The principal teaching hospital for Tufts University School of Medicine

Tufts Medical Center

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September 11, 2015

VIA ELECTRONIC MAIL

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109
HPC-Testimony@state.ma.us

RE: Request for Written Testimony

Dear Mr. Seltz:

Please find attached Tufts Medical Center response to the request for written testimony submitted by the Health Policy Commission and the Office of Attorney General.

I am legally authorized by the Tufts Medical Center Board to represent Tufts Medical Center in this matter. I am informed and believe, and upon such information and belief declare under penalty of perjury, that the statements made herein are true and correct

Sincerely,

Michael Wagner, MD
President and Chief Executive Officer

Encl. Exhibit B and C responses

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.

Tufts Medical Center (Tufts MC) has experienced a moderate revenue growth between FY 14 and YTD FY 15. We attribute our increases to a material increase in case mix intensity and increasing outpatient volume. Both changes have occurred while payer policies re-categorize traditionally high intensity inpatient care as outpatient, where procedures and services are often not reimbursed at a level commensurate with the high level of complexity and intensity of care and services provided.

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

The Tufts MC strategy in 2014 focused on developing partnerships with community providers, exporting care teams and expertise into the community and channeling tertiary and quatenary care to Tufts Medical Center and Floating Hospital for Children. Our strategy has resulted in more high level care being provided in lower cost settings. This strategy has proven to drive only the highest levels of care to the medical center and helped raise the level of care at community hospitals; we have seen evidence of this reported by the Center for Health Information and Analysis (CHIA) which in its most recent hospital financial profile reported that Tufts MC has the highest case mix index of all of the academic medical centers in the state and among the lowest relative price in its peer group.

In 2014 Tufts Medical Center, in affialition with Circle Health, created a new healthcare system: Wellforce. Wellforce united organizations who share a demonstrated high quality, lower-cost approach to health care services and an established set of population health management practices and programs. The aim of the new system was to :

- Create a unique balance of community and academic care, teaching and research.
- Promote effective relationships among community-based and academic physicians and community-based and academic hospitals
- Support collaboration in care coordination and effective implementation of population health management
- Help deploy care models closer to where our patients actually live

Results of this affiliation to date have shown a 32% grown in inpatient referrals from Circle Health to Tufts MC. The case mix index (CMI) for referred patients from LGH's primary service area who were treated at Tufts MC was 50% higher than those treated at LGH, validating our appropriate deployment of care to the right setting, with non-tertiary care generally rendered at LGH and tertiary/quaternary care provided at Tufts MC.

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?

Tufts Medical Center will continue to build upon our commitment to drive only complex care downtown and our distributed academic medical center model, to advancing patient care, innovating in teaching the next generation of physicians and conducting groundbreaking basic clinical and public policy research. We will continue our commitment to cost containment through a multi-layered approach of enhancing primary care through adult and pediatric primary care for our downtown Boston community and for the dispersed suburban communities we serve.

Through Wellforce we will continue to support care high quality, cost effective care delivery in the most appropriate setting. As noted in the Wellforce response, increased referrals to Wellforce providers result in significant financial savings to the Commonwealth based on Tufts MC and LGH's lower commercial prices compared to their Massachusetts' hospital cohort groups. According to CHIA's *Feb 2015 Relative Price (RP) Chartbook on Health Care Provider Price Variation in the Massachusetts Commercial Market*, both hospitals had close to the lowest commercial RPs of their respective cohort group of hospitals. Tufts MC had the 2nd lowest Composite RP Percentile of the six Massachusetts' Academic Medical Centers, while LGH had the 3rd lowest of the twenty Massachusetts' non-DSH Community Hospitals.

Tufts MC is a participant in the CMS MSSP ACO through New England Quality Care Alliance Accountable Care. Tufts MC embraces the drive to a value based healthcare marketplace and looks forward to more opportunities collaborate with providers and payers to bring greater value to the market.

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

Uniform application of the healthcare cost benchmark across all providers is not accurately portraying the trends in healthcare marketplace or the drivers of cost increases or decreases for any particular provider. In its current form the benchmark is being used as a tool to further entrench the current healthcare pricing disparities. Tufts MC urges the HPC to revise the cost benchmark and consider application of the benchmark at a more stringent level for those providers with relative prices significantly higher than the relative price of their peer group and application of a higher benchmark for providers with a significantly lower relative price.

Creating a more competitive healthcare marketplace is imperative to ensuring a healthy marketplace that will provide consumers with choices and access to high-quality, affordable healthcare providers. The current marketplace is not innovating to address the market dysfunction that has been reported for the past five years and it is in fact, less competitive than ever. The State should further examine the mechanics of the industry to correct for this lack of competition and cost efficiency; ears for

examination include: payer/provider reimbursement contracting among the highest cost providers, geographic rating bands for insurance premiums, establishment of global budgets, risk arrangements and retention of insurer reserves.

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

At Tufts Medical Center delivering high quality, safe patient care is our top priority. We have consistently ranked among the top in state and national quality and patient experience measurements. APMs have helped provide the data and funding to targeted quality programs that have resulted in marked quality achievements. APMs also provide the platform for better alignment of incentives and focused measurement and improvement around specific disease states and quality metrics. APMs that provide robust, timely and complete information about patients provide the best opportunities to truly coordinate care, whereas APMs that carve out specific areas of care, such as behavioral health and pharmacy, lack the funding and data to influence and improve upon some of the most critical areas of care.

The need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs and all other payment methodologies continues to be a concern for Tufts Medical Center. The areas where the most impact could be felt in regard to patient quality, care coordination and cost are in the PPO sector and in APMs where certain areas of care are removed from the overall APM, such as behavioral health and pharmacy care. The lack of information on the PPO population is a significant hindrance to providing more coordinated patient care across a broader population and to better understanding trends in quality, variations in care and cost. This data currently exists with the payers and we would strongly encourage the dissemination of this data to achieve greater resulsts in population health. These issues will also be critical to the adoption of APMs for the MassHealth population. Timely, accurate and complete data, along with sufficient payment to support the necessary infrasturcure, will be key components for successful implementation of APMs for the complex MassHealth population.

Another barrier to greater adoption of APMs is the basis of the payment; if payments continue to be based on historic budgets and costs, the inequities in healthcare resources across providers and across communities is exacerbated and makes engaging and suceeding in an APM very difficult.

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.

As a provider of tertiary and quaternary levels of care Tufts Medical Center consistently strives to ensure the patient receives the most appropriate care in the most appropriate setting. We have kept even more care in the local community by sending experts to work side by side with physicians and care teams in community hospitals to raise the level of care that can be provided in the local setting – allowing patients to receive high levels of care closer to home, allowing families to stay near their loved

ones when they need hospitalization. This model has proven to be beneficial for our patients, for our organization and for the community providers; our continuously high case mix demonstrates that we are caring for the sickest patients and providing highly complex care that can only be attained in a setting such as Tufts Medical Center and Floating Hospital for Children. The complexity and intensity of care received by our patients at the Medical Center often means they will require post-acute care. At Tufts Medical Center and Floating Hospital for Children we continuously strive to ensure the care needed by our patients is delivered in the most appropriate setting.

Tufts MC serves a very complex and diverse patient population, many of our patients do not have robust support networks available to them. To address this and a number of other issues that may lead to a re-admission, and to better serve the needs of our high-risk patients, we provide a number of services and interventions, which include:

- Pharmacy interventions at the time of discharge
- The use of care coordination for complex Medicare and managed care patients
- Discharge facilitators who arrange post-discharge appointments and education about access to their electronic health record
- Coordination of onsite primary care including participation in care coordination of rounds for high-risk patients
- Medication reconciliation at discharge
- Pharmacist teaching regarding high risk medications
- Expanded palliative care service
- Program for PCPs to make in-hospital care coordination visits
- Participation in a safe transitions program with community providers

Tufts MC's efforts to reduce the use of the Emergency Department are concentrated on ensuring access to primary and urgent care services; we have extended access to many of these services in our clinics into evening and weekend hours.

The primary care practices within Tufts MC, which serve nearly 34,000 patients, have all been recognized with the highest level Patient-Centered Medical Homes (PCMH) status from the National Committee for Quality Assurance (NCQA). This distinction helps focus our efforts to serve some of the most complex patients with a number of tools from close monitoring and analysis of their overall care to providing dedicated care coordinators and social workers, prescription management and ensuring access and follow-up to specialty care services.

While Tufts MC has a strong commitment to reducing re-admissions and reducing post-acute care costs, significant barriers exist to achieving better results. Chief among those barriers is a deficiency in coordination with post-acute care providers, this is driven by the lack of infrastructure and standardized communication and reporting channels between acute and post-acute providers, which makes coordination extremely challenging. Post-acute care is highly fragmented, incentives among acute and post-acute providers are not aligned and acute providers have neither control over post-acute care decisions nor access to the data about costs of post- acute care. As an acute care provider we have little access to data about care or costs that go beyond our own services, making it difficult to

target improvement opportunities or high-quality providers. Mechanisms for improved coordination and access to data about post –acute care would be very helpful.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
Please see response to 3a. above.

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?

Variations in price should be examined by provider peer group and should only vary due to differences in case mix acuity, health status, quality, socioeconomic status, and academic and research costs.

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.

The state is seeing the impact of the extreme disparity in healthcare pricing as the Commonwealth soars past the cost benchmark, a practice that will undoubtedly continue if national projections for utilization and pharmaceutical growth hold true. The current price disparities and concentration of volume at the highest cost providers means healthcare costs will continue to cannibalize other critical priorities, such as education, transportation and housing.

Price variations have impacted our ability to expand our distributed academic model and provide greater specialty services to community providers. Higher cost providers are better able to cover the cost of exporting their specialists to community settings because of the higher payment rate they receive. The underlying result of this is often overlooked, which is that as a result of the relationship with the higher cost specialty provider, more care is directed to the higher cost setting, thereby adding to the increase in overall healthcare costs.

Price variation impacts lower cost providers in a plethora of ways – BUT DOES NOT impact delivery of high quality care. Tufts Medical Center and Floating Hospital for Children have consistently been lower cost providers and the data proves that we deliver some of the most complex care and achieve some of the highest quality and patient experience scores, both locally and nationally.

However, the price variations in this marketplace impact providers in everything from their ability to recruit and retain physicians and clinical staff, adopt alternative payment methodologies that include taking on more risk or require building infrastructure to support more coordinated and integrated care, to making capital improvements to their facilities or modernizing to meet the demands of patients in a new era of consumerism.

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.

Tufts Medical Center has a strong commitment to behavioral health, to the integration of psychiatric and general healthcare needs and to treating a broad spectrum of patients with behavioral health needs in hospital and community settings. We have a 20 bed secure inpatient unit for adult patients, many of whom have complex medical and psychiatric illness including substance use. On a percentage basis we provide more psychiatric beds as part of our total bed complement than any other full service major academic medical center in Boston.

We have integrated care with our Department of Psychiatry and our Primary Care practice for our outpatients, including all specialties that refer their patients the Department of Psychiatry. The Department of Psychiatry has been providing specialized consultation to our entire physician network at Tufts and through the New England Quality Care Alliance. These include regular consultations with physicians who are members of the Primary Care practice and New England Quality Care Alliance, working with their care managers to review options for care for the most complex patients and to provide education and clinical guidelines to our primary care colleagues. These efforts also include our almost 10 years of work as a key eastern Massachusetts hub for the Massachusetts Child Psychiatry Access Project, which enables a child's pediatrician to obtain immediate telephonic consultation about a patient in their office with a child psychiatrist and to access information and resources regarding options for ongoing psychiatric care and treatment. We have been also providing increased specialized consultations to our NEQCA pediatric colleagues and are currently building a model for increased office based support for them.

Tufts Medical Center's Department of Psychiatry has highly trained psychiatric physicians, many with specialized training in internal medicine, consult-liaison psychiatry and pediatrics working on our medical, surgical and pediatric inpatient services and clinics. They are deeply experienced in treating highly complicated, comorbid, high-risk patients. These physicians care for patients with complex medical and psychiatric illness on these inpatient services and in our emergency room. These consultations and direct care also occur in our specialized ambulatory settings. Emergency consultation is available in the hospital around the clock and 7 days a week by the psychiatric service.

The biggest barrier to the integration of services is the lack of payment mechanisms that adequately pay for psychiatric services, particularly in general hospitals. Of the almost 400-500 new psychiatric beds which are reported to be coming on line in the commonwealth over the next two years, very few

of these will be in general hospitals where the patients with the greatest medical co-morbidities or the highest total cost are found. The reasons for this are clearly related as outlined in the Attorney General's outstanding report on behavioral health. Additional challenges are related to the lack of payment for telephonic consultation and case management, and the carve out funding models which have disincentives for the integration of care.

In order to truly integrate care we must align the information and incentives across the system, which is particularly misaligned within the current behavioral health and payer construct. The state could assist behavioral health integration in several areas: creating standards for data collection and sharing, transparent metrics around quality, utilization and costs. Making sure all payers look at total medical costs associated patients with co-morbid medical and psychiatric illness is essential.

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.
Please see response to 5a. above.

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?
The primary care practices within Tufts MC, which serve nearly 34,000 patients, have all been recognized with the highest level Patient-Centered Medical Homes (PCMH) status from the National Committee for Quality Assurance (NCQA). Through NEQCA Accountable Care, Tufts MC is a participant in the MSSP 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	21	n/a	20	See list below
	Q2	15	n/a	14	
	Q3	15	n/a	15	
	Q4	6	n/a	6	
CY2015	Q1	4	n/a	4	
	Q2	9	n/a	9	

The following services are those for which a price is most often requested: Cardiology services, Cosmetic Surgery, Dermatology, ENT services, Gastrointestinal services, Neurology, Primary Care, Obstetrics and Gynecology, Oncology, Orthopedics.

The complex nature of the tertiary and quaternary care provided at Tufts Medical Center often means a physician and care team may make care decisions on the spot or may alter a care plan based on the complexities presented upon surgery or as a patient's condition changes, which cannot be included in estimates. Providing an accurate cost assessment requires compiling and cross referencing several different data points, which are not currently synthesized within our organization. We do not have an ability to track how a patient uses the information we provide them; we also remain concerned with the release of charge and pricing information if it is not accompanied with the appropriate quality information to allow a consumer to make a fully informed decision.

Pricing transparency for consumers is an important component to informing patients about healthcare costs and for engaging consumers in the state's cost containment endeavors. However, the current information available to consumers is far from helpful or truly informative. The current consumer price transparency tools do not provide consumers with the most helpful information to easily compare across a number of providers the cost differential, quality or patient payment responsibility.

Consumers should be provided with information to easily compare costs across a range of services and providers, which Payers can provide to their members.

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 Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

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 do not subject you to any "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 Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements 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.

Tufts Medical Center

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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		
BCBSMA	45,177,828	59,080,326	2,382,286	3,115,383												109,755,823	
Tufts					38,285,050		(105,000)				-					38,180,050	do not distinguish HMO v. PPO, reported all as HMO
HPHC	35,895,959		180,382													36,076,341	do not distinguish HMO v. PPO, reported all as HMO
Fallon												2,695,712				2,695,712	no delineation by product, reprt as PPO
CIGNA												5,227,296				5,227,296	no delineation by product, reprt as PPO
United												9,017,879				9,017,879	no delineation by product, reprt as PPO
Aetna												7,236,219				7,236,219	no delineation by product, reprt as PPO
Other Commercial												22,616,133				22,616,133	no delineation by product, reprt as PPO
Total Commercial	81,073,787	59,080,326	2,562,668	3,115,383	38,285,050	-	(105,000)	-	-	-	-	46,793,239	-	-	-	230,805,453	no delineation by product, reprt as PPO
																-	
Network Health											12,741,326					12,741,326	do not distinguish HMO v. PPO, reported all as HMO
NHP											29,075,375					29,075,375	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											6,666,457					6,666,457	do not distinguish HMO v. PPO, reported all as HMO
Fallon											650,399					650,399	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											49,133,557					49,133,557	do not distinguish HMO v. PPO, reported all as HMO
																-	
Mass Health		47,349,665		1,750,824											526,849	49,627,338	classified all as PPO
																-	
Tufts Medicare Preferred					16,971,787		(413,400)									16,558,387	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											2,959,026					2,959,026	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											9,800,369					9,800,369	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					16,971,787						12,759,395					29,731,182	do not distinguish HMO v. PPO, reported all as HMO
																-	
Medicare												151,092,783				151,092,783	classified all as PPO
																-	
All Other Payors												26,061,894				26,061,894	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	81,073,787	106,429,991	2,562,668	4,866,207	55,256,837	-	(105,000)	-	-	-	61,892,952	223,947,916	-	-	526,849	536,452,207	

Tufts Medical Center

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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		
BCBSMA	43,233,460	62,928,587	2,219,466	3,230,551												111,612,064	
Tufts					40,246,659		(250,000)				-					39,996,659	do not distinguish HMO v. PPO, reported all as HMO
HPHC	40,293,154		243,218													40,536,372	do not distinguish HMO v. PPO, reported all as HMO
Fallon												2,378,254				2,378,254	no delineation by product, reprt as PPO
CIGNA												4,805,869				4,805,869	no delineation by product, reprt as PPO
United												12,051,403				12,051,403	no delineation by product, reprt as PPO
Aetna												7,902,093				7,902,093	no delineation by product, reprt as PPO
Other Commercial												23,232,200				23,232,200	no delineation by product, reprt as PPO
Total Commercial	83,526,614	62,928,587	2,462,685	3,230,551	40,246,659	-	(250,000)	-	-	-	-	50,369,819	-	-	-	242,514,914	no delineation by product, reprt as PPO
																-	
Network Health											11,109,059					11,109,059	do not distinguish HMO v. PPO, reported all as HMO
NHP											14,194,715					14,194,715	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											7,196,100					7,196,100	do not distinguish HMO v. PPO, reported all as HMO
Fallon											179,908					179,908	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											32,679,782					32,679,782	do not distinguish HMO v. PPO, reported all as HMO
																-	
Mass Health		53,980,955		3,510,173												57,491,128	classified all as PPO
																-	
Tufts Medicare Preferred					16,517,115		(130,800)									16,386,315	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											3,696,645					3,696,645	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											11,297,093					11,297,093	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					16,517,115						14,993,738					31,510,853	do not distinguish HMO v. PPO, reported all as HMO
																-	
Medicare												166,333,188				166,333,188	classified all as PPO
																-	
All Other Payors												20,753,361				20,753,361	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	83,526,614	116,909,542	2,462,685	6,740,724	56,763,774	-	(250,000)	-	-	-	47,673,520	237,456,368	-	-	-	551,283,226	

Tufts Medical Center

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			Grand Total	Notes:
	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	39,487,233	59,589,394	1,859,789	2,806,570												103,742,986	
Tufts Health Plan					47,011,237		-250,000									46,761,237	do not distinguish HMO v. PPO, reported all as HMO
Harvard Pilgrim Health Care	41,582,848		335,346													41,918,194	do not distinguish HMO v. PPO, reported all as HMO
Fallon Community Health Plan												3,039,417				3,039,417	no delineation by product, reprt as PPO
CIGNA												4,859,619				4,859,619	no delineation by product, reprt as PPO
United Healthcare												10,776,601				10,776,601	no delineation by product, reprt as PPO
Aetna												8,307,004				8,307,004	no delineation by product, reprt as PPO
Other Commercial												23,675,005				23,675,005	no delineation by product, reprt as PPO
Total Commercial	81,070,081	59,589,394	2,195,135	2,806,570	47,011,237	0	-250,000	0	0	0	0	50,657,646	0	0	0	243,080,063	
Network Health											10,668,767					10,668,767	do not distinguish HMO v. PPO, reported all as HMO
Neighborhood Health Plan											16,630,435					16,630,435	do not distinguish HMO v. PPO, reported all as HMO
BMC HealthNet, Inc.											6,243,495					6,243,495	do not distinguish HMO v. PPO, reported all as HMO
Health New England																	
Fallon Community Health Plan											136,215					136,215	do not distinguish HMO v. PPO, reported all as HMO
Other Managed Medicaid																	
Total Managed Medicaid	0	0	0	0	0	0	0	0	0	0	33,678,912	0	0	0	0	33,678,912	do not distinguish HMO v. PPO, reported all as HMO
MassHealth		52,143,015		1,917,031												54,060,046	classified all as PPO
Tufts Medicare Preferred					19,308,848		-509,030									18,799,818	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											4,361,578					4,361,578	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											14,083,270					14,083,270	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal	0	0	0	0	19,308,848	0	-509,030	0	0	0	18,444,848	0	0	0	0	37,244,666	
Medicare												169,831,609				169,831,609	classified all as PPO
Other												22,096,836				22,096,836	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	81,070,081	111,732,409	2,195,135	4,723,601	66,320,085	0	-759,030	0	0	0	52,123,760	242,586,091	0	0	0	559,992,132	

Tufts Medical Center

2014

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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		
BCBSMA	32,835,876	67,288,286	1,131,100	2,317,885												103,573,147	
Tufts					47,738,550		-				-					47,738,550	do not distinguish HMO v. PPO, reported all as HMO
HPHC	38,902,561		333,507													39,236,068	do not distinguish HMO v. PPO, reported all as HMO
Fallon												3,505,914				3,505,914	no delineation by product, reprt as PPO
CIGNA												4,364,424				4,364,424	no delineation by product, reprt as PPO
United												11,352,529				11,352,529	no delineation by product, reprt as PPO
Aetna												9,395,021				9,395,021	no delineation by product, reprt as PPO
Other Commercial												28,404,280				28,404,280	no delineation by product, reprt as PPO
Total Commercial	71,738,437	67,288,286	1,464,607	2,317,885	47,738,550	-	-	-	-	-	-	57,022,168	-	-	-	247,569,933	no delineation by product, reprt as PPO
Network Health											16,341,638					16,341,638	do not distinguish HMO v. PPO, reported all as HMO
NHP											19,992,924					19,992,924	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											8,585,348					8,585,348	do not distinguish HMO v. PPO, reported all as HMO
Fallon											528,072					528,072	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											45,447,982					45,447,982	do not distinguish HMO v. PPO, reported all as HMO
Mass Health		49,399,900		1,191,000										3,000,000		53,590,900	classified all as PPO
Tufts Medicare Preferred					14,117,629		30,859									14,148,488	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											5,592,697					5,592,697	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											15,969,807					15,969,807	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					14,117,629						21,562,504					35,680,133	do not distinguish HMO v. PPO, reported all as HMO
Medicare												168,491,378				168,491,378	classified all as PPO
All Other Payors												27,291,504				27,291,504	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	71,738,437	116,688,186	1,464,607	3,508,885	61,856,179	-	-	-	-	-	67,010,486	252,805,050	-	3,000,000	-	578,071,830	