Emerson Hospital

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September 8, 2014

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

We are in receipt of your letter dated August 1, 2014 identifying Emerson Hospital as a witness for the annual public hearings concerning health care cost trends in the Commonwealth. We are pleased to participate in this important process and wish to support the efforts of the HPC and the AGO in its efforts to identify ways to deliver healthcare in a more affordable, effective and accountable manner.

To this end, we respectfully submit the attached written testimony in response to the questions of the HPC in Exhibit B and questions of the AGO in Exhibit C.

Please do not hesitate to contact me if there are any questions or if more information is needed. I can be reached at cschuster@emersonhosp.org or at 978-287-3111.

Thank you.

Sincerely,

Christine C. Schuster

Christine Schuster
President and CEO

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.

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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: .As noted in the chart in Appendix A, the cost growth at Emerson Hospital, if defined as hospital expenses, equaled the growth benchmark of 3.6% in 2013 and is ahead of the benchmark through June of 2014 with expense growth of 0.37%. The cost growth at Emerson Hospital, if defined as patient revenues received, was 1.73% in 2013 and 1.39% through June of 2014. Both are better than the benchmark.
   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.
      See Appendix A
   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?
      See Appendix A
   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?
      See Appendix A
   a. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
      See Appendix A

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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: The only risk product that Emerson participates in is Tufts Medicare Preferred. Through the Emerson PHO we have a number of pay-for-performance contracts.
   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?
      See Appendix A

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 conducted any such analyses.
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.
We have not conducted any such analyses.

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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: Health status adjustment methodologies are handled at the PCHI network level.
   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?
   This is handled at the network level.
   b. How do the health status risk adjustment measures used by different payers compare?
   This is handled at the network level.
   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?
   This is handled at the network level.

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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: There is additional data that would be helpful to improve performance under APMs.
ANSWER: See Appendix A

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: See below
   a. Which attribution methodologies most accurately account for patients you care for?
   HMO members are required to choose a primary care physician. If patient is not required to choose a primary care physician, or not required to have a referral, we look at number of visits with provider.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
We require all patients to have a primary care physician to manage their care and refer to specialist.

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: The level of effort required to report quality measures to public and private payers continues to represent a significant resource challenge to Emerson Hospital.
ANSWER: See Appendix A

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: There is a large outmigration of patients form our service area to academic medical centers across many specialties.
   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.
   See Appendix B (Excel worksheet)
   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.
   We have implemented a number of collaborative programs with various AMCs such that high levels of care can be provided in the community at community rates. We have joint programs such that AMC specialists practice in the community part time at community rates. We have also invested substantially in the recruitment of our own specialists in various areas such that care does not need to leave the community for lack of a specialty service. In addition, we invest heavily to acquire sophisticated technology and equipment so that diagnostic testing, procedures and treatment can remain local (e.g. MRI, CT, 3-D breast imaging, and IMRT).

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: See below
   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.

Available data indicates that our post-acute utilization is higher than the state average particularly in joint replacements. We attribute some of this to patient preference.

b. How does your organization ensure optimal use of post-acute care?
We have developed a joint replacement clinical pathway to reduce utilization. We conduct continual education for our care managers, surgeons and hospitalists on optimal post-acute utilization.

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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: See below

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		113	24h
	Q2	3	144	16-24h
	Q3		69	12-24h
	TOTAL:	3	326	

** Please indicate the unit of time reported.*

ANSWER: Emerson has a dedicated Estimate Phone Line. For each phone call, we fill out an estimate request including the time of the phone call. The form is filled out to include estimate amount given and time we returned the call. There are times we need to call the physician's office to get the exact test ordered. If patient is pre-registered for the procedure, we will note the accounts' billing notes. The top ten procedures that we are asked about are diagnostic mammograms, ultrasound, MRI of the knee, lumbar, colonoscopy, c-sections and vaginal deliveries, basic lab tests, and physical therapy. Patients use this information to estimate their out-of-pocket expenses or self-pay pricing. They will discuss payment options. Some who did not schedule may be price shopping. Currently, we have been checking on the number of patients for radiology that requested an estimate and actually scheduled a test with Emerson. We also check some accounts each month to see how close our estimate was to the actual bill. We are working on a tracking mechanism to record thisdata. Our estimate software also does an analysis for us as requested.

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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: Tiered and limited network volume represents less than one percent of Emerson Hospital's patient care activity.
    ANSWER: See Appendix A

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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: See below
    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.
       The Behavioral Health Department collaborates closely with both hospital-based and community health care providers during and after admission to our Behavioral Health Service. We also maintain a comprehensive Consult Service that provides psychiatric evaluation and treatment support services to medically hospitalized patients and their providers. We view these offerings as an "extension" of our expertise to other members of the treatment team.
    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.
       We prepare our patients from the day of admission for a comprehensive outpatient plan to avoid readmissions and the inappropriate use of Emergency Room services. We have a twenty-four hour Psychiatric Triage Service that is based in the Emerson Hospital's Emergency Department. The Triage Service is able to divert new patients to lower levels of care when appropriate and to act as the conduit to implement diversion plans we have established for our patients.
    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.
       The dearth of outpatient and diversionary services are the central challenges we face when attempting to care for this cohort. We often are unable to identify appropriate group and individual treatment options that would obviate the need for inpatient admission. We have addressed these thorny issues by intensifying our efforts to collaborate with already in place treatment providers and community support systems. We believe that barriers to integration of services are best addressed by regular and open communication and collaboration with our medical colleagues. We have facilitated that collaboration in a number of different ways, including centralizing our Consult Service so that our medical colleagues have "one stop" access to or Consult Service.

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.
We would be very willing to engage with other organizations to establish a data collection regime that would assist us in developing a more comprehensive and responsive approach to this cohort of patients. Our ability to report discharge data could be enhanced as well.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: See below
    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?
    Approximately 60% of the primary care physicians on Emerson's active medical staff are certified by NHQC as a PCMH. These 60% are organized into two groups - Harvard Vanguard Concord and Acton Medical Associates. At this time none of the PCPs in the Emerson PHO are certified; however, they are in the process of preparing to submit their certification application for Spring 2015.
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
    Approximately 60%.
    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.
    No such analyses have been conducted.

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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: See Appendix A
ANSWER: See Appendix A

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

   See Exhibit C Question 1

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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

   See Exhibit C Question 2

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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.

   Risk, including risk of deficit scenarios, are handled at the PCHI network level for Emerson PHO patients.

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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.

Emerson Hospital uses Crimson Market Advantage (CMA), a web-based business intelligence tool, to help identify attending business and referrals. CMA is a database that includes Emerson's discharge, revenue, and physician roster data. It also has claims-backed "leakage" estimates for the Emerson market area, and physician network data showing connections between physicians based on historical claims data. The following are examples of how Emerson Hospital has used this information:

o Use CMA to monitor year to year service line performance change by referring MD to help identify opportunities and possible service gaps.

o Identified non-Emerson physicians with connections to competitor weight loss programs to assist with outreach efforts.

o Identify possible PCP recruitment candidates in certain markets by looking at physician connections in that market.

Cost Trends Public Hearing
Pre-Filed Testimony for Emerson Hospital
Exhibit B
Appendix A

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%.**

Annual Change:	2010	2011	2012	2013	Jun 2014
Revenue (NPSR)	4.11%	-1.78%	4.96%	1.73%	1.39%
Expense	4.82%	-4.14%	4.54%	3.60%	0.37%

   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.**

      The above chart shows the Emerson Hospital growth trend for revenues and expenses for 2010 through year-to-date 2014. As noted in the summary, Emerson Hospital has performed better than the benchmark growth in both 2013 and 2014. This is true if looking at the growth in the hospital's expense base or the hospital's revenue base (which is the cost growth applicable to the purchasers of healthcare). Inpatient utilization, defined as inpatient discharges, has steadily declined over this 5 year period. This is primarily attributable to a shift from inpatient admission to outpatient observation status on patients receiving 1 or 2 days of patient care in an overnight bed. Outpatient care has grown in the same timeframe particularly related to observation care, physical therapy and laboratory testing. While the level of discharges has declined, the intensity of service for the remaining inpatients has increased. Medicare case mix increased over the past 2 years from 1.30 to 1.40 while commercial payer case mix increased from .677 to .757. These shifts represent an increase in inpatient intensity of between 7 and 11 percent.

   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?**

      The hospital has undertaken numerous initiatives in the past couple of years to minimize the growth in healthcare expenditures. The results of these actions have contributed to the aforementioned growth rates that are at or below the benchmark targets. These initiatives include:

      - Completed a labor benchmarking study to determine best practice staffing levels
      - Developed processes to flex staffing levels to actual volume.

- Replacement hires for non-clinical positions are hired at 37.5 hours per week instead of 40.
- Strengthened our care management systems and processes to ensure patient placement in the appropriate setting at the appropriate time.
- Transitioned to a new group purchasing organization to maximize the savings associated with the purchase of supplies.
- Entered into an ongoing relationship with outside experts on identifying opportunities to minimize costs and maximize efficiencies.
- Implemented a Homecare information system that assists in meeting the patients healthcare needs at home, thereby minimizing trips to the hospital.
- In conjunction with the Emerson Hospital physicians, developed an electronic health record that allows for the flow of patient information across the continuum of care.
- Upgraded the majority of our mammography machines to 3-D tomosynthesis resulting in a significant decline in the need for patients to have repeat imaging.
- Active member of an ACO focusing on carefully managing patient care and associated costs.
- Streamline several clinical pathways.
- Added dedicated chronic care case managers.
- Supporting Patent Centered Medical Home implementation for many of our primary care practices.
- Implemented a Care Transitions Collaborative comprising area SNFs, home care, pharmacies and senior centers to manage transition of care among them and the hospital.
- Implemented a community Integrative Health & Wellness Center focused on educational classes.

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?

- Work with the community physicians to coordinate the flow of patient information through a health information exchange.
- Support the physician-hospital organization with the implementation of a patient centered medical home system of care.
- Provide a mechanism to physicians to admit patients directly to our transitional care unit; bypassing the inpatient medical/surgical unit.
- Implement a Post-Acute Care Transitions initiative to maximize appropriate hospital utilization.
- Continue to streamline diagnosis-specific clinical care pathways.
- Continue to expand community-based Health and Wellness Center.
- Implement clinical affiliations with CVS Health/ Caremark.

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

Emerson Hospital recognizes and supports the healthcare imperative to operate more efficiently without reducing the quality of care delivered to its patients. To that end, we consistently explore opportunities to achieve efficiencies particularly within the realms of care transitions, preventive care and wellness programs. As Emerson evaluates the health needs of the communities it serves the aforementioned have been identified as opportunities to partner with community stakeholders to reduce cost and increase efficiency.

Care transitions, or more specifically, ensuring the safe and effective discharge of patients to skilled nursing facilities, rehabilitation centers or even home, are fraught with challenges and complexities which can adversely impact patient care. For example, access to pharmacies, patient teaching and in-home support can often be lacking for a significant portion of Emerson patients. Surrounding these processes with the necessary resources for patient education and assistance (e.g., expanded reimbursement for home care visits) would result in a reduction in unnecessary readmissions and emergency room level of care.

Similarly, in the arenas of preventive care and wellness programs, Emerson is committed to the delivery of services to mitigate the need for higher levels of care. Through patient education and preventive services delivered in collaboration with Emerson physician practices, patient risk is diminished and outcomes improved.

To the extent that policy changes within the Act could support through resource allocation, care transitions, preventive care and wellness programs, efficiency would be improved and a positive impact to health care cost metrics realized.

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.**

   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?**

   In an effort to obtain greatest reimbursement for our risk product (Tufts Medicare Preferred) we have improved focus on decreasing hospitalization, readmissions to hospitals, nursing home bounce backs to hospital, and improved quality outcome measures. We have added outpatient care managers, and imbedded them in our primary care offices. The care managers work directly with physicians to identify high risk patients, and then directly with patients to increase awareness of disease state and empower patients to take part in their care. Emphasis on "in-network" referrals and decrease in tertiary utilization has been an additional focus of physicians and their staff.

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.**

The types of data that would be most valuable are:

- Real time data-pharmacy data, both from claims as well as cash paying customers. We are seeing an increase in PPO products that have high deductibles. Claims only capture data if pharmacy benefit is used.
- Real time office visits to specialists. For patients that do not require a referral, knowledge of visit with out of network specialist would be helpful.
- Historic data on patients who change plans frequently. Once this happens we no longer have that ability to track preventative tests such as colonoscopy that is required every 10 years.

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.**

The level of effort required to report quality measures to public and private payers continues to represent a significant resource challenge to Emerson Hospital. Although in recent history, there is some consistency in the focus or selection of specific metrics across payers, the format in which it must be delivered remains challenging. Further, the addition of multiple new measures in the outpatient emergency and psychiatric arenas has added additional layers of complexity. Similar to other health care entities, Emerson has increased its ability to electronically capture required data elements for reporting. Regrettably, this has not resulted in increased efficiency in the submission process. Medical record abstraction by 2.0 full-time equivalents to enter this information into an approved format for government/third party payer submission means that the process remains time consuming, manual and costly. The ability for medical record systems to directly transmit this data without the need to enter it elsewhere would greatly enhance health care providers' ability to affect change in outcomes via training and education. In the current construct, these opportunities are severely limited by the complexities of the required reporting programs.

9. **C. 224 require 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.**

   Emerson has a dedicated Estimate phone line. For each phone call we fill out an estimate request including the time of the phone call. The form is filled out to include estimate amount given and time we returned the call. There are times we need to call the physician's office to get the exact test ordered. If patient is pre registered for the procedure we will note the accounts billing notes.

   The top ten procedures that we are asked about are diagnostic mammograms, ultrasound, MRI knee, lumbar, colonoscopy, c-sections and vaginal deliveries, basic lab tests, and physical therapy.

   Patients use this information to estimate their out of pocket expenses or self pay pricing. They will discuss payment options. Some who did not schedule may be price shopping.

   Currently we have been checking on the number of patients for radiology that requested an estimate and actually scheduled a test with Emerson. We also check some accounts each month to see how close our estimate was to the actual bill. We are working on a tracking mechanism to record this; also our estimate software does an analysis for us as requested.

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.**

    Tiered and limited network volume represents less than one percent of Emerson Hospital's patient care activity. Emerson Hospital is assigned to favorable tiers with most health plans. One payer, Tufts, has Emerson in the unfavorable tier and patients have a high co-pay. We believe some Tufts patients seek high-end imaging and outpatient surgical care at institutions with more favorable tiers but this lost volume is offset by patients with other insurance coverage seeking care at Emerson because of the more favorable tier. There are instances when the patient accesses care at Emerson and is not aware of the higher co-pay requirement resulting in frustration for both the patient and the hospital.

Recently United Healthcare terminated Emerson physicians from their Medicare Advantage plan resulting in loss of access to the hospital for patients with those primary care providers. Emerson Hospital continues to be a hospital provider for the Medicare Advantage plan but not the associated primary care medical staff thereby facing a likely loss of patient care volume.

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.

The Commission's Report (2013 and 2014 July Supplement) offer a comprehensive review of the key drivers of health care costs in the Commonwealth as well as a fairly complete articulation of the challenges and opportunities we face as an industry to reduce the growth of health care spending while ensuring high quality and safe care to all. We agree with any and all efforts to improve the "value" of health care---recognizing it is not just about price and cost but importantly about the consistent delivery of high quality, well-coordinated and appropriate level of care in the most appropriate setting.

At Emerson, we have undertaken efforts to continue to reduce our cost structure and operate in the most efficient way possible. We consistently explore opportunities to advance care transitions (with our work with a host of community providers); prevention and wellness (with our Integrative Health and Wellness Program and many community collaborations); and the integration of medical and behavioral health (with our inpatient psychiatry unit and various outpatient psychiatry and substance abuse programs). Additionally, we have embraced Alternative Payment Methods (APM) such as our participation in the Medicare Pioneer ACO and the Blue Cross AQC among others.

One of the greatest challenges we face is the issue of outmigration of patients to academic medical centers for care that can capably be provided in the community. We are an independent community hospital close to Boston with a highly mobile, affluent and educated population. The outmigration we experience is almost entirely patient choice. In order to keep care locally, we have instituted a number of collaborative programs with teaching hospitals that have demonstrated year after year that our patients will stay for care locally if they know there is an affiliated relationship with a teaching hospital.

We have seen an increase in the patient population with those who have high deductible health plans (HDHP) and participate in tiered insurance products. However, while the consumer has become more price-sensitive to their own health care expenditures with a greater portion of health care spending out of their pocket, we have seen the result, thus far, to be largely on the *avoidance* of care or the *delay* of care rather than an actual and significant *shift* in care from teaching hospitals to the community setting. We feel there is much more to be done to increase the use of APM (e.g. to include PPO membership)

as well as providing consumers the clear and accurate data they need to make informed decisions about where to get their health care----data not just around price but also quality and outcomes.

An equally significant challenge as an independent community hospital with a largely independent medical staff are the needs to access, collect, coordinate and translate data into meaningful information in order to effectively manage and coordinate care for populations. This is a particular challenge when patients are shared by various providers in the same community who operate with disparate electronic systems. A sensible, reasonably priced Statewide Health Information Exchange solution is imperative.

EMERSON HOSPITAL SERVICE AREA
INPATIENT MARKET SHARE BY HOSPITAL
FY 2010 - FY 2012
(excludes Nursery)

	FY 2010		FY 2011		FY 2012	
	Total Disch.	Mkt. Share	Total Disch.	Mkt. Share	Total Disch.	Mkt. Share
Primary Market Area						
Emerson Hospital	**4,963**	**42.4%**	**4,757**	**41.4%**	**4,677**	**42.0%**
Lahey Clinic	1,191	10.2%	1,205	10.5%	1,254	11.3%
Massachusetts General Hospital	885	7.6%	831	7.2%	890	8.0%
Brigham and Women's Hospital	609	5.2%	591	5.1%	561	5.0%
Beth Israel Hospital & Deaconess Hospital	503	4.3%	536	4.7%	485	4.4%
Lowell General Hospital	481	4.1%	463	4.0%	433	3.9%
MetroWest Medical Center	363	3.1%	294	2.6%	362	3.3%
Newton-Wellesley Hospital	425	3.6%	432	3.8%	360	3.2%
Children's Hospital	364	3.1%	309	2.7%	287	2.6%
UMass Memorial/University	201	1.7%	164	1.4%	218	2.0%
Nashoba Valley Medical Center	243	2.1%	168	1.5%	207	1.9%
New England Baptist Hospital	142	1.2%	146	1.3%	176	1.6%
Mt. Auburn	212	1.8%	196	1.7%	169	1.5%
Marlborough Hospital	162	1.4%	156	1.4%	114	1.0%
Steward St. Elizabeth's Medical Center	99	0.8%	116	1.0%	100	0.9%
All Other	862	7.4%	1,120	9.8%	836	7.5%
Total Primary	11,705	100.0%	11,484	100.0%	11,129	100.0%
Secondary Market Area West						
Nashoba Valley Medical Center	1,186	29.7%	1,298	32.6%	1261	32.1%
Emerson Hospital	**627**	**15.7%**	**585**	**14.7%**	**547**	**13.9%**
Health Alliance-Burbank/Leominster	311	7.8%	299	7.5%	279	7.1%
UMass Memorial/University	234	5.9%	240	6.0%	252	6.4%
Massachusetts General Hospital	165	4.1%	165	4.1%	190	4.8%
Lowell General	220	5.5%	178	4.5%	187	4.8%
Beth Israel Hospital & Deaconess Hospital	328	8.2%	297	7.5%	168	4.3%
Steward St. Elizabeth's Medical Center	20	0.5%	47	1.2%	161	4.1%
Lahey Clinic	171	4.3%	162	4.1%	157	4.0%
Brigham & Women's Hospital	127	3.2%	162	4.1%	146	3.7%
Tufts New England Medical Center	72	1.8%	77	1.9%	81	2.1%
Children's Hospital	91	2.3%	82	2.1%	67	1.7%
All Other	444	11.1%	392	9.8%	427	10.9%
Total Secondary - West	3,996	100.0%	3,984	100.0%	3,923	100.0%
Total Emerson Hospital Service Area						
Emerson Hospital	**6,242**	**23.4%**	**6,068**	**22.8%**	**5,943**	**23.0%**
Lahey Clinic Burlington	2,724	10.2%	2,730	10.3%	2,658	10.3%
Lowell General Hospital	2,307	8.6%	2,402	9.0%	2,469	9.6%
Massachusetts General Hospital	1,670	6.3%	1,619	6.1%	1,663	6.4%
Nashoba Valley Medical Center	1,545	5.8%	1,030	3.9%	1,590	6.2%
Beth Israel Deaconess Medical Center	1,277	4.8%	1,279	4.8%	1,128	4.4%
Brigham and Women's Hospital	1,223	4.6%	1,225	4.6%	1,195	4.6%
UMass Memorial/University	1,259	4.7%	1,277	4.8%	1,335	5.2%
Marlborough Hospital	1,015	3.8%	968	3.6%	849	3.3%
Newton-Wellesley Hospital	988	3.7%	1,053	4.0%	981	3.8%
All Other	6,456	24.2%	6,933	26.1%	6,009	23.3%
Total Emerson Service Area	26,706	100.0%	26,584	100.0%	25,820	100.0%

Exhibit C - AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010 (millions)

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	26.4	29.8	1.4	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	6.8	7.7	0.4	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.6	7.5	0.3	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	3.8	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	4.7	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	8.3	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	5.1	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	8.8	x	x	x
Total Commercial	39.8	45	2.1	x	x	x	x	x	x	x	x	30.7	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.1	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	1	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.2	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	x	x	x	x	x	x	x	x	x	x	x	2.3	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.3	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.5	x	0.3	x	x	x	3.3	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	0.6	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.5	x	x	x	x	x	3.9	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	39.2	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.4	x	x	x
GRAND TOTAL	39.8	45.0	2.1	x	x	4.5	x	0.3	x	x	x	80.8	x	x	x

2011(millions)

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	26.9	30.3	1.3	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	6.0	6.7	0.3	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.8	7.6	0.3	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	3.1	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	4.6	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	8.4	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.5	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	6.4	x	x	x
Total Commercial	39.7	44.6	1.9	x	x	x	x	x	x	x	x	27	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.5	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	1.6	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.3	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	x	x	x	x	x	x	x	x	x	x	x	3.4	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.3	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.9	x	0.2	x	x	x	3.5	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	1.1	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.9	x	x	x	x	x	4.6	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	37.9	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.2	x	x	x
GRAND TOTAL	39.7	44.6	1.9	x	x	4.9	x	0.2	x	x	x	77.4	x	x	x

2012 (millions)

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	24.8	28.0	1.1	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	5.9	6.7	0.3	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	6.7	7.6	0.3	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	2.8	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	5.6	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	9.2	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.5	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	5.7	x	x	x
Total Commercial	37.4	42.3	1.7	x	x	x	x	x	x	x	x	27.8	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.5	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	3.6	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.3	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	x	x	x	x	x	x	x	x	x	x	x	5.4	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.6	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	4.7	x	0.2	x	x	x	4.7	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	1.1	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	4.7	x	x	x	x	x	5.8	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	40.4	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.4	x	x	x
GRAND TOTAL	37.4	42.3	1.7	x	x	4.7	x	0.2	x	x	x	84.4	x	x	x

2013 (millions)

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	25.2	28.0	1.2	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Health Plan	6.4	7.1	0.3	x	x	x	x	x	x	x	x	x	x	x	x
Harvard Pilgrim Health Care	7.7	8.5	0.4	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	2.9	x	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	6.3	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	9.3	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	4.4	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	7.5	x	x	x
Total Commercial	39.3	43.6	1.9	x	x	x	x	x	x	x	x	30.4	x	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	1.6	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	2.2	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	0.4	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	x	x	x	x	x	x	x	x	x	x	x	4.2	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	2.8	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	5.5	x	x	x	x	x	3.5	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	1.3	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	5.5	x	x	x	x	x	4.8	x	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	39.2	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	2.5	x	x	x
GRAND TOTAL	39.3	43.6	1.9	x	x	5.5	x	N/A	x	x	x	83.9	x	x	x

EMERSON HOSPITAL FY 2010

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)
Inpatient Critical Care/Med/Surg	23,860,454	10,755,913			22,926,306	7,763,066			353,622	(243,960)			47,140,381	18,275,018		
Maternal Child Health	8,107,389	2,251,567			825,246	62,271			2,692	(1,414)			8,935,327	2,312,424		
Psych/Substance Abuse	5,153,390	2,409,885			2,117,619	615,108			247,030	(111,893)			7,518,039	2,913,100		
Transitional Care Unit	1,467,052	226,069			2,118,844	(154,953)			-				3,585,896	71,116		
Other Inpatient	13,604	6,969			-	-			-				13,604	6,969		
Ambulatory Surgery			17,582,441	6,543,620			3,414,434	319,040			386,979	(246,793)			21,383,854	6,615,868
Imaging			16,127,473	10,626,006			2,552,344	609,362			86,818	51,765			18,766,635	11,287,133
Offsite Ambulatory Centers			15,096,937	9,309,027			1,433,715	213,206			86,233	29,476			16,616,885	9,551,709
Emergency Department			9,840,366	5,326,221			2,699,550	769,261			423,948	65,103			12,963,864	6,160,585
Laboratory			7,305,815	3,882,609			1,112,342	139,957			454,267	98,570			8,872,424	4,121,136
Home Care			1,280,105	(400,052)			3,758,479	868,417			60,077	9,393			5,098,661	477,758
Outpatient Infusion			2,382,260	258,716			1,154,941	(175,581)			6,643	45			3,543,843	83,180
Therapies			1,775,148	616,321			874,530	160,954			76,565	9,724			2,726,242	786,999
Observation			1,752,203	653,933			527,840	(133,567)			24,416	2,616			2,304,459	522,981
Wound Care			796,381	338,664			652,426	117,726			16,584	(309)			1,465,391	456,081
Other Outpatient			4,571,265	1,526,007			1,186,197	44,526			(293,735)	(69,285)			5,463,727	1,501,248
SUBTOTAL	38,601,889	15,650,403	78,510,394	38,681,072	27,988,015	8,285,492	19,366,798	2,933,300	603,343	(357,268)	1,328,794	(49,693)	67,193,248	23,578,627	99,205,986	41,564,678
MD Practices															4,650,853	(3,007,837)
Radiation Oncology															2,371,684	2,371,684
GRAND TOTAL													**67,193,248**	**23,578,627**	**106,228,523**	**40,928,525**

EMERSON HOSPITAL FY 2011

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)	Inpatient Revenue ($)	Inpatient Contribution Margin ($)	Outpatient Revenue ($)	Outpatient Contribution Margin ($)
Inpatient Critical Care/Med/Surg	23,529,473	11,318,823			20,649,595	7,251,159			344,386	(32,812)			44,523,454	18,537,170		
Maternal Child Health	9,193,459	3,307,558			1,212,222	365,057			22,441	5,662			10,428,122	3,678,277		
Psych/Substance Abuse	5,331,268	2,290,188			1,972,617	707,118			366,413	117,940			7,670,297	3,115,246		
Transitional Care Unit	1,388,250	218,909			2,263,817	(3,958)			-	-			3,652,067	214,951		
Other Inpatient	34,174	18,126			0	0			0	0			34,174	18,126		
Ambulatory Surgery			18,170,619	7,346,089			3,678,969	534,451			343,920	(342,790)			22,193,509	7,537,751
Imaging			14,074,473	9,216,864			2,331,888	703,780			69,946	44,704			16,476,307	9,965,348
Offsite Ambulatory Centers			13,235,063	7,899,429			1,446,313	228,081			98,718	36,852			14,780,094	8,164,363
Emergency Department			9,251,532	5,209,629			2,304,390	656,408			448,705	156,917			12,004,627	6,022,954
Laboratory			7,650,731	4,176,192			1,007,131	176,349			69,235	14,266			8,727,096	4,366,808
Home Care			1,385,041	(390,503)			3,679,676	845,801			9,077	(2,067)			5,073,793	453,231
Outpatient Infusion			2,648,782	226,108			992,781	(207,592)			4,844	1,643			3,646,407	20,158
Therapies			1,982,737	722,890			871,755	166,472			68,021	16,041			2,922,513	905,402
Observation			1,561,752	579,639			437,798	(54,283)			41,231	24,353			2,040,782	549,708
Wound Care			579,128	186,575			688,431	100,790			753	(5,259)			1,268,312	282,106
Other Outpatient			4,008,594	1,589,494			1,166,793	152,018			85,817	19,951			5,261,204	1,761,462
SUBTOTAL	39,476,624	17,153,603	74,548,452	36,762,406	26,098,252	8,319,376	18,605,923	3,302,274	733,239	90,790	1,240,268	(35,388)	66,308,115	25,563,770	94,394,643	40,029,292
MD Practices															6,290,100	(3,642,421)
Radiation Oncology															1,598,520	1,598,520
GRAND TOTAL													**66,308,115**	**25,563,770**	**102,283,264**	**37,985,391**

EMERSON HOSPITAL FY 2012

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**
Inpatient Critical Care/Med/Surg	22,558,518	11,746,479			22,359,475	9,103,395			275,844	(87,487)			45,193,837	20,762,387		
Maternal Child Health	8,911,186	3,079,608			1,431,476	465,943			4,000	(3,841)			10,346,662	3,541,710		
Psych/Substance Abuse	5,208,617	2,267,897			2,171,149	917,232			353,674	40,628			7,733,440	3,225,757		
Transitional Care Unit	1,668,669	335,050			1,902,948	(108,265)			16,361	1,643			3,587,978	228,428		
Other Inpatient	30,859	12,965			0	0			0				30,859	12,965		
Ambulatory Surgery			20,418,443	8,619,679			4,567,767	1,073,308			373,403	(296,723)			25,359,613	9,396,265
Imaging			13,554,399	8,989,705			2,684,100	993,385			98,318	67,199			16,336,817	10,050,289
Offsite Ambulatory Centers			12,615,108	7,386,206			1,573,052	277,238			102,727	39,368			14,290,887	7,702,811
Emergency Department			8,592,723	4,902,525			2,793,283	1,186,551			432,023	168,201			11,818,028	6,257,277
Laboratory			7,357,572	3,751,530			1,070,105	123,724			33,382	(25,318)			8,461,058	3,849,935
Home Care			1,309,823	(548,220)			3,512,212	776,216			4,636	(5,163)			4,826,670	222,833
Outpatient Infusion			2,670,162	183,366			856,856	(250,700)			1,226	496			3,528,245	(66,838)
Therapies			2,176,193	753,206			1,075,976	241,684			92,470	10,899			3,344,639	1,005,789
Observation			1,923,203	829,843			615,420	29,608			28,879	13,675			2,567,502	873,126
Wound Care			605,512	208,579			591,645	76,382			33,672	18,062			1,230,830	303,023
Other Outpatient			3,954,644	1,856,731			1,450,297	305,523			95,621	18,846			5,500,562	2,181,101
SUBTOTAL	38,377,848	17,441,999	75,177,782	36,933,150	27,865,048	10,378,305	20,790,713	4,832,920	649,879	(49,057)	1,296,356	9,542	66,892,775	27,771,247	97,264,851	41,775,611
MD Practices															8,232,834	(5,106,353)
Radiation Oncology															1,365,651	1,365,651
GRAND TOTAL													**66,892,775**	**27,771,247**	**106,863,336**	**38,034,909**

EMERSON HOSPITAL FY 2013

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Contribution Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Contribution Margin ($)**
Inpatient Critical Care/Med/Surg	23,457,150	11,926,956			20,364,379	7,794,123			158,192	(341,689)			43,979,721	19,379,390		
Maternal Child Health	9,344,410	3,590,044			1,354,031	398,705			879	(5,465)			10,699,320	3,983,285		
Psych/Substance Abuse	5,206,824	2,025,733			1,671,556	652,107			63,040	(294,132)			6,941,419	2,383,707		
Transitional Care Unit	1,447,702	155,131			1,709,438	(194,899)			8,549	59			3,165,689	(39,709)		
Other Inpatient	85,393	46,007			5,960	4,826			-							
Ambulatory Surgery			19,774,675	9,038,007			4,665,861	1,255,975			497,128	(423,472)			24,937,663	9,870,510
Imaging			13,449,793	9,133,505			2,880,109	1,034,243			77,550	54,082			16,407,453	10,221,830
Offsite Ambulatory Centers			12,789,474	7,613,604			1,752,727	297,255			92,962	30,119			14,635,163	7,940,978
Emergency Department			9,124,147	5,663,522			3,049,451	1,347,859			413,894	171,918			12,587,492	7,183,299
Laboratory			7,203,435	3,838,805			1,009,972	60,626			30,255	(48,758)			8,243,662	3,850,674
Home Care			1,281,212	(556,885)			3,716,821	864,558			4,119	(1,867)			5,002,152	305,806
Outpatient Infusion			3,281,563	299,290			988,895	(284,866)			3,390	(4,552)			4,273,848	9,872
Therapies			2,173,602	676,552			1,004,605	199,596			68,278	5,364			3,246,484	881,513
Observation			1,873,981	743,332			1,105,260	140,877			27,743	(11,311)			3,006,984	872,898
Wound Care			486,740	113,741			671,139	74,830			11,299	(28,766)			1,169,178	159,805
Other Outpatient			4,348,902	(200,610)			1,729,534	(410,254)			107,280	4,273			6,185,716	(606,591)
SUBTOTAL	39,541,478	17,743,872	75,787,523	36,362,864	25,105,364	8,654,861	22,574,374	4,580,698	230,660	(641,227)	1,333,899	(252,970)	64,786,149	25,706,673	99,695,796	40,690,592
MD Practices															7,914,292	(2,408,902)
Radiation Oncology															1,188,534	1,188,534
GRAND TOTAL													**64,786,149**	**25,706,673**	**108,798,622**	**39,470,224**