Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, 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 (2) 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 Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. 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.

We encourage you to refer to and build upon your organization's 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. 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. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. **Strategies to Address Health Care Cost Growth.**

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Our first concern is who we need to partner with in a ACO as we work with so many entities. Second we are just a small portion of health care costs, we can do things to control our costs but that won't make a big impact if hospitals don't partner with us and cut their costs significantly. Third is access to specialists for our patients, many specialists may try to keep their costs down by refusing to see our most complicated patients as those patients increase their costs and make their practices look to costly.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

The first change we would like to have better access to records at local hospitals for our patients, we cannot avoid patients use of the emergency room and inpatient if we don't know the patients are accessing those facilities. Second we'd like to see the state insurance plans consolidated as there are too many to deal with and patients often jump from one to the other, the MCOs work well, privatizing the whole system could be very cost affective for all of us. Third legal tort reform is needed to allow providers to practice without high risk and expensive malpractice insurance, high malpractice insurance takes away a lot of funds that should be going to patient care and not insurance companies and the court system!

2. **Strategies to Address Pharmaceutical Spending.**

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Plans to Implement in the Next 12 Months

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Plans to Implement in the Next 12 Months

iv. Establishing internal formularies for prescribing of high-cost drugs

Plans to Implement in the Next 12 Months

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Does NOT Plan to Implement in the Next 12 Months

vii. Other: Implement MTM Program

Currently Implementing

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

Caring Health Center created our Integrated Medical-Behavioral/Recovery Health Program in 2015. Interventions aimed toward increasing integration include: 1. "warm handoffs" from our PCPs to a Behavioral Health clinician with the goal of assessment, stabilization and referral to our Relaxation Group and/or individual therapy on site or at collaborating agency. Our Community Support Staff provides case management and care coordination to complement all services; 2. CHC has hired 1.6 FTE Psychiatric APRNs to prescribe mental health medications directly for our patients and to consult with and train our PCPs about prescribing medications; 3. We have developed and are in initial stages of implementing a comprehensive Integrated Recovery Program with MAT services.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

Our primary barriers thus far have been the Dept. of Public Health licensure and the insurance credentialing processes. DPH inspectors were "appalled" that we conducted "warm handoffs" in a medical office or a BH office. They didn't know what a "warm handoff" was. They also wanted more segregation of our medical and BH office space. Their demands made licensure of our BH Dept. difficult and lengthy. They insisted that we change our department name from Behavioral Health Dept. to Mental Health Dept. as there is no license for behavioral health. DPH hasn't adjusted their guidelines and specifications to match the current changes in health care. We had to seek advocacy from the Mass League for Community Health Centers.

Contracting and credentialing with Mass Health has also been a significant and prolonged challenge. Their demands are extensive and again lengthy. We are still working on our Beacon contract and credentialing process before we can bill for any services.

Extremely low reimbursement rates are major barriers to providing comprehensive integrated care as many services needed are not billable; documentation for BH services is onerous and again not billable; the reimbursement rates are so low that it is difficult to sustain a fully integrated model of care.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

We serve numerous nationalities and languages our first objective is to provide as much translation and ability to communicate with our patients to provide appropriate care. Second to understand the cultures of our patients, each approaches health care based on their ethnic back ground, some cultures stand by regular appointments and following advice, others only come in when they are sick and if follow up appointments are made, they don't show, we are working to try and get these no show rates down. Third we are developing wellness programs. We have a wellness center, have the local framers market set up outside our center, have exercise and other health related classes including food & nutrition presentations and cooking classes.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

The first is the cultural and language differences, what works with one culture doesn't work for another, we deal with many cultures as we translate into 35+ languages. Second we can treat their illness, but if they go back to a home where housing is subpar or there is domestic violence or food is lacking then it is like us putting a bandage on an infected wound, the patient's health situation does not improve or even worsens. Third is whether the patients actually follow through with their care and do what is recommended or fill their prescriptions and actually take their medications.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

We refer where we can, but our referral network has shrunk in recent years. Our patients are all low income, many on Medicaid. We have difficulty finding any specialists. We have also been told by practices that they will not see our patients as many of our patients don't show for scheduled appointments. We do urge our providers to refer to the best possible care, but many times we are very limited as to where we can refer our patients.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.

38T

ii. If no, why not?

Our electronic health record does not include any provider cost data as it is not connected with our accounting system, we are not sure if our system has the capability to do this.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
38T

ii. If no, why not?
We don't know if our system can do this and we are not really sure what this question means.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
We currently work closely with our lab to obtain patient lab results which are electronically submitted to EHR. We also are doing e-Prescribing in most cases. If we need access with outside organizations, there is always a cost to build a tunnel or other means of access which become very expensive to implement.

ii. If no, why not?
38T

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)
We have worked to become a certified PCMH and are working to increase our level of certification. Second we are attending workshops and other informational sessions to learn more about ACOs and how can become active in an ACO in the near future.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)
The biggest barrier is the uncertainty of the process and how we should proceed and who we should approach, nothing seems clear on this topic. The second is a fear of the large hospital systems and us getting lost in the process. Third is our lack of control over the process, the insurance companies have all the funds and they seem to be determining how they want to proceed and they are all taking different roads which makes it difficult to manage to become part of the system.

c. Are behavioral health services included in your APM contracts with payers?
Yes

i. If no, why not?
38T

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Having to do different things for different payers is always difficult and cumbersome. We have not spent a lot of time on this issue as yet. We implemented our new electronic health record about two years ago so we are still struggling just to use it and put information in the proper fields. Now that we seem to have that completed we will move on to build base information that we can use in the future to improve on, this will take a few years before we have usable information to measure improvements.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

All payers should be asking us to report on the same top costly illnesses, most notable, heart disease, diabetes and obesity. If we all tackle these most common and costly illnesses, we can all work as a team to achieve improvements and cost savings for the health care industry. It has to be understood, that quality measurements are indicators, but sometimes not very good indicators. Just because a patient doesn't improve may not be a good measure, sometimes just not getting worse is a major accomplishment! We also have to remember that providers can do everything right, but if patients do not do as advised, then quality does not improve through no fault of the provider and we have a lot of these patients.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

We are a health center and our patients are so different then patients in private practice. We treat patients in 35+ languages and we also work with the Refugee resettlement program. To treat patients we need to communicate with them, a challenge and cost that most providers don't deal with or certainly on a scale that we do. Our costs are going to be high with all the translation services we need to provide, that adds an extra person to all our medical teams. Then there are the cultural differences of all patients which we need to understand in order to treat the patients, all this adds time to patient visits, thus making our visits more costly, but if we don't treat these patients who will. Health centers already provide quality treatment for less than any private provider could, if they would even attempt to see our level of patients. To put most health centers into a cookie cutter payment system is not the answer, it will on.ly give us more struggles to overcome and we are already having trouble making ends meet. Many patients come to us as the only place they can receive treatment. Private practices prefer not to see many of our patients because they are the most expensive to treat and will negatively affect their quality scores and their bottom lines. We would recommend that Community Health Centers be carved out of this ACO world and be the safety net for our most vulnerable population as we were designed to be. Allow us funding to hire CHWs, MTM pharmacists and other support service personnel. Let us provide mental health, nutritional and educational services to our patients to help them maintain and improve their health. Giving us these things would allow us to be real PCMH centers and treat the whole patient, that is where you will get the best quality care and bang for your buck. Thank you.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.
   Most of our revenue has been and continues to be Fee-For Service, please see Exhibit one which is attached.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.
      This does not apply to us, we do not have admissions and most of our patients are Medicaid and low income and are not directly charged fees, we also have a sliding fee scale for the few patients that may not have any insurance coverage.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.
      N/A

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
      We have no barriers, when needed which is seldom, we can provide all price information requested by our patients.

Exhibit 1 AGO Questions to Providers

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. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **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.
5. **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.
6. **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.
7. **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).
8. **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.

9. **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.
10. **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.
11. **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.

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											2571				
Tufts Health Plan											248				
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
CIGNA															
United Healthcare															
Aetna															
Other Commercial											434470				
Total Commercial											437289				
Network Health											166171				
Neighborhood Health Plan											222111				
BMC HealthNet, Inc.											1154106				
Health New England											169469				
Fallon Community Health Plan															
Other Managed Medicaid											414				
Total Managed Medicaid											1712271				
MassHealth											1572936				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare											577557				
Other											462084				
GRAND TOTAL											4762137				

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											2507				
Tufts Health Plan											617				
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
CIGNA															
United Healthcare											36				
Aetna															
Other Commercial											460796				
Total Commercial											463956				
Network Health											180064				
Neighborhood Health Plan											223165				
BMC HealthNet, Inc.											1336206				
Health New England											241256				
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											1980691				
MassHealth											1658038				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal											0				
Medicare											612650		18396		
Other											496011				
GRAND TOTAL											5211346		18396		

2014

	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			1127								22901				
Tufts Health Plan			175								6796				
Harvard Pilgrim Health Care											1073				
Fallon Community Health Plan											$16,664				
CIGNA											$13,699				
United Healthcare			12								4282				
Aetna											$3,451				
Other Commercial											458285				
Total Commercial			1314								527151				
Network Health											211357				
Neighborhood Health Plan											435146				
BMC HealthNet, Inc.											1111455				
Health New England											338203				
Fallon Community Health Plan											1319				
Other Managed Medicaid											59586				
Total Managed Medicaid											2157066				
MassHealth											1440750				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											114318				
Commercial Medicare Subtotal											114318				
Medicare											489904		29970		
Other											123720				
GRAND TOTAL			1314								4852909		29970		

2015

	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			612								38234				
Tufts Health Plan			297								44896				
Harvard Pilgrim Health Care											2914				
Fallon Community Health Plan											$9,604				
CIGNA											$17,996				
United Healthcare			49								9224				
Aetna											$5,696				
Other Commercial			4732								86129				
Total Commercial			5690								214693				
Network Health											257074				
Neighborhood Health Plan											631454				
BMC HealthNet, Inc.											986117				
Health New England											709317				
Fallon Community Health Plan											571				
Other Managed Medicaid											122317				
Total Managed Medicaid											2706850				
MassHealth											1923036				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare											331199				
Commercial Medicare Subtotal											331199				
Medicare											681721				
Other											160973				
GRAND TOTAL			5690								6018472				