CMIPA INC.
An Independent
Physician Association

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September 1, 2016

To Whom It May Concern,

I certify that I am an authorized representative of Central Massachusetts Independent Physician Association for the purposes of this testimony.

The following testimony has been submitted under the pains and penalties of perjury and is complete and accurate to the best of my knowledge and ability.

Sincerely,

Gail Sillman
CEO, CMIPA

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 top concern is that the Health Care Cost Growth Benchmark is not currently tied to a standardized budget for all provider organizations. A large system with a rich budget, can easily afford to absorb a reduction from 3.6% to 0%. A small organization with an aggressive budget, can't realistically afford a benchmark set at 3.6% or lower. As a small organization with no market clout and no access to hospital funds, we have a low budget and limited resources to operate our medical management program. We are concerned that by lowering the benchmark, the third party payors will decrease our infrastructure funds, which will significantly impact our ability to continue to fund our high quality/care management programs. Furthermore, since we don't have hospital funds to use to shift to pay for these programs, we are concerned that many of these programs will be discontinued. We recommend the following: **(1) a different benchmark for ACOs without a hospital partner; and (2) a standardized budget across all provider groups, regardless of the size of a provider organization or their academic affiliation.**

    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 state should establish: 1) a standardized budget for all provider organizations regardless of their market clout and size; 2) different benchmark for ACOs without a hospital partner; 3) a government sponsored organization to negotiate prescription costs; 4) incentives for the development of narrow networks; 5) policies to reimburse for telemedicine; 6) waivers for the co-insurance or co-pays for routine screening for teenagers; 7) policies to eliminate the 3-day hospital stay prior to being admitted to the SNFs.

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)
Plans to Implement in the Next 12 Months

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
Does NOT Plan to Implement in the Next 12 Months

v. Implementing programs or strategies to improve medication adherence/compliance
Plans to Implement in the Next 12 Months

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

vii. Other: We have hired a part-time pharmacist who will be developing a program for us, initially trying to focus on our chronically ill patients with the highest expenditures.

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)
We will be developing a telemedicine platform, where we hope to include telepsychiatry as part of the platform.

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)
Access. It is challenging to obtain timely behavioral health appointments. Financial. We do not currently have the resources to pay for implementation of these programs, aside from potential inclusion in our larger telemedicine strategy.

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)
No specific initiatives at this time. We do not have the resources to pay for these programs.

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)
No specific initiatives at this time. We do not have the resources to pay for these programs.

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 are a community based provider organization independent of hospitals. We encourage referrals to stay within our system and to limit leakage as much as possible.

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?
The individual practices are not part of one unified electronic medical record. As a multi-specialty organization, we have over a dozen different electronic medical records. We are a small organization. We do not have the funds to interface with other provider organizations' systems.

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.
However, our data warehouse does display cost information that is available to our physicians.

ii. If no, why not?
The individual practices are not part of one unified electronic medical record. As a multi-specialty organization, we have over a dozen different electronic medical records. We are a small organization. We do not have the funds to interface with other provider organizations' systems.

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?
No

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.
38T

ii. If no, why not?
We are a small organization. We do not have the funds to interface with other provider organizations' systems.

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 are currently participating in risk- based/global budget contracts with all of the major plans.

   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)
   We are a small provider organization with limited resources. While we have implemented programs around quality and efficiency, we cannot control prescription costs which currently accounts for 20% of our budget. It is extremely risky, therefore, for us to assume full risk regarding areas that we have no control.

   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.
   We have included all of the quality measures from various organizations in our data warehouse and we provide access to this information directly to our offices and visit their offices approximately every 8 weeks to review this information. We also try to negotiate similar quality measures for all of our major payors.

   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).
   It would be preferred if we have one set of quality measures that we had to perform against~~,~~ and report on at the same time.

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.

Health care policy at the state and federal level seems to be encouraging the consolidation of health care providers into larger health systems. The financial and administrative requirements make it increasingly difficult for smaller provider organizations to survive. Smaller groups are unable or unwilling to assume the financial risk associated with alternative payment arrangements and are unable to achieve the economies of scale in order to make the necessary investments in IT and new technologies that are required.

In addition, we believe the health care growth benchmark is ineffective in curbing medical costs, because the larger systems with market clout are able to negotiate rich, padded budgets that are significantly higher than smaller groups without the market clout and a 3.6% reduction in a fat budget is irrelevant to those groups because their initial budgets are set at disproportionately higher levels. There needs to be one standardized budget for which all provider organizations are measured against, regardless of size or academic affiliation. Until such time as there is a one standardized budget across the state, price variation will continue to escalate and the overall cost of care and increase in medical expenditures will grow. Furthermore, there will be a continue eroding of small, efficient systems, as they will continue to align with larger inefficient systems, because they can't compete with the low budgets that they are given by the third party payors even if their TME is much lower than the larger system. The first, and most important, step to bend the cost curve is to standardize the commercial, Medicaid and Medicare budgets so all provider groups are starting on equal footing.

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.

   CMIPA enters into risk contracts with several Massachusetts Health plans on behalf of its physician membership. Beginning in CY2014 CMIPA developed a claim data warehouse for the purpose of aggregating and reporting on medical expenses and quality indicators associated with these contracts. Unfortunately, CMIPA does not have the ability to report on claims based revenue prior to CY2014. All other available information has been reported for CY2012 and CY2013.

   CMIPA physicians may enter into contractual relationships directly with an insurer if no contractual relationship exists between CMIPA and that insurer. In these cases CMIPA does not receive, nor have access to, any FFS claim information associated with these contracts and as a result cannot provide information on these FFS arrangements.

   Notes to Exhibit #1:

   1. Data reported for CY2015 is based on preliminary settlements and will not be final until Q42015.
   2. Information reported under "Quality Incentive Revenue" includes dollars for quality programs as well as PCP management fees.
   3. "Other Revenue" includes Infrastructure dollars paid directly to CMIPA.

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.

      CMIPA does not receive requests for financial information directly from patients.

      CMIPA independent physicians provide primarily office-based, ambulatory services. It is our understanding that patients are made aware of copays and deductibles at the time the appointment is scheduled or at time of check-in. Also, information on office-based copays may vary by employer or by type of insurance product but office staff assists patients in determining their specific obligation by referencing their membership cards. It is our understanding that no significant changes have occurred in the process.

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.

CMIPA does not currently monitor timeliness or accuracy of financial information given to patients by their physicians' office staff.

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?

It is our understanding that due to the variety of insurance products and employer-specific benefit options it can be difficult for providers to determine a patient's financial responsibility at time of service.

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 CMIPA

	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							$1.06M		$1.038M				$.427M		
Tufts Health Plan			$.207M										$.050M		
Harvard Pilgrim Health Care			$.175M										$.095M		
Fallon Community Health Plan			$.318K										$.070M		
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial			$.700M				$1.06M		$1.038M				$.642M		
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth															
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare									$.210M				$.031M		
Commercial Medicare Subtotal															
Medicare															
Other															
GRAND TOTAL			$.700M				$1.06M		$1.248M				$.673M		

2013 CMIPA

	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							$1.97 M		$2.38M				$1.1M		
Tufts Health Plan							$.151M		$0				$.046M		
Harvard Pilgrim Health Care							$0		$.120M				$.081M		
Fallon Community Health Plan							$.446M		$0				$.195M		
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial							$2.56M		$2.5M				$1.42M		
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.													$.051M		
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid													$.051M		
MassHealth															
Tufts Medicare Preferred													$.061M		
Blue Cross Senior Options							$.014M						$.030M		
Other Comm Medicare															
Commercial Medicare Subtotal							$.014M						$.091M		
Medicare															
Other															
GRAND TOTAL							$2.58M		$2.5M				$1.56M		

2014 CMIPA

	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					$5.9M		$2.1M		$1.1M				$.900M		
Tufts Health Plan					$1.61M		$.137M		$.052M				$.038M		
Harvard Pilgrim Health Care					$2.69M		$.379M		$.051M				$.068M		
Fallon Community Health Plan					$3.46M		$.889M		$.092M				$.337M		
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial					$13.66M		$3.5M		$1.295M				$1.34M		
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.													$.028M		
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid													$.028M		
MassHealth															
Tufts Medicare Preferred													$.094M		
Blue Cross Senior Options													$.019M		
Other Comm Medicare							$.129M						$.414M		
Commercial Medicare Subtotal							$.129M						$.527M		
Medicare															
Other															
GRAND TOTAL					$13.66M		$3.63M		$1.295M				$1.89M		

2015 CMIPA - DATA REPRESENTS PRELIMINARY 2015 CONTRACT SETTLEMENTS - NOT FINAL

	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					$6.29M		$.945M		$.774M				$.933M		
Tufts Health Plan					$1.28M		$.501M		$.050M				$.030M		
Harvard Pilgrim Health Care					$2.93M		$.307M		$.050M				$.067M		
Fallon Community Health Plan					$4.19M		$.602M		$.077M				$.285M		
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial					$14.7M		$2.355M		$.951M				$1.32M		
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth															
Tufts Medicare Preferred															
Blue Cross Senior Options													$.018M		
Other Comm Medicare							($.004M)						$.110M		
Commercial Medicare Subtotal							($.004M)						$.128M		
Medicare															
Other															
GRAND TOTAL					$14.7M		$2.351M		$.951M				$1.44M		