MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided 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, 2014, 2015, 2016, and/or 2017 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

HPC Contact Information

For any inquiries regarding HPC questions, please contact HPC-Testimony@mass.gov or (617) 979-1400.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@mass.gov or (617) 963-2030.

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.
For Lawrence General Hospital the top areas of concern to meet the 3.1% benchmark are as follows:

1. If community appropriate care delivered at higher cost academic medical centers continues to increase on its current trend;
2. If the 3.1% benchmark continues to be used by health plans in Massachusetts as a reason to limit rate increases, thereby perpetuating the low commercial rates paid to providers like Lawrence General;
3. If large systems with relatively high commercial payer mix grow and continue to exclude community hospitals that provide care to large numbers of MassHealth patients

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
The Lawrence General Hospital identifies the following as potential changes in policy, market behavior, payment, regulation and/or statute:

1. Adoption of a floor of 90% of the statewide relative price (S-RP) for commercial payment rates;
2. Legislation requiring health plans to demonstrate that they are advancing and subsequently maintaining rate equity so that premium dollars are supporting providers which provide care and access to people in all communities, particular those with lower health status;
3. Legislation requiring health plans to offer products which reward efficient, high value, providers and systems through lower patient cost sharing for patients choosing high value providers;
4. Increased focus by HPC on the impact of commercial health plan price inequities and how it will continue to shape health system development, and negatively impact access to affordable health care services for low income populations.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

The Lawrence General's top strategic priority has been and remains the identification and implementation of vital health care services and programs to meet the needs of the population within our service area. In particular, the organization is focused upon those services that are currently offered and accessed at more costly providers outside of the LGH service area but which can be provided safely and more efficiently at LGH.

 Our top three strategic priorities to reduce health care expenditures are:

1. Achieving higher rates of payment from the commercial health plans in Massachusetts. This will ensure access to affordable care in the local region and also prevent community appropriate care from leaking to higher cost providers because we are not able to sustain certain services locally.
2. Enhancing the integration of care with providers across the continuum of care locally for all community appropriate services, and ensuring adequate local access to specialists.
3. Expanding services locally to serve the needs of the community while eliminating expenses to operate a highly efficient organization.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond normal weekday business hours. Information requested in question (a) below may be provided in the form of a link to an online directory or as an appended directory.*

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.

Lawrence General Hospital does not own, operate or otherwise maintain alternative care sites as described above as of this filing. While LGH has supported the expansion of after – hours access at local primary care locations, these sites are not hospital owned. Lawrence General Hospital would be interested in establishing alternative care sites in the future but is currently focused on using its resources to expand primary care services and access.

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through a joint venture with another organization (information from non-owned affiliates should not be included):

Number of unique patient visits	N/A

Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	N/A
Percentage of patient visits where the patient is referred to a more intensive setting of care	N/A

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.
N/A

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?
NA

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).

Lawrence General Hospital, as part of the Medicaid ACO, has been working in partnership with local physician practices and Neighborhood Health Plan to understand the cost and patterns of ED utilization so that we can identify interventions to help reduce unnecessary utilization and improve access for patients to the most appropriate site of care. This group, the ED Utilization Task Force, has examined historical data and is implementing a multi-targeted approach to decrease unnecessary ED utilization. Lawrence General Hospital in partnership with Greater Lawrence Family Health Center will be hiring a patient navigator to meet with patients in the Emergency Center, who have been identified as having a condition that would have been appropriately treated by their PCP. The patient navigator will educate patients about common conditions that can be cared for by the Primary Care Provider, provide access to appointments and walk in hours, and extended hours at each clinic. Additionally, all patients who have been identified as having unnecessary ED Utilization through claims analysis will be outreached to and provided the same education as outlined for the Patient Navigator.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.

While we do not have the resources to build alternative care sites, we believe they can be a complimentary component of the health care system by providing immediate care for uncomplicated illness in a cost effective manner. However, the care provided in these settings is unlikely to address all aspects of a patient's condition, their care may not be captured in an EMR and if the patient's insurer is in a risk contract with the hospital, the visit and related payments made to this alternative care site would be ideally delivered at a primary care practice or an affiliated off hours site. The Hospital has been working with local primary care providers to make these after hours services available in conjunction with the local health care providers.

In addition, while the cost of a visit to an urgent care center may be on par with a primary care visit, the primary care visit would provide an opportunity for the patient to get other needed care that would not be available at an alternative care site. While the cost of individual visits at alternative care sites is favorable when compared with hospital emergency departments, sometimes patients require both an urgent care and an emergency department visit, and studies have shown that the convenience of alternative care sites may foster increased utilization.

Finally, most alternative care sites require payment at the time of service and therefore are focused on the insured population who can pay at the time of service. A large majority of patients in low income areas cannot access these services, yet those who can access them would otherwise choose to pay a co-pay to get care within the walk-in of an emergency department. The care that insured patients who can pay their co-pay at the time of service helps to support care to the populations who rely on Medicaid or are underinsured or uninsured. Therefore, the growth of these alternative care sites diminishes the financial cross subsidy that has been a longstanding support for emergency departments, particularly in community hospital settings.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

- ☒Legal barriers related to data-sharing
- ☒Structural/technological barriers to data-sharing
- ☒ Lack of resources or capacity of your organization or community organizations
- ☐ Organizational/cultural barriers
- ☐ Other:

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?

We would recommend the Commonwealth of Massachusetts examine the issue of equity in commercial health plan payments and specifically how the not for profit health insurance plan dollars are invested in providers. The Commonwealth should require that the health plan premiums paid to these plans get invested more equitably within the health care system in Massachusetts. Failure to equitably resource providers in Massachusetts is creating a two tier health system where some providers have robust resources and are part of large systems serving larger numbers of well insured higher income residents with better health status, and other providers are under resourced and care for lower income residents with lower health status.

Currently, the lowest rates of payment are paid to providers like Lawrence General who care for patients with the greatest need for coordinated accessible care who also have poor health status. More resources should be required to be paid by health plans in rate to address high socio economic challenges and patients with higher levels of co-morbidities. Communities like Lawrence have extremely limited resources to combat the greatest health and income disparity

challenges. Providing resources to communities that would address the higher level of health status issues should be a shared responsibility borne by health plans, and providers.

Patient privacy is a serious concern and a large barrier to providing adequate coordinated care. The inability to share patient information without patient consent can often create a barrier, particularly for our highest risk patients to access the care and services that they need. For example, we may have a treatment plan in place for a patient with high risk medical and behavioral health complexities but we are unable to find the patient in the community. When contacting an outside agency to determine if the patient has been seen by them to ensure they are getting the care they need and are safe, this outreach is often met with resistance due to the need to protect the patient's privacy. Improving the ability to communicate among agencies on behalf of our very high-risk patients would provide better care across the continuum. A work group should be established to come up with solutions and models for achieving this.

AGO Pre-Filed Testimony Questions

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**		
	Q2		
	Q3		
	Q4		
CY2017	**Q1**		
	Q2		
	Q3		23
	Q4		9
CY2018	**Q1**		
	Q2		

	TOTAL:		

b) Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.

We had engaged and relied on an external vendor to respond to price inquiries (Sutherland). They were not able to provide a log describing the nature of the call and resolution. The Hospital has terminated the relationship effective 9/30/2018 as a result. We undertook the task internally in the last two quarters of 2017 which we reported here and we are resuming that work internally now.

c) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

Historically, patients did not always have the correct information in order to provide a complete estimate. Patients often call requesting information for a single test or procedure when they in fact are having more than one test or procedure.

d) For hospitals and provider organizations corporately affiliated with hospitals:

Merrimack Valley Health Services, a provider of magnetic resonance imaging services which operates as an affiliate of Lawrence General Hospital responds to these inquiries and has provided documentation for seven such requests during the timeframe.

e) For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

At this time the Hospital's systems are not capable of providing this information at a level of accuracy which we believe to be appropriate for distribution. However, Lawrence General Hospital's reliance on government sources of payment and relatively low commercial insurance payor mix makes reimbursement from those commercial insurers of critical importance to funding its mission of providing health care services to patients in our service area.

To highlight the low relative payments we receive, we extracted the table below from the Commonwealth's Center for Health Information and Analysis April, 2018 report, *Relative Price Provider - Price Variation in the Massachusetts Commercial Market.*

Hospital	Payer-Abbrev.	Insurance Category	Product Type	Data Year	Blended RP	Blended RP Percentile (100 = high)
Lawrence General Hospital	NHP	Commercial (self and fully insured)	All Product Types Combined	2016	0.49	4.00%
Lawrence General Hospital	Cigna East	Commercial (self and fully insured)	All Product Types Combined	2016	0.55	23.00%
Lawrence General Hospital	United	Commercial (self and fully insured)	All Product Types Combined	2016	0.61	16.00%
Lawrence General Hospital	Fallon	Commercial (self and fully insured)	All Product Types Combined	2016	0.63	7.00%
Lawrence General Hospital	Minuteman	Commercial (self and fully insured)	All Product Types Combined	2016	0.67	14.00%
Lawrence General Hospital	Tufts	Commercial (self and fully insured)	All Product Types Combined	2016	0.70	8.00%
Lawrence General Hospital	BCBS	Commercial (self and fully insured)	All Product Types Combined	2016	0.75	3.00%
Lawrence General Hospital	HPHC	Commercial (self and fully insured)	All Product Types Combined	2016	0.75	11.00%
Lawrence General Hospital	Aetna	Commercial (self and fully insured)	All Product Types Combined	2016	0.78	15.00%
Lawrence General Hospital	UniCare	Commercial (self and fully insured)	All Product Types Combined	2016	0.79	25.00%
Lawrence General Hospital	BMC	Commercial (self and fully insured)	All Product Types Combined	2016	1.01	71.00%
Lawrence General Hospital	Network Health	Commercial (self and fully insured)	All Product Types Combined	2016	1.01	60.00%

Source: CHIA *Relative Price Report (April 2018) - Databook*

We note that none of the commercial health plans listed in the CHIA Report pays the Hospital 90th percent of average relative price we seek to be paid to sustain services and access, and continue to invest at the level required to ensure a vibrant community hospital.

f) For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

At this time the Hospital's systems are not capable of providing this information at a level of accuracy which we believe to be appropriate for distribution to external parties.

AGO Provider Exhibit 1

2014	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$9M	$11M	$0.30	$0.30	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	$5M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Harvard Pilgrim Health Care	$5M	X	$0.02	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$18M	X	X	X
Total Commercial	**$19M**	**$11M**	**$0.30**	**$0.30**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$18M**	**$ -**	**$ -**	**$ -**
Network Health (Tufts MCD)	X	X	X	X	X	X	X	X	X	X	X	$9M	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	$14M	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	$3M	X	X	X
Total Managed Medicaid	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**$26M**	**X**	**X**	**X**
MassHealth	X	$21M	X	$1M	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	$15M	X	X	X
Commercial Medicare Subtotal	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**$15M**	**X**	**X**	**X**
Medicare	X	X	X	X	X	X	X	X	X	X	X	$75M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	$24M	X	X	X
GRAND TOTAL	**$19M**	**$32M**	**$0.32**	**$1M**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$158M**	**$ -**	**$ -**	**$ -**

The Hospital contracts with non - government payors through a third party which provides reporting at a summary level. Because not all of the Hospital's private sector business involves risk sharing settlements, the Hospitals total NPSR is reflected under the columns "P4P Contracts" while only the risk sharing surplus/<deficit> is reported under the columns "Risk Sharing".

Because the Hospital accrues for MasHealth P4P reveneu in the fiscal year subsequent to the RFA rate year to which the P4P bonus applies, there will be a one year difference between the amounts in EOHHS's records the the amounts reported on this schedule. And, as such the FY 2017 MassHealth P4P amount is an estimate.

2015	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	$8M	$11M	$0.30	$0.40	X	X	($0.01)	($0.02)	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	$5M	X	($0.02)	X	X	X	X	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	$5M	X	$0.03	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	$2M	X	X	X
United Healthcare	X	X	X	X	X	$5M	X	$0.00	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$8M	X	X	X
Total Commercial	**$8M**	**$11M**	**$0.30**	**$0.40**	**$5M**	**$10M**	**($0.03)**	**$0.01**	**$ -**	**$ -**	**$ -**	**$11M**	**$ -**	**$ -**	**$ -**
Network Health (Tufts MCD)	X	X	X	X	X	X	X	X	X	X	X	$8M	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	$14M	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	**$27M**	-	-	-
MassHealth	**X**	**$25M**	**X**	**$0.80**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	$16M	X	X	X
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	-	**$16M**	-	-	-
Medicare	X	X	X	X	X	X	X	$0.20	X	X	X	$73M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	$16M	X	X	X
GRAND TOTAL	**$8M**	**$36M**	**$0.30**	**$1.2M**	**$5M**	**$10M**	**($0.03)**	**$0.21**	**$ -**	**$ -**	**$ -**	**$143M**	**$ -**	**$ -**	**$ -**

The Hospital contracts with non - government payors through a third party which provides reporting at a summary level. Because not all of the Hospital's private sector business involves risk sharing settlements, the Hospitals total NPSR is reflected under the columns "P4P Contracts" while only the risk sharing surplus/<deficit> is reported under the columns "Risk Sharing".

Because the Hospital accrues for MasHealth P4P reveneu in the fiscal year subsequent to the RFA rate year to which the P4P bonus applies, there will be a one year difference between the amounts in EOHHS's records the the amounts reported on this schedule. And, as such the FY 2017 MassHealth P4P amount is an estimate.

2016	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	$9M	$12M	$0.20	$0.30	X	X	$0.10	$0.10	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	$5M	X	($0.10)	X	X	X	X	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	$13M	X	($0.10)	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	$0.70	X	X	X
United Healthcare	X	X	X	X	X	$3M	X	$0.00	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	$0.50	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X
Total Commercial	**$9M**	**$12M**	**$0.20**	**$0.30**	**$5M**	**$16M**	-	**$0.00**	-	-	-	**$8M**	-	-	-
Network Health (Tufts MCD)	X	X	X	X	X	X	X	X	X	X	X	$6M	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	$16M	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	**$27M**	-	-	-
MassHealth	**X**	**$31M**	**X**	**$1M**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	$17M	X	X	X
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	-	**$17M**	-	-	-
Medicare	X	X	X	X	X	X	X	$0.50	X	X	X	$73M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	$16M	X	X	X
GRAND TOTAL	**$9M**	**$43M**	**$0.20**	**$1.3M**	**$5M**	**$16M**	-	**$0.50**	-	-	-	**$141M**	-	-	-

The Hospital contracts with non - government payors through a third party which provides reporting at a summary level. Because not all of the Hospital's private sector business involves risk sharing settlements, the Hospitals total NPSR is reflected under the columns "P4P Contracts" while only the risk sharing surplus/<deficit> is reported under the columns "Risk Sharing".

Because the Hospital accrues for MasHealth P4P reveneu in the fiscal year subsequent to the RFA rate year to which the P4P bonus applies, there will be a one year difference between the amounts in EOHHS's records the the amounts reported on this schedule. And, as such the FY 2017 MassHealth P4P amount is an estimate.

2017	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	$8M	$13M	$0.20	$0.30	X	X	$0.01	$0.01	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	$5M	X	$0.01	X	X	X	X	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	$11M	X	$0.01	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	$4M	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$10M	X	X	X
Total Commercial	**$8M**	**$13M**	**$0.20**	**$0.30**	**$5M**	**$11M**	**$0.02**	**$0.02**	-	-	-	**$16M**	-	-	-
Network Health (Tufts MCD)	X	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	$12M	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	$6M	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	-	**$25M**	-	-	-
MassHealth	**X**	**$28M**	**X**	**$0.50**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	$18M	X	X	X
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	-	**$18M**	-	-	-
Medicare	X	X	X	X	X	X	X	X	X	X	X	$76M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	$22M	X	X	X
GRAND TOTAL	**$8M**	**$41M**	**$0.20**	**$0.80**	**$5M**	**$11M**	**$0.02**	**$0.02**	-	-	-	**$157M**	-	-	-

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