Exhibit B: HPC Questions for Written Testimony

Not to exceed 120 words for each response. Can use supporting testimony or documentation in an Appendix.

Questions:

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

a. What are the actions your organization has undertaken to reduce the total cost of care for your patients?

Heywood Hospital proactively seeks opportunities to reduce costs which include standardization of supplies, and working with our Group Purchasing Organization, opportunities to utilize generic less costly drugs, and evaluating and holding managers accountable to reduce overtime costs.

Heywood Hospital is the lead organization on a cross-continuum community steering committee working to reduce preventable admissions and readmissions, and working to keep patients within their home setting with supports, when appropriate.

One of the key grant funded efforts we have taken is to assign a discharge pharmacist to a selected population of elderly patients who are at risk of readmission if medications are not managed appropriately.

b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

Coordination of care across the continuum of care is a primary focus for hospital and medical staff. We collaborate with managed care plans and other community healthcare organizations to increase preventive care, intervene early, and improve coordination of care for chronic conditions.

The primary limiting factor is the availability of resources, especially financial resources. The efforts described above will have a positive impact on cost and efficiency "down the road" but do involve upfront costs that are not currently adequately funded.

The other key factor is that there is a plethora of funding and grant "opportunities" but there does not appear to be a good coordination of efforts across the continuum. This is improving, but not at an efficient level at this time. 124 words

c. What systematic or policy changes would encourage or help organizations like your to operate more efficiently without reducing quality?

While healthcare organizations seem to agree on the objectives and goals to improve quality and reduce costs, there are too many diverse approaches or approaches that are duplicative in nature. A statewide coordinated "pathway" to improvement would streamline the process, expedite implementation, and reduce the cost of "improvement" along the way. Each healthcare organization is spending considerable resources on improvement efforts that are the same or similar to those in other organization. More statewide organizations to take the lead and provide sound guidance would be helpful.

d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?

By working closely with managed care organizations, and in collaboration with our PHO, we are striving to improve quality and reduce cost. The outcome of these efforts is that we expect to be assigned to the lowest cost tier for co-pays and deductibles, and as a result of low cost, the employers in our area should enjoy lower health insurance premiums for their employees.

2. The 2013 Examination of Health Care Costs Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?

Heywood has not increased its prices in 4 years. There have been minimal increases in contractual relationships with payors, as evidenced by the HPC reports that show Heywood is in the bottom 3rd of the State in terms of contract prices received by payors.

3. C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?

a. What potential opportunities have you identified for such integration?

Our hospital has been actively involved in community health coalitions and shares the goal of improving access to behavioral health services, which are in short supply on both the in-patient and out-patient side, and non-existent in our region for children. Discussions are preliminary at this time but it is clear that there is a shared vision to improve access in the community. Area physicians and other healthcare professionals all agree on the need for expanded services in our community.

Heywood Hospital is a recipient of a state funded grant to expand and better integrate 24 hour mental health therapy and social services within the Emergency Department setting.

b. What challenges have you identified in implementing such integration?

Access to capital and operational funding through parity in government and commercial payment for services are among the most prevalent challenges. Reimbursement levels do not support necessary resources to adequately support these populations.

c. What systematic or policy changes would further promote such integration?

Any policy change that would improve access to financial resources would promote such integration. In addition, managed care organizations need to recognize behavioral health as a true medical service and provide adequate reimbursement. Cost effective integration would ideally include reimbursement for transportation services for those without access.

4. C.224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.

a. Describe your organization's efforts to promote these goals.

The hospital is a member of the Heywood PHO and participates in contracts that are designed to promote quality and reduce overall cost. Our medical staff has a very strong primary care base which by its nature tends to be prudent in utilization of healthcare services and is very quality focused. Patient and Family centered care is one way to help improve outcomes and efficiency.

b. What current factors limit your ability to promote these goals?

Adequate funding for enhanced clinical integration programs is lacking.

c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

A fair amount of limited resources are expended on pre-authorization processes for hospital and physicians. If managed care plans are rarely denying requests, it seems that all those expended resources on the payor and provider side are wasteful. New programs that incentivize provider groups to efficiently control their own authorizations would be a step in the right direction and save significant dollars throughout the healthcare system.

5. What metrics does your organization use to track trends in your organization's operational costs?

a. What unit(s) of analysis do you use to track cost structure? (e.g., at organization, practice, and/or provider level)? For the Hospital we use following:

- Hours/ patient day
- Cost/patient day
- Compensation Ratio defined as Salary + Fringe benefits/ Total net revenue
- Supply expense per patient day
- For Physician practices that are employed the traditional income statement is used. For independent physicians expenses can not be tracked by physicians

From the managed care side, we track overall utilization of services, referrals to tertiary care that could be done locally, preventive services, quality performance, and overall cost per member per month, when that data is available.

b. How does your organization benchmark its performance on operational costs structure again peer organizations?

Heywood uses some external benchmarking data from MHA and GPO but timing of data is lagged and outdated, so value is limited

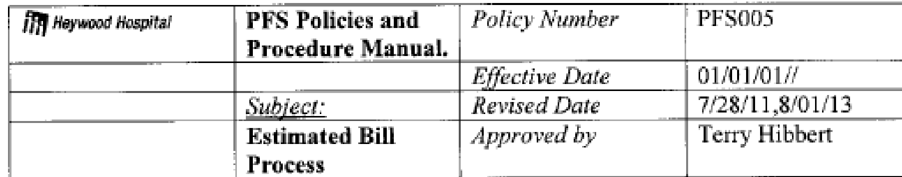
On the managed care side, we compare ourselves to other provider groups when that data is available, and if we vary significantly from others, we drill down to see the cause when data is available.

c. How does your organization manage performance on these metrics?

Hospital indicators that are substantially outside benchmarks will be analyzed for to explain variances then if necessary, operations will be adjusted to come into line with industry norms. We use a combination of operational directives, education, and improvement processes to improve quality and reduce costs.

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee as required by c.224.

Patients and families have access to charge information upon request. When our patient portal goes live in the near future, additional information will become available.



Heywood Hospital	**PFS Policies and Procedure Manual.**	*Policy Number*	PFS005
		Effective Date	01/01/01//
	Subject:	*Revised Date*	7/28/11,8/01/13
	Estimated Bill Process	*Approved by*	Terry Hibbert

POLICY

This policy applies to the Heywood Hospital Patient Financial (PFS) Department

PURPOSE

To define the process of providing patients who request an estimated cost statement for anticipated medical procedures and tests.

PROCEDURES

1. The Patient requests the anticipated costs for services.
2. The request is processed either through the Registration, Scheduling or Patient Accounting departments.
3. The patient or physician will provide the hospital with the Current Physician Procedural code or if the services are for surgical or inpatient services any anticipated Surgical or Discharge diagnostic codes (ICD9).
4. The staff receiving the request will access the hospital's charge master for single test items and provide the charge amount listed in the hospital's current charge master.
5. For surgical procedures the staff member will obtain the anticipated discharge surgical procedure code.
6. This information is then forwarded to the Director or their assignee and an internal report will be run using the surgical procedure code provided by the attending physician.
7. The report will use a time line parameter of the previous 6 months historical patient data containing charges and the same surgical procedure.
8. Using the data provided on the report an average anticipated cost is obtained and provided to the patient.
9. For inpatient non surgical procedures the request will be sent to the Director, An internal report using statistical data of past patients within the last 6 months with the same discharge diagnosis will be created. The report will use an anticipated discharge diagnosis if the patient is requesting an estimate prior to admission.

7. After reviewing the reports issued by the Attorney General (April 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Exhibit C: OAG Questions for Written Testimony

1. For each year 2009 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

   See Excel Spreadsheet: OAG Exhibit C, Question 1

2. If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mx, payer mix, or patient member type (e.g., HMO v. PPO, fully-insured v. self-insured) on your opportunities for surpluses.

The hospital is a member of the Heywood PHO and works through that organization to manage risk. Our hospital is acutely aware of general efforts to reduce preventable admissions and readmissions, provide an efficient and effective discharge plan for our patients, work with the community to improve access to primary care and selected specialties, and work with our patients and family to educate them on how best to maintain their health and ward off illness and disease as much as possible.

We have as one of our primary objectives the need to effectively manage referrals, especially those which go to tertiary care centers which could be managed locally.

Pharmacy benefit management is also key. We have a strong focus on the appropriate use of generic medications and the overall management of medication regimens, particularly for those polypharmacy patients.

3. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage),solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or governmental business.

   At this time, we rely on the Heywood PHO to assist in obtaining key data from the managed care organizations. If the amount of risk was to significantly increase, it would be necessary for us to reserve large sums of money as a protection against deficit scenarios.

4. Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient populations or any population subgroups (e.g., subgroups, by carrier, product, or geographic area).

   There are some managed care contracts that provide to our PHO, which our hospital is a member of, health status indicator changes over the years. In addition, our hospital leads efforts to conduct periodic community health status studies.

5. Please submit a summary table showing for each year 2009- 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue. Responses must be submitted electronically using the Excel version of the attached exhibit. To receive the Excel spreadsheet, please email HPC-Testimony@state.ma.us.

   See Excel Spreadsheet: OAG Exhibit 1, question 6

6. Please identify categories of expenses that have grown (a) 5% or more and (b) 10% or more from 2010 to 2012. Please explain and submit supporting documents that show your understanding as to the factors underlying any such growth.

   See Excel Spreadsheet: OAG Exhibit 1, question 6

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter “wellness programs”) for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

   Over the past six months, Heywood Hospital kicked off a variety of health and wellness programs open to employees, patients, and the community at large. Additionally, Heywood Hospital adopted a “Smoke-Free” campus policy. Analysis has not yet been conducted to determine the cost benefit of these programs.
   Programs include:

- Offered 3-times a year
- **Pilates -** *6-week session -Tuesdays - 5:30p-6:30pm – September 17th – October 22nd. Fee: $50 – 6 week session or $10 drop-in. 50% discount for employees*

- **Tai Chi Chi Kung (the Brocade of Eight) –**

- *9-week session: Wednesdays – 6:00 – 7:30pm – September 18 (introductory class) – September 25th – November 13th.*
- *Fee: $80 – 9 week session – First 1 hour introductory class free, 50% discount for employees*

- **Gentle Yoga** –
- *6-week session -Thursdays - 5:30p-6:30pm – September 19th - October 24th.*
- *Fee: $50 – 6 week session or $10 drop-in, 50% discount for employees*

- **Health and Nutrition Classes, open to the public**
- At least one per quarter, free or 50% discount

- Employee Fitness Center
- Walking Trail
- Free Flu Shots on site
- Quit to Win – Smoking Cessation
- CPR and First Aid
- On-site Support Groups
    - Bariatric Surgery Patient Support Group
      Better Breathers Club
      Breast Cancer Support Group
      Breastfeeding Support Group
      Cancer Support Group
      Caregiver Support Group
      Celiac Support Group
      Community Birth/Loss Support Group
      Diabetes Education & Support Group
      HIV & AIDS - Support, Education & Advocacy
      Parkinson's Support Group
      Substance Abuse Family Support Group
      Suicide Survivor Support Group

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

NOTES:

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

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	X	X	X	X	X	X	$9M	$5M	X	X	X
Tufts	$5M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HPHC	$2M	X	X	X	X	X	X	X	$117K	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$4M	X	X	X	X
Total Commercial	$7M	X	X	X	X	X	X	X	$117K	X	$21M	$5M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X	X
Mass Health	$5M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$1M	X	$24K	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	$10M		$571K	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$11M	X	$595K	X	X	X	X	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$25M	X	X	X	X
GRAND TOTAL	$12M	X	X	X	$11M	X	$595K	X	$117K	X	$53M	$5M	X	X	X

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	X	X	X	X	X	X	$9M	$5M	X	X	X
Tufts	$5M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HPHC	$3M	X	X	X	X	X	X	X	$15K	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$3M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$3M	X	X	X	X
Total Commercial	$8M	X	X	X	X	X	X	X	X	X	$18M	$5M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$6M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$8M	X	X	X	X
Mass Health	$5M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$1M		$38K	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	$11M	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$12M	X	$38K	X	X	X	X	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$26M	X	X	X	X
GRAND TOTAL	$13M	X	X	X	$12M	X	X	X	$15K	X	$52M	$5M	X	X	X

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	X	X	X	X	X	X	$9M	$5M	X	X	X
Tufts	$4M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HPHC	$3M	X	X	X	X	X	X	X	$10K	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	$3M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$3M	X	X	X	X
Total Commercial	$7M	X	X	X	X	X	X	X	$10K	X	$18M	$5M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$6M	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$8M	X	X	X	X
Mass Health	$5M	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$1M	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	$11M	X	$320k	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$12M	X	$320K	X	X	X	X	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$26M	X	X	X	X
GRAND TOTAL	$12M	X	X	X	$12M	X	$320K	X	$10K	X	$52M	$5M	X	X	X

Heywood Hospital
Exhibit B question 6

	FY 2010	FY 2011	% change
Salaries & Wages	$40,893,209	$42,651,629	4%
Fringes	$7,951,320	$9,969,109	25%
Physician Fees	$6,136,777	$6,457,735	5%
Supplies and Expenses	$29,564,044	$31,093,140	5%
Health Safety Net	$743,333	$724,331	-3%
Interest	$395,434	$827,777	109%
Depreciation	$3,393,142	$3,919,409	16%
BD Provision	$2,698,170	$3,004,533	11%
Total Expenses	$91,775,429	$98,647,663	7%

A) Fringe Benefits from 2010 to 2011 increases 25% due to a 16% increase in Health Insurance P
There has been a 14% increase from 2010 to 2012,mainly due to Health Insurance premium i
costs due to a reduction in force in 2011.

B) There was a 5% increase in MD fees from 2010 to 2011 due to the need to have locum MDs t
MD staff is off

C) Interest and Depreciation increased 109% and 16% respectively from 2010 to 2011. In additio
2010 to 2012 due to a $37M building project coming on line. The project included new inpati

D) The Bad debt provision increased 11% from 2010 to 2011 due to payer shifts from Commerci
This caused A/R to age and the resulting requirement to provide additional monies for Bad D

FY 2012	% change	2 year change
$43,395,894	2%	6%
$9,034,859	-9%	14%
$6,077,714	-6%	-1%
$31,329,502	1%	6%
$673,097	-7%	-9%
$894,164	8%	126%
$4,560,864	16%	34%
$0	-100%	-100%
$95,966,094	-3%	5%

remiums.
ncreases and unemployment

o provide on call services to patients when core

n, these catagories increased 102% and 34% from
ent units and Emergency Room.

al insurance products to Medicaid products.
ebt.

Heywood Hospital
OAG Exhibit C Information
FY 2009 - 2013

	2009		2010	
Govt Payers				
Medicare	$58,840,410		$63,494,424	
Fallon - Medicare	$27,705,676		$29,843,712	
Blue Cross - Medicare				
Tufts - Medicare				
AARP				
Sr. Whole Life				
United - Medicare				
Medicaid	$12,266,738		$12,810,105	
Medicaid HMO's	$17,628,887		$18,697,476	
Other Gov't	$1,063,747		$1,124,335	
Total	$117,505,458	56%	$125,970,052	59%
Commercial				
Blue Cross - all products	$66,984,221		$61,735,573	
Fallon - All Products	$733,547		$482,150	
Harvard - All products	$2,266,402		$2,419,267	
Tufts - All products				
Aetna	$3,684,273		$3,975,672	
Neighborhood Health				
Other PPO's	$11,832,788		$12,145,037	
Cigna	$196,558		-$98,923	
Other HMO's	$53,463		$44,164	
Total	$85,751,252	41%	$80,702,940	38%
Other				
Workers Comp	$2,281,844		$2,251,170	
Motor Vehicle				
Self Pay	$4,530,875		$4,734,468	
Total	$6,812,719	3%	$6,985,638	3%
Grand Total	$210,069,429	100%	$213,658,630	100%

2011		2012		Projected 2013	
$66,523,373		$69,035,366		$71,775,814	
$30,569,873		$29,205,412		$31,677,384	
$12,487,258		$14,959,452		$15,133,003	
$21,813,868		$24,061,833		$26,652,267	
$1,232,931		$1,513,724		$2,026,215	
$132,627,303	60%	$138,775,787	62%	$147,264,683	63%
$60,929,897		$60,159,240		$60,047,734	
$402,648		$323,646			
$2,502,837		$2,251,034		$2,946,307	
$3,994,043		$3,262,145		$2,407,441	
$13,887,290		$12,736,415		$12,325,067	
-$242,019		-$69,214			
$63,255		$33,425		$209,054	
$81,537,951	37%	$78,696,691	35%	$77,935,603	33%
$2,216,273		$2,344,229		$2,286,362	
$5,000,122		$5,629,118		$5,958,000	
$7,216,395	3%	$7,973,347	4%	$8,244,362	4%
$221,381,649	100%	$225,445,825	100%	$233,444,648	100%

Heywood Hospital
OAG Exhibit C Information
FY 2009 - 2013
Question 1

	2009	2010	2011	2012	Projected 2013
Govt Payers					
Medicare					
Fallon - Medicare					
Blue Cross - Medicare					
Tufts - Medicare					
AARP					
Sr. Whole Life					
United - Medicare					
Medicaid					
Medicaid HMO's					
Other Gov't					
Total	56%	59%	60%	62%	63%
Commercial					
Blue Cross - all products					
Fallon - All Products					
Harvard - All products					
Tufts - All products					
Aetna					
Neighborhood Health					
Other PPO's					
Cigna					
Other HMO's					
Total	41%	38%	37%	35%	33%
Other					
Workers Comp					
Motor Vehicle					
Self Pay					
Total	3%	3%	3%	4%	4%
Grand Total	100%	100%	100%	100%	100%

Financial Systmes do not break out expenses by insurance carrier therfore margins can not be displayed by insurance product.
Above percentages represent utilization.