## 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.

      Revenue, from FY13 to FY14 has increased by 1.26% and for the first 10 months of FY 15 compared to the same time period in FY14 revenues have increased by 6.41%.

      From FY13 to FY14, our patient days and discharges declined by (7.2%) and (6.6%) respectively. Patient days and discharges through July of 2015 when compared to the ten months ended July 2014 have rebounded and surpassed prior year by 2.8% and 4.8% respectively, but have yet to reach levels seen in 2013. However, a point worth noting is that the acuity of the patients being seen at the organization has increased by 9.29% since 2013. This increase is considered one of the key factors driving the increase in revenue when compared solely to volume.

      FY14 expenses exceeded FY13 by 2.58%. Expenses for F15 through July when compared to the same time period in FY14 have increased by 3.78%. Although this increase exceeds the state target of 3.6%, it is primarily due to the increased volume and acuity that the organization has experienced.

   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?

      Since Ch 224 was enacted, we have attempted to manage to the State's healthcare cost trend benchmark, which is an aggressive target given our payor mix and labor costs. All payor contract renewals and negotiated increases have been at or below the Commonwealth's benchmark of 3.6%. To support our expense reduction efforts we are currently seeking to combine our Pediatric and Maternity units which would improve operational efficiencies, generate cost reductions, and maintain the ability to provide high quality care to those respective patient populations. We are awaiting DPH approval of our plans at this time. We have also opened a Hospital Licensed Urgent Care clinic in the region to provide patients with a lower cost alternative than the traditional emergency department. HealthAlliance continuously evaluates ways to provide the highest quality care in the lowest cost setting.

      Other programs that have gotten underway during the course of 2015 include an expanded Family Medicine Residency Clinic in Fitchburg. This clinic was opened in July of 2014 to provide additional primary care capacity to the residents of the North Central MA. In addition to being a teaching site for primary care physicians, the site offers patients the ability to obtain care in lower cost settings.

We are also a participant in the State's newly formed CHART program. Our CHART award is being used to help create a care coordination platform for those patients with mental health and substance abuse issues in the North Central MA region. The goal of the program is to help improve the coordination of care for those patients who have been medically cleared, but are still in need of services. Our goal is to reduce emergency room visits by 15% and reduce the length of stay by 31% within 24 months. Our program is being designed in collaboration with other providers of mental/behavioral health/substance abuse services in the region (Community Health Connections, and Community Health Link), to ensure that these patients are being placed appropriately, and have access to the care that they truly need.

Additionally we are currently exploring entering into the Medicare Bundled Payment Initiative for specific service lines to help reduce overall medical expenses.

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?

Our CHART program is still in the development/implementation stage and is slated to begin operations in early November 2015.

The Fitchburg Family Practice Residency Clinic has been open since July of 2014, and we are actively growing that practice to help reduce the number of non-emergent patients that present at our emergency room.

The Leominster Urgent Care has far exceeded initial volume assumptions, seeing 48 patients per day on average. As a result of the Urgent Care's success, and the positive feedback we have received from patients, we are currently exploring opening a second urgent care center to help meet the demand of the patients in the region. Lower cost alternatives will aid in reducing the total medical expenses incurred by the patients in the North Central MA region.

Finally, we are also working diligently with our parent Umass Memorial HealthCare, Inc. to help expand the system-wide population health initiatives. Expanded population health programs will help us better manage all of the above actions.

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

Changes such as the following would help our organization on both the efficiency and quality fronts:

- Encourage provider participation in alternative payment programs without mandating the provider take risk

- Programmatic reimbursement for care coordination and care management resources
- Adequate and flexible behavioral health access and reimbursement
- Access to clinical data from external organizations (HIE)
- Provider engagement in benefit and program design for new/evolving programs
- Administrative simplification – eliminate duplication in credentialing by providers and health plans
- Claims data standardization among all programs, reduction of duplicative administrative efforts (HPC RPO and EOHHS RFI for Provider System Configurations)
- Review of regulations/policies for reasonableness (HPC Material Change Notice).
- Reduce unfunded state mandates and documentation requirements
- Improved alternatives to substance abuse treatment
- Encourage patients to be engaged in their care (i.e. active wellness efforts)

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

    - Infrastructure investment required to manage alternative payment arrangements is significant and the payments available for this investment do not cover these costs
    - Access to real-time data from the payors has always been a challenge and often does not allow us to do required analyses. Some programs mandate assumption of risk too soon - sometimes before data is available to analyze initial results. The requirement of a more thoughtful transition to risk to adopt alternative payment mechanisms.
    - Significant variability exists in the many different programs and models among the payors. This increases the level of complexity (and therefore cost) involved in implementing and analyzing these new programs and payment models.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

        1. Spending on post-acute care:
            a. The Hospital has held meetings with many of the local skilled nursing facilities in the region to express to them our concern regarding treatment for our patients. During those meeting we have reiterated our position that we need to try and better coordinate the patients care during any transition, to help eliminate and redundant services and curb unnecessary expenditures.
            b. Our Home Health agency has successfully rolled out and utilized fifty (50) telehealth monitors to patients on service. This has aided in our

ability to help manage patients in the home rather than sending those patients to post-acute settings.

2. Reducing avoidable 30 day readmissions:
    a. Reducing 30 day readmissions has been a focus of the organization during FY15. The readmission metric is monitored regularly. We have created a task force specifically to address patient flow which also looks at readmissions and steps that can be taken to help reduce the overall number that occur.
    b. The Hospital has acquired and installed electronic bed boards on all of the inpatient units to help identify those patients who are readmissions, as well as identify those patients who may result in a readmission given specific criteria. This information is used when assessing the patient for discharge to help prevent unavoidable readmissions.
    c. The telehealth program referenced in 1b. above has also helped prevent readmissions for our home health patients by allowing us to intercede with a patient before a readmission is necessary.
3. Reducing avoidable ED visits:
    a. Opening the Leominster Urgent Care clinic has helped provide patients with an alternative lower cost setting to receive care.
    b. Expanding primary care coverage at the Fitchburg Family Practice residency program has helped provide patients with an alternative lower cost setting to receive care.
    c. Our CHART program is helping reduce the “frequent fliers” in our organization by helping coordinate the services that these patients need, which in many cases isn’t a visit to our ED.
    d. Our Home Health agency’s telehealth system has helped us interact with patients prior to the patient going to our ED unnecessarily
4. Providing focused care for high risk / high cost patients:
    a. Our CHART program as referenced in 3c.above.

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

1. Spending on post-acute care:
    a. We are starting a Hospital based palliative care program to help patients understand what palliative care is about, and make a thoughtful informed determination of “next steps” in their care plan, which in some cases may be to acquire hospice services rather than post-acute services.
2. Reducing avoidable 30 day readmissions:
    a. We are starting a diabetes education program that will target diabetic patients prior to discharge to help provide guidance with regards to medication adherence, and potential lifestyle changes that should be made to better manage their disease.
3. Reducing avoidable ED visits:

a. We are exploring opening a second urgent care site, to provide additional alternatives to patients in the region to get care that may not be considered emergent.
b. We are expanding of our CHART program. In 2015, our CHART program will be open extended hours and will be able to better service the mental / behavioral health and substance abuse patients in the region.
c. We are continuing to utilize of our telehealth service to help intercede with patients and hopefully prevent ED visits where appropriate.

4. Providing focused care for high risk / high cost patients:
    a. We are continuing to reach out to local skilled nursing facilities through forums and meetings to better coordinate care with patients.
    b. See 3b. 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?

    All providers are not equal and consideration needs to be given to the complexity of the patient populations they serve, their payor mix, and the breadth and depth of services which may not be directly reimbursed under the current payment methodologies.

    <u>Acceptable Reasons for price variation</u>:

    - Rate structure which over time blended rates for IP, undervalued OBs
    - Many FFS reimbursement methodologies do not recognize all services rendered, specifically some that may be leading contributors to cost reduction activities. (i.e. telemedicine).
    - Underfunded behavioral health, substance abuse and ancillary rates
    - Disproportionate Share Status
    - Collective bargaining environments
    - Geographical wage rate variances
    - Overall levels of available services, such as 24/7 MRI/CT (weekend & evening hours) v. freestanding, level of care differences such as conscious sedation/ 1v1 supervision of pediatric patients

    <u>Unacceptable Reasons for price variation:</u>

    - Traditional cot structures that exceed norms rolled forward

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.

While fundamentally different, all alternative payment models being discussed have one thing in common, they all rely on the current FFS payment structure to provide a baseline. We are therefore building on assumptions that FFS reflects appropriate fair and logical payments. Pricing an episode of care assumes savings from FFS equivalent rates. Budgeted capitation assumes a budget based on historical utilization and cost, with assumptions around future trends, and relies on discount pricing to achieve savings.

We need to change the payment methodology to align incentives for both the facility and professional. We also need to change the care delivery model and ensure that payment systems are updated to support this change in the delivery of care.

In the current environment, it appears that all providers are not "playing" by the same rules with regards to reimbursement; however, all patients are expected to receive the same level of care. It is extremely costly to successfully manage an organization that is trying to adhere to standards under multiple sets of rules.

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.

      Please see responses in question 1B and 1C for information pertaining to our CHART program.

   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 responses in question 1B and 1C for information pertaining to our CHART program.

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?

As a member of UMMHC, HealthAlliance will be actively participating in the System's Office of Clinical Integration (OCI). The OCI will serve as the main decision making body as it relates to the oversight of care delivery reform. It is our belief that such reforms will be most successfully implemented using a population health management approach, rather than a siloed programmatic approach.

Population health services that are managed and delivered by OCI:

- Performance improvement. Functions include:
  - Practice improvement facilitation provided by an in-house staff of practice coaches who assist practices in quality improvement and achievement of the goals for PCMH, AQC, PCPR, ACO and other payer programs
  - Outreach coordination to engage patients in their own wellness and prevention services
  - Coding feedback to educate providers about risk stratification opportunities on their patient panels
- Care Delivery Innovation. Functions include:
  - Development, testing and implementation of centralized and practice-based care management models
  - Coordination between primary care and psychiatry for the implementation of integrated behavioral health models
  - Identification of EMR functionality required for successful success tracking and monitoring of timely care management functions
- Reporting and Analytics. Functions include:
  - Practice and provider specific performance reporting on quality measures
  - Development and testing of population health dashboards
  - Development of actionable claims reporting to assist providers with targeted interventions
- IT Strategy and Operations. Functions include:
  - Assessment of reporting and analytics hardware and software needs to support timely and integrated analysis and reporting
  - Identification of data capture and reporting needs for external affiliates participating in managed care network and ACO activities

- Program Operations.  Functions include:
  - Project and program management to ensure alignment with system level and program level requirements
- Finance, Compliance and Regulatory.  Functions include:
  - Financial analysis of shared savings and risk based contracts
  - Identification of grant opportunities to assist with care delivery transformation and infrastructure development
  - Identification and monitoring of key compliance and regulatory issues
- Clinical Guidelines and Standards.  Functions include:
  - Physician led identification and development of evidence-based internal clinical standards for prevalent conditions
  - Regular communication with physicians and practice teams regarded recommended care delivery standards

## 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 | 4 | 0 | 4 | Strep Test, Ultrasound, Removal of tonsils |
| | Q2 | 7 | 0 | 7 | X-ray, mammography, Ultrasound, Rhinoplasty UPPP Surgical Procedure, |
| | Q3 | 5 | 0 | 5 | CT Scan, Ultrasound, Semen Analysis, X-ray, Lab work |
| | Q4 | 4 | 0 | 4 | PFT, Broncoscopy, Ultrasound, X-ray |
| CY2015 | Q1 | 1 | 0 | 1 | Ultrasound Thyroid |
| | Q2 | 4 | 0 | 4 | Vasectomy, Evaluation of Wheezing, Pulmonary Function Test |

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 **<u>AGO Hospital Exhibit 1</u>** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

**Please see Attached form.**

## 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.

**HealthAlliance Hospitals**
**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 | 11.76 | 7.67 | | | | | | | | | | | | | |
| Tufts Health Plan | 3.27 | 2.30 | | | | | | | | | | | | | |
| Harvard Pilgrim Health Care | 4.84 | 2.36 | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 6.15 | | | | |
| CIGNA | | | | | | | | | | | 1.96 | 0.14 | | | |
| United Healthcare | | | | | | | | | | | 2.36 | | | | |
| Aetna | | | | | | | | | | | 1.87 | | | | |
| Other Commercial | | | | | | | | | | | 10.32 | 0.05 | | | |
| ***Total Commercial*** | 19.87 | 12.34 | - | - | - | - | - | - | - | - | 22.65 | 0.19 | - | - | - |
| Network Health | | | | | | | | | | | 9.83 | | | | |
| Neighborhood Health Plan | | | | | | | | | | | 1.51 | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | 1.00 | | | | |
| Health New England | | | | | | | | | | | - | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 1.20 | | | | |
| Other Managed Medicaid | | | | | | | | | | | 0.15 | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | 13.70 | | | | |
| ***MassHealth*** | | 5.061016 | | 0.3 | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | 12.10 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | 0.78 | | | | |
| Other Comm Medicare | | | | | | | | | | | 9.37 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | 22.25 | | | | |
| ***Medicare*** | | | | | | | | | | | | 32.08518 | | | |
| ***Other*** | | | | | | | | | | | 1.43 | 3.4786 | | | |
| **GRAND TOTAL** | 19.87 | 17.40 | - | 0.30 | - | - | - | - | - | - | 60.03 | 35.75 | - | - | - |

**HealthAlliance Hospitals**
**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 | 10.67 | 7.22 | | | | | | | | | | | | | |
| Tufts Health Plan | 4.22 | 2.41 | | | | | | | | | | | | | |
| Harvard Pilgrim Health Care | 4.78 | 2.29 | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 4.50 | | | | |
| CIGNA | | | | | | | | | | | 0.94 | 0.04 | | | |
| United Healthcare | | | | | | | | | | | 2.21 | | | | |
| Aetna | | | | | | | | | | | 1.99 | | | | |
| Other Commercial | | | | | | | | | | | 9.47 | 0.06 | | | |
| ***Total Commercial*** | 19.68 | 11.93 | - | - | - | - | - | - | - | - | 19.10 | 0.10 | | | |
| Network Health | | | | | | | | | | | 11.00 | | | | |
| Neighborhood Health Plan | | | | | | | | | | | 1.55 | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | 0.71 | | | | |
| Health New England | | | | | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 1.52 | | | | |
| Other Managed Medicaid | | | | | | | | | | | 0.00 | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | 14.78 | | | | |
| ***MassHealth*** | | 7.22 | | 0.22 | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | 12.17 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | 0.96 | | | | |
| Other Comm Medicare | | | | | | | | | | | 9.22 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | 22.34 | | | | |
| ***Medicare*** | | | | | | | | | | | | 35.36 | | | |
| ***Other*** | | | | | | | | | | | 1.61 | 4.78 | | | |
| **GRAND TOTAL** | 19.68 | 19.15 | - | 0.22 | - | - | - | - | - | - | 57.84 | 40.24 | - | - | - |

**HealthAlliance Hospitals**
**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 | 7.10 | 7.06 | | | 2.90 | | (0.15) | | | | | | | | |
| Tufts Health Plan | 4.69 | 1.90 | | | | | | | | | | | | | |
| Harvard Pilgrim Health Care | 3.99 | 2.20 | 0.01 | 0.00 | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 4.51 | | | | |
| CIGNA | | | | | | | | | | | 0.80 | 0.05 | | | |
| United Healthcare | | | | | | | | | | | 2.11 | | | | |
| Aetna | | | | | | | | | | | 1.99 | | | | |
| Other Commercial | | | | | | | | | | | 3.40 | 6.21 | | | |
| ***Total Commercial*** | 15.78 | 11.16 | 0.01 | 0.00 | 2.90 | - | (0.15) | - | - | - | 12.81 | 6.27 | - | 0 | 0 |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | 12.73 | | | | |
| Neighborhood Health Plan | | | | | | | | | | | 1.66 | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | 0.68 | | | | |
| Health New England | | | | | | | | | | | - | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 1.90 | | | | |
| Other Managed Medicaid | | | | | | | | | | | 0.16 | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | 17.14 | | | | |
| | | | | | | | | | | | | | | | |
| ***MassHealth*** | | 6.82 | | 0.24 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | 11.57 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | 1.16 | | | | |
| Other Comm Medicare | | | | | | | | | | | 8.08 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | 20.81 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | 35.91 | | | |
| | | | | | | | | | | | | | | | |
| ***Other*** | | | | | | | | | | | 1.48 | 4.51 | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | 15.78 | 17.99 | 0.01 | 0.24 | 2.90 | - | (0.15) | - | - | - | 52.24 | 46.68 | - | - | - |

**HealthAlliance Hospitals**
**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 | 2.04 | 7.65 | | | 7.30 | | (0.80) | | | | | | | | |
| Tufts Health Plan | 3.03 | 1.67 | | | | | | | | | | | | | |
| Harvard Pilgrim Health Care | 3.68 | 2.24 | 0.01 | 0.00 | | | | | | | | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 4.26 | | | | |
| CIGNA | | | | | | | | | | | 0.77 | 0.03 | | | |
| United Healthcare | | | | | | | | | | | 2.35 | | | | |
| Aetna | | | | | | | | | | | 2.00 | | | | |
| Other Commercial | | | | | | | | | | | 4.25 | 5.89 | | | |
| ***Total Commercial*** | 8.75 | 11.56 | 0.01 | 0.00 | 7.30 | - | (0.80) | - | - | - | 13.62 | 5.92 | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | |
| Network Health | | | | | | | | | | | 13.85 | | | | |
| Neighborhood Health Plan | | | | | | | | | | | 2.44 | | | | |
| BMC HealthNet, Inc. | | | | | | | | | | | 1.63 | | | | |
| Health New England | | | | | | | | | | | 0.02 | | | | |
| Fallon Community Health Plan | | | | | | | | | | | 2.11 | | | | |
| Other Managed Medicaid | | | | | | | | | | | - | | | | |
| ***Total Managed Medicaid*** | | | | | | | | | | | 20.05 | | | | |
| | | | | | | | | | | | | | | | |
| ***MassHealth*** | | 6.11 | | 0.24 | | | | | | | | | | 0.62 | |
| | | | | | | | | | | | | | | | |
| Tufts Medicare Preferred | | | | | | | | | | | 13.28 | | | | |
| Blue Cross Senior Options | | | | | | | | | | | 1.62 | | | | |
| Other Comm Medicare | | | | | | | | | | | 6.70 | | | | |
| ***Commercial Medicare Subtotal*** | | | | | | | | | | | 21.60 | | | | |
| | | | | | | | | | | | | | | | |
| ***Medicare*** | | | | | | | | | | | | 34.87 | | | |
| | | | | | | | | | | | | | | | |
| ***Other*** | | | | | | | | | | | 1.51 | 4.72 | | | |
| | | | | | | | | | | | | | | | |
| **GRAND TOTAL** | 8.75 | 17.67 | 0.01 | 0.24 | 7.30 | - | (0.80) | - | - | - | 56.77 | 45.51 | - | 0.62 | - |