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)

(1) Unsustainable Revenue and Expense Trends. The most effective way to meet the cost growth benchmark is to enable high-value (low to moderate cost and high quality) providers to invest in population health and other mechanisms to control medical expense within a defined population. These resources are significantly limited due to expense trends that outpace revenues. Commercial health plans have capped annual rate increases at a level well below the Cost Growth Benchmark, Medicare reimbursement has been reduced, and Medicaid reimbursement has been relatively flat.

(2) Uncontrollable Cost Drivers. The largest cost drivers include pharmaceuticals, new technology, and the aging of the baby boomer population. Pharmaceutical spending and the cost of technology have outpaced inflation, and have grown at approximately three times the rate of the Cost Growth Benchmark. The aging of the baby boomer population will cause increases in utilization, and Medicare eligible patients are generally costlier than non-Medicare patients.

(3) Regressive Cost Growth Benchmark. The cost growth benchmark enables the highest priced providers to grow at a greater absolute rate than lower-cost providers. Because market share is generally concentrated at higher priced providers, more health care dollars will continue to shift to the highest cost providers under a statewide cap, and to the disadvantage of lower cost, high-value providers.

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)

(1) Cost Growth Benchmark. Providers should be rewarded, and not disadvantaged, for delivering high-quality care at an affordable and sustainable price point. The Cost Growth Benchmark, in its current state, has the practical effect of disadvantaging high-value providers. Indexing the Benchmark to allow lower-cost providers to grow at a higher rate than higher-cost providers would mitigate this disadvantage.

(2) Insurance Product Design. Insurance products do not adequately incent or reward purchasers for choosing high-value services and procedures or for selecting high-value networks and beneficiaries who choose high-value providers subsidize those who choose low-value providers. Insurers could offer products that tier premiums based on the subscriber's selection of the primary care provider. This type of plan would

offer reduced premiums and out of pocket expenses for patients who select high-value (low to moderate cost and high quality) primary care providers and their affiliated systems, and would function similar to a tiered network at the point of plan enrollment and selection of a PCP. Overall, the type of product design would facilitate consumer choice, more accurately reflect the actual cost of the member's total cost of care, and increase competition among providers.

(3) Price Variation. Policy makers should consider regulatory intervention to address unwarranted provider price variation. It has been widely acknowledged that market leverage is not an acceptable factor for price variation. Provider prices that are not attributable to acceptable factors and are attributable to market leverage should be disallowed, because the Commonwealth, consumers and patients ultimately pay the cost of unjustified prices.

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

vii. Other: Insert Text Here

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)

(1) Longitudinal care for highly complex patients who are identified as high and moderate users of 4 local EDs (2 projects). The 2 projects' central aims are to: To reduce ED usage and provide patients with appropriate community health wraparound services. The ED serves as initial point of identification and contact for qualified (moderate and frequent ED users with behavioral health and medical diagnoses) patients. Upon discharge, teams of community health workers have been trained and assigned to provide care management. Patients' care plans are being reviewed by a multidisciplinary medical and social work team. The two projects (CHART II and 'Here for You') are being funded by the HPC and Beacon Health, respectively.

Status. Currently, 1,692 CHART-eligible patients qualified as high or moderate users across all 4 EDs. Among these, 668 are engaged (consented and signed releases) and receiving the community-based services. In the 'Here For You' initiative, 87 have been identified, and 70 are enrolled in services.

(2) Addiction recovery coaches in Beverly and Addison Gilbert Hospitals EDs. This year, we successfully secured MBHP funding to participate in a pilot program to embed addiction recovery coaches in two local EDs (AGH and Beverly Hospitals). Both EDs serve communities with state-data-identified high opioid overdose rates. The project provides non-clinical recovery coach services onsite, 8 hours per day; 7 days per week, with higher coverage during high usage time periods. The hospitals (and the ED recovery coach program) will serve 25 North Shore towns.

Status. Through collaboration with a statewide advocacy non-profit, we have recruited and hired two recovery coaches, who began delivering services in August 2016.

(3) Embedding behavioral health services in primary care and other medical practices. Using the Collaborative Care Model, we are working to embed behavioral health clinicians and services within internal medicine and family practices. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment.

Status. In the first three years of this project, and across the currently integrated 8 practices, we have served over 1,000 patients, and show a 95% patient and provider satisfaction with the program. Research initiatives include those funded with the Wise grant (Lahey based) and BCBS Foundation to expand this integration program into underserved populations, including obstetrics and pediatrics.

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)

(1) Funding Sustainability. These integration initiatives, particularly Strategies (1) and (2), face the perennial challenge of post-pilot and -funding sustainability. Early and current trends and outcomes are promising, but the degree to which the care models become standard and integral to Lahey Health's long-term continuum of treatment services largely depends on stable and adequate funding.

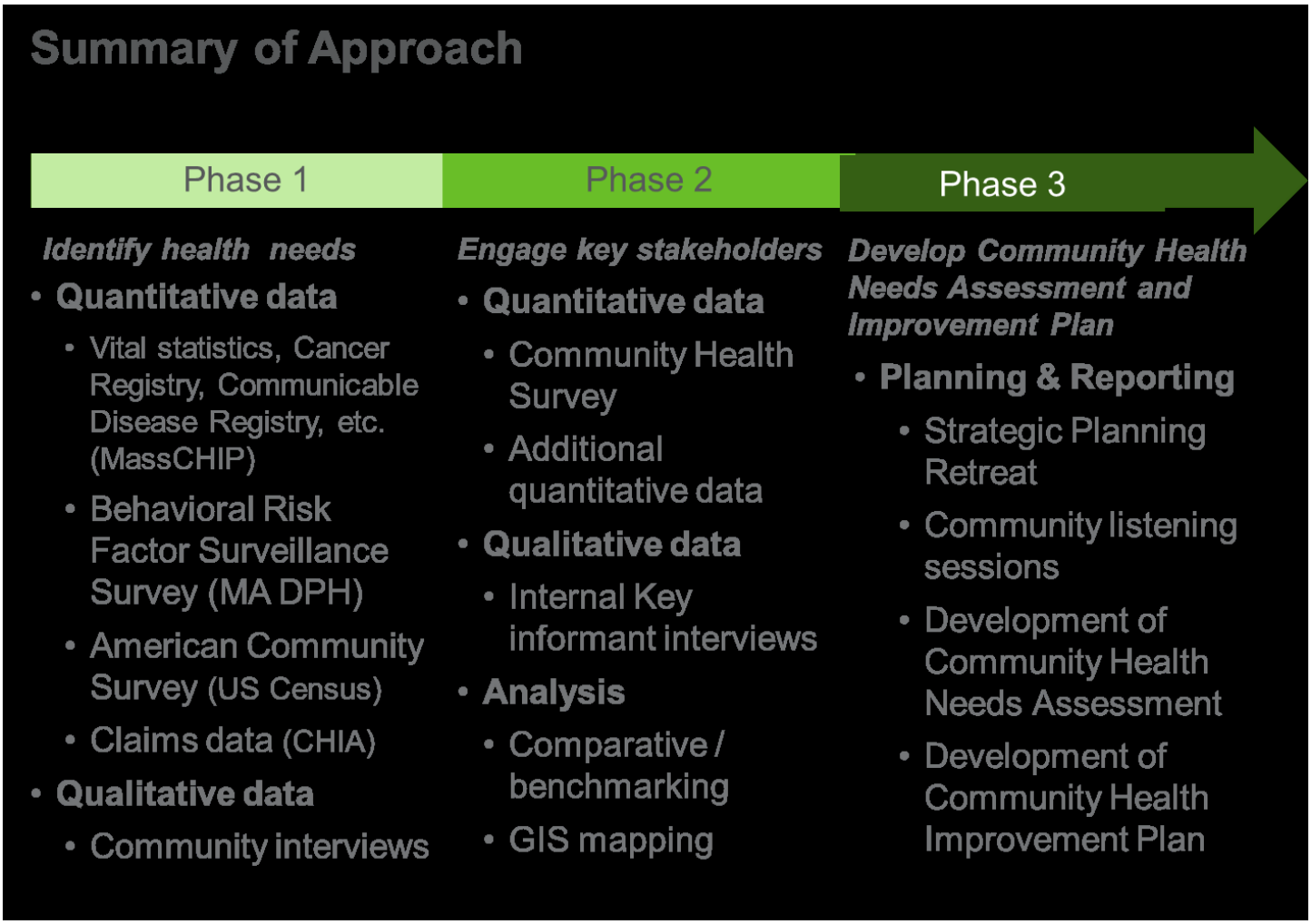
(2) Social Determinants. In these integrated health initiatives, our patients' medical and behavioral health treatment needs co-exist (or are often upstaged) by social deficits such as stable housing, reliable (or any) telephone, transportation, food and employment. In many cases, these social determinants are compromising the timeliness and efficient continuity of providing wraparound care to complex patients.

(3) Workforce Development. We operate in a competitive hiring market, where recruitment is a persistent challenge to staffing these and other projects. Added to this is the challenge of hiring or re-training for a new "brand" of social worker and clinician who can quickly adapt to and embrace the parameters and requirements of this integrated, less fragmented model of care delivery.

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)

(1) Lahey Health Community Relations has strong relationships with community partners including local rotary clubs, chambers of commerce, public health departments, community groups, senior centers and schools (to name a few). Our activities in the community allow us to talk with residents and public health experts on an ongoing informal basis to understand need and emerging health trends.

(2) Every three years a formal community health needs assessment is conducted to help us understand the health needs of our local communities. During this process we review community-specific health data analysis, conduct random household surveys and meet with key community stakeholders. The community health data is then reviewed and compared on the town, county and state levels to allow us to assess need in various domains**.** The graphic below "Summary of Approach" provides additional detail on the methodology and process.



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)

(1) While we conduct a formal assessment every three years the data that is collected is often outdated. For example, the 2016 report is utilizing public health and census data that is three years old.

(2) Capturing a solid sample size in our household survey has been difficult.

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.

The Lahey model of care emphasizes keeping care local, and doing so requires the leadership of and partnership with local physicians, regardless of whether these physicians are employed or independent. Strong physician alignment and engagement will drive the clinical and cost effectives outcomes desired.

Participation in the Lahey Clinical Performance Network, our risk contracting entity, provides physicians a strong voice with regard to contracting, funds flow, and all other major clinical, operational, and strategic physician practice issues.

In addition, Lahey Health forms a Physician Leadership Council (PLC) with each of our community hospitals. The PLC consists of broad and equal representation of the local community medical staff and Lahey Hospital and Medical Center physicians. They evaluate gaps and develop collaborative solutions to keep care local and mechanisms for regular communication among physicians.

The PLC also serves as the voice of the local primary care community, communicating to the Lahey system the need for additional subspecialist coverage as it arises. Lahey Health provides coverage as invited, and level of assistance can fluctuate based on needs.

Further, the PLC will facilitate knowledge sharing about Lahey tertiary/quaternary capabilities, forge stronger physicians-to-physicians relationships, initiate the development of strategies to stem outmigration in key specialties, and if desired, provide a forum to invite Lahey Health physicians to more directly support local specialty care capacity. To the extent that low-complexity cases are leaving a service area unnecessarily to be treated at LHMC, and working through the PLC structure, we are committed to ensuring a greater proportion of this volume stays at the local facility when appropriate.

Another key forum is the Chief Medical Officer/Chief Nursing Officer (CMO/CNO) Council. This group focuses on all of our partners achieving objective success on key value-based performance metrics. This Council is directly linked to our success under population health management and related referral management. This year a major focus is on reducing readmissions. Drawing on the experience of each organization, several pilot studies have been developed and implemented. Once pilot phases are complete, the Council reviews results, and then identifies, shares, and provides resources to deploy the best practice(s) most correlated with successful outcomes.

How Our Model Benefits the Community

Retention and incremental growth of community hospital clinical volume define success of our partnership approach. We facilitate retention and incremental growth in a variety of ways:

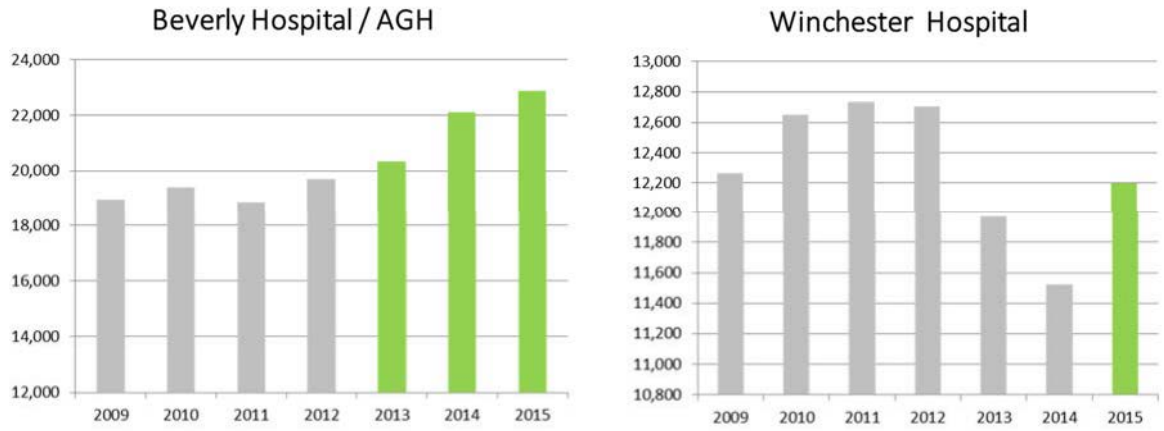
- Enhancing the level of care provided in the community, increasing services offered and overall CMI[1]

Winchester CMI

2014	*2016*
1.299	*1.372*

- Bi-directional system referrals
- Only complex and tertiary patients are referred to and stay at LHMC, which consistently operates at or above 90% capacity[2], which in turn increases community hospital occupancy
- Creating mechanisms within the system to actively refer and redirect patients back to their home community for care.
- The LHMC ED transfer protocol identifies low to moderate acuity patients presenting at LHMC's ED with a zip code indicating residence closer to member community hospitals; LHMC offers to transport to the closer system hospital, if preferred by the patient. This processed has been highly successful both in retaining the most complex patients at LHMC and also with assisting growth of our community hospitals.

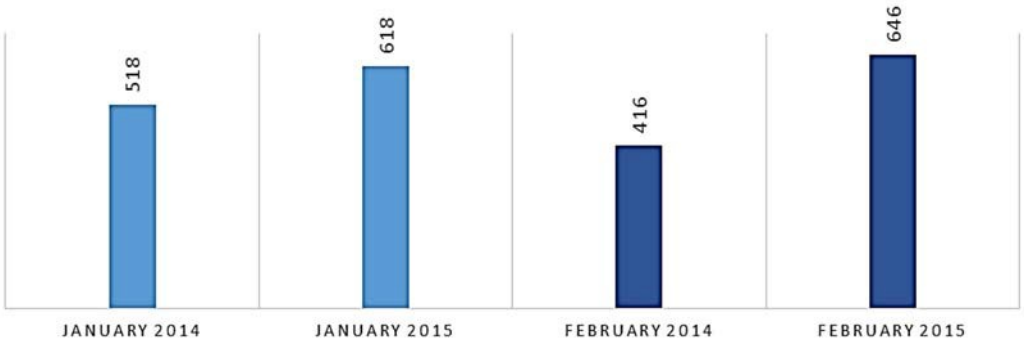
1CMI = Case Mix Index. 2014 data from Fiscal Year End, 9/30/2014 and through four months 2016, 1/31/16.
2LHMC has operated at over 90% capacity every quarter since Q1 of 2013, and regularly approaches 95% occupancy.



Referrals from Lahey's primary care physicians to specialists affiliated with Winchester have increased upon partnership and continue to grow. Lahey's growth is directly attributable to the relationships and care management systems established between and among our physicians. These pathways and care management success stories also contribute to high patient quality and experience outcomes.

Green bars indicate Lahey Health System. Volume is Q1 FY2015 vs. Q1 FY2016.
Green bars indicate volume after joining Lahey Health System (Beverly Hospital/Addison Gilbert Hospital in May, 2012; Winchester Hospital in July 2014)./

Two-Month 2014 vs. 2015 Snapshot of LACU Referrals to Winchester Specialists



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?

Cost and quality information on Lahey Health affiliated providers is not in our EHR or electronically available to the referring providers at the point of electronically entering a referral. The process of interfacing with payors continues to be complex and to our knowledge the automated functionality to display this information at the time of referral is not standard or currently available. Lahey Health invests considerable administrative resources to appropriately navigate and assist patients and providers. Financial counselors are available to work with patients and providers and may provide information on the potential out-of-pocket costs. Additionally, each health plan requires its own process for authorization and referrals.

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?

Cost and quality information on Lahey Health affiliated providers is not in our EHR or electronically available to the referring providers at the point of electronically entering a referral. The process of interfacing with payors continues to be complex and to our knowledge the automated functionality to display this information at the time of referral is not standard or currently available. Lahey Health invests considerable administrative resources to appropriately navigate and assist patients and providers. Financial counselors are available to work

with patients and providers and may provide information on the potential out-of-pocket costs. Additionally, each health plan requires its own process for authorization and referrals.

Lahey Health is focused on reducing out-of-network referral requests by suggesting alternatives within the system. This administrative support is provided to individual patients and may include information on the status of other providers and their potential out-of-pocket costs.

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.

Lahey Health's instance of Epic Care Everywhere improves continuity of care by facilitating the secure exchange of patient records with outside organizations in a consistent format. Lahey has Care Everywhere connections with other Epic EHRs and is actively testing Care Everywhere functionality with other non-Epic EHRs.

Care Everywhere automatically queries using Advanced Record Location to find records from organizations near the patient's home and work address or manually if a patient has been seen elsewhere.

Lahey Health is testing connectivity to the eHealth Exchange, a nationwide network for exchanging clinical data with participating Epic and non-Epic healthcare organizations, Health Information Exchanges (HIEs), and federal agencies including the VA, DoD, and SSA.

   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)

Lahey Health's strategy includes continued system-wide implementation and optimization of Epic, performance under BCBSMA's PPO risk contract, and performance under various bundled payment programs for Congestive Heart Failure, Coronary Artery Bypass Graft, Hip & Femur Procedures (excluding total joint arthroplasty), Major Bowel Procedures, Total Joint Arthroplasty (lower extremity), and Stroke (note: initially slated to occur primarily at LHMC).

Lahey Health will also implement the CMS Oncology Care Model. Lahey Health Cancer Institute was selected as one of nearly 200 physician group practices and 17 health insurance companies to participate in a care delivery model that supports and encourages higher quality, more coordinated cancer care. Medicare patients at Lahey Health hospitals will be participating in the program. The Medicare arm of the Oncology Care Model

includes more than 3,200 oncologists and will cover approximately 155,000 Medicare beneficiaries nationwide. Lahey Health is the only provider in the region to be selected.

The Oncology Care Model encourages practices to improve care and lower costs through episode- and performance-based payments that reward high-quality patient care. The Oncology Care Model is one of the first CMS physician-led specialty care models and builds on lessons learned from other innovative programs and private-sector models. As part of this model, physician practices may receive performance-based payments for episodes of care surrounding chemotherapy administration to Medicare patients with cancer, as well as a monthly care management payment for each beneficiary. The two-sided risk track of this model would be an Advanced Alternative Payment Model under the newly proposed Quality Payment Program, which would implement provisions from the Medicare Access and CHIP Reauthorization Act of 2015.

Practices participating in the five-year Oncology Care Model will provide treatment following nationally recognized clinical guidelines for beneficiaries undergoing chemotherapy, with an emphasis on person-centered care. They will provide enhanced services to beneficiaries who are in the Oncology Care Model to help them receive timely, coordinated treatment. These services may include:

Coordinating appointments with providers within and outside the oncology practice to ensure timely delivery of diagnostic and treatment services;
Providing 24/7 access to care when needed;
Arranging for diagnostic scans and follow up with other members of the medical team such as surgeons, radiation oncologists, and other specialists that support the beneficiary through their cancer treatment;
Making sure that data from scans, blood test results, and other tests are received in advance of patient appointments so that patients do not need to schedule additional visits; and
Providing access to additional patient resources such as emotional support groups, pain management services, and clinical trials.

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)

(1) The cost of infrastructure and operations to succeed under APMs is significant. These barriers could be addressed through subsidization of infrastructure costs, payor/provider cost-sharing to build infrastructure, and standardized quality and cost reporting across payors.

(2) Claims data that is required to understand APM performance, and subsequently make appropriate modifications, may be unavailable if attributed patients are treated outside of the system and such data may not be provided in a timely fashion. These barriers could be addressed by enhancing access to patient data regardless of care delivery site and by requiring more routine and comprehensive claims data reporting.

(3) Behavioral health services are generally carved out of APMs, but clearly such conditions significantly impact the need for and use of medical care services, as we have so effectively learned through our CHART Grant at Addison Gilbert Hospital that focused on identifying such patients through the creation of High Risk Intervention Teams. This barrier would be addressed through contract design that incents integration of behavioral and physical health care delivery and a focus specifically on patients with co-morbid behavioral and physical health issues.

c. Are behavioral health services included in your APM contracts with payers?
No
   i. If no, why not?

Behavioral health has been carved out due to lack of timely data and a concern regarding insufficient funding.

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.

The lack of alignment in quality reporting is inherently confusing to our care providers, as well as a costly resource burden for our organization.

The variability of quality measures and the performance thresholds in quality measures that are consistent leads to ambiguity in our processes used to support our providers in the delivery of high quality care. It necessitates processes that are sensitive to the patient's insurance so that we ensure we are compliant with the payer's metrics. These different processes can potentially lead to a different level of care delivery for patients with certain insurances.

Further, with different measures, there can be confusion for our providers as they seek to deliver the highest quality patient care. For example, if a physicians' specialty society has published a standard of care recommending one level of outcome, yet the measure tracks a different outcome, the process we have developed to support the reporting may be in conflict with what the physician believes is the right standard of care.

Management process differences are compounded by our challenges in reporting inconsistent measures. Most payers require us to use EHRs as the sole source of patient outcome data. At Lahey Health, that requires use of multiple EMRs that are still in the process of being integrated. Reporting of the measures is time consuming enough, made more so by having to report multiple different measures.

   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).

CMS has managed a robust set of measures that track performance in managing quality for many chronic disease states. We would recommend driving consistency with CMS measures, where available. With a standardized set of measures, our data vendors would be able to support monthly electronic submission of outcome data, consistent with electronic claim submission files.

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.
   38T

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.
   38T

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.

Lahey Hospital and Medical Center and Northeast Hospital
There is a formal business process at each hospital to respond to these consumer inquiries. The Patient Access Department is the initial contact for charge estimate requests.

Patient will typically call and are routed to the financial counselors when requesting price estimates.

Based on the type of service required, a CPT code is requested and obtained from the coding department. Contact will then be made to the patient's insurance to identify: if the procedure is a covered service; and what the patient's responsibility will be (co-pay, insurance, deductible, out of pocket).

Once this information is obtained, the Patient Access Department will process a quote utilizing the CarePricer Product, which will compute the charges associated with the type of service requested.

Most of the charge estimate price quotes are delivered to the patient at the time of the request by the financial counselors.

For more complex requests, Lahey will inform the patient within two (2) business days.

Winchester Hospital
There is an established formal business process for charge estimate requests.

The Revenue Cycle Team will identify the CPT codes required for the particular service requested.

Based on the CPT provided, a charge estimate will be generated based on a review of the charges associated with each CPT.

Winchester provides an estimate within 24 hours of the request.

   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.

Based on these established business processes, Lahey Health hospitals are able to respond to patient inquiries within two business days. For many requests, the estimate is provided to the patient on the day of the request.

The accuracy of the estimate will ultimately be the result of being provided the CPT codes that will be utilized during that particular service. As with any health care service, the price estimate is based on historical average for the same type of procedure or service. If additional services are performed or complications occur requiring added treatment to the patient, the original estimate would not have incorporated these additional services.

Please note that all self pay estimates clearly denote that they are estimates.

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?

The most significant barrier to self pay requests is the ability to accurately identify the estimate service for each test or procedure to the actual services incurred. Each test or procedure could require additional services that would ultimately generate additional CPT codes which would add additional charges versus the initial estimate.

Each service provided to a particular patient is not an identical due to the complexities of procedures and treatments and unforeseen complications. Therefore, it is difficult to address this barrier.

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2012 - restated

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 49,659,934	$ 147,834,895	$ 1,027,444	$ 2,646,205	$ 85,621,552	$ -	$ (1,450,219)	$ -	$ 4,822,627	$ -	$ 5,256,714	$ -	$ 552,920	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 25,814,259	$ -	$ 439,793	$ -	$ 103,923	$ -	$ 19,994,739	$ 26,285,754	$ 192,863	$ -	$ -
HPHC	$ 92,239,987	$ 26,060,693	$ 497,916	$ 147,339	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,338,495	$ 42	$ -	$ -	$ -
Fallon	$ 9,075,505	$ 2,011,682	$ 37,301	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 249,513	$ -	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,720,236	$ 24,610,276	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,569,483	$ 18,172,791	$ -	$ -	$ -
Aetna	$ 2,346,529	$ -	$ 300,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 317,523	$ 21,608,542	$ -	$ -	$ -
Other Commercial	$ 6,264,682	$ -	$ 13,441	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 433,908	$ 55,959,800	$ -	$ -	$ -
Commercial	$ 159,586,636	$ 175,907,270	$ 1,876,103	$ 2,793,543	$ 111,435,811	$ -	$ (1,010,426)	$ -	$ 4,926,550	$ -	$ 58,880,611	$ 146,637,205	$ 745,783	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,883,259	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 40,654,273	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,236,628	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,160	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,281,823	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,637,032	$ 1,615,082	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 99,694,175	$ 1,615,082	$ -	$ -	$ -
Mass Health	$ 8,072,118	$ 6,154,116	$ -	$ 389,595	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,359,808	$ 25,192,626	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 33,140,423	$ -	$ 265,360	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,146,023	$ 751,714	$ -	$ -	$ -
Other Commercial Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,045,062	$ 14,067,770	$ -	$ 200,000	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 42,489,991	$ -	$ (1,592,496)	$ -	$ 630,240	$ -	$ 57,331,508	$ 14,819,484	$ 265,360	$ 200,000	$ -
Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,151,718	$ 422,378,367	$ -	$ 11,280,059	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,332,137	$ 40,435,715	$ -	$ 5,264,213	$ -
Grand Total	$ 167,658,754	$ 182,061,387	$ 1,876,103	$ 3,183,138	$ 153,925,802	$ -	$ (2,602,922)	$ -	$ 5,556,790	$ -	$ 246,749,957	$ 651,078,480	$ 1,011,143	$ 16,744,272	$ -

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2013 - restated

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 42,233,198	$ 147,413,138	$ 910,753	$ 2,802,192	$ 73,324,405	$ -	$ 91,856	$ -	$ 4,172,611	$ -	$ 3,905,542	$ -	$ 417,132	$ -	$ -
Tufts	$ -	$ -	$ -	$ -	$ 24,279,912	$ -	$ 45,897	$ -	$ 22,949	$ -	$ 19,678,420	$ 30,598,997	$ 317,188	$ -	$ -
HPHC	$ 89,607,012	$ 34,870,999	$ 494,123	$ 279,669	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,211,023	$ 2,196	$ -	$ -	$ -
Fallon	$ 9,507,234	$ 2,410,610	$ 38,874	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 263,130	$ -	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,661,854	$ 24,542,245	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,713,781	$ 28,057,185	$ -	$ -	$ -
Aetna	$ 1,642,769	$ -	$ 90,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 197,147	$ 20,774,429	$ -	$ -	$ -
Other Commercial	$ 5,899,647	$ -	$ 13,746	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 528,102	$ 49,545,931	$ -	$ -	$ -
Commercial	$ 148,889,859	$ 184,694,747	$ 1,547,496	$ 3,081,861	$ 97,604,317	$ -	$ 137,753	$ -	$ 4,195,560	$ -	$ 48,159,000	$ 153,520,983	$ 734,320	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,787,769	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 44,385,196	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,130,491	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 26	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,391,471	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,204,344	$ 1,967,516	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 110,899,297	$ 1,967,516	$ -	$ -	$ -
Mass Health	$ 7,836,828	$ 6,484,071	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,242,675	$ 21,178,871	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 30,198,376	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,578,058	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,123,972	$ 15,072,833	$ -	$ 236,100	$ -
Commercial Medicare Subtotal	$ -	$ -	$ -	$ -	$ 43,579,413	$ -	$ (1,339,517)	$ -	$ -	$ -	$ 60,900,406	$ 15,072,833	$ -	$ 236,100	$ -
Medicare	$ -	$ -	$ -	$ -	$ 83,038,348	$ -	$ -	$ -	$ -	$ -	$ 806,448	$ 352,215,661	$ -	$ 11,914,365	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,247,446	$ 39,308,293	$ -	$ 2,914,220	$ -
Grand Total	$ 156,726,687	$ 191,178,818	$ 1,547,496	$ 3,081,861	$ 224,222,078	$ -	$ (1,201,764)	$ -	$ 4,195,560	$ -	$ 244,255,273	$ 583,264,157	$ 734,320	$ 15,064,685	$ -

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2014 - restated

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 68,770,848	$ 190,405,032	$ 1,544,522	$ 3,923,568	$ 72,263,837	$ -	$ 490,937	$ -	$ 4,231,095	$ -	$ 4,170,732	$ -	$ (841,269)	$ -	$ -
Tufts	$ 8,783,628	$ -	$ 1,023,282	$ -	$ 23,906,902	$ -	$ (321,342)	$ -	$ 44,951	$ -	$ 19,908,091	$ 40,965,450	$ 80,337	$ -	$ -
HPHC	$ 99,119,020	$ 31,393,906	$ 844,351	$ 105,703	$ 14,910,647	$ -	$ 124,582	$ -	$ 253,125	$ -	$ 2,009,424	$ 1,337	$ (677,336)	$ -	$ -
Fallon	$ 9,521,150	$ 2,158,807	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 298,734	$ 1,823,731	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,540,985	$ 35,809,141	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,495,942	$ 43,115,997	$ -	$ -	$ -
Aetna	$ 1,664,736	$ -	$ 75,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 323,027	$ 29,428,269	$ -	$ -	$ -
Other Commercial	$ 7,087,656	$ -	$ 19,911	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,139,048	$ 71,380,661	$ -	$ -	$ -
Commercial	$ 194,947,038	$ 223,957,745	$ 3,507,066	$ 4,029,271	$ 111,081,386	$ -	$ 294,176	$ -	$ 4,529,170	$ -	$ 49,885,983	$ 222,524,585	$ (1,438,268)	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 38,711,939	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 60,951,101	$ -	$ (47,147)	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,606,029	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,327	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,446,889	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,275,948	$ 1,287,617	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 138,993,233	$ 1,287,617	$ (47,147)	$ -	$ -
Mass Health	$ 6,713,339	$ 14,921,665	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,764,817	$ 32,298,008	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 45,752,795	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 51,767,421	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,462,100	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ 93,658	$ -	$ 234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,571,306	$ 17,028,946	$ -	$ 211,789	$ -
Commercial Medicare Subtotal	$ 93,658	$ -	$ 234	$ -	$ 45,752,795	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 88,800,827	$ 17,028,946	$ -	$ 211,789	$ -
Medicare	$ -	$ -	$ -	$ -	$ 127,893,170	$ -	$ 3,000,000	$ -	$ -	$ -	$ 750,593	$ 375,896,493	$ -	$ 17,689,861	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,727,442	$ 53,260,467	$ -	$ 4,188,750	$ -
Grand Total	$ 201,754,035	$ 238,879,410	$ 3,507,300	$ 4,029,271	$ 284,727,351	$ -	$ 1,668,251	$ -	$ 4,529,170	$ -	$ 301,922,894	$ 702,296,116	$ (1,485,416)	$ 22,090,400	$ -

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2015

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 67,709,268	$ 181,664,361	$ 831,769	$ 2,560,765	$ 78,604,605	$ -	$ 930,986	$ -	$ 4,606,196	$ -	$ 5,567,132	$ -	$ (83,004)	$ -	$ -
Tufts	$ 10,369,863	$ 2,150,780	$ 980,123	$ -	$ 18,630,227	$ -	$ (17,960)	$ -	$ -	$ -	$ 32,196,587	$ 35,562,571	$ (11,731)	$ -	$ -
HPHC	$ 105,256,093	$ 32,401,803	$ 521,082	$ 227,051	$ 14,049,339	$ -	$ 163	$ -	$ 154,037	$ -	$ 2,278,263	$ -	$ (817,649)	$ -	$ -
Fallon	$ 7,949,765	$ 3,796,279	$ 13,340	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 364,984	$ 399,443	$ -	$ -	$ -
Cigna	$ -	$ 1,967,563	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,591,078	$ 26,320,994	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,108,553	$ 41,194,476	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,351,720	$ 23,139,892	$ -	$ -	$ -
Other Commercial	$ 5,559,182	$ -	$ 17,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,330,964	$ 65,722,517	$ -	$ -	$ -
Commercial	$ 196,844,171	$ 221,980,786	$ 2,363,965	$ 2,787,816	$ 111,284,171	$ -	$ 913,189	$ -	$ 4,760,233	$ -	$ 76,789,281	$ 192,339,894	$ (912,383)	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 38,993,458	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 73,221,123	$ -	$ (168,016)	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,140,076	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,844	$ -	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,207,747	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,399,627	$ 2,908,755	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 148,967,875	$ 2,908,755	$ (168,016)	$ -	$ -
Mass Health	$ 2,635,088	$ 12,181,075	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,525,951	$ 28,352,021	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 43,726,257	$ -	$ (2,981,213)	$ -	$ -	$ -	$ 58,684,560	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,386,364	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ 9,202,599	$ -	$ 3,554	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,574,212	$ 16,241,366	$ -	$ 345,971	$ -
Commercial Medicare Subtotal	$ 9,202,599	$ -	$ 3,554	$ -	$ 43,726,257	$ -	$ (2,981,213)	$ -	$ -	$ -	$ 92,645,136	$ 16,241,366	$ -	$ 345,971	$ -
Medicare	$ -	$ -	$ -	$ -	$ 141,063,282	$ -	$ 999,999	$ -	$ -	$ -	$ 753,109	$ 414,470,682	$ -	$ 15,820,763	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,717,369	$ 57,224,816	$ -	$ 1,588,717	$ -
Grand Total	$ 208,681,857	$ 234,161,861	$ 2,367,519	$ 2,787,816	$ 296,073,710	$ -	$ (1,068,025)	$ -	$ 4,760,233	$ -	$ 342,398,721	$ 711,537,535	$ (1,080,399)	$ 17,755,451	$ -