

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the [HPC's website](#).

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School [website](#) for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's [website](#). Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template**, written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

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

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

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Questions:

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

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

SUMMARY: UMass Memorial Medical Center is fully engaged in the movement to transform the health care system to deliver more accountable, cost effective and value based services. During FY14, our efforts have started to pay off - our expense growth has slowed and we project in FY14 that expenses will increase only about 2%. This is a result of cost reduction efforts (see 1b), as well as care redesign (for example, work to reduce inappropriate emergency room utilization through Primary Care Medical Homes, MyLink Program, etc.). Also, changes in payer contractual increases (see 1b) have been modest and below the state's growth benchmark.

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

UMass Memorial Medical Center's revenue increased by 3.3% from FY10 through FY13, while its expenses increased by 9.8%. From FY10 to projected FY14, revenues are up 8.8% (about 2% per year) and expenses are up 12.0% (about 3% per year). Although discharges decreased during those same timeframes (-8.8% from FY10 to FY13 and -12.8% from FY10 to projected FY14), observation cases were up significantly (64.7% from FY10 to FY13, 81.2% from FY10 to projected FY14), with the combination of inpatient and observation cases being basically flat from FY10 through FY14. From FY10 to projected FY14, outpatient clinic visits increased by 10.7%, while ED visits decreased by 4.9%. The major factor driving the slowing of the increase in expenses is the major cost reduction effort that has been ongoing since FY13. See above for additional factors.

- 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?

UMass Memorial Medical Center has been contributing to the Commonwealth's ability to meet the benchmark in two significant ways: 1) All contract renewals and new contract negotiations, proposals and negotiated increases have been at or below the Commonwealth's health care growth benchmark, and 2) significant internal cost reduction initiatives (including layoffs, consolidation of facilities and services, work redesign, etc.) have been underway since FY13. The results are a slowing of the growth in expenses at UMass Memorial Medical Center over the past year, with the FY13 to FY14 increase projected to be 2.1%, enabling us to accept lower contract rate increases from payers. Also, as noted in CHIA's most recent report (Annual Report on the Performance of the Massachusetts Health

Care System), TME for our medical group increased just 1.4% from 2012 to 2013.

- 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?

Medicare MSSP, Medicare BPCI, MassHealth PCPR, BCBS AQC, FCHP One Care, Other Commercial shared savings contracts; Negotiate bundled payment arrangements for diabetes care with commercial payers; Contract to use DxCG risk scores on our entire primary care population to measure and improve access to pcps as well as identify individuals at risk for high cost; Implement the Humedical OptumOne reporting systems which enables us to provide near real-time information on gaps in care, utilization and cost reporting, predictive analysis to target patients at risk of hospitalization and ED visits related to CHF, Diabetes, COPD, Pediatric Asthma; Implement point of care reminders through Clinical Quality Systems, Allscripts EMR, and Med CPU to identify gaps in care and promote adherence to clinical quality guidelines, Develop and implement Depression Registry in PCP practices.

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

Encourage provider participation in alternative payment programs without mandating the provider take risk; Programmatic reimbursement for care coordination and care management resources; Adequate and flexible Behavioral Health access and reimbursement; Easier access to clinical data from external organizations (HIE); Continued provider engagement in benefit and program design for new/evolving programs; Administrative simplification – eliminate duplication in credentialing by providers and health plans; claims data standardization among all programs

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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: UMass Memorial Medical Center (UMMMC) is fully engaged in the movement to transform the health care system to deliver more accountable, cost effective and value based services. We support the core components of Chapter 224 and the desire to reduce health care costs in a thoughtful and transparent manner. At the same time, we recognize the critical importance of maintaining fiscal and operational stability during this transition to ensure long term, meaningful and sustainable reductions in costs while ensuring access to high quality vital services. We must make substantial multi-year investments in our evolving information systems and clinical redesign in order to improve quality and reduce costs over the long term.

- 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? Our entry into risk based contracts is still in the very early stages, therefore the overall impact has yet to be realized. To the extent possible we have attempted to coordinate quality incentives across contracts to maximize efficiency and align incentives. The stronger financial incentives associated with quality measures under our current APM contracts have enabled greater attention and resource deployment. The varying complex methodologies the plans employ to establish risk and shared savings budgets are challenging to manage. The application of network based trends rather than hospital specific trends which more accurately account for adverse selection and differentiate between community and tertiary cost structure differences needs to be corrected. In terms of clinical operations, we are witnessing a transformation in care delivery practices, with greater focus on outreach and preventive services in our primary care practices; requires patient engagement as well (eg, call the practice instead of going to the ED). In order to continue this transformational change and keep up with the high demand for analytics among varying APM models major investment in reporting and analytical infrastructure are required. Additionally extensive project management and change management resources are needed in the practices. Currently, the implementation of APMs has had a negative impact on our non-clinical operations as it increases our administrative expenses, puts strain on our limited resources and increases the burden on our organization as we need to develop the formal infrastructure necessary to properly implement population health management while these new contracts, each presenting different financial models, are being implemented. Unfortunately we are not provided with up front infrastructure dollars and development time before payers are looking to move quickly into risk based programs. Significant analysis is necessary to ensure the payer base budget includes all claims from the prior period for which the budget is based upon. Application of the trend assumptions and negotiated exclusions are inconsistent and vary by payer contract. The manpower required to support the contract negotiation, contract management and implementation, financial analysis and maintenance is substantial and completely unfunded.

- 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). Significant analysis is necessary to ensure the payer base budget includes all claims from the prior period for which the budget is based upon. Application of the trend assumptions and negotiated exclusions are inconsistent and vary by payer contract. The manpower required to support the negotiation, ongoing operational support, financial analysis and maintenance is substantial.
- c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

We do not have additional analysis (see 2a above) to share.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.

SUMMARY: Health status risk adjustment measures are an important component of APM contracts and population health management in general. We are just gaining experience with how best to use these measures, and are finding that a) we need to build the internal expertise to evaluate and effectively leverage these measures, b), the limitations of the methodology often are not well understood by users, and c) their predictive value at a sub-population and individual level can be poor. While the risk scores generated by external entities as part of a contract may help manage success in that contract, we find that to effectively manage risk and costs in our system we need a more comprehensive, longitudinal, population-based measure.

- 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?

No. Lags in data availability, shifts of patients between payers, and variability in provider coding practices – particularly around sensitive diagnoses such as behavioral health issues and morbid obesity – may lead to risk scores that do not adequately represent the risk of the population in APM contracts and are insufficiently accurate for reporting and intervention. These models work best when they are specific to a particular population (eg, Medicare), but it is a challenge to use different risk scores to manage different populations; nor do many models account for the pediatric population. UMass Memorial has achieved success with our provider community by taking an all-patient approach to quality measurement and we believe that we need to take a similar approach with a population-level risk measures to better manage our entire patient population.

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

For the most part, the different payers appear to all be using similar methodologies, which is of benefit to us. There are, however, discrepancies in how those methodologies are implemented. For example, one payer used a common, commercially available risk-adjustment methodology, but then decided to augment the results with other. Moreover, it is not clear to us that risk scores generated by different payers, even if implemented in exactly the same way, are comparable since the population norms will vary such that risk scores with the same value from two different payers may actually represent different levels of illness burden

- 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?

We believe that risk adjustment measures are critical to the management of a total medical expense (TME) based population as it accounts for the level of population acuity within the TME budget. We are not certain that risk adjustment measures closely correlate to risk share and/or quality or performance based

incentives. For example, a population can have higher acuity members and it could still be possible to achieve high quality scores and therefore lower risk sharing; we plan to conduct analyses in this area in the near future. We hope and believe that risk adjustment measures positively affect our organization. Finally, we note that while we recognize the importance of each element in these contracts, their overall complexity is a challenge for both communication and intervention. An initiative in one area can divert resources and attention from others (e.g., initiative to improve coding and therefore risk scores may distract attention from the quality/performance measures).

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: UMass Memorial Health Care is working to align its analytical tools, care delivery models and staff development with factors that will make it successful in population health management. As we move into more risk-based contractual arrangements, we continue to invest in infrastructure to improve the timeliness and accuracy of data and streamline the use of that data for the care teams responsible for managing the needs of individual patients and increasingly complex populations of patients. Access to timely, reliable and actionable data and information remains key to facilitating high-value care for our patients and to performing successfully under new alternative payment methodologies. The combination of improving care for our patients while managing the costs to deliver that care are foundational elements for population health management at UMass Memorial.

ANSWER: More actionable real time data could be further facilitated by:

Reduced turnaround time for preventive service claims: Typically claims are reported 90 days in arrears. If the claims lag for preventive services could be reduced, we believe the impact for our outreach interventions would be improved, both from a resource use perspective and from a patient satisfaction perspective. Standard data formats for payer claims: Payer claims data is a critical element for our patient registries. Non-standardized data formats require additional processing time and effort for our analytics teams, reducing the amount of time they can spend on analyzing and financial modeling. Site and Provider level cost and utilization data: Improvement in patient outcomes is driven by the work of site level care teams, coupled with the use of accurate and standardized analytical reports.

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

SUMMARY: Holding providers accountable for the health of populations that they serve is an essential element of Alternative Payment methodologies that seek to improve the value of the health care delivered in the Commonwealth. It is important, however, that the methodology for attributing patients to providers is reflective of the provider-

patient relationships that exist in reality and are accompanied by initiatives to promote patient engagement with health systems, such as patient-centered medical homes. A transparent attribution methodology with responsiveness to provider feedback will be most successful.

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

The reporting that we provide to primary care practices relies on attribution through the Electronic Medical Record (EMR) and through health plan eligibility data for HMO patients. This type of self-attribution has been very well-received but leaves some patients unattributed. We have some experience with post-hoc attribution algorithms and have generally observed that those based on E&M visits are preferable for primary care attribution than those based on cost.

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

While some level of error is inevitable, critical success factors to a workable attribution methodology include:

- A public and transparent development process;
- Alignment with commonly used methodologies;
- Clear communication to providers on how the methodology works;
- The ability to get feedback, monitor accuracy on an ongoing basis, and make adjustments as necessary.

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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: We find that the level of effort for required quality reporting is great, involving analytic expertise, information systems infrastructure and alignment, strong communication and practice transformation support, and most importantly, clinical acceptance and leadership. The number of quality measures that we are required to report is growing rapidly, and for each new measure we need to have all the above elements in place. In addition, while we have observed that there is growing use of standard quality measures, small variations between the measures from different payers and from clinical quality guidelines can have a large impact on our operations.

ANSWER: The level of effort required to report quality measures to public and private payers is enormous. For each measure, we must understand each data element completely, including eligibility, denominator, numerator, and exclusion criteria. We must then align our information systems to collect each of these elements. This means that the end users must be collecting and entering all the required information in a standard manner, and that the electronic medical record (EMR) or other technology is capable of capturing the information and providing the data for analysis and reporting in a timely and usable format. While the expertise and infrastructure can be leveraged across measures, we sometimes have found that it can be difficult to adapt reporting capabilities developed for one payer to another, either because the capability to identify the different eligible patient populations was not included in the original functionality, or because the data elements required vary between the payers.

At a high level, most of the quality measures in our programs are fairly well aligned. There are, however, nuances in how we may meet the measures in different programs. For example, some payers consider good control of Hemoglobin A1c tests to be <8% while others consider it to be <7%. Also, whether data come from claims or from an EMR can significantly affect success in a measure: to achieve success in a measure that involved inappropriate antibiotic prescribing, for example, is different when the measure is EMR based and only providers' prescription data is included than when the measure is claims-based, and success is defined by whether or not the patient filled an antibiotic prescription. Similarly, some of the same quality measures differ by whether or not they permit patient refusal of a service as an exclusion criterion. Even seemingly small differences in quality measures create challenges for designing reports, setting up information systems, and communicating to providers.

Differences between the measures from different payers AND from the clinical quality guidelines put forth by various academic institutions has led to some skepticism from providers regarding the value of these quality measures overall. This not only affects performance on these measures, but also requires us to spend considerable resources on communication plans on how best reconcile these measures and make sure providers understand exactly for what they are being held accountable. Clinical leadership is essential to our endeavors, and if the required quality measures do not align well with the most up-to-date understanding of what constitutes high value medical care, we will not be successful in improving patient care.

Finally, many of the quality measures we are required to report involve primary care. As noted elsewhere, UMass Memorial is making significant investments to support our primary care providers, but we are concerned about the burden that may be felt by our practices as the number of required quality measures grows at the same time that the need for better cost and utilization management increases.

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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: UMMMC is an academic medical center. We have seen significant decreases in our inpatient utilization. Much of that has been a shift to observation status; however, both the combined inpatient and observation cases and our patient days have decreased over FY13 at -1.4% and -2.8%, respectfully.

- 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.

As an academic medical center, UMass Memorial Medical Center (UMMMC) does not do analysis specifically to identify the flow of patients to other higher cost care settings, however, we do track volume trends at UMMMC (see attached). We also look at "leakage", the loss of patients from our service area to other hospitals. We use "bubble maps" (see AG4 for more information and attachment) to look at the inpatient discharges for patients that live in our service area to UMMMC and other hospitals, both within our system and outside our system. However, because this analysis relies on statewide data, there is a fairly long lag time to get the data; at this point we only have data through FY 12. We do get some data on volume trends from other hospitals which we use to compare

to our internal volume trends. We have found that our discharge trend over the past few years is comparable to other teaching hospitals in Massachusetts.

- 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.

As noted in our response to question 1, our inpatient volume trends have been declining. That volume decline coupled with decreasing prices and a shift from commercial payer mix to a greater governmental payer mix requires constant attention and monitoring. We are evaluating cohorting and consolidation opportunities which can help maximize use of the most cost efficient sites of care, increase efficiency for medical staff and raise patient satisfaction. An example of this is our electronic ICU (eICU) services based in Worcester but provided to our member and affiliated community hospitals' patients at those hospitals. This allows ICU care to be managed in a lower cost setting and patients remain closer to home.

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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: UMass Memorial ACO has applied to be designated a CMS, MSSP ACO, effective January 2015. Additionally we plan to enter the Medicare BPCI Bundled Payment Initiative January 2015 for certain surgical procedure episodes. At the outset for both of these programs, the UMass Memorial will focus its care management efforts on managing post acute care, leveraging the work already underway at UMass Memorial Medical Center in optimizing Transitions of Care.

- 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.

Over the past few years we have focused our attention and resources to our Transitions of Care initiatives where we have been successful in reducing readmissions and have improved patient flow. We have now just begun a focused effort to include post acute care utilization and management (see 1b below). Data and analysis is difficult in this area and has been sporadic and difficult to obtain in a systematic and regular manner. As part of the Medicare ACO and Bundled payment programs we will receive post acute claims data from Medicare which will enable much more robust and consistent reporting and analysis to inform ongoing post acute care management, oversight and redesign efforts.

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

With funding from the State Infrastructure and Capacity Building Grant we are working on a focused post acute care management strategy: The project plan includes the following efforts over the coming 4 to 6 months:

- Organize a cross functional work group to assist in evaluation and selection of preferred network of post acute providers for the ACO

- Catalogue current activities/relationships within the UMass Memorial Health Care system related to post acute care facilities/agencies, especially skilled nursing facilities
- Identify all area post acute providers; profile using available data
- Establish/refine criteria for evaluation of post acute providers including criteria to ensure patients are discharged to the most clinically appropriate, cost effective setting.
- Define resource requirements and approach to managing post acute care
- Develop operating guidelines for managing post acute care
- Select preferred providers; negotiate interface protocols among and between ACO, its participating providers and post acute providers

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: UMass Memorial Medical Center has been helping patients understand their financial responsibility related to their medical bills for a number of years. This includes patients who are insured, but may have some out of pocket costs, as well as patients who are uninsured. With the implementation of the provisions in Chapter 224, we have reviewed and updated our procedures to ensure that we are in compliance with all aspects of the law.

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	147	36h
	Q2	0	125	24h
	Q3	0	33	24h
	TOTAL:	0	305	

* Please indicate the unit of time reported.

ANSWER: Chapter 224 requires that prior to an admission, procedure or service and upon request by a patient or prospective patient, a healthcare provider shall within two (2) working days, disclose the allowed amount or charge of the admission, procedure or service.

The UMass Memorial Patient Financial Counseling Department coordinates all patient pricing requests for UMass Memorial Hospital, the UMass Memorial Medical Group and Clinton Hospital. The Financial Counselors work with the health care provider to obtain

the appropriate CPT/Procedure codes in order to obtain a more accurate estimate of charges.

Many of the requests are from patients who are primarily concerned with their out of pocket responsibility. The patient financial counselors also work with patients by providing them with their insurers toll free telephone number and web site to obtain the estimate of any patient liability such as co-insurance and or deductibles. All requests are tracked in a database to determine the number, type and nature of the request and to monitor the turnaround time. An oral and a written estimate is provided to the patient for each request.

Requests are received via email, telephone and in person. The contact information is as follows: Telephone: 508-334-9300; Internal e-mail: Financial Counseling; External e-mail: NeedInsurance@UMassmemorial.org.

The template above was completed as requested, however, we have also attached an analysis of the pricing transparency inquiries from January 2014 through July 2014. The top requests are as follows: 1) Visits- consults, new, established, etc 71; 2) Surgery: all types 58; 3) Radiology: x-rays, ultrasounds, MRI's etc 47; 4) Vaccines: majority from the Travel Clinic 35; 5) Test: sleep study 30; 6) Colonoscopy 14; 7) Blood Test 8; 8) Vaginal Deliveries 7; 9) Dermatology procedures 6.

As mentioned above, most pricing requests from patients are related to the patient's expected financial responsibility, in the form of copayments, deductibles and coinsurance. As of this time, we have not performed any analysis to compare the estimates provided to patients against the actual final payment amounts.

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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: Tiering has a significant impact on a tertiary facility since pricing changes concurrently with case mix and this has not been accurately addressed when comparing a provider network on a sole set of criteria.

ANSWER: As we discussed in our 2013 Cost Trend Testimony, tiering/steerage has a significant impact on UMMC as a tertiary facility, where prices go up appropriately as case mix increases. This impact must be accounted for when data and price trends are reported. Also, current tiering criteria which compare costs per admission vs. an entire episode of care can be misleading. Facilities with lower infection and complication rates have lower downstream costs and this needs to be taken into consideration in the cost comparisons rather than the single cost of the inpatient admission. This puts tertiary facilities who appropriately have higher pricing at a disadvantage with community hospitals even though the tertiary facility may have lower downstream costs and better outcomes.

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with

a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

SUMMARY: see attached

- 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.
see attached
- 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.
see attached
- 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.
see attached
- 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.
see attached

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

SUMMARY: Our experience with the patient-centered medical home (PCMH) model began with a series of learning collaboratives for 20 of our primary care practices. The practice teams learned the basic principles of the PCMH model and quality improvement by using patient registries to manage the health of specific populations of patients, such as diabetics. In 2011, six practices continued to the next phase of transformation by either participating in the EOHHS PCMH program or an internal UMMHC program to be recognized as NCQA accredited PCMH practices. Between September 2012 and January 2014, all six practices were recognized as Level III NCQA PCMH practices.

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

We estimate that 15-20% of our primary care providers are in our six practices that have been recognized as NCQA Level III Patient Centered Medical Homes. Another 15% of providers are in 2 practices participating in PCPR; those practices will be applying for NCQA recognition as part of the PCPR program deliverables

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

We estimate that 15-20% of our primary care providers are in our six practices that have been recognized as NCQA Level III Patient Centered Medical Homes. Another 15% of providers are in 2 practices participating in PCPR; those practices will be applying for NCQA recognition as part of the PCPR program deliverables

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

We are in the discussion stages to develop an evaluation of the impact of PCMH recognition on the six practices that have completed the recognition process.

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: UMass Memorial Medical Center supports the movement to transform the health care system to an accountable, value-based industry. We appreciate the Health Policy Commission's Cost Trend Reports which continue the discussion around provider and insurer costs and trends pointing out many of the areas requiring our focus and diligent attention. We support the need to reduce health care costs in a thoughtful and transparent manner. Maintaining stability during this transition to afford the best decisions and our ability to meaningfully and sustainably reduce costs is critical. The continuous, multi-year investments needed to make to our evolving information systems and clinical redesign are enormous as we are fully committed to improving quality and reducing costs.

ANSWER: Many of the opportunities and recommendations in both the 2013 Cost Trend Report and the July 2014 Supplement are areas that UMass Memorial Medical Center (UMMMC) has been focusing on over the past few years. One example of this is our work to increase the integration of behavioral and medical health (see question #11). The reports noted a higher concentration of high cost patients with behavioral health issues and chronic conditions in low income areas. Worcester's mean and median household incomes are far below the Massachusetts average (32%) and we have experienced this at UMMMC, which led us to start addressing this issue several years ago through the MyLink program, the medical home implementation at our primary care clinics and other initiatives as mentioned in question #11.

Several recommendations focused on the need to reduce avoidable care, wasteful spending and utilization of post-acute care. At UMMMC, we have partnered with Worcester Elder Services (CMS Section 3026 initiative) to reduce readmissions. Our 30 day all cause readmission rates have dropped from 15.85% in 2011 to 14.81% in 2013. We are working on several fronts to reduce unnecessary ED utilization (see Q#11). We are also focusing on decreasing unnecessary utilization of high cost post-acute care by sending more patients directly home through initiatives in several of our surgical specialties (related to Medicare bundling initiative, work to reduce TME related to Medicare ACO, BC AQC).

The reports state that large hospital systems have seen an increase in their market share for commercially insured inpatients between 2009 and 2014, however, it should be noted that UMMMC's market share for commercially insured inpatients has remained stable (at 7%) throughout that same period. It should also be noted that CHIA's 2013 report on Relative Prices shows that although UMMMC's relative prices for commercially insured patients are above the average for MA hospitals (which is to be

expected given its status as an academic medical center that is also a disproportionate share hospital and the safety net hospital for Central Massachusetts, as well as being legislated to provide significant financial support to the University of Massachusetts Medical School), they are below those of its peer academic medical centers. The most recently published CHIA annual report (9/1/2014) reports that UMass Memorial commercial TME rate of change over 2012 ranged from a decrease of .6% to an increase of 1.4% among commercial payers - below the statewide trend and peer academic medical centers.

The Cost Trend Reports also highlight the opportunity and need for Massachusetts providers to move towards alternative payment methods. UMMC has recently been accelerating the pace at which it is converting patients from a fee for service payment mechanism to alternative payment methods. UMMC joined the Blue Cross AQC contract in 2013, began participation in MassHealth's Primary Care Payment Reform program in March, 2014, recently applied to be a Medicare ACO beginning in January 2015 and is in the process of applying to join CMS's Bundled Payment for Care Improvement initiative. As we further our work in implementing these programs by redesigning how we care for our patients, we expect to be able to meet the goals stated in the Cost Trend Reports by becoming a more efficient delivery system and reducing the total medical expenditures for our patient population.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

Completed in Attachment AGO Hospital Exhibit 1

See attached Exhibit I

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

Completed in Attachment AGO Hospital Exhibit 2

See attached Exhibit 2

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.

We use data from payers to build funds flow models and surplus/deficit scenarios. After validating the starting point on a PMPM basis, we project the initial budget PMPM with a degree of accuracy. We estimate member count, project an annual member month total and TME, analyze the funds flow of medical expenses within the budget and make an assumption about the quality score. Then we can then calculate the provider and health plan risk share, and surplus/deficit after the risk share. We model out the potential withhold dollars associated with the contract and estimate the potential for quality incentive payments and management fees. Then we build in variables to the trend, leakage, and other aspects of the model to forecast and project surplus and deficit scenarios, for which we reserve withholds. See attached letter, which shows our risk is insignificant.

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.

Attached are the most recent inpatient referral reports by service line that we produce each year. We also do service line inpatient market share reports as well for each hospital within our system. We utilize the Statewide Hospital Discharge Dataset to compile these reports. Unfortunately, we don't have a strong outpatient market share tool available to us as we have yet to find a product that reports outpatient information well. The inpatient market data we have available to us doesn't have providers listed so we cannot use the database for physician(s) or provider group(s) analysis rather we use Crimson to understand physician referral patterns. We have physician liaisons within our physician pods and our centers of excellence (MSK, Oncology and Surgery) who utilize the data as they go out to meet with physicians.

Attachment for HPC Question 1a

Medical Center:

Statistic	FY09 Actual	FY10 Actual	FY11 Actual	FY12 Actual	FY13 Actual	FY14 July YTD	FY14 Annualized	FY 10-FY 13	FY 10 - FY 14	FY 13 - FY 14
Acute Discharges	40,369	40,139	40,826	39,631	36,463	29,172	35,006	-9.2%	-12.8%	-4.0%
Psych Discharges	2,105	1,973	1,901	1,823	1,940	1,437	1,724	-1.7%	-12.6%	-11.1%
Total Discharges	42,474	42,112	42,727	41,454	38,403	30,609	36,731	-8.8%	-12.8%	-4.4%
Observation Cases	5,485	6,090	6,864	8,447	10,028	9,196	11,035	64.7%	81.2%	10.0%
Inpt + Observ	47,959	48,202	49,591	49,901	48,431	39,805	47,766	0.5%	-0.9%	-1.4%
Patient Days	216,350	214,494	215,001	205,596	203,606	164,950	197,940	-5.1%	-7.7%	-2.8%
Inpatient Surgical Cases	13,167	13,138	13,051	12,917	11,210	8,706	10,447	-14.7%	-20.5%	-6.8%
Outpatient Surgical Cases	17,485	17,936	17,485	17,427	18,438	16,134	19,361	2.8%	7.9%	5.0%
Total Surgical Cases	30,652	31,074	30,536	30,344	29,648	24,840	29,808	-4.6%	-4.1%	0.5%
Ambulatory Visits (excl. Home Health)	725,248	757,555	780,566	817,813	832,921	698,925	838,710	9.9%	10.7%	0.7%
ER Visits	138,159	137,795	140,915	139,708	134,891	109,238	131,086	-2.1%	-4.9%	-2.8%
Ambulatory Visits + ED Visits	863,407	895,350	921,481	957,521	967,812	808,163	969,796	8.1%	8.3%	0.2%

Attachment for
HPC Question 9

Umass Memorial Medical Center/Medical Group Pricing Transparency Metrics

	January-14	February-14	March-14	April-14	May-14	June-14	July-14	Total
Volume #	32	52	63	52	36	37	33	305
Turn around Time (%)								
Initial Request								
< 2 Business Days	91%	77%	81%	81%	89%	89%	85%	84%
> 2 Business Days	9%	23%	19%	19%	11%	11%	15%	16%
Turn around Time (#)								
Initial Request								
< 2 Business Days	29	40	51	42	32	33	28	255
> 2 Business Days	3	12	12	10	4	4	5	50
Turn around Time (%)								
Sufficient Data								
< 2 Business Days	91%	81%	81%	92%	94%	89%	88%	87%
> 2 Business Days	9%	19%	19%	8%	6%	11%	12%	13%
Turn around Time (#)								
Sufficient Data								
< 2 Business Days	29	42	51	48	34	33	29	266
> 2 Business Days	3	10	12	4	2	4	4	39
InPatient	4	3	5	4	4	6	3	29
OutPatient	28	49	58	48	32	31	30	276
Major Procedures	5	4	6	11	7	9	6	48
Minor Procedures	5	8	15	7	9	5	6	55
Radiology	4	10	9	5	2	9	5	44
Visits	8	19	19	22	5	6	7	86
Test	10	11	14	7	13	8	9	72

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.

Clearly the recent increase in deaths relating to opioid use highlights the impact of this issue from a human perspective. UMass Memorial, including Community HealthLink, CHL, provides a significant number of services/programs designed to integrate behavioral and medical services for our patient population. CHL's psychiatric medical home, our system's participation in the PCPR and One Care initiatives and our embedding of psychiatry, psychology, social work and special case management in our health centers and primary care sites are our examples of outpatient initiatives that we believe will improve outcomes and decrease costs. In addition to these outpatient initiatives we are presently operating two programs that are directly focused on clinical outcomes within the hospital inpatient and emergency departments. A recent internal study found 21.4% of high inpatient utilizers were found to have comorbid conditions including alcohol or drug dependence which not only impacted the admission acuity but also contributed to longer and more frequent hospitalization. To address this problem we have implemented a social work component on our inpatient medical floors focusing on individuals with substance abuse dependence. This intervention has decreased length of stay and the rate of unnecessary referrals to psychiatric hospitals and has increase the use of more community based substance abuse services.

Within the emergency department we have developed a successful program based on a Screening, Brief Intervention and Referral to Treatment (SBIRT) and we have worked with CHL to implement their very successful "MY Link" program that focuses on repeat users of the emergency system. Both programs, while successful are supported either through time-limited extramural funding or through internal system support.

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.

Significant areas of collaborative care have recently been implemented:

(1) MyLink Program: coordinated effort between UMMC & CHL to respond to individuals with multiple health and social needs who had ten or more ED visits within a year. Patients are assigned care workers who provide interventions such as phone outreach, home visits, limited case management and, linkage to community resources. Highly successful showing 20% decrease in ED utilization over a 1 year period. (2) Implementation in our Psych. ED of the Crisis Triage Rating Scale and referral to CHL: expedited screenings, patient stabilization and movement of patients offsite to CHL for follow up. (3) The operation of the successful SBIRT program with referral to community based resources. (4) Concerted efforts with CHL and a variety of community based providers to encourage the use of the community based emergency service programs rather than the emergency department use unless safety precautions require a hospital based approach. (5) Primary Care Payment Reform Program: 7 UMMC's primary care & family health centers and CHL continue to expand upon existing integrated medical and behavioral health within the practices. (6) Participation in the very successful MCPAP program

(initially developed at UMass Medical Center) (7) Developed a very successful Geriatric consultation program modeled after MCPAP (currently closed because of funding) (8) we have worked with a number of community based providers and DDS to develop and operate a very successful Medical Home for individuals with Intellectual Disabilities, co-morbid medical and psychiatric illness and problematic behaviors. First year results demonstrate a significant decrease in ED use and inpatient days (8) Working with DDS we developed an outpatient multidisciplinary evaluation clinic offering a comprehensive outpatient evaluation for Individuals with Intellectual Disabilities, co-morbid medical and psychiatric illness and problematic behaviors which were offered in lieu of hospitalization at a cost of less than 25% of an average hospitalization. Unfortunately this service was closed because of a lack of adequate funding.

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.

In addition to implementing and operating the services described in 11.a above we are struggling to identify clinical resources other than inpatient psychiatric referral for those patients who present in the inpatient department or through the community based systems who are often referred to psychiatric units while their primary clinical need is more substance abuse related. These patients are often drug seeking with decreased psychiatric acuity and more character disordered presentations. We have recently have created a Malingering & Deception in the Hospital Setting Committee. This committee is comprised of a group of service medical directors and is establishing internal standards for management of this population focusing on diversion and alternative treatment sites. Additionally we have enhanced our behavioral health screening tools and are implementing software changes to increase data provided to PCPs via the EMR;

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.

We have found successful outcomes (reduced emergency/repeat inpatient visits and cost savings) from a variety of pilots and grant funded programs. While we have seen a significant decrease in the use of the emergency department by youth and families our adult volumes continues to remain somewhat stable in spite of significant work to encourage community based services and clinicians to connect with the community based emergency services before coming to the hospital. Of note, on our University Campus, 30% of our volume comes from individuals outside the area designated for our local emergency service team. While our major challenge will be to find on-going support for our programs described above, it is also clear that the largest barrier to care is access to the needed service and investment in community based resources. We strongly recommend re-investment in the Massachusetts community based system. From a hospital perspective we suggest the following : Funding for IT infrastructure, data integration and analysis; Programmatic Funding for Behavioral Health Counselors; Programmatic Funding for social workers and community mental health workers, Our pilots have shown that increased intervention with these patients results in reduced overall total medical expenditure and increased patient outcomes and satisfaction.

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.

UMass Memorial currently provides discharge data to the CHIA through the HDD submissions inclusive of behavioral health discharges including diagnosis and other data elements.

Exhibit 1 AGO Questions to Hospitals

NOTES:

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

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	\$ 134.6	\$ 102.5	\$ 2.6	\$ 2.5											
Tufts Health Plan											\$ 40.7	\$ 21.8			
Harvard Pilgrim Health Care											\$ 47.2	\$ 19.9			
Fallon Community Health Plan											\$ 73.8	\$ 0.6			
CIGNA											\$ 12.3	\$ 2.8			
United Healthcare											\$ 13.9	\$ 0.1			
Aetna											\$ 5.5	\$ 15.3			
Other Commercial											\$ 39.9	\$ 19.6			
Total Commercial	\$ 134.6	\$ 102.5	\$ 2.6	\$ 2.5							\$ 233.3	\$ 80.1			
Network Health											\$ 43.9				
Neighborhood Health Plan											\$ 14.0				
BMC HealthNet, Inc.											\$ 25.5				
Health New England															
Fallon Community Health Plan											\$ 6.7				
Other Managed Medicaid															
Total Managed Medicaid											\$ 90.1				
MassHealth		\$ 69.4		\$ 4.9											
Tufts Medicare Preferred											\$ 8.4				
Blue Cross Senior Options											\$ 32.4				
Other Comm Medicare											\$ 46.4				
Commercial Medicare Subtotal											\$ 87.2				
Medicare												\$ 308.8			
Other											\$ 27.4	\$ 35.5			
GRAND TOTAL	\$ 134.6	\$ 171.9	\$ 2.6	\$ 7.4	X	X	X	X	X	X	\$ 438.0	\$ 424.4	X	X	X

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	\$ 131.6	\$ 105.1	\$ 2.6	\$ 2.5											
Tufts Health Plan	\$ 41.5	\$ 23.4	\$ 0.3	\$ 0.1											
Harvard Pilgrim Health Care											\$ 46.5	\$ 23.4			
Fallon Community Health Plan											\$ 78.4	\$ 0.5			
CIGNA											\$ 12.9	\$ 2.8			
United Healthcare											\$ 18.9	\$ -			
Aetna											\$ 5.9	\$ 16.4			
Other Commercial											\$ 33.9	\$ 19.2			
Total Commercial	\$ 173.1	\$ 128.5	\$ 2.9	\$ 2.6							\$ 196.5	\$ 62.3			
Network Health											\$ 43.6				
Neighborhood Health Plan											\$ 21.3				
BMC HealthNet, Inc.											\$ 21.9				
Health New England															
Fallon Community Health Plan											\$ 5.7				
Other Managed Medicaid															
Total Managed Medicaid											\$ 92.5				
MassHealth		\$ 74.1		\$ 3.0											
Tufts Medicare Preferred											\$ 9.3				
Blue Cross Senior Options											\$ 28.7				
Other Comm Medicare											\$ 44.0				
Commercial Medicare Subtotal											\$ 82.0				
Medicare												\$ 319.0			
Other											\$ 26.5	\$ 32.8			
GRAND TOTAL	\$ 173.1	\$ 202.6	\$ 2.9	\$ 5.6	X	X	X	X	X	X	\$ 397.5	\$ 414.1	X	X	X

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	\$ 113.7	\$ 103.2	\$ 2.6	\$ 2.5											
Tufts Health Plan	\$ 40.2	\$ 21.0	\$ 0.3	\$ 0.1											
Harvard Pilgrim Health Care	\$ 42.9	\$ 26.7	\$ 0.3	\$ 0.1											
Fallon Community Health Plan											\$ 77.7	\$ 0.5			
CIGNA											\$ 13.7	\$ 10.3			
United Healthcare											\$ 19.2	\$ 0.3			
Aetna											\$ 5.5	\$ 14.5			
Other Commercial											\$ 45.4	\$ 22.5			
Total Commercial	\$ 196.8	\$ 150.9	\$ 3.2	\$ 2.7							\$ 161.5	\$ 48.2			
Network Health											\$ 47.9				
Neighborhood Health Plan											\$ 16.3				
BMC HealthNet, Inc.											\$ 15.8				
Health New England															
Fallon Community Health Plan											\$ 7.3				
Other Managed Medicaid															
Total Managed Medicaid											\$ 87.3				
MassHealth		\$ 86.1		\$ 3.0											
Tufts Medicare Preferred											\$ 10.0				
Blue Cross Senior Options											\$ 26.7				
Other Comm Medicare											\$ 41.8				
Commercial Medicare Subtotal											\$ 78.5				
Medicare												\$ 329.3			
Other											\$ 29.7	\$ 42.4			
GRAND TOTAL	\$ 196.8	\$ 237.0	\$ 3.2	\$ 5.7	X	X	X	X	X	X	\$ 357.0	\$ 419.9	X	X	X

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	\$ 47.9	\$ 90.8	\$ 2.6	\$ 2.5	\$ 57.0		\$ (2.6)								
Tufts Health Plan	\$ 48.2	\$ 16.1	\$ 0.3	\$ 0.1											
Harvard Pilgrim Health Care	\$ 51.6	\$ 22.1	\$ 0.3	\$ 0.1											
Fallon Community Health Plan											\$ 75.6	\$ 0.8			
CIGNA											\$ 13.7	\$ 3.7			
United Healthcare											\$ 13.0	\$ 3.5			
Aetna											\$ 5.4	\$ 18.1			
Other Commercial											\$ 44.8	\$ 22.0			
Total Commercial	\$ 147.7	\$ 129.0	\$ 3.2	\$ 2.7	\$ 57.0	\$ -	\$ (2.6)	\$ -	\$ -	\$ -	\$ 152.5	\$ 48.1	\$ -	\$ -	\$ -
Network Health											\$ 48.3				
Neighborhood Health Plan											\$ 16.0				
BMC HealthNet, Inc.											\$ 16.2				
Health New England											\$ 0.2				
Fallon Community Health Plan											\$ 7.9				
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	\$ -	-	-	-	-
Total Managed Medicaid											\$ 88.6				
MassHealth		\$ 85.4		\$ 2.0											
Tufts Medicare Preferred											\$ 10.6				
Blue Cross Senior Options											\$ 26.7				
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	\$ 45.9	-	-	-	-
Commercial Medicare Subtotal											\$ 83.2				
Medicare												\$ 313.1			
Other											\$ 29.0	\$ 41.1			
GRAND TOTAL	\$ 147.7	\$ 214.4	\$ 3.2	\$ 4.7	\$ 57.0	\$ -	\$ (2.6)	\$ -	\$ -	\$ -	\$ 353.3	\$ 402.3	\$ -	#VALUE!	\$ -

AGO Hospital Exhibit 2
UMass Memorial Medical Center
Margin by Payer Group trended by Year Inpatient Cases and Outpatient Discharges

source: EPSI decision support system

Payer Group	FY 2010			FY 2011			FY 2012			FY 2013		
	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin
Commercial	569,973,171	452,993,396	116,979,775	568,353,595	454,679,178	113,674,417	541,587,449	455,872,491	85,714,958	531,148,527	450,598,390	80,550,138
Governmental	548,095,880	629,523,694	(81,427,814)	570,219,978	654,487,764	(84,267,786)	590,432,058	686,746,297	(96,314,239)	592,752,308	727,684,266	(134,931,958)
Other	10,479,745	17,619,038	(7,139,293)	9,762,827	15,786,447	(6,023,620)	9,120,710	17,914,753	(8,794,043)	8,300,214	17,277,635	(8,977,421)
Grand Total	1,128,548,796	1,100,136,128	28,412,668	1,148,336,400	1,124,953,389	23,383,011	1,141,140,217	1,160,533,542	(19,393,325)	1,132,201,049	1,195,560,291	(63,359,242)

Notes -

- These reports are for internal analytical purposes only.
- Net Revenue and Cost calculations employ numerous allocations in order to report them at the payer and service line level. The methodology employed by UMass Memorial Medical Center is an internal allocation methodology which limits comparability to other hospitals.
- Special Medicaid payments made to the medical center as an "essential MassHealth hospital have been excluded from this analysis due to the unique nature of the payments.
- Service line groupings are based on a set of internal groupings used by UMass Memorial Medical Center.
- Certain unique medical education costs have been excluded from this analysis.

UMMMC
Margin by Payer Group trended by Year Inpatient Cases

source: EPSI decision support system

	FY 2010			FY 2011			FY 2012			FY 2013		
Payer Group	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin
Commercial	287,133,458	243,841,830	43,291,629	288,688,486	236,336,735	52,351,752	279,798,561	239,156,970	40,641,590	270,153,516	232,227,243	37,926,273
Governmental	394,762,509	432,505,842	(37,743,332)	420,516,508	440,259,798	(19,743,290)	407,389,403	437,053,046	(29,663,644)	394,557,450	456,403,358	(61,845,909)
Other	5,552,941	7,474,027	(1,921,086)	3,867,460	5,772,185	(1,904,725)	4,511,484	5,899,263	(1,387,779)	3,083,885	4,869,493	(1,785,609)
Grand Total	687,448,908	683,821,698	3,627,210	713,072,455	682,368,718	30,703,737	691,699,447	682,109,279	9,590,168	667,794,851	693,500,095	(25,705,244)

UMMMC

Margin by Payer Group trended by Year Outpatient Discharges

source: EPSI decision support system

Payer Group	FY 2010			FY 2011			FY 2012			FY 2013		
	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin	Est Net Revenue	Total Cost	Total Margin
Commercial	282,839,713	209,151,566	73,688,147	279,665,108	218,342,443	61,322,665	261,788,888	216,715,521	45,073,368	260,995,011	218,371,147	42,623,864
Governmental	153,333,371	197,017,853	(43,684,482)	149,703,470	214,227,966	(64,524,496)	183,042,656	249,693,251	(66,650,596)	198,194,858	271,280,908	(73,086,050)
Other	4,926,804	10,145,011	(5,218,207)	5,895,368	10,014,262	(4,118,895)	4,609,226	12,015,491	(7,406,264)	5,216,329	12,408,141	(7,191,812)
Grand Total	441,099,888	416,314,430	24,785,458	435,263,946	442,584,671	(7,320,726)	449,440,770	478,424,262	(28,983,492)	464,406,198	502,060,196	(37,653,997)

source: EPSI decision support system

	FY2010						FY2011					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Inpatient Cases												
Service Line												
8 East IP	2,402,019	(423,944)	6,801,185	(3,685,964)	4,029	(31,658)	2,914,817	(861,708)	6,762,107	(4,481,477)	4,713	(46,929)
AAA IP	4,290,619	865,833	6,891,980	24,585	398,889	177,784	2,907,479	463,353	7,878,963	(176,707)	1,463	(15,415)
Ablations/Cardioversions IP	1,264,823	361,196	3,946,579	223,322	515	(2,030)	1,868,048	702,424	3,790,352	233,201	4,551	(59,465)
All Other	45,399	14,562	242	(70,502)	-	-	1,080	(2,537)	4,643	(28,749)	-	-
AMI IP	1,166,097	85,447	4,331,766	46,498	48,082	16,095	1,526,082	320,030	4,450,767	(215,254)	11,013	(146,180)
Amputations IP	855,230	228,128	2,502,449	416,683	65,698	(28,510)	885,089	226,072	2,450,773	151,476	-	-
Anal/Stomal IP	311,780	(47,049)	297,976	(60,269)	-	-	235,446	10,694	220,505	(66,524)	-	-
Antepartum IP	1,097,748	60,887	796,515	(479,719)	-	-	1,231,940	134,656	760,746	(411,330)	-	-
Appendix IP	2,396,669	68,005	1,154,187	(536,851)	11,877	(50,779)	2,006,661	(57,032)	1,129,776	(557,276)	686	(4,000)
Bariatrics IP	3,568,683	(652,006)	1,850,625	(247,549)	21,364	2,641	3,463,999	(296,533)	1,714,426	(367,199)	2,324	(25,908)
Biliary IP	1,851,729	6,319	2,071,900	(209,290)	67,002	29,548	1,825,626	173,218	2,053,923	(344,410)	7,361	(71,277)
BMT IP	5,293,897	410,541	2,544,471	(450,214)	-	-	4,351,042	703,495	2,696,775	(174,924)	-	-
Breast Surgery IP	394,326	(24,658)	194,491	(31,643)	-	-	389,636	(31,518)	114,684	(58,403)	-	-
CABG IP	3,781,260	243,457	6,137,370	(810,004)	10,730	(118,860)	5,179,448	529,641	6,713,251	(1,109,221)	101,227	15,204
Cardiac Cath Other IP	2,385,609	152,727	2,442,116	(110,383)	876	(6,174)	2,190,149	569,036	3,278,303	25,475	2,622	(12,690)
Cardiac Surgery Other IP	384,033	14,291	970,343	(28,132)	-	-	179,969	7,841	130,979	(29,012)	-	-
Cardiology Medicine Other IP	3,149,691	684,666	6,352,755	337,997	32,365	(20,128)	3,424,151	978,785	6,480,762	902,131	12,721	(37,857)
Chest Pain IP	538,869	129,795	2,246,407	214,204	2,026	(13,115)	688,718	148,838	2,003,663	195,124	2,935	(13,190)
Colorectal IP	6,455,237	1,128,262	6,992,466	(611,305)	150,858	31,235	5,570,894	952,899	8,345,307	(117,834)	74,302	(14,695)
Deliveries IP	17,203,139	(326,916)	9,142,829	(3,656,705)	3,243	(34,950)	17,609,190	(45,971)	10,156,449	(4,866,431)	8,064	(61,014)
DES/BMS IP	10,416,098	3,574,790	8,650,783	195,401	280,459	96,171	11,089,410	4,801,216	9,249,232	1,546,785	125,284	(55,450)
Diagnostic IP	1,695,684	288,634	3,703,073	(164,983)	74,049	(20,130)	1,870,194	434,453	3,009,089	100,304	4,923	(31,380)
Electrophysiology Other IP	437,953	116,595	975,159	12,075	60,065	31,173	473,825	203,016	902,658	190,610	-	-
Emergency Medicine Boarders IP	-	-	-	-	-	-	-	-	-	-	-	-
Endoscopy & GI IP	8,673,401	1,485,232	17,818,359	(1,331,658)	133,964	(112,220)	9,918,633	1,348,639	20,648,341	(1,714,810)	80,020	(122,892)
ENT Thyroidectomy IP	74,561	12,509	113,423	(5,483)	-	-	33,873	(4,732)	111,111	(6,915)	-	-
Epilepsy IP	667,227	55,074	1,905,710	(219,492)	7,507	(10,078)	759,773	135,755	2,119,596	(123,380)	3,857	(1,426)
Foot & Ankle IP	419,030	171,981	181,948	(28,339)	32,543	(12,594)	501,305	54,908	288,452	(96,157)	33,930	(4,849)
Fracture IP	9,935,037	2,480,889	8,284,096	(2,026,515)	699,366	(289,798)	9,055,887	2,140,020	8,939,424	(1,347,379)	426,393	(288,370)
General Neurology IP	1,566,410	115,843	2,397,039	1,610	1,226	(11,181)	1,353,889	141,548	2,526,858	(45,652)	10,949	(20,663)
General Orthopedics IP	2,950,139	567,106	2,820,823	(321,559)	113,038	(49,863)	2,042,057	477,466	2,982,145	146,331	74,442	(21,916)
General Surgery Other IP	9,483,085	2,089,444	12,389,342	(861,152)	200,670	(139,319)	9,309,243	1,789,075	12,397,679	(505,366)	105,041	(142,761)
GYN Onc IP	1,094,304	127,271	1,328,324	46,972	-	-	1,319,635	280,853	1,325,422	63,992	-	-
Hand IP	121,553	44,961	74,710	(46,243)	28,169	(24,203)	86,012	5,930	52,563	(20,265)	15,782	(6,190)
Heart Failure IP	1,830,138	348,810	8,098,700	431,359	73,997	24,584	1,331,727	122,325	8,063,987	799,445	1,417	(51)
Hem Onc IP	10,102,782	1,454,528	12,999,895	(791,316)	3,180	(2,418)	8,718,313	2,905,049	12,619,893	469,842	-	-
Hernia IP	390,201	34,395	610,615	(23,675)	18,732	(2,034)	586,984	63,172	687,228	(49,862)	-	-
Hospital Medicine IP	14,078,665	2,485,665	35,595,468	(1,722,160)	207,896	(206,122)	14,580,998	2,278,427	35,542,629	(4,145,804)	56,716	(242,040)
ICD/BiVs IP	2,077,320	467,091	5,474,947	263,013	116,247	2,843	3,407,236	1,422,349	5,236,815	1,278,088	160,189	58,811
Infectious Diseases IP	1,063,103	430,230	5,359,211	(381,432)	8,255	(81,545)	2,120,372	526,989	5,120,968	(257,727)	122,686	59,319
Joints IP	7,833,438	680,942	10,562,183	(388,290)	13,936	(3,639)	7,790,271	1,894,085	10,811,222	758,576	104,357	(15,539)
MS IP	276,570	12,386	207,842	(195,661)	-	-	304,777	(6,821)	234,787	(48,925)	-	-
Nephrology IP	1,551,861	342,242	5,713,634	(216,615)	126,534	17,519	2,162,258	488,185	7,180,938	(242,710)	9,723	(1,984)
Neuro-Interventional Radiology IP	57,235	(46,646)	146,882	(50,559)	-	-	145,546	63,132	300,898	24,585	1,393	(9,796)
Neuromuscular IP	544,621	115	942,402	(207,070)	-	-	306,586	3,267	896,685	66,997	-	-
Neurosurgery IP	10,613,723	2,487,092	8,868,334	(28,823)	19,623	(32,155)	10,486,630	2,433,139	9,437,510	(566,953)	29,590	(33,193)
Newborns	4,788,083	(2,192,926)	7,090,150	1,513,413	2,847	(33,266)	5,343,920	(646,033)	6,120,724	1,042,525	6,528	(33,254)
NICU	18,434,868	4,234,632	10,619,862	(2,136,909)	1,169	(8,092)	15,226,301	2,969,243	16,089,358	(604,951)	-	-
OB/GYN IP	3,916,074	521,568	2,491,266	(208,245)	-	-	3,357,183	622,518	2,666,757	(315,756)	11,598	(22,016)
Other IP	455,844	107,627	396,816	3,061	13,972	(3,433)	520,279	202,106	462,644	50,249	4,602	(3,690)
Otolaryngology IP	539,348	138,462	565,354	(192,340)	10,318	(51,698)	574,354	236,796	670,144	(3,219)	26,429	(6,354)

source: EPSI decision support system

	FY2010						FY2011					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Pacemakers IP	1,193,558	22,444	4,615,206	(559,633)	84,540	33,677	1,142,741	164,158	4,390,811	363,462	2,757	(19,488)
Pediatric IP	11,807,912	936,032	6,902,767	(2,944,675)	3,959	(42,910)	12,156,843	291,368	7,148,080	(3,842,925)	12,527	(29,177)
Peripheral IP	726,854	210,574	1,443,677	131,730	9,612	(28,835)	632,690	62,868	1,500,269	(40,795)	1,866	(14,986)
Plastic IP	1,349,314	143,053	1,680,497	(229,645)	124,294	(68,433)	1,034,360	155,438	1,770,505	199,502	32,214	(53,004)
PTRC IP	740,086	48,623	5,418,358	(2,380,199)	3,449	(22,306)	1,004,155	(223,120)	5,993,413	(2,901,225)	10,423	(86,132)
Pulmonary IP	4,394,658	838,275	13,582,969	(969,511)	46,392	(38,831)	5,057,769	1,344,833	14,173,775	267,510	8,220	(15,547)
Rad Onc IP	20,886	(840)	17,251	(2,217)	-	-	-	-	3,129	1,343	-	-
Rheumatology IP	164,128	(7,191)	378,907	28,763	-	-	239,846	117,312	752,699	108,859	689	(3,602)
Solid Organ Disorders IP	4,339,268	740,142	6,252,596	(1,392,636)	8,948	(71,343)	3,979,099	516,455	6,717,063	(1,287,858)	35,946	(47,592)
Spine - MSK IP	9,686,173	1,366,417	9,724,357	(1,935,027)	780,292	(209,210)	8,895,147	1,466,480	11,586,460	(422,358)	380,473	(71,771)
Spine - Neuro IP	5,635,621	293,289	5,297,929	(769,471)	246,410	(85,111)	5,817,413	935,250	6,286,226	(289,644)	260,253	(108,445)
Sports Medicine IP	918,277	109,407	1,589,314	(191,493)	89,296	(27,303)	1,144,431	147,685	1,679,926	(141,719)	114,097	(17,674)
Stroke IP	2,765,267	555,012	6,470,395	86,424	44,244	(29,350)	2,984,364	900,134	7,372,107	385,314	6,737	(50,422)
Thoracic IP	3,132,678	636,889	4,848,892	(84,843)	111,774	(91,506)	3,589,408	783,972	5,154,822	(194,944)	39,233	(3,775)
Transplant IP	5,532,600	1,366,553	7,076,017	(569,291)	-	-	5,843,510	605,946	10,826,908	1,336,018	-	-
Trauma IP	15,153,579	6,118,588	3,385,746	(234,972)	371,594	(146,755)	13,142,022	5,021,138	4,999,553	(415,941)	433,661	(107,236)
Trauma Related IP	1,474,124	409,477	2,136,407	18,192	33,406	(13,047)	1,944,430	465,547	3,158,784	358,939	19,222	(4,059)
Upper GI IP	2,093,557	453,494	1,786,918	(595,277)	-	-	1,798,707	299,079	2,478,664	(152,400)	-	-
Uro/Gyn IP	49,263	14,386	23,245	1,331	-	-	556,919	(110,198)	537,157	(58,694)	-	-
Urology IP	3,175,657	560,371	5,461,101	178,746	19,182	(17,786)	3,413,767	576,642	4,807,790	(111,132)	8,352	(9,489)
Valves IP	2,203,615	32,554	5,528,033	(613,990)	93,724	43,813	3,692,696	607,688	6,399,846	(12,180)	4,851	(39,065)
Vascular Other IP	2,657,680	647,675	9,204,155	1,116,906	60,173	24,729	2,989,531	538,857	9,713,354	1,510,092	5,307	(32,775)
Vent IP	22,993,489	2,180,319	47,882,771	(7,025,686)	356,338	(160,178)	24,401,701	5,672,460	45,232,254	652,333	840,802	248,615
Total IP	287,133,458	43,291,629	394,762,509	(37,743,332)	5,552,941	(1,921,086)	288,688,486	52,351,752	420,516,508	(19,743,290)	3,867,460	(1,904,725)

Outpatient Discharges

Service Line												
All Other	89,803	33,981	34,733	(4,503)	1	(2)	55,715	22,935	27,302	(1,376)	68	(196)
Ambulance OP	6,044,596	2,308,208	6,770,879	(1,829,876)	139,295	(324,030)	4,850,896	1,506,706	6,042,485	(3,580,244)	158,884	(363,163)
Ancillary OP	14,499,089	1,673,785	7,631,314	(2,952,459)	80,308	(55,622)	13,619,640	720,242	7,080,755	(4,606,967)	110,928	8,684
Audiology OP	1,293,130	370,687	478,432	(286,647)	10,796	(77,935)	1,169,755	371,516	456,725	(344,604)	16,260	(94,247)
Barre Health Center OP	2,408,620	15,187	1,599,773	(594,140)	15,093	(56,151)	2,243,661	(138,951)	1,465,693	(826,816)	31,601	(46,832)
Behavioral Med Clinic OP	15,098	(17,777)	8,557	(18,956)	21	(380)	3,503	(6,660)	8,326	(7,466)	15	(373)
BMT OP	458,547	(36,705)	181,804	(141,086)	-	-	174,687	(26,609)	123,273	(123,189)	-	-
Cardiac Surgery Clinic OP	82,574	(20,637)	102,537	(81,306)	807	(1,483)	144,157	(18,381)	147,663	(132,681)	2,384	(840)
Cardiology Medicine Ancillary OP	5,087,352	1,651,376	2,641,399	(184,976)	28,549	(6,859)	4,982,218	1,315,597	2,557,245	(292,176)	20,470	(4,466)
Cardiology Medicine Clinic OP	2,001,133	(303,688)	2,611,753	(1,155,135)	12,448	(16,366)	2,145,180	(654,743)	2,717,752	(2,001,960)	17,312	(16,343)
Cardiology Observation OP	402,617	(84,885)	288,351	(229,217)	1,525	(1,787)	516,389	(225,614)	381,302	(414,685)	10,301	2,866
Cath Lab - Cardiac	7,206,440	2,960,282	3,630,812	(335,642)	131,842	86,089	5,480,818	2,107,219	3,379,354	(551,220)	40,511	5,892
Cath Lab - Vascular	1,065,422	474,395	1,547,821	(18,198)	69,624	36,103	1,391,784	699,958	1,487,405	113,930	8,963	2,950
Colorectal Day Surgery OP	663,712	160,901	204,138	(111,863)	-	-	784,244	108,981	259,811	(191,420)	476	(3,517)
CWC OP	480,414	(72,902)	1,314,015	(714,778)	1,776	(10,034)	464,943	(26,123)	1,416,940	(785,070)	1,673	(12,113)
Dermatology Day Surgery OP	5,268	691	5,378	(5,749)	-	-	6,689	(5,680)	6,634	(9,686)	-	-
Dermatology Procedure Center OP	526,048	177,691	449,172	1,662	500	(3,507)	541,315	158,806	457,469	(70,065)	902	(2,376)
Diabetes & Endocrine Clinic OP	1,801,033	(165,244)	932,760	(575,974)	1,159	(5,243)	1,969,169	(922,024)	1,103,587	(1,399,035)	5,163	(13,734)
Dialysis OP	291,636	(35,476)	532,546	(835,310)	1,572	626	236,083	(54,328)	297,485	(850,332)	-	-
Dye Laser OP	180,801	72,004	43,178	(9,287)	107	(1,068)	126,398	56,121	19,977	(10,787)	81	(419)
Electrophysiology OP	6,707,339	1,470,329	6,174,523	(1,435,094)	185,484	87,724	7,944,369	2,492,053	5,256,118	(537,581)	114,646	58,616
Emergency Medicine CDU Observation OP	-	-	-	-	-	-	-	-	-	-	-	-
Emergency Medicine OP	35,156,662	18,736,760	22,918,007	1,257,069	2,216,731	53,596	33,647,844	17,964,678	21,770,877	355,160	3,086,201	1,019,795
Emergency Mental Health OP	1,104,402	(2,273,792)	175,546	(702,791)	405	(17,834)	1,119,641	(2,965,153)	93,610	(500,431)	881	(24,496)
Endoscopy OP	11,610,075	4,276,481	4,198,701	(1,864,737)	8,879	(11,605)	11,494,918	4,403,304	4,001,149	(1,922,612)	11,252	(15,387)

source: EPSI decision support system

	FY2010						FY2011					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Epilepsy OP	382,925	182,909	279,616	(23,065)	1,392	(2,757)	444,360	207,624	314,707	(51,788)	2,108	(1,085)
Family Community Med Clinic OP	2,631,381	(1,133,626)	1,992,371	(2,664,240)	17,077	(93,144)	2,409,386	(1,054,017)	1,861,046	(2,716,787)	32,400	(86,665)
Foot & Ankle Day Surgery OP	1,396,233	358,237	351,101	(190,579)	45,859	(103,544)	1,658,692	137,255	485,393	(465,567)	33,722	(57,988)
Foot Ankle Clinic OP	1,086,542	515,568	453,634	6,067	20,023	(32,696)	974,381	(72,722)	384,610	(386,975)	46,464	(67,663)
Fracture Day Surgery OP	663,095	26,006	161,646	(153,830)	22,101	(56,453)	722,247	1,192	234,001	(233,348)	33,351	(38,058)
Gastroenterology Clinic OP	970,140	(210,653)	624,396	(510,821)	965	(5,407)	946,018	(147,655)	615,548	(498,855)	3,053	(8,837)
Gastroenterology Infusion OP	-	-	-	-	-	-	-	-	-	-	-	-
General Medicine Clinic OP	4,425,079	(474,558)	2,655,320	(1,675,430)	14,546	(57,193)	4,099,728	(188,984)	2,601,770	(1,601,601)	26,054	(38,757)
General Neurology OP	2,507,423	923,422	1,325,853	(177,923)	41,790	(13,513)	2,211,023	686,452	1,250,476	(344,767)	51,731	3,181
General Orthopedics Day Surgery OP	652,789	10,401	138,954	(45,696)	14,175	(28,728)	502,805	(40,355)	116,324	(102,300)	33,355	(35,580)
General Surgery Clinic OP	943,662	(180,326)	336,682	(393,670)	9,182	(12,295)	989,088	(258,262)	367,112	(512,038)	7,614	(19,924)
General Surgery Day Surgery OP	4,854,245	808,857	1,710,544	(594,738)	38,593	(56,910)	4,776,992	602,588	1,693,583	(1,039,351)	47,138	(41,405)
General Surgery Endo OP	642,775	255,050	181,538	(57,447)	4,084	1,730	614,343	219,026	184,930	(93,666)	33	(301)
GI/Endo Day Surgery OP	26,915	6,181	11,619	(6,418)	-	-	148,296	18,142	106,501	(84,706)	-	-
Gyn Onc Clinic OP	1,186,690	(596,119)	898,660	(1,092,468)	271	(3,672)	986,607	(541,009)	735,181	(1,017,179)	285	(3,718)
Hand and Physical Therapy OP	2,934,664	486,622	1,193,934	(1,146,814)	323,459	(161,738)	2,378,312	213,833	1,043,279	(993,488)	231,287	(184,458)
Hand Clinic OP	2,682,168	1,664,219	1,040,696	266,011	103,934	(9,149)	2,575,835	1,580,684	1,006,233	188,774	169,377	59,054
Hand Day Surgery OP	3,504,688	865,928	1,303,213	(874,574)	263,069	(158,096)	3,364,981	543,530	1,187,004	(1,243,290)	135,355	(200,050)
Hem Onc OP	20,978,068	3,586,252	12,133,231	(5,698,169)	9,638	(40,837)	22,415,321	3,369,346	13,038,626	(6,007,560)	6,661	(30,090)
Infectious Disease Clinic OP	654,307	152,321	615,304	(274,769)	3,827	(11,693)	612,869	57,413	616,449	(406,366)	6,268	(5,524)
Infectious Disease Infusion OP	-	-	-	-	-	-	-	-	-	-	-	-
Joint Center OP	1,221,200	89,650	943,929	(397,193)	11,137	(26,839)	1,090,072	56,731	890,003	(490,862)	23,199	(16,701)
Joints Day Surgery OP	357,214	82,361	64,818	(31,663)	2,710	(22,763)	284,132	15,781	50,602	(43,290)	10,519	(9,287)
Lab OP	3,256,524	1,451,354	1,237,687	82,040	3,492	(6,043)	2,871,273	1,225,342	1,079,291	76,757	3,643	(5,614)
Labor Checks OP	397,748	146,258	362,274	(2,210)	716	(2,183)	379,781	67,078	368,942	(62,707)	667	(1,702)
Med Derm OP	1,390,448	300,032	748,030	(117,432)	1,463	(5,336)	1,458,570	292,609	803,116	(278,933)	2,504	(7,826)
Medicine Observation OP	2,451,803	(404,236)	3,025,965	(1,129,242)	18,617	(21,280)	3,011,903	(1,047,369)	3,142,926	(4,049,064)	15,724	(51,277)
MFM OP	151,438	56,998	28,442	(946)	6	(68)	363,102	118,007	103,488	5,798	193	(132)
MOH OP	1,298,644	550,065	1,204,027	(165,584)	304	(2,875)	1,255,681	476,339	1,279,785	(301,103)	1,170	(5,605)
MS OP	526,807	46,457	380,386	(120,425)	537	(1,163)	395,554	(4,728)	709,597	199,892	984	(1,196)
MSK Ancillary	107,758	(41,434)	65,197	(31,070)	1,553	(6,408)	83,375	5,725	52,999	(15,101)	2,524	(2,910)
MSK Observation OP	88,357	(20,135)	69,624	(29,941)	4,206	(2,112)	100,987	(22,206)	75,566	(116,739)	20,468	6,443
Nephrology Clinic OP	298,295	(166,450)	477,792	(552,777)	1,064	(1,243)	245,354	(165,543)	392,003	(457,035)	283	(1,070)
Neurology Infusion OP	-	-	-	-	-	-	-	-	-	-	-	-
Neurology Observation OP	218,869	(55,980)	104,314	(103,607)	-	-	315,087	(28,910)	114,483	(123,397)	-	-
Neuromuscular OP	649,770	41,630	1,277,195	571,537	3,076	(7,648)	694,352	136,588	693,639	(836,327)	392	(6,270)
Neurosurgery Clinic OP	119,736	(107,765)	97,196	(145,649)	3,637	(8,851)	84,982	(93,395)	89,388	(152,185)	4,317	(6,690)
Neurosurgery Observation OP	3,399	(1,298)	2,110	(2,298)	-	-	20,186	6,145	1,106	(2,965)	-	-
OB Ultrasound Ancillary OP	1,671,780	753,555	1,797,894	939,636	1,663	(5,402)	1,469,319	705,687	1,719,305	898,499	3,194	(9,645)
OB/GYN OP	3,276,278	54,944	731,097	(421,307)	7,387	(16,557)	1,995,427	282,392	560,704	(176,161)	1,406	(6,909)
Oncology Observation OP	104,884	(21,779)	94,046	(47,724)	-	-	118,714	(40,015)	122,294	(30,789)	-	-
Ophthalmology Clinic OP	28,399	18,924	10,504	2,609	0	(3)	368,402	(967,356)	321,282	(1,781,913)	11,351	(63,891)
Ophthalmology Day Surgery OP	1,149,104	(177,666)	1,158,512	(886,165)	845	(26,223)	1,198,584	(42,550)	1,007,533	(796,122)	2,835	(8,886)
Orthopedic Clinic OP	2,413,545	(6,196)	926,679	(741,588)	15,842	(118,356)	2,656,891	317,214	1,046,470	(842,011)	62,218	(70,554)
Other Community Health Clinic OP	339,825	(150,628)	192,254	(109,761)	100,747	(1,881,637)	241,069	(161,794)	134,551	(167,268)	145,723	(1,933,013)
Other Day Surgery OP	529,274	5,264	238,657	(180,735)	233	(3,797)	557,241	(37,221)	175,870	(290,244)	3,176	(9,723)
Otolaryngology Clinic OP	769,023	58,986	487,718	(158,463)	4,585	(5,195)	713,936	118,044	427,683	(151,702)	3,209	(2,878)
Otolaryngology Day Surgery OP	3,057,191	547,073	1,280,096	(810,603)	40,522	(16,965)	2,875,131	205,780	1,190,748	(1,277,871)	1,396	(11,688)
Pedi Emergency Medicine OP	9,453,952	3,685,843	5,184,006	516,161	48,583	(127,093)	9,109,080	3,835,108	4,947,631	379,176	51,659	(126,981)
Pediatric Clinic OP	5,906,690	(2,386,911)	2,330,998	(3,302,074)	8,235	(80,867)	5,727,950	(1,216,178)	2,350,412	(2,819,351)	5,506	(57,523)
Pediatrics Ancillary OP	-	-	-	-	-	-	-	-	-	-	-	-

UMMMC

Margin by Payer Group trended by Year Inpatient Cases and Outpatient Discharges

source: EPSI decision support system

	FY2010						FY2011					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Pediatrics Day Surgery OP	771,308	(39,483)	226,828	(167,900)	526	(3,739)	720,169	(129,156)	233,927	(255,057)	356	(2,904)
Pediatrics MSK Day Surgery OP	572,773	24,230	152,172	(95,074)	347	(3,693)	723,337	(174,088)	172,348	(192,049)	10,253	(22,124)
Pediatrics Observation OP	1,473,677	(109,837)	444,364	(404,257)	7,679	1,894	1,382,242	(570,292)	427,676	(734,420)	255	(2,383)
Phototherapy OP	188,115	(7,905)	63,158	(84,067)	-	-	241,562	(1,831)	64,317	(80,270)	1,961	(1,290)
Plastic Clinic OP	1,083,101	(142,712)	573,545	(340,850)	80,146	(60,118)	1,123,049	(80,843)	696,503	(390,120)	89,114	(72,286)
Plastic Surgery Day Surgery OP	3,898,771	301,332	1,123,475	(1,079,463)	132,469	(1,069,893)	3,427,396	228,952	1,150,824	(1,062,909)	134,301	(941,576)
Podiatry Day Surgery OP	464,490	106,223	124,156	(65,057)	-	-	319,542	57,892	56,123	(55,213)	1,714	(295)
Psychiatry Clinic OP	1,161,454	(1,020,410)	900,353	(2,055,043)	6,656	(49,549)	1,120,942	(1,216,685)	811,395	(2,419,698)	12,205	(45,143)
Psychiatry Other OP	474,211	(47,537)	458,498	(368,023)	-	-	461,710	(99,633)	305,662	(487,444)	-	-
Pulmonary Clinic OP	1,954,263	(272,828)	1,161,337	(998,279)	6,955	(17,092)	2,217,636	286,176	1,319,476	(727,321)	4,019	(4,781)
Pulmonary Day Surgery OP	3,451	(951)	-	-	-	-	5,946	1,762	11,819	(13,927)	-	-
Pulmonary Infusion OP	-	-	-	-	-	-	-	-	-	-	-	-
Rad Onc OP	16,361,661	8,022,919	7,609,345	(1,638,920)	23,574	(9,122)	17,575,496	9,490,864	8,027,006	(1,229,889)	246	(756)
Radiology OP	18,043,910	11,109,240	7,892,841	2,696,480	33,425	(91,624)	16,694,119	9,701,313	7,454,249	1,558,104	89,441	(8,371)
Radiology-Mammography OP	6,550,801	3,531,602	1,388,426	(259,945)	3,255	(6,055)	7,269,371	3,911,629	1,438,769	(505,507)	3,892	(8,228)
REI OP	881,915	(82,660)	96,053	(126,879)	474	(3,486)	1,516,142	(256,514)	239,340	(380,754)	619	(5,738)
Renal Infusion OP	-	-	-	-	-	-	-	-	-	-	-	-
Rheumatology Clinic OP	1,689,442	178,816	1,117,456	(359,289)	1,714	(6,177)	1,571,098	(68,004)	1,100,582	(643,840)	7,660	(15,321)
Rheumatology Day Surgery OP	-	-	-	-	-	-	-	-	-	-	-	-
Rheumatology Infusion OP	-	-	-	-	-	-	-	-	-	-	-	-
Sat-Radiology OP	792,748	134,478	123,614	(90,833)	1,461	(11,846)	849,549	326,467	135,054	(73,762)	7,883	(12,365)
Spine - MSK Day Surgery OP	92,394	20,490	42,565	6,677	1	(4,792)	95,616	(6,418)	22,975	(29,317)	9,446	1,699
Spine - Neuro Day Surgery OP	1,347,467	285,061	860,306	(302,259)	74,006	(28,484)	1,940,026	464,798	718,104	(306,594)	85,666	15,019
Spine Center OP	852,364	(6,690)	682,562	(242,211)	33,679	(42,055)	784,906	(25,182)	690,732	(314,434)	51,491	(14,316)
Spine Procedure Room OP	2,914,238	2,277,979	1,744,008	997,142	12,489	(8,394)	2,871,765	2,237,981	1,826,116	1,049,931	42,075	17,499
Sports Medicine Clinic OP	2,581,380	716,391	453,164	(50,234)	35,294	(42,355)	2,720,166	580,022	542,177	(119,304)	61,788	(28,401)
Sports Medicine Day Surgery OP	8,431,576	1,630,322	1,302,212	(642,392)	283,292	(148,881)	8,102,130	250,002	1,210,944	(1,037,233)	301,826	(198,878)
Stroke OP	43,997	(2,148)	71,425	1,427	107	(193)	49,593	(13,032)	80,920	(7,836)	617	(55)
Surg Onc Clinic OP	471,354	(603,280)	273,873	(452,793)	604	(3,207)	445,303	(1,135,421)	291,908	(858,145)	1,575	(9,727)
Surg Onc Day Surgery OP	1,827,415	303,138	663,546	(234,503)	1,801	(4,464)	1,983,994	147,285	799,105	(591,528)	964	(5,706)
Surgery Observation OP	381,778	126,152	78,782	(66,762)	25,854	3,747	275,553	10,920	70,789	(135,652)	37,188	12,971
Therapy OP	236,675	34,986	69,835	(49,331)	6,075	(9,103)	214,322	81,307	68,643	(30,755)	1,071	(532)
Thoracic Day Surgery OP	98,995	18,849	72,597	(25,295)	-	-	158,401	15,838	67,062	(48,406)	-	-
Transplant Clinic OP	285,318	(1,006,182)	501,002	(255,498)	289	(3,923)	320,566	(1,143,790)	438,875	(365,185)	288	(1,930)
Trauma Day Surgery OP	52,197	(13,529)	24,648	(15,951)	-	-	59,608	(16,202)	20,791	(31,171)	-	-
Tri River OP	1,713,248	1,457,675	487,957	373,507	6,495	3,661	3,778,293	199,806	1,236,790	(531,195)	21,912	(39,321)
Uro/Gyn OP	144,442	1,964	81,337	(52,267)	19	(183)	367,046	(39,944)	215,662	(186,556)	40	(500)
Urology Clinic OP	206,816	(142,023)	235,896	(485,457)	417	(5,245)	178,210	(170,609)	235,156	(553,892)	791	(9,382)
Urology Day Surgery OP	4,264,305	1,787,492	2,122,793	(41,807)	7,054	(20,587)	3,297,649	998,789	1,889,639	(463,113)	11,037	(12,106)
Urology Observation OP	3,649	607	7,925	(2,375)	-	-	2,230	(3,625)	1	(3,128)	-	-
Vascular Ancillary OP	890,808	434,124	619,884	(69,102)	6,689	1,793	784,302	373,600	501,175	(158,988)	9,388	2,089
Vascular Clinic OP	355,355	15,429	570,282	(318,362)	11,125	(1,376)	507,147	(119,865)	634,171	(677,470)	4,711	(19,318)
Vascular Day Surgery OP	792,075	210,650	1,104,972	(437,283)	401	(3,123)	1,020,135	196,636	863,751	(613,785)	1,482	(1,886)
Womens Health Day Surgery OP	4,544,798	1,352,770	1,261,850	(311,805)	369	(1,769)	4,456,878	766,919	1,247,155	(666,846)	1,893	(11,776)
Womens Health Observation OP	397,425	136,140	138,442	(56,114)	-	-	400,528	9,610	132,633	(144,624)	2,706	(1,689)
Total OP	282,839,713	73,688,147	153,333,371	(43,684,482)	4,926,804	(5,218,207)	279,665,108	61,322,665	149,703,470	(64,524,496)	5,895,368	(4,118,895)
Grand Total	569,973,171	116,979,775	548,095,880	(81,427,814)	10,479,745	(7,139,293)	568,353,595	113,674,417	570,219,978	(84,267,786)	9,762,827	(6,023,620)

source: EPSI decision support system

Inpatient Cases Service Line	FY2012						FY2013					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
8 East IP	3,353,091	(883,206)	5,678,915	(4,223,913)	91,696	(103,126)	3,083,708	(779,410)	5,587,519	(5,139,714)	10,953	(50,793)
AAA IP	3,000,982	128,494	4,922,416	(566,804)	-	-	2,852,086	346,130	5,538,342	(554,872)	-	-
Ablations/Cardioversions IP	1,564,130	656,194	3,494,956	191,681	6,569	(33,736)	1,307,091	290,787	2,733,056	(154,496)	19,560	2,318
All Other	29,801	(6,837)	5,397	(34,934)	95	(181)	116,300	15,068	83	(1,048)	-	-
AMI IP	1,183,220	168,679	3,760,262	(188,263)	2,977	(17,033)	1,226,548	188,576	3,043,523	(708,064)	-	-
Amputations IP	850,439	256,509	3,017,553	388,219	9,416	(3,647)	863,620	182,819	3,341,866	507,877	2,089	(15,822)
Anal/Stomal IP	61,613	7,391	352,006	23,636	765	(5,217)	186,891	(2,450)	227,927	28,506	669	(2,557)
Antepartum IP	971,885	(63,074)	802,715	(244,601)	7,053	(6,014)	702,738	184,967	769,362	(24,403)	3,417	(16,212)
Appendix IP	1,912,765	45,123	849,660	(307,482)	1,635	(11,664)	1,281,379	103,965	601,413	(377,899)	1,672	(12,573)
Bariatrics IP	3,248,659	287,400	2,054,990	85,527	-	-	2,523,683	129,505	1,342,757	(8,259)	-	-
Biliary IP	1,961,688	113,979	1,993,299	(353,148)	3,181	(23,224)	1,964,565	(85,343)	1,959,093	(536,403)	2,358	(11,654)
BMT IP	4,937,624	787,271	4,065,995	(1,190,001)	-	-	2,904,873	378,218	4,297,383	(669,637)	-	-
Breast Surgery IP	281,949	(248,326)	179,643	(213,406)	1,144	(13,286)	425,345	(78,414)	94,187	(85,999)	-	-
CABG IP	5,967,428	(110,266)	7,732,674	(1,935,418)	86,573	8,613	5,667,877	(55,740)	8,810,118	(2,126,174)	-	-
Cardiac Cath Other IP	1,436,406	399,354	2,491,050	23,288	34,791	2,699	1,292,297	(26,828)	1,406,617	(179,368)	7,666	(51,153)
Cardiac Surgery Other IP	143,644	(17,580)	352,406	(7,491)	-	-	310,861	24,097	157,402	(88,512)	-	-
Cardiology Medicine Other IP	2,115,732	569,903	5,150,096	(151,283)	42,609	(73,485)	1,527,843	267,970	5,001,755	(462,086)	13,447	(28,455)
Chest Pain IP	359,469	85,116	1,324,607	35,724	2,854	(11,524)	180,435	30,557	539,980	(26,538)	2,571	(5,782)
Colorectal IP	6,418,360	1,679,039	7,580,504	488,076	5,105	(44,082)	6,133,333	917,217	7,181,562	(739,596)	-	-
Deliveries IP	17,809,236	838,723	9,860,494	(4,165,721)	5,267	(32,308)	17,232,097	(1,619,800)	11,179,354	(5,524,887)	6,042	(39,045)
DES/BMS IP	8,509,814	3,114,512	8,803,674	706,580	63,133	(41,071)	7,920,680	2,688,464	7,995,956	(244,931)	13,529	(37,893)
Diagnostic IP	1,599,570	290,445	3,552,147	(157,683)	20,884	960	1,376,953	44,222	2,298,074	(684,377)	1,590	(7,389)
Electrophysiology Other IP	234,987	144,238	623,120	33,723	-	-	329,582	125,929	417,028	55,086	-	-
Emergency Medicine Boarders IP	362,016	153,770	653,828	382,293	6,900	(24,694)	521,077	360,181	1,143,227	770,250	1,268	(2,023)
Endoscopy & GI IP	10,317,513	2,210,573	18,769,602	(1,629,132)	34,106	(106,447)	9,530,278	1,959,404	16,381,157	(2,050,128)	24,003	(36,419)
ENT Thyroidectomy IP	77,264	(42,760)	325,049	(31,942)	-	-	46,285	(32,218)	195,276	(136,039)	-	-
Epilepsy IP	731,798	127,639	1,778,519	(260,354)	2,123	(12,381)	736,687	112,910	1,807,559	(345,206)	3,573	(647)
Foot & Ankle IP	314,689	35,179	197,714	(13,098)	15,335	(17,535)	192,296	19,376	141,148	(61,156)	4,614	(7,823)
Fracture IP	7,121,827	959,458	8,329,160	(1,239,584)	657,976	6,460	7,793,844	1,066,244	7,700,076	(2,199,569)	531,433	(173,876)
General Neurology IP	1,484,567	159,305	1,971,184	255,117	78,745	(21,261)	1,169,156	280,830	1,736,669	(217,826)	17,666	(6,756)
General Orthopedics IP	2,150,999	114,426	2,581,848	(45,675)	43,702	1,826	2,240,389	180,364	2,825,466	(283,748)	154,661	(55,821)
General Surgery Other IP	8,315,467	1,292,214	12,626,137	(182,435)	108,122	(65,684)	6,641,859	590,358	11,578,700	(1,665,611)	208,602	(196,440)
GYN Onc IP	1,393,700	(415,139)	1,828,394	(60,321)	-	-	1,361,707	(33,489)	1,233,520	(260,617)	-	-
Hand IP	62,708	3,331	83,302	(37,228)	72,335	1,122	31,558	4,284	106,198	(59,518)	73,124	(46,703)
Heart Failure IP	1,683,619	487,553	7,656,822	539,743	566	(3,047)	1,411,351	291,730	7,528,029	(879,786)	1,889	(7,763)
Hem Onc IP	8,115,165	1,278,056	11,439,511	(978,258)	13,682	(16,732)	8,127,189	1,331,760	13,083,899	(4,039,888)	2,943	(15,017)
Hernia IP	575,091	16,351	654,802	(42,505)	10,636	(1,296)	398,174	39,024	774,383	(119,663)	26,773	(10,748)
Hospital Medicine IP	12,765,804	1,773,754	32,452,822	(2,704,663)	168,376	(306,284)	13,349,331	2,463,198	31,817,102	(7,973,721)	137,988	(245,847)
ICD/BiVs IP	1,793,841	476,645	5,380,404	1,324,936	-	-	2,303,664	494,707	4,221,228	659,123	-	-
Infectious Diseases IP	2,311,958	555,551	4,033,519	(385,412)	-	-	3,703,285	622,031	5,128,948	(692,629)	12,371	(48,017)
Joints IP	7,813,818	1,484,328	12,240,250	458,554	21,938	4,820	5,859,942	396,830	10,101,291	(1,098,862)	35,973	(2,460)
MS IP	150,688	45,665	238,390	(6,996)	11,068	(65)	213,819	61,774	162,040	(38,790)	-	-
Nephrology IP	2,287,698	405,718	7,223,092	(540,610)	31,174	(31,993)	2,075,287	548,804	5,949,876	(243,119)	20,788	(32,872)
Neuro-Interventional Radiology IP	171,479	76,259	519,898	(71,500)	-	-	168,347	40,217	180,757	19,675	-	-
Neuromuscular IP	522,375	72,591	1,157,569	(172,336)	-	-	183,178	45,075	986,959	(271,307)	-	-
Neurosurgery IP	9,439,855	2,182,317	9,441,761	589,659	11,965	(5,174)	9,257,600	1,779,236	9,625,119	(1,468,010)	12,014	(61,903)
Newborns	4,722,799	(1,673,733)	7,753,189	2,348,293	8,462	(60,456)	5,352,184	199,149	8,421,768	3,643,127	4,938	(23,063)
NICU	15,915,584	4,256,791	13,655,392	(3,514,686)	-	-	19,188,826	4,208,893	13,742,776	(3,704,120)	-	-
OB/GYN IP	3,385,253	253,220	2,310,541	(445,097)	4,118	(24,090)	2,579,092	141,940	1,988,252	(440,504)	1,918	(9,895)
Other IP	387,355	139,875	610,742	18,684	9,425	(3,935)	288,344	12,302	467,818	15,501	583	(4,756)
Otolaryngology IP	467,526	67,172	526,858	(57,225)	-	-	460,404	37,539	628,854	(260,156)	-	-

source: EPSI decision support system

	FY2012						FY2013					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Pacemakers IP	1,027,833	382,362	3,869,247	211,352	-	-	1,106,918	423,766	3,887,085	636,137	-	-
Pediatric IP	12,413,360	213,812	8,216,696	(3,415,693)	3,500	(27,800)	15,382,429	1,832,697	7,556,179	(3,537,738)	41,946	(59,089)
Peripheral IP	705,486	142,978	1,585,493	(35,256)	11,721	(61,893)	539,109	162,970	1,208,280	(28,154)	6,422	2,037
Plastic IP	1,150,202	80,199	1,331,696	(285,533)	205,373	2,666	1,082,750	160,872	1,587,807	(281,533)	13,593	(8,620)
PTRC IP	1,492,925	11,699	5,808,859	(2,601,636)	9,967	(45,652)	850,268	(66,638)	5,592,830	(4,772,018)	9,073	(40,925)
Pulmonary IP	4,632,801	512,246	12,940,390	(710,316)	57,255	(80,081)	4,399,392	537,208	12,552,507	(1,393,373)	37,135	(47,911)
Rad Onc IP	-	-	-	-	-	-	-	-	13,662	8,933	-	-
Rheumatology IP	125,881	53,982	367,537	33,096	1,221	(8,410)	101,830	10,993	1,694,713	89,234	-	-
Solid Organ Disorders IP	3,961,478	278,084	6,711,531	(1,656,863)	18,497	(12,741)	3,588,030	802,533	7,074,637	(1,907,136)	-	-
Spine - MSK IP	9,496,450	2,244,906	13,447,877	1,077,965	595,367	38,507	6,511,578	1,248,327	8,360,919	(441,890)	302,720	(49,693)
Spine - Neuro IP	5,002,744	432,361	7,942,084	663,872	457,824	62,092	5,628,922	50,750	6,482,539	(454,650)	277,505	(38,695)
Sports Medicine IP	1,197,478	(43,211)	2,179,346	(424,673)	53,622	9,015	1,109,721	95,262	1,775,865	(249,809)	79,893	(13,755)
Stroke IP	3,289,500	720,610	7,724,614	(21,097)	23,487	(69,582)	3,052,697	769,793	7,825,349	(702,896)	11,444	(17,645)
Thoracic IP	3,513,219	(66,624)	4,758,175	(974,568)	1,849	(13,684)	2,789,194	110,028	5,211,327	(1,355,639)	3,792	(22,713)
Transplant IP	7,947,316	586,657	10,792,117	812,824	17,388	(13,716)	4,761,623	(504,128)	11,455,315	(683,069)	-	-
Trauma IP	11,279,667	3,010,922	5,484,820	(968,398)	517,745	(33,004)	11,853,245	3,261,479	4,440,452	(1,423,953)	394,119	(135,471)
Trauma Related IP	2,300,079	864,130	3,440,950	131,161	85,233	4,087	1,218,260	387,055	3,059,772	(91,008)	7,999	(5,094)
Upper GI IP	2,520,587	575,192	3,259,483	2,144	-	-	2,141,070	518,397	2,782,390	2,298	-	-
Uro/Gyn IP	881,838	(374,262)	689,635	(365,668)	-	-	859,172	(46,323)	600,769	(48,260)	-	-
Urology IP	3,484,033	616,881	5,424,768	(250,176)	4,063	(27,246)	2,644,989	734,648	5,207,269	(155,358)	1,960	(5,353)
Valves IP	3,302,956	(309,709)	6,616,386	(1,150,896)	-	-	3,533,549	31,174	8,842,493	(1,385,617)	-	-
Vascular Other IP	2,296,962	310,265	9,068,821	435,100	1,452	(8,860)	2,480,383	369,660	8,104,326	49,629	-	-
Vent IP	24,980,819	5,658,919	40,640,003	(1,904,911)	749,418	(7,305)	27,922,449	6,542,789	45,058,516	(2,571,948)	533,598	(76,822)
Total IP	279,798,561	40,641,590	407,389,403	(29,663,644)	4,511,484	(1,387,779)	270,153,516	37,926,273	394,557,450	(61,845,909)	3,083,885	(1,785,609)

Outpatient Discharges

Service Line												
All Other	252,253	(143,623)	80,191	(36,846)	207,732	(339,577)	446,259	(484,816)	361,957	(224,386)	292,328	(458,787)
Ambulance OP	2,532,081	(133,246)	5,867,428	(2,553,397)	65,643	(311,571)	-	-	-	-	-	-
Ancillary OP	7,299,985	926,491	5,577,228	(1,965,507)	102,456	(256,605)	4,983,807	1,092,429	4,511,962	(1,255,072)	63,889	(255,355)
Audiology OP	1,082,471	344,095	670,185	(245,336)	3,780	(34,774)	951,262	199,200	533,943	(263,227)	6,558	(53,454)
Barre Health Center OP	2,042,699	(583,464)	1,798,471	(1,038,079)	12,250	(65,931)	2,124,334	(354,852)	1,980,411	(951,752)	12,904	(57,202)
Behavioral Med Clinic OP	47,543	16,416	41,396	6,270	6,395	(2,434)	30,663	(51,476)	23,431	(57,651)	4,248	(12,479)
BMT OP	168,864	25,551	100,161	(73,453)	-	-	101,350	9,290	90,158	(40,495)	-	-
Cardiac Surgery Clinic OP	154,154	(17,358)	179,032	(139,856)	349	(815)	129,099	(1,986)	166,190	(70,314)	92	(205)
Cardiology Medicine Ancillary OP	5,656,595	2,636,044	4,041,281	(54,076)	157,446	(102,900)	5,089,770	2,637,741	3,792,486	219,653	269,213	(176,738)
Cardiology Medicine Clinic OP	2,779,648	(596,046)	4,512,440	(1,548,439)	8,615	(31,464)	1,991,923	(771,252)	3,877,918	(1,213,878)	7,879	(42,737)
Cardiology Observation OP	442,050	(341,920)	617,407	(1,011,625)	1,259	(16,136)	496,291	(355,876)	957,819	(1,473,369)	686	(8,596)
Cath Lab - Cardiac	4,877,176	1,558,337	3,349,601	(969,259)	23,879	(17,417)	5,848,028	2,248,211	4,169,499	(570,546)	4,424	(17,000)
Cath Lab - Vascular	1,368,154	574,905	2,584,114	475,230	5,362	955	1,355,126	482,910	3,535,369	707,075	5,197	2,368
Colorectal Day Surgery OP	807,043	121,318	463,821	(183,828)	183	(2,023)	842,240	58,775	433,144	(261,914)	119	(1,187)
CWC OP	404,467	(56,923)	1,103,104	(1,133,652)	1,656	(22,757)	363,541	(172,611)	1,058,536	(1,307,743)	2,268	(23,563)
Dermatology Day Surgery OP	4,792	(6,334)	6,759	(8,713)	-	-	10,840	(8,188)	7,489	(6,683)	-	-
Dermatology Procedure Center OP	573,514	114,690	572,060	(37,137)	1,264	(3,991)	448,507	74,580	561,352	11,354	879	(3,276)
Diabetes & Endocrine Clinic OP	1,708,106	(976,880)	1,442,269	(1,072,040)	5,822	(14,637)	1,932,843	(237,276)	1,632,351	(594,748)	3,107	(13,573)
Dialysis OP	303,636	3,798	568,218	(629,722)	829	(457)	235,984	5,275	687,177	(790,092)	806	(238)
Dye Laser OP	146,014	58,039	31,332	(12,297)	105	(1,748)	145,832	62,548	39,653	(8,512)	261	(2,167)
Electrophysiology OP	5,929,036	1,780,116	5,459,668	(1,159,758)	3,470	(18,751)	8,362,982	3,459,205	7,030,948	(66,109)	12,130	2,346
Emergency Medicine CDU Observation OP	2,838,044	1,027,669	1,799,684	(439,564)	73,214	(57,452)	3,941,913	1,449,836	2,621,113	(679,334)	120,180	(56,381)
Emergency Medicine OP	25,285,701	10,751,184	22,004,482	(474,512)	1,140,314	(1,008,182)	23,731,246	9,374,385	22,709,633	(1,053,756)	1,324,762	(794,589)
Emergency Mental Health OP	548,884	(3,382,614)	107,753	(383,179)	185	(15,650)	265,911	(4,320,836)	30,732	(720,599)	287	(34,467)
Endoscopy OP	11,764,190	5,112,549	4,819,172	(1,460,598)	27,471	(38,673)	11,645,810	4,872,535	5,580,867	(1,629,436)	22,860	(19,039)

source: EPSI decision support system

	FY2012						FY2013					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Epilepsy OP	347,166	160,363	297,139	(34,236)	1,190	(1,910)	313,948	135,490	261,639	(46,797)	372	(1,213)
Family Community Med Clinic OP	2,317,245	(1,481,316)	2,525,225	(2,537,336)	17,943	(131,972)	2,246,063	(1,153,283)	2,601,135	(2,421,989)	12,107	(132,872)
Foot & Ankle Day Surgery OP	983,215	28,964	493,517	(408,591)	38,680	(29,409)	1,324,246	252,664	663,092	(539,765)	46,720	(19,069)
Foot Ankle Clinic OP	770,822	77,201	471,462	(126,234)	28,004	(23,181)	898,322	122,449	631,482	(70,443)	24,057	(9,177)
Fracture Day Surgery OP	713,273	(153,130)	192,015	(290,425)	53,991	(43,130)	918,522	(197,378)	414,236	(481,721)	64,131	(37,542)
Gastroenterology Clinic OP	881,667	(159,982)	982,027	(404,218)	7,313	(23,836)	803,924	(315,317)	948,400	(696,821)	1,819	(15,884)
Gastroenterology Infusion OP	1,709,647	(339,675)	735,431	(544,318)	3,150	(31,168)	2,430,081	(739,820)	1,524,263	(690,605)	-	-
General Medicine Clinic OP	3,871,470	(829,942)	3,590,081	(1,351,808)	15,505	(48,785)	3,856,875	(433,446)	3,686,178	(1,178,567)	10,975	(45,555)
General Neurology OP	2,005,041	310,330	1,735,700	(220,028)	17,667	(15,491)	1,792,022	26,433	1,434,536	(663,517)	20,642	(17,241)
General Orthopedics Day Surgery OP	324,224	68,522	77,160	(30,941)	14,890	(10,637)	127,556	39	42,623	(36,754)	-	-
General Surgery Clinic OP	758,030	(429,355)	480,598	(417,017)	3,122	(33,740)	735,008	(855,622)	537,504	(906,622)	2,818	(30,733)
General Surgery Day Surgery OP	3,970,019	283,257	1,782,071	(1,173,732)	42,256	(43,704)	4,017,610	22,726	2,036,251	(1,538,676)	48,549	(30,079)
General Surgery Endo OP	629,750	254,803	234,684	(62,747)	-	-	603,396	192,195	222,747	(81,205)	123	(1,387)
GI/Endo Day Surgery OP	87,632	(8,815)	64,967	(89,574)	-	-	77,497	(48,121)	140,340	(270,183)	-	-
Gyn Onc Clinic OP	2,120,707	(159,420)	1,437,332	(1,361,473)	486	(5,973)	2,155,560	(141,271)	1,324,981	(1,176,635)	170	(4,716)
Hand and Physical Therapy OP	2,204,836	334,651	1,417,404	(882,387)	181,070	(171,478)	2,153,835	538,088	1,256,597	(708,541)	168,946	(122,526)
Hand Clinic OP	2,641,995	1,582,563	1,515,163	426,326	106,714	12,097	2,316,928	960,284	1,408,637	88,997	111,663	19,809
Hand Day Surgery OP	3,225,929	1,220,594	1,443,425	(451,444)	189,993	(95,839)	3,538,245	1,671,613	1,527,124	(263,512)	248,446	(24,052)
Hem Onc OP	19,601,609	2,478,548	13,985,559	(6,592,589)	68,851	(66,638)	19,803,337	5,092,730	17,770,220	(1,882,894)	9,085	(24,551)
Infectious Disease Clinic OP	511,912	(177,504)	729,146	(656,860)	7,473	(14,632)	466,368	(86,812)	804,011	(486,066)	9,024	(9,099)
Infectious Disease Infusion OP	95,796	(7,344)	107,765	(53,084)	4,764	(8,695)	107,440	(22,300)	61,677	(39,960)	46	(549)
Joint Center OP	1,124,428	2,887	1,269,497	(422,245)	13,163	(11,219)	1,221,471	68,568	1,438,968	(332,759)	12,760	(5,747)
Joints Day Surgery OP	197,844	2,912	57,221	(47,595)	8,302	(2,225)	154,194	7,645	70,907	(57,061)	6,254	(2,310)
Lab OP	4,008,794	1,926,112	2,286,294	457,237	264,663	(93,158)	3,599,494	1,397,914	2,239,428	40,123	414,562	(723,227)
Labor Checks OP	434,023	26,198	402,971	(194,001)	1,250	(8,959)	690,372	(453,931)	611,400	(1,090,270)	1,621	(17,956)
Med Derm OP	1,418,970	187,147	1,064,563	(213,244)	1,306	(8,875)	1,609,316	351,363	1,288,687	(125,860)	1,499	(9,945)
Medicine Observation OP	2,979,795	(3,033,896)	5,981,976	(10,567,089)	23,230	(105,727)	3,710,117	(4,072,572)	9,202,922	(16,047,876)	55,029	(172,617)
MFM OP	359,389	45,745	91,251	(52,847)	267	(1,367)	199,880	(182,303)	102,439	(112,779)	212	(5,404)
MOH OP	1,167,626	356,868	1,319,651	(258,306)	1,372	(5,716)	997,720	253,758	1,544,064	(151,713)	158	(2,019)
MS OP	400,999	(37,890)	438,397	(7,756)	1,557	(2,458)	385,588	(147,579)	383,137	(181,040)	158	(1,451)
MSK Ancillary	58,859	(21,893)	54,958	(23,332)	1,206	(2,803)	51,772	(28,248)	65,170	(54,913)	724	(612)
MSK Observation OP	101,356	(53,169)	65,874	(109,824)	4,870	(6,855)	82,226	(32,277)	71,237	(170,008)	-	-
Nephrology Clinic OP	174,060	(129,489)	440,776	(317,508)	3,865	(4,161)	184,819	(224,620)	360,451	(512,126)	1,073	(5,791)
Neurology Infusion OP	2,768,361	(135,529)	1,557,188	(668,182)	19,547	(13,596)	3,917,628	(377,440)	2,423,703	(798,569)	6,709	(3,781)
Neurology Observation OP	187,902	(139,801)	171,553	(203,234)	2,790	(1,445)	374,904	(169,038)	367,710	(458,819)	4,688	(14,440)
Neuromuscular OP	653,930	(96,732)	1,031,547	(108,960)	9,894	(5,245)	633,106	(267,348)	881,278	(742,423)	12,359	(11,675)
Neurosurgery Clinic OP	96,722	(45,274)	97,092	(88,460)	1,344	(4,236)	115,658	(145,018)	135,857	(194,986)	3,402	(6,662)
Neurosurgery Observation OP	7,051	3,227	-	-	-	-	13,304	(15,141)	5,513	(2,115)	-	-
OB Ultrasound Ancillary OP	1,881,642	978,830	1,447,799	426,544	5,125	(14,828)	2,016,295	978,698	1,617,199	448,341	4,048	(20,279)
OB/GYN OP	1,831,526	(909,563)	685,361	(868,855)	1,791	(16,689)	1,792,029	(1,092,716)	826,652	(989,500)	1,822	(35,602)
Oncology Observation OP	151,998	(76,786)	117,642	(188,817)	285	(969)	172,060	(114,514)	505,281	(387,036)	-	-
Ophthalmology Clinic OP	667,840	(323,051)	701,495	(939,383)	6,740	(24,775)	566,172	(395,403)	789,174	(1,221,049)	5,757	(25,281)
Ophthalmology Day Surgery OP	862,367	112,969	1,375,668	(220,830)	347	(3,840)	1,182,559	244,458	1,440,963	(213,410)	17,173	(7,275)
Orthopedic Clinic OP	2,679,929	376,042	1,647,731	(460,621)	68,521	(56,924)	2,371,245	444,530	1,689,422	(197,266)	71,675	(26,532)
Other Community Health Clinic OP	99,892	(101,814)	123,197	(161,245)	338,552	(1,542,479)	32,595	(45,917)	98,070	(145,163)	439,026	(1,178,092)
Other Day Surgery OP	1,941,044	70,327	878,075	(731,348)	22,328	(59,697)	318,431	(32,609)	412,536	(387,890)	12,023	(27,956)
Otolaryngology Clinic OP	889,090	325,047	626,614	(32,345)	2,216	(5,380)	799,239	98,538	690,307	(106,518)	7,658	(11,785)
Otolaryngology Day Surgery OP	2,435,909	32,978	1,109,189	(1,093,149)	1,063	(14,345)	2,968,407	112,054	1,288,198	(1,096,994)	1,953	(27,362)
Pedi Emergency Medicine OP	7,918,971	2,466,541	5,240,942	232,913	34,294	(192,396)	7,905,872	2,187,792	5,213,998	(41,660)	33,175	(181,816)
Pediatric Clinic OP	6,779,871	(1,333,458)	2,816,754	(2,999,349)	6,187	(87,435)	6,663,389	(1,795,032)	3,116,298	(3,217,824)	8,251	(116,644)
Pediatrics Ancillary OP	115,556	(97,084)	45,385	(24,370)	-	-	-	-	-	-	-	-

source: EPSI decision support system

	FY2012						FY2013					
	Commercial		Government		Other		Commercial		Government		Other	
	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin	Est Net Rev	Total Margin
Pediatrics Day Surgery OP	610,223	(314,587)	315,726	(384,541)	219	(2,287)	737,854	(192,340)	383,509	(399,931)	244	(3,310)
Pediatrics MSK Day Surgery OP	621,751	(298,691)	253,346	(293,052)	4,160	(26,968)	735,513	(250,567)	346,981	(400,970)	6,701	(1,923)
Pediatrics Observation OP	868,346	(615,567)	545,812	(1,070,106)	3,845	(29,786)	869,025	(569,029)	775,291	(1,405,203)	4,393	(10,725)
Phototherapy OP	236,771	1,348	151,771	(50,436)	159	(2,180)	280,533	(28,936)	199,411	(108,247)	647	(7,972)
Plastic Clinic OP	1,033,072	(71,585)	955,147	(120,953)	13,809	(171,450)	929,100	(54,970)	893,564	(160,763)	12,991	(181,784)
Plastic Surgery Day Surgery OP	3,063,670	79,520	1,191,572	(1,094,682)	121,910	(1,049,090)	3,172,554	598,422	1,370,595	(1,016,884)	145,955	(1,073,028)
Podiatry Day Surgery OP	469,104	11,610	178,354	(154,129)	5,861	(2,561)	650,843	60,601	266,758	(231,975)	8,777	(3,292)
Psychiatry Clinic OP	1,197,870	(1,167,999)	1,170,842	(2,206,256)	7,187	(38,321)	1,276,322	(1,247,928)	1,358,665	(2,386,534)	13,356	(46,947)
Psychiatry Other OP	504,184	(367,691)	227,584	(382,270)	-	-	539,765	(304,371)	227,734	(340,422)	1,934	(3,121)
Pulmonary Clinic OP	2,738,134	261,261	2,182,106	(757,785)	19,426	(13,427)	2,311,328	(172,512)	2,258,481	(1,284,887)	10,072	(16,311)
Pulmonary Day Surgery OP	32,306	(14,287)	59,708	(78,445)	-	-	124,744	(40,322)	183,950	(209,752)	-	-
Pulmonary Infusion OP	55,435	(25,361)	446,506	(118,175)	-	-	451,005	(76,419)	230,711	(90,167)	-	-
Rad Onc OP	16,246,060	7,997,618	8,493,878	(1,853,447)	848	(4,756)	15,901,254	8,823,209	9,794,867	(1,641,268)	15,670	(89,258)
Radiology OP	15,863,764	8,476,907	9,451,947	2,399,342	151,946	(27,651)	14,869,048	8,002,369	9,900,344	2,404,586	176,456	17,970
Radiology-Mammography OP	7,824,404	4,378,138	2,091,804	(130,164)	5,822	(13,474)	7,997,180	4,456,316	2,388,506	(85,680)	4,950	(25,713)
REI OP	1,423,238	476,873	301,133	1,275	979	(2,504)	1,611,526	505,147	383,336	(32,410)	834	(9,136)
Renal Infusion OP	167,615	(121,724)	51,492	(40,281)	115	(200)	367,247	(263,716)	58,495	(86,368)	268	(198)
Rheumatology Clinic OP	1,549,127	(143,680)	1,402,237	(470,110)	4,768	(13,564)	1,416,899	(214,277)	1,518,289	(618,207)	4,457	(9,124)
Rheumatology Day Surgery OP	-	-	3,300	(68)	-	-	-	-	-	-	-	-
Rheumatology Infusion OP	1,002,222	(79,011)	713,158	(470,037)	4,004	(8,906)	1,271,764	(235,914)	1,272,233	(570,030)	1,949	(3,114)
Sat-Radiology OP	647,463	258,077	151,149	(20,680)	5,116	(2,591)	857,986	340,033	411,887	14,249	13,777	(4,519)
Spine - MSK Day Surgery OP	107,243	(22,659)	39,786	(26,408)	2,383	(642)	86,209	2,935	65,356	(73,389)	-	-
Spine - Neuro Day Surgery OP	777,472	(164,037)	518,246	(536,578)	34,620	(23,574)	1,071,141	(99,806)	845,405	(657,088)	47,510	(31,940)
Spine Center OP	841,599	39,107	1,088,284	(6,710)	27,607	(18,355)	779,208	48,314	1,078,399	14,035	29,939	(12,743)
Spine Procedure Room OP	2,954,737	2,285,853	2,209,645	1,331,893	43,948	24,836	2,572,528	2,002,857	2,225,015	1,416,871	41,269	25,123
Sports Medicine Clinic OP	2,774,618	958,534	833,408	154,870	49,193	(6,005)	2,660,021	464,154	810,613	(37,422)	60,463	(6,837)
Sports Medicine Day Surgery OP	8,009,031	1,751,417	1,524,532	(709,714)	250,585	(174,430)	8,781,524	2,568,162	1,657,833	(648,816)	316,956	(89,721)
Stroke OP	69,049	1,153	102,219	(19,625)	60	(910)	61,786	(31,747)	108,949	(27,311)	20	(500)
Surg Onc Clinic OP	365,889	(1,329,207)	283,326	(1,020,824)	323	(14,095)	359,318	(668,562)	225,441	(607,595)	353	(6,791)
Surg Onc Day Surgery OP	1,534,825	(23,930)	733,623	(548,478)	-	-	2,045,870	(366,296)	1,044,474	(1,049,370)	-	-
Surgery Observation OP	353,674	(48,502)	197,494	(267,734)	24,488	(13,349)	347,714	41,173	235,388	(301,353)	4,357	(7,949)
Therapy OP	128,070	46,668	58,497	(19,065)	20	(222)	8,803	4,244	3,533	(1,649)	-	-
Thoracic Day Surgery OP	131,662	(52,355)	114,852	(109,294)	-	-	150,169	(50,532)	140,588	(151,364)	-	-
Transplant Clinic OP	744,306	(178,217)	702,093	(295,979)	294,315	(190,782)	639,661	(280,858)	793,438	(675,069)	189,511	(257,538)
Trauma Day Surgery OP	86,729	11,212	41,815	(48,729)	496	(5,827)	192,698	(63,447)	143,032	(182,937)	5,031	(2,145)
Tri River OP	3,811,421	(344,407)	1,820,349	(425,587)	15,561	(48,187)	3,898,538	(453,424)	1,841,005	(570,447)	18,420	(63,266)
Uro/Gyn OP	225,865	7,642	254,414	(36,563)	394	(2,071)	162,230	(79,051)	203,425	(146,056)	45	(898)
Urology Clinic OP	257,014	(257,136)	424,600	(856,075)	1,524	(18,311)	464,029	(696,218)	613,051	(2,106,812)	2,252	(24,060)
Urology Day Surgery OP	2,661,447	631,864	2,361,570	(582,264)	2,559	(13,227)	3,152,826	500,374	3,056,884	(873,056)	7,033	(22,463)
Urology Observation OP	-	-	10,096	(7,362)	-	-	16,390	(2,400)	10,525	(9,825)	-	-
Vascular Ancillary OP	1,190,503	551,629	1,137,846	(48,181)	3,881	(2,713)	980,385	235,794	957,694	(393,012)	5,845	(4,707)
Vascular Clinic OP	523,221	(28,149)	732,732	(423,982)	1,705	(17,095)	216,434	(201,758)	609,298	(528,287)	2,896	(12,459)
Vascular Day Surgery OP	674,093	(137,777)	753,798	(655,137)	2,612	(11,582)	667,366	(106,675)	832,208	(652,732)	-	-
Womens Health Day Surgery OP	3,892,455	402,852	1,356,066	(728,131)	858	(9,045)	4,165,168	(54,311)	1,688,525	(979,275)	1,685	(18,265)
Womens Health Observation OP	334,384	6,135	163,003	(171,648)	3,105	(2,053)	251,301	(66,560)	208,394	(250,257)	779	(8,131)
Total OP	261,788,888	45,073,368	183,042,656	(66,650,596)	4,609,226	(7,406,264)	260,995,011	42,623,864	198,194,858	(73,086,050)	5,216,329	(7,191,812)
Grand Total	541,587,449	85,714,958	590,432,058	(96,314,239)	9,120,710	(8,794,043)	531,148,527	80,550,138	592,752,308	(134,931,958)	8,300,214	(8,977,421)

Payor Code Groupings

Commercial	Governmental	Other
AETNA US	BLUECARE65	CLIENT
BLUE CROSS	BOSTONMED	GRANTS
BX INDEMN	CHAMPUS	OTHER
BX INTERPL	CORRECTIONAL	OUTREACH
BX OTHER	FALLON SR	Parsons Hill
BX PPO	FREE CARE	PHYS HLTH
CIGNA	INSTIT	SELF PAY
COMMERCIAL	MEDICAID	WORK COMP
FALLON	MEDICARE	
Fallon Total	NEIGHBOR	
FALLONSEL	NETWORK	
HARV/PILG	OTHER GOVT	
HEALTH VAL	TUFTS SH	
HMO BLUE		
HMO OTHER		
HPUHC Choic		
TUFTS		
UNITED HLT		

Attachment for AGO Question #3



Managed Care Finance
306 Belmont Street, Suite #110
Worcester, Massachusetts 01604
Phone: 508-334-5867
Facsimile: 508-334-8551
E-Mail: Randy.Jacques@umassmemorial.org

July 16, 2014

Mr. Kevin Beagan
Commonwealth of Massachusetts
Division of Insurance
1000 Washington Street
Boston, MA 02118-6200

Re: UMass Memorial Healthcare, Inc. - Request for Risk Certificate Waiver

Gentlemen,

Per the requirements noted in 211 CMR 155.00: Risk-Bearing Provider Organizations, and further to section 155.05 (4) & (5): Risk Certificate Waivers, the following and attached comprise our application for a Risk Certificate Waiver:

(4) The application for a Risk Certificate Waiver shall include the following information certified by an officer of the applicant Risk-Bearing Provider Organization:

- a) Name of the provider organization:
UMass Memorial Health Care, Inc.
306 Belmont Street, Suite 110
Worcester, MA 01604
- b) Name and contact information for the Division's primary contact:
Randy M. Jacques
Tel. (508) 334-5867
Randy.Jacques@umassmemorial.org
- c) The official names of Health Care Payers and Employers with which the applicant is seeking to enter into an arrangement, or has already entered into an arrangement to manage the treatment of a group of patients, and a statement

describing the type(s) of payment arrangement entered into with each Health Care Payer and Employer;

Blue Cross Blue Shield of MA - Alternative Quality Contract, eff. 1/1/2013.

- d) Whether the applicant is seeking to enter into an arrangement, or has already entered into an arrangement directly with individuals to manage the treatment of a group of patients;

Not Applicable.

- e) Filing Fee in the amount of \$250.00 payable to the Commonwealth of Massachusetts;

Enclosed

- f) Any additional information deemed necessary by the Commissioner.

Justification for our request for a Risk Certificate Waiver is as follows:

- 1. Attached please find our Audited Financials for the YE 9/30/13.**
- 2. Net Patient Services Revenue for the YE 9/39/13 - \$2,046,619,000**
- 3. The BCBSMA AQC is our only Risk Based Contract for CY 2014.**
- 4. The total Net Patient Service Revenue attributable to the BCBSMA AQC contract is estimated at \$77,749,074 (see attached detail), which represents approximately 3.8% of our total Net Patient Service Revenue.**
- 5. The BCBSMA AQC agreement contains a limit to our downside risk of \$20.00 PMPM, therefore the total risk is estimated to be approximately \$10,440,000 or 0.51% of total Net Patient Service Revenue.**
- 6. We are currently fully reserving for this worst case downside risk, and will only release reserves if the data proves favorable versus the budget, and over a sustained period of time.**
- 7. At 0.51% of total Net Patient Service Revenue, and being fully reserved for, we do not believe that the Downside Risk we have entered into is significant given the size of our organization.**

Sincerely,

Randy Jacques

Certified by:

Cathy Rossi,
Vice President, Managed Care Contracting

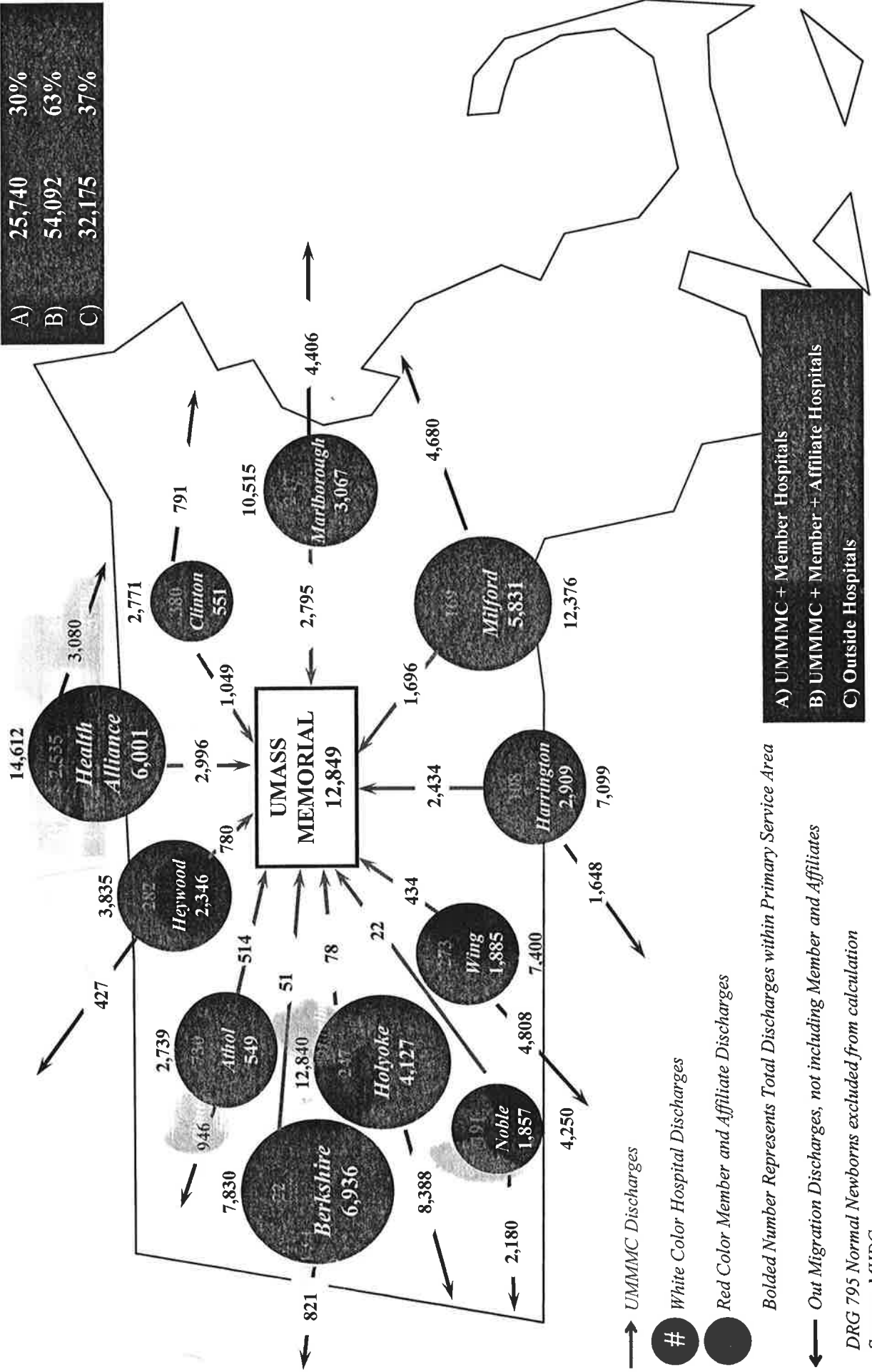
UMass Memorial Health Care

Confidential
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FY12 Hospital Inpatient Discharges For All Service Lines
Generated from Affiliated Hospital Primary Service Areas

Total Discharges: 86,267

A)	25,740	30%
B)	54,092	63%
C)	32,175	37%



Bolded Number Represents Total Discharges within Primary Service Area

← Out Migration Discharges, not including Member and Affiliates