result of our diligent focus on the fiduciary management of hospital resources by controlling operating costs, improving efficiencies and reducing waste.

Lowell General Hospital is fully committed to retaining and furthering our position as a low-cost provider. However, we recognize that historically, low cost providers were effectively penalized when it came to negotiating prices with commercial payers, while high cost providers were able to negotiate prices to cover their higher cost structure. These relative prices were baked into historical commercial payer contracts and continue to be a predominant reason for the large disparity in provider pricing.

Lowell General Hospital fully supports the current direction of payment reform through value-based payment models which reward providers for cost efficiency and quality outcomes. The financial health and sustainability of community and low-cost providers is dependent upon the elimination of price variation due to the factors we identified as unacceptable in section 4.a. Commercial payers should level the playing field so that all providers are compensated equitably for comparable services, and reward providers for cost efficiency and quality outcomes. Additionally, providers must be compensated for services that promote wellness, health

improvement and population health management which have traditionally seen little or no payment coverage by third party payers.

We applaud the Commonwealth for setting health care cost growth benchmarks through Chapter 224 and holding payers and providers collectively accountable to achieve these annual goals. We believe the 3.6% benchmark is achievable but should be more equitably administered by holding the higher-priced hospitals below the benchmark for commercial payer pricing while recognizing that lower-priced hospitals deserve price increases that may be above the 3.6% threshold in order to reduce the long-standing disparity in relative prices.

Patient migration to high-cost Boston hospitals has a significant financial impact to the Commonwealth. In FY13, Lowell General Hospital cared for 60% of the 35,000 patients hospitalized from our Primary Service Area (PSA). However, we only cared for 47% of the cohort of patients with commercial insurance. The higher outmigration of commercial patients is financially detrimental to the Commonwealth given the substantial price disparity between LGH and the top Boston hospitals treating patients from our PSA, as evident in the table below:

	CY13 Commercial Payer Price Level Percentile*	2012 Hospital Relative Price Quartile** for top 3 Commercial Health Plans Q1 (lowest RP) thru Q4 (highest RP)		
Facility		BCBS	HPHC	THP
Lowell General Hospital	32	Q2	Q2	Q2
Saint Elizabeth's Medical Center	68	Q3	Q3	Q3
Massachusetts General Hospital	94	Q4	Q4	Q4
Brigham And Womens Hospital	91	Q4	Q4	Q4
Beth Israel Deaconess Medical Center	72	Q4	Q3	Q4
Boston Medical Center	57	Q2	Q3	Q1
Tufts Medical Center	62	Q4	Q3	Q3
Boston Children's Hosptial	93	Q4	Q4	Q4

* Source: Massachusetts Hosptial Profiles, CHIA - January 2015
** Source: Annual Report on the Massachusetts Health Care Market, CHIA - August 2013

According to CHIA's report on Health Care Provider Price Variation in the Massachusetts Commercial Market (Feb 2015), Lowell General Hospital's relative commercial price percentile was 32, which is considerably lower than the relative price percentile range of 57 to 94 for the key Boston hospitals drawing patients from our PSA.

In CY14, the estimated value of total leaked revenue (inpatient and outpatient revenue, valued at LGH contract rates, which went to providers other than LGH) was $315M based on physician claims data from our Primary Service Area. (Source: Advisory Board Crimson Market Advantage tool). The commercial portion of this leakage is estimated at $100M. The commercial price disparity between Lowell General Hospital and the higher priced Boston hospitals varies by provider, but a conservative estimate of a 20% price disparity would translate to $20M additional

payments paid to other hospitals for these commercially insured patients. Or conversely, the total medical spend could have been reduced by an estimated $20M if these commercially insured patients had been treated at Lowell General Hospital instead of receiving care at higher-priced hospitals outside of our service area.

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.
    See response in #3

    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.
    See response #3

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?

With 30% of our affiliated physician practices comprised of 1-2 physicians, obtaining and maintaining Patient-Centered Medical Home (PCMH) certification for those practices is extremely cost-prohibitive. While we appreciate the spotlight and emphasis on PCMH, we strongly encourage that HPC and MassHealth to develop models that are not cost-prohibitive to implement for small provider groups and welcome any opportunity to provide feedback and guidance on potential alternative models of patient-centered medical care. Circle Health and our affiliated physicians are dedicated to promoting patient-centered care and are committed to innovation and improved health outcomes. We firmly believe that a market driven by innovation and competition will achieve better outcomes than a state-prescribed mandated model could.

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	8	0	8	Please
	Q2	1	0	1	see
	Q3	0	0	0	below.
	Q4	4	0	4	
CY2015	Q1	1	0	1	
	Q2	12	0	10	

Date of inquiry	Mode of inquiry	Services	Resoved?
1/3/2014	phone	Cholecystectomy	y
1/20/2014	in person	Chest xray (pa and lateral)	y
1/31/2014	in person	Abdomen Supine Upright PA Chest	y
2/7/2014	in person	Total Knee Replacement	y
2/7/2014	email to Linette	Labs/Xrays	y
3/19/2014	in person	Labs	y
3/27/2014	in person	Labs/pregnancy	y
3/27/2014	in person	Labs	y
6/7/2014	in person	Labs	y

10/10/2014	in person	Complete semen analysis	y
10/13/2014	phone	Removal of an implant	y
10/30/2014	in person	Chest xray and EKG	y
12/16/2014	phone	Cystic fibrosis testing	y
3/6/2015	email from BC	Artificial insemination and IVF	y
4/26/2015	fax	Prolia Administration	y
4/26/2015	fax	Reclast and Prolia	y
4/27/2015	fax	Reclast and Prolia	y
4/27/2015	fax	Prolia	y
4/27/2015	fax	Reclast and Prolia	y
4/30/2015	in person	Western blot for Lyme disease	y
5/12/2015	fax	US NDL BX Thyroid	y
5/13/2015	phone	uvulopalatopharyngoplasty, Excision and Destruction Procedures on the Palate and Uvula	n - request came via Ortho. Unable to reach pt.
6/1/2015	phone	RhoGam	y
6/1/2015	phone	Mammogram	y
6/2/2015	in person	Labs	n - unable to reach pt.
6/10/2015	phone	Bone density	y
7/14/2015	phone	Dual pacemaker	y
7/21/2015	phone	Xray	y
7/21/2015	phone	Stitches removal	y
7/29/2015	phone	Newborn delivery	y
8/7/2015	website	VCUG and Endoscopy	n - unable to reach pt.

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. **Please see the attached Excel file with the revenue data**

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue				
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							Total	
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	Net Rev	
Blue Cross Blue Shield					31,893,797	23,523,389			17,319,973							72,737,159	AQC Contract
Tufts Health Plan					10,089,760		348,774									10,438,534	Commercial Plan
Harvard Pilgrim Health Care											10,807,815					10,807,815	
Fallon Community Health Plan											3,044,418					3,044,418	
CIGNA											4,472,623					4,472,623	
United Healthcare											9,546,774					9,546,774	
Aetna											3,958,796					3,958,796	
Other Commercial											7,281,512					7,281,512	
Total Commercial	-	-	-	-	41,983,557	23,523,389	348,774	-	17,319,973	-	39,111,938					122,287,631	
Network Health											10,769,875					10,769,875	
Neighborhood Health Plan											5,094,623					5,094,623	
BMC HealthNet, Inc.											2,923,388					2,923,388	
Health New England											-					-	
Fallon Community Health Plan											-					-	
Other Managed Medicaid											-					-	
Total Managed Medicaid			-	-	-	-	-	-	-	-	18,787,886	-	-	-	-	18,787,886	
MassHealth		14,013,772		653,000							-	-				14,666,772	
Tufts Medicare Preferred					15,366,382			661,000								16,027,382	
Blue Cross Senior Options																-	
Other Comm Medicare											6,218,272					6,218,272	
Commercial Medicare Subtotal	-	-	-	-	15,366,382	-	-	661,000	-	-	6,218,272	-	-	-	-	22,245,654	
Medicare											-	56,591,542				56,591,542	
Other												14,986,671				14,986,671	
GRAND TOTAL	-	14,013,772	-	653,000	57,349,939	23,523,389	348,774	661,000	17,319,973	-	64,118,096	71,578,213	-	-	-	249,566,156	

2012

Saints Medical Center was acquired July 1, 2012 - 3 months of net revenue is captured

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue				
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							Total	
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	Net Rev	
Blue Cross Blue Shield					34,226,982	24,803,952			21,879,764							80,910,698	AQC Contract
Tufts Health Plan					12,937,607		1,175,637		111,960							14,225,204	Commercial Plan
Harvard Pilgrim Health Care											11,134,843					11,134,843	
Fallon Community Health Plan											3,526,141					3,526,141	
CIGNA											6,347,662					6,347,662	
United Healthcare											12,122,054					12,122,054	
Aetna											4,185,018					4,185,018	
Other Commercial											11,129,440					11,129,440	
Total Commercial	-	-	-	-	47,164,589	24,803,952	1,175,637	-	21,991,724	-	48,445,158					143,581,060	
Network Health											11,247,581					11,247,581	
Neighborhood Health Plan											7,449,517					7,449,517	
BMC HealthNet, Inc.											1,679,077					1,679,077	
Health New England											-					-	
Fallon Community Health Plan											-					-	
Other Managed Medicaid																-	
Total Managed Medicaid			-	-	-	-	-	-	-	-	20,376,175	-	-	-	-	20,376,175	
MassHealth		19,602,139		611,000							-	-				20,213,139	
Tufts Medicare Preferred					16,191,073			665,000								16,856,073	
Blue Cross Senior Options																-	
Other Comm Medicare											8,403,247					8,403,247	
Commercial Medicare Subtotal	-	-	-	-	16,191,073	-	-	665,000	-	-	8,403,247	-	-	-	-	25,259,320	
Medicare											-	74,510,882				74,510,882	
Other												21,979,166				21,979,166	
GRAND TOTAL	-	19,602,139	-	611,000	63,355,662	24,803,952	1,175,637	665,000	21,991,724	-	77,224,580	96,490,048	-	-	-	305,919,742	

2013

Full Year of Saints Medical Center acquisition

	P4P Contracts				**Risk Contracts**						**FFS Arrangements**		**Other Revenue**			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							Total
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	Net Rev
Blue Cross Blue Shield					30,831,777	32,519,160			19,677,262							83,028,199
Tufts Health Plan					15,894,766		983,210		198,210							17,076,186
Harvard Pilgrim Health Care									44,783		14,777,568					14,822,351
Fallon Community Health Plan											4,675,085					4,675,085
CIGNA											8,415,959					8,415,959
United Healthcare											16,071,856					16,071,856
Aetna											5,548,648					5,548,648
Other Commercial											12,766,502					12,766,502
Total Commercial	-	-	-	-	46,726,543	32,519,160	983,210	-	19,920,255	-	62,255,618					162,404,786
																-
Network Health											15,895,658					15,895,658
Neighborhood Health Plan											9,876,838					9,876,838
BMC HealthNet, Inc.											1,982,181					1,982,181
Health New England											-					-
Fallon Community Health Plan											-					-
Other Managed Medicaid																-
Total Managed Medicaid			-	-	-	-	-	-	-	-	27,754,677	-	-	-	-	27,754,677
																-
MassHealth		28,689,222		1,000,500							-	-				29,689,722
																-
Tufts Medicare Preferred					19,798,389			2,550,000								22,348,389
Blue Cross Senior Options																-
Other Comm Medicare											11,141,328					11,141,328
Commercial Medicare Subtotal	-	-	-	-	19,798,389	-	-	2,550,000	-	-	11,141,328	-	-	-	-	33,489,717
																-
Medicare											-	123,761,551				123,761,551
																-
Other												28,064,583				28,064,583
																-
GRAND TOTAL	-	28,689,222	-	1,000,500	66,524,932	32,519,160	983,210	2,550,000	19,920,255	-	101,151,623	151,826,134	-	-	-	405,165,036

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							Total
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	Net Rev
Blue Cross Blue Shield					30,055,398	32,534,117			19,668,142							82,257,657
Tufts Health Plan					14,100,335		3,174,346		65,560							17,340,241
Harvard Pilgrim Health Care									84,436		15,270,166					15,354,602
Fallon Community Health Plan									107,320		4,257,893					4,365,213
CIGNA											5,846,881					5,846,881
United Healthcare											15,910,675					15,910,675
Aetna											5,069,750					5,069,750
Other Commercial											7,923,126					7,923,126
Total Commercial	-	-	-	-	44,155,733	32,534,117	3,174,346	-	19,925,458	-	54,278,491					154,068,145
																-
Network Health											19,115,114					19,115,114
Neighborhood Health Plan											14,236,699					14,236,699
BMC HealthNet, Inc.											2,381,590					2,381,590
Health New England											-					-
Fallon Community Health Plan											-					-
Other Managed Medicaid																-
Total Managed Medicaid			-	-	-	-	-	-	-	-	35,733,403	-	-	-	-	35,733,403
																-
MassHealth		27,464,566		1,000,000							-	-				28,464,566
																-
Tufts Medicare Preferred					19,142,262			2,290,000								21,432,262
Blue Cross Senior Options																-
Other Comm Medicare											28,785,601					28,785,601
Commercial Medicare Subtotal	-	-	-	-	19,142,262	-	-	2,290,000	-	-	28,785,601	-	-	-	-	50,217,863
																-
Medicare											-	119,085,443				119,085,443
																-
Other												30,648,032				30,648,032
																-
GRAND TOTAL	-	27,464,566	-	1,000,000	63,297,995	32,534,117	3,174,346	2,290,000	19,925,458	-	118,797,495	149,733,475	-	-	-	418,217,452