MOUNT AUBURN CAMBRIDGE INDEPENDENT PRACTICE ASSOCIATION, INC.

MACIPA

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September 8, 2014

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

VIA EMAIL AT HPC-Testimony@state.ma.us

Dear Mr. Seltz:

Enclosed please find our written testimony in answer to the questions provided by the Health Policy Commission and the Attorney General's Office.

Sincerely yours,

Barbara Spivak, M.D.
President and Chair of Board

Enclosures

Exhibit B: Responses to Health Policy Commission (HPC) Questions for Written Testimony

Brief Summary

Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA) is a physician membership organization established in 1985. MACIPA has had risk contracts since the inception of the organization and most recently with CMS for their Pioneer Accountable Care Organization program. The risk is shared with our partner hospital Mount Auburn Hospital. Surplus earned under the contracts is distributed to MACIPA and shared with Mount Auburn Hospital. A significant amount of the surplus goes to support MACIPA's infrastructure that is essential to perform well in risk contracts. MACIPA also subsidizes the cost of the EHR in the physician practices. Understanding and support for the costs involved in providing non-billable services that supports population management and quality improvement expectations is essential.

Statement that signatory is legally authorized to represent MACIPA, signed under pain of perjury

I, Barbara Spivak, MD, the President and Chairman of the Board of the Mount Auburn Cambridge Independent Practice Association, Inc. am legally authorized to represent MACIPA, signed under pain of perjury.

09/08/2014

Questions:

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

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

   SUMMARY:

   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

      We have seen favorable revenue trends through 2013 due to favorable performance in health plan contracts. We expect to see a significant drop beginning in CY 2014 due to contractual changes.

We have seen a consistent small percentage decreases in our utilization throughout CY 2010 -2013. For specific utilization trends, please reference materials on utilization sent to Ms. Megan Wulff on February 3, 2014 in response to the RFI regarding the acquisitions of Winchester Hospital and Hallmark Health System.

Operational costs have increased over the past few years as a result of the additional infrastructure needed to support us in meeting the goals of our extensive and expanding risk contracts.

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?

We have developed programs to reduce the cost of patient services including complex care management provided by nurse care managers and social workers who deal with behavioral health issues, disease management, social work, pharmacy management, quality improvement, utilization management, and referral management. We manage, train and support the EHR for over 200 physicians. These programs contribute to controlling health care costs, improving the quality of care and patient outcomes. They are interconnected and together improve the patient experience of health care, care outcomes and reduce cost.

<u>Complex Care and Case Management -</u> MACIPA is delegated to provide its own case management services for two of the major commercial health plans. The plans require us to comply with NCQA requirements in order to delegate this function to us. The services provided by MACIPA care managers include:

- Care Management services for patients with complex needs at all levels, e.g., home, inpatient, SNF, rehab.
- Utilizing clinical criteria to identify the most cost effective setting for care delivery.
- Directing patients to preferred contracted ancillary providers, when appropriate.
- Ensuring that patients are prepared for discharge from the hospital and understand their post-discharge instructions:
    - Have a follow- up PCP appointment scheduled by the case manager.
    - Understand their medications and how to take them.
    - Understand what symptoms to watch for and what to do if they arise.
    - Patients are called at home by Care Management post discharge.

Together these activities help to keep the patient from being readmitted to the hospital after discharge.

To manage our ACO population effectively, we have embedded Care Managers to specific practices to manage the high risk patient population. Patients are identified as high risk by physician assessment, the use of high risk criteria, and predictive modeling software. The Guided Care Model is our standard of care. NCQA standards for disease management are used for assessment of high risk patients. They are included in our Care Management software application.

We work closely with the skilled nursing facilities (SNFs) where the highest volume of our patients transition from an acute hospital setting. We collaborate with the SNFs to decrease average length of stay and to improve the quality of transitions in care.

We have a Case Manager who works with our preferred SNFs to review and track discharge goals and therapies provided. The Case Manager partners with the physician and the facilities to educate, facilitate, and assist in coordinating care for our patients. We educate the SNFs on our expectations including the services that can be provided when the patient is discharged. We are steadily improving communications and workflows between the facility, Case Manager, and attending physician.

A collaborative effort was also developed and approved by the five Eastern Massachusetts Pioneer ACOs. The work has been motivated by the desire to provide a common vision for quality improvement in nursing home care, and to reduce the need of skilled facilities to respond to multiple sets of potentially conflicting expectations. Many of the criteria should be easily achievable, while others will require some time and additional resources. The goal is to have the collaboration effort among these ACOs serve as a shared blueprint for long-standing quality improvement efforts between our ACOs and nursing facilities and their provider teams.

<u>Social Work Department</u> - In 2012 we established a social work department. We now have a team of a director, three social workers and four health coaches. A consultative model was selected, and the social worker is the point of contact with the nurse case manager, who works with each of our primary physician Pods.

The social work team has researched the various community support programs available which would benefit our patients. By aligning our efforts with the state-wide network of Aging Services Access Points (ASAPs), the patients benefit from various services <u>at no cost to them</u>. The philosophy of the program is to provide consumer directed care which supports providing the patient with options, helping the patient understand their options, all while respecting patient choice.

MACIPA Social Workers also work collaboratively with the Mount Auburn Hospital (MAH) Social Workers regarding Medicare ACO patients in order to facilitate seamless transition back to the community. A goal of the Social Work referrals and interventions is decreased utilization, e.g., ER use, hospital admissions, and readmissions.

Electronic Health Record (EHR) – MACIPA implements, trains, hosts and supports member physicians on an electronic health record. Currently, 397 providers and over 1100 staff are using the EHR software provided by MACIPA. We have developed interfaces to the Mount Auburn Hospital system, Meditech, to provide laboratory and radiology test results and department reports (e.g., discharges, History and Physical). We also have an interface with Quest Laboratory. We have implemented a community record to improve continuity of care across multiple settings, making information available to our providers who are using the EHR at the point of care. The EHR will continue to improve the quality of care and reduce costs as physicians share information on their patients, see the results of tests that were already performed and are better informed than with paper record systems. Our staff works closely with the staff of the physician practices, holding Superuser and Office Manager meetings on a regular basis. We support our EHR users to achieve Meaningful Use and have an IT Committee of physicians who continue to look for better ways to use the EHR. These services are critical to our performance in risk contracts. While they support our goal of reducing the cost of care, they are nevertheless costly and increase our infrastructure expense.

Coordination of Data – MACIPA has worked hard to improve the quality of care provided to all patients by standardizing specific clinical care processes across our members' practices. We use both data systems and human resources to drive standardization. MACIPA started its Quality Improvement Program in 2004, before any pay-for-performance contracts were in place. Recognizing the need to improve quality through population health management we use an interdisciplinary team including case managers, physicians, nurses and a pharmacist to review areas ripe for quality improvement.

The Quality team recognized that data must drive its efforts. It sought to identify current performance, preferably from MACIPA EHRs, as the data source that most closely represents the 'clinical reality' that we could hope to measure at this time. We implemented an ongoing training program to promote our quality metrics with our Primary Care Physicians. We outlined new measures and provided physicians guidance on workflows that would allow us to begin to measure performance. We offer educational sessions with Specialists on specific measures that need their collaboration.

We remind physicians about existing reporting and performance improvement work including:

- Diabetes Metrics
- Colon, breast, and cervical cancer screening
- Blood pressure control in DM and HTN
- Patient experience improvement work

We have created a Business Intelligence team that includes a Data Warehouse Manager, Database Administrator, and analysts. We extract data from the EHR

and combine it with claims data and other clinical data to produce reports that help to support the clinical work done by our physicians.

Pharmacy management – Our clinical pharmacist works with physicians on alternatives to higher cost drugs and to identify harmful drug-drug interactions. The clinical pharmacist provides a MACIPA formulary annually to physicians and tracks the use of generic vs. brand name drugs. The result is lower cost of medications for MACIPA patients, their employers and health plans. Physicians are free to reject the recommendation of the clinical pharmacist in the exercise of their independent medical judgment.

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?

   We plan on continuing the actions and efforts as outlined in section B above and will continue to monitor our performance and identify additional areas of opportunity, as necessary.

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

      Promoting more use of local community hospitals. In our case that is Mount Auburn Hospital. Mount Auburn Hospital offers more than the typical community hospital's services since it is also a teaching hospital and is more cost effective than using a quaternary medical center. Insurance products that help move care to lower cost, local community hospitals will help to control cost. On the other hand, patients with complicated procedures that require care in an academic facility should not be penalized, with higher copays, for being sick.

      We also believe that all patients should be required to identify a physician of choice. Patients are better served when a Primary Care Physician (PCP) is managing their care. Many patients are now in PPO plans that do not require designation of a PCP. With realignment of a patient and a PCP, preventive care is enhanced, care management for high risk patients can be instituted and gaps in care identified.

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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:

   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?

Unlike other provider organizations in Massachusetts, our contracts have always been risk-based since the inception of our organization. The majority of our contracts are risk based including the newest form of risk contracting, with the Centers for Medicare and Medicaid Services (CMS) and its Center for Medicare and Medicaid Innovation as a Pioneer Accountable Care Organization. Inherent in risk contracts is the goal of providing the appropriate care in the appropriate setting while optimizing quality and reducing cost. Financial savings are theoretically passed on to businesses and consumers.

We are happy to see the Commonwealth of Massachusetts Group Insurance Commission (GIC) is moving in this direction. We have finalized contracts with two health plans for the GIC's initiative for the development of Integrated Risk Bearing Organizations. While the current model is an attribution versus patient-selection of PCP, we hope that the GIC transitions towards encouraging patients to select a primary care physician or physician of choice.

MACIPA was the first physician organization in Massachusetts to sign an Alternative Quality Contract with Blue Cross and Blue Shield of Massachusetts in 2009. We continue to participate in the AQC and recently renegotiated our contract early to be more in line with desired trends. Many other physician organizations and hospitals have sought our advice on successful physician engagement in care coordination and quality improvement efforts, what type of services should be provided and the staff needed to provide these. We have a reputation as an innovative, risk taking organization that develops its own solutions to managed care issues.

MACIPA is one of the original thirty-two organizations nationwide participating in CMS's first Pioneer Accountable Care Organization program contracts for Medicare beneficiaries. We were chosen in a highly competitive selection process. We are one of the thirteen organizations of the thirty-two that saved money for Medicare in the first year and second year of the program due to our efforts to improve the quality of care, the health of populations and to reduce per capita costs.

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).

   Since MACIPA has always been in risk contracts this question is not applicable to us. This is applicable for organizations that were in FFS contracts and are now pursuing APM contracts.

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

See response above in B.

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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:
    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?

       Although we are not health status risk adjustment experts our opinion is that the absence of socioeconomic factors and behavioral health conditions are problematic. Depending on the risk arrangement structure, it is important to have risk adjusters applied to the budgeted capitation to reflect changes in patient acuity and changes to the health status of patients moving in and out of our patient panel. In general we find that they directionally account for differences patient acuity and that it is preferential to measure acuity concurrently rather than prospectively. The risk adjustment methodology is a black box analysis and we are not privy to the details to make any conclusions regarding whether or not the risk adjustment sufficiently accounts for acuity and therefore the correct allocation of dollars to the budgeted capitation. We also have concerns regarding the impact on the transition to ICD-10 and the accuracy of risk adjustment during this transition period. We also believe that there should be risk adjustment for quality metrics.

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

       All commercial payors use the same risk adjustment tool from Verisk Health, DXCG.

    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?

       In contracts where changes in DXCG risk scores are applied, it can have a positive or negative effect on the budgeted capitation which could impact surplus. Risk share is not affected by risk adjustment nor are the quality incentives.

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:

   We already receive claims data from the health plans where we have risk contracts. We are able to, although not easily, extract data from the back-end of our primary EMR. In our partnership with Mount Auburn Hospital and Cambridge Health Alliance we are able to obtain some clinical data such as lab values and screening tests such as mammograms and colonoscopies. All these data sets are incorporated into our home grown data warehouse and used for reporting.

   Historic claims data is valuable as patients change insurers or even insurer products within the same plan. For example, being able to access a patient's colonoscopy performed five years ago when the patient was at one health plan but is now at another health plan would help to verify that the patient had the test done regardless of payer or plan i.e., PPO, HMO, or POS.

   With respect to real time data, that would only be achieved if the data was available directly from the providers such as physician EMRs and hospital information systems such as Meditech or Epic.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY

   a. Which attribution methodologies most accurately account for patients you care for?

      As more employers move to PPO products, it is difficult to manage care, even with a well-designed attribution methodology. Using the Physician of Choice Model (POC) ensures that the patient has chosen the system they wish to be part of, yet does not limit access.

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

      We feel the adoption of Physician of choice model is the best method for accurately accounting for patients.

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 effort required to report on quality measures is significant. It starts with educating providers and office staff on measures by payer, making necessary modification in the EMRs for data capture that is accompanied by significant amounts of training at the practice level with respect to work flow changes to accommodate the measures as well as teaching providers and staff where to document for these. Lab tests values done at non MACIPA facilities are usually not available. Our recent experience with collecting the data for the public payer, Medicare, was extremely time consuming. It took staff dedicated to this task 6 weeks of doing chart reviews. For one private payer the effort is still significant but less cumbersome due to smaller membership as well as fewer measures that require outcomes data such as lab values.

   There is variability in measures across public and private payers. We are responsible for over 100 quality measures across various payers. The private payers use HEDIS measures, but often times there is a lag as to when these measures are updated to reflect changes in clinical recommendations. Medicare has a separate set of quality measures; there are small similarities in these measures. There is even variability in the diabetic and cardiac measures in our contracts which make it very difficult to manage. This requires education to physicians and office staff on different goals by payer.

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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:
   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.

      Please see Attachment 2 for 2013 Inpatient Utilization for our Medicare ACO population for top 10 hospitals with Medicare ACO patient discharges.

   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 handle referral management by educating of our physicians about specialist expertise in our system. We monitor leakage on a quarterly basis with our PCPs. We have also monitored access to specialists and have worked with our specialist to improve access. We believe integration of nurse and social work case management as well as population health efforts have also helped to decrease leakage and has had the effect of directing more patients to Mount Auburn Hospital verses other hospitals. Due to these efforts we have seen an increase in the number of patients staying within MACIPA and Mount Auburn Hospital for specialty services.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
   SUMMARY:

   a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

      Please see Attachment 3 with utilization and average length of stay data at our preferred skilled nursing facilities.

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

   We firmly believe that there are significant opportunities in transferring patients to lower level facilities and ultimately to home that would represent decreased costs in the post-acute care settings without compromising the quality of patient care.

   We have recently engaged with Optum to provide post-acute care services to our ACO patients who are in a skilled nursing facility (SNF). Optum Nurse Practitioners work with our preferred SNFs to set realistic and appropriate goals for patients at these SNFs. This has helped in shortening the length of stay with no adverse effects on patient care. We have also developed a preferred list of SNFs that we utilize. This gives us the ability to have enhanced medical care teams at these facilities. Patients still have the option to go to non-preferred SNF's, but there is great value to those transferred to our preferred SNFs. We also have an advanced home care team that has helped to reduce length of stay in SNFs.

   Another program Optum provides is a transition to home program. This is a 30 day program where a nurse practitioner provides in home post-discharge services. We are encouraged by our early experience using this program and hope to see favorable outcomes for our ACO patients.

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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:

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

** Please indicate the unit of time reported.*

ANSWER:

We have received no patient inquiries to provide this information. Patients direct these inquiries to their PCP, specialist or hospital that would be performing procedures. We have no data on any of those inquiries.

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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:

ANSWER:

One of the biggest struggles we face regarding tiered and limited networks is the variability in health plan tiers and methodologies as well as variability within health plans products. Each health plan has goals for tiering (e.g., 1/3rd of network in tier 1.) Because of this our physician's tiers differ by health plan. We were very surprised to learn that we were in the highest tier for one particular commercial payer's tiered network, while we were in the lowest tier for another payer. With one payer who has two tiered products we were in the favorable tier for the one product and in the unfavorable tier for the other product. After discussing this with the payer, it was realized that this was an unintended consequence of performing well under our defined contract terms. We have not done any analytics on how tiering has impacted referral patterns for our patients.

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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:
    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.

       We have developed an internal behavioral health and social work program and have incorporated these services within our PCP practices.

    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.

       Unfortunately due to poor access of behavioral health services in the community we have been unable to make an impact on the use or emergency room and psychiatric inpatient care services.

    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.

       Behavioral Health Care needs to be addressed in a totally different payment model. It is not reasonable to hold physicians accountable for care in a system where access is limited by provider's unwillingness to take insurance because managed care behavioral companies pay such low rates and make reimbursement so difficult. Work provided by Social Worker's and Health Coaches in the PCP offices is not reimbursable and there is limited Case Management of this population.

    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.

    Behavioral health discharge data should be reported through health plans or the inpatient mental health facilities. We do not take financial risk on behavioral health uniformly across risk contracts; therefore we do not receive behavioral health data from all plans.

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY:
    e. 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?

       We currently have 41% of our PCPs in NCQA Level 3 Certified Patient Centered Medical Homes. We are currently in the process of getting an additional 28% of PCPs in NCQA Level 3 Certified Patient Centered Medical Homes

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

       We currently have 43% of our risk patients in NCQA Level 3 Certified Patient Centered Medical Home practices. Once we have the additional PCPs in NCQA Level 3 Certified Patient Centered Medical Homes we will have 67% of our risk patients in NCQA Level 3 Certified Patient Centered Medical Home practices.

    g. 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.

       We have not done any analysis on the impact of PCMH recognition.

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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.

    We would like to share some thoughts on few different areas.

    As finances are becoming more restrictive for the health plans, the hospitals and the physicians it becomes harder for the physicians in particular to support the ACO model. Resources are needed through reimbursement to support PCP's in their work on population management and support of case management and social work functions. At the system level it is vital to have and maintain the infrastructure necessary to support the practices, physicians, and patients. The infrastructure to do all that needs to be done in a well-functioning Accountable Care Organization is very costly. Of note is that because we have the infrastructure to do all this work it has had a positive cost saving effect on the non-risk business that is attributed to the system without any financial support or rewards to that system. While we are not at risk for PPO patients we have seen data that suggests that the TME for that population is lower because our physicians focus on

appropriate quality care in the appropriate setting for that PPO population the same way they manage the risk population.

As more of the health care in the state is delivered by just a few systems, independent groups like MACIPA are concerned about our ability to stay independent from a contractual point of view with the health plans. This also impacts about our ability to hire physicians and therefore growth our patient population.

Behavioral Health Care needs to be addressed in a totally different payment model. It is not reasonable to hold physicians accountable for care in a system where access is limited by providers' unwillingness to take insurance because managed care behavioral companies pay such low rates and make reimbursement so difficult. Work provided by social workers and health coaches in the PCP offices is not reimbursable and there is limited case management of this population.

The Cost Trend report does not accurately reflect the TME. For example, MACIPA receives the entire surplus from one of our insurers and we then share a significant amount of that surplus with our hospital partner. That is not reflected in the Cost Trend Report. We would ask that the Health Policy Commission and or CHIA take this into consideration when publishing MACIPA's TME. We also would ask that some accounting for infrastructure costs be included in the report at least at the system level as running an Accountable Care Organization to provide services to patients and physicians is very costly.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital 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 Provider 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. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   Completed in Attachment AGO Provider Exhibit 1

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2. 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.

   We have built up our expertise in risk contracting and what it takes to perform well over the past two decades. We create projections at the time the contract is being negotiated about the potential to develop a surplus. Once the contract is underway, the health plans provide regular, lagged, reports of financial performance to the budget. We track those patients who are likely to hit the stop-loss threshold and can gauge that performance. Over the years we have built a strong staff and infrastructure that support our mission of improving the quality of care, reducing cost and improving the health of populations.

   We receive lagged fund reports on a monthly basis from the payers showing our performance against budget. Based on our analysis of claims, we put utilization management programs together, identify opportunities for improvement and act on them. We purchase reinsurance on the open market, which is less expensive than buying it from the payer. Reinsurance covers and protects us from catastrophic cases.

   We take a number of factors into account when figuring out whether a budget offered by a payer will be sufficient to be successful. We look at the immediate prior year's performance, the payer's statewide premium as available from the Division of Insurance,

and the member relativity factor. We make assumptions about the likely increases in facility reimbursements at the hospitals we utilize and other facilities and providers our patients utilize We make assumptions about ancillary service increases, pharmacy costs based on national/statewide trends and our own trend, price and utilization assumptions for mental health, out of area expenses, IBNR as compared to prior years. Many of these factors are estimates. We have the claims data to review how costs have trended over multiple years. We factor in reinsurance premium expenses for those plans that give us the option to buy reinsurance on the open market. If we are aware of large outstanding claims from the prior year that will be expensed against the next year, they are included.

We seek advice from an actuary periodically regarding the level of reserves that are appropriate given the amount of risk we have in our contracts. The Physician Participation Agreement (PPA) that binds each physician member to MACIPA describes the way in which a deficit would be paid back by the physicians in the event that MACIPA had a deficit beyond the withheld amount and the reserves we hold. MACIPA has a Line of Credit with the Cambridge Savings Bank. All of these, the withhold, risk reserves, reinsurance, physician liability and limit of liability, and the line of credit, represent MACIPA's "contingency plan" in the event that we run a deficit. We have been fortunate that we have not had an overall deficit and have never had to exercise these resources.

Human resources, salaries and benefits, are our biggest expense. Salaries for RNs, experienced IT professionals, staff with expertise in contract negotiations, data analysis and reporting are high. As more organizations in Massachusetts have taken on risk contracts, it has become more competitive, and expensive, to attract and retain these professionals. Our staff has grown substantially as additional services to support our members became necessary. These now include a large IT department to support the electronic health record used by our physicians. Data warehouse and business intelligence staff is essential to mine the data for the information we need to identify the sickest, frailest patients. Providing preventive health services and population management means that our physicians need information and registries on their patient panels so that they know what each patient needs and work to provide those services and procedures. Our clinical staff works with the patients identified by the tools and reports to coordinate care. All of these services are essential to perform well within risk and they are expensive.

Reserves

We have built risk reserves over many years against the day when we might have an overall deficit in all of our risk contracts. We were also required in our Pioneer ACO contract to provide a financial guarantee, a type of escrow account, with CMS as the beneficiary, this year. The problem with reserves for a for-profit organization is that when we retain funds to put aside for reserves, we have to pay taxes on them, so a great deal of the money is paid in taxes. This puts physician organizations who have taken the risk away from insurance companies at a disadvantage compared to the insurance company. We would like to have the state and federal governments change the requirements and waive taxes on reserves.

Solvency standards

We have gotten actuarial advice at various times about how much we should have in reserve based on the level of risk that we hold. Based on the requirements set by C. 224, we expect to seek advice as required. Our calculations show that we have an average of 5% of the global budget for our commercial risk contracts set aside in our reserves.

Projections and plans for deficit scenarios

We have built Reserves over many years and have provided a financial guarantee where required. There are opportunities to terminate our Pioneer ACO contract if the early financial reports show a significant deficit, therefore, minimizing our losses.

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3. Please explain and submit supporting documents that show the process by which (a) your physicians refer patients to providers within your provider organization and outside of your provider organization; and (b) your physicians receive referrals from within your provider organization and outside of your provider organization. Please include a description of how you use your electronic health record and care management systems to make or receive referrals, any technical barriers to making or receiving referrals, and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization.

Patient referral practices

Wherever possible, we try to keep the services provided to our patients within the MACIPA network. There are several reasons for this. Coordination of care is better when the patient is being seen within our network. Most of our physicians participate in the same electronic health record (EHR) and are able to share information with each other through the EHR, which includes an interface with Mount Auburn Hospital's (MAH) information systems. Services provided at MAH are less expensive than the same procedures provided at a downtown medical center, so the overall cost will be less as well. We refer patients to a small number of Skilled Nursing Facilities (SNF) that work with us to develop a clinically appropriate discharge plan with a shorter length of stay, and enhanced services at home. The services we have built to support these efforts – complex case managers, SNF case manager, social workers, information available in the EHR – can be used to provide a coordinated approach with a managed care philosophy.

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4. Please explain and submit supporting documents that describe how, if at all, information on cost and quality is made available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care. Include in your response any type of information on costs or quality made available to your physicians

through electronic health management, care management, disease management, large case-management or other clinical management programs.

Coordination of Data – MACIPA has worked hard to improve the quality of care provided to all patients by standardizing specific clinical care processes across our members' practices. We use both data systems and human resources to drive standardization. MACIPA started its Quality Improvement Program in 2004, before any pay-for-performance contracts were in place. Recognizing the need to improve quality through population health management we use an interdisciplinary team including case managers, physicians, nurses and a pharmacist to review areas ripe for quality improvement.

The Quality team recognized that data must drive its efforts. It sought to identify current performance, preferably from MACIPA EHRs, as the data source that most closely represents the 'clinical reality' that we could hope to measure at this time. We implemented an ongoing training program to promote our quality metrics with our Primary Care Physicians. We outlined new measures and provided physicians guidance on workflows that would allow us to begin to measure performance. We offer educational sessions with Specialists on specific measures that need their collaboration.

We remind physicians about existing reporting and performance improvement work including:

- Diabetes Metrics
- Colon, breast, and cervical cancer screening
- Blood pressure control in DM and HTN
- Patient experience improvement work

We have created a Business Intelligence department with Business Intelligence and Data Warehouse Managers. We extract data from the EHR and combine it with claims data and other clinical data to produce reports that help to support the clinical work done by our physicians.

For specific sample quality reports please reference materials on quality sent to Ms. Megan Wulff on February 3, 2014 in response to the RFI regarding the acquisitions of Winchester Hospital and Hallmark Health System.

Exhibit 2

2013 Top 10 Acute Facilities for Medicare ACO Discharges

ADMIT YEAR	PROV NAME	NBR OF DAYS	NBR OF DISCH	AVG LOS	% Total DISCH	% Total COST	% In Service Area Discharges	% Total In Service Area Cost
2013	MOUNT AUBURN HOSPITAL	7,856	1,554	5.1	63.92%	60.47%	67.74%	63.38%
2013	LAHEY CLINIC HOSPITAL, INC.	761	144	5.3	5.92%	6.00%	6.28%	6.39%
2013	THE GENERAL HOSPITAL CORPORATION	797	127	6.3	5.22%	7.37%	5.54%	7.86%
2013	BETH ISRAEL DEACONESS MEDICAL CENTER, INC.	444	74	6	3.04%	4.34%	3.23%	4.58%
2013	BRIGHAM AND WOMEN'S HOSPITAL,INC.	376	65	5.8	2.67%	4.77%	2.83%	5.07%
2013	NEWTON WELLESLEY HOSPITAL	229	51	4.5	2.10%	1.52%	2.22%	1.60%
2013	WINCHESTER HOSPITAL	254	50	5.1	2.06%	1.31%	2.18%	1.45%
2013	VHS ACQUISITION SUBSIDIARY NUMBER 9 INC	154	42	3.7	1.73%	1.39%	1.83%	1.48%
2013	CAMBRIDGE PUBLIC HEALTH COMMISSION	169	36	4.7	1.48%	1.45%	1.57%	1.54%
2013	STEWARD ST. ELIZABETH'S MEDICAL CENTER OF BOSTON, INC.	84	24	3.5	0.99%	1.33%	1.05%	1.41%

Exhibit 3

2013 SNF Utilization Medicare ACO Discharges

2013					
ADMIT YEAR	PROV NAME*	AVG LOS	% Total DISCH	% Total COST	2012 ALOS
2013	SNF 1	20.5	15.78%	17.19%	26.10
2013	SNF 2	20.8	8.62%	9.18%	28.90
2013	SNF 3	17.5	8.20%	6.89%	23.00
2013	SNF 4	16.6	4.98%	3.78%	23.70
2013	SNF 5	18.2	4.67%	3.87%	18.50
2013	SNF 6	28.5	4.57%	5.41%	32.80
2013	SFN 7	20.9	3.95%	4.04%	28.30

Note

SNF Facility Names are not listed

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "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 Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements 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 **(a)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$15.14M	X	$8.61M	X	$5.28M	X	X	X	$2.86M	X	X
Tufts	X	X	X	X	$4.70M	X	$2.23M	X	X	X	X	X	$0.73M	X	X
HPHC	X	X	X	X	$4.21M	X	$4.36M	X	X	X	X	X	$0.60M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$24.05	X	$15.20M	X	$5.28M	X	X	X	$4.21M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	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	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(b)**	X	X	X	X	$5.95M	X	$1.72M	X	$0.08M	X	X	X	$1.31M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$5.95M	X	$1.72M	X	$0.08M	X	X	X	$1.33M	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$30.00M	X	$16.92M	X	$5.36M	X	X	X	$5.54M	X	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims payments. Claims-based revenue are received by physicians/practices directly. The numbers provided are per claims data files received by MACIPA.

BCBS includes HMO and POS claims data

Tufts provides claims payment data for HMO products only

HPHC provided claims data for HMO products only in 2010

(b) Tufts Medicare Preferred: Primary Care Physicians (PCP) contracted with Tufts for the TMP product. MACIPA charges the PCP a PMPM management fee to provide administration and management services.

**Surplus received by MACIPA is shared with Mount Auburn Hospital. The numbers reported in this section reflect only the MACIPA portion of the surplus. Some of the surplus received is used to fund the MACIPA infrastructure.

2011

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(a)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$14.45M	X	$10.26M	X	$5.35M	X	X	X	$2.62M	X	X
Tufts	X	X	X	X	$4.63M	X	$3.65M	X	X	X	X	X	$0.74M	X	X
HPHC	X	X	X	X	$11.72M	X	$4.36M	X	X	X	X	X	$0.59M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$30.80M	X	$18.27M	X	$5.35M	X	X	X	$3.97M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	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	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(b)**	X	X	X	X	$6.31M	X	$2.58M	X	$0.02M	X	X	X	$1.45M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.04M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.31M	X	$2.58M	X	$0.02M	X	X	X	$1.49M	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.11M	X	$20.85M	X	$5.37M	X	X	X	$5.46M	X	X

Notes:

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Tufts provides claims payment data for HMO products only
HPHC provided claims data for HMO and POS in 2011, 2012 and 2013

(b) Tufts Medicare Preferred: Primary Care Physicians (PCP) contracted with Tufts for the TMP product. MACIPA charged the PCP a PMPM management fee to provide administration and management services.

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2012

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(a)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$11.60M	X	$9.66M	X	$4.59M	X	X	X	$2.51M	X	X
Tufts	X	X	X	X	$4.88M	X	$3.47M	X	X	X	X	X	$0.70M	$0.03M	X
HPHC	X	X	X	X	$15.34M	X	$4.33M	X	X	X	X	X	$0.59M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.01M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$31.82M	X	$17.46M	X	$4.59M	X	X	X	$3.81M	$0.03M	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	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	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(b)**	X	X	X	X	$5.96M	X	$2.67M	X	$0.06M	X	X	X	$1.55M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.04M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$5.96M	X	$2.67M	X	$0.06M	X	X	X	$1.59M	X	X
Medicare	X	X	X	X	X	X	$1.01M	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.78M	X	$21.14M	X	$4.65M	X	X	X	$5.40M	$0.03M	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims payments. Claims-based revenue are received by physicians/practices directly. The numbers provided are per claims data files received by MACIPA.

BCBS includes HMO and POS claims data

Tufts provides claims payment data for HMO products only

HPHC provided claims data for HMO and POS in 2011, 2012 and 2013

Pioneer ACO Medicare claims are not inclusive of all claims data due to CMS data issues

(b) Tufts Medicare Preferred: Primary Care Physicians (PCP) contracted with Tufts for the TMP product. MACIPA charged the PCP a PMPM management fee to provide administration and management services.

**Surplus received by MACIPA is shared with Mount Auburn Hospital. The numbers reported in this section reflect only the MACIPA portion of the surplus. Some of the surplus received is used to fund the MACIPA infrastructure.

2013

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(a)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$12.17M	X	$4.23M	X	**(c)**	X	X	X	$1.42M	X	X
Tufts	X	X	X	X	$4.63M	X	$3.44M	X	X	X	X	X	$0.70M	$0.06M	X
HPHC	X	X	X	X	15.03M	X	$4.56M	X	X	X	X	X	$0.62M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.01M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$31.83M	X	$12.23M	X	**(c)**	X	X	X	$2.75M	$0.06M	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	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	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(b)**	X	X	X	X	$6.13M	X	$2.09M	X	**(c)**	X	X	X	$1.48M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.03M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.13M	X	$2.09M	X	(c)	X	X	X	$1.51M	X	X
Medicare	X	X	X	X	X	X	$1.13M	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.96M	X	$15.45	X	(c)	X	X	X	$4.26M	$0.06M	X