Baystate Medical Center

September 8, 2014

Mr. David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Subject: Testimony for Public Hearing Concerning Health Care Cost Trends

In response to your August 1, 2014 letter, we have prepared this letter, and associated template, appendix and exhibits (collectively "Written Testimony"). The deadline for submitting the Written Testimony was short and some of the requested information was not readily available. Accordingly, the Written Testimony has been prepared based on reasonable inquiry and is true and correct to the best of our knowledge, information and reasonable belief.

Your letter is directed to Baystate Medical Center, Inc. (BMC). BMC is part of the Baystate Health, Inc. integrated health care delivery system, which includes Baystate Medical Practices, Inc. (BMP), Baystate Mary Lane Hospital Corporation (BMLH) and Baystate Franklin Medical Center, Inc. (BFMC). BMC is also associated with Baycare Health Partners, Inc. (Baycare), which is a physician hospital organization and includes accountable care organizations. In some responses when appropriate, we have included information about these related organizations.

In closing, I am legally authorized and empowered to represent BMC for the purposes of the Written Testimony. I hereby certify under the pains and penalties of perjury that, under my direction, BMC has made a diligent effort to respond to the questions submitted to it, and that, to the best of my knowledge, information and reasonable belief, the Written Testimony is true and correct.

Sincerely,

Dennis W. Chalke
Senior Vice President Finance & Community Hospitals/
CFO and Treasurer, Baystate Health

Enclosures:
- Associated template
- Appendix
- Exhibits

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, 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:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 Tuesday, October 7. 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 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, 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.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk 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 Kelly.A.Mercer@state.ma.us a minimum of two 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. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses 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 begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

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

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

[Remainder of page intentionally left blank]

Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 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 between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

      BMC experienced a decline in inpatient discharges between our FY2010 to FY2011 of 4% primarily due to an increase in outpatient observation volume; however since FY2011 inpatient discharges have grown between 2%-4% each year including about 2% for FY2014 year to date. This growth along with an increase in patient acuity has put significant pressure on our expense base. From FY2010 to FY2013, our expenses grew at an annual rate of about 4.7% with our most recent FY2014 year to date expense growth of about 6%. However after adjusting for patient volumes (inpatient and outpatient and contract pharmacy) and patient acuity, the annual growth in expenses is less than 1%, including our most recent FY2014 year-to-date experience. See Appendix for Exhibit B, Question 1 for additional information.

   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

      As reflected in our answer to question #1.a. above, BMC expense growth, after adjusting for patient volumes and patient acuity, is less than 1%, which is well below the c. 224 health care cost growth benchmark. While we would like to have the Commonwealth clarify in more detail how the c. 224 health care cost growth benchmark will be applied to hospitals, we believe there needs to be an adjustment to hospital expense growth for changes in patient volume and patient acuity. As reflected in our answer to question 1.c., below, BMC has many efforts ongoing to address health care costs. See Appendix for Exhibit B, Question 1 for additional information.

   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

BMC is committed to the continual development and application of a comprehensive model for system wide continuous improvement in the areas of staff engagement, quality outcomes, patient satisfaction and cost reduction. We have a long history of continuous improvement and cost control based on scientific methods. We continue this tradition with the aggressive development of a model for process improvement that engages leadership and staff at all levels toward a common set of organizational goals and objectives. Cost containment and reduction are expected as key outcomes in conjunction with improved quality and patient satisfaction. We are developing leadership and staff capabilities around the utilization of proven models of teamwork, waste elimination and value enhancement. See Appendix for Exhibit B, Question 1 for additional information.

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

Despite broadening the definition of an appropriate inpatient stay under the two-midnight rule, CMS continues to exclude time spent under observation from the three-day requirement for Skilled Nursing Facility (SNF) stays. Inpatient stays do not begin until a physician writes an order for patient admission; thus any time spent in observation preceding an admission will not count toward the length of stay requirement. This policy along with observation status, generally, has been the subject of recent media scrutiny. Further clarifications and policy changes are needed.

In addition, administrative simplification among governmental and commercial payers is needed to gain operating efficiencies and reduce costs. Please see 2013 Written Testimony of Baystate Medical Center, Inc. (2013 Written Testimony) at Section 1.C.

---

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. SUMMARY:
    a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations? We don't believe that APMs have significantly impacted our organization's overall quality, care delivery practices, or referral patterns. Baystate Health's hospitals and physician practices have historically performed well on quality metrics prior to the implementation and our participation in APM's. Baystate Health has made significant investments in primary care and ambulatory care settings which has improved access for the population that we serve. APM's have required additional administrative and operational resources, as the use of data

analytics and information systems has increased, to report and provide meaningful and actionable information on performance.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

We have not yet conducted detailed analyses on the impact of APM's on non-clinical operations. However, the growth in administrative and information systems to support APM's is evident in our operational expenses. In addition, with the implementation of c. 224 regulations related to Registration of Provider Organizations and Risk Bearing Provider Organizations, additional burdens and operating costs are expected.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

See response in Section 2.b. above.

---

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers. SUMMARY: Baycare has limited experience to date with health status risk adjustment measures in risk and alternate payment contracts. A subset of hospital and community physicians participate in risk contracts with Health New England, Inc. (HNE) and Blue Cross Blue Shield of Massachusetts (BCBSMA), the latter through its Alternative Quality Contract (AQC). HNE does not use health status adjustments to establish our health services fund budget, while BCBSMA uses Verisk Health's DxCG Medical Classification System to risk adjust our budget. See Appendix for Exhibit B, Question 3 for additional information.

   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

   Based on our limited experience, we do not believe health status risk adjustment measures sufficiently account for changes in patient population acuity. Further, to the best of our knowledge, none take into account socio-economic characteristics of the members/patients, and we believe such factors may have a significant impact on, for example, patient compliance. We encourage public and private payers to adopt a common risk adjustment methodology to the extent possible.

   b. How do the health status risk adjustment measures used by different payers compare?

   Both the DxCG and HCC methodologies use hierarchies of medical conditions to predict which members/patients are likely to have high medical costs in the

future. They are intended to account for differences in expected health costs of individuals to ensure that adequate budgets are available to care for given populations.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

The presence or absence of risk adjusters is one factor among many that physicians consider when they evaluate whether to participate in a given risk or alternate payment contract. While, for example, current agreements with Tufts and UniCare do not have risk adjusted budgets, each includes a provision to adjust for high cost cases, which physicians factored into their analyses of the attractiveness of these agreements. Further, we find it valuable to use risk-stratified data from MedInsight (the business intelligence application that we use for claims analysis to help us manage our risk and alternate payment contract performance) to identify patients appropriate for care management services.

---

4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
SUMMARY: Healthcare information is necessary to improve the care coordination and healthcare delivery for our patients. Healthcare data is necessary both for improvement at the level of the individual patient as well as at a level of population health. At a minimum, data needs to become more fluid moving from an individual patient that is mostly patient specific transactional data to the ability to use the data to improve health. At the individual patient level, data should be able to be used to track a patient's conditions, their medications, their health maintenance and other needs of chronic conditions. These data need to be used by healthcare workers to track and improve care for individual patient. See Appendix for Exhibit B, Question 4 for more information.
ANSWER:

---

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY:
   a. Which attribution methodologies most accurately account for patients you care for?

      Baycare uses a specific “layering” process by which to attribute membership until the majority of members are effectively assigned to a risk unit or provider pool. See Appendix for Exhibit B, Question 5, for the process details.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Please refer to detailed response contained in Part 5.a., above, and in the Appendix for Exhibit B, Question 5.

---

6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
SUMMARY:
ANSWER: Public and private quality measures reporting are important drivers for ensuring quality, patient safety and improvement efforts. Additionally, measurement and reporting to the private and public payers allows for external benchmark comparisons. This promotes organizational accountability and fosters transparency of hospital performance to patients, providers, and payers. However, there are many challenges with quality measures reporting. There is a significant resource burden around measure collection, abstraction and reporting. Most measures are not automated and require professionally trained clinicians to manual review records to capture the specified elements. Measure sets are not harmonized among payers (public and private sector) contributing to duplicity of work.

---

7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
SUMMARY:
   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

      We have not conducted comprehensive analyses on inpatient utilization trends and the flow of patients to AMCs or other higher cost care settings. However, CHIA annually publishes data on inpatient costs per case mix adjusted discharges for every acute care hospital in the state. In reviewing these data, it is important to note that BMC, a comprehensive Level I Trauma and 710-bed Tertiary Care Center, represents a unique entity among the hospitals in the Commonwealth. Its inpatient costs per case mix adjusted discharges (adult and pediatric combined) are not only the lowest among AMCs, specialty and teaching hospitals in Massachusetts, they are also low when compared with community hospitals. Therefore, although many of the AMCs and specialty and teaching hospitals in the state - particularly those in the Boston region - have among the highest costs, BMC contradicts the generalization that an AMC/teaching hospital is by necessity a higher cost care setting (once care has been case mix adjusted). The CHIA data indicate that rather than focusing on the flow of patients to AMCs, attention must be made to highlighting the highest value providers for the level of care required - in BMC's case, whether that care is tertiary pediatric, cancer, or other specialty care. See also chart submitted herewith as HPC Exhibit 1.

b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

Baystate Health is working to keep secondary care in the patients' communities at community hospitals such as Baystate Franklin Medical Center (BFMC) and Baystate Mary Lane Hospital (BMLH). This work includes expanding specialist presence at our community hospitals. Most recently, as part of a CHART(Community Hospital Acceleration, Revitalization, & Transformation) Phase 2 grant proposal being submitted on September 12, 2014, BFMC, Baystate Wing Hospital (BWH), and BMLH seek to maximize appropriate regional hospital use through reducing unnecessary outmigration of patient care to tertiary care facilities and retaining appropriate care locally. If successful, the initiative would result in a significant percent reduction of regional outmigration and transfers from within Western Massachusetts to tertiary care and high cost care settings.

---

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
SUMMARY:
   a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

      We do not have data on the overall level and variation in the utilization and site of post-acute care. However, through the participation of the hospital in the PVAC, BMC receives some data on post-acute care utilization. This information is evaluated for opportunities for improvement around efficiency, cost and quality. BMC also is participating in the new Bundle Payments for Care Improvement initiative under the Centers for Medicare and Medicaid Innovation program. Under the initiative, BMC has entered into payment arrangements that include financial and performance accountability. Monthly statistics are collected for these patient populations regarding discharge setting disposition, post-acute length of stay and acute stay encounters for a 90 day post-acute period. These data reveal best practice as reflected in patient return to function and time to total care discharge. CMS provides BMC with claims data for the 90 day bundle; this information is used for improvement and benchmarking.

   b. How does your organization ensure optimal use of post-acute care?

      BMC assures that patients are discharged to the most clinically appropriate, high value setting through a variety of decision processes that are activated daily.

There is a planning and selection process to ensure each patient is assigned to the most appropriate care setting post discharge. Analysis of appropriate and most clinically valuable post-acute setting is evaluated for trends and improvement opportunities.

BMC has conducted an extensive outreach and investigative inquiry to area Skilled Nursing and Acute rehabilitation facilities from November 2013 to May 2014. Each facility was evaluated for Structure, Process and Quality measures and evaluated for preference as a quality partner based upon the facility's ability to achieve shortest length of stay (post-acute) while assuring clinical goals. The facilities have also agreed to ongoing reporting of readmissions to acute care should that occur, and to providing a root cause analysis of conditions leading to the readmission. This measurement collaboration adds value and a feedback loop between acute and post-acute clinicians to assure appropriate continuum. Patient and family choice is also a key factor in the process to ensure the right care setting and services for each patient.

---

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: BMC has spent considerable resources to meet and exceed the regulations outlined in c. 224 for Patient Price Transparency. Well prior to the regulation, Baystate partnered with a software developer in order to provide patient price estimations and patients estimated out of pocket amounts prior to and at the time of service. Baystate and its software developer use a combination of prior claims history, patient insurance coverage, and anticipated future charges to provide scheduled patients an estimated charge and patient out of pocket amount. See Appendix for Exhibit B, Question 9 for additional information.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**	0	63	3h
	Q2	0	58	3h
	Q3	0	61	3h
	TOTAL:	0	182	

** Please indicate the unit of time reported.*

ANSWER:

---

10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: We have not performed analyses on the impact of tiered or limited networks on BMC or BMP. We have not altered our pricing or contracting strategies as a result of tiered products or limited networks. In addition, referral patterns have not significantly changed patient volumes or behaviors. BMC has consistently been rated in the best tiers by many of the plans due to the high quality and lower cost structure of our institution when compared to similar sized institutions.
ANSWER:

---

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 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.
SUMMARY:
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

       Baystate Health recognizes the increased expense and poorer health outcomes experienced by patients with co-morbid behavioral health and chronic medical conditions. In response, Baystate's efforts to integrate physical and behavioral health care services are ongoing and extend across the continuum of primary, specialty, inpatient and emergency care. See Appendix for Exhibit B, Question 11 for additional information.

    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

       Our IBH team is developing a program with primary care-based Care Coordinators to identify high utilizers of emergency and inpatient care, and to proactively offer behavioral health screening, education, support and treatment, as needed, for these patients. We have engaged in a project with the Institute for Healthcare Improvement ("IHI") to further advance this effort.

    c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

In our efforts to provide integrated behavioral health care in medical settings, we have encountered numerous challenges, including "siloed" thinking within different care settings, mental health stigma among primary care patients, and fee-for-service payment models (including separate co-payments for behavioral health and medical visits) that discourage more fully integrated care. Please see Appendix for Exibit B, Question 11, for more detail on these challenges and Baystate's strategy for addressing each.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

Baystate is collecting baseline data on utilization and outcomes of IBH in primary care settings, and we plan to continue this effort in the coming years. Our 2013-2014 Executive Office of Health and Human Services (EOHHS) Grant for Health Care Infrastructure and Capacity Building included support for data collection and analysis for our IBH services in primary care settings. In addtion, we have applied for a BCBSMA "Fostering Effective Integration" grant that will support continuing this effort, and will also involve sharing outcomes data with BCBSMA and other grantee providers to identify best practices and learn from each others' challenges and successes. We look forward to any opportunities to widen this circle of shared learning among other providers in the commonwealth.

---

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: In 2010, Baycare launched a multiyear PCMH Prototype, comprised of a subset of primary care physicians and their practices who were culturally ready and willing to embrace practice redesign coupled with alternative payment methodologies (i.e., shared savings evolving to comprehensive payment). Ultimately, our PCMH Prototype transformed into an accountable care organization, which we believe serves as a means to bend the health care cost curve, enhance quality, and improve the experience and overall health of the community served. See Appendix for Exhibit B, Question 12 for additional information.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

Currently nine Baycare practices with 34 sites have achieved Patient-Centered Medical Home National Committee for Quality Assurance (NCQA) recognition. Together, these 208 physicians represent 57% of the Baycare primary care physician members and 16% of total Baycare physician members.

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

   All of the NCQA recognized practices participate in risk and/or alternate payment contracts through Baycare. Together, these practices care for approximately 115,000 patients under risk and alternate payment contracts.

c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

   Due to limited experience to date, we have not specifically analyzed the impact of achieving PCMH recognition on outcomes, quality, or costs of care per se. That said, our practices have consistently performed well on the quality and efficiency measures of our alternative payment contracts.

---

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY:
    ANSWER: We have not yet reviewed in detail every aspect of the Commissioner's 2013 Cost Trend Report and the July 2014 Supplement to that report. BMC has always strived to be a high quality, low cost provider. In other sections of our response and in our 2013 Written Testimony, we have detailed our quality and cost control efforts, successes to date, and the resulting recognition that we have received.

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 submit a summary table showing for each year 2010 to 2013 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. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

   Completed in Attachment AGO Hospital Exhibit 1

   Submitted herewith.

---

2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital 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.

   Completed in Attachment AGO Hospital Exhibit 2

   Submitted herewith.

---

3. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

   Baycare on a monthly basis produces performance reports on risk contracts for participating providers. The reports track pmpm costs compared to budgets and key drivers for variances. In addition to these reports there is the ability to drill down at the patient level to determine specific trends and/or areas for improvement or opportunity. To date Baycare and Baystate have performed well in our risk contracts and have not experienced negative deficits that would require payments to the plans. See Appendix for Exhibit C, Question 3 for additional information.

---

4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

Due to current system constraints, we do not effectively track inpatient and outpatient referrals to our hospitals and the associated revenue from those referrals by specific physicians or provider groups. Therefore, we don't do any such analysis.

Appendix for Exhibit B, Question 1

a. Operating revenues grew at an annual rate of about 4.9% between FY2010 to FY2013 and about 6% for the most recent FY2014 year-to-date experience. However, this growth includes the benefit of an increase in Medicare payments due to the increase in the Massachusetts Rural Wage floor which we estimate added over $30 million per year since FY2012. We are concerned about the efforts in Washington to change the calculation of the Rural Wage floor and the negative impact that would have on BMC.

b. Additionally, we established in 2012 a team, led by senior management of Baystate Health, to identify and implement financial improvement initiatives recognizing the need to offset the impacts of the Affordable Care Act and potential loss of the Rural Wage floor on Medicare revenues and other health care payment reforms which may impact our revenues. These financial improvement initiatives include cost saving projects in our supply chain, utilities and productivity improvement initiatives in addition to revenue diversification initiatives, such as our contract and specialty pharmacy programs.

   Consistent with these efforts, BMC is among the lowest cost hospitals, whether looking at academic medical centers, community, teaching, or specialty hospitals. See chart based on information from Massachusetts Center for Health Information and Analysis (CHIA) submitted herewith as HPC Exhibit 1.

c. BMC is participating in the new Bundle Payments for Care Improvement initiative under the Centers for Medicare and Medicaid Innovation program. Under the initiative, BMC has entered into payment arrangements that include financial and performance accountability for episodes of care. For example, the total joint and coronary artery bypass graft (CABG) populations are in the Model 2 bundle program.

   BMC provides hospitalized care to patients supported in the Patient-Centered Medical Home (PCMH) initiative. The medical home model supports fundamental changes in primary care service delivery and payment reforms, with the goal of improving health care quality. All 18 adult and pediatric primary care BMP practices have been officially recognized as PCMH's. The PCMH's employ care managers who work directly with each access point of care including BMC to ensure coordination and efficiencies of care to each patient.

   BMC is also participating in the Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Through the participation of the hospital in the Pioneer Valley Accountable Care Organization, LLC (PVAC), BMC is working to improve care coordination, improve quality of care and lower costs of care.

Baystate Health, a national leader in quality and patient safety, has long leveraged information technology in its pursuit of excellence in care for the individual as well as the community at large. Baystate is now involved in the design and deployment of a regional health information exchange, Pioneer Valley Information Exchange (PVIX), in order to create the health information exchange hub for the healthcare organizations of Western MA that will facilitate real-time access to patient health information for use at the point of care. Providing the right information, at the right time, to the right provider, regardless of entity or individual, promises to improve the experience of the patient by expediting efficient care, improve the health of the population by building platforms for analysis and predictive modeling, and decrease the total cost of care by preventing the duplication of services while enabling the most effective course of treatment. A replete health information exchange will serve these efforts and improve the satisfaction of the provider by reducing the inefficiencies created by disparate sources of data and its presentation.

Appendix for Exhibit B, Question 3

SUMMARY: The majority of Baycare physicians participate in alternate payment contracts with Cigna, Tufts, and UniCare, none of which use health status adjustments. A majority of Baycare physicians also participate in Medicare Advantage agreements with HNE, BCBSMA, and CeltiCare, although the membership in each is small. A subset of physicians participates in MSSP through PVAC. CMS uses hierarchical condition categories (HCCs) to adjust its Medicare capitation payments to the Medicare Advantage plans with which Baycare contracts and to adjust PVAC's expenditure target under the MSSP.

Appendix for Exhibit B, Question 4

In addition, the patient's medical record needs to be made available to all healthcare workers caring for that patient. This level of health information exchange will improve the care coordination of patients across multiple providers. Finally, the data for each individual patient must be able to be used in aggregate to improve the health of the entire population. Individual patient data needs to be able to be rolled up and then queried for population health statistics and to be used to help risk stratify a population to manage risk in that population and then to manage the conditions in that population. See also information in Appendix for Exhibit B, Question 1.c.

Appendix for Exhibit B, Question 5

The following methodology is utilized to attribute members in non-health maintenance organization products, including Preferred Provider Organization (PPO) and Administrative Services Organization (ASO) product types.

First - If the PPO or ASO member has designated a provider as their primary care physician (PCP) then that member will be attributed to that PCP.

Next - For remaining unassigned members, if the member had a well visit/physical exam that was billed by the MD, we attribute their care to that PCP. If the member had a well visit/physical with 2 or more PCPs, we attribute the member's care to the PCP with the most recent well visit/physical exam.

Next - For remaining unassigned members who saw only one specialist, we attribute their care to that one specialist if the member had a well visit/physical exam that was billed by this MD. If the member has a well visit/physical with 2 or more specialists, we attribute the member's care to the specialist with the most recent well visit/physical exam.

Next – For remaining unassigned members, who saw only one PCP, we attribute their care to that PCP even though none of the visits to that PCP was a well visit. If the member saw more than 1 PCP and none of those visits were well visits, we attribute this member to the PCP the patient saw most frequently; if there is a tie between 2 or more PCPs, then we attribute to the PCP with the most recent visit.

Next – For remaining unassigned members, who saw only one specialist, we attribute their care to that PCP even though none of the visits to that PCP was a well visit. If the member saw more than 1 specialist but none of those visits were well visits, we attribute the member to the specialist the member saw most frequently; if there is a tie between 2 or more specialists, then we attribute to the one with the most recent visit.

Next - For remaining unassigned members, if the patient had not had a visit with any physician but had multiple pharmacy claims through one PCP or specialist, we attribute the member to that physician. If a patient has multiple pharmacy claims from more than one PCP, we attribute that patient to the physician with the most claims; if there is a tie, then we attribute to the PCP with the most recent pharmacy claims.

All other members will remain unassigned.

Appendix for Exhibit B, Question 9

While the accuracy of the estimates is relatively good on many types of services, there is further opportunity to improve the accuracy with improved data from the insurance companies on more complex and/or less routine services. Software vendors depend on the HIPAA transaction codes to inquire and receive data specific to patients specific coverage in an electronic format and, while the transactions are standardized, the information provided within the transaction can differ by insurance company and result in inaccuracies. Further refinement in this area will lead to improved data flowing between providers and payers and should result in more accurate estimates for patients.

Appendix for Exhibit B, Question 11

a. In the primary care setting, BMC's Springfield-based Health Centers have partnered for many years with a number of community mental health centers, most notably Behavioral Health Network (BHN) and Gandara, to provide co-located behavioral health services for primary care patients with behavioral health needs.

In addition, over the past 18 months, Baystate Behavioral Health has developed and begun to implement more fully Integrated Behavioral Health Services (IBH) for the ten community-based primary care practices operated by BMP throughout the Pioneer Valley. IBH consists of co-located mental health clinicians functioning as full members of each primary care team, with a licensed therapist planned for each practice. The role of the IBH clinician is to help the primary care team detect and assess the mental health needs of its patients, including those who are highest utilizers of inpatient and ED services; to develop care plans for these patients; and to provide short-term counseling aimed at reducing health risk behaviors and improving skills and capacity to cope with medical illness.

For patients in need of more intensive ongoing services, the IBH clinician coordinates community referrals, assisted by a centrally located IBH Care Coordinator who will establish collaborative referral relationships with behavioral health providers and community support resources throughout our service area. In addition, we have applied for BCBSMA Grant funds to augment the Care Coordinator's work with a part-time IBH Peer/Family Partner who will provide telephone follow up and support to patients referred for community services. Finally, our IBH model provides each primary care practice with a designated psychiatrist who is available for consultation via telephone, secure electronic messaging within Baystate Health, and face-to-face patient visits. The IBH psychiatrist, clinician, care coordinator and peer/family partner will work as a team with primary care to address patients' behavioral health needs, with the ultimate aim of supporting the overall health of the population cared for by each practice.

In the Specialty Care arena, the primary focus of Baystate Behavioral Health's Adult and Child Outpatient Services is to provide collaborative mental health services for Baystate's medical specialty practices. Licensed social workers and psychologists partner with specialty practices to provide behavioral health treatment to their patients with psychiatric co-morbidities, backed up by psychiatrists and advanced practice nurses who can provide psychopharmacological care as needed.

Adult Outpatient Behavioral Health has established collaborative partnerships with Baystate Gastroenterology, Infectious Disease, Pain Management, Adult Weight Management, Bariatric Surgery and Neurology. A new program works with Baystate OB/GYN to identify and treat women with post-partum depression.

Child/Adolescent Outpatient Behavioral Health has established collaborative partnerships with Baystate Pediatric Pulmonary, Pediatric Neurology, Pediatric Sleep Center, Adolescent Medicine's Comprehensive Eating Disorders Program, Pediatric

Gastroenterology, Pediatric Endocrinology, Pediatric Cardiology, Pediatric Genetics and Pediatric Hemoncology, not to mention General Pediatrics. In addition to providing psychological evaluations and psychotherapy treatment for children and adolescents with both complex medical and psychiatric illnesses, we also support medical specialty practices working with young people who struggle with self-care regimens required by their medical condition, such as diabetes, sleep apnea, cystic fibrosis, irritable bowel syndrome, just to name a few.

In the inpatient setting, Baystate's Psychiatry Consultation Service has operated for many years as a dedicated team of psychiatrists, clinical nurse specialists and social workers to provide rapidly available psychiatry consultation for medical inpatients who are identified has having co-morbid psychiatric illness. In addition, a multi-disciplinary ad hoc committee was convened in 2011 to address the care for Behaviorally Challenging Patients on Med/Surg Units. This committee, with representation from psychiatry consultation, inpatient psychiatry, hospital medicine, nursing, spiritual services, security and risk management, developed an algorithm that clarified resources for med/surg nursing staff caring for patients with challenging behaviors. Among these resources is the Behavioral Interdisciplinary Collaborative Team (BICT), which can be called with 24 hour notice to help resolve particularly challenging care, resource or disposition scenarios. The ad hoc committee has evolved into an ongoing oversight team that meets quarterly to review the hospital's care of these challenging patients and to identify opportunities for performance improvement.

In the emergency arena, since 1999 Baystate has had a collaborative agreement with Behavioral Health Network's Crisis Team to provide crisis assessments to emergency patients who may need inpatient psychiatric admission. A short-term EOHHS Grant in 2013-2014 funded a trial program of Enhanced Emergency Behavioral Health Services, including a half-time psychiatric clinical nurse specialist and a full-time care coordinator. Outcomes data are currently being reviewed in consideration of continued funding for similar enhanced emergency behavioral health services on an ongoing basis.

c. Challenge: The traditional separation of behavioral and physical health service delivery systems can result in "siloed thinking" among providers.

Baystate Strategy: All IBH clinicians are sent to the UMass Integrated Primary Care Certificate Program to help us develop an effective shared approach to providing IBH in primary care. Regular supervision with the IBH medical director and clinical supervisor reinforces the clinicians in this new model of care. For PCPs, new practices receive three sessions of orientation with IBH clinicians and psychiatrists prior to initiating IBH. Monthly IBH-Primary Care team meetings thereafter are a forum for learning from successes and exploring strategies to address challenges. On a daily basis, IBH clinicians participate in any team "huddles" that occur in the practice. Baystate's fully integrated medical record assures an open flow of clinical information between IBH and PCPs. In addition, we propose to convene multi-practice PCP focus groups three times during the grant year to assess IBH's successes, obstacles, best practices and areas for improvement. In the community, Baystate is collaborating with two different Community Mental Health

Center (CMHC) partners, Clinical and Support Options (CSO) and Carson Center, in applications for two Healthcare Workforce Transformation Fund Training Grants to increase the knowledge and skills of community-based behavioral health providers in addressing co-occurring health issues with their patients. The result of these efforts has been strong support among primary care provides for IBH services, with growing utilization.

Challenge: Mental health stigma produces resistance among primary care patients unfamiliar with behavioral health services.

Baystate Strategy: IBH clinicians work directly with PCPs to strategize and promote non-stigmatizing ways of introducing IBH referrals to their patients, with a focus on IBH as a fully integrated partner in the care team. In addition, the planned development of an IBH Patient/Family Advisory Council (PFAC) to coordinate with the planned primary care PFAC will be a means to address mental health stigma among primary care patients.

Challenge: Current fee for service payment models do not support the kind of flexible, informal and brief patient contacts, nor the collateral and team interventions, that must be part of truly integrated behavioral health services in primary care.

Baystate Strategy: Senior leadership has dedicated strategic dollars for at least three years to support starting an IBH model that includes dedicated time for non-billable collateral and team-based services. In addition, IBH is maximizing its billing capture for all allowable interventions, without compromising the non-billable time needed for non-traditional IBH services. EOHHS Grant funds have supported aggressive data analysis during FY14, and we've applied for BCBSMA Grant funds to continue this effort in FY15 and FY16, with a goal of demonstrating outcomes to justify support from the direct budget of each practice as we transition to global payment systems.

Challenge: Charging insurance co-payments for behavioral health on the same day as co-payment for medical services can be confusing and off-putting for patients.

Baystate Strategy: "Warm Hand-off" meetings with IBH clinicians are usually brief and involve no charge. When an appointment is made for a follow-up IBH session, information about co-payment is provided.

Appendix for Exhibit B, Question 12

The initial scope of the PCMH Prototype in 2010 was a commercial managed care population; we began by entering into risk contracts with HNE and BCBSMA. Since then, its scope expanded to include additional commercial payers (Cigna, Tufts, and UniCare) and to encompass Medicare beneficiaries, both through commercial Medicare Advantage agreements and participation in the MSSP. The experience we have gained in implementing the critical elements of the PCMH model (a physician-directed team; coordinated care; enhanced access; and safe, quality outcomes, supported by embedded care managers and care coordinators and the availability of actionable data) and more important, the cultural change that we have witnessed across our PCMH Prototype practices has positioned us, our providers, and their patients for success under health care reform.

Appendix for Exhibit C, Question 3

It is expected that Baycare will need to comply with the Risk Bearing Provider Organization (RBPO) regulations that will go into effect later this year, which will address solvency and other disclosure requirements. Baycare and Baystate Health continue to express concern regarding the RBPO regulations that in effect turn provider organizations into insurance companies (i.e. maintaining cash and statutory reserves). The regulations may force provider organizations out of the business of accepting risk contracts due to the capital and reserve requirements, not to mention the administrative burden being placed on these organizations.

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 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.

AGO Hospital Exhibit 1
2010

	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	65,292,267	61,103,044	1,077,527	1,050,912											
Tufts Health Plan	10,360,041	5,068,345	-	-											
Harvard Pilgrim Health Care	2,833,904	3,477,851	-	-											
Fallon Community Health Plan	10,091,651	-	-	-											
CIGNA											3,225,205	9,833,094			
United Healthcare											9,758,929	1,408,073			
Aetna											2,328,163	11,005,297			
Other Commercial					55,434,759	16,459,236	558,879	-			66,391,333	21,688,409			
Total Commercial	88,577,864	69,649,241	1,077,527	1,050,912	55,434,759	16,459,236	558,879	-			81,703,630	43,934,874			
Network Health											2,757,253	-			
Neighborhood Health Plan											14,946,865	-			
BMC HealthNet, Inc.											85,523,830	-			
Health New England					683,806										
Fallon Community Health Plan											283,612	-			
Other Managed Medicaid															
Total Managed Medicaid	-	-	-	-	683,806	-	-	-			103,511,560	-			
MassHealth	62,236,516	-	1,717,381												
Tufts Medicare Preferred											4,225,355	-			
Blue Cross Senior Options					22,520,277	6,723,266	119,036								
Other Comm Medicare											17,736,210	-			
Commercial Medicare Subtotal	-	-	-	-	22,520,277	6,723,266	119,036	-			21,961,565	-			
Medicare											236,465,064	-			
Other											27,704,402				
GRAND TOTAL	150,814,380	69,649,241	2,794,908	1,050,912	78,638,842	23,182,502	677,915	-	-	-	471,346,221	43,934,874	-	-	-

Note: The above table reflects information for Baystate Medical Center

AGO Hospital Exhibit 1
2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	61,508,737	68,119,737	921,967	1,085,947											
Tufts Health Plan	12,305,732	1,628,578	-	-											
Harvard Pilgrim Health Care	3,850,475	3,381,083	-	-											
Fallon Community Health Plan	10,320,793	-	-	-											
CIGNA											9,155,830	8,180,780			
United Healthcare											9,441,000	882,199			
Aetna											5,067,145	6,259,379			
Other Commercial					65,212,475	18,262,525	1,054,362	-			56,796,016	14,201,370			
Total Commercial	87,985,738	73,129,397	921,967	1,085,947	65,212,475	18,262,525	1,054,362	-			80,459,990	29,523,728			
Network Health											2,333,674	-			
Neighborhood Health Plan											13,439,122	-			
BMC HealthNet, Inc.											84,805,276	-			
Health New England					7,187,843										
Fallon Community Health Plan											403,179				
Other Managed Medicaid												-			
Total Managed Medicaid	-	-	-	-	7,187,843	-	-	-			100,981,251	-			
MassHealth	61,244,504	-	1,717,381												
Tufts Medicare Preferred											4,510,275	-			
Blue Cross Senior Options					16,767,044	7,476,402	407,275								
Other Comm Medicare											22,899,289	-			
Commercial Medicare Subtotal	-	-	-	-	16,767,044	7,476,402	407,275	-			27,409,564	-			
Medicare											226,237,255	-			
Other											22,972,349				
GRAND TOTAL	149,230,242	73,129,397	2,639,348	1,085,947	89,167,362	25,738,928	1,461,637	-	-	-	458,060,409	29,523,728	-	-	-

Note: The above table reflects information for Baystate Medical Center

AGO Hospital Exhibit 1
2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	48,840,685	67,989,588	649,671	927,469											
Tufts Health Plan	14,378,018	2,117,275	100,641	-											
Harvard Pilgrim Health Care	3,005,844	3,767,901	-	-											
Fallon Community Health Plan	9,190,767	-	-	-											
CIGNA											12,682,859	7,506,790			
United Healthcare											10,282,780	953,879			
Aetna											7,348,465	4,626,054			
Other Commercial					66,255,058	24,892,755	4,664,350	-			51,404,014	13,801,653			
Total Commercial	75,415,315	73,874,764	750,312	927,469	66,255,058	24,892,755	4,664,350	-			81,718,119	26,888,375			
Network Health											3,438,574	-			
Neighborhood Health Plan											10,991,499	-			
BMC HealthNet, Inc.											86,657,910	-			
Health New England					7,118,986		277,683								
Fallon Community Health Plan											497,530				
Other Managed Medicaid												-			
Total Managed Medicaid	-	-	-	-	7,118,986	-	277,683	-			101,585,514	-			
MassHealth	66,069,497		2,485,544												
Tufts Medicare Preferred											4,202,342	-			
Blue Cross Senior Options					12,297,474	7,777,639	480,487								
Other Comm Medicare											31,812,901	-			
Commercial Medicare Subtotal	-	-	-	-	12,297,474	7,777,639	480,487	-			36,015,243	-			
Medicare											279,892,373	-			
Other											24,915,682				
GRAND TOTAL	141,484,812	73,874,764	3,235,856	927,469	85,671,518	32,670,394	5,422,520	-	-	-	524,126,931	26,888,375	-	-	-

Note: The above table reflects information for Baystate Medical Center

AGO Hospital Exhibit 1
2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	49,290,388	66,383,301	797,438	1,141,728											
Tufts Health Plan	15,567,304	1,853,248	64,273	-											
Harvard Pilgrim Health Care	3,251,943	3,186,669	-	-											
Fallon Community Health Plan	9,635,343	-	-	-											
CIGNA											16,038,789	7,686,018			
United Healthcare											10,214,535	682,530			
Aetna											8,184,272	2,957,549			
Other Commercial					73,293,433	31,354,864	806,755				40,299,907	14,277,277			
Total Commercial	77,744,977	71,423,218	861,711	1,141,728	73,293,433	31,354,864	806,755	-	-	-	74,737,503	25,603,374	-	-	-
Network Health											3,454,049				
Neighborhood Health Plan											10,756,302				
BMC HealthNet, Inc.											85,709,791				
Health New England					14,847,745		1,204,055								
Fallon Community Health Plan											405,734				
Other Managed Medicaid															
Total Managed Medicaid	-	-	-	-	14,847,745	-	1,204,055	-	-	-	100,325,876	-	-	-	-
MassHealth	57,201,288		3,196,360												
Tufts Medicare Preferred											4,535,774	-			
Blue Cross Senior Options					12,072,087	8,067,995									
Other Comm Medicare											43,818,956	1,879			
Commercial Medicare Subtotal	-	-	-	-	12,072,087	8,067,995	-	-	-	-	48,354,730	1,879	-	-	-
Medicare											299,226,405				
Other											20,282,953				
GRAND TOTAL	134,946,265	71,423,218	4,058,071	1,141,728	100,213,265	39,422,859	2,010,810	-	-	-	542,927,467	25,605,253	-	-	-

Note: The above table reflects information for Baystate Medical Center

AGO Hospital Exhibit 2

2010

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cardiology Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Invasive Cardiology	11,667,365	3,110,386	4,034,955	788,404	9,233,030	1,267,185	2,825,556	(371,307)	-	-	-	-	20,900,395	4,377,572	6,860,511	417,097
Medical Cardiology	16,736,926	3,216,126	13,844,469	2,102,811	28,145,093	4,436,606	7,321,752	(1,668,092)	-	-	-	-	44,882,019	7,652,732	21,166,221	434,719
Cardiac Surgery	13,330,246	3,072,814	-	-	16,192,863	259,296	-	-	-	-	-	-	29,523,108	3,332,110	-	-
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dermatology	2,571,361	190,256	-	-	2,883,965	400,013	-	-	-	-	-	-	5,455,326	590,270	-	-
Endocrinology	3,097,985	399,964	-	-	4,608,688	644,775	-	-	-	-	-	-	7,706,673	1,044,739	-	-
Gastroenterology	12,743,678	1,847,534	9,747,230	2,410,718	15,260,565	2,444,283	3,045,279	97,162	-	-	-	-	28,004,243	4,291,817	12,792,508	2,507,880
General Medicine	-	-	7,762,750	(4,114,431)	-	-	6,087,501	(3,355,002)	-	-	-	-	-	-	13,850,251	(7,469,433)
General Surgery	31,358,121	3,786,068	-	-	23,828,052	(2,539,279)	-	-	-	-	-	-	55,186,173	1,246,790	-	-
Gynecology	2,572,724	(84,585)	5,240,779	(397,219)	1,119,407	98,161	905,546	(381,670)	-	-	-	-	3,692,130	13,576	6,146,326	(778,889)
Hematology	2,545,698	246,700	-	-	2,375,115	165,175	-	-	-	-	-	-	4,920,813	411,875	-	-
Infectious Disease	5,750,812	1,061,157	-	-	9,301,960	113,695	-	-	-	-	-	-	15,052,772	1,174,852	-	-
Neonatology	18,628,936	(1,187,687)	-	-	5,174,198	(1,718,427)	-	-	-	-	-	-	23,803,134	(2,906,114)	-	-
Nephrology	3,904,891	369,933	169,241	(2,077)	7,855,921	741,594	62,125	(42,462)	-	-	-	-	11,760,812	1,111,527	231,367	(44,539)
Neurology	18,258,911	3,668,048	8,559,592	4,223,585	17,418,468	2,119,727	1,964,333	(192,380)	-	-	-	-	35,677,378	5,787,775	10,523,925	4,031,205
Neurosurgery	4,306,113	825,561	2,267,509	84,828	2,475,572	447,775	1,028,506	(469,321)	-	-	-	-	6,781,685	1,273,336	3,296,015	(384,493)
Normal Newborns	4,301,099	(971,329)	-	-	572,462	(482,913)	-	-	-	-	-	-	4,873,562	(1,454,242)	-	-
Obstetrics	28,033,410	1,556,358	10,534,834	(845,498)	3,549,107	(2,480,978)	1,672,948	(1,230,548)	-	-	-	-	31,582,517	(924,620)	12,207,782	(2,076,046)
Oncology	7,012,611	1,454,031	46,290,618	16,202,471	5,321,403	(370,585)	16,131,948	(2,887,990)	-	-	-	-	12,334,014	1,083,446	62,422,566	13,314,481
Ophthalmology	237,295	36,798	-	-	235,976	51,231	-	-	-	-	-	-	473,271	88,028	-	-
Orthopedics	28,607,417	4,964,061	11,678,304	2,387,086	21,683,668	279,198	1,975,735	187,036	-	-	-	-	50,291,085	5,243,259	13,654,039	2,574,122
Otolaryngology	561,368	89,651	249,948	(268,171)	109,832	(25,019)	25,912	(140,654)	-	-	-	-	671,200	64,631	275,860	(408,825)
Psychiatry	6,837,024	(2,038,197)	5,698,279	(2,467,813)	10,609,111	(3,918,801)	2,465,615	(2,437,144)	-	-	-	-	17,446,135	(5,956,999)	8,163,894	(4,904,957)
Pulmonary	22,314,544	2,735,421	915,459	122,541	26,140,771	310,871	452,472	(198,281)	-	-	-	-	48,455,315	3,046,292	1,367,931	(75,740)
Rehab	-	-	5,675,402	38,377	-	-	1,538,675	(1,365,260)	-	-	-	-	-	-	7,214,077	(1,326,884)
Rheumatology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transplant Surgery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Trauma	-	-	30,130,987	8,862,293	-	-	8,608,790	(2,298,970)	-	-	-	-	-	-	38,739,777	6,563,323
Urology	4,029,945	859,806	-	-	4,356,668	1,162,588	-	-	-	-	-	-	8,386,613	2,022,394	-	-
Vascular Surgery	12,676,292	2,014,769	272,665	(25,425)	13,233,188	656,695	233,692	(57,631)	-	-	-	-	25,909,480	2,671,464	506,357	(83,056)
Other Inpatient	34,206,257	(1,010,804)			16,298,334	(3,703,724)			9,486,090	1,928,651			59,990,681	(2,785,877)		
Imaging			21,285,058	10,485,075			5,057,420	(138,800)			-	-			26,342,478	10,346,275
Other Treatments			6,275,920	1,468,461			3,163,239	(1,339,201)			-	-			9,439,159	129,260
Laboratory			29,611,952	(5,810,164)			8,207,620	(5,193,786)			-	-			37,819,572	(11,003,950)
Ambulatory Surgery			45,665,791	856,973			14,554,480	(4,431,361)			-	-			60,220,271	(3,574,387)
Therapies			-	-			-	-			-	-			-	-
Office Visits			1,507,799	(1,048,994)			348,127	(514,954)			-	-			1,855,926	(1,563,948)
Observation			19,676,254	5,413,034			6,040,681	(5,928,170)			-	-			25,716,935	(515,137)
Other Outpatient			62,430,775	(704,484)			24,305,487	(6,682,600)			50,506,126	9,053,761			137,242,388	1,666,677
GRAND TOTAL	296,291,030	30,212,839	349,526,570	39,762,382	247,983,415	359,142	118,023,439	(41,041,387)	9,486,090	1,928,651	50,506,126	9,053,761	553,760,535	32,500,633	518,056,135	7,774,756

Notes

In accordance with the Office of the Attorney General's instructions, this table includes Baystate Medical Center, Baystate Franklin Medical Center, and Baystate Mary Lane Hospital.
Consistent with prior year testimony the above table includes our physicians' group revenues and margins.

2011

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cardiology Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Invasive Cardiology	11,332,211	3,557,807	3,561,323	833,720	7,360,918	1,079,007	2,697,229	(187,655)	-	-	-	-	18,693,130	4,636,814	6,258,552	646,064
Medical Cardiology	15,497,568	3,459,883	13,844,392	1,909,336	24,295,482	2,865,643	7,651,515	(1,231,474)	-	-	-	-	39,793,050	6,325,526	21,495,907	677,862
Cardiac Surgery	12,226,275	2,315,877	-	-	13,995,388	(133,128)	-	-	-	-	-	-	26,221,663	2,182,748	-	-
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dermatology	2,837,758	380,708	-	-	2,793,644	213,679	-	-	-	-	-	-	5,631,402	594,386	-	-
Endocrinology	3,058,097	293,824	-	-	3,443,651	143,214	-	-	-	-	-	-	6,501,749	437,038	-	-
Gastroenterology	13,162,694	2,026,008	8,852,845	2,327,632	13,767,468	1,274,946	3,145,628	(42,199)	-	-	-	-	26,930,163	3,300,954	11,998,472	2,285,433
General Medicine	-	-	8,143,086	(4,806,516)	-	-	6,123,336	(3,823,810)	-	-	-	-	-	-	14,266,422	(8,630,326)
General Surgery	34,785,093	4,388,033	-	-	22,349,948	(2,847,368)	-	-	-	-	-	-	57,135,041	1,540,664	-	-
Gynecology	2,316,626	(37,229)	5,433,217	(605,587)	716,303	(140,082)	1,015,622	(342,275)	-	-	-	-	3,032,930	(177,311)	6,448,839	(947,861)
Hematology	2,799,636	477,946	-	-	2,317,169	118,368	-	-	-	-	-	-	5,116,805	596,314	-	-
Infectious Disease	6,066,332	1,895,155	-	-	9,092,498	469,854	-	-	-	-	-	-	15,158,830	2,365,009	-	-
Neonatology	18,201,138	(689,654)	-	-	4,415,185	(2,528,728)	-	-	-	-	-	-	22,616,324	(3,218,382)	-	-
Nephrology	4,495,956	800,456	174,307	(7,638)	6,854,342	420,669	84,758	(34,775)	-	-	-	-	11,350,298	1,221,125	259,065	(42,413)
Neurology	18,516,179	4,077,623	9,483,138	4,470,550	15,062,430	649,036	2,044,527	(164,982)	-	-	-	-	33,578,609	4,726,659	11,527,665	4,305,568
Neurosurgery	5,918,853	1,611,066	3,510,281	(64,323)	2,589,496	271,010	998,504	(363,010)	-	-	-	-	8,508,349	1,882,075	4,508,785	(427,333)
Normal Newborns	4,555,800	(590,820)	-	-	654,925	(507,469)	-	-	-	-	-	-	5,210,725	(1,098,289)	-	-
Obstetrics	27,679,320	1,879,274	10,284,699	(1,288,723)	3,408,163	(2,345,683)	1,822,999	(1,266,677)	-	-	-	-	31,087,483	(466,409)	12,107,697	(2,555,400)
Oncology	7,528,550	1,382,685	43,673,193	13,885,828	4,640,467	(283,311)	16,565,019	(3,212,489)	-	-	-	-	12,169,017	1,099,375	60,238,213	10,673,339
Ophthalmology	242,563	54,684	-	-	119,150	7,245	-	-	-	-	-	-	361,714	61,928	-	-
Orthopedics	29,138,430	5,366,984	12,595,453	3,421,989	20,513,036	(388,924)	2,161,660	451,748	-	-	-	-	49,651,466	4,978,060	14,757,113	3,873,737
Otolaryngology	632,852	66,769	191,409	(125,853)	125,168	10,527	55,349	(71,947)	-	-	-	-	758,020	77,296	246,757	(197,801)
Psychiatry	7,184,049	(1,316,138)	4,713,837	(1,438,408)	9,877,132	(3,679,999)	1,166,885	(1,232,674)	-	-	-	-	17,061,180	(4,996,138)	5,880,722	(2,671,082)
Pulmonary	20,165,281	2,847,738	958,089	167,697	23,657,785	948,355	491,301	(187,168)	-	-	-	-	43,823,067	3,796,092	1,449,390	(19,471)
Rehab	-	-	6,122,152	31,542	-	-	1,413,861	(1,401,318)	-	-	-	-	-	-	7,536,013	(1,369,776)
Rheumatology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transplant Surgery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Trauma	-	-	26,743,669	5,819,541	-	-	7,714,730	(2,846,809)	-	-	-	-	-	-	34,458,400	2,972,732
Urology	3,398,662	529,501	-	-	2,877,883	(182,783)	-	-	-	-	-	-	6,276,546	346,717	-	-
Vascular Surgery	13,312,742	2,389,945	256,462	(37,682)	13,772,499	(265,146)	213,499	(38,615)	-	-	-	-	27,085,241	2,124,799	469,961	(76,297)
Other Inpatient	35,149,594	(662,813)			14,712,963	(4,216,456)			15,886,633	6,334,647			65,749,190	1,455,377		
Imaging			21,129,201	10,479,942			4,317,154	(727,169)			-	-			25,446,355	9,752,773
Other Treatments			10,902,764	3,677,993			4,907,524	(1,860,021)			-	-			15,810,288	1,817,972
Laboratory			27,764,177	(9,482,428)			7,360,617	(4,861,229)			-	-			35,124,794	(14,343,657)
Ambulatory Surgery			50,197,725	684,222			16,455,997	(4,734,602)			-	-			66,653,722	(4,050,380)
Therapies			-	-			-	-			-	-			-	-
Office Visits			1,279,400	(1,002,328)			413,027	(605,217)			-	-			1,692,428	(1,607,545)
Observation			20,211,397	4,249,135			8,536,369	(8,302,031)			-	-			28,747,766	(4,052,897)
Other Outpatient			66,679,014	(1,581,110)			26,159,554	(8,750,642)			42,879,338	(4,285,527)			135,717,906	(14,617,279)
GRAND TOTAL	300,202,259	36,505,311	356,705,231	31,518,532	223,413,097	(9,047,527)	123,516,663	(45,837,042)	15,886,633	6,334,647	42,879,338	(4,285,527)	539,501,990	33,792,430	523,101,232	(18,604,037)

Notes

In accordance with the Office of the Attorney General's instructions, this table includes Baystate Medical Center, Baystate Franklin Medical Center, and Baystate Mary Lane Hospital.
Consistent with prior year testimony the above table includes our physicians' group revenues and margins.

2012

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cardiology Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Invasive Cardiology	11,898,464	4,495,798	3,586,297	1,132,685	9,083,934	2,645,436	3,465,781	669,667	-	-	-	-	20,982,398	7,141,234	7,052,078	1,802,352
Medical Cardiology	15,732,022	2,221,585	15,684,885	4,474,882	28,767,299	4,778,637	9,442,369	538,559	-	-	-	-	44,499,322	7,000,221	25,127,254	5,013,441
Cardiac Surgery	15,020,660	3,013,296	-	-	17,573,189	3,148,466	-	-	-	-	-	-	32,593,849	6,161,762	-	-
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dermatology	2,677,821	401,934	-	-	3,302,542	441,339	-	-	-	-	-	-	5,980,362	843,273	-	-
Endocrinology	2,956,013	216,338	-	-	4,413,487	583,094	-	-	-	-	-	-	7,369,500	799,432	-	-
Gastroenterology	14,690,457	2,162,377	9,874,637	2,645,248	16,078,832	1,445,599	3,871,906	263,981	-	-	-	-	30,769,289	3,607,976	13,746,542	2,909,229
General Medicine	-	-	9,012,373	(4,403,253)	-	-	7,011,338	(3,184,434)	-	-	-	-	-	-	16,023,711	(7,587,687)
General Surgery	28,902,765	1,052,293	-	-	25,829,459	598,969	-	-	-	-	-	-	54,732,225	1,651,262	-	-
Gynecology	3,073,200	(397,400)	6,102,841	(1,002,594)	1,132,139	(95,366)	1,146,518	(366,155)	-	-	-	-	4,205,339	(492,766)	7,249,360	(1,368,749)
Hematology	3,042,902	338,699	-	-	2,910,385	287,915	-	-	-	-	-	-	5,953,287	626,614	-	-
Infectious Disease	7,593,842	1,450,912	-	-	12,090,579	1,986,495	-	-	-	-	-	-	19,684,420	3,437,407	-	-
Neonatology	14,533,675	(2,659,158)	-	-	4,590,095	(2,281,514)	-	-	-	-	-	-	19,123,771	(4,940,673)	-	-
Nephrology	4,785,817	756,491	240,831	(30,166)	8,532,621	1,339,440	143,979	(38,274)	-	-	-	-	13,318,438	2,095,931	384,810	(68,440)
Neurology	21,496,515	3,802,046	9,728,767	4,933,553	19,977,473	4,129,060	2,531,720	215,242	-	-	-	-	41,473,988	7,931,106	12,260,487	5,148,795
Neurosurgery	5,629,153	1,472,066	2,840,024	19,876	3,627,889	896,587	1,498,079	(256,201)	-	-	-	-	9,257,042	2,368,653	4,338,103	(236,325)
Normal Newborns	4,310,036	(796,906)	-	-	908,393	(535,964)	-	-	-	-	-	-	5,218,429	(1,332,871)	-	-
Obstetrics	24,999,294	(463,016)	10,306,625	(2,132,901)	4,317,821	(2,568,118)	2,318,873	(1,440,165)	-	-	-	-	29,317,115	(3,031,133)	12,625,498	(3,573,067)
Oncology	6,855,943	847,258	44,939,767	12,610,237	5,339,481	481,362	18,045,666	(3,614,587)	-	-	-	-	12,195,424	1,328,620	62,985,433	8,995,650
Ophthalmology	226,648	(1,077)	-	-	222,044	9,579	-	-	-	-	-	-	448,692	8,503	-	-
Orthopedics	28,176,120	2,530,507	13,969,574	1,411,195	25,208,997	2,490,534	2,714,947	49,013	-	-	-	-	53,385,118	5,021,041	16,684,521	1,460,207
Otolaryngology	519,716	(21,736)	221,300	(120,192)	455,659	(285,427)	66,168	(76,931)	-	-	-	-	975,375	(307,163)	287,468	(197,123)
Psychiatry	7,741,043	(1,877,677)	4,538,522	(1,622,830)	11,222,355	(4,092,178)	1,225,834	(1,257,194)	-	-	-	-	18,963,397	(5,969,855)	5,764,356	(2,880,025)
Pulmonary	20,750,829	2,936,912	903,083	135,307	27,328,379	3,337,294	469,472	(224,130)	-	-	-	-	48,079,208	6,274,206	1,372,555	(88,823)
Rehab	-	-	6,391,162	199,486	-	-	1,519,026	(1,401,363)	-	-	-	-	-	-	7,910,187	(1,201,877)
Rheumatology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transplant Surgery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Trauma	-	-	29,252,351	8,147,534	-	-	8,834,576	(2,106,407)	-	-	-	-	-	-	38,086,927	6,041,127
Urology	3,050,400	151,056	-	-	3,837,800	706,929	-	-	-	-	-	-	6,888,200	857,985	-	-
Vascular Surgery	11,544,034	695,068	468,754	(253,146)	15,195,435	443,824	465,500	(399,086)	-	-	-	-	26,739,469	1,138,892	934,255	(652,232)
Other Inpatient	35,563,287	(1,503,810)			16,344,415	(5,217,986)			28,262,694	19,217,403			80,170,396	12,495,607		
Imaging			20,643,694	9,166,352			5,228,582	(188,051)			-	-			25,872,275	8,978,301
Other Treatments			10,180,748	2,941,387			5,748,014	(1,525,773)			-	-			15,928,763	1,415,614
Laboratory			28,082,565	(8,960,412)			7,463,701	(4,717,789)			-	-			35,546,266	(13,678,202)
Ambulatory Surgery			50,142,256	(900,735)			17,645,335	(4,263,159)			-	-			67,787,591	(5,163,895)
Therapies			-	-			-	-			-	-			-	-
Office Visits			1,263,248	(993,606)			368,070	(556,095)			-	-			1,631,318	(1,549,701)
Observation			19,481,703	3,612,336			8,119,172	(6,472,696)			-	-			27,600,876	(2,860,360)
Other Outpatient			68,181,357	(1,425,511)			27,070,308	(9,740,661)			43,855,199	(147,264)			139,106,863	(11,313,437)
GRAND TOTAL	295,770,655	20,823,857	366,037,362	29,584,730	268,290,703	14,674,004	136,414,935	(40,092,691)	28,262,694	19,217,403	43,855,199	(147,264)	592,324,052	54,715,264	546,307,497	(10,655,226)

Notes

In accordance with the Office of the Attorney General's instructions, this table includes Baystate Medical Center, Baystate Franklin Medical Center, and Baystate Mary Lane Hospital.
Consistent with prior year testimony the above table includes our physicians' group revenues and margins.

2013

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cardiology Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Invasive Cardiology	12,573,236	4,110,868	3,171,157	723,919	8,394,701	1,788,970	4,158,892	1,129,372	-	-	-	-	20,967,937	5,899,838	7,330,049	1,853,291
Medical Cardiology	18,630,863	2,846,993	16,255,291	4,951,576	30,188,787	3,650,379	10,379,540	803,960	-	-	-	-	48,819,650	6,497,372	26,634,831	5,755,536
Cardiac Surgery	18,246,141	4,610,733	-	-	20,379,271	3,082,658	-	-	-	-	-	-	38,625,412	7,693,391	-	-
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dermatology	2,951,276	407,657	-	-	3,459,564	447,629	-	-	-	-	-	-	6,410,840	855,286	-	-
Endocrinology	3,978,533	290,292	-	-	4,545,203	335,326	-	-	-	-	-	-	8,523,736	625,618	-	-
Gastroenterology	14,991,116	2,104,005	9,706,239	2,365,014	16,178,289	2,434,727	3,648,514	251,492	-	-	-	-	31,169,405	4,538,733	13,354,753	2,616,506
General Medicine	-	-	9,501,830	(4,974,035)	-	-	6,722,494	(3,136,527)	-	-	-	-	-	-	16,224,324	(8,110,561)
General Surgery	31,492,025	992,164	-	-	25,582,106	860,048	-	-	-	-	-	-	57,074,131	1,852,212	-	-
Gynecology	2,436,739	(433,664)	6,265,034	(1,163,442)	1,012,968	(107,823)	1,466,153	(368,314)	-	-	-	-	3,449,707	(541,488)	7,731,187	(1,531,756)
Hematology	2,594,170	311,336	-	-	2,974,782	(180,708)	-	-	-	-	-	-	5,568,952	130,628	-	-
Infectious Disease	9,382,491	2,212,244	-	-	15,398,845	2,523,493	-	-	-	-	-	-	24,781,336	4,735,737	-	-
Neonatology	17,106,418	(2,422,460)	-	-	3,853,064	(2,816,040)	-	-	-	-	-	-	20,959,482	(5,238,500)	-	-
Nephrology	4,971,798	633,275	261,809	(40,681)	8,801,786	1,554,169	167,021	(38,248)	-	-	-	-	13,773,584	2,187,444	428,830	(78,929)
Neurology	21,328,120	4,284,634	8,836,490	4,125,065	19,703,426	3,741,889	2,392,459	13,554	-	-	-	-	41,031,545	8,026,523	11,228,949	4,138,619
Neurosurgery	5,435,515	1,356,217	2,159,295	(165,753)	4,554,646	869,950	1,025,964	(94,647)	-	-	-	-	9,990,161	2,226,167	3,185,259	(260,400)
Normal Newborns	4,360,267	(802,855)	-	-	662,484	(378,045)	-	-	-	-	-	-	5,022,751	(1,180,900)	-	-
Obstetrics	26,260,965	581,972	10,185,594	(1,534,827)	3,344,853	(2,112,277)	1,716,500	(1,171,077)	-	-	-	-	29,605,819	(1,530,305)	11,902,093	(2,705,903)
Oncology	9,206,167	1,452,890	43,272,859	13,322,242	5,844,231	335,552	17,775,375	(1,329,186)	-	-	-	-	15,050,398	1,788,442	61,048,233	11,993,056
Ophthalmology	326,101	86,973	-	-	210,603	(21,691)	-	-	-	-	-	-	536,704	65,282	-	-
Orthopedics	29,200,757	2,962,257	15,387,918	(76,994)	26,601,217	2,755,383	2,956,068	(359,725)	-	-	-	-	55,801,974	5,717,641	18,343,986	(436,719)
Otolaryngology	696,556	4,125	269,534	59,541	132,440	(37,466)	51,923	(39,943)	-	-	-	-	828,996	(33,341)	321,456	19,598
Psychiatry	8,316,150	(1,627,065)	4,642,334	(1,532,316)	10,004,974	(4,002,805)	1,239,778	(1,344,212)	-	-	-	-	18,321,124	(5,629,870)	5,882,112	(2,876,528)
Pulmonary	21,085,972	2,812,680	915,050	202,514	27,146,076	3,083,792	503,364	(249,328)	-	-	-	-	48,232,048	5,896,472	1,418,414	(46,814)
Rehab	-	-	6,247,888	(41,859)	-	-	1,505,882	(1,366,026)	-	-	-	-	-	-	7,753,769	(1,407,885)
Rheumatology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transplant Surgery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Trauma	-	-	27,258,960	4,567,599	-	-	8,180,531	(3,070,706)	-	-	-	-	-	-	35,439,491	1,496,893
Urology	2,956,901	(85,920)	-	-	5,138,807	1,657,432	-	-	-	-	-	-	8,095,709	1,571,512	-	-
Vascular Surgery	11,988,559	1,152,314	565,899	(351,570)	17,015,759	1,424,065	449,635	(287,786)	-	-	-	-	29,004,318	2,576,379	1,015,534	(639,357)
Other Inpatient	35,810,168	(2,105,159)			16,002,956	(5,083,424)			25,314,209	23,450,515			77,127,334	16,261,932		
Imaging			28,396,744	11,560,596			6,441,170	(810,594)			-	-			34,837,914	10,750,002
Other Treatments			10,052,116	2,068,271			5,896,140	(1,669,403)			-	-			15,948,256	398,868
Laboratory			26,411,562	(8,508,401)			6,707,401	(5,000,110)			-	-			33,118,963	(13,508,512)
Ambulatory Surgery			49,452,870	(1,297,061)			17,039,610	(4,626,813)			-	-			66,492,479	(5,923,875)
Therapies			-	-			-	-			-	-			-	-
Office Visits			1,226,003	(888,458)			368,270	(663,873)			-	-			1,594,272	(1,552,331)
Observation			18,245,368	1,889,318			7,548,149	(6,279,202)			-	-			25,793,517	(4,389,883)
Other Outpatient			66,297,624	(4,600,964)			26,730,992	(10,320,908)			34,822,102	3,167,261			127,850,718	(11,754,611)
GRAND TOTAL	316,327,006	25,736,508	364,985,465	20,659,292	277,131,837	15,805,183	135,071,823	(40,028,249)	25,314,209	23,450,515	34,822,102	3,167,261	618,773,052	64,992,206	534,879,389	(16,201,696)

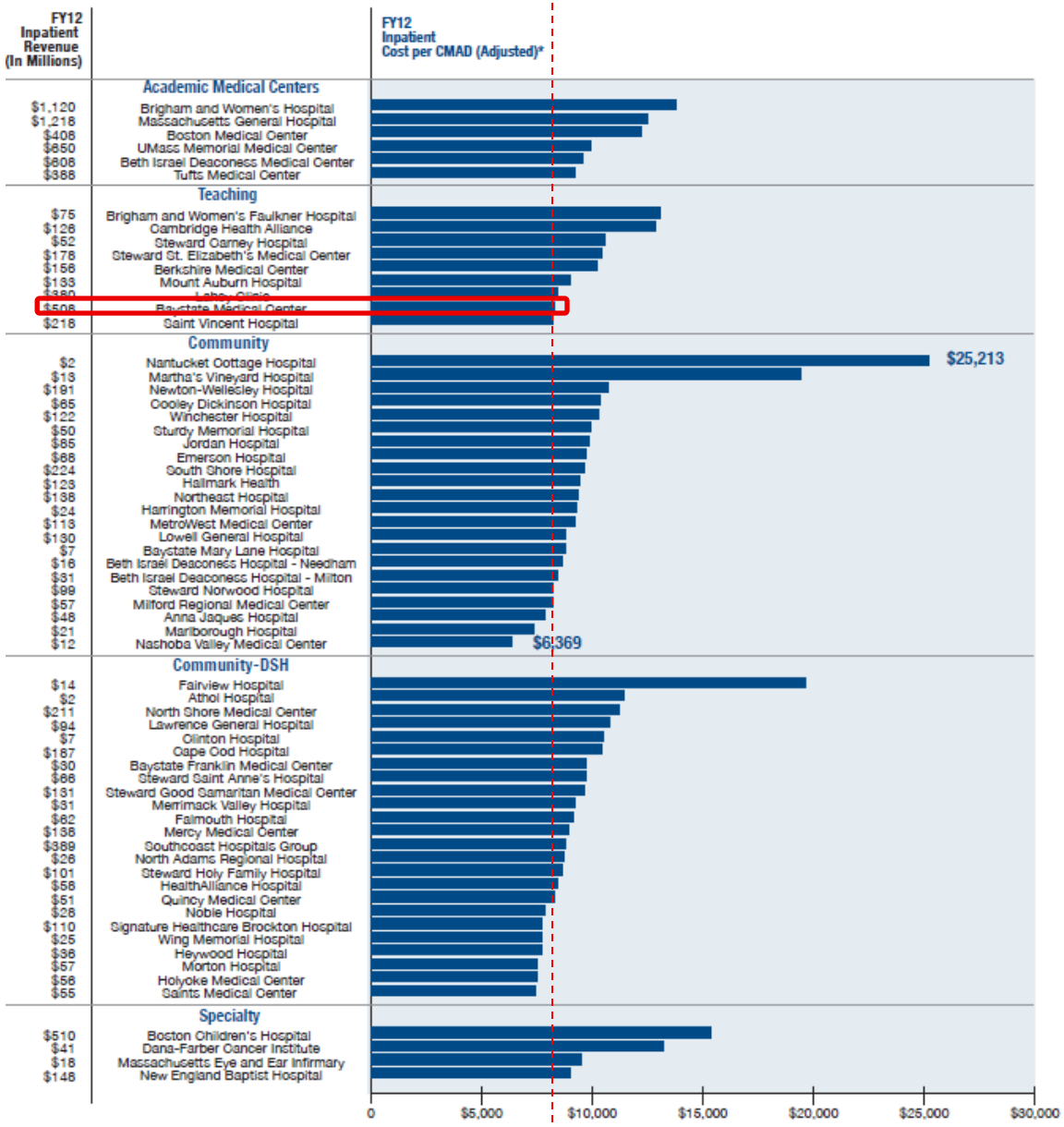
Notes

In accordance with the Office of the Attorney General's instructions, this table includes Baystate Medical Center, Baystate Franklin Medical Center, and Baystate Mary Lane Hospital.
Consistent with prior year testimony the above table includes our physicians' group revenues and margins.

Inpatient Costs: Baystate Medical Center is among the lowest cost hospitals

HPC Exhibit 1

Note: Whether looking at AMCs, Community, Teaching, or Specialty Hospitals, Baystate Medical Center differentiates itself as among the highest-value/lowest cost providers, which is noteworthy given its status as a comprehensive Level I Trauma/Tertiary Care Center



Source: CHIA, Massachusetts Hospital Profiles, March 2014

Baystate Health