SIGNATURE HEALTHCARE

September 11, 2015

Health Policy Commission
Attn: Lois H. Johnson
Two Boylston Street, 6th Floor
Boston, MA 02116

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

Dear Ms. Johnson:

Pursuant to your request and in accordance with Massachusetts General Laws chapter 6D, §8, please find included herein Signature Healthcare Corporation's 2015 Pre-Filed Testimony responses and Exhibit C along with AGO Hospital Exhibit 1.

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

Sincerely,

Kim Hollon
President/CEO

Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

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

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

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

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

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

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

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

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

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

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

[Remainder of page intentionally left blank]

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.

    Cost control efforts temper Signature Healthcare (SHC) Brockton Hospital's significant dependence on governmental payers allowing for stable operating performance with operating margin averaging 8.1% over the four year period, while costs per adjusted day grew by an average of 5.3% over the same four year period (FY 11 – FY 14).

    Inpatient volumes for BH, as measured by admissions, were below plan for the year and the prior year by 7% and 3%, respectively partially due to the reclassification of inpatients as outpatient observation cases as well as lower admission rates from the emergency department. Outpatient volumes for BH were right on target for the year and ahead of prior year by 5%. We are seeing a continuation of the shift from inpatient to outpatient revenue.

    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?

    We are moving forward with implementing the NCQA Patient Centered Medical Home model at our ambulatory sites. We've invested in a new case management service/team with social work support, new IT systems to monitor TME from claims and provide predictive analysis solutions for improving TME outcomes. Signature continues to move from fee for service to alternative payments, risk models and bundled payments. The TME for our Medicaid and Commercial plans has been below the state's 3.6% benchmark.

    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?

    Effective July 2015, we began accepting bundled payments from Medicare for hip and knee replacement surgery. Beginning in October of this year we will be accepting bundled payments for Medical DRGs. We anticipate these bundles collectively will comprise about 1000 of our Medicare inpatient admissions during the next year. In an

effort to be successful with this new change in payment, we will be focusing heavily on reducing our readmissions, improving our transitions in care from the hospital, and reducing the length of stay in post acute care (skilled nursing, long term acute care and rehab). We believe this is the right thing to do for our patients and this change finally aligns our payment with the patient's needs. Over the next year this will help us focus on improving our ability to educate patients and their family in how to engage in their care, and it will improve the way we follow and support patients after being discharged.

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

- We believe that the state should pool all our Medicaid and managed Medicaid patients together into one group and partner with providers to reduce TME.
- Create a system of limited choice for the patient to keep them in a network so that they have a reason to engage with a provider on their long term health.
- Allow Patient Centered Medical Home to be designed based on patient needs and ROI for reducing TME and not on arbitrary criteria.
- Standardize the insurance plan approach for mid-level providers, to allow them to care for patients and bill the same way for all insurers
- Allow hospitals to provide post discharge medications as part of the inpatient stay and be paid for them outside the DRG. Medication compliance and management at this transition is critical. The payment rules are a barrier
- Allow providers to sign binding non-compete agreements with employed primary care doctors
- Compel law enforcement to provide behavioral health resources to appropriate individuals under arrest.
- Treat battery and abuse of others while under the influence of drugs as harshly as driving under the influence is treated by law enforcement and the courts

Also, we are currently participating in the PCPRI MassHealth contract. We are in the second year of this three year arrangement. Data support has proved inadequate with lack of monthly financial data and detailed patient quality data. We have invested in IT systems to do manage claims and provide predictive analytic models but unfortunately we are not provided the data or claims detail required to feed these systems.
We would suggest that the management of these patients would be more effective if the state eliminated the open enrollment option to MassHealth members and require them to remain in the plans for a year. This would allow effective Case Management and coordination of medical, social and behavioral health management.
Furthermore, the state should provide access to ALL MassHealth claims data including Mental Health. This would allow the members to stay with us and for us to better manage their medical and behavioral health care needs.

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

   To engage in significant risk based contracts the membership must reach a statistical size. The current contracting system of the multiple MCO's creates isolated contracts decreasing the efficiency of population management and increased level of risk. In addition, entering risk requires significant infrastructure cost as well as the need for risk reserves. Early years of risk and alternative payment contracts would require a component of financial payments to support cash flow and required infrastructure for Safety Net Hospitals.

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 are a safety net hospital serving the needs of our community. We recognize the need for appropriate selection of patients to receive post-acute care. With the social and economic conditions of our patient population, there are challenges during the convalescence phase. We assess a patient's needs and ability to be safe at home at the time the patient is ready for discharge. With input of Physical Therapy, Social Services, and Case Management colleagues, the care team determines if care in the home setting is the right choice for the patient. High utilization due to readmission and avoidable Emergency Department use are also areas of focus for our healthcare organization. The social and economic complexity of the population we serve contributes to this avoidable utilization. We have been working on reducing avoidable 30-day readmissions by not only addressing the health issue that brings our patient to the hospital, but by providing some education about their medical problem and strategies for self-management. Determining the drivers that bring patients back to the ED and hospital has led to the understanding that the causes are deep-seated in the socioeconomic complexity of our population. Difficulty with access to medications and mental health issue support complicate the situation. Medically, our patients are also complex. We have established a complex care clinic to help address these needs, but capacity is limited as the demand outweighs our infrastructure to meet our population's needs.

   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, we are planning to expand our complex care team to meet the needs of those patients who are high-risk, high-cost which result in high utilization of ED services, and potentially lead to readmission. The team will consist of a medical provider, social services, and a care manager. Our plan is to have the team at the point of entry to the hospital and begin caring for this group of patients, not only in the ED, but

transition them through the hospital care (if that is needed) and through care outside of the hospital. A Community Health Worker will aide our patients in navigating the elements of care management in the community. We will place clinical pharmacy services in the ED to help with medication reconciliation and will partner with community resources to improve access to medication and help provide support in the home for our patients. Our post-acute care work is positioned as part of the transition for patients from the acute medical problem to recovery, if needed. The team will support the patient through these transitions. As we receive support for our infrastructure, we will be working to provide the resources for the full spectrum of care, including services at the end-of-life. Stratification of population according to socioeconomic and behavioral health needs could help guide the needed infrastructure support.

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 is no acceptable reason that severity-adjusted global budgets should vary across hospitals other than the impact of government policy. Within a global budget for a significant size population, the risk of illness and cost should not be different based on providers. Global budgets should be based on average Boston market cost and adjusted for severity of patients and their socio-economic needs. That presumes of course that the government payers reimburse for the cost of care in each of their programs such that cross subsidization is not required from commercial payers for government programs. Within our current system of purposeful government underpayment and cross-subsidization, payments from commercial payers must make up the shortfall. Location is a strong determinant of percentage of government-sponsored payments; and transportation is a barrier to access of care in more affluent areas, therefore unless the government's method of payment changes, global budgets should be higher in areas with higher poverty.

    Employing physicians to provide access to care in a service area with significant governmental reimbursement will create a need for insurance payments to offset the cost of under reimbursed professional services. In addition, some payer must pay the cost of educating future health professionals, if we retain a supply of providers into the future. Finally there may be some tertiary services society desires, but would refuse to pay for if reimbursed at reasonable cost, which therefore must be cross-subsidized by other patients.

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 includes both professional provider price; professional provider choice regarding who to serve (some providers with higher prices limit lower reimbursed government pay patients) and facility price variation. These three price variations impact cost significantly. The price variation has allowed providers with higher prices to flourish and re-invest in their facilities, and market share growth, creating a virtual cycle of inflation. The internal investment engine attracts more patients, reinforcing the cycle and market power for higher prices. The opposite cycle exists for the institutions and providers with lower prices. They are relatively less able to re-invest the same amount in facilities and market growth, further weakening their market share and power to negotiate fair rates, creating a negative cycle of decline, further supporting the upward spiral of the wealthy hospitals.

In summary, a disproportionate share of the healthcare dollars historically and currently go to organizations with market power and leverage at the expense of other community providers who typically are under reimbursed for the services that they provide. The historic disadvantage in the fee structure to community hospitals cries out for an adjustment necessary for their sustainability in rebuilding infrastructure and competitive systems of care. Years of disproportional distribution of contracting dollars requires some adjusting in the near term for those hospitals with minimal cash reserves and aging physical plants.

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.

      We have contracted with Northeast Behavioral Health Services to provide access to our patients with behavioral health needs. We have set a two week access standard and have developed standard protocols for referral and for sharing clinical information. We have added a manager of social work and 4 social workers to function within the practice to help meet these needs as well.

      The social work team takes on patients at the direction of the care team and develops plans for each patient. For those with clinical psychiatric needs they facilitate the referral to Northeast Behavioral Health Services.

We are now also working with High Point to develop a shared approach to SMG patients needing substance abuse and detox support, by putting social workers in the care team and connecting them to daily huddles and physicians directly, they can help educate and identify how behavioral needs are impacting medical health.

We are too early to have impact data on ED use and readmissions – we expect to have that over the next 12 months. Anecdotally, we are getting reports from our social workers that they are getting patients into services and into the practices such their use of the ED is less.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

Over the next 12 months we will have a data tracking system that distributes high risk patients in each practice to the care team and social workers; we will have improved software for tracking and reporting their activities and results. We will have a more fully integrated the ambulatory and hospital case management and social work departments to better coordinate across the care continuum. We have started standing meetings with local Visiting Nurse Association and will expand on that as the team grows, and will have completed training in team based care for our providers and staff.

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?

Through the PCPRI contract we are working to transform our medical practices to Patient Centered Medical Home, as defined by NCQA. Our implementation team has submitted the corporate application to NCQA for 7 of our practices which are scheduled to be certified by NCQA by March 2016 with another 7 practices on target for March 2017. As part of this effort Signature is integrating case managers into the care teams, engaging physicians in a new way of practicing, and re-designing physician compensation to support this transformation.

Additional capabilities have been added including the addition of TME based predictive software and reporting as well as palliative care and end of life planning support. Signature continues to negotiate with payers for additional risk and is open to exploring a Medicaid ACO.

Exhibit C: Instructions and AGO Questions for Written Testimony

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

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

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	14		14	Maternity, Colonoscopy, Labs & Mri
	Q2	27		27	Maternity, X-Ray, Labs, EKG,Ultrasound
	Q3	18		18	Maternity, Mammogram, Labs, EKG
	Q4	3		3	Nutrition, PAP, Labs
CY2015	Q1	6		6	CT Scan, Xray, Tooth Removal
	Q2	11		11	Maternity, MRI Labs, PT

37T

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.
37T

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

In millions	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$17.5	$1.5	$.8	$.1	$9.4	-	-	-	$1.2	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.6	-	-$.2	-	-	-	$2.8	$1.6			
Harvard Pilgrim Health Care	$9.8	-	$.2	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.2	-			
HPI	-	-	-	-	-	-	-	-	-	-	$.2	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$2.7	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$.8	-			
NHP	-	-	-	-	-	-	-	-	-	-	$.9	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	$.1	$6.5			
Total Commercial	$27.3	$1.5	$.9	$.1	$12.0	-	-$.2	-	$1.2	-	$9.9	$8.1			
Network Health	-	-	-	-	-	-	-	-	-	-	$5.5	-			
NHP	-	-	-	-	-	-	-	-	-	-	$8.2	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$10.7	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$.9	$.9			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$25.2	$.9			
MassHealth	-	$16.6	-	$.0	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$5.7	-	$.0	-	-	-	$2.7	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$2.4	$1.2			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$4.6	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$.4	$.2			
Commercial Medicare Subtotal	-	-	-	-	$5.7	-	$.0	-	-	-	$10.2	$1.5			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$59.0			
Other	-	-	-	-	-	-	-	-	-	-	-	$12.0			
GRAND TOTAL	$27.3	$18.1	$.9	$.1	$17.7	-	-$.2	-	$1.2	-	$45.3	$81.4			

2012

In millions	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$17.9	$1.9	$.8	$.1	$9.2	-	-	-	$2.2	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.6	-	$.8	-	-	-	$2.4	$1.7			
Harvard Pilgrim Health Care	$10.6	-	$.2	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.2	-			
HPI	-	-	-	-	-	-	-	-	-	-	$3.4	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.3	-			
NHP	-	-	-	-	-	-	-	-	-	-	$1.3	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	$.3	$7.1			
Total Commercial	$28.6	$1.9	$1.0	$.1	$11.8	-	$.8	-	$2.2	-	$14.3	$8.7			
Network Health	-	-	-	-	-	-	-	-	-	-	$4.0	-			
NHP	-	-	-	-	-	-	-	-	-	-	$8.6	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$10.7	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$.7	$.7			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$24.0	$.7			
MassHealth	-	$19.8	-	$1.9	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$5.0	-	-$.9	-	-	-	$2.5	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$2.2	$1.3			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$5.2	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Commercial Medicare Subtotal	-	-	-	-	$5.0	-	-$.9	-	-	-	$11.1	$1.3			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$67.9			
Other	-	-	-	-	-	-	-	-	-	-	-	$12.5			
GRAND TOTAL	$28.6	$21.7	$1.0	$1.9	$16.8	-	-$.1	-	$2.2	-	$49.4	$91.2			

2013

In millions	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$18.1	$1.7	$.9	$.1	$8.5	-	-	-	$1.1	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.9	-	$.2	-	-	-	$2.5	$1.7			
Harvard Pilgrim Health Care	$11.1	-	$.1	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.9	-			
HPI	-	-	-	-	-	-	-	-	-	-	$4.6	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.2	-			
NHP	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	$.3	$7.1			
Total Commercial	$29.3	$1.7	$1.0	$.1	$11.4	-	$.2	-	$1.1	-	$16.3	$8.9			
Network Health	-	-	-	-	-	-	-	-	-	-	$5.2	-			
NHP	-	-	-	-	-	-	-	-	-	-	$8.7	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$12.3	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$.9	$.8			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$27.1	$.8			

2013

In millions	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
MassHealth	-	$19.7	-	$.6	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$5.4	-	$.4	-	-	-	$2.3	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$1.5	$1.1			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$5.8	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.2	-			
Commercial Medicare Subtotal	-	-	-	-	$5.4	-	$.4	-	-	-	$10.8	$1.1			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$64.2			
Other	-	-	-	-	-	-	-	-	-	-	-	$11.5			
GRAND TOTAL	$29.3	$21.4	$1.0	$.7	$16.8	-	$.6	-	$1.1	-	$54.2	$86.6			

2014

In millions	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$19.3	$2.0	$.8	$.1	$8.7	-	-	-	$1.7	-	$.1	-			
Tufts Health Plan	-	-	-	-	$2.7	-	$.1	-	-	-	$2.5	$1.8			
Harvard Pilgrim Health Care	$10.3	-	$.1	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$2.2	-			
HPI	-	-	-	-	-	-	-	-	-	-	$5.3	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.0	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.1	-			
NHP	-	-	-	-	-	-	-	-	-	-	$1.5	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$7.0			
Total Commercial	$29.6	$2.0	$.9	$.1	$11.4	-	$.1	-	$1.7	-	$17.1	$8.8			
Network Health	-	-	-	-	-	-	-	-	-	-	$8.2	-			
NHP	-	-	-	-	-	-	-	-	-	-	$9.3	-			
BMC HealthNet	-	-	-	-	-	-	-	-	-	-	$15.7	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$2.5	$.6			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$35.8	$.6			

2014

In millions	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
MassHealth	-	$23.7	-	$1.8	-	-	-	-	-	-	-	-			
Tufts Medicare	-	-	-	-	$4.5	-	-$.1	-	-	-	$1.5	$.0			
Blue Cross Medicare	-	-	-	-	-	-	-	-	-	-	$1.5	$1.9			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$6.3	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$1.4	-			
Commercial Medicare Subtotal	-	-	-	-	$4.5	-	-$.1	-	-	-	$10.7	$1.9			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$67.3			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.2			
GRAND TOTAL	$29.6	$25.6	$.9	$1.9	$15.9	-	-$.1	-	$1.7	-	$63.6	$86.8			