Mercy
MEDICAL CENTER

Our mission is to heal. Our passion is to care.

271 Carew Street
P.O. Box 9012
Springfield, MA 01102-9012
413-748-9000
mercycares.com

September 8, 2014

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

RE: Testimony for Annual Health Care Cost Trends Hearing - October 6 and 7, 2014

Dear Mr. Seltz:

In response to your letter of August 1, 2014, Mercy Medical Center submits the attached written testimony. Mercy and Sisters of Providence Health System share a mission to be a transforming, healing presence in the communities we serve. With Mercy serving as the hub, SPHS is continues to develop of a high-value, integrated, patient-centered network. This network utilizes the full SPHS continuum of care, including acute care, behavioral health, primary care, rehabilitation, long-term care, home care, lab services and end-of-life care. The SPHS network includes:

- *Mercy Medical Center*: A 182-bed, acute care hospital located in Springfield that. The following entities are also licensed under Mercy:
  - *Weldon Rehabilitation Hospital:* A 60-bed hospital-based rehabilitation center located at Mercy.
  - *Providence Behavioral Health Hospital:* The 120-bed behavioral health campus of Mercy, located in Holyoke, is one of the largest providers of acute behavioral health services in the Commonwealth. Services include inpatient and outpatient psychiatric care for children and adults, inpatient substance abuse treatment, outpatient Methadone treatment and Suboxone treatment.
- *Brightside for Families and Children:* Offers a range of social support services for families with psychiatrically distressed children. Services include home-based family stabilization and treatment, community support programs.
- *Mercy Home Care:* One of the largest home health providers in Western Massachusetts.
- *Mercy Hospice*: patient-centered, culturally-competent, end-of-life care.
- *Mercy Continuing Care Network:* Comprised of six long-term care facilities, an adult day health program and a PACE program.

I am legally authorized and empowered to represent Mercy Medical Center for the purposes of this testimony. I hereby certify under the pains and penalties of perjury that Mercy has made a diligent effort to respond to the foregoing questions, and that, to the best of my knowledge and reasonable belief, the foregoing answers are true and correct.

Sincerely,

Thomas Robert
Sr. Vice President of Finance and CFO
Sisters of Providence Health System

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 websit e .

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: The Commonwealth's growth benchmark has emphasized the need to control cost and Mercy has continued to engage in initiatives to reduce the total cost of care for our patients by focusing on clinical and patient safety processes and systematically looking for opportunities to improve operating performance. Focus has been on: Utilization Management; Readmission within 30 days of discharge; Comprehensive Care Management (movement through the continuum of care); Clinical Improvement (prevention of hospital acquired conditions); and System-wide opportunities (productivity improvements, information technology enhancements, supply costs and other savings). Though many of these areas of focus have achieved success, much impact has been achieved through the Mercy's CareConnect process which is highlighted in the response to Question 1b.
   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.
      Overall revenue was fairly consistent from 2010 to 2014, but there was a signifigant shift in payer mix from Medicaid to Managed Mediciad Care and from Medicare to Managed Medicare Care. Inpatient utilization has seen an interesting trend with Mercy showing a decrease in discharges from 10,797 in 2010 to 10,077 in 2013, while Providence Behavioral Health Hospital (Mery's behavioral health campus) saw in increase in discharges from 4,063 in 2010 to 4,549 in 2013. Mercy's costs were relativley consistent over time (Cost per Case Mix Adjusdted Discharge went from $6,547 in 2010 to $7,014 in 2013 (less than 2.4% per year). Acute care inpatient decreases in utilizaion is the most signifigant trend over the 2010 to 2013 time period. Efforts to manage care transitions and focus on high risk patient post- acute care are factors influencing this trend.
   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?
      Mercy has undertaken many, but the most significant is the continued re-engineering of care coordination and management: This initiative implemented a new, patient-centered, care coordination and management system that integrates departmental and hospital system workflows to reduce the time it takes to place patients in available beds, treat them effectively and discharge them safely to the

next appropriate level of care. The CareConnect Hub utilizes new IT system, real time applications and new staffing to track all inpatients and ED patients in real time. This project has transformed care management to reduce case costs, average LOS, patient flow times, discharge process times, readmission rates, ED holds and the rates of ED patients LWT, while improving quality and patient satisfaction. Signifigantly, Mercy LOS reduced from 4.66 in 1/13 to 3.4 in 7/14.

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?
   Actions include: Integration of Behavioral Health - initiative will expand physical health care capacity to serve adults with serious mental and/or substance abuse illnesses and co-existing chronic illnesses on-site at our behavioral health hospital and in the community. Behavioral Health Care Management – Implementation of a CareConnect Hub model of care management in our behavioral health hospital to improve patient flow, quality and patient experience. High End Utilizer - this initiative will focus on community health outreach to redirect "High-End Utilizers" who habitually seek non- emergent care at Mercy ED. Clinically Integrated Network - for hospitals, like Mercy, without a network of employed physicians, it is imperative to develop a strategy that aligns the hospital and physicians through both clinical and administrative integration.
d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
   Reimbursement policies related to government and government funded payers should be addressed to assure that payment levels are appropriate to encourage involvement in alternative payment contracts. Adequate reimbursement rates from MassHealth, MMCOs and Health Safety Net would provide the resources for hospitals like Mercy to operate more efficiently and improve quality and progress with alternative models. Reimbursement policies specific to behavioral health services are a significant challenge. A recent analysis conducted by the Public Consulting Group for the Massachusetts Behavioral Health Partnership indicated that for acute care hospitals within the MBHP network rates of reimbursement covered less than 70% of the cost of care.

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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: Mercy has two alternative payment agreements that meet the definition established in the question. They are both global budget agreements with Medicare Advantage carriers. Both plans include downside risk to the hospital for over utilization of hospital related services; therefore, there are significant incentives financially and in terms of quality to assure that services are provided in the most efficient and appropriate manner for patients.

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?
Mercy's involvement in these plans has affected our care delivery practices in that we are vigilant about monitoring the utilizaiotion of inpatient care, as well as monitoring post acute care. A team of hospitalists and skilled nurses are used to perform on-going quality and medical necessity review. To the greatest extent possible, as the medical home for these two plans we have sought to monitor and avoid having care provided at other higher cost hospitals whenever it is possible to treat patients at our lower cost facility. These plans have developed joint operation committees for the purpose of examining the metrics that drive cost and quality. They are being constantly reviewed to ensure they stay at benchmark to our high quality and low cost standards. Therefore, these global payment models which have struggled though to receive adequate funding from CMS have worked harmoniously with the CMS Triple AIM as well as Mercy‟s policies for excellence in quality care. As a general statement, Mercy's involvment in these plans have improved our quality and cost metrics.

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).
N/A

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.
Though not directly related to this question, examples from Mercy's involvement in the Medicare Shared Savings Program inlcude:Total cost per assigned beneficiary declining from $12,186 in 2013 to $11,700 in the second quarter of 2014; Total inpatient spending decreasing by 4% from 2013 to the second quareter of 2014; and, ED utilization remaining flat from 2013 to the second quarter of 2014.

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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: In our experience with alternative payment contracts, health status risk adjustment measures do play a significant role in the process of determining the amount of funding from CMS. CMS Risk Adjustment Factor scores upon review of the population to be served determine the overall acuity of our global pool which in turn drives the 100% CMS blended payment which becomes the overall gross budget of the respective pools.
    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?

As a general rule, these acuity levels have been indicative of the overall health status risk of the pool. CMS does state that there is a variance allowed after actual medical experience has been learned and does permit the pool to perform a retrocoding reconciliation which does allow the pool to receive additional funding in the event the acuity to the whole pool is understated. This flexibility and variance adjustment does help make the model adjust for significant changes in acuity that may occur. It should be noted that this reconciliation process is very arduous and supplemental payment is not received until frequently years after the close out of the affected calendar year.

b. How do the health status risk adjustment measures used by different payers compare?
   The two alterntive payment models that Mercy is most familiar with use identical methodologies for health status risk adjustment.
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?
   There is largely no interaction between the two. The Risk Adjustment factors for individuals or the pool generally does not affect risk share which is established by contract on the basis of utilization of services between medical services and hospital services. There are currently no incentives to reduce health status risk adjustment factors. Numerous tools have been put into place clinically to ensure that we are accurately accounting for the patients risk adjustment factor so that we receive accurate payment to have the resources to properly treat them.

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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: Healthcare delivery under the current system of care is inherently fragmented. Healthcare data and information important to both individual patient care and population health management is therefore equally fragmented. While providers may have discrete data and information from their individual EHRs and claims data, even providers with sophisticated health information exchanges struggle to access and aggregate essential clinical information.
   ANSWER: A data repository containing all-payer claims data that includes diagnosis and procedure information (code based) and pharmacy claims that includes drug and dosage information would be a huge resource to providers. Provider networks could access the repository via the Mass HIway utilizing their individual HIEs. In turn providers could

provide, at a minimum, ADT data that could link important information regarding diagnosis, procedure and diagnostic information (laboratory test information and diagnostic imaging). Development of regional HIO cooperatives could facilitate provider data exchange using the type of "federated" model that has proven successful in the Albany, NY region.

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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:

   a. Which attribution methodologies most accurately account for patients you care for?
      The most reliable methodology for attributing members to a primary care provider is by direct assignment when a member chooses their designated primary care provider. This allows for clear and immediate attribution. The ideal arrangement for attribution is having a member select a primary care provider at enrollment and maintain a primary care provider throughout plan participation.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
      Though, we do think that direct assignment methodalogy is best, other alternative attribution methodologies, such as the "plurality of primary care services" model used by CMS in the Medicare Shared Savings program, have been adequate but present many challenges. One significant issue is attribution of beneficiaries to physicians who fit the definition of primary care provider/primary care services (internal medicine for example) who may provide the plurality of primary care services but are actually rendering some type of specialist care (allergists for example).

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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:

   ANSWER: Mercy reports quality measure to many different entities including public and private payers. We report to CMS which include Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting and Hospital Psychiatric Quality Reporting which are publicly reported on Hospital Compare. We report many of the same quality metrics to MassHealth, The Joint Commission and Blue Cross Blue Shield. Many of these quality measures in quality improvement are publicly reported and are linked to pay-for-performance programs for the Health System. There are redundancies in reporting quality data and a quality measure maybe "topped off" for one reporting agency but still be required for

another. Public quality reporting continues to drive improvement in care delivery and patient outcomes, but reproting varying metrics to multiple payers can be burdensome.

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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: Mercy has not conducted specific analysis relative to utilization of inpatient care at academic medical centers, but Mercy has focused on educating physicians and payers about the benefits of Mercy as a high quality low cost provider.
    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.
    N/A
    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.
    Mercy continues to focus on improvments in quality and cost through initiatives such as CareConnect (referenced in Queston 1b). Mercy also provides education to community physicans and payers regarding the high quality low cost care available at Mercy and has utlizied recent CHIA reports and Mercy's recognition as Cleverly and Associates as a "Top 100 Community Value Hospital-Five Star Award" to validate Mercy's cost and quality value.

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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: Mercy did some retrospective analysis of 2013 and identified 30 day readmissions based on the disposition category from our facility. The analysis showed a higher percentage of readmits were attributed to a Home Health, Hospice or SNF/Long Term Care Facilities (see summary attached). Based on this research, we did further analysis and identified the facilities that led to the largest amount of our readmissions.
    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 attahced Mercy Exhibit - Question 8
    b. How does your organization ensure optimal use of post-acute care?
    Mercy is planning to use this new data to improve post discharge communication and facilitate operational integration between acute care and post discharge 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: Mercy started its efforts retative to price transparency for admissions, procedures and services on October 1, 2013 and has seen increasing interest in this information.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	0	8	0
	Q2	0	12	0
	Q3	0	10	0
	TOTAL:	0	30	

** Please indicate the unit of time reported.*

ANSWER: Mercy started The top procedures requested are outpatient ancillary CT scans, outpatient surgical procedures, with the DaVinci robot and spinal outpatient procedures. Patients tell us that they are using the information to understand their cost for health care as well as shopping around for cost. Analysis of our data is accurate to the amounts in our chargemaster. Observations are that patients are utilizing data to a better degree to make informed healthcare decisions.

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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: SPHS is very cognizant of the tier ratings from the 4 payers who rate us for tiered network purposes. We score the top rating for 3 out of the 4, and have the middle rating for the last. Generally speaking we meet or exceed all cost and quality measures for the top ratings for all payers. For the one we received the middle rating, we meet the highest quality goal but missed the cost goal. Our ratings place us at the very top of our immediate market in Greater Hampden County. We have not made any specific extraordinary additional responses as an organization in light of our high ratings that were not already plans on cost and quality that we planned to take anyway.
ANSWER: Please see attached Mercy Exhibit B - Question 10

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: As one of the largest provider of acute, mental health and substance abuse services in Massachusetts, the 120-bed Providence Behavioral Health Hospital is the Holyoke campus of Mercy and plays a pivotal role in maintaining the safety net for vulnerable populations. Providence contains five, specialized inpatient units: Substance Abuse Detoxification, Adult Psychiatric, Older Adult Psychiatric, Child and Adolescent, and Acute Residential Treatment for Children and Adolescents. Providence operates two, community-based Methadone Maintenance Treatment Programs that serve nearly 900 persons a day and a new Suboxone Program. Mercy and Providence recognize the challenges of over utilizaion of ED and inpatient care and have engaged in initiatives to impact that utilization by focusing on collaboration with community based providers.
    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.
    Mercy has been working collaboratively with the Behavioral Health Network "BHN" (a large community provider of behavioral services). Mercy began this collaboration after an analyis of behavioral health ED patient flow, staff satisfaction and patient satisfaction conducted by HealthMETRICS. Initiatives have inlcuded, full time Emergency Service Provider coverage in the ED which has resulted in a signifigant decrease in LOS for behavioral health patients in the ED by moving patients to the next appropiate level of care (out-patient or inpatient) more efficiently.
    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.
    Mercy's collaboration with BHN has addressed the need to avoid unecessary utilization of emergency department psychiatric care in several ways: The immediate invlovement of ESP services has resulted in ED pshyciatirc patients receiving care at the best appropriate level of care in a more time effective mannrer and has decreased ED LOS for these patients. Another focus of the collaboration with BHN has been on direct admission to inpatient units from the community for appropriate behavioral health patients. This initiative has the potential to decrease ED utilization for certain patients.
    c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
    Mercy's behavioral healht patients have benefited from the community based provider collaboraton with reductions in the time it takes to move from the ED to the most appropraite level of care. Medical clearance for patients who will be directly admitted to inpatient units continues to be a challenge for a re-designed direct admission process. The ED does provide a fully developed process for medical clearance that is effective, but inefficient.

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.
Mercy Medical Center and Providence Behavioral Health Hosptial agree that access to discharge data for behavioral health patients would be helpful in attempting to compare providers and determine if best practices can be identified. Mercy and Providence would be interested in exploring participation in this type of initiative.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: Currently, Mercy does not employ primary care physicans and has limited experience with the patient-centered medical home model.
    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?
    N/A
    f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
    N/A
    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.
    N/A

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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: The Commission's Report highlight several areas which resonate with Mercy's experiences and have informed our transformational direction, including fostering a value-based market, promoting an efficient, high-quality health care delivery system and advancing alternative payment methods. Fostering a value-based market - Mercy continues to face challenges because of the hospital's higher percentages of Medicaid patients and lower percentages of patients covered by commercial insurance. Mercy has used this challenging payer mix to be become of the more cost-effective, acute care hospitals in the Commonwealth (reports from Massachusetts AGO and CHIA). Even with these reimbursement challenges, Mercy has focused on quality and safety and for the fourth year in a row, Mercy Medical Center was recognized by Cleverly and Associates as a "Top 100 Community Value Hospital-Five Star Award."

ANSWER: Additional alignment with HPC Report findings - Promoting an efficient, high-quality health care delivery system - As reported in responses to questions included in this request, Mercy has continued to focus efforts on being a more efficient, high quality health system. Those efforts have included the implementation of the CareConnect care management which among other improvements has resulted in lowering the LOS at Mercy from 4.66 days in January of 2013 to 3.4 days in July of 2014. These efforts have also included a focus on the integration of behavioral health between Providence Behavioral Health Hospital, the Mercy ED and community based providers. Planned initiatives will focus on after-care for behavioral health patients discharged from inpatient care and connecting patients with serious medical and behavioral health issues to primary care in behavioral health setting. Advancing alternative payment methods - Mercy has also continued to build capacities to accept an manage alternative payment. Ongoing initiatives include the operation of a Medicare MMSP ACO and PACE program for dual eligible seniors. Future initiatives will focus on the creation of a clinically integrated network that aligns the hospital and physicians through both clinical and administrative integration. Mercy envisions that the CIN will utilize quality and cost incentives and a performance management infrastructure to improve ability to participate in value-based payment models.

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

   Please see attached Mercy Exhibit C – Question 1

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2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital Exhibit 2 with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

   Completed in Attachment AGO Hospital Exhibit 2

   Please see attached Mercy Exhibit C – Question 2

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

   Mercy‟s exposure on risk contracts is limited to its participation in Medicare Advantage plans. These plans have risk associated with member utilization (direct cost) and ineffective cost control (excessive "out-of-network "referrals) depleting the hospital surplus fund or medical service fund pools. Initial per-member/per-month payments somewhat mitigate financial risk but would not sustain the model if either variable was not well-managed. Baseline historical revenue and utilization data is analyzed on an annually. Revenue projections are compared to projected administrative and clinical costs to determine financial risk, prior to care coordination interventions. A sensitivity analysis related to the

impact of care coordination on the cost of care is also conducted on an annual. Reinsurance is purchased to mitigate unanticipated costs.

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

   Although Mercy does conduct analysis relative to inpatient and outpatient utilization, Mercy does not specifically track the volume of inpatient and outpatient referrals to the hospital from specific physcians or provider groups.

30 Day Readmits 2013 by Quarter

Dispo Grouping	Q1	Q2	Q3	Q4	Grand Total
BHH	4	8	6	7	**25**
Fed Hosp	1			2	**3**
HH	69	67	69	92	**297**
Home	88	82	60	74	**304**
HOSPICE	6	2	6	4	**18**
SNF	90	100	119	105	**414**
Grand Total	**258**	**259**	**260**	**284**	**1061**

> 30 day readmits 2013 by Quarter

Dispo grouping	Q1	Q2	Q3	Q4	Grand Total
BHH	6	10	13	10	**39**
Fed Hosp	1	1	1	1	**4**
HH	386	440	398	445	**1669**
Home	796	846	715	809	**3166**
HOSPICE	15	12	18	16	**61**
SNF	476	511	499	465	**1951**
Grand Total	**1680**	**1820**	**1644**	**1746**	**6890**

No readmission 2013 by Quarter

Dispo Grouping	Q1	Q2	Q3	Q4	Grand Total
BHH	5	10	8	5	**28**
Fed Hosp			1	2	**3**
HH	157	190	202	173	**722**
Home	1069	1039	1112	1132	**4352**
HOSPICE	2	5	2	4	**13**
SNF	158	134	193	176	**661**
Grand Total	**1391**	**1378**	**1518**	**1492**	**5779**

Total of > 30 day and No readmits 2013 by Quarter

Dispo Grouping	Q1	Q2	Q3	Q4	Grand Total
BHH	11	20	21	15	**67**
Fed Hosp	1	1	2	3	**7**
HH	543	630	600	618	**2391**
Home	1865	1885	1827	1941	**7518**
HOSPICE	17	17	20	20	**74**
SNF	634	645	692	641	**2612**
Grand Total	**3071**	**3198**	**3162**	**3238**	**12669**

Total of > 30 day and No readmits 2013 by Quarter

Dispo Grouping	Q1	Q2	Q3	Q4	Grand Total
BHH	11	20	21	15	**67**
Fed Hosp	1	1	2	3	**7**
HH	543	630	600	618	**2391**
Home	1865	1885	1827	1941	**7518**
HOSPICE	17	17	20	20	**74**
SNF	634	645	692	641	**2612**
Grand Total	**3071**	**3198**	**3162**	**3238**	**12669**

ALL 30 day readmit % compared to all DCs 2013 by Quarter

Dispo Grouping	Q1	Q2	Q3	Q4	Grand Total
BHH	36%	40%	29%	47%	**38%**
Fed Hosp	100%	0%	0%	67%	**42%**
HH	13%	11%	12%	15%	**12%**
Home	5%	4%	3%	4%	**4%**
HOSPICE	35%	12%	30%	20%	**24%**
SNF	14%	16%	17%	16%	**16%**
Grand Total	**34%**	**14%**	**15%**	**28%**	**23%**

ALL 30 day readmit % compared to all DCs 2013 by Quarter

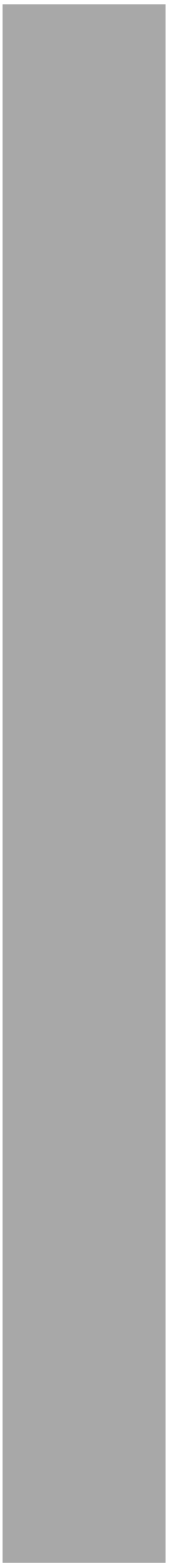
Dispo Grouping	Q1	Q2	Q3	Q4	Grand Total
HH	13%	11%	12%	15%	**12%**
Home	5%	4%	3%	4%	**4%**
SNF	14%	16%	17%	16%	**16%**
Grand Total	**11%**	**10%**	**11%**	**12%**	**11%**

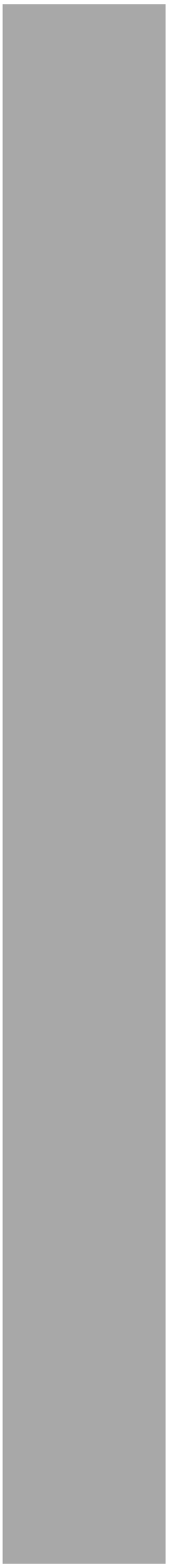
Readmits with a disposition of Home Care, SNF, Hospice or other Long Term Care Facility 2013 with % of Readmission and the # of days on average a patient was seen again at our facility

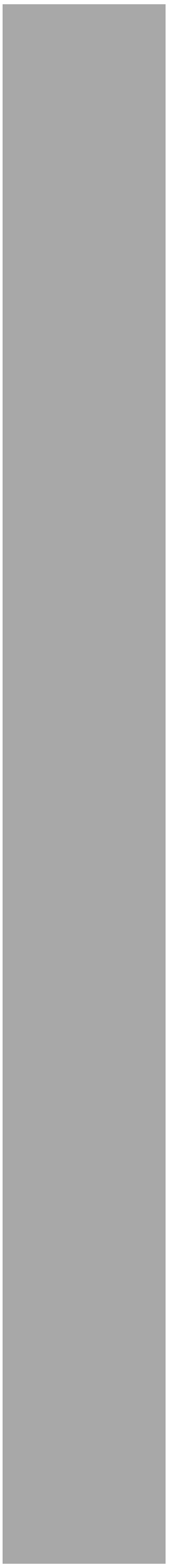
Current DispositionName	(Multiple Items)
DC_hour	(All)
Current DC Facility	(All)

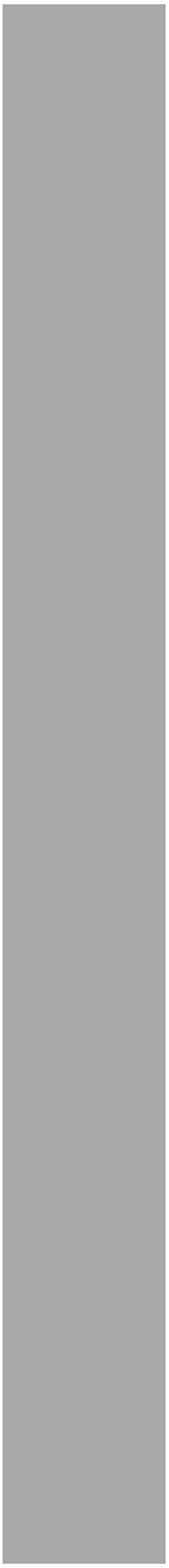
Row Labels	Count of AccountNumber	Average of Days_since_Last_DC_DATE
Country Estates of Agawam/Kindred Healthcare	13%	17
Mercy Home Care	10%	15
Wingate at Springfield (Formerly Radius Ring Healthcare Center)	7%	12
Wingate at West Springfield	6%	14
Chapin Center	6%	11
Genesis HC - Heritage Hall South	6%	18
Wingate at East Longmeadow	4%	16
Genesis HC - Heritage Hall North	4%	19
Genesis HC - Heritage Hall West	4%	9
Julian J. Leavitt Family Jewish Nursing Home	4%	11
Wingate at South Hadley	3%	11
Wingate at Wilbraham	3%	9
HEALTHSOUTH Rehabilitation Hospital of Western MA	2%	13
Redstone Rehabilitation and Nursing Center	2%	18
East Longmeadow Skilled Nursing Center/Berkshire Healthcare Systems	2%	5
Vibra Hospital of Western Massachusetts - SNU (Formerly Kindred Hospital - Park View)	2%	12
Vibra Hospital of Western Massachusetts - Central (Formerly Kindred Hospital - Park View)	2%	16
Willimansett Center West and East	2%	19
Mount Saint Vincent Nursing Home	2%	19
Life Care Center of Wilbraham/Life Care Centers of America	2%	22
Chicopee Visiting Nurse Association/VNA	1%	4
Genesis HC - Heritage Hall East	1%	16
Home and Community Health Services, Inc/Johnson Health Network	1%	8

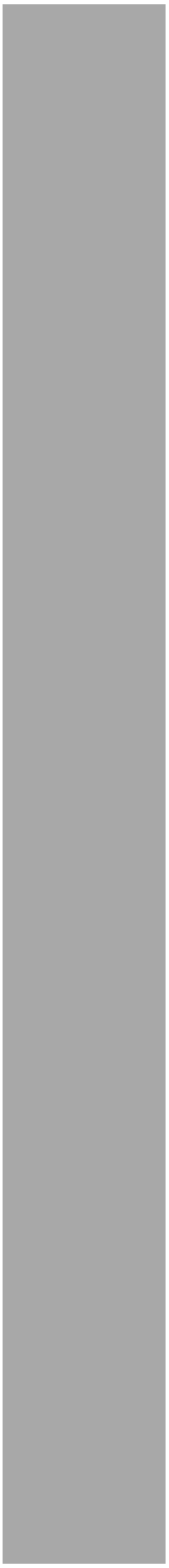
Genesis HC - Hadley at Elaine Care and Rehabilitation Center	1%	9
Governor's Center	1%	25
Weldon Rehabilitation Hospital	1%	15
The Renaissance Manor on Cabot	1%	24
Allied Health Systems, LLC	1%	23
Mary's Meadow at Providence Place	1%	21
Grand Total	**100%**	**15**

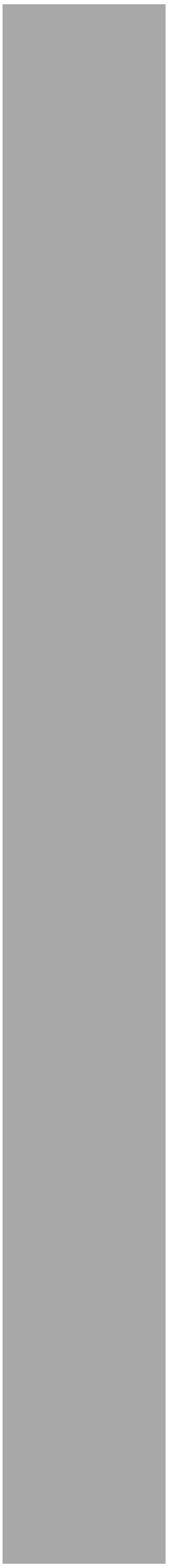


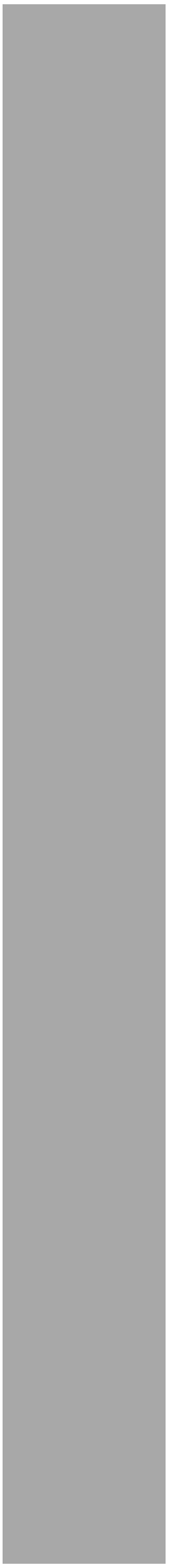


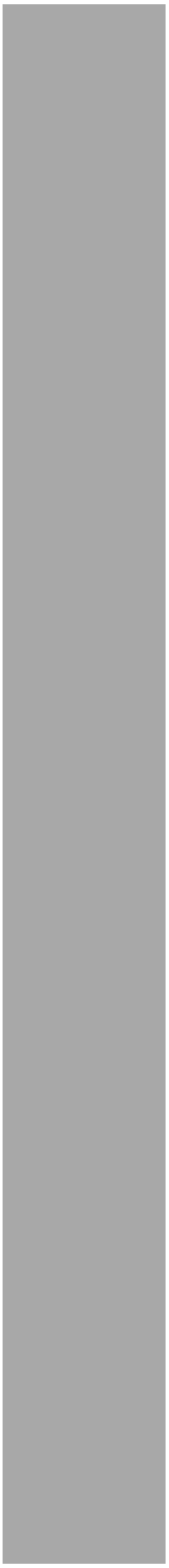


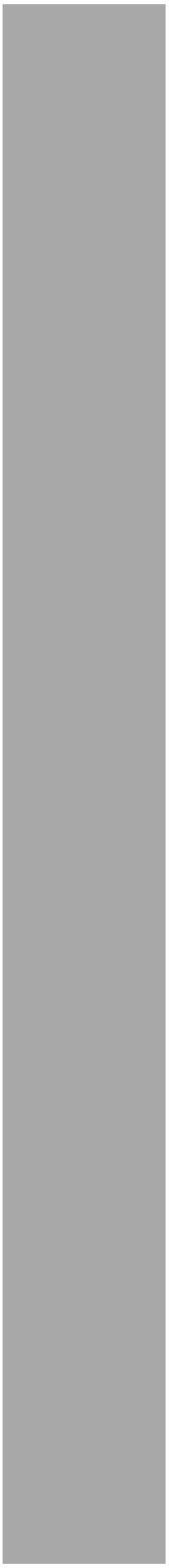


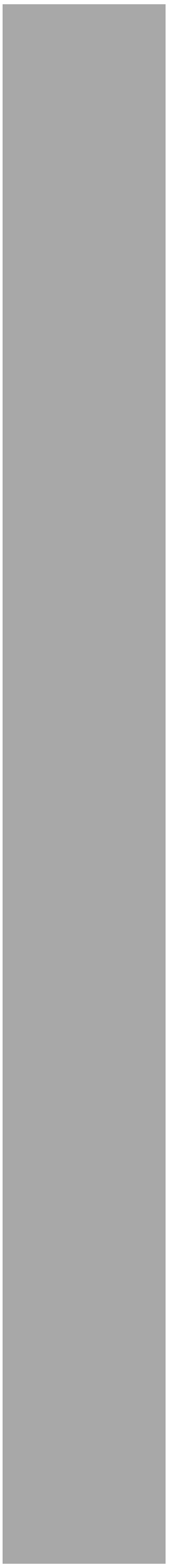


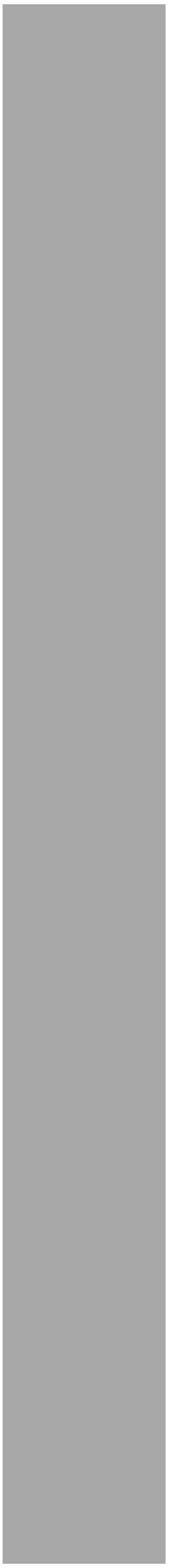


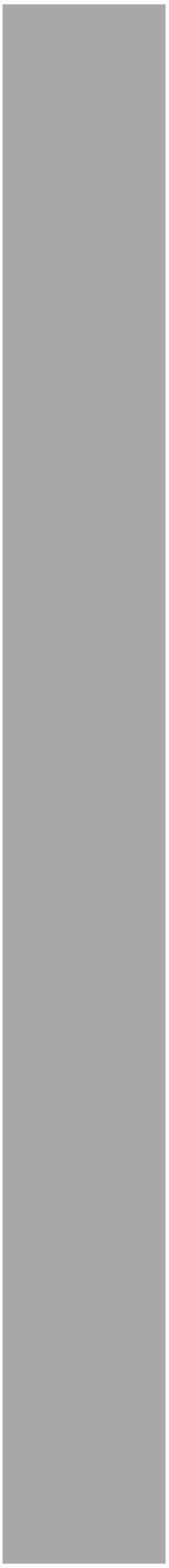


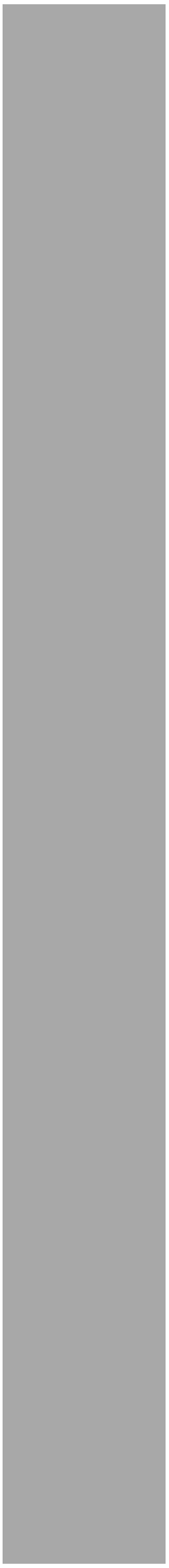


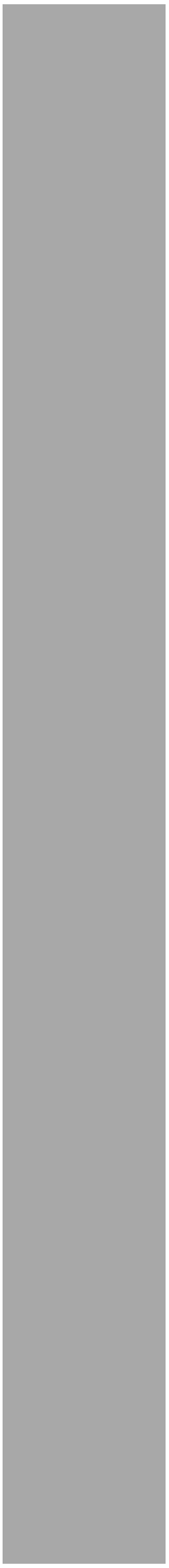


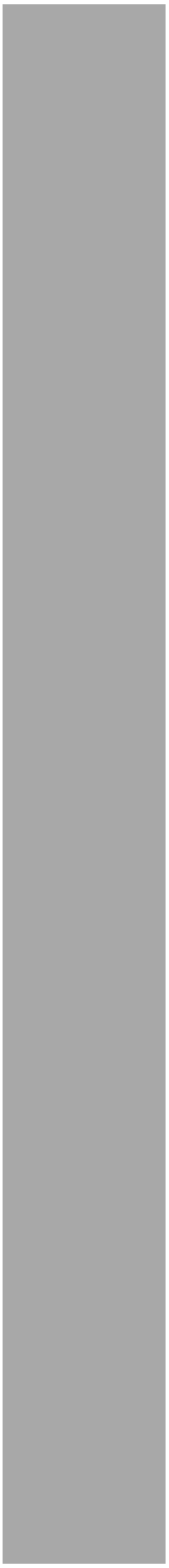


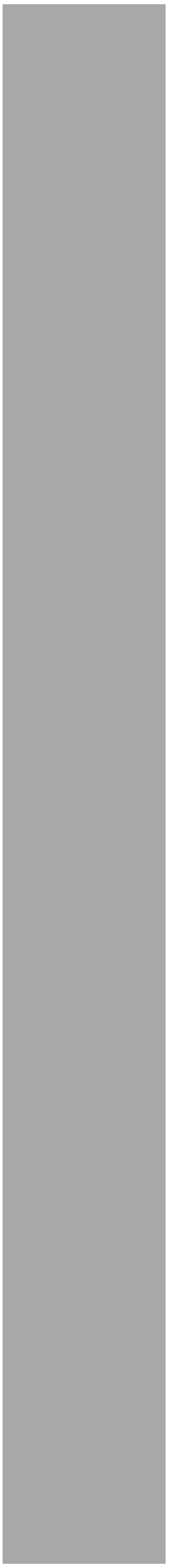


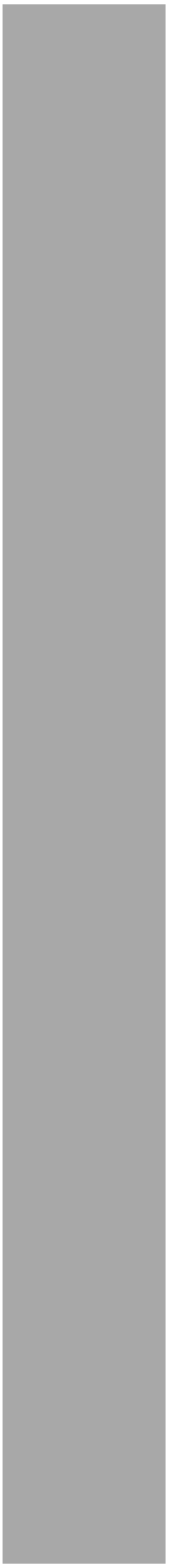


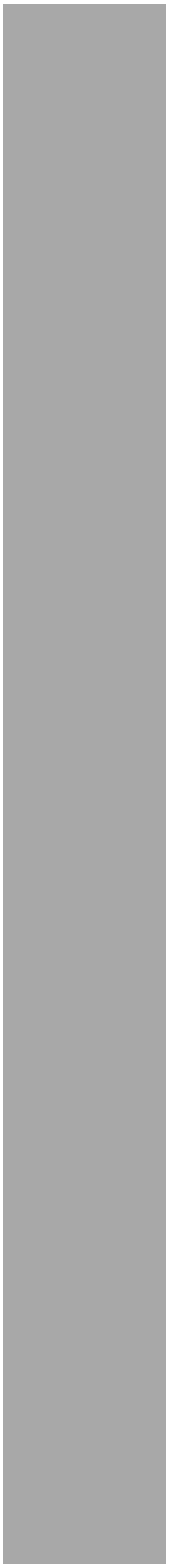


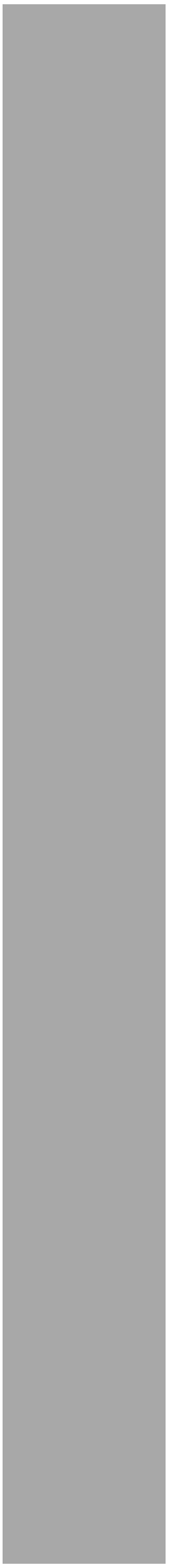


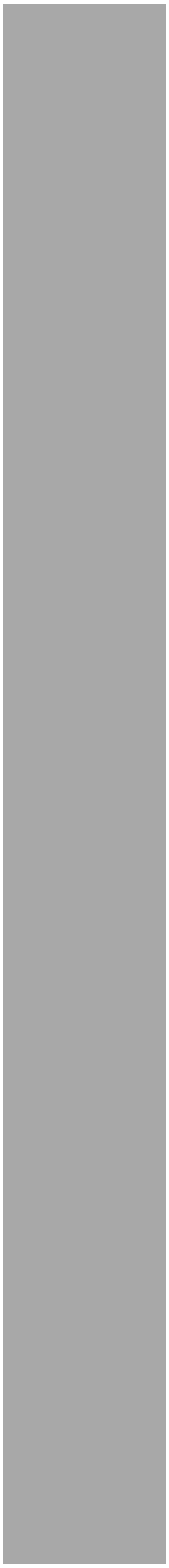


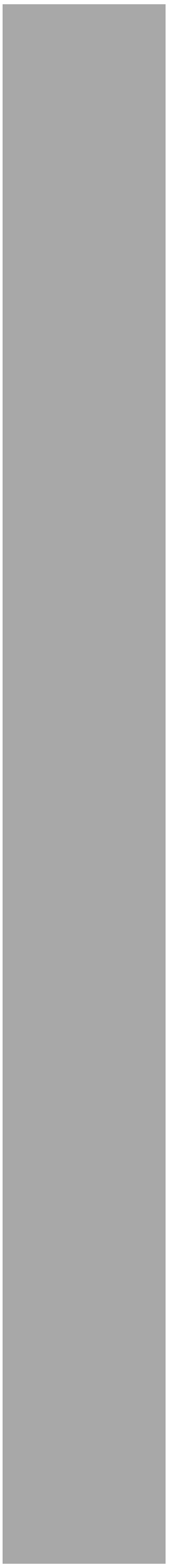


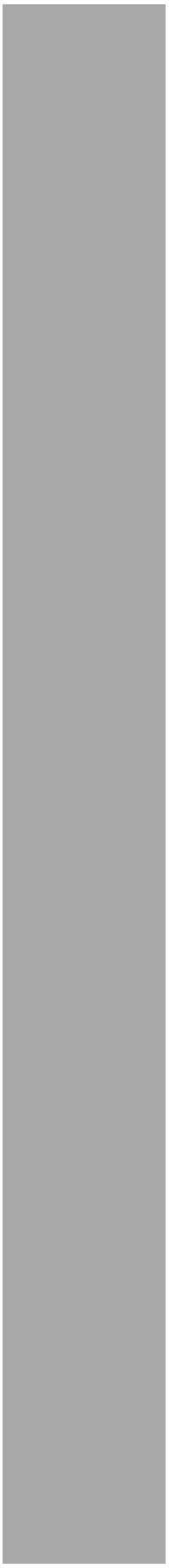


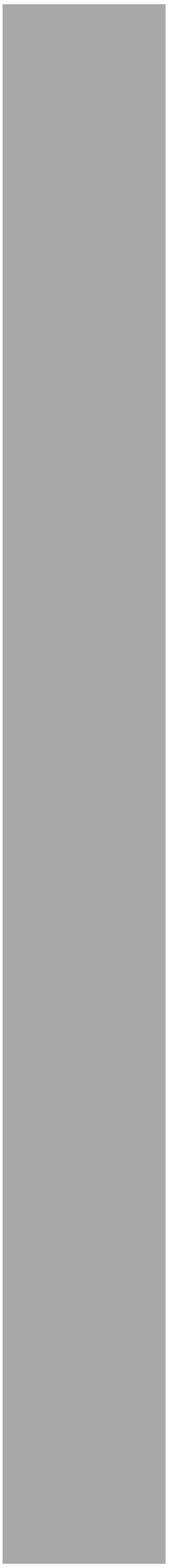


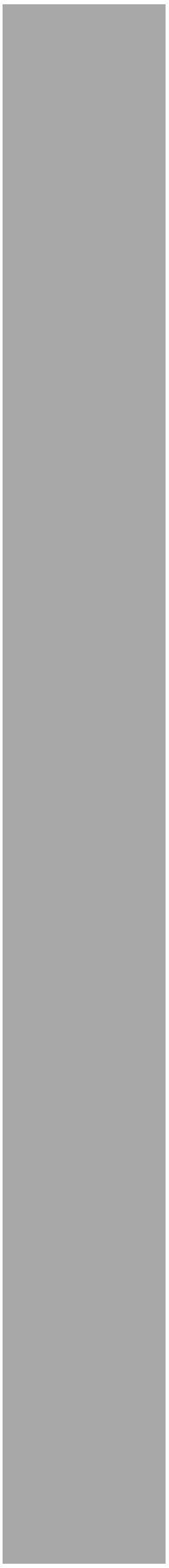


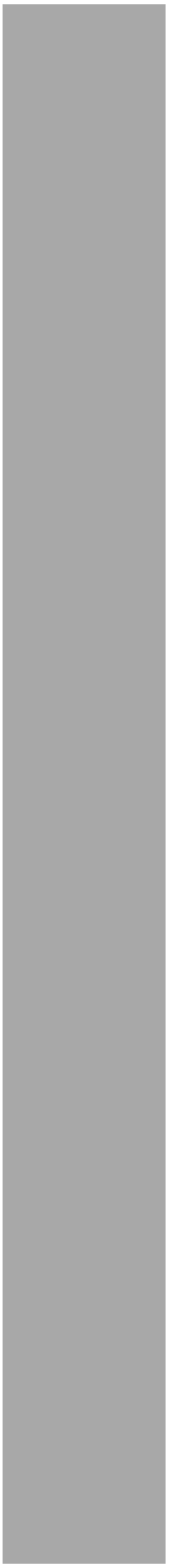


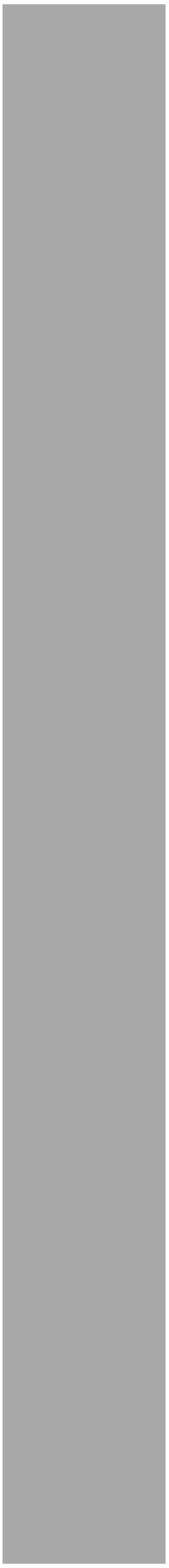


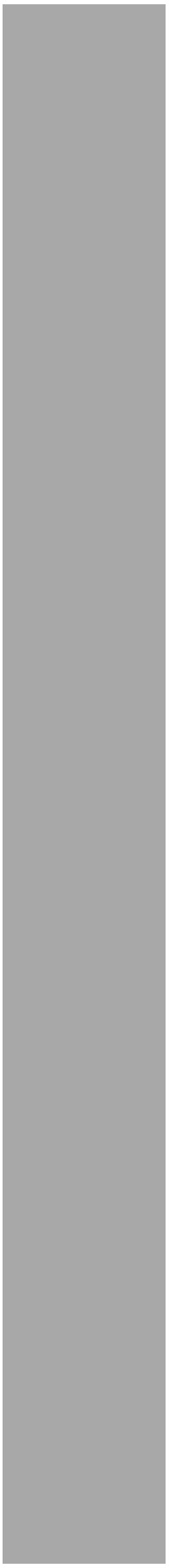


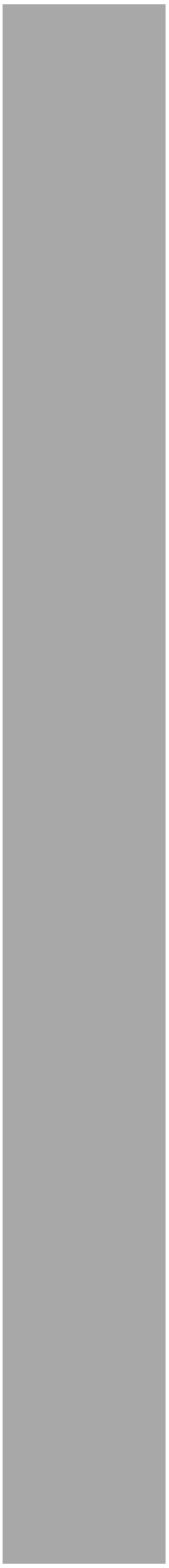


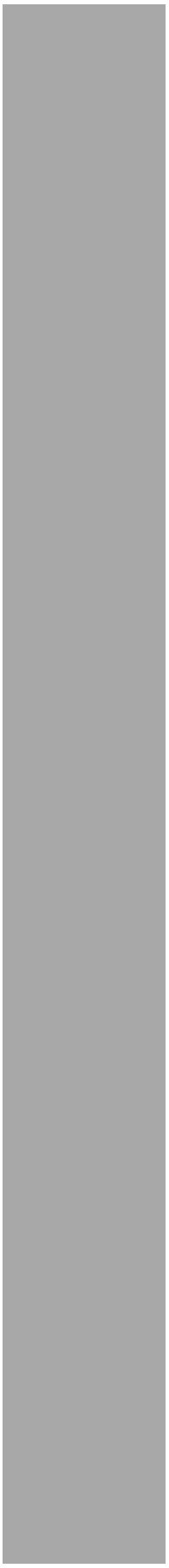


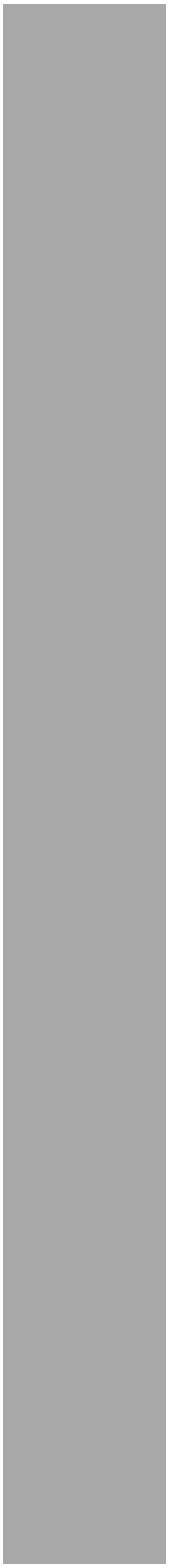


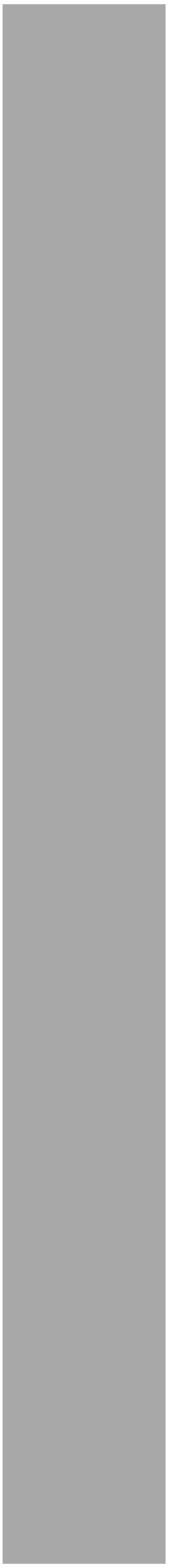


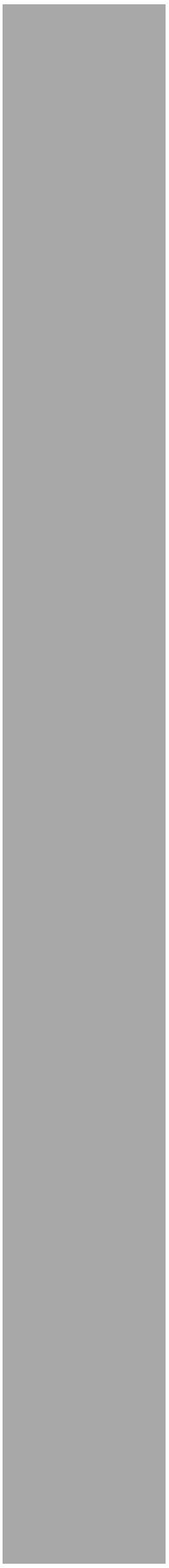


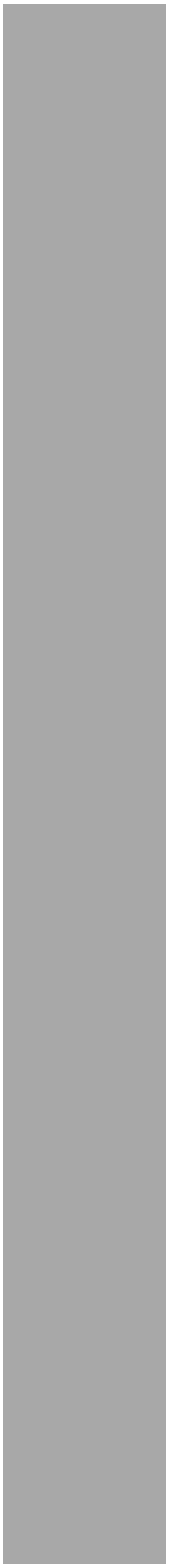


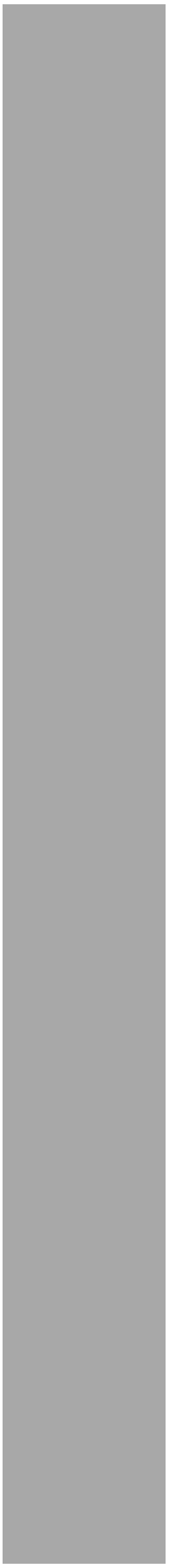


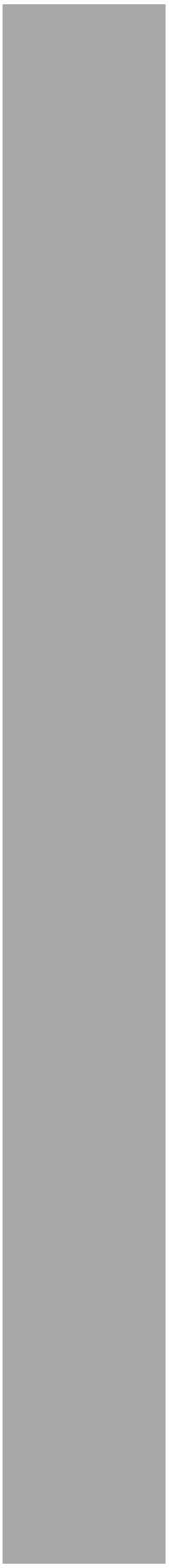


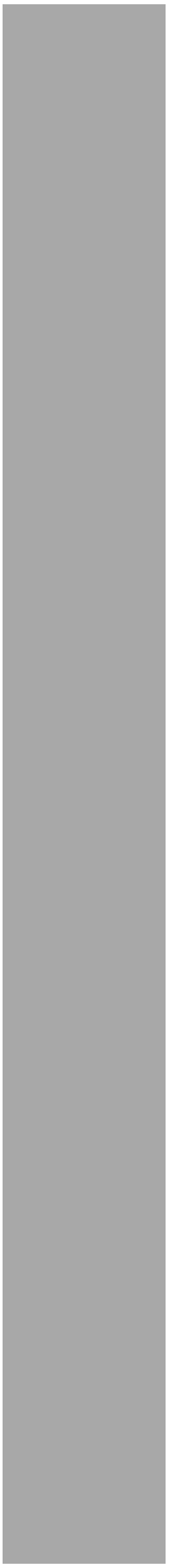


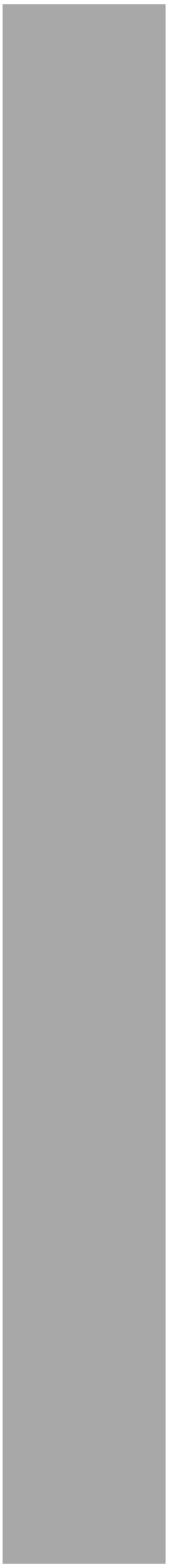


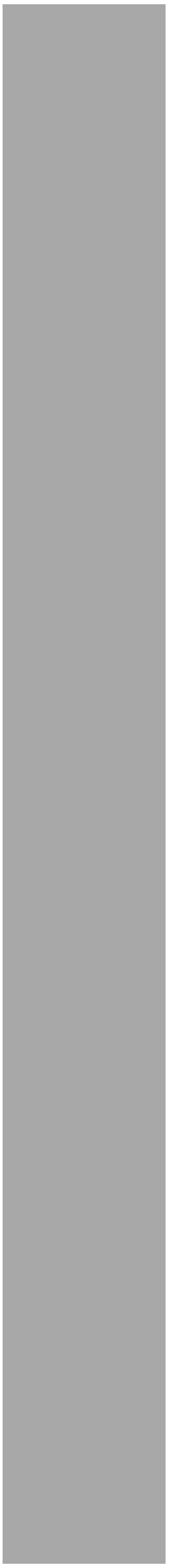


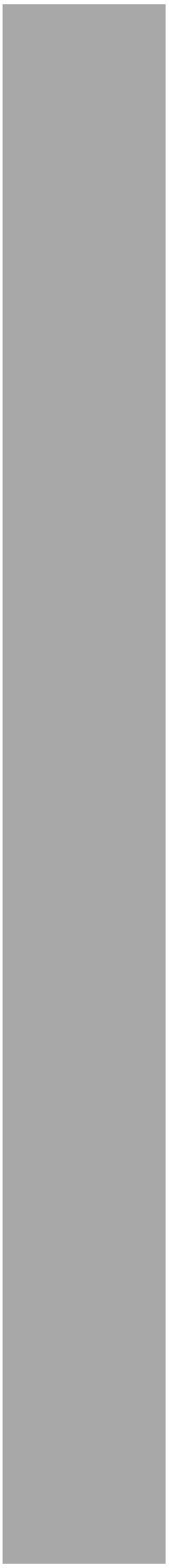


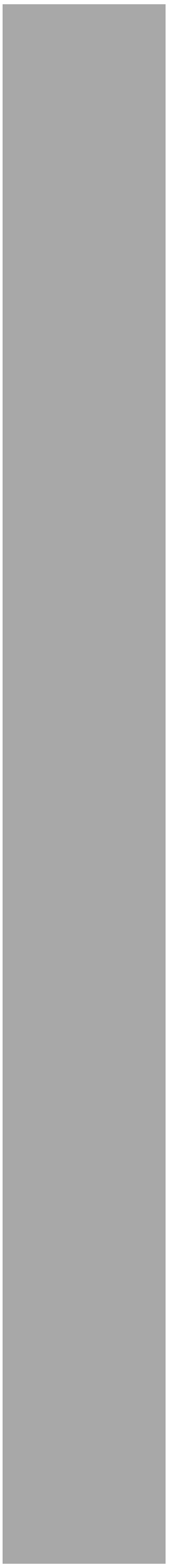


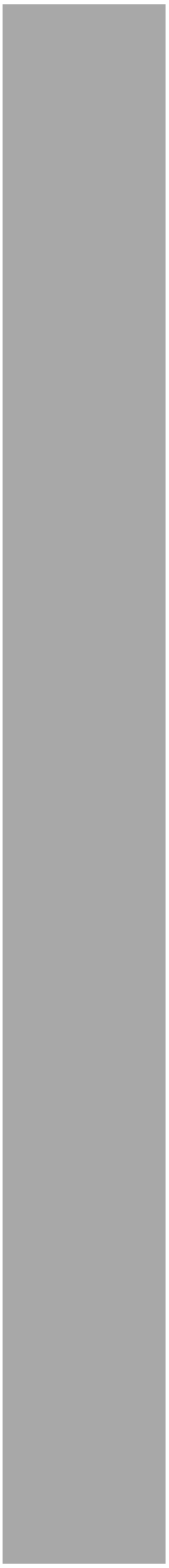


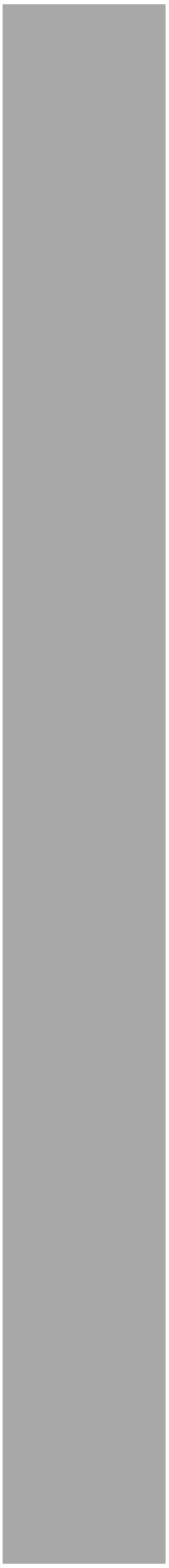


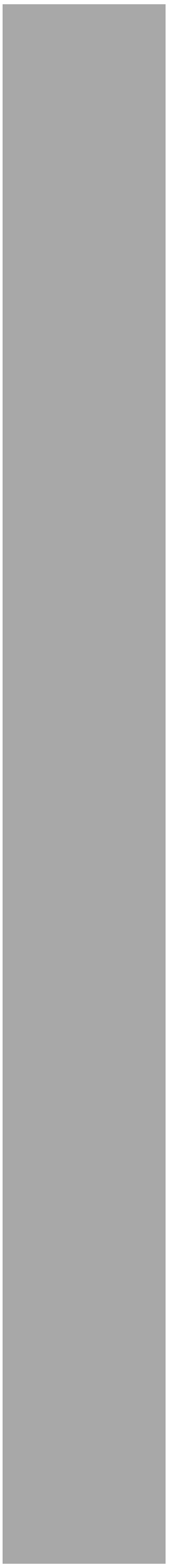


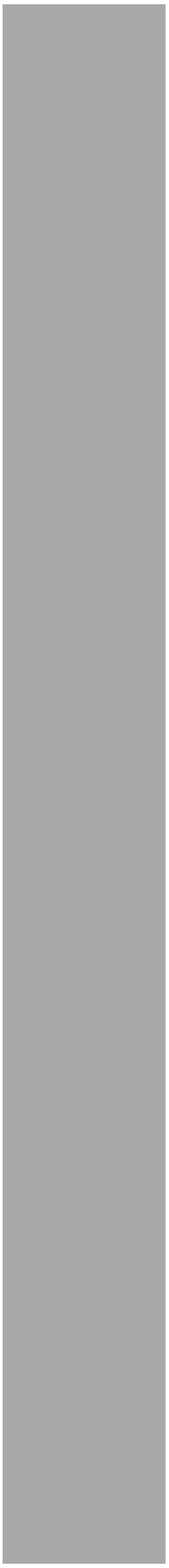


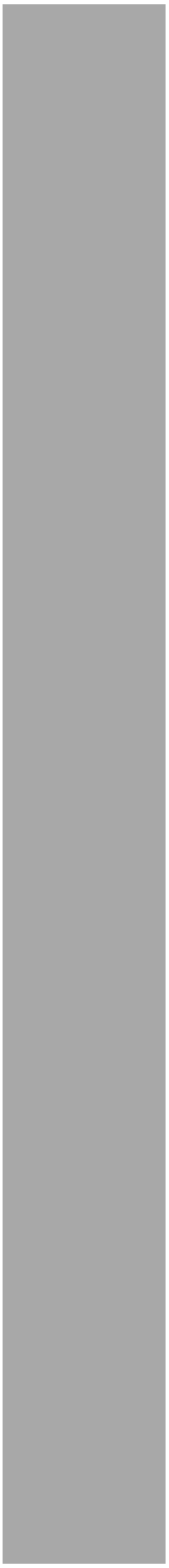


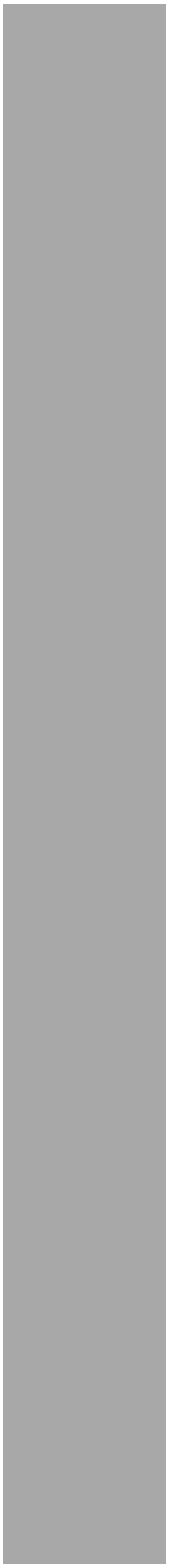


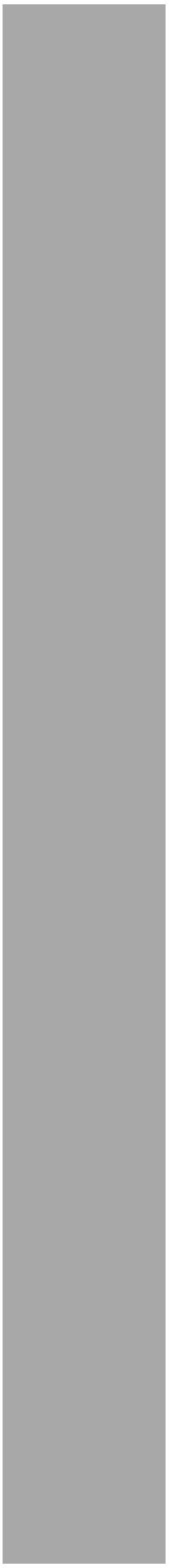


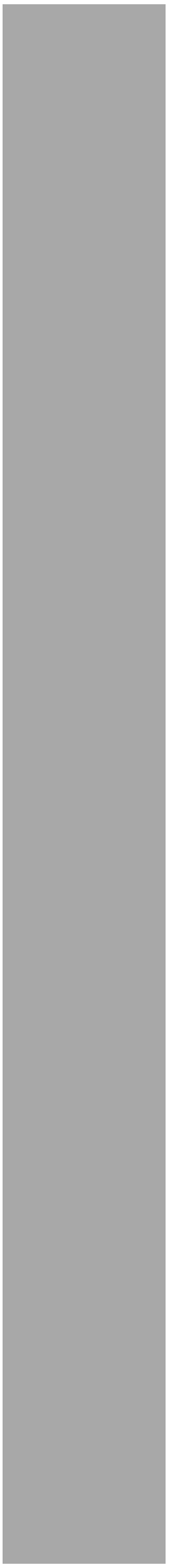


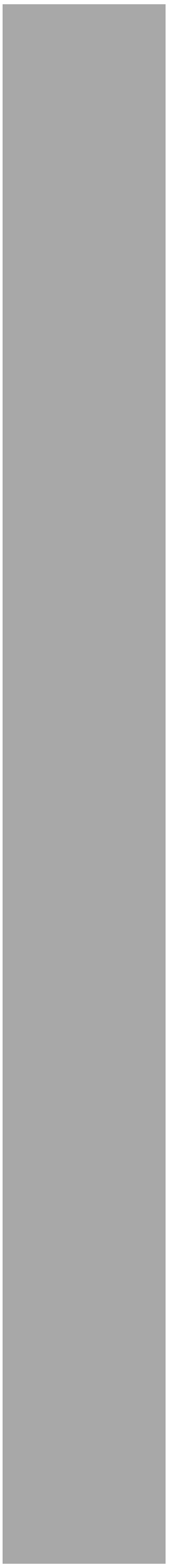


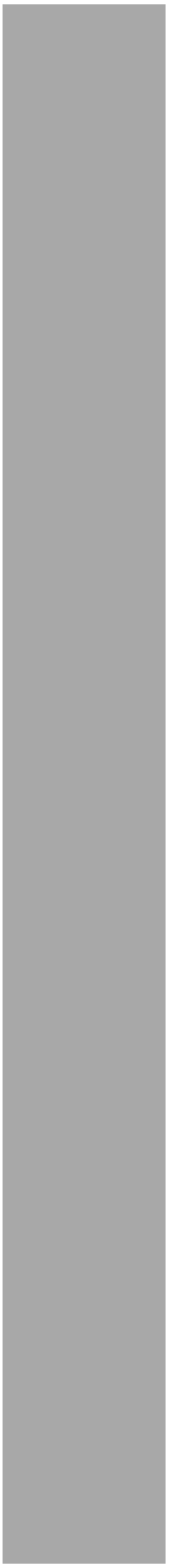


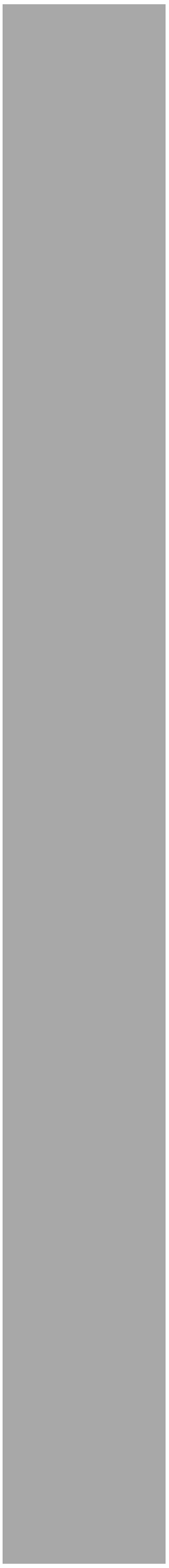


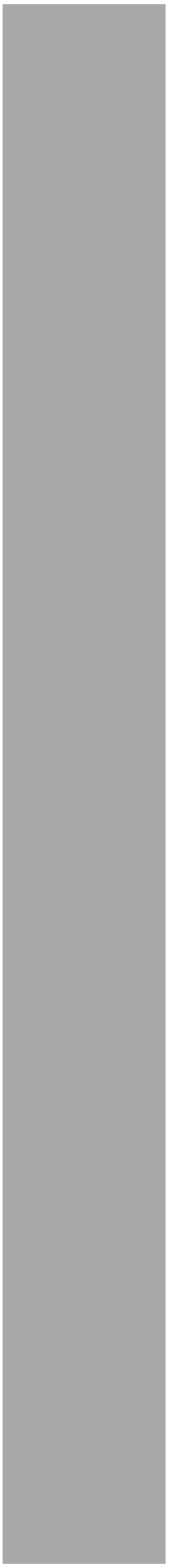


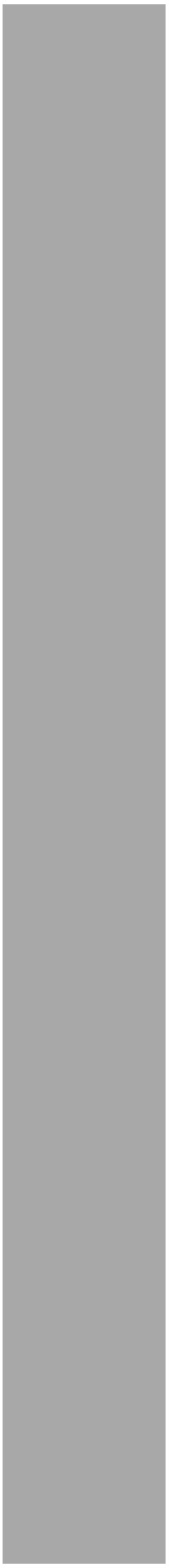


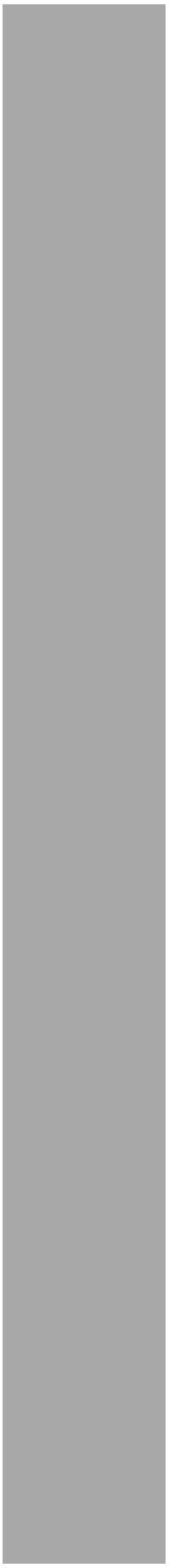


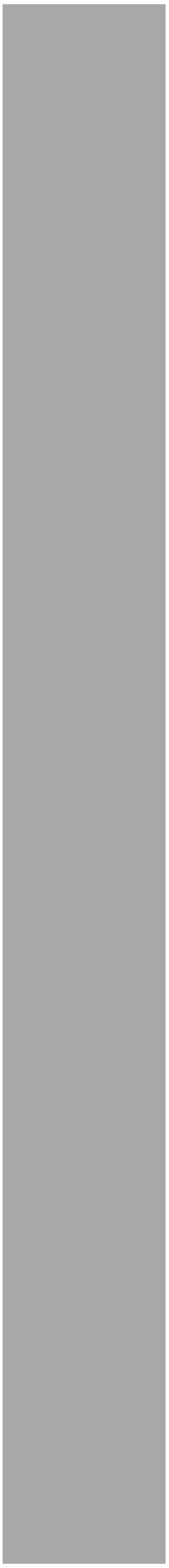


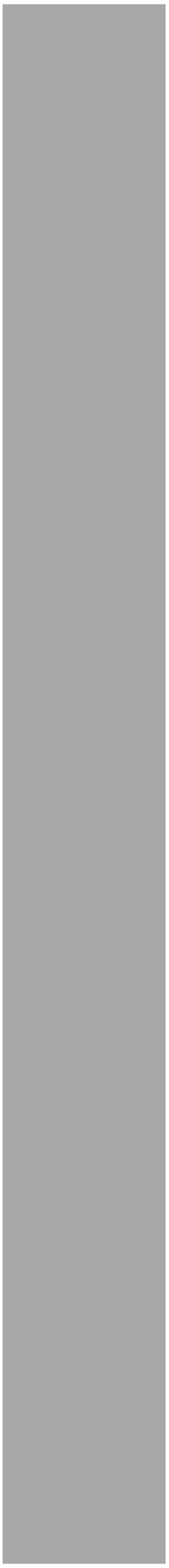


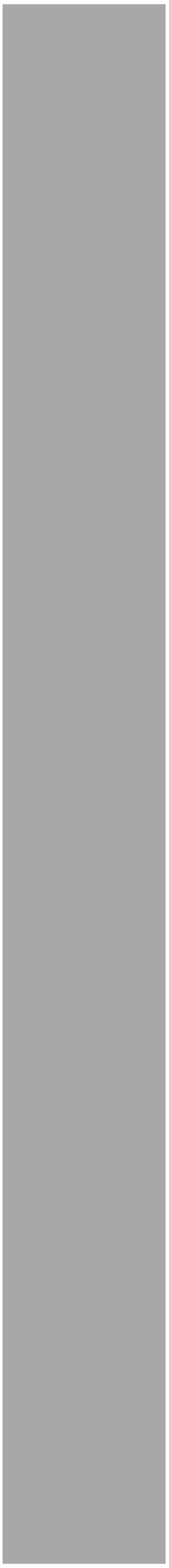


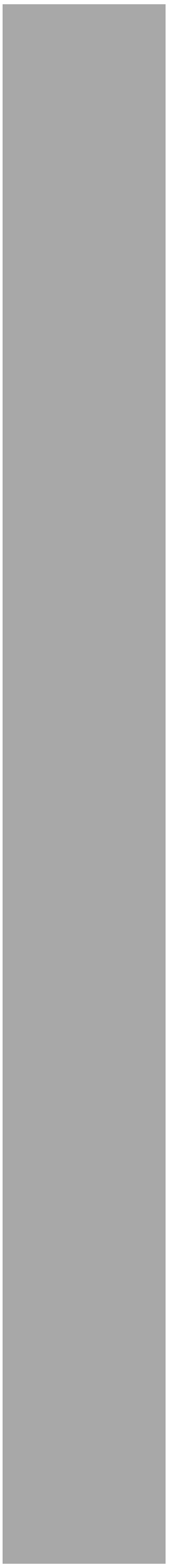


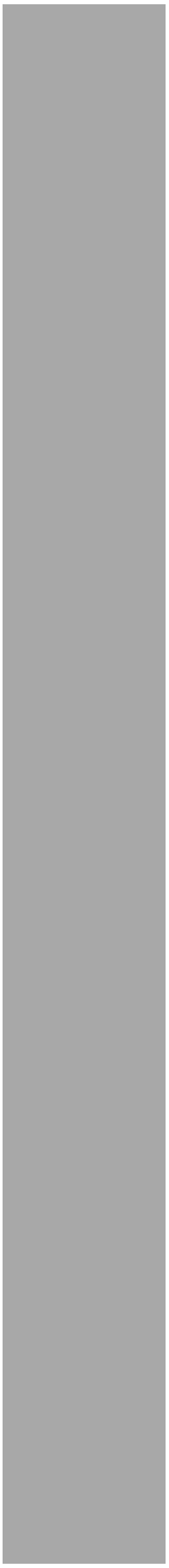


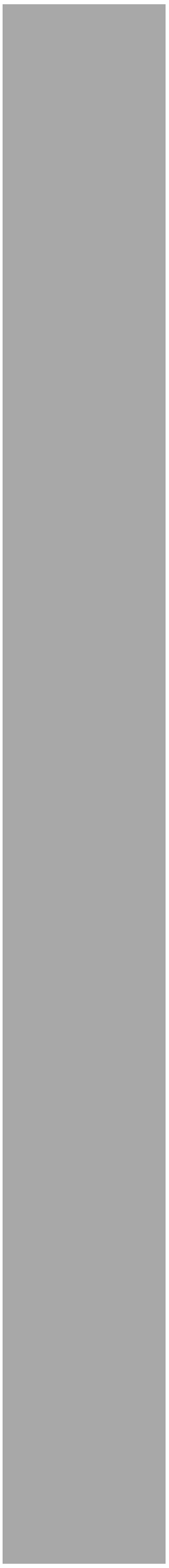


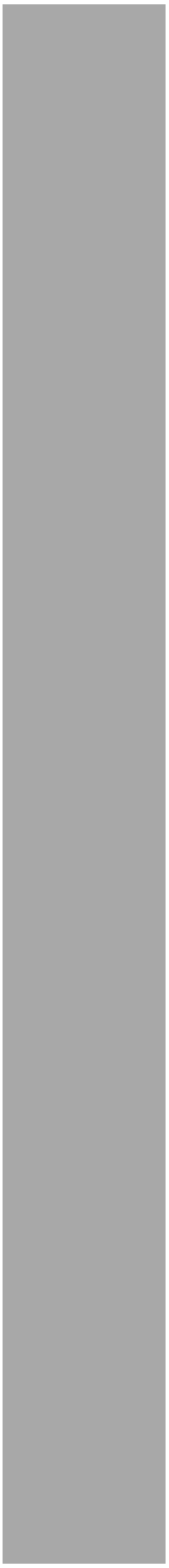


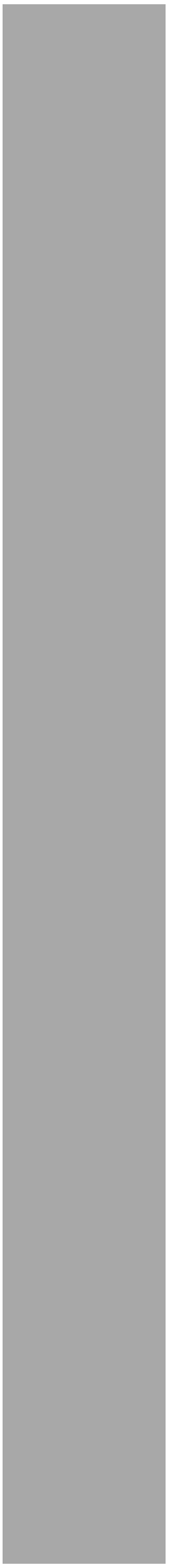


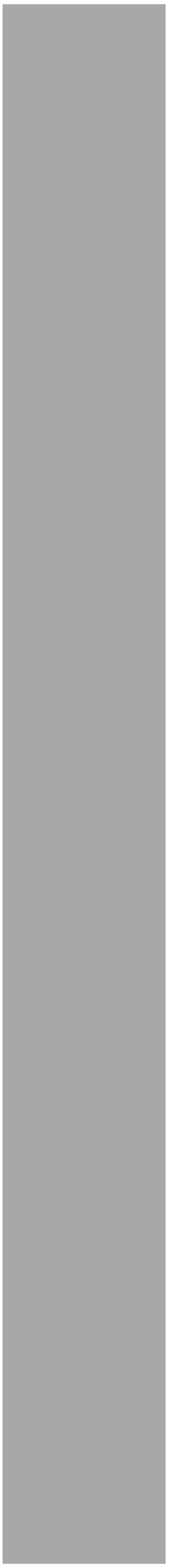


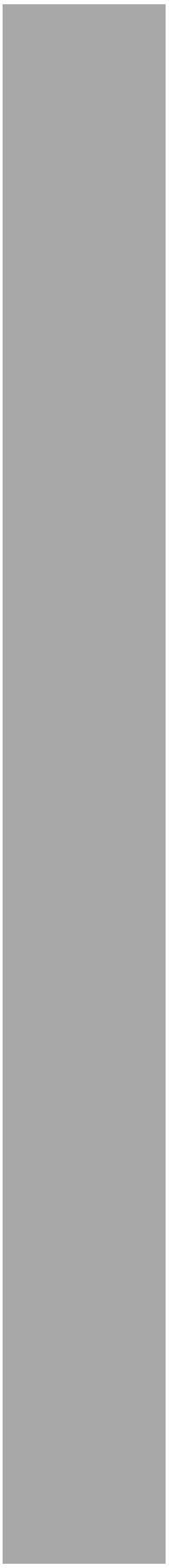


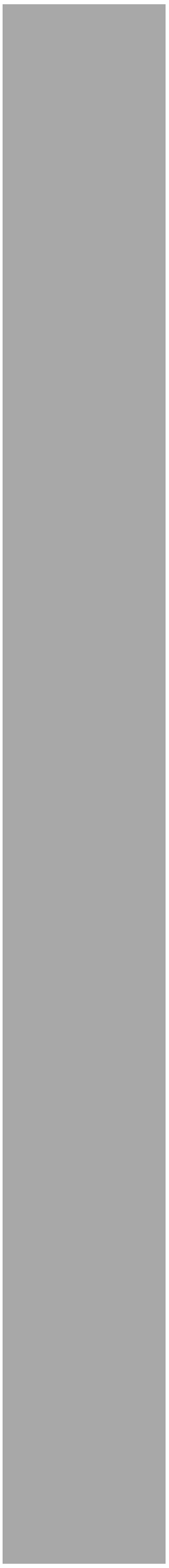


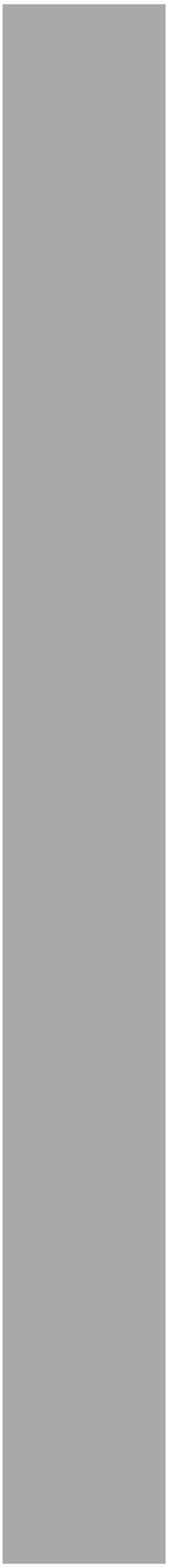


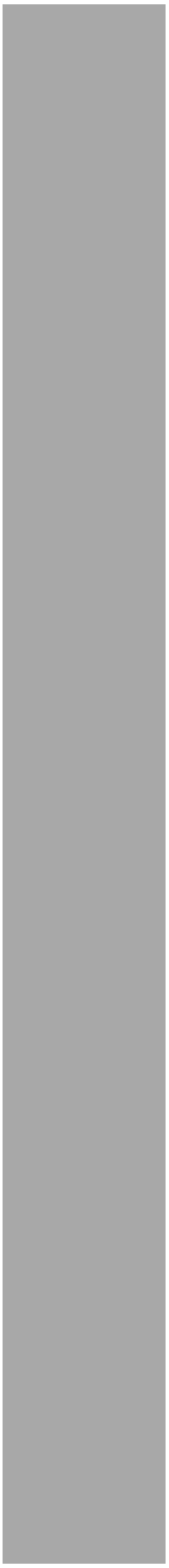


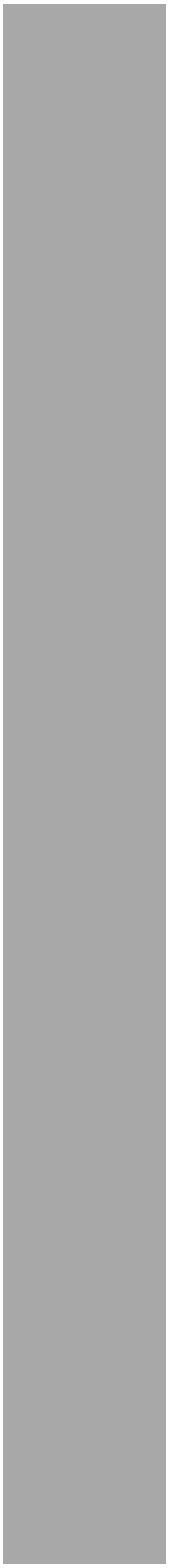


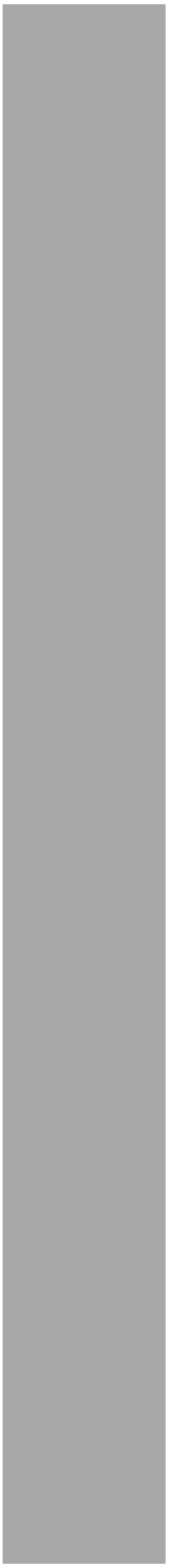


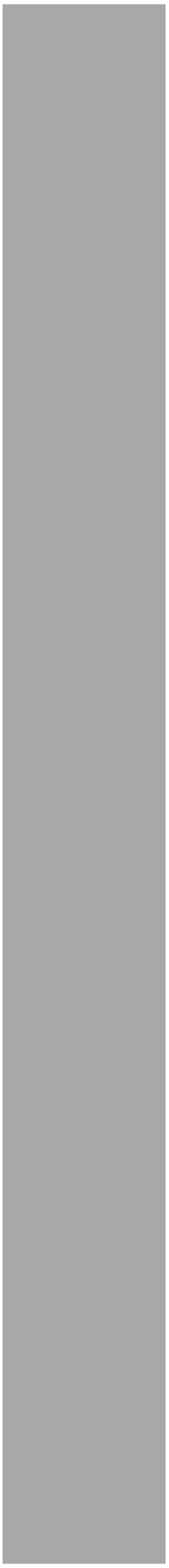


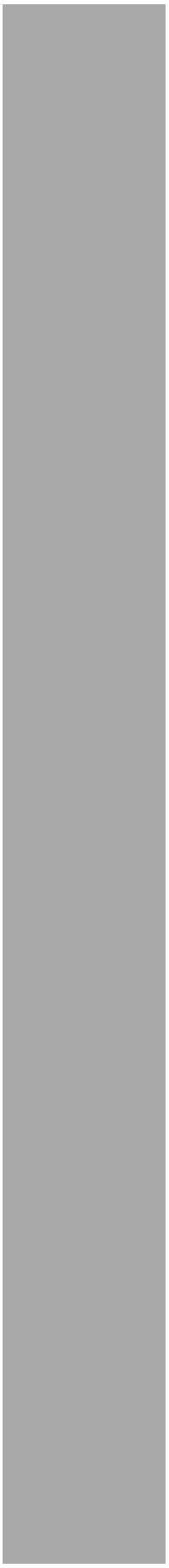


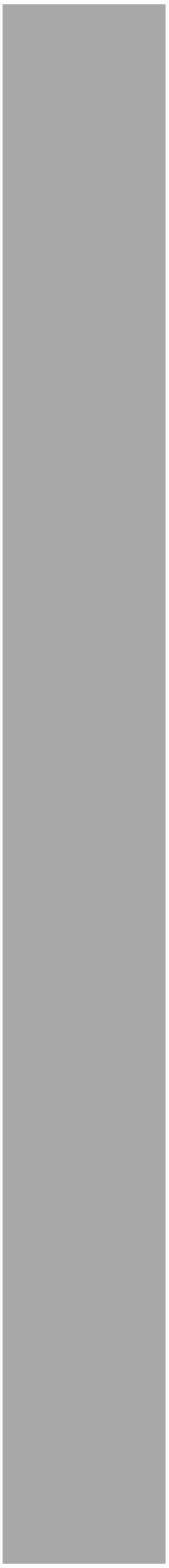


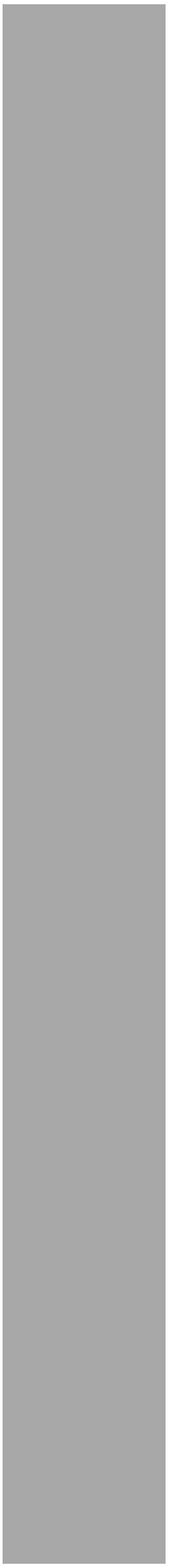


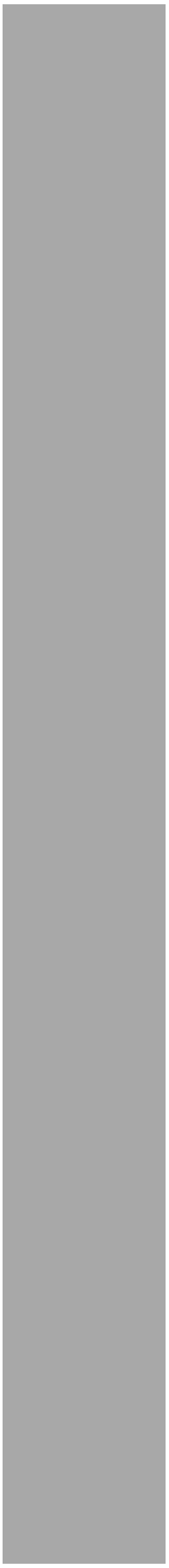


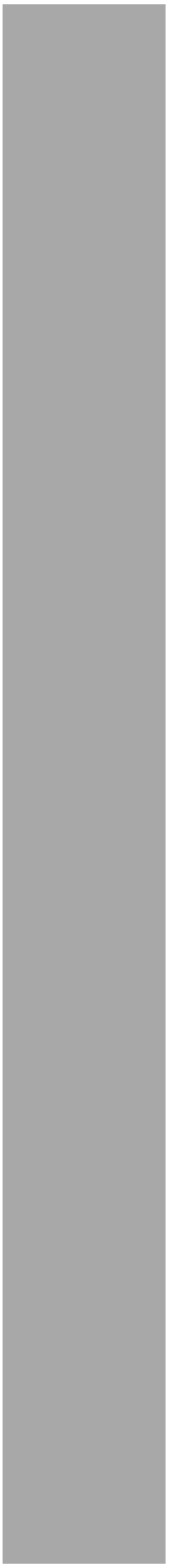


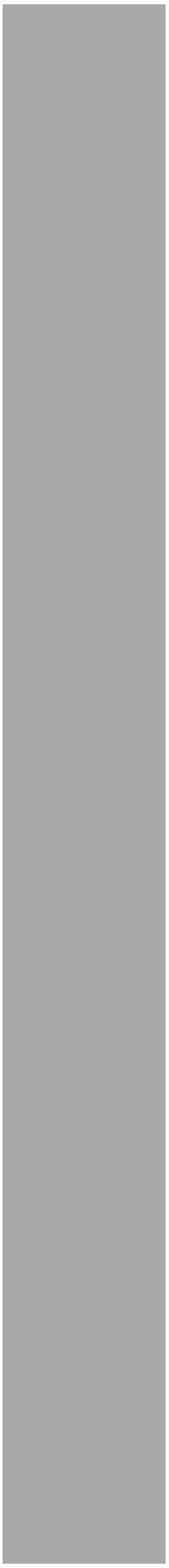


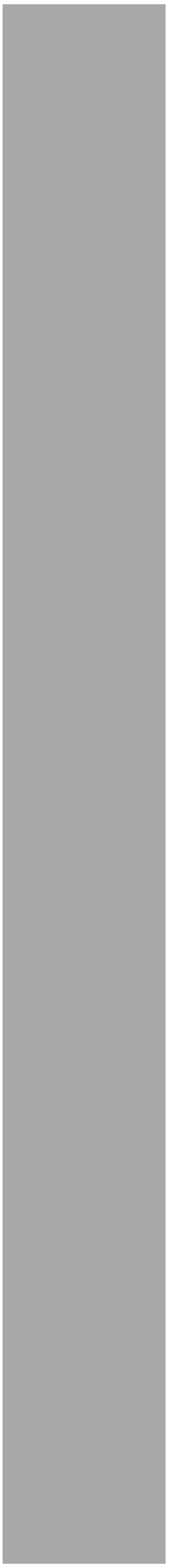


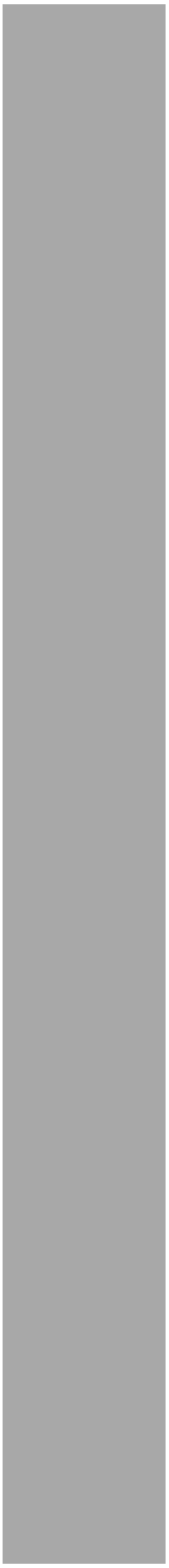


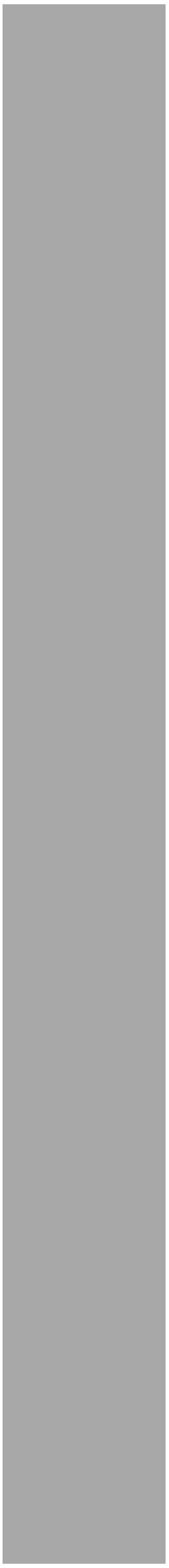


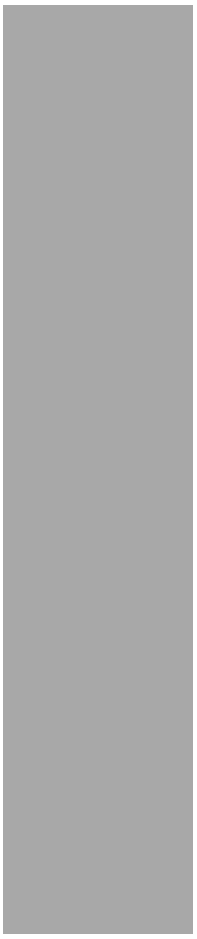












Readmits with a disposition of Home Care, SNF, Hospice or other Long Term Care Facility 2013 by hour of discharge and the # of days on average a patient was seen again at our facility

Current DispositionName	(Multiple Items)
DC_hour	(All)
Current DC Facility	(All)

Row Labels	Count of AccountNumber	Average of Days_since_Last_DC_DATE
Country Estates of Agawam/Kindred Healthcare	**12**	**17**
1	1	11
2	4	16
3	1	17
4	4	21
5	2	11
Mercy Home Care	**9**	**15**
1	4	16
2	2	14
3	1	14
4	2	14
Wingate at Springfield (Formerly Radius Ring Healthcare Center)	**6**	**12**
1	3	13
2	1	19
3	1	12
4	1	4
Wingate at West Springfield	**5**	**14**
1	2	9
3	1	13
4	1	18
5	1	22
Chapin Center	**5**	**11**
2	3	12

3	2	9
Genesis HC - Heritage Hall South	**5**	**18**
2	1	20
3	2	21
4	1	15
5	1	15
Wingate at East Longmeadow	**4**	**16**
2	3	17
3	1	16
Genesis HC - Heritage Hall North	**4**	**19**
2	3	16
5	1	27
Genesis HC - Heritage Hall West	**4**	**9**
2	1	4
3	3	11
Julian J. Leavitt Family Jewish Nursing Home	**4**	**11**
2	2	12
3	1	11
4	1	8
Wingate at South Hadley	**3**	**11**
2	1	15
3	2	8
Wingate at Wilbraham	**3**	**9**
1	1	6
4	1	1
5	1	21
HEALTHSOUTH Rehabilitation Hospital of Western MA	**2**	**13**
1	1	3
4	1	22
Redstone Rehabilitation and Nursing Center	**2**	**18**
1	2	18
East Longmeadow Skilled Nursing Center/Berkshire Healthcare Systems	**2**	**5**
4	2	5
Vibra Hospital of Western Massachusetts - SNU (Formerly Kindred Hospital - Park View)	**2**	**12**
4	2	12
Vibra Hospital of Western Massachusetts - Central (Formerly Kindred Hospital - Park View)	**2**	**16**
1	1	2
2	1	31
Willimansett Center West and East	**2**	**19**
2	1	16

5	1	22
Mount Saint Vincent Nursing Home	**2**	**19**
1	1	22
2	1	15
Life Care Center of Wilbraham/Life Care Centers of America	**2**	**22**
3	1	28
4	1	15
Chicopee Visiting Nurse Association/VNA	**1**	**4**
3	1	4
Genesis HC - Heritage Hall East	**1**	**16**
3	1	16
Home and Community Health Services, Inc/Johnson Health Network	**1**	**8**
4	1	8
Genesis HC - Hadley at Elaine Care and Rehabilitation Center	**1**	**9**
1	1	9
Governor's Center	**1**	**25**
1	1	25
Weldon Rehabilitation Hospital	**1**	**15**
3	1	15
The Renaissance Manor on Cabot	**1**	**24**
4	1	24
Allied Health Systems, LLC	**1**	**23**
4	1	23
Mary's Meadow at Providence Place	**1**	**21**
5	1	21
Grand Total	**89**	**15**

	Insurer	Plan Name	Mercy Rating	Last Rating Change	Rationale if not top level	IP Admission
	Blue Cross	Blue Options	Enhanced (1 of 3)	1/1/2013		150 no deductible/ 150 after deductible / 1000 after deductible
	Fallon	Fallon Select Care	Tier 1 (1 of 3)	7/1/2014		250/500/750
	Fallon	Fallon Tiered Choice	Tier 1 (1 of 3)	7/1/2014		250/500/750
	Harvard Pilgrim	HPHC Hospital Prefer	Tier 2 (2 of 3)	7/1/2014	Cost Unmet by 11%, Quality met	250/500/750
	Harvard Pilgrim	HPHC Choice Net	Tier 2 (2 of 3)	7/1/2014	Cost Unmet by 11%, Quality met	250/500/750
	Tufts	Tufts Your Choice Network	Tier 1 (1 of 3)	1/1/2014		NA
	Tufts	Tufts Navigator	Tier 1 (1 of 3)	7/1/2014		300/700 state employees for 2 tier plans

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 MMC

	P4P Contracts				Risk Contracts						FFS Arrangements		
	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
BCBSMA	$ 20,282,674		$ -										
Tufts	$ 2,281,621		$ (22,816)										
HPHC													
Fallon													
CIGNA											$ 2,276,506		
United													
Aetna											$ 1,284,827		
Other Commercial											$ 24,211,954		$ 1,812,693
Total Commercial	$ 22,564,295		$ (22,816)								$ 27,773,287		$ 1,812,693
Network Health											$ 3,101,415		
NHP											$ 463,026		
BMC Healthnet											$ 16,346,004		
MBHP											$ -		
Total Managed Medicaid	$ -	.									$ 19,910,445		
Mass Health	$ 11,055,095		$ 455,188										
Tufts Medicare Preferred					$ 11,420,078		3,707,513						
Blue Cross Senior Options											$ 4,344,421		
Other Comm Medicare					$ 4,123,516		$ 257,164						
Commercial Medicare Subtotal					$ 15,543,594		$ 3,964,677				$ 4,344,421		
Medicare											$ 62,508,625		
GRAND TOTAL	$ 33,619,390		$ 432,372	$ -	$ 15,543,594	$ -	$ 3,964,677	$ -	$ -	$ -	$ 114,536,778	$ -	$ 1,812,693

Other Revenue Arrangements

PPO	Both
$ -	$ -

2010 PBH

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA											$ 1,491,088				
Tufts											$ 81,854				
HPHC															
Fallon															
CIGNA											$ 149,103				
United															
Aetna											$ 60,966				
Other Commercial											$ 1,415,866				
Total Commercial	$ -		$ -								$ 3,198,876				
Network Health											$ 3,302,074				
NHP											$ 1,408,830				
BMC Healthnet											$ 680,938				
MBHP											$ 7,974,356				
Total Managed Medicaid	$ -	.									$ 13,366,198				
Mass Health	$ 1,313,392.20												$ 1,020,733		
Tufts Medicare Preferred					$ 238,042										
Blue Cross Senior Options											$ 106,144				
Other Comm Medicare					$ 135,857										
Commercial Medicare Subtotal					$ 373,899		$ -				$ 106,144				
Medicare											$ 6,073,684				
GRAND TOTAL	$ 1,313,392		$ -	$ -	$ 373,899	$ -	$ -	$ -	$ -	$ -	$ 22,744,903	$ -	$ 1,020,733	$ -	$ -

2010 MMC & PBH

					Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	``	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 20,282,674	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,491,088	$ -	$ -	$ -	$ -
Tufts	$ 2,281,621	$ -	$ (22,816)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 81,854	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,425,609	$ -	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,345,793	$ -	$ -	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,627,819	$ -	$ 1,812,693	$ -	$ -
Total Commercial	$ 22,564,295		$ (22,816)								$ 30,972,163		$ 1,812,693		
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,403,489	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,871,857	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,026,942	$ -	$ -	$ -	$ -
MBHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,974,356	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	.									$ 33,276,644				
Mass Health	$ 12,368,487.22	$ -	$ 455,187.89	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,020,733.40	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 11,658,120	$ -	$ 3,707,513	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,450,564	$ -	$ -	$ -	$ -
Other Comm Medicare			$ -	$ -	$ 4,259,373	$ -	$ 257,164	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial Medicare Subtotal					$ 15,917,493		$ 3,964,677				$ 4,450,564				
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 68,582,309	$ -	$ -	$ -	$ -
GRAND TOTAL	$ 34,932,782		$ 432,372	$ -	$ 15,917,493	$ -	$ 3,964,677	$ -	$ -	$ -	$ 137,281,681	$ -	$ 2,833,427	$ -	$ -

2011 MMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 20,095,651		$ 401,913												
Tufts	$ 2,389,847		$ (23,898)												
HPHC															
Fallon															
CIGNA											$ 2,681,212				
United															
Aetna											$ 924,482				
Other Commercial											$ 23,537,391		$ 1,595,256		
Total Commercial	$ 22,485,499		$ 378,015								$ 27,143,085		$ 1,595,256		
Network Health											$ 3,436,821				
NHP											$ 595,096				
BMC Healthnet											$ 16,363,989				
MBHP											$ -				
Total Managed Medicaid	$ -	.									$ 20,395,906				
Mass Health	$ 10,669,967		$ 912,216												
Tufts Medicare Preferred					$ 13,246,109		$ 1,883,713								
Blue Cross Senior Options											$ 3,047,541				
Other Comm Medicare					$ 4,571,781										
Commercial Medicare Subtotal					$ 17,817,890		$ 1,883,713				$ 3,047,541				
Medicare											$ 62,006,947				
GRAND TOTAL	$ 33,155,465		$ 1,290,231	$ -	$ 17,817,890	$ -	$ 1,883,713	$ -	$ -	$ -	$ 112,593,480	$ -	$ 1,595,256	$ -	$ -

2011 PBH

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA											$ 1,633,712				
Tufts											$ 167,026				
HPHC															
Fallon															
CIGNA											$ 206,544				
United															
Aetna											$ 49,465				
Other Commercial											$ 1,716,792				
Total Commercial	$ -		$ -								$ 3,773,540				
Network Health											$ 3,716,667				
NHP											$ 1,635,292				
BMC Healthnet											$ 118,391				
MBHP											$ 7,599,721				
Total Managed Medicaid	$ -	.									$ 13,070,071				
Mass Health	$ 1,115,465.89												$ 947,744		
Tufts Medicare Preferred					$ 251,723										
Blue Cross Senior Options											$ 101,180				
Other Comm Medicare					$ 122,992										
Commercial					$ 374,715		$ -				$ 101,180				
Medicare											$ 7,573,235				
GRAND TOTAL	$ 1,115,466		$ -	$ -	$ 374,715	$ -	$ -	$ -	$ -	$ -	$ 24,518,025	$ -	$ 947,744	$ -	$ -

2011 MMC &PBH

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 20,095,651	$ -	$ 401,913	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,633,712	$ -	$ -	$ -	$ -
BCBSMA	$ 2,389,847	$ -	$ (23,898)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 167,026	$ -	$ -	$ -	$ -
BCBSMA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BCBSMA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BCBSMA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,887,756	$ -	$ -	$ -	$ -
BCBSMA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BCBSMA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 973,947	$ -	$ -	$ -	$ -
BCBSMA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,254,183	$ -	$ 1,595,256	$ -	$ -
Total Commercial	$ 22,485,499		$ 378,015								$ 30,916,625				
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,153,488	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,230,389	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,482,380	$ -	$ -	$ -	$ -
MBHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,599,721	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	.									$ 33,465,977				
Mass Health	$ 11,785,432.72	$ -	$ 912,216.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 947,743.97	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 13,497,832	$ -	$ 1,883,713	$ 1,883,713	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,148,721	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ 4,694,773	$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial Medicare Subtotal					$ 18,192,605		$ 1,883,713				$ 3,148,721				
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 69,580,183	$ -	$ -	$ -	$ -
GRAND TOTAL	$ 34,270,931		$ 1,290,231	$ -	$ 18,192,605	$ -	$ 1,883,713	$ -	$ -	$ -	$ 137,111,505	$ -	$ 2,543,000	$ -	$ -

2012 MMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue A	
	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
BCBSMA	$ 19,163,710		$ 383,274											
Tufts	$ 2,461,952		$ (24,620)											
HPHC														
Fallon														
CIGNA											$ 2,880,262			
United														
Aetna											$ 1,078,744		$ 1,736,523	
Other Commercial											$ 24,616,473			
Total Commercial	$ 21,625,662		$ 358,655								$ 28,575,479		$ 1,736,523	
Network Health											$ 4,369,515			
NHP											$ 797,081			
BMC Healthnet											16,697,298.69			
MBHP											$ -			
Total Managed Medicaid	$ -	.									$ 21,863,895			
Mass Health	$ 10,859,036		$ 669,194											
Tufts Medicare Preferred					$ 13,820,007		$ 876,404							
Blue Cross Senior Options											$ 4,910,389			
Other Comm Medicare					$ 8,068,382									
Commercial Medicare Subtotal					$ 21,888,388		$ 876,404				$ 4,910,389			
Medicare											$ 73,641,789			
GRAND TOTAL	$ 32,484,698		$ 1,027,849	$ -	$ 21,888,388	$ -	$ 876,404	$ -	$ -	$ -	$ 128,991,551	$ -	$ 1,736,523	$ -

rrangements

Both
$ -

2012 PBH

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA											$ 1,362,862				
Tufts											$ 229,342				
HPHC															
Fallon															
CIGNA											$ 390,946				
United															
Aetna											$ 123,840				
Other Commercial											$ 2,018,865				
Total Commercial	$ -		$ -								$ 4,125,855				
Network Health											$ 3,812,766				
NHP											$ 1,654,269				
BMC Healthnet											$ 158,357				
MBHP											$ 7,218,577				
Total Managed Medicaid	$ -	.									$ 12,843,967				
Mass Health	$ 768,449.25												$ 1,126,410		
Tufts Medicare Preferred					$ 138,805										
Blue Cross Senior Options											$ 82,584				
Other Comm Medicare					$ 297,056										
Commercial Medicare Subtotal					$ 435,861		$ -				$ 82,584				
Medicare											$ 8,106,419				
GRAND TOTAL	$ 768,449		$ -	$ -	$ 435,861	$ -	$ -	$ -	$ -	$ -	$ 25,158,825	$ -	$ 1,126,410	$ -	$ -

2013 MMC

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 18,473,199		$ 369,464												
Tufts	$ 2,215,133		$ (22,151)												
HPHC															
Fallon															
CIGNA											$ 4,035,088				
United															
Aetna											$ 1,248,243		$ 1,629,748		
Other Commercial											$ 28,484,378				
Total Commercial	$ 20,688,333		$ 347,313								$ 33,767,709		$ 1,629,748		
Network Health											$ 4,776,905				
NHP											$ 176,922				
BMC Healthnet											18,664,579.08				
Fallon															
Total Managed Medicaid	$ -	.									$ 23,618,407				
Mass Health	$ 10,703,196		$ 649,587												
Tufts Medicare Preferred					$ 14,258,007		$ 849,494								
Blue Cross Senior Options											$ 4,702,991				
Other Comm Medicare					$ 11,023,710										
Commercial Medicare Subtotal					$ 25,281,717		$ 849,494				$ 4,702,991				
Medicare											$ 76,323,187				
GRAND TOTAL	$ 31,391,528		$ 996,900	$ -	$ 25,281,717	$ -	$ 849,494	$ -	$ -	$ -	$ 138,412,293	$ -	$ 1,629,748	$ -	$ -

196,715,287
$ 195,085,539 $ (1,629,748)
$ 391,800,826.00 1,629,748 #########

Payor Group	Total NPSR
BC ELECT PPO	4,551,720
BC INDEMNITY	846,659
BC OUT OF STATE	5,330,067
BLUE CARE 65	4,702,991
BLUE HMO	7,744,755
CIGNA	4,035,088
COM'L INSURANCE	7,598,684
COMMONWEALTH CARE	2,706,425
DMH	0
DPH	0
HEALTH NET	15,479,976
HEALTH NEW ENG	15,775,399
HEALTH SAFETY NET	301,079
MBHP	0
MEDICAID/OTHER GOV'T	10,703,196
MEDICARE	68,795,103
MEDICARE PSYCH	0
MEDICARE REHAB	6,749,812
OTH GOVT/VETERANS SVCS	778,271
OTHER HMO/PPO	6,358,538
OTHER MANAGED MEDICAID	5,432,007
OTHER MANAGED MEDICARE	11,023,710
SELF	8,788,570
TUFTS	2,215,133
TUFTS MEDICARE PRE	14,258,007
WORK COMP	1,629,748
Total	205,804,936
	8788569.78
	1629747.833
	195386618.1

36% BMC, 54% NH, 2% NHP, 8% spread

	COMMONWEALTH CARE	%
11	BMC	39.13%
9	NH	58.70%
10	NHP	2.17%

Grand Total	198,561,681
Self Pay	8,788,570
Sub Total	207,350,250

total 100.00%

		BC ELECT PPO		4,551,720		1	1	BCBSMA	18,473,199	x
		BC INDEMNITY		846,659		1	2	Tufts	2,215,133	x
		BC OUT OF STATE		5,330,067		1	3	HPHC	0	
		BLUE CARE 65		4,702,991		15	4	Fallon	0	
		BLUE HMO		7,744,755		1	5	CIGNA	4,035,088	
		CIGNA		4,035,088		5	6	United	0	
		COM'L INSURANCE		7,598,684		8	7	Aetna	0	
	x	COMMONWEALTH CARE		2,706,425			8	Other Commercial	29,732,621	BROUT
		DMH		0		13		***Total Commercial***	0	
		DPH		0		13			0	
		HEALTH NET		15,479,976		11	9	Network Health	1,588,554	
		HEALTH NEW ENG		15,775,399		8	10	NHP	58,835	
301,079	x	HEALTH SAFETY NET		301,079			11	BMC Healthnet	16,539,011	
		MBHP		0		12	12	other managed Medicare	5,432,007	
		MEDICAID/OTHER GOV'T		10,703,196		13		***Total Managed Medicaid***	0	
		MEDICARE		68,795,103		17			0	
		MEDICARE PSYCH		0		17	13	***Mass Health***	10,703,196	
		MEDICARE REHAB		6,749,812		17	14	Tufts Medicare Preferred	14,258,007	
		OTH GOVT/VETERANS SVCS		778,271		17	15	Blue Cross Senior Options	4,702,991	
		OTHER HMO/PPO		6,358,538		8	16	Other Comm Medicare	11,023,710	
		OTHER MANAGED MEDICAID		5,432,007		12		***Commercial Medicare Subtotal***	0	
		OTHER MANAGED MEDICARE		11,023,710		16			0	
8,788,570	x	SELF		8,788,570	X		17	***Medicare***	76,323,187	
		TUFTS		2,215,133		2			0	
		TUFTS MEDICARE PRE		14,258,007		14		**GRAND TOTAL**	195,085,539	
1,629,748	x	WORK COMP		1,629,748	X					
			0	0					10,719,397	
		Total		205,804,936						
10,719,397			0	8,788,570	self pay				205,804,936	
			0	1,629,748	wc				0	
			0	195,386,618						
			0	0						
			0	0						
			0	0						
			0	0						
			0	0						
			0	0						
			0	0						
			0	0						
			0 %			2,706,425				
			11	0		1,059,036	1,059,036			
			9	1		1,588,554	1,588,554			
			10	0		58,835	58,835			
			0	0						
			0	1		2,706,425	2,706,425			
			0	0						

	jan-jun ip	july dec ip	jan-jun OP	july dec OP	Total
BC ELECT PPO	1,169,391	850,805	1,224,065	1,307,458	4,551,720
BC INDEMNITY	87,213	235,465	242,292	281,689	846,659
BC OUT OF STATE	1,532,200	1,502,217	1,035,216	1,260,433	5,330,067
BLUE CARE 65	1,697,804	1,566,705	727,988	710,495	4,702,991
BLUE HMO	1,965,578	1,536,762	2,195,511	2,046,904	7,744,755
CIGNA	836,378	593,047	1,270,202	1,335,461	4,035,088
COM'L INSURANCE	1,453,991	1,342,711	2,459,570	2,342,412	7,598,684
COMMONWEALTH CARE	567,262	559,503	750,225	829,435	2,706,425
DMH	0	0	0	0	0
DPH	0	0	0	0	0
HEALTH NET	3,574,345	4,178,555	3,907,236	3,819,840	15,479,976
HEALTH NEW ENG	3,163,848	3,611,706	4,380,306	4,619,540	15,775,399
HEALTH SAFETY NET	0	224,538	0	76,541	301,079
MBHP	0	0	0	0	0
MEDICAID/OTHER GOV'T	2,889,473	2,658,133	2,715,377	2,440,213	10,703,196
MEDICARE	23,159,327	22,289,484	11,007,380	12,338,912	68,795,103
MEDICARE PSYCH	0	0	0	0	0
MEDICARE REHAB	2,893,377	3,420,244	222,004	214,187	6,749,812
OTH GOVT/VETERANS SVC	257,758	215,619	161,758	143,135	778,271
OTHER HMO/PPO	1,404,447	1,302,620	1,570,890	2,080,580	6,358,538
OTHER MANAGED MEDICA	1,280,253	1,552,131	1,262,818	1,336,805	5,432,007
OTHER MANAGED MEDICA	3,517,834	3,333,373	1,753,350	2,419,153	11,023,710
SELF	766,183	719,796	3,585,300	3,717,291	8,788,570
TUFTS	399,332	381,935	802,767	631,099	2,215,133
TUFTS MEDICARE PRE	4,094,220	3,564,826	3,216,205	3,382,756	14,258,007
WORK COMP	318,725	228,542	549,771	532,709	1,629,748
					0
total	57,028,939	55,868,719	45,040,229	47,867,048	205,804,936

2012	atna	1078744	0.041982278
	other comm	25695223	

$ - faalon

36% BMC, 54% NH, 2% NHP, 8% spread

	COMMONWEALTH CARE	%		$ 5,432,007		
11	BMC	39.13%	0	$ 2,125,567.88	$ 2,125,567.88	
9	NH	58.70%	0	$ 3,188,351.81	$ 3,188,351.81	
10	NHP	2.17%	0	$ 118,087.10	$ 118,087.10	
	total	100.00%	0	5,432,007	5,432,007	
	OTHER MANAGED MEDICAID	5,432,007				
9	NH					
10	NHP					
		mmc ip				
	NETW	532883.526				
	NHP	142524.4326				
		675407.9585				
9	NH	-				

			5,432,007	
9	NH	4369515	3802699.219	other comm
10	NHP	797081	693683.2642	
11	BMC	1075085	935624.3107	
		6241681	5432006.794	

10	NHP	-
11	BMC	-
		-

192788725.9 #######

186502933.9 #######

2013 PBH

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA											$ 1,097,062				
Tufts											$ 173,003				
HPHC															
Fallon															
CIGNA											$ 231,615				
United															
Aetna											$ 123,840				
Other Commercial											$ 1,797,655				
Total Commercial	$ -		$ -								$ 3,423,174				
Network Health											$ 4,929,834				
NHP											$ 2,185,813				
BMC Healthnet											$ 131,485				
MBHP											$ 7,800,004				
Total Managed Medicaid	$ -	.									$ 15,047,137				
Mass Health	$ 994,294.14												$ 1,104,732		
Tufts Medicare Preferred					$ 163,906										
Blue Cross Senior Options											$ 111,038				
Other Comm Medicare					$ 244,552										
Commercial Medicare Subtotal					$ 408,458		$ -				$ 111,038				
Medicare											$ 8,194,214				
GRAND TOTAL	$ 994,294		$ -	$ -	$ 408,458	$ -	$ -	$ -	$ -	$ -	$ 26,775,563	$ -	$ 1,104,732	$ -	$ -

2012 MMC & PBH

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	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
BCBSMA	$ 19,163,710	$ -	$ 383,274	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,362,862	$ -	$ -	$ -	$ -
Tufts	$ 2,461,952	$ -	$ (24,620)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 229,342	$ -	$ -	$ -	$ -
HPHC	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CIGNA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,271,207	$ -	$ -	$ -	$ -
United	$ -	#VALUE!	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,202,584	$ -	$ 1,736,523	$ -	$ -
Other Commercial	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,635,339	$ -	$ -	$ -	$ -
Total Commercial	$ 21,625,662		$ 358,655								$ 32,701,334				
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,182,280	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,451,350	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,855,655	$ -	$ -	$ -	$ -
MBHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,218,577	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	.									$ 34,707,862				
Mass Health	$ 11,627,485	$ -	$ 669,194	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,126,410	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 13,958,812	$ -	$ 876,404	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,992,973	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -	$ 8,365,438	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 22,324,250	$ -	$ 876,404	$ -	$ -	$ -	$ 4,992,973	$ -	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 81,748,208	$ -	$ -	$ -	$ -
GRAND TOTAL	$ 33,253,147		$ 1,027,849	$ -	$ 22,324,250	$ -	$ 876,404	$ -	$ -	$ -	$ 154,150,376	$ -	$ 2,862,934	$ -	$ -

2012 MMC & PBH

	P4P Contracts			
	Claims-Based Revenue		Incentive-Based Revenue	
	HMO	PPO	HMO	PPO
BCBSMA	$ 18,473,199	$ -	$ 369,464	$ -
Tufts	$ 2,215,133		$ (22,151)	$ -
HPHC	$ -		$ -	$ -
Fallon	$ -		$ -	$ -
CIGNA	$ -		$ -	$ -
United	$ -		$ -	$ -
Aetna	$ -		$ -	$ -
Other Commercial	$ -		$ -	$ -
Total Commercial	$ 20,688,333		$ 347,313	
Network Health	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -
MBHP	$ -	$ -	$ -	$ -
Total Managed Medicaid	$ -	.		
Mass Health	$ 11,697,490	$ -	$ 649,587	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -
Other Comm Medicare	$ -	$ -	$ -	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -
Medicare	$ -	$ -	$ -	$ -
GRAND TOTAL	$ 32,385,823		$ 996,900	$ -
	$ 32,385,823	$ -	$ 996,900	$ -

0	0	0	0

Risk Contracts					
Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue	
HMO	PPO	HMO	PPO	HMO	PPO
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ 14,421,913	$ -	$ 849,494	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ 11,268,262	$ -	$ -	$ -	$ -	$ -
$ 25,690,175	$ -	$ 849,494	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -
$ 25,690,175	$ -	$ 849,494	$ -	$ -	$ -
$ 25,690,175	$ -	$ 849,494	$ -	$ -	$ -

0	0	0	0	0	0

FFS Arrangements		Other Revenue Arrangements		
HMO	PPO	HMO	PPO	Both
$ 1,097,062	$ -	$ -	$ -	$ -
$ 173,003	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ 4,266,703	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ 1,372,083	$ -	$ 1,629,748	$ -	$ -
$ 30,282,032	$ -	$ -	$ -	$ -
$ 37,190,883		$ 1,629,748		
$ 9,706,739	$ -	$ -	$ -	$ -
$ 2,362,736	$ -	$ -	$ -	$ -
$ 18,796,064	$ -	$ -	$ -	$ -
$ 7,800,004	$ -	$ -	$ -	$ -
$ 38,665,543				
\				
$ -	$ -	$ 1,104,732	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ 4,814,029	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -
$ 4,814,029	$ -	$ -	$ -	$ -
$ 84,517,401	$ -	$ -	$ -	$ -
$ 165,187,856	$ -	$ 2,734,480	$ -	$ -
$ 165,187,856	$ -	#######	$ -	$ -

0 0 0 0 0 0

Total Cost= Direct & OH
Calendar Year

Inpatient

Check-in Date & Time	2013		
	Sum of Total Payments	Sum of Total Cost	CM
Managed medicaid	1,780,888	4,147,853	(2,366,965)
Managed medicare	11,020,129	9,561,183	1,458,947
Medicaid	4,414,304	4,433,710	(19,406)
Medicare	45,213,832	32,489,795	12,724,037
Private other	40,154,045	38,130,094	2,023,952
Self pay	942,627	1,079,315	(136,688)
Workers comp	619,746	456,251	163,495
	104,145,572	**90,298,200**	**13,847,371**

Check-in Date & Time	2012		
	Sum of Total Payments	Sum of Total Cost	CM
Managed medicaid	1,737,531	4,084,010	(2,346,479)
Managed medicare	10,296,813	8,228,486	2,068,328
Medicaid	5,188,994	5,071,595	117,399
Medicare	47,690,660	31,301,801	16,388,859
Private other	39,186,261	36,687,049	2,499,212
Self pay	377,684	476,402	(98,718)
Workers comp	605,237	470,565	134,672
	105,083,179	**86,319,907**	**18,763,273**

Check-in Date & Time	2011		
	Sum of Total Payments	Sum of Total Cost	CM
Managed medicaid	42,561,235	30,815,978	11,745,257
Managed medicare	37,857,893	34,040,442	3,817,451
Medicaid	10,673,797	8,735,438	1,938,359
Medicare	1,773,514	4,549,730	(2,776,216)
Private other	5,734,519	5,317,272	417,247
Self pay	375,266	493,203	(117,937)
Workers comp	399,436	326,772	72,664
	99,375,661	**84,278,835**	**15,096,826**

Outpatient

Check-in Date & Time	2013	
Sum of Total Payments	Sum of Total Cost	CM
4,850,612	7,913,853	(3,063,241)
11,704,005	12,619,662	(915,657)
5,553,632	6,726,475	(1,172,843)
28,663,833	34,094,073	(5,430,240)
57,430,302	58,852,218	(1,421,916)
1,520,586	2,998,668	(1,478,082)
1,038,300	1,487,798	(449,498)
110,761,271	**124,692,747**	(13,931,477)

Total Inpatient & Outpatient

Check-in Date & Time
Sum of Total Payments
6,631,500
22,724,134
9,967,937
73,877,665
97,584,347
2,463,213
1,658,046
214,906,842

Check-in Date & Time	2012	
Sum of Total Payments	Sum of Total Cost	CM
4,391,798	8,094,520	(3,702,722)
10,461,573	10,566,675	(105,102)
4,964,434	6,420,471	(1,456,036)
25,693,502	29,999,099	(4,305,598)
51,295,230	53,263,611	(1,968,380)
1,504,699	2,598,340	(1,093,642)
1,033,539	1,302,459	(268,921)
99,344,775	**112,245,175**	(12,900,400)

Check-in Date & Time
Sum of Total Payments
6,129,329
20,758,387
10,153,428
73,384,161
90,481,491
1,882,383
1,638,775
204,427,954

Check-in Date & Time	2011	
Sum of Total Payments	Sum of Total Cost	CM
4,262,532	7,548,589	(3,286,058)
9,420,024	9,687,802	(267,777)
4,598,239	7,581,697	(2,983,458)
20,910,346	27,273,413	(6,363,067)
43,992,494	49,174,068	(5,181,574)
1,442,624	2,441,502	(998,878)
1,206,841	1,460,363	(253,522)
85,833,100	**105,167,433**	(19,334,334)

Check-in Date & Time
Sum of Total Payments
46,823,767
47,277,917
15,272,036
22,683,860
49,727,014
1,817,890
1,606,276
185,208,760

2013	
Sum of Total Cost	**CM**
12,061,706	(5,430,206)
22,180,845	543,290
11,160,185	(1,192,249)
66,583,868	7,293,797
96,982,312	602,036
4,077,982	(1,614,769)
1,944,049	(286,003)
214,990,947	(84,105)

2012	
Sum of Total Cost	**CM**
12,178,530	(6,049,201)
18,795,161	1,963,226
11,492,066	(1,338,637)
61,300,900	12,083,261
89,950,659	530,832
3,074,742	(1,192,359)
1,773,024	(134,249)
198,565,082	5,862,872

2011	
Sum of Total Cost	**CM**
38,364,567	8,459,200
43,728,244	3,549,673
16,317,135	(1,045,098)
31,823,143	(9,139,283)
54,491,340	(4,764,327)
2,934,705	(1,116,814)
1,787,134	(180,858)
189,446,268	(4,237,508)