Holyoke Medical Center
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September 8, 2014

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Dear Mr. Seltz:

On behalf of our Board of Directors, employees, nurses, volunteers, affiliated organizations and the entire Holyoke Medical Center community, I want to thank you for the opportunity to submit written testimony to the Health Policy Commission in response to your recent letter and in connection with the upcoming public hearings on health care cost trends.

We strongly believe that community hospitals, such as ours, play a very vital role in the effort to control the cost growth in the Commonwealth's healthcare system. We have a number of ongoing activities, projects and improvement efforts all aimed at delivering the highest quality and most cost efficient care in our community. In addition to answering the questions that have been presented to us, I want to briefly outline for the Commission our strategy for the next few years as it relates to the goal of achieving greater efficiency of the healthcare delivery system.

At the system level, we have undertaken two overarching initiatives: One, we have made a three year minimum commitment with the Studer Group for leadership training/development and cultural transformation of our organization; Two, we have engaged with Kaufman Hall to formalize a strategic plan for the next three to five years that will guide our actions towards further transformation.

Fostering a value-based market

While the outmigration of patients from the Pioneer Valley to other regions of the Commonwealth is not very large, there is "secondary" outmigration within the Pioneer Valley from community based hospitals, such as ours, to the large teaching institution at the center of our region. We believe that significant progress can be made in controlling costs and improving outcomes by keeping the appropriate care local. To that end, we have undertaken initiatives to educate our community about the services we offer through outreach and marketing, we have established new and stronger relationships with other community based providers such as the local FQHC (Holyoke Health Center), and we are establishing better analytics tools to help us understand the flow of supply and demand for services in our market.

While we are engaging in an effort to keep more of the care local, in our community, we are actively engaging in dialogue and partnerships with the larger neighboring providers on efforts to share resources, explore the potential for shared specialty call schedules, telemedicine links and other innovative ideas on ramping up efficiency while improving quality.

Promoting an efficient, high-quality health care delivery system

Our Chronic Obstructive Pulmonary Disease (COPD) and heart failure initiatives have already started to yield results in terms of reducing preventable re-admissions. We are moving forward with two more conditions, Diabetes and Depression. In addition, we are re-engineering our patient care management and "navigation" system to provide a more comprehensive support structure for our patients in order to avoid gaps in care. A significant aspect of this initiative is expanding the patient call-back system, which currently includes COPD, heart failure and surgical patients, to include all inpatients and, in phase two, the emergency room and primary care sites. Study after study shows that a call-back system can significantly reduce preventable re-admission rates and unnecessary repeat ED visits.

Our primary care practices are pursuing Patient Centered Medical Home Certification in the spring of 2015, an important step towards a more efficient and effective model of care delivery.

One of the most important initiatives in this domain is one we hope to launch early next year that will seek to introduce an innovative model of addressing overutilization of the ED from patients with behavioral health conditions. Among other things, this model will deploy behavioral health professionals in primary care practices and provide much more robust support of the ED with appropriate behavioral health resources. It will also leverage our existing technology, as well as emerging mobile technology, to provide access and support to patients and primary care providers in order to address behavioral health conditions at the earliest possible stage before they become more critical.

Advancing alternative payments systems

As you will see from our answers, we have started exploring alternative payment systems in earnest and have participated in pay-for-performance contracts and shared savings arrangements. We have also just executed an agreement with Accountable Care Associates for participation in a national ACO. While our size and availability of resources does not allow us to dive deeper into more complex alternative payment systems, we will continue to look at opportunities to potentially engage in those systems in partnership with other organizations.

Enhancing transparency and data availability

Holyoke Medical Center has been at the forefront of the effort to connect providers, collect standardized data and advance the efforts of the Commonwealth to make the exchange and use of clinical and payment data meaningful. Our HIE is one of the most developed and sophisticated data exchanges for a community hospital, linking many providers, both hospital affiliated and private. We are actively developing plans to expand the data collection and availability into

behavioral health, in conjunction with our outpatient behavioral counseling center (River Valley Counseling Center) and other providers such as BHN and Sisters of Providence.

In addition, with our participation in a national ACO, we are expanding the network of providers and covered lives connected to our HIE.

In closing, I would like to once again thank you for the opportunity to participate in the public hearing process and invite you and the members of the HPC to reach out to my office with any questions or feedback.

Best Regards,

Spiros Hatiras
President & CEO
Holyoke Medical Center/Valley Health Systems

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: Holyoke Medical Center (HMC) over the last several years has embarked on the implementation of clinical and management information systems along with new clinical protocols and community linkages to create an effective and efficient delivery system in the community. HMC believes that these efforts will result in improved care and reductions in the overall cost of healthcare for the community and state.
   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.
      From FY 2010 through year-to-date July, 2014, HMC experienced a 4% decrease in inpatient admissions on average. This decrease results from multiple factors including a shift in services to the outpatient setting, a decrease in utilization as a result of uncertainties in the economy, and lost market share. During the same period, HMC experienced a 1% decrease in outpatient services (less than the inpatient decrease) due to the shift in services to the outpatient setting as previously noted as well as an increase in the provision of new outpatient services primarily specialty physician services. The impact on revenue during this period generally followed the changes in volume except for a change in Medicare reimbursement as a result of the Rural Floor which helped to offset the loss in revenue due to volume. See Exhibit 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?
      HMC has implemented a Health Information Exchange (HIE) to share patient clinical data with other providers on a timely basis. HMC's HIE provides a connection to the MA HIway. Through the use of the Exchange, providers can avoid potential adverse outcomes and reduce unnecessary tests. Additionally, HMC focused on avoidable readmissions through the use of a disease registry for heart failure (HF) and chronic obstructive pulmonary disease (COPD), and the implementation of care coordinators to help manage the care of these complex patients. This program has also created more robust linkages with other community providers and has resulted in a reduction in readmissions for HF and for COPD.

      See Exhibit 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?

Dependent on available resources, HMC will undertake the programs noted below.

HMC will start a program to leverage existing strengths and existing community partnerships to enhance the delivery of behavioral healthcare. The focus will be to reduce the use of the Emergency Department by utilizing a robust patient navigation system to insure that patients receive appropriate and timely services that are integrated with primary care. HMC expects that by January, 2017, it will have fully functional behavioral health emergency care services with the aim of reducing emergency room visits and inpatient readmissions by 25% while providing evaluation services, appropriate real time treatment, care navigation and referral follow-up. See Exhibit A.

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

The move by non-governmental payors to quality indicators based on Medicare standards and formats by payors is positive and improves comparisons and cost. The adopted standards should remain in place for several years to allow for a more comprehensive focus on quality improvement.

Standardized billing forms, service approval processes and utilization review processes should be considered for adoption. The multitude of forms and policies are costly to administer and manage and we believe add little to the quality of care.

HMC believes that service definitions, i.e., observation, should be standardized across all payors. Currently, payors adhere to different policies and procedures that create confusion for patients and providers and increase cost. See Exhibit 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: HMC believes that properly structured and financed programs, such as some of the shared savings products, can have a positive impact on quality and cost. For smaller institutions with limited resources, risk contracts may be counter productive. However, properly structured savings arrangements with realistic budgets and goals can help align incentives, improve quality and reduce overall healthcare costs.

   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?
Through a PHO, HMC participates in surplus sharing agreements based on global budget contracts with a managed care company. These contracts include commercial, Medicare and Medicaid members. Under this PHO contract, HMC and participating physicians share in any surplus with the managed care company. HMC and participating physicians periodically review utilization and quality measures for possible improvement. Additionally, HMC affiliated practices and other participating community practices are working to achieve PCMH status with some support from the managed care organization. This is expected to improve quality of care, care management and navigation and reduce healthcare costs. HMC and the other participating providers have shared in a surplus on these contracts over the last several years. The commercial agreement also includes several P4P provisions as the practices move towards PCMH certification. Recently, HMC entered into a new surplus sharing agreement through an ACO with another managed care company. This contract is just getting started and, as such, HMC has no results to comment on.

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).
HMC has not conducted an analysis.

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.
HMC has not conducted an analysis.

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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: HMC currently has no risk contracts, however, it participates in several shared savings agreements. Its experience with health status adjustments is limited. HMC, however, believes that a patient's behavioral health and socio-economic status should be fully incorporated into the health status adjustment, as it is HMC's experience, and as noted in the 2013 Cost Trends Report, these conditions have a material impact on the healthcare resources utilized by these patients.

   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?
   Please see summary above.

   b. How do the health status risk adjustment measures used by different payers compare?
   HMC does not have enough experience with this.

   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?
   HMC participates in a managed care contract that provides incentives to providers for performing annual patient risk assessments. Although the risk assessments are

helpful in managing patient care, they are cumbersome and should be simplified. Instead of starting the time consuming risk assessment form from scratch, the physician should be allowed to carry over pertinent information from prior years.

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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: HMC believes that to improve care quality and to reduce costs, timely and sufficient granular data is necessary to effectively manage a population or an individual's health needs and related cost. As noted in Exhibit A, response to Question 1d, HMC is planning to start the implementation of population management software. Noted below are some of the types of data that will be reviewed.
   ANSWER: Types of data: 1) Patient clinical data that would be available at the time of service. 2) Co-morbid conditions that a patient needs to be managed for such as diabetes, CHF, asthma, behavioral health, etc. 3) Feedback as to whether a patient has kept appointments and/or has complied with prescriptions and other clinical protocols. 4) Information on services received by patients at other facilities/providers. These types of data should be available on a real time basis in order to effectively manage care and improve outcomes.
   Financial and usage data should be provided at least monthly to be actionable. The data should include the population as a whole, types of diseases, types of service, and site of service. The data should allow for comparison of care to clinical protocols and service use rates.

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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: HMC believes that the Medicare approach of assigning a patient to the provider providing the preponderance of the care may be more appropriate.
   a. Which attribution methodologies most accurately account for patients you care for?
      For commercial carriers, the attribution method is based on the chosen or assigned PCP. The problem with this approach is that some patients don't choose or know the assigned PCP and, as such, go to the ED when they need care. Medicare patients are assigned based on the preponderance of care.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
      HMC believes that using the Medicare approach of attributing the patient to the provider that provides the preponderance of the care is most appropriate.

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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: HMC is encouraged by the trend of payors moving towards similar quality measures as those used by Medicare. HMC believes that quality data measures used for meaningful use should also continue to migrate towards alignment with Medicare quality measures.
   ANSWER: HMC notes that many of the payors are moving to adopt the same measures as Medicare and/or Medicaid, with some modifications. The process is currently labor intensive and primarily retrospective. HMC is currently evaluating the possibility of moving to an electronic abstracting and reporting system to complete the quality measures. Additionally, HMC is exploring the possibility of capturing quality measures on a real time basis to the extent possible. HMC believes that the more timely that quality measures are available for review, the better and more efficienct the care.

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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: See response to Question 13.
   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.
      HMC has not conducted any analysis.
   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.
      HMC has 24/7 intensivist coverage to maximize the retention of patients at the appropriate level of acute services. HMC has also implemented a Care Transitions Program utilizing patient navigators and case managers to ensure patients are placed in the proper care settings. Additionally, see response to Question 13.

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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: HMC currently utilizes the Case Management Department and Disease Manager to map care post discharge. HMC conducts daily patient clinical rounds to assess the patient's clinical status and to assess patient needs while inhouse and post discharge.
   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.
      Although HMC has not conducted any analysis regarding the variation in the use of post-acute care, it believes that the following variables may affect the use of

post-acute care as was pointed out in the 2013 Cost Trends Supplement: 1) Age of the patients served as some communities have a higher proportion of elderly. 2) The socio-economic status of the communities and patients served. 3) The health status of the community and the levels of co-morbidities of the patients including behavioral health and the prevalence of chronic conditions such as diabetes, CHF and asthma.

HMC serves a poor community that sees many patients as described above, many have limited support services at home. It is HMC's goal to get the patients to the proper clinical setting and, through its care managers, it believes it is making progess on this goal.

The availability of services in the community, such as adult day care and family support services, especially for those patients who have multiple chronic conditions, language barriers and limited home support will have an impact on the use of post-acute facilities.

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

HMC has implemented a Care Transition Program utilizing patient navigators and case managers to ensure patients are placed in the proper care settings.

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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: HMC does not currently track the number or nature of pricing requests, however, it estimates that it receives approximately 3 per quarter via telephone or in person. Estimates are given based on actual charges for single procedures such as x-rays or a range of charges for other conditions that require multiple resources such as surgical procedures. Generally, HMC responds to these requests within 24 hours.

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**			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER:

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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: HMC participates in several tiered networks and is pleased to be primarily included in the top tier for these types of contracts. The tiering process is challenging as payors have different methodologies for calculating provider tier assignments. A standard statewide approach should be developed based on consistent quality and cost measures.
ANSWER: HMC strives to provide high-quality and high-value healthcare and as such, strives to be included in the top most patient favorable tier. HMC works with all of its providers to help deliver care in a cost-efficient manner.
HMC has not performed an analysis as to the impact of tiered networks on its volumes. Since, HMC has generally been in the top tiers, it does not believe that they have negatively or positively impacted volumes. However, it does believe that the marketing clout of larger academic and/or healthcare organizations with more resources have affected some volume shifts.

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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: HMC concurs that these patients require a great deal of resources when they present to the ED. Many of these patients have multiple medical co-morbidities that require medical attention, but also may require one-on-one sitters while they are being taken care of.
    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.
    HMC is currently working to develop a program to better coordinate the medical and behavioral health care needs of these patients. Please see response to Question 1c. Additionally, HMC is planning to implement an electronic psychiatric record to capture, store and share pertinent psychiatric data with appropriate clinical providers on a timely basis.
    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.
    Please see response to Question 1c.
    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.
    Over the past decade, significant cuts and changes to the behavioral health system in Massachusetts have correlated with the steady rise in emergency room use. The behavioral health system in HMC's region is strained, frequently resulting in

long wait lists to access counseling and psychiatric medications. It is not unusual for a resident of the community to wait 3-6 months for a first appointment with a psychiatric medications provider. Structural, systemic issues like this drive patients to the emergency department. Please see response to Question 11a above on HMC's proposed approach to helping overcome some of these barriers.

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.
HMC is willing and working to increase its capabilities to share this data, however, many legal obstacles need to be resolved, especially as they relate to behavioral health records.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: HMC is currently working with Western Mass Physician Associates, an affiliate, to have it become PCMH accredited. It is currently preparing for the accreditation process which is expected to take place in March of 2015. This affiliate provides Primary, Obstetric and Pediatric services. Additionally, HMC is working with 5 community practices to assist them in attaining PCMH accreditation.
    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 none.
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
    Currently none.
    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.
    HMC has not conducted an analysis.

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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: Based on its review of the 2013 Cost Trends Report and the July, 2014 Supplement, HMC would like to provide several comments related to the findings. In particular, HMC would like to comment on the higher I/P costs relating to the migration to large academic centers and the higher costs associated with patients who have medical and behavioral health conditions.
ANSWER: HMC agrees that higher costs for many services can be attributed to the migration to large academic centers for services that might just as well be provided in a community hospital. HMC agrees with the report's findings that some of the shift to these large centers is due to market clout. Some of these organizations have more resources and, as such, have the ability to spend more on marketing their services. HMC

also believes that some of the shift to the large number of academic centers in Massachusetts is due to the inability of smaller quality and efficient community hospitals to recruit various specialities to serve their communities.
HMC serves a significant number of patients with both behavioral and medical conditions. HMC agrees that these patients utilize a significant amount of resources, including one-on-one sitter services when they are inpatients. HMC noted in response to Question 1c in Exhibit A and Question 11a that it is working to redesign the delivery of services that HMC, its affiliates and community providers offer to behavioral health patients. The redesigned service model will work to coordinate the various behavioral health services a patient needs between behavioral health providers and medical providers. HMC believes that this coordinated approach will reduce visits to the ED and improve the patient's overall health status. Additionally, this integrated approach should reduce the overall cost of treating these patients. HMC believes that this needed project will be a model program for the improvement of care and reducing overall costs.

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

   HMC does not track the data with the same degree of detail as requested. HMC has provided the information at the most detailed level currently available.

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

   HMC is currently implementing and validating a cost accounting system which will more accurately allocate cost between service lines and payors. Until that system has been fully implemented, HMC is utilizing the ratio of cost to charge (RCC) method of cost allocation. As you are aware, this method has been used by CMS, the state and providers for many years. However, the RCC method of costing has its limitations as it is only a relative measure of cost during a given period and care should be taken in comparing the results from one period to the next. These limitations are the result of the impact that changes in charge volume, charge structure and expense components, from one period to the next, have on the ratio.

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.

   Currently, HMC does not have any risk contracts.

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.

HMC is currently working to develop and implement such a tracking system. In 2015, HMC will begin the implementation of a population management system and will seek to integrate the tracking system and the population management systems.

2014 Cost Trends Hearing Exhibits – Holyoke Medical Center

EXHIBIT A

Response to Question 1a:

Expenses increased for FY 2010 through year-to-date FY 2014 on an average of 1.4%. This increase is primarily attributed to cost-of-living increases provided to employees in order to stay competitive with the market, an increase in the number of specialty physicians and related support staff offset by a favorable experience in health insurance cost and medical supplies.

Response to Question 1b:

HMC recently implemented a new Emergency Department (ED) physician documentation system with the assistance of a CHART Phase I grant. This project helped streamline and align healthcare information, particularly for those patients seen in the ED with chronic diseases, substance abuse and/or behavioral health issues, by providing capabilities to transmit improved medical information to surrounding community providers including other acute care facilities, behavioral health facilities, primary care and other behavioral health care providers. The implementation of the electronic documentation for HMC's ED physicians aligns with HMC's current and future efforts to provide better access to its behavioral health and substance abuse patients within the community. This, HMC believes, will help reduce ED revists, reduce overall healthcacre costs, improve the timeliness and quality of care and enhance the provider and patient experience. This project is also helping with the development of the Patient Centered Medical Home program that is currently in process by providing the capabilities to exchange ED visit information utilizing the MA HIway with other healthcare institutions throughout the state.

Response to Question 1c:

HMC will focus on the chronic care of diabetes by providing diabetes services and education. It is expected that these services will enhance the management of diabetic patients and improve access to care. This will improve outcomes and reduce costs.

HMC will continue to implement its Health Information Exchange to increase its functionality so providers will have access to more timely and pertinent clinical information to improve care and to reduce cost.

In 2015, HMC plans to start the implementation of a Transition of Care System that will utilize the best practices of Care Transition Models that will improve communication between providers, patients and care givers. HMC will improve the hand off of critical information at the time of transition in order for the next provider to be able to safely and effectively care for the patient. Families, caregivers and community providers will have readily available treatment plans that are patient driven. These plans will be evaluated at timely intervals so that progress and failures may be promptly addressed.

HMC will continue to expand its work on the chronic care disease programs of Heart Failure (HF), and Chronic Obstructive Pulmonary Disease (COPD) by further identifying more complex patients in this population who may have other chronic diseases such as diabetes, depression and hypertension. Additionally, the program will also consider social barriers faced by the patient such as lack of housing, support, and/or insurance coverage. It is expected that this program will improve health outcomes, reduce hospital readmissions and reduce cost.

Starting in 2015, HMC will begin the implementation of a population health management system through the integration with its HIE. Once fully implemented, this will allow HMC to perform data analytics to better identify patients with high risk co-morbidities such as behavioral health and substance abuse, COPD, CHF and diabetes. This will be instrumental in allowing HMC to help reduce avoidable ED visits and readmissions.

Response to Question 1d:

Encourage patients to use lower-cost community providers. Payors, employers and policy makers should more actively promote the high-quality care available in a patient's community. This may help reduce the shift of services to large and more costly academic medical centers.

HMC recommends that there be more specific interoperability standards related to the exchange of information.

Exhibit 1 AGO Questions to Hospitals

NOTES:

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

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											16,244,928	7,199,274			
Tufts Health Plan											2,111,885	96,589			
Harvard Pilgrim Health Care											656,901				
Fallon Community Health Plan											1,696,296				
CIGNA											2,873,853	59,805			
United Healthcare											2,057,100				
Aetna											597,918				
Health new england					13,373,189										
Other Commercial											2,549,784	2,900,896			
Total Commercial					13,373,189						28,788,665	10,256,564			
Network Health											5,986,069				
Neighborhood Health Plan											3,067,749				
BMC HealthNet, Inc.											26,544,831				
Health New England					257,403										
Fallon Community Health Plan															
Other Managed Medicaid											336,266				
Total Managed Medicaid					257,403						35,934,915	0			
MassHealth											26,876,727				
Tufts Medicare Preferred											772,963				
Blue Cross Senior Options											4,816,337				
Health New England					1,935,919										
CCASR Medicare											1,449,328				
United healthcare															
AARP															
Other Comm Medicare											1,932,048				
Commercial Medicare Subtotal					1,935,919						8,970,676	0			
Medicare											82,861,751				
Other											16,222,916				
GRAND TOTAL					15,566,511						199,655,650	10,256,564			

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											14,550,892	8,814,007			
Tufts Health Plan											2,415,312	114,318			
Harvard Pilgrim Health Care											705,939				
Fallon Community Health Plan											1,449,547				
CIGNA											2,786,724	458,323			
United Healthcare											1,043,841				
Aetna											835,853				
Health new england					14,952,461										
Other Commercial											3,928,956	2,839,182			
Total Commercial					14,952,461						27,717,064	12,225,830			
Network Health											6,192,018				
Neighborhood Health Plan											2,601,689				
BMC HealthNet, Inc.											31,139,010				
Health New England					2,779,807										
Fallon Community Health Plan															
Other Managed Medicaid											1,590,062				
Total Managed Medicaid					2,779,807						41,522,779	0			
MassHealth											28,165,587				
Tufts Medicare Preferred											1,176,145				
Blue Cross Senior Options											5,239,048				
Health New England					3,200,863										
CCASR Medicare											2,704,020				
United healthcare															
AARP															
Other Comm Medicare											2,149,095				
Commercial Medicare Subtotal					3,200,863						11,268,308	0			
Medicare											91,335,551				
Other											18,666,699				
GRAND TOTAL					20,933,131						218,675,988	12,225,830			

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											14,560,633	8,380,268			
Tufts Health Plan											2,159,261	192,033			
Harvard Pilgrim Health Care											1,039,167				
Fallon Community Health Plan											1,442,409				
CIGNA											1,907,810	1,381,772			
United Healthcare											1,866,933				
Aetna											597,918				
Health new england					14,470,269										
Other Commercial											3,171,678	2,971,322			
Total Commercial					14,470,269						26,745,809	12,925,395			
Network Health											7,735,815				
Neighborhood Health Plan											2,464,171				
BMC HealthNet, Inc.											32,015,893				
Health New England					2,379,458										
Fallon Community Health Plan															
Other Managed Medicaid											1,415,696				
Total Managed Medicaid					2,379,458						43,631,575	0			
MassHealth											28,628,682				
Tufts Medicare Preferred											1,196,390				
Blue Cross Senior Options											4,124,765				
Health New England					4,106,762										
CCASR Medicare											3,601,671				
United healthcare											468,286				
AARP											685,974				
Other Comm Medicare											1,341,526				
Commercial Medicare Subtotal					4,106,762						11,418,612	0			
Medicare											90,511,066				
Other											19,253,376				
GRAND TOTAL					20,956,489						220,189,120	12,925,395			

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											12,540,563	8,111,868			
Tufts Health Plan											2,273,864	424,398			
Harvard Pilgrim Health Care											1,006,798				
Fallon Community Health Plan											1,741,301				
CIGNA											1,349,872	1,714,284			
United Healthcare											1,925,365				
Aetna											617,871				
Health new england					14,251,966										
Other Commercial											2,855,029	3,067,954			
Total Commercial					14,251,966						24,310,663	13,318,504			
Network Health											7,051,264				
Neighborhood Health Plan											2,428,642				
BMC HealthNet, Inc.											36,291,293				
Health New England					3,397,753										
Fallon Community Health Plan															
Other Managed Medicaid											774,229				
Total Managed Medicaid					3,397,753						46,545,428				
MassHealth											26,076,750				
Tufts Medicare Preferred											1,497,044				
Blue Cross Senior Options											4,229,195				
Health New England					5,013,463										
CCASR Medicare											3,258,981				
United healthcare											951,906				
AARP											961,661				
Other Comm Medicare											1,372,188				
Commercial Medicare Subtotal					5,013,463						12,270,975				
Medicare											88,330,117				
Other											17,957,219				
GRAND TOTAL					22,663,182						215,491,152	13,318,504			

2014

	P4P Contracts				Risk Contracts			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue	
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO
Blue Cross Blue Shield								
Tufts Health Plan								
Harvard Pilgrim Health Care								
Fallon Community Health Plan								
CIGNA								
United Healthcare								
Aetna								
Health new england					11,642,167			
Other Commercial								
Total Commercial					11,642,167			
Network Health								
Neighborhood Health Plan								
BMC HealthNet, Inc.								
Health New England					3,456,119			
Fallon Community Health Plan								
Other Managed Medicaid								
Total Managed Medicaid					3,456,119			
MassHealth								
Tufts Medicare Preferred								
Blue Cross Senior Options								
Health New England					4,558,399			

CCASR Medicare								
United healthcare								
AARP								
Other Comm Medicare								
Commercial Medicare Subtotal					4,558,399			
Medicare								
Other								
GRAND TOTAL					19,656,685			

Quality Incentive Revenue		FFS Arrangements		Other Revenue		
HMO	PPO	HMO	PPO	HMO	PPO	Both
		9,128,000	6,714,732			
		2,129,065	470,281			
		797,975				
		1,636,623				
		965,289	1,892,430			
		1,584,712				
		439,959				
		2,002,492	3,395,947			
		18,684,115	12,473,390			
		5,786,755				
		2,767,673				
		29,174,153				
		712,999				
		38,441,580				
		21,951,795				
		977,632				
		3,030,219				

		3,781,906				
		1,280,552				
		983,594				
		1,446,261				
		11,500,164				
		70,391,645				
		11,834,992				
		172,804,291	12,473,390			

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													-	-		
Medical	6121094	-918592			34,574,161	(3,016,993)			186,346	(252,082)			40,881,601	(4,187,667)		
Cardiac Surgery													-	-		
Dental													-	-		
Dermatology													-	-		
Endocinology													-	-		
Gastroenterology													-	-		
General Medicine													-	-		
General Surgery													-	-		
Gynecology													-	-		
Hematology													-	-		
Infectious Disease													-	-		
Neonatology													-	-		
Nephrology													-	-		
Neurology													-	-		
Neurosurgery													-	-		
Normal Newborns	193669	-54218			2,405,278	1,684,553			8,373	1,641			2,607,320	1,631,976		
Obstetrics	650261	-332164			2,561,672	(36,739)			7,441	(6,164)			3,219,374	(375,067)		
Oncology													-	-		
Ophthalmology													-	-		
Orthopedics													-	-		
Otolaryngology													-	-		
Psychiatry	827060	-252145			3,437,271	(1,565,567)			77,075	(33,731)			4,341,406	(1,851,443)		
Pulmonary													-	-		
Rehab													-	-		
Rheumatology													-	-		
Transplant Surgery													-	-		
Trauma													-	-		
Urology													-	-		
Vascular Surgery													-	-		
Other Inpatient													-	-		
Imaging															-	-
Other Treatments															-	-
Laboratory															-	-
Ambulatory Surgery															-	-
Therapies															-	-
Office Visits															-	-
Emergency			2217696	47,677			8,084,621	(620,957)			1,292,328	1,635			11,594,645	(571,645)
Observation			953456	290,223			2,417,811	(1,026,728)			105,763	9,412			3,477,030	(727,093)
Surgical day care			3362345	(193,012)			3,973,641	(2,234,869)			119,088	(24,419)			7,455,074	(2,452,300)
Referral			9611387	1,437,012			16,723,893	(1,483,296)			818,349	261,820			27,153,629	215,536
Recurring			951834	371,268			1,462,498	464,560			594,424	165,397			3,008,756	1,001,225
Other Outpatient																-
GRAND TOTAL	**7792084**	**-1557119**	**17096718**	**1,953,168**	**42,978,382**	**(2,934,746)**	**32,662,464**	**(4,901,290)**	**279,235**	**(290,336)**	**2,929,952**	**413,845**	**51,049,701**	**(4,782,201)**	**52,689,134**	**(2,534,277)**

2011

Service Category	Commercial				Government				All Other				Total			
	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													-	-		
Medical	5,700,829	485,009			34,323,597	(1,281,119)			247,575	(197,239)			40,272,001	(993,349)		
Cardiac Surgery													-	-		
Dental													-	-		
Dermatology													-	-		
Endocinology													-	-		
Gastroenterology													-	-		
General Medicine													-	-		
General Surgery													-	-		
Gynecology													-	-		
Hematology													-	-		
Infectious Disease													-	-		
Neonatology													-	-		
Nephrology													-	-		
Neurology													-	-		
Neurosurgery													-	-		
Normal Newborns	225,796	(6,547)			2,171,890	1,517,978			8,064	4,217			2,405,750	1,515,648		
Obstetrics	711,093	(308,189)			2,267,573	(347,585)			15,383	(11,952)			2,994,049	(667,726)		
Oncology													-	-		
Ophthalmology													-	-		
Orthopedics													-	-		
Otolaryngology													-	-		
Psychiatry	986,176	(111,956)			3,468,759	(1,119,846)			73,905	(13,853)			4,528,840	(1,245,655)		
Pulmonary													-	-		
Rehab													-	-		
Rheumatology													-	-		
Transplant Surgery													-	-		
Trauma													-	-		
Urology													-	-		
Vascular Surgery													-	-		
Other Inpatient													-	-		
Imaging															-	-
Other Treatments															-	-
Laboratory															-	-
Ambulatory Surgery															-	-
Therapies															-	-
Office Visits															-	-
Emergency			2,318,028	291,356			8,605,287	20,986			1,448,539	263,433			12,371,854	575,775
Observation			922,477	(177,347)			2,266,064	(3,680,956)			66,574	(70,159)			3,255,115	(3,928,462)
Surgical day care			3,402,156	(1,227,255)			3,930,211	(4,377,100)			157,113	(78,856)			7,489,480	(5,683,211)
Referral			8,746,580	557,092			16,839,469	(2,095,768)			861,140	237,857			26,447,189	(1,300,819)
Recurring			995,391	330,432			1,513,643	422,739			614,802	151,266			3,123,836	904,437
Other Outpatient															-	-
GRAND TOTAL	**7,623,894**	**58,317**	**16,384,632**	**(225,722)**	**42,231,819**	**(1,230,572)**	**33,154,674**	**(9,710,099)**	**344,927**	**(218,827)**	**3,148,168**	**503,541**	**50,200,640**	**(1,391,082)**	**52,687,474**	**(9,432,280)**

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													-	-		
Medical	6,052,020	(1,011,181)			35,465,447	(5,735,757)			350,580	(390,023)			41,868,047	(7,136,961)		
Cardiac Surgery													-	-		
Dental													-	-		
Dermatology													-	-		
Endocinology													-	-		
Gastroenterology													-	-		
General Medicine													-	-		
General Surgery													-	-		
Gynecology													-	-		
Hematology													-	-		
Infectious Disease													-	-		
Neonatology													-	-		
Nephrology													-	-		
Neurology													-	-		
Neurosurgery													-	-		
Normal Newborns	154,476	(47,037)			1,859,904	1,150,031			2,068	(12,691)			2,016,448	1,090,303		
Obstetrics	575,436	(178,505)			2,024,681	(247,481)			5,851	(16,399)			2,605,968	(442,385)		
Oncology													-	-		
Ophthalmology													-	-		
Orthopedics													-	-		
Otolaryngology													-	-		
Psychiatry	642,116	(59,948)			3,353,623	(1,547,647)			54,099	(32,124)			4,049,838	(1,639,719)		
Pulmonary													-	-		
Rehab													-	-		
Rheumatology													-	-		
Transplant Surgery													-	-		
Trauma													-	-		
Urology													-	-		
Vascular Surgery													-	-		
Other Inpatient													-	-		
Imaging															-	-
Other Treatments															-	-
Laboratory															-	-
Ambulatory Surgery															-	-
Therapies															-	-
Office Visits															-	-
Emergency			2,310,559	207,368			9,303,875	(179,949)			1,344,997	139,111			12,959,431	166,530
Observation			903,804	116,777			2,501,379	(2,034,012)			85,564	(31,939)			3,490,747	(1,949,174)
Surgical day care			3,348,608	9,878			4,540,454	(2,212,406)			252,275	(63,576)			8,141,337	(2,266,104)
Referral			8,151,796	(632,866)			17,186,337	(4,336,159)			915,884	114,768			26,254,017	(4,854,257)
Recurring			1,040,780	276,307			1,486,814	258,952			533,641	58,893			3,061,235	594,152
Other Outpatient															-	-
GRAND TOTAL	**7,424,048**	**(1,296,671)**	**15,755,547**	**(22,536)**	**42,703,655**	**(6,380,854)**	**35,018,859**	**(8,503,574)**	**412,598**	**(451,237)**	**3,132,361**	**217,257**	**50,540,301**	**(8,128,762)**	**53,906,767**	**(8,308,853)**

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													-	-		
Medical	4,659,881	(1,371,206)			36,019,010	(7,982,162)			303,932	(379,466)			40,982,823	(9,732,834)		
Cardiac Surgery													-	-		
Dental													-	-		
Dermatology													-	-		
Endocinology													-	-		
Gastroenterology													-	-		
General Medicine													-	-		
General Surgery													-	-		
Gynecology													-	-		
Hematology													-	-		
Infectious Disease													-	-		
Neonatology													-	-		
Nephrology													-	-		
Neurology													-	-		
Neurosurgery													-	-		
Normal Newborns	198,838	(31,546)			2,035,003	1,345,373			1,785	(21,081)			2,235,626	1,292,746		
Obstetrics	669,982	(125,069)			2,046,797	74,981			5,533	(8,955)			2,722,312	(59,043)		
Oncology													-	-		
Ophthalmology													-	-		
Orthopedics													-	-		
Otolaryngology													-	-		
Psychiatry	902,917	(76,347)			3,758,456	(1,716,924)			37,325	(67,970)			4,698,698	(1,861,241)		
Pulmonary													-	-		
Rehab													-	-		
Rheumatology													-	-		
Transplant Surgery													-	-		
Trauma													-	-		
Urology													-	-		
Vascular Surgery													-	-		
Other Inpatient													-	-		
Imaging															-	-
Other Treatments															-	-
Laboratory															-	-
Ambulatory Surgery															-	-
Therapies															-	-
Office Visits															-	-
Emergency			2,145,553	235,500			9,789,338	203,768			1,316,741	197,470			13,251,632	636,738
Observation			963,501	165,080			2,544,251	(1,753,306)			73,602	(15,719)			3,581,354	(1,603,945)
Surgical day care			3,543,319	354,177			4,331,506	(1,616,025)			210,073	(55,945)			8,084,898	(1,317,793)
Referral			7,832,504	(901,200)			18,846,789	(2,934,944)			905,887	202,222			27,585,180	(3,633,922)
Recurring			919,295	249,892			1,812,544	491,447			468,334	63,581			3,200,173	804,920
Other Outpatient															-	-
GRAND TOTAL	**6,431,618**	**(1,604,168)**	**15,404,172**	**103,449**	**43,859,266**	**(8,278,732)**	**37,324,428**	**(5,609,060)**	**348,575**	**(477,472)**	**2,974,637**	**391,609**	**50,639,459**	**(10,360,372)**	**55,703,237**	**(5,114,002)**

2014

Service Category	Commercial				
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)
Burns					
Cardiology Total					
Invasive					
Medical	4,221,710	-1,220,579			28,235,169
Cardiac Surgery					
Dental					
Dermatology					
Endocinology					
Gastroenterology					
General Medicine					
General Surgery					
Gynecology					
Hematology					
Infectious Disease					
Neonatology					
Nephrology					
Neurology					
Neurosurgery					
Normal Newborns	197,176	22,037			1,642,413
Obstetrics	522,494	-62,902			1,655,051
Oncology					
Ophthalmology					
Orthopedics					
Otolaryngology					
Psychiatry	559,454	-146,196			3,402,087
Pulmonary					
Rehab					
Rheumatology					
Transplant Surgery					
Trauma					
Urology					
Vascular Surgery					
Other Inpatient					
Imaging					
Other Treatments					
Laboratory					
Ambulatory Surgery					
Therapies					
Office Visits					
Emergency			1,659,608	126,433	
Observation			715,800	63,382	
Surgical day care			2,806,809	288,386	

Referral			6,951,589	-891,228	
Recurring			763,123	167,858	
Other Outpatient					
GRAND TOTAL	**5,500,834**	**-1,407,640**	**12,896,929**	**-245,169**	**34,934,720**

Government			All Other			
Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
(7,787,832)			156,245	(296,965)		
1,115,703			697	(104)		
123,452			3,616	(239)		
(1,390,547)			-	(23,352)		
	8,788,120	975,996			1,492,490	656,002
	2,402,145	(1,264,120)			10,806	(20,602)
	3,476,024	(1,522,349)			218,198	(19,961)

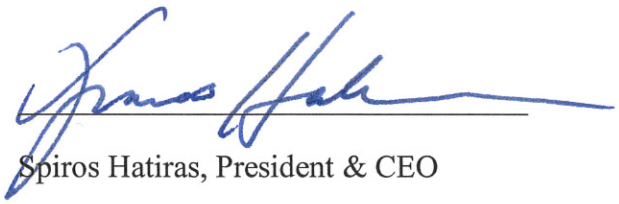
	16,739,316	(1,940,806)			870,942	260,101
	1,774,186	551,647			371,096	6,568
(7,939,224)	**33,179,791**	**(3,199,632)**	**160,558**	**(320,660)**	**2,963,532**	**882,108**

Total			
Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
-	-		
-	-		
-	-		
32,613,124	(9,305,376)		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
1,840,286	1,137,636		
2,181,161	60,311		
-	-		
-	-		
-	-		
-	-		
3,961,541	(1,560,095)		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
-	-		
		-	-
		-	-
		-	-
		-	-
		-	-
		-	-
		11,940,218	1,758,431
		3,128,751	(1,221,340)
		6,501,031	(1,253,924)

		24,561,847	(2,571,933)
		2,908,405	726,073
			-
40,596,112	**(9,667,524)**	**49,040,252**	**(2,562,693)**

EXHIBIT B – Holyoke Medical Center

Spiros Hatiras, the signatory, is legally authorized and empowered to represent Holyoke Medical Center for the purposes of this testimony, and the testimony is signed under the pains and penalties of perjury.



Spiros Hatiras, President & CEO