PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

David F. Torchiana, MD
President and Chief Executive Officer

Submitted Electronically via HPC-Testimony@state.ma.us

September 11, 2015

Dear Ms. Johnson:

Enclosed you will find written testimony for the Partners HealthCare as requested for the upcoming cost trend hearings.

By my signature below, I certify that I am legally authorized and empowered to represent Partners HealthCare for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Aimee Golbitz, Office of Government Affairs at Partners HealthCare (agolbitz@partners.org 617-278-1119).

Sincerely,

David Torchiana

David F. Torchiana, MD

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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.

       See attachment #1.

    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?

       Across the system, we have developed and are implementing a robust Population Health Management (PHM) model that is designed to improve the availability and accessibility of care, enhance clinical offerings, and yield economic and operational efficiencies. Our goal is to provide integrated care, less expensively, and closer to home for patients by optimizing our network of providers to bring coordinated care to patients locally. We have implemented over a dozen programs across the health care delivery chain. We provide the resources and technology for our hospitals and community practices to implement PHM in all phases of care and have organized our activities into five key areas outlined below, with details on progress to date and plans for the future addressed in questions #3, #5, and #6.

       - Primary Care: Supporting primary care practices in practice redesign (patient-centered medical home (PCMH)) and coordination of care for patients with complex care needs (integrated Care Management Program (iCMP))
       - Specialty Care: Improving care coordination between primary care and specialty practices and enhancing access to specialty services
       - Non-Hospital Care: Providing home-based care for patients with acute illness and developing services to better manage transitions of care (among hospitals, nursing facilities, and home)
       - Patient Engagement: Offering providers and patients tools to improve communication, education, and patient self-care
       - Analytics and Technology: Creating a single, centralized electronic health record with decision-support tools and a data warehouse for analytics and performance reporting

       We believe that our efforts have been successful as evidenced by the data recently reported by the Center for Health Information Analysis (CHIA). CHIA found that our final total medical expense (TME) trend for 2013 was below the cost growth benchmark for Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan at 0.7%, 2.4%, and 3.0% respectively. It is important to note that these numbers were revised, substantially in the case of Blue Cross, from the preliminary numbers published in 2014.

In the case of Blue Cross, our TME trend was preliminarily reported as 4.3%, and was later revised in the final report to 0.7%. The final TME trend reflects actual claims for the entire year, while preliminary numbers were based on claims from only three quarters of the year with projections made by CHIA for the 4th quarter.

While we understand that the timing of the CHIA Cost Trend report and the required HPC cost trend hearings are set by statute; we urge the HPC and CHIA to take whatever steps necessary to change the timeline for the release of the CHIA report and the conduct of the annual cost trend hearings to coincide with the time when final year end data are available. This would allow payers the time necessary to provide a complete set of claims experience and insure an accurate cost report. Issuing a report with only preliminary numbers, that needs to be revised six months later, leads to incomplete and misleading conclusions and public perceptions that do not serve our mutual public policy objectives.

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 of to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

Our focus is to continue expansion of PHM across our network in the 5 key areas listed in question #1b. The details of these programs are described in the responses to questions #3, #5, and #6. In summary, we will:

- Continue our transformation of primary care into PCMH certified practices. (See question #6.)
- Continue our high risk care management program, iCMP, which over the past decade, has had more than 13,000 patients enrolled in active care management. This program engages 85 care managers, 18 social workers, 5 pharmacists, and 8 community resource specialists. (See question #3.)
- Expand our integrated mental health resources across primary care. (See question #5.)
- Expand our e-consult, virtual visit, and eVisit programs.
- Expand the number of conditions requiring procedural decision support.
- Expand the number of practices collecting patient reported outcomes, as well as the number of conditions for which such outcomes are reported.
- Develop additional primary care physicians and specialty collaborative care agreements across the network.
- Expand Partners Urgent Care Centers. We have recently opened one center and it is our current plan to open as many as 12 others in Eastern Massachusetts over the next 3 years. These centers provide a convenient, low cost alternative to ED care and complement our other PHM efforts.
- Expand access to our Partners Mobile Observation Unit, telemonitoring for Congestive Heart Failure, Diabetes and Hypertension, and the use of our Pioneer ACO 3-day Waiver for skilled nursing facilities (SNF). (See question #3.)
- Continue development of our SNF Collaborative. (See question #3.)

- Expand the use of patient engagement videos, shared decision making tools and online patient communities.
- Continue roll-out of a unified electronic medical record across Partners (EPIC).
- Continue development of a unified analytical data warehouse connecting all data systems across Partners, and allow for self-service analytics.

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

We are committed and will continue to make progress in reducing the growth in health care costs; but, do so in the face of serious challenges. Removing or minimizing these challenges would greatly accelerate the pace towards lowering health care costs. These challenges include:

- Reimbursement models with non-aligned incentives (e.g., global budgets based on underlying fee for service payments; and inadequate reimbursement of services such as nurse care managers);
- Public payer shortfalls;
- Duplicative reporting requirements;
- Complex billing policies;
- Lack of access to real-time patient claims data;
- Labor costs;
- Undue legal and regulatory barriers to pursuing new partnerships with community hospitals and community physicians that would allow our tertiary centers to move more care back to the community;
- Lack of reimbursement for telemedicine services;
- Undue regulatory barriers to integrating behavioral health and primary care;
- Heightened demand for high-cost technology and interventions;
- Pricing of new treatments by the pharmaceutical industry (e.g. Hepatitis C treatments); price escalation and shortages of generic medications; and
- Undue regulatory barriers to the growth of provider networks in contiguous geographies that undercut more effective delivery of clinical services.

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

We are invested in trying new payment models as demonstrated by our participation in the Centers for Medicare and Medicaid (CMS) care management demonstration in 2006 and our current participation in CMS Pioneer ACO program. Over 3 years as a Pioneer ACO, Partners has saved a total of $39.2 million—$18.8 million of which were shared with the federal government. Our efforts combined with the other Boston–area Pioneers ACOs have saved a total of $140 million over 3 years.

We are also interested in exploring bundled payments in order to more effectively engage specialists in our network. However, to date, we have not identified nor been made aware of a sustainable model from public or private payers or from elsewhere in the market. In addition to

the absence of a viable bundles model, another major barrier among commercial health plans has been the mandated changes to existing payment and other administrative systems. There are also barriers to obtaining reliable claims data that we hope will be resolved with the establishment of our new electronic data warehouse. With CMS piloting an approach to bundles, we may find a way to effectively address these barriers.

We have been interested in taking risk on PPO lives; however, it appears to us that existing relationships between health plans and self-insured accounts (which in this case are responsible for payment), have so far limited the development of a comparable model to the one that exists for the HMO population.

We are actively exploring other next steps in the conversion of fee for service payments. We are engaged with various payers to develop and implement a conversion of primary care payments to per member per month panel payments which we hope will free up these providers to use resources in the most optimal way for the care of patients. Such conversions have complexities for both providers and payers: what services should be included; adjusting for patient acuity differences; and, avoiding perverse incentives.

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.

We have developed a number of programs to address post-acute care.

- SNF Collaborative: We have developed a network of approved SNFs across Massachusetts based on quality of care, clinical offerings, and technology measures. This collaborative allows us to (1) provide better coordination of care through improved transitions from the hospital to the SNF and enhanced communication among the patient's providers, and (2) avoid unnecessary and preventable hospitalizations, many of which are readmissions. We have seen a 7% reduction in the length of stay and 12% reduction in 30-day readmissions compared to those patients in SNF outside the collaborative.

- Remote monitoring for congestive heart failure patients:[1] This program offers daily monitoring of symptoms, "just-in-time" and scheduled telephonic heart failure interventions and education sessions, and coordination of care with primary care and cardiology clinicians. The program is designed to lower 30-day and 6-month readmission rates, morbidity and mortality rates, and total acute care cost. Last year we had over 700

[1] http://www.partnersathome.org/our-services/healthcare-technology/telemonitoring.aspx

patients in the program with a 30-day readmission rate of 7.5%, considerably lower than the national average for heart failure patients on CMS' Hospital Compare of 22%

A number of readmissions programs are deployed at the local entity level such as post discharge follow-up calls and appointments, greater use of electronic communication via the patient portal and an expansion of our capabilities to provide healthcare in the home. But, in addition, we have three programs at the system level that focus on reducing readmissions:

- iCMP (description below): This program has been proven to reduce readmission rates and lower mortality rates by as much as 20% and 4%, respectively.
- Remote monitoring for congestive heart failure patients:[2] (See above.)
- Preferred skilled nursing network, referred to as the SNF Collaborative: (See above.)

We have numerous programs that prevent unnecessary ED visits that include:

- iCMP (See below.)
- Mental Health (See below.)
- Mobile Observation (PMOU) program:[3] This program focuses on reducing unnecessary ED visits and hospital stays. When a patient is referred to this service by their physician or upon admission at the ED, the patient is sent home and a nurse is sent to the patient's home to conduct an intensive home visit. PMOU allows the nurse to educate patients on self management and to coordinate with the patient's primary care physician to ensure all providers involved in the care plan are updated.
- Urgent care centers: We offer patients convenient, accessible care to prevent unnecessary ED visits. Our plan is to grow urgent care and open as many as 12 new urgent care centers across Eastern Massachusetts over the next 3 years.

We have a strong focus on managing patients who are high risk/high cost and with chronic conditions. We have programs that focus on the most acute and complex patient population and programs that are integrated with existing programs such as primary care, but that also are directed at specific chronic conditions:

- Integrated Care Management Program (iCMP)[4] matches high-risk patients with a nurse care manager who works closely with patients and their family to develop a customized health care plan to address specific health care needs. The program focuses on reducing hospital utilization and ED visits. On a regular basis, we share iCMP-specific process and outcomes measures with leaders across the organization so that they are able to assess performance and dial up or down the need for additional resources. There are currently over 11,000 high risk patients enrolled in this initiative. In the last quarter alone admissions per 1,000 declined from 500 to 484.

[2] http://www.partnersathome.org/our-services/healthcare-technology/telemonitoring.aspx
[3] http://www.partnersathome.org/why-us/about-us/news/mobile-observation.aspx
[4] http://www.partners.org/Innovation-And-Leadership/Population-Health-Management/Current-Activities/Integrated-Care-Management-Program.aspx

Partners uses a commercially-based algorithm each year to identify patients who are high cost and/or high risk and who may be eligible for high risk care management (iCMP). While this can help create an initial list of potential patients for the program, our physicians add perspectives on such important factors as patient social supports and executive functioning levels. This additional information improves the specificity of the initial algorithm outputs, enabling clinicians to play an important role in finalizing the list of patients eligible for high-risk care management. We have also developed an analytical tool called the iCMP cohort tool that monitors trend performance by cohort of iCMP patients. This tool is accessible to and used by system and local leaders to track this population. We are currently developing a dynamic tool to enable clinicians and administrators to analyze medical utilization via claims activity of patients enrolled in this program.

- Mental Health: We deploy a collaborative care model (CCM) that integrates depression treatment resources into primary care. This program focuses on universal mental health screening, with consulting psychiatrists and mid-level health providers either virtually or physically integrated into primary care teams. Mental health is an important focus for us in the commercial population as nearly 25% of American adults suffer from diagnosable mental health disorders each year. Please see our response to question #5 for more details.

- Diabetes and Hypertension remote monitoring: This remote monitoring program for patients with Diabetes and Hypertension helps to ensure that their HbA1c and blood pressure levels are in control.

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

Our plan is to continue deployment of these programs, as detailed in question #1c. Our high risk care management program is fully implemented, and will focus on both end of life care and pediatric care for this year. For mental health, remote monitoring, and our post-acute strategies, we will continue to drive enrollment into these programs, while optimizing the clinical protocols.

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?

   There are certain assumptions that underlie the way in which the question is presented to which we would like to respond.

First, the premise that all quality is essentially the same is inaccurate. The more precise statement would be that given current measurements of quality, our ability to measure variations and distinctions in quality among hospitals is limited. Yet, even given the shortcomings of currently accepted quality measurements, both CHIA and the HPC in separate statements have acknowledged differences in quality of care in MA. CHIA found in its January 2015 Cost Trend final report that "... there are large differences between the highest and lowest scores received by providers on some measures, suggesting variation in provider quality." These differences were reaffirmed in the data provided in CHIA's most recent September 2015 preliminary Cost Trend Report that found "The quality of Massachusetts providers was generally at or above national benchmarks, but there was performance variation across providers." And specifically as the quality issue relates to Partners, the HPC recently concluded, "After examining over 100 nationally recognized measures across these dimensions, we found Partners, [South Shore Hospital], and [South Shore Physician Hospital Organization] (including Harbor) have high quality performance compared with Massachusetts and national averages." (Source: Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital (HPC-CMIR-2013-1) and Harbor Medical Associates (HPC-CMIR-2013-2), February 2014.

Because many current quality measurements are either "maxed out" with providers clustered at the top of the scale or provide little or no meaningful difference among providers, we have been working internally and in collaboration with others on more sophisticated quality metrics that we hope in the future will allow for more meaningful distinctions. This new measurement framework, which includes Patient Reported Outcome Measures (PROMSs), is based on recently completed work of the Institute of Medicine (http://iom.nationalacademies.org/Reports/2015/Vital-Signs-Core-Metrics.aspxin). The new measures will be ones that clinicians and the patients they serve agree are clinically important and are actionable.

Second, there is an implication in the statement introducing the question that price variation is unique to Massachusetts and has a significant impact on overall healthcare costs. In fact, price variation exists in health care markets across the country. (See data from New Hampshire Division of Insurance, Oregon Health Policy and Research, Pennsylvania Health Care Cost Containment Commission, Rhode Island Health Insurance Commissioner, Center for Studying Health System Change, and Oregon Health Policy and Research)

A study has shown that hospital prices are directly related to the costs of providing services to patients and their communities, including wages, capital investment, and the level and specialization of services. It found, "[u]p to 72% of the differences across hospitals in non-Medicare prices can be explained by factors that include case mix, regional costs, hospital investments in capital and other improvements, type of hospital, and other tangible factors. These factors also explain up to 83% of differences across hospitals in all-payor prices (which include Medicare), further validating the importance of cost and services as the sources of price differences." (Source: Assessment of Cost Trends and Price Differences for U.S. Hospitals," Compass Lexecon, March 2011)

Specifically with respect to acceptable reasons for higher prices, we would suggest the list below as rational justifications for variation. We acknowledge that some of these areas reflect choices that we have made as an institution, but we would argue that these are services that contribute to the overall health care of our patients, the local community and the system as a whole. If we choose not to makes these investments, society would look to others to carry out these activities. But we believe there are important societal and patient benefits for conducting these activities within a hospital setting. For example, conducting research in a hospital allows researchers to better understand and fully appreciate the clinical applications of new developments, as well as, offers our patients access to the latest advances in medical treatment.

- Complexity and uniqueness of clinical services
    - Partners is the largest not-for-profit provider of behavioral health services in Massachusetts. We maintain 354 inpatient and 253 residential beds system wide. Total budget for behavioral health clinical services, training and research for FY13 was $323M. Behavioral health clinical services require an annual subsidy of $52M.
    - Partners invested $220 million to build a new rehabilitation hospital at a time when hundreds of rehabilitation facilities across the country have closed over the past decade.
    - Post-acute clinical services require an annual subsidy of $49M (FY14).
- Severity of patients
    - 1 in 6 patients to Massachusetts General Hospital (MGH) and the Brigham and Women's Hospital (BWH) are transferred from local community and teaching hospitals. These patients account for nearly 40% of our in hospital mortality and a disproportionate fraction of our costs.
- Emergency standby capacity
    - MGH and BWH are both level 1 trauma centers for adults, and MGH is the only hospital in the state that is level 1 trauma for both adults and pediatrics.
    - MGH and BWH offer the only adult burn units in the state.
- Research capacity
    - Partners' total annual research enterprise is $1.4B.
    - MGH and BWH are the nation's top recipients of NIH funding for independent research hospitals.
    - The annual subsidy by Partners' to its research enterprise is $135M.
    - In addition, Partners funds $40M annually in cutting-edge research, supporting promising new investigators and early, proof-of-concept research
- Physician and other clinical training programs
    - MGH and BWH offer 250 clinical training programs, training over 2,000 physicians annually.
    - System-wide, education and training programs require $300M in support.
- Community health programs, including community health centers
    - Partners is the largest contributor to community benefit spending in the state - $206M in FY14.

    - BWH, MGH, and the North Shore Medical Center (NSMC), along with all Partners' hospitals, have made substantial investments in their communities. Our hospitals operate 5 community health centers, and maintain active affiliations with an additional 15 health centers.
- Technology
    - Partners is implementing a single health IT system to include all of its hospitals at a cost of $1.2B.
    - MGH is home to New England's only Proton Beam Therapy Center a regional resource uniquely suited to treat pediatric and central nervous system malignancies.
- Quality of care
    - MGH and BWH are the only two hospitals in the region listed among the top ten hospitals by US News and World Report.
    - Mclean ranked 4th in the nation for psychiatry by US News.
    - Spaulding ranked 6th in the nation for rehabilitation by US News.
    - Both Newton Wellesley and NSMC received Regional Best Distinction by US News.
- Caring for low income and vulnerable patients (e.g., Medicare and Medicaid patients)
    - Partners' hospitals provided care to 130,000 Medicaid patients at a net loss of $345M in FY14.
    - Partners' hospitals also cared for 219,000 Medicare patients at a net loss of $648M in FY14.
- Cost of providing care
    - Partners' inpatient costs per case mix adjusted discharge are in line with our national competitors.
    - Partners is a leader in reducing healthcare costs as evidenced by the recent results of the Pioneer ACO. Over 3 years Partners has saved a total of $39M—$18.8M of which were shared with the federal government.

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.

As healthcare continues to move away from fee for service to alternative payments, greater emphasis should be placed on total medical expense than unit pricing. Tackling the growth in total medical expense provides the best opportunity to reduce overall healthcare costs. We do not think artificially setting or suppressing unit prices will be successful in the long term in containing or reducing overall health care costs. A case in point is Medicare, where a rate setting system has long been in place, and yet policy makers continue to worry about the overall affordability and sustainability of the program.

Therefore, we do not think price variation in and of itself is the problem that threatens the affordability of our healthcare system. Rather, we believe that the greatest threat derives from the historical growth in health care costs over time. This growth has been fueled by

technological advances, utilization growth both appropriate and inappropriate, lack of coordination of care, and inadequate data systems. This is why, across Partners HealthCare, we have focused our attention on achieving the statewide cost growth benchmark and have made investments to better manage the health of our patients. Our strategy is focused on managing the total cost of care of a patient's illness over time.

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.

    One quarter of all American adults suffer from a diagnosable mental health disorder every year and it is estimated that primary care physicians manage 40% to 80% of these patients. Rates of detection and adequate treatment of mental health disorders in primary care settings are currently suboptimal. In addition to issues with access to services and medication compliance, mental health disorders can lead to poor management of physical health conditions and excess use of services leading to an increase in healthcare costs.

    To address these issues, we have developed a Behavioral Health Integration (BHI) program that provides tools and resources for primary care providers to help manage patients with depression. We employ a team-based collaborative care model, which includes input from psychiatrists, social workers and non-clinical behavioral health care coordinators. The BHI program was launched in 2014 and we are implementing our efforts in a phased approach.

    Core components of our BHI program include:

    - Screening: Universal screening program in primary care for mental health disorders (i.e. depression, anxiety and substance use) using brief well validated tools
    - Clinical support: Consulting psychiatrists and mid-level health providers, functioning as mental health specialists virtually or physically integrated into our primary care teams
    - Education: Educational programs to train primary care personnel in brief interventions for improved disease management such as motivational interviewing, behavioral activation, problem-solving therapy, and other first-line interventions suitable for primary care
    - Workflows: Standard workflows in primary care for the identification and treatment of mental health illnesses, starting with depression

- Technology: Telehealth technologies to improve access to specialty care and provide care in lower cost settings
- Data: Registries to track mental health outcomes and provide prompts to ensure that follow-up screening tests are administered at periodic intervals and treatment plans can be modified if needed

Below are descriptions of two active programs within the BHI Program.

Depression–Consultation, Assistance with Resources and Education (D-CARE) -
D-CARE is a Partners-wide program available to all adult primary care practices in the network that need assistance with managing patients with depression. We provide primary care practices with a dedicated team of behavioral health professionals who can answer questions regarding diagnosis and treatment as well as provide education and resource information that will benefit patients. The behavioral health team includes Resource Specialists, Social Workers, Psychiatrists and Psychologists. This integration of services means that primary care patients are able to receive care for depression that is appropriate and timely.

Collaborative Care -
Our Collaborative Care program uses a specific evidence-based approach (based on the IMPACT model) to manage patients with depression. This treatment model has been shown to improve depression symptoms and decrease overall healthcare costs. Through this program, patients with depression are connected with a behavioral health care manager who will help the primary care team monitor the patient's response to treatment and can work on behavioral interventions with the patient. A consulting psychiatrist provides guidance to the team on treatment recommendations. We are currently piloting this program in a number of practices across the network with the goal of making it available to all primary care practices at Partners over the next few years.

In addition to the above, there are numerous smaller programs and pilots ongoing at our member hospitals to better integrate physical and behavioral services and reduce unnecessary emergency department visits or inpatient utilization. These efforts include embedding mental health specialists in primary care practices at several regional service organizations (RSOs); a large-scale proposal led by MGH to improve inpatient-to-outpatient transitions and provide recovery coaches for patients with substance use disorders; and urgent care clinics located in outpatient clinics at MGH.

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.

Recently, we announced our plans, pending regulatory approval, to better organize and expand our behavioral health services at NSMC, by creating a 100-plus bed Center of Excellence in Behavioral Health that will be directly aligned with MGH and add 40-50 new beds to the region for psychiatry and behavioral health services. The Center will

integrate addiction treatment with inpatient and outpatient psychiatry, behavioral health services, and further development of community-based programs.

As part of our PHM plan over the next year, we will continue to expand our depression collaborative care model into additional primary care practices. We also intend to expand the scope of D-CARE to include anxiety, a condition that may drive medical overutilization (both outpatient and emergency room visits). As part of this expansion, we will offer curbside consultations on anxiety, facilitate connecting providers and patients with anxiety resources, and develop training and treatment algorithms to guide management. We hope that expanding our services to cover anxiety will enable primary care doctors to manage more patients with anxiety in the primary care setting rather than relying on specialty care, emergency room visits, or inpatient admissions.

We also have convened a substance use disorders (SUDs) task force to develop a proposal on how to best address the needs of the population with SUDs. The expectation is that the model proposed will enhance collaboration in medical care and behavioral health care, lead to improved utilization of appropriate levels of care and focus on prevention efforts.

In the meantime, we will continue to encourage our member organizations to pursue smaller-scale pilots that might help improve the continuum of care and reduce unnecessary utilization.

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?

Care coordination is integral to our PHM strategy. We have increased funding to support the transformation of primary care at Partners into patient centered medical homes[5] grounded in a team based care model. We certify practices as National Committee for Quality Assurance (NCQA) certified when they have transformed their care processes to provide the following:

i. Patient-Centered Access
ii. Team-Based Care
iii. Population Health Management
iv. Care Management and Support
v. Care Coordination and Care Transitions
vi. Performance Measurement and Quality Improvement

Today, 27% of our practices representing 245 providers across 52 practices have achieved NCQA certification. This is a rigorous process and we ensure that practices have really

[5] https://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/what.htm; http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

transformed care processes to earn this certification. We also recognize practices that have achieved 'Prime Status' which is an important milestone in care transformation (but not yet fully transformed). There are 77% practices or 700 providers that have achieved Prime Status. Our other programs, such as iCMP and mental health care programs, are layered on top of this patient centered medical home model to ensure care coordination for our patients.

In addition, we have invested heavily in information systems, analytic capacity, and data warehouses to ensure that care coordination is enabled and supported by a robust infrastructure. These include 1) patient care registries and patient outreach systems, 2) decision support tools to assist physicians in determining the appropriateness of surgical procedures and radiology tests, such as spine fusion, spine laminectomy, knee arthroplasty, hip replacement, angioplasty with stent, coronary artery bypass graft, heart valve repair/replacement, MRIs, and hysterectomies 3) data warehouse tools for care pattern analytics, and 4) common clinical information system across the network so that providers can view longitudinal care patterns, identify any clinical variation, and have data to compare and share best practices across all services and practices.

7. Since 2013, Partners has completed a number of material changes, including acquiring a community hospital—Cooley Dickinson Hospital (Cooley), and major physician groups—Harbor Medical Associates and Pentucket Medical Associates (Pentucket), and other expansion plans are pending (Hallmark Health Corporation). Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.
    a. How have costs (e.g. prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes? Please include summary tables showing, prior to and subsequent to the acquisition of Cooley, the volume of Cooley Dickinson Physician Hospital Organization (CDPHO) patients referred to each of the top five hospitals to which these physicians refer.

       The Harbor Medical Associates and the Pentucket Medical Associates transactions were finalized this year, and it is too early at this time to evaluate any significant impacts on costs and quality.

       With respect to Cooley Dickinson Hospital, we have observed no significant change in prices and TME, and for changes in quality and access, please see the response to 7b. Although we do not track referrals for all Cooley Dickinson Physician Hospital Organization (CDPHO) patients, we do have data from our two largest commercial insurers, Health New England and Blue Cross Blue Shield, on where CDPHO members are going for inpatient care. Please see the attachment #2 for the top 5 hospitals, other than Cooley, utilized by CDPHO members of these plans.

    b. Partners stated in its notice of material change for Cooley that "Mass General and [Cooley] will work to develop clinical programs that focus on clinical services where

gaps currently exist." What gaps were identified after the acquisition, and what clinical programs have been developed to date to address those gaps?

Gaps that were identified and the programs that were developed include the following:

1. *Access to acute neurological services for emergent care in the case of stroke and stable acute inpatient care.*

MGH contracted with Cooley to provide telemedicine services to provide patients who present in the Emergency Department with a stroke to have an assessment by a stroke neurologist using tele-medicine. The MGH physician can assist the Cooley physician in making the decision to administer the clot busting drug, TPA, which can reverse the effects of a stroke.

The tele-neurology program also provides for neurological consults via telemedicine to patients in the intensive care unit. These are scheduled consults and assist the CDH intensive care physicians in determining the care plan for a patient.

2. *Ability to provide timely surgical care to patients as a result of Cooley having only one general surgeon on staff.*

MGH assisted Cooley in recruiting a recent graduate of the general surgery fellowship program to work at Cooley full time. The individual was able to provide back up for the existing surgeon and increased the ability for the hospital to provide surgical care to patients in the community in a more timely fashion.

3. *In response to a series of sentinel events in the Cooley Childbirth Center, Cooley collaborated with MGH to provide clinical consultation and on-site support. Some of the key areas of support included:*

<u>Clinical Consultation</u>

- Introduction of a team charged with coordination of leadership, assignment of resources and elimination of barriers related to the implementation and follow through on a Department of Public Health Plan of Correction submitted in February 2015. Dr. Elizabeth Mort, Senior Vice President Quality & Safety, Chief Quality Officer MGH/MGPO, was a member of the committee.
- Collaborated in the development of Obstetrics (OB) Harm Triggers.
- Identification of harm triggers served as an upstream way of identifying potential harm that became the core component of our Quality Assurance and Performance Improvement plan redesign for the Board of Registration in Medicine.
- Dr. Jeff Ecker, Director of Obstetrical and Clinical Research and Quality Assurance at MGH, participated and helped to improve the OB Peer Review.

- Drove the expansion of peer review to a broad multidisciplinary approach which included nursing and other clinical team members. The goal of medical peer review is to improve quality and patient safety by learning from past performance.

On-site Support

- Dr. Mark Phillippe, Maternal Fetal Medicine Specialist at MGH, provided on-site support with the perinatal improvement initiatives, morbidity and mortality peer review of difficult cases, and a review of triggers that resulted in real time case review, i.e. elevated Blood Pressure readings during late pregnancy
- Partners Employee Assistance Program provided on-site support to the Childbirth Center providers and staff upon request.

4. *Cooley Dickinson had a desire and need to develop a comprehensive cancer center that would bring medical, surgical, and radiation oncology services together in one location.*

MGH assisted Cooley in developing a plan and model for a comprehensive cancer center to provide multi-disciplinary care to the community. MGH has provided clinical and administrative guidance in the construction of a new center that has been built on the Cooley campus. The new center will be designated as the MGH Cancer Center at Cooley Dickinson Hospital and opens in September 2015.

MGH supports the cancer center at Cooley with ongoing clinical and administrative oversight. Some examples of this are the provision, via telemedicine, of a monthly patient case review conference by MGH specialists, onsite genetics counseling one day per month by a certified MGH genetics counselor, quarterly steering committee meetings, and ongoing physician and community education programs.

c. Partners stated in its notice of material change regarding Pentucket that the acquisition would allow it to "better align compensation incentives with the implementation of its population health management programs that are designed to control the growth of total medical expenditures and improve the quality of healthcare…." Partners has made similar statements regarding its other acquisitions and affiliations. What progress has been made toward these goals?

As we noted in our Notice of Material Change regarding Pentucket Medical Associates (PMA), because of the increasing emphasis on controlling the growth of total medical expenditures through population health management, bundled pricing, risk contracting, and other methods, aligning physician compensation and other financial incentives across all providers in the Partners network has become an important priority. In the case of the PMA physicians, moving to a fully employed model has enabled Partners Community Physicians Organization (PCPO) to initiate some important changes to PMA's physician

compensation plans, including conversion to a compensation model based on Relative Value Units (RVUs) that PCPO anticipates will have the added benefit of improving access for patients because it is payer-blind. Furthermore, PCPO is also beginning to redesign its physician compensation model to tie compensation more directly to a number of the metrics in Partners Population Health Management (PHM) programs.

In addition, the fully employed physician model enables PCPO to make investments in the practice that are not a possible for so-called "affiliated" physician practices. For example, PCPO recently provided funding to PMA for an innovative behavioral health pilot program. These types of changes and direct investments are neither possible with, nor available to, our affiliated practices.

While the PMA providers became employees of PCPO on July 1, 2014, due in part to an understanding with the HPC, the transition to the fully employed model was not completed until January 30, 2015. Therefore, PCPO is just in the early stages of the fully employed model for the PMA physicians and cannot yet report on its impact on total medical expenditures. Nevertheless, PCPO believes that the fully employed physician model will, over time, have a substantial impact on PCPO's ability to deliver high-quality, efficient health care.

Exhibit C: Instructions and AGO Questions for Written Testimony

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

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

PHS*		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	IP: 14 OP: 80	N/A	94	IP: Natural Childbirth, Cesarean Section, Hernia Repair, Prostatectomy, Hysterectomy, Mastectomy, Breast Reconstruction, Gastric Bypass, Knee Replacement, Hip Replacement, Laminectomy, Sleep Study, Cardiac Ablation, Pectus Excavatum, Hepatectomy, Triple Bypass OP: MRI (various), X-ray (various), CT Scan, Dermatology office visit, Removal of Skin Lesion, ACL Meniscus Repair, Colonoscopy, Mammogram, Arthroscopy, Hysteroscopy, Ultrasound, Physical Therapy, Occupational Therapy, Neuropsych Testing, Bone Density, Upper GI, Carpal Tunnel Release, Office Visits
	Q2	IP: 41 OP: 126	N/A	167	
	Q3	IP: 82 OP: 258	N/A	340	
	Q4	IP: 121 OP: 345	N/A	466	
CY2015	Q1	IP: 87 OP: 406	N/A	493	
	Q2	IP: 92 OP: 363	N/A	455	

*includes BWH, BWFH, MGH, NWH, NSMC, SRN
**Website directs patients to call Patient Billing Solutions to request an estimate; this information is included in the telephone inquiries

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **AGO Provider Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   See attachment #3.

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

   Although Partners does not have one referral management process for the entire system, Massachusetts General and Brigham and Women's Hospital have each implemented local referral management systems. The overall purposes of the two referral management systems are to increase clinical integration, improve access by enabling better triage of patients to the right physician, and reduce TME by avoiding unnecessary referrals and diagnostic tests. Both systems are tied to the electronic health record and managed centrally. The Massachusetts General system is also tied to its scheduling system. In addition to facilitating the referral between primary care physicians and specialists, the referral systems at Massachusetts General and Brigham and Women's allow specialists to communicate more effectively with each other. Massachusetts General is also able to capture external referrals with its system. At this time, no cost or quality information is made available to physicians at the point of referral. Further, we do not routinely check whether the provider is in the patient's insurance network. However, as we implement eCare across our system (i.e., a single Health IT system) we will have a single portal which referring providers can access to facilitate the referral process and will also improve the content and timeliness of information we share on the care of patients within our system.

Acute Hospitals Only (MGH, BWH, BWFH, NSMC, NWH)
Does not include MD data or DFCI patients
Data is Fiscal Year based
FY2010 - 2014 (Oct - Sept) is based on reconciled data, FY15 Q2 (Oct - Mar) is based on reconciled data

Fiscal Year	Cases	Net Patient Service Revenue	Total Costs
FY 2010	4,513,012	$ 4,411,415,783	$ 4,124,969,576
FY 2011	4,531,087	$ 4,604,932,221	$ 4,308,265,816
FY 2012	4,681,752	$ 4,852,042,986	$ 4,532,245,849
FY 2013	4,643,990	$ 5,011,057,203	$ 4,722,569,695
FY 2014	4,672,576	$ 5,092,683,126	$ 4,760,153,696
FY 2015 Q2	2,322,877	$ 2,608,920,273	$ 2,458,410,662

Financial Definitions
Net Patient Service Revenue = Contracted Payer Net Revenue - Free Care - Bad Debt - Denial - HSN Assessment + HSN Receipts
Total Costs = Direct + Indirect

Health New England IP Referrals

	2012		2013		2014	
member months		*121,182*		*121,859*		*122,827*
Cooley Dickinson Hospital		49.8%		44.8%		39.8%
Baystate Medical Center	1	24.0%	1	26.0%	1	29.3%
Mercy Medical Center	2	3.5%	5	2.5%	5	2.2%
Brattleboro Retreat	3	3.2%	2	3.9%	4	2.7%
Franklin Medical Center	3	3.2%	4	3.1%	2	6.9%
Holyoke Medical Center	4	2.3%	3	3.3%	3	3.1%

Blue Cross HMO Inpatient Referrals

	2012		2013		2014		Q1 2015	
member months		97,989		*95,765*		*97,914*		*23,305*
Cooley Dickinson Hospital		46.4%		43.9%		35.7%		30.5%
Baystate Medical Center	1	19.5%	1	21.6%	1	21.4%	1	26.6%
Mass General Hospital	2	4.8%	2	4.0%	2	7.5%	3	3.9%
Brigham & Women's	3	4.0%	4	3.1%	5	2.1%		
Franklin Medical Center	4	3.8%	3	4.2%	3	3.2%	2	4.7%
Brattleboro Retreat	5	1.9%						
Holyoke Medical Center			5	1.8%			3	3.9%
Mercy Medical Center					4	2.7%	3	3.9%

Exhibit 1 AGO Questions to Providers

NOTES:

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

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

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 448.2		$ 47.5		$ 199.3	$ 8.3					$ 125.0	$ 896.1	$ 5.1		
Tufts Health Plan	$ 137.2		$ 12.7		$ 7.2	$ 0.3					$ 95.5	$ 156.7	$ 0.5		
Harvard Pilgrim Health Care	$ 166.6		$ 0.4		$ 5.7	$ 0.2					$ 204.0	$ 172.4	$ 0.9		
Fallon Community Health Plan											$ 28.9				
CIGNA											$ 100.4	$ 5.6			
United Healthcare												$ 198.2			
Aetna											$ 162.5	$ 26.1			
Other Commercial												$ 391.2			
Total Commercial	$ 752.1		$ 60.5		$ 212.2	$ 8.8					$ 716.4	$ 1,846.3	$ 6.5		
Network Health											$ 81.7				
Neighborhood Health Plan											$ 85.9				
BMC HealthNet, Inc.											$ 8.0				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$ 175.5				
MassHealth											$ 199.8				
Tufts Medicare Preferred											$ 72.7				
Blue Cross Senior Options											$ 13.8				
Other Comm Medicare											$ 18.7	$ 28.3			
Commercial Medicare Subtotal											$ 105.1	$ 28.3			
Medicare												$ 1,249.7			
Other												$ 306.2			
GRAND TOTAL	$ 752.1		$ 60.5		$ 212.2	$ 8.8					$ 1,196.8	$ 3,430.5	$ 6.5		

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available; they represent ~8% of total PHS revenue.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.

[7] Change from 2014 submission – Other Revenue restated with updated information.

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	$ 112.2		$ 11.7		$ 271.9	$ 245.0	$ 2.6		$ 2.0		$ 293.7	$ 860.7	$ 3.9		
Tufts Health Plan	$ 34.2		$ 3.3		$ 72.5	$ 5.7	$ (0.3)		$ 0.3		$ 123.6	$ 190.6	$ 0.4		
Harvard Pilgrim Health Care	$ 41.6		$ 4.2		$ 81.9	$ 5.4	$ 0.8		$ 1.1		$ 281.7	$ 202.6	$ 0.8		
Fallon Community Health Plan											$ 31.2				
CIGNA											$ 129.1	$ 3.8			
United Healthcare												$ 211.5			
Aetna											$ 182.1	$ 27.4			
Other Commercial												$ 398.1			
Total Commercial	$ 188.0		$ 19.1		$ 426.4	$ 256.0	$ 3.1		$ 3.4		$ 1,041.5	$ 1,894.7	$ 5.1		
Network Health											$ 57.8				
Neighborhood Health Plan											$ 78.6				
BMC HealthNet, Inc.											$ 5.5				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$ 141.8				
MassHealth											$ 213.4				
Tufts Medicare Preferred											$ 79.5				
Blue Cross Senior Options											$ 16.4				
Other Comm Medicare											$ 11.4	$ 32.3			
Commercial Medicare Subtotal											$ 107.2	$ 32.3			
Medicare						$ 195.6		$ 5.40				$ 1,167.5			
Other												$ 343.7			
GRAND TOTAL	$ 188.0		$ 19.1		$ 426.4	$ 451.6	$ 3.1	$ 5.4	$ 3.4		$ 1,503.9	$ 3,438.2	$ 5.1		

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available; they represent ~8% of total PHS revenue.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.

[7] Change from 2014 submission – Revenue under Risk Contracts and FFS Arrangements for Medicare has been restated with updated information.

[8] Change from 2014 submission – Other Revenue restated with updated information.

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					$ 314.8	$ 285.8	$ (2.4)		$ 2.1		$ 279.2	$ 912.6	$ 3.4		
Tufts Health Plan					$ 96.4	$ 5.2	$ (3.0)		$ (3.1)		$ 143.8	$ 203.1	$ 0.4		
Harvard Pilgrim Health Care					$ 112.5	$ 5.4	$ (0.7)		$ 1.2		$ 285.5	$ 222.4	$ 0.8		
Fallon Community Health Plan											$ 35.6				
CIGNA											$ 139.8	$ 5.3			
United Healthcare												$ 208.2			
Aetna											$ 195.7	$ 29.5			
Other Commercial					$ 20.0						$ 11.6	$ 380.3			
Total Commercial					$ 543.6	$ 296.5	$ (6.1)		$ 0.2		$ 1,091.3	$ 1,961.5	$ 4.6		
Network Health											$ 70.3				
Neighborhood Health Plan					$ 27.9		$ (0.9)		2013 not yet settled		$ 54.8				
BMC HealthNet, Inc.											$ 11.0				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid					$ 27.9		$ (0.9)				$ 136.2				
MassHealth											$ 221.9				
Tufts Medicare Preferred											$ 77.1				
Blue Cross Senior Options											$ 18.9				
Other Comm Medicare											$ 15.4	$ 39.2			
Commercial Medicare Subtotal											$ 111.5	$ 39.2			
Medicare						$ 214.7		$ 1.8				$ 1,187.7			
Other												$ 354.5			
GRAND TOTAL					$ 571.5	$ 511.1	$ (7.0)	$ 1.8	$ 0.2		$ 1,560.8	$ 3,483.5	$ 4.6		

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available; they represent ~8% of total PHS revenue.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.

[7] Change from 2014 submission – Revenue under Risk Contracts and FFS Arrangements for Medicare has been restated with updated information.

[8] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue for services provided via risk agreement with Neighborhood Health Plan.

[9] Change from 2014 submission – Other Revenue restated with updated information.

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					$ 304.6	$ 302.1	2014 not yet settled		2014 not yet settled		$ 274.3	$ 925.0	$ 3.5		
Tufts Health Plan					$ 100.8	$ 5.2	2014 not yet settled		2014 not yet settled		$ 128.6	$ 210.5	$ 0.4		
Harvard Pilgrim Health Care					$ 89.3	$ 5.0	-$1.6		2014 not yet settled		$ 300.7	$ 228.6	$ 0.8		
Fallon Community Health Plan											$ 43.1				
CIGNA											$ 136.9	$ 12.9			
United Healthcare												$ 219.9			
Aetna											$ 191.5	$ 30.8			
Other Commercial					$ 28.4		2014 not yet settled		2014 not yet settled		$ 55.9	$ 363.4			
Total Commercial					$ 523.1	$ 312.3	$ (1.6)				$ 1,131.0	$ 1,991.1	$ 4.7		
Network Health											$ 27.9				
Neighborhood Health Plan					$ 66.4		2014 not yet settled		2014 not yet settled		$ 84.4				
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 24.8				
Total Managed Medicaid					$ 66.4						$ 137.1				
MassHealth											$ 240.7				
Tufts Medicare Preferred											$ 77.1				
Blue Cross Senior Options											$ 20.1				
Other Comm Medicare											$ 6.8	$ 66.5			
Commercial Medicare Subtotal											$ 104.0	$ 66.5			
Medicare						$ 229.3		$ 9.9				$ 1,220.1			
Other												$ 309.8			
GRAND TOTAL					$ 589.5	$ 541.6	$ (1.6)	$ 9.9			$ 1,612.8	$ 3,587.5	$ 4.7		

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS. Payer specific information for other PHS providers (McLean, Spaulding Network, MVH, and NCH) is not available; they represent ~8% of total PHS revenue.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account.