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Submitted Electronically via
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David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

September 11, 2015

Dear Mr. Seltz:

Dana-Farber Cancer Institute is committed to continue working alongside the Health Policy Commission, the Attorney General's Office, and the Center for Health Information and Analysis to further our shared goal of improving access to cost-effective health care services in the Commonwealth.

We are pleased to submit the enclosed information as a testament to our efforts to reduce costs and improve quality in the delivery of adult and pediatric cancer care and believe that our testimony reflects the unique role that Dana-Farber fulfills in the continuum of care as the state's only free-standing comprehensive cancer center.

Enclosed you will find written testimony for Dana-Farber as requested for the upcoming Annual Cost Trends Hearing in your letter dated August 6, 2015.

By my signature below, I certify that I am legally authorized and empowered to represent Dana-Farber Cancer Institute for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Anne Levine, Vice President of External Affairs, at 617-632-4433 or Anne_Levine@dfci.harvard.edu.

Sincerely,

Edward J. Benz Jr., MD
President and Chief Executive Officer

Dana-Farber Cancer Institute
2015 Pre-Filed Written Testimony
September 11, 2015

Exhibit B: HPC Questions for Written Testimony

1. **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 for growth in CY2013 and CY2014 is 3.6%.**

    a. **What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.**

Revenue:

- Payment rate adjustments from DFCI's top-3 Massachusetts commercial payors averaged approximately 2% during CY2014 and YTD CY2015.
- Medicare continues to reimburse DFCI at a rate that is below operating cost, the rate approximated 90% of cost in CY2014 and YTD CY2015.
- On an overall net basis, DFCI's charges were not increased in CY2014 and YTD CY2015.
- Imaging charges were reduced by 10% in CY2014.

Utilization:

- Volume from clinic visits grew by approximately 6% in CY2014 and 4% YTD in CY2015.

Operating Expenses:

- On a per unit basis, operating expenses decreased slightly in CY2014 and increased by approximately 3.4% YTD in CY2015 primarily due to one-time expenses related to the implementation of the enterprise-wide Epic Revenue Cycle and Clinical system.

    b. **What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?**

- Established a physician practice model through Dana-Farber Cancer Care Network (d/b/a Dana-Farber Community Cancer Care) to provide cost effective care in a community setting.
- Improved the efficiency of our care delivery through Care Model Redesign. This effort has entailed clearly defining roles and responsibilities of all individuals involved in caring for patients, both administrative and clinical, to ensure that tasks are apportioned appropriately according to a staff or faculty members license and skill set. This redesign seeks to minimize the use of more highly trained and expensive personnel to perform tasks that may be performed by less expensive resources.

- Established an adult inpatient palliative care unit to expand access to integrated palliative care services and to reduce the use of unnecessary high-cost interventions for hospitalized patients.
- Implemented a program to enhance advanced care planning and reduce unnecessary resource use by aligning care delivery with patient preferences.
- Implemented interventions to reduce the use of high-cost drugs in accordance with clinical evidence.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

- Implementing a "shared-care" model for patients undergoing stem-cell transplantation to coordinate patient care between the DFCI care team and the patient's community oncologist. The model will allow patients to receive appropriate post-transplant care in lower-cost community settings.
- Expanding the implementation of DFCI's Clinical Pathways system to standardize cancer care and remove unnecessary variability and cost in care delivery. This effort is described in greater detail in Section #7.
- Enhancing and streamlining the discharge planning process for hospitalized cancer patients to ensure appropriate post-acute care and reduce unnecessary readmissions.
- Planning and testing an Urgent Care Model to improve care transitions to the outpatient setting and reduce unnecessary ED utilization and hospital readmissions as described in Section #3.
- Despite our interest, DFCI has been notified that we are not eligible to participate in the Center for Medicare & Medicaid Innovation (CMMI) Oncology Care model (OCM), due to our status as a Prospective Payment System (PPS) exempt institution. We collaborate with local Accountable Care Organizations (ACOs) and payers as we describe in Section #6.

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

Prior Authorizations (PA) & Referrals: PAs for radiology and drugs, which are almost always approved, require significant resources that add cost to the care delivery system and offer little to no benefit. For example, it was necessary for DFCI to add 6 FTEs in FY15 to manage growing prior authorization requirements for services including drugs, imaging, and labs. A more efficient system, particularly for cancer care, would allow hospitals to obtain approval for an episode of care or treatment plan instead of requiring a PA for discrete services in addition to a referral for access to the hospital/facility. For example, on-pathway treatment plans should not require prior authorizations.

Specialty Pharmacy: Recent changes to certain health plan benefit structures require patients to obtain non-self-administered, injected or infused specialty medications through a specialty pharmacy. Impacted

medications will no longer be covered in most cases unless: (1) the patient brings the drug to his/her physician's office to be administered by a clinician (brown bagging); or (2) the specialty pharmacy delivers the product directly to a clinic for use by the specific patient (white bagging).

Because of the significant patient safety concerns associated with brown bagging and white bagging, we believe these practices should be prohibited for a subset of drugs used for the supportive care of oncology patients. We are deeply concerned that these practices put our patients at risk, compromise continuity of care, and add an undue resource burden on providers trying to manage these policies and benefit changes for cancer patients. Specific patient safety concerns include:

- The integrity of the affected prescription drugs – which have specific handling, storage, and temperature control requirements, and must be compounded prior to administration – cannot be verified in cases where a patient procures the medication on his or her own and brings it to a hospital or clinic for administration. As a result, providers are unable to confirm that the medication has not been exposed to conditions that would render it ineffective or unsafe.

- Brown bagging precludes the clinical care team from having a complete record of drugs administered to the patient, as the prescription order would be written as 'patient own medication' instead of being ordered through the pharmacy's regular distribution channels, which are linked to the patients' medical record. The record would exclude information such as the drug specific lot number and expiration dates, in addition to documentation of any potential side effects, adverse reactions, or drug recalls.

- Brown bagging policies are a cause of potential confusion for patients who may not understand where or how to procure their medication at a specialty pharmacy and are therefore at risk for missing doses or experiencing delays in medication administration.

- The medication supply provided for a patient may exceed the number of doses intended for treatment, as specialty pharmacies typically dispense a 3-month supply of patient-specific medication. This could result in a patient continuing to receive treatment when the medication has either been discontinued or the intended number of doses has been administered. This can also result in an increase in drug waste.

Reimbursement for Psychosocial, Palliative Care, & Patient Support Services: Mental health, behavioral health, palliative care and other psychosocial and practical supports provided by nurse coordinators, social workers, patient navigators, and other care team members improve quality of care and reduce unnecessary health services utilization but are not adequately reimbursed. The stress associated with the diagnosis and treatment of cancer often causes significant emotional and/or psychological distress for patients and family members, which necessitates appropriate patient and

caregiver support services. At DFCI, these services are provided through an integrated psychosocial approach, which includes individualized assessments and access to an array of support services as described in Section #5. Our staff of 18 psychiatrists and psychologists and 27 social workers provide more than 11,000 adult and pediatric mental health visits per year and do not receive sufficient reimbursements for the services provided. Increased reimbursement would allow DFCI to operate more efficiently and enhance our efforts to provide comprehensive psychosocial care for patients and family members.

Reimbursement for Telemedicine: Reimbursement for telemedicine should be encouraged, particularly for teaching hospitals that provide care for the highest acuity patients. Telemedicine improves the efficiency of care delivery by affording patients more convenient access to specialists located outside their geographic area. This service is critical for cancer patients who often undergo treatment regimens that include multiple visits for chemotherapy, radiation therapy, and follow-up care that may require a significant travel burden. Telemedicine allows patients to receive the sub-specialized expertise of DFCI clinicians in a convenient closer-to-home or community setting, which minimizes barriers to care such as transportation or mobility limitations. As a result, telemedicine has the potential to increase the efficiency of care delivery and improve the patient experience, especially for patients with chronic diseases like cancer, and we believe it should be reimbursed accordingly.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

DFCI has been a continuous source of innovation in high-quality, cost-effective cancer care and has developed a number of payment redesign projects that further our progress towards alternative payment methodologies (APM) and reward value-driven cancer care. Our efforts in this area reflect DFCI's distinctive role as the state's only freestanding comprehensive cancer center and highlight our leadership in developing unique arrangements that align with our specialized focus.

We are unable to meaningfully participate in the APMs launched by our health plan partners (as discussed in Section #6), including global budgets and risk arrangements because of our unique structure as a specialty cancer hospital. However, DFCI has pioneered a bundled payment arrangement for our hematopoietic stem cell transplant program where stem cells are reimbursed based on case rate bundles and piloted a number of projects focused on delivering high-value cancer care.

Substantial effort and resources are required to develop, implement, and manage payment pilots and projects. Without appropriate funding for the coordination and management associated with the changes in prior authorizations, billing, and patient support, the implementation of such projects can significantly increase a hospital's administrative expenses. As health plans implement strategies for cost reduction and delivery reform, we have experienced a need for increased administrative staffing to meet the growing volume of required prior authorizations and bill processing. Payor administrative policies are routinely based on the operations and functions of a general hospital, not a specialty cancer center. As a

result, the application of one-size-fits-all policies to DFCI requires both DFCI and the health plans to expend time and effort to develop necessary exceptions, appeal processes, and alternative payments.

In place of APMs, as part of our health plan performance programs, we work collaboratively with large payers in the state on many initiatives for which DFCI is at financial risk. To-date, our work has focused primarily on evaluating unnecessary use of biologic compounds (e.g., Bevacizumab (Avastin) and Cetuximab (Erbitux)), in addition to other high-cost drugs such as granulocyte colony stimulation factors (Filgrastim/ Pegfilgrastim) and intensity-modulated radiation therapy (IMRT). By leveraging evidence-based strategies to eliminate utilization of such services when not clinically indicated, we have demonstrated cost savings and improved patient care. In addition, the best-practice guidelines derived from these projects have helped to shape several health plan policies for relevant services and have contributed to reductions in system-wide costs as the guidelines are applied across payers and providers.

3. **In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.**

    a. **Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.**

Post-Acute Care: DFCI partners with a variety of post-acute providers across the continuum of care, including skilled nursing facilities, long-term acute care hospitals, and home health services to ensure that the optimal post-acute care services are available and accessible to our patients. DFCI also maintains a robust partnership with our preferred hospice provider, Care Dimensions, which works closely with our staff and patients to manage care transitions for patients entering hospice.

The care coordinators who work with our inpatients receive regular training about community-based options for post-acute care. In addition, Dana-Farber / Brigham and Women's Cancer Center (DF/BWCC) has a specially-designated liaison nurse from Care Dimensions Hospice who provides patient support and discharge planning coordination services to patients entering hospice. Care Dimensions has also recently started an "Open Access" program, which has the potential to allow DFCI patients to receive both ongoing cancer-directed care and hospice services simultaneously. We believe this program has the potential to make a significant impact in reducing the barriers our patients and clinicians face in determining appropriate care options for patients with late-stage disease, especially as treatment options for advanced disease continue to expand.

In addition, our palliative care leadership team is working with Care Dimensions and other partners to enhance home-based palliative care services in order to better meet the needs of our patients.

Reducing Avoidable-30 Day Readmissions: Our palliative care service leverages the unique expertise of its clinicians and support staff to coordinate care for our sickest patients and has demonstrated success in reducing hospital readmissions through effective discharge planning and care transition management.

DFCI's departments of Gastrointestinal Oncology and Palliative Care are currently collaborating with the state's largest health plans to pilot an intervention that aims to reduce avoidable hospitalizations and readmissions in patients with pancreatic cancer. This population is known to have a high rate of hospitalization, hospital readmission, and mortality, and there is broad recognition that home-based, symptom-directed care is optimal compared to hospital admission for recently discharged patients. This intensive pilot intervention involves daily identification of patients admitted to the hospital with a diagnosis of pancreatic cancer, coordination of post-discharge palliative care appointments, and subsequent tracking of process and outcome measures. These measures are then analyzed and discussed jointly by the Gastrointestinal Oncology and Palliative Care experts to guide rapid-cycle program changes.

Over the next year, interventions will continue to be honed with the goal of reducing unnecessary oncology-related hospital admissions. Successful interventions could potentially be applied to other oncology disease settings with the opportunity to translate reductions in hospital admissions on a much broader level.

Reducing Avoidable ED Use: Emergency Departments in the United States are often the site of disease management for cancer patients, typically as a consequence of the side effects of toxic cancer therapies and/or a complication of the patient's disease. Tackling this issue is crucial to improve the quality of care for our patients and to reduce unnecessary health care expenditures.

This year, DFCI has partnered with several of the largest Massachusetts health plans to analyze our patient population's overall ED utilization across all providers/emergency facilities within the state. In the absence of this type of data sharing arrangement with our health plan partners, ED use is often unknown to providers. The data yielded thus far have allowed us to identify patterns in the types of patients who are utilizing ED services and the most common reasons our patients seek emergency care. These findings will inform future clinical and outcome-based, data-driven interventions. This project will continue next year as we develop our understanding of the patterns and define ED avoidability. Ultimately, our goal is to reduce overall ED utilization among our patient population by a certain margin. In addition, we are in the process of identifying risk factors that could preemptively flag and enroll high-risk patients, (for example, patients receiving end-of-life care), into care management programs in order to avoid the unnecessary use of hospital and ED services.

Further, as noted in Section #1, we are piloting an Urgent Care Model, which is designed to address the fact that cancer patients, by virtue of their diseases, can develop symptoms or urgent clinical issues that warrant prompt evaluation and treatment. Statistics show that when cancer patients are seen in an emergency room, they are more likely to be admitted for further evaluation and treatment if they are seen by medical personnel unfamiliar with their diseases, treatments or individual medical issues. A

pilot study is ongoing to determine if staffing an emergency room with an oncologist on-call can avoid unnecessary admissions. As an extension of this study, we are planning to develop an outpatient, urgent care setting to allow DFCI patients to be seen by members of their care team on an urgent basis during regular clinic hours to prevent the need for both unnecessary emergency room visits and to decrease unnecessary hospitalizations.

Managing high-risk/high-cost patients: People with cancer are often categorized as high-risk patients given the high cost of oncology services (including cancer therapies, diagnostic tests and hospitalizations and ED visits). Since treatment costs are primary drivers of a patient's total health care costs, DFCI has advanced several initiatives to support our providers in the judicious use of high-cost therapies, such as biologics and new chemotherapeutic agents. For example, DFCI has developed and implemented our own clinical pathways system known as DFCI Clinical Pathways. This system allows our medical and radiation oncologists to rapidly update clinical best practice with the latest discoveries and streamline patterns of care to reduce unwarranted variation and better manage the use of high-cost agents. These capabilities are critical as advancements in molecular pathology and other new technologies continue to evolve rapidly and shape the way cancer is treated.

In addition, DFCI is working with all 12 of our disease centers to manage utilization of supportive therapies like antiemetics, and diagnostic tests such as imaging and molecular pathology, that contribute substantially to the cost of treating cancer. Efforts include increasing awareness of current utilization of high-cost services, disseminating information about the costs of these services, and fostering discussion about best practices.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

Each of the pilots and projects described in Section #3(a), which focus on post-acute care, reducing avoidable readmissions and ED use, and managing high-risk patients are ongoing and will continue as priorities throughout the next 12 months. As noted above, our goal with several of these projects is to set a target to reduce avoidable utilization and/or to expand goal-oriented interventions to other oncology disease settings in future years.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.

a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

Hospitals represent a significant portion of overall health care costs because of the nature of the services we provide and the missions we fulfill, which include caring for complex patients and diseases; training the next generation of physicians, nurses, and allied health professionals; identifying and implementing new treatments and cures; and contributing substantially to the health and well-being of our surrounding communities. There are many legitimate and desirable reasons for price variations such as the availability of multidisciplinary care, the ability to treat rare, complex, and orphan diseases, and the utilization of innovative technologies that improve care delivery and patient outcomes. For example, the use of molecular diagnostics constitutes a state-of-the-art technology that may have a measurable impact on patient care and outcomes, but is expensive to implement and offer.

Teaching hospitals, for example, treat the highest acuity patients, provide highly specialized services that are a community resource, and must absorb the unreimbursed cost of medical education. Price variation resulting from these mission-driven activities and specialized services are legitimate and allow teaching hospitals to sustain their mission and service to patients and surrounding communities.

The reports referenced above that highlight differences in provider price variation may also present a misleading picture of how DFCI's prices compare to other providers, as some editions of these annual reports do not account for DFCI's unique cost structure and status as a specialty hospital. For example:

- DFCI is one of only eleven free-standing NCI-designated comprehensive cancer centers in the country and should not be compared to all other acute care hospitals in the Commonwealth. DFCI's uniqueness is recognized by Medicare, which exempts DFCI from the Medicare Prospective Payment System, and by the major payers in Massachusetts, who negotiate non-standard payment contracts with DFCI that reflect our specialized services and structure.

- DFCI physicians are employed by DFCI and are paid salaries, as opposed to other hospitals where most physicians bill separately on a fee-for-service basis. The charges and net revenues reported to CHIA by the payers with regard to DFCI are global payments which include physician fees. For other hospitals, those fees would be reported separately in the Physician Group Relative Price Analysis also issued by CHIA. Including physician fees in DFCI's global payments significantly increases these figures and makes comparisons of payments between and among hospitals misleading.

- DFCI provides a majority of care in the outpatient setting. Information on hospital payments is often reported with the assumption that all hospitals have the same split between inpatient and outpatient services, which is typically around 45% of payments for inpatient and 55% for outpatient. With only 30 inpatient beds, DFCI experienced a ratio of 5% inpatient payments to 95% outpatient in YTD FY2015. Using an incorrect assumption of our split between inpatient

and outpatient services skews the estimate of DFCI's costs substantially. Further, DFCI's inpatient business is atypical because DFCI does not have a surgical service – adult cancer surgery is performed at the Brigham and Women's Hospital and pediatric cancer surgery is performed at Boston Children's Hospital – which makes our reported inpatient data further misleading compared to other hospitals.

- Some reports assume that all hospitals have the same mix of services (clinic, imaging, pharmacy, radiation therapy, emergency room, etc.). DFCI's service mix is distinctly different from a typical hospital because of our specialized focus on cancer and the much higher use of certain services such as radiation therapy and chemotherapy. Over 50% of DFCI's total patient care costs are attributed to pharmacy (YTD FY2015). This mix of services and disproportionately high pharmacy cost is unique to DFCI, making comparisons of relative price across hospitals misleading.

- In addition to our higher utilization of pharmacy and related services, DFCI has one of the highest case mix index scores compared to other providers in Massachusetts. The case mix reflects an acute care hospital's patient population according to criteria approved by EOHHS including common diagnoses and procedures and illness severity.

- DF/BWCC (Dana-Farber / Brigham and Women's Cancer Center) is one of the very few programs in Massachusetts to perform bone marrow transplants and performs the most transplants by far in the state. Bone marrow transplants cost well over $100,000 per procedure and are usually reimbursed under different contracts than other inpatient activity. The inclusion of transplants in provider price variation reports skews DFCI's reported prices significantly because DFCI performs a disproportionately high number of these costly procedures compared to other hospitals.

We are pleased to have worked successfully with CHIA in recent years to address how DFCI's activities and prices are reflected in public reporting but believe it is important to acknowledge that earlier reports referenced above may not provide an accurate portrait of our relative price.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

As discussed in Section #7(a), price variation may result from legitimate and desirable factors. When institutions leverage these differentiating factors, such as specialized expertise, tertiary level care capacity, innovative therapies, and comprehensive patient support services, the result may be lower overall costs for an episode of care. While prices on a per unit basis may be higher in some cases, this

variation does not account for the overall cost of caring for patients throughout the course of their illness.

For example, failure to establish the correct diagnosis can result in initiating the wrong treatment, leading to poor outcomes and greatly increasing the overall cost of care for a patient. In a 2011 study,[1] formal analysis of pathologic material obtained at outside institutions and reviewed at the Brigham and Women's Hospital identified frequent serious misdiagnoses at the outside institutions. Among 335 sarcoma cases, the DF/BWCC diagnosis varied from the outside institution in 24% of cases. In 16% of these cases, discordance was clinically significant such that the correct diagnosis would have led to a different treatment approach. In this way, when complex diseases like sarcoma are not managed in an appropriate setting with specialized expertise, misdiagnoses and other inefficiencies in care can occur and may result in worse outcomes and a higher overall cost of care.

The impact of price variation on lower cost or community providers is difficult to fully understand and quantify. DFCI's care model emphasizes that the right care should be provided in the right place, at the right time. Ninety-five percent of care at DFCI is provided in the outpatient setting and nearly one-third of the care we provide is delivered at our hospital satellite facilities, which are located in convenient community settings associated with less costly support services. We offer patient care in our hospital satellites and physician practice locations when treatment can be safely and appropriately managed in a community setting. When a patient's condition or disease requires a higher level of care, treatment is managed at our Longwood facility to optimize outcomes including quality of life and survival. We recognize the importance of treating patients in the most appropriate setting as well as our responsibility to provide high-value, high-quality, cost-effective cancer care, and we are committed to continuing our work with community partners to meet these shared aims.

5. **The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.**

    a. **Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.**

Integration of Physical and Behavioral Health Care Services: As a result of our specialized focus, DFCI is well-positioned to integrate the care of our patients' behavioral, oncologic, palliative care, and practical needs in a seamless program. Our behavioral and palliative care clinicians are embedded on the

[1] Raut et al. Connective Tissue Oncology Society presentation, Chicago, 2011

oncology floors and function as an interdisciplinary team in collaboration with oncologists and oncology nurses. DFCI maintains a comprehensive team of social workers, psychologists, psychiatrists, and resource specialists who provide holistic, patient-centered care, with a particular focus on high-needs patients, including those who may have co-morbid behavioral health conditions.

Mental health clinicians work closely with our palliative care clinicians through an integrated approach to address the needs of our sickest patients and their families. Mental health treatment is provided to patients in collaboration with pediatric and adult oncology teams through an integrated psychosocial approach, which includes individualized assessments and access to an array of support services. The broad range of treatment and support services available to our patients include psychotherapy, psychopharmacology, and support groups, in addition to specialized support services for sexual health, menopausal symptoms, bereavement, survivorship, and cognitive dysfunction, among others. In our cost-conscious model, social workers provide the majority of mental health care because they are highly competent and less costly.

Patients who have completed active cancer treatment but are in need of ongoing mental health treatment or services are referred to community providers.

Avoiding Unnecessary Utilization of ED and Psychiatric Inpatient Care: As discussed above, mental health treatment is integrated into DFCI's care model. Patients may access mental health services by referral from oncology clinicians and/or by self-referral. We provide timely access to behavioral or mental health services as needed to prevent escalation of symptoms. This includes an urgent referral system by which social workers are contacted for immediate assessment and intervention to triage issues and coordinate the involvement of other care team members as needed. Our clinicians are accessible and can intervene proactively around psychosocial issues that may interfere with medical decision-making, adherence to treatment, coping and quality of life. Social workers evaluate high-risk patients receiving complex treatments such as bone marrow transplant; pediatric patients are evaluated by mental health clinicians based on need; and psychiatrists, psychologists and social workers are embedded on each of our 12 disease center floors.

DFCI is piloting other tools to identify and intervene in cases where a patient is experiencing emotional distress, such as anxiety or depression. For example, The Young Adult Program at DFCI has begun testing of a communication tool for their patients with cancer who are particularly vulnerable to emotional distress due to the life disruptions of illness.

In addition, DFCI partners with a variety of post-acute providers across the continuum of care, including skilled nursing facilities, long-term acute care hospitals, and home health services to help reduce unnecessary readmissions and ED utilization, as discussed in Section #3.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to

these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

Each of the initiatives and services described in Section #5(a) are ongoing and will continue as priorities throughout the next 12 months.

In addition, we are developing a new collaboration with Boston Children's Hospital Inpatient Social Work service to streamline communication with other areas of Boston Children's (general and surgical floors, ICU, ED) that care for our patients during the acutely distressing pre- and peri-diagnostic time period. This collaboration is also intended to address the psychosocial determinants of extended inpatient stays and re-admission.

6. **The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?**

PCMH: While DFCI does not provide primary care services, we have been exploring and piloting oncology-based PCMH models that focus on referral management and care coordination between oncologists, primary care providers, and other specialists on a patient's care team.

In 2013, Commonwealth Hematology Oncology (CHO), acquired in 2014 by DFCI and now operating as Dana-Farber Cancer Care Network, d/b/a Dana-Farber Community Cancer Care (DFCCC), submitted an application to the National Committee for Quality Assurance (NCQA) as an early adopter of the Patient Centered Specialty Practice (PCSP), recognition program, which recognizes practices that demonstrate patient-centered care and clinical quality.

The objectives of NCQA's recognition program are to: enhance coordination between primary care and specialty care; strengthen relationships between primary care and clinicians outside the primary care specialties; improve the experience of patients accessing specialty care; align requirements with processes demonstrated to improve quality and eliminate waste; use clinical performance measurement and results to demonstrate improvement; identify requirements appropriate for various specialty practices seeking recognition for excellent care integration with the medical home; and align with the Centers for Medicare & Medicaid Services (CMS) proposed measures of Meaningful Use.

CHO was one of only two Massachusetts practices to seek this designation as an early adopter. In June 2015, DFCCC was awarded the NCQA PCSP recognition, for a standard three-year term. We believe that our PCSP model's emphasis on clinical management throughout the cancer experience provides the greatest opportunity to improve patient outcomes and enhance the quality and value of care.

DFCCC captures patient satisfaction data using the Press Ganey Outpatient Oncology survey instrument, which is a validated patient satisfaction tool used by more than 150 oncology practices across the country. The survey measures patient experience, satisfaction with the practice, physician communication, clinical and administrative staff, waiting time, timely access to care, and health care services provided. In addition, DFCCC continues to partner with Harvard Pilgrim Health Care (HPHC) on a pilot program launched in July 2012, which focuses on value-based initiatives, such as measuring treatment adherence for specific cancers; education and compliance tracking for oral chemotherapy; ongoing analysis of pharmacy costs and utilization; and establishment of a relationship with behavioral health providers to promote integration.

ACOS: As a sub-specialized comprehensive oncology provider, DFCI is not structured to provide medically necessary services across the continuum of care outside of oncology. Our single disease focus prevents us from having access to meaningful metrics to capture and reflect value across the continuum; risk adjustment models to compare populations; and complete administrative data across the continuum of care. These data and metric constraints preclude us from participation in most Alternative Payment Methodologies (APMs) and pose challenges to obtaining timely, reliable, and actionable data needed to inform the population health management approach required for an ACO.

However, DFCI is committed to taking a more active role in managing oncology patients across the continuum of care and achieving the gains associated with sharing care among specialists, community oncologists, and primary care providers. To meet this goal, we have made significant progress in developing partnerships with payers and ACOs to leverage the data-sharing capabilities needed to implement timely interventions, improve patient care, and be accountable for patients' overall care and well-being.

DFCI has developed data-sharing pilots in partnership with several health plans to improve care management and coordination. Areas of study include end-of-life care, oral chemotherapy adherence, and potentially avoidable hospitalizations and emergency department visits, as discussed in Section #3. For example, DFCI has partnered with our patients' health plans to send real-time chemotherapy treatment plans to their nurse care coordinators who use the information to flag individuals beginning a treatment regimen who may be at risk for side-effects or complications. This partnership allows the nurse care coordinators to proactively coordinate services/interventions the patient may require as a result of the prescribed treatment. In addition, we are actively sharing data with one of our referring ACOs to track patients up to 2 years post-active therapy in order to monitor outcomes and early signs of relapse or disease progression. These pilot programs reflect our commitment to leverage data-sharing partnerships in order to improve patient care and reduce the need for high-cost interventions.

As ACOs continue to evolve, one of our key priorities is to ensure that patients who could benefit from our sub-specialized care, clinical trials, and differentiated expertise in treating rare and complex cancers can access services at DFCI. The growth of risk sharing arrangements where ACOs are accountable for the cost of care means that providers may face a disincentive to refer out-of-network to a comprehensive cancer center in an effort to control costs – even when such care may give a patient the best opportunity

to maximize quality of life and survival. It is critical for ACOs to ensure that the services of a comprehensive cancer center are accessible within the ACO network. Patients should not face barriers to accessing medically necessary cancer care. We believe strongly that ACOs ought to be designed to promote, and not impede, affordable access to appropriate cancer care services for all patients.

7. **Since 2014, Dana-Farber Cancer Institute (DFCI) has completed a number of material changes, including entering into clinical affiliations with Steward's St. Elizabeth's and Holy Family Hospitals and acquiring a physician practice, Commonwealth Hematology and Oncology (CHO). Since its acquisition of CHO, DFCI has transitioned some oncology care to physician practice locations, including at Steward Holy Family Hospital. Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.**

    a. **How have costs (e.g., prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes?**

On July 1, 2014, DFCI acquired the assets of Commonwealth Hematology and Oncology (CHO) to continue operating the physician practice under the DFCI umbrella with the overall goal of expanding DFCI's ability to provide cost-effective medical oncology and hematology care in the community setting.

In addition, DFCI entered into clinical affiliations with Steward St. Elizabeth's Medical Center on June 24, 2014, and with Holy Family Hospital on June 1, 2015. The purpose of these new affiliations is to increase patient access to high-quality oncology care in more convenient, cost-effective, integrated community settings.

The transactions identified above have all taken place within approximately the last year. Therefore, we have limited data to inform a comprehensive understanding of their impacts. However, we are able to comment on observations relevant to cost, quality, and access during this limited time period.

Charges: Overall, DFCI's charges did not increase in CY2014 or YTD CY2015 across our hospital satellites and Longwood facility. Our CY2016 budget also assumes no charge increases.

Referral patterns: There has not been sufficient time elapsed since the beginning of these new relationships to quantify any potential changes in referral patterns. In addition, there is no comprehensive, reliable data on referral patterns or outpatient market share that would allow us to evaluate potential post-transaction changes in referral patterns. However, we are working to the best of our ability to understand any changes or impacts to referral patterns that may exist as a result of these new relationships/affiliations.

Quality: DFCI has implemented a rigorous quality and safety program which ensures that care delivered across the DFCI network is safe, consistent, equitable, and high-quality. As is the case with all of our

sites, our practices at DFCCC, including the new practice at Holy Family, and St. Elizabeth's satellite gained access to quality resources and innovations of the DFCI Longwood campus, including:

- Expert assessment of technical clinical quality, process efficiencies, and safety (e.g., infection control practices).

- Satellites and physician practices are integrated into the DFCI safety event/near-miss reporting system, which includes data analysis, multidisciplinary committee review, expert investigation of safety events, and dissemination of learning and best practices.

- DFCI leadership participates in executive patient safety rounds to evaluate safety and quality concerns and work with front-line staff in developing solutions.

- Quality assessment and improvement metrics are used and shared across sites to benchmark performance. Clinicians from each DFCI site convene quarterly to review this data, share best practices, and identify opportunities for improvement using a quality improvement framework.

In addition, DFCI has prioritized safety and compliance for patients receiving oral chemotherapy for all sites. For example, DFCCC launched their Oral Oncology Medication Adherence (OOMA) program in 2014. The program involves monitoring the adherence to oral chemotherapy agents and non-chemotherapy oral agents used for hormonal treatment of breast cancer and counseling patients regarding treatment side effects through a telephone support model. As of April 2015, DFCCC has enrolled more than 300 patients in the OOMA program and completed nearly 600 support calls to patients.

Further, DFCI provides support for sites and practices to participate in the Quality Oncology Practice Initiative (QOPI), which is a national benchmarking and quality improvement program. Through participation in the QOPI program, both DFCI and DFCCC are able to share and compare validated oncology care quality metrics. The QOPI certifications held by both DFCI and DFCCC indicate that they deliver the highest level of quality oncology care.

Finally, as mentioned in Section #6, DFCCC recently obtained a designation as a Patient Centered Specialty Practice by the NCQA. As part of this process, structural changes were implemented in 2014 to enhance communication with other clinicians involved in the care of people with cancer. These initiatives include sending follow-up letters to referring clinicians after an oncology visit (5,280 sent to-date) and implementation of an assessment tool to monitor timeliness and completeness of DFCCC's interactions with the referring provider and/or the patient's PCP. We believe these efforts and initiatives promote quality care and improve the experience of our patients.

Access to Care: As noted above, we are not currently able to quantify access to care given the limited time period during which these new relationships have been active and the difficulty in obtaining this

type of data. However, we are able to provide some information about the number of patients who have been treated through our new locations at St. Elizabeth's and DFCCC:

Since the opening of our new hospital satellite at St. Elizabeth's, approximately 600 patients have been seen at this location. An average of 50 new patients were seen per month since the site opened.

Since the establishment of DFCCC, approximately 4000 patients have been seen at the DFCCC physician practice sites. An average of 354 unique patients were seen per month since the practice began operating as DFCCC.

We believe this preliminary data reflects a positive shift in moving certain care to community settings, which is more convenient and accessible to patients.

b. DFCI stated that the CHO acquisition was "an important step in developing and expanding its compassionate cancer care model in a lower cost, physician practice model, community setting," the goal of which was to "provide high-quality oncology care in a convenient community location...." DFCI also indicated it anticipated that the clinical affiliations with both Steward St. Elizabeth's and Steward Holy family would "increase the coordination of oncology care between community providers and specialists, and enable patients to access such care in their local community." To what extent have these transactions resulted in more patients receiving such care in their local community?

Providing High-Quality Care in the Community:

The DFCI Clinical Pathways Program is a key part of our quality strategy that allows us to extend our value-based cancer care model throughout our network and into the community by promoting adherence to standardized care pathways. Clinical pathways are integrated care maps that improve quality by reducing variation in clinical decision making based on cancer diagnosis, line of therapy, patient demographics, and treatment site. This consensus driven, evidence-based approach supports the standardization of care, enables knowledge sharing, and permits the systematic management of our cancer patient population across our network of hospital satellites and physician practices. While the system fosters consistency in care delivery, it is also sufficiently flexible to allow clinicians to manage clinical nuances and provide personalized medicine to each patient.

DFCI Longwood campus provides structured support in local implementation of the pathways and routine feedback to clinicians. When fully implemented, sites will be able to review site-specific quality improvement data and metrics such as adherence to disease specific pathways, reasons for not choosing a pathway, and detailed clinical population characteristics for patients treated at their facility. As DFCI continues to grow and expand our Pathways program, all DFCI network sites will be engaged in the

development and maintenance of pathways. The program provides a powerful tool for clinical collaboration and standardization of clinical care across multiple geographic locations.

Steward:

As noted above, the goal of DFCI's clinical affiliation with Steward in establishing a medical oncology hospital satellite unit at St. Elizabeth's Medical Center is to increase patient access to cost-effective, high-quality oncology care in a community setting. The clinical affiliation allows for seamless transitions of care to and from local tertiary and quaternary settings where such care is in the best interests of the patient and is medically appropriate.

In addition, the recent establishment of a physician practice location at Steward Holy Family Hospital will permit DFCI and Steward to better achieve the goals of our affiliation as stated above and to offer patients convenient access to high-quality care in a local community physician practice setting. Our affiliation with Steward is a key component of DFCI's integrated community care model and reflects our commitment to delivering the best care possible at the right time and in the most appropriate setting.

As noted above, we have limited data to inform a comprehensive understanding of the potential impacts of these new relationships due to insufficient time and challenges obtaining this type of information. While we are working to the best of our ability to understand any changes or impacts that may exist, preliminary data is very positive and suggests shifts in certain appropriate care to community settings.

Dana-Farber Community Cancer Care (DFCCC):

As noted above, DFCI views the acquisition of CHO and creation of DFCCC as an important step in developing and expanding our compassionate cancer care model in a lower cost, physician practice model, community setting. The goal of this initiative is to provide high-quality oncology care in a convenient community location, while providing patients seen in those locations access to the hospital-based tertiary and quaternary services of DFCI when appropriate, including genomic testing, clinical trials, and other forms of subspecialty care. This model allows DFCI to more fully meet our commitment to provide the right care at the most appropriate location for patients' clinical needs.

Given that the DFCCC model is relatively new, and this is the first instance of DFCI providing clinical services in Massachusetts outside of a licensed hospital setting, we are continuing to fine-tune how we measure and improve care delivery in physician practice settings. While the data is not yet fully mature, we believe that combining DFCI's clinical research enterprise and subspecialty expertise with CHO's expertise in providing community oncology/hematology care and strong history serving the Eastern Massachusetts community is bringing meaningful benefit to patients.

Further, based on preliminary data, we are experiencing positive shifts in care to the DFCCC community practice sites including increases in patient exams and infusions compared to last year.

Exhibit C: Instructions and AGO Questions for Written Testimony

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

1. **Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.**

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	17		14	Bone marrow biopsy Chemotherapy and/or medication treatment CT scan Lab Mammogram MRI Physician consult / 2nd opinion Radiation therapy
	Q2	16		12	Chemotherapy and/or medication treatment Lab Mammography MRI Pathology Physician consult / 2nd opinion Standard of care services while on a clinical trial
	Q3	14		10	Chemotherapy and/or medication treatment Physician consult / 2nd opinion Radiation therapy
	Q4	23		19	Chemotherapy and/or medication treatment Lab

					Nutrition Pathology Physician consult / 2nd opinion
CY2015	Q1	19		17	Chemotherapy and/or medication treatment Lab Pathology Physician consult / 2nd opinion Standard of care services while on a clinical trial
	Q2	35		33	Chemotherapy or medication treatment CT scan Lab PET scan Physician consult / 2nd opinion

The table above summarizes the patient requested price estimates by quarter. For CY2014 and the first half of CY2015, there were a total of 124 inquiries which resulted in 105 completed estimates. During this time, there were 19 cases, or approximately 1 case per month, where a patient or potential patient (requester) inquired about an estimate and the estimate was not provided. In each of these cases, the Financial Counselor followed-up with the requester to collect the information necessary to complete the request and learned that the estimate was no longer needed. Reasons include that the requester had already sought care at another facility and no longer wanted an estimate; or the requester actually had questions about their insurance coverage for services and was ultimately not interested in receiving an estimate.

Please note, our website will direct anyone who has a price estimate request to contact a Financial Counselor by telephone and provides the telephone number.

2. **Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.**

   Please see attached document AGO Hospital Exhibit 1.

Exhibit 1 AGO Questions to Hospitals

NOTES:

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

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	144,658,487		2,350,765												
Tufts Health Plan	29,662,691		-												
Harvard Pilgrim Health Care	64,300,793		-												
Fallon Community Health Plan											12,097,524				
CIGNA											11,320,849				
United Healthcare											22,404,351				
Aetna											19,790,402				
Other Commercial											3,975,900				
Total Commercial	238,621,971		2,350,765								69,589,026		-		
Network Health											4,522,917				
Neighborhood Health Plan											13,254,886				
BMC HealthNet, Inc.											1,670,025				
Health New England											576,752				
Fallon Community Health Plan											205,726				
Other Managed Medicaid											2,206,932				
Total Managed Medicaid	-		-								22,437,237		-		
MassHealth											15,605,345				
Tufts Medicare Preferred											7,973,503				
Blue Cross Senior Options											1,669,424				
Other Comm Medicare											5,099,474				
Commercial Medicare Subtotal	-		-								14,742,401		-		
Medicare													110,723,707		
Other											58,161,105				
GRAND TOTAL	238,621,971		2,350,765								180,535,114		110,723,707		

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	139,435,089		2,698,746												
Tufts Health Plan	33,268,427		1,140,387												
Harvard Pilgrim Health Care	72,746,370		1,058,120												
Fallon Community Health Plan											11,564,867				
CIGNA											11,238,206				
United Healthcare											26,185,975				
Aetna											24,377,375				
Other Commercial											2,470,176				
Total Commercial	245,449,885		4,897,253								75,836,598		-		
Network Health											4,845,568				
Neighborhood Health Plan											15,420,383				
BMC HealthNet, Inc.											1,244,687				
Health New England											1,116,529				
Fallon Community Health Plan											108,178				
Other Managed Medicaid											2,504,900				
Total Managed Medicaid	-		-								25,240,245		-		
MassHealth											17,782,008				
Tufts Medicare Preferred											8,833,258				
Blue Cross Senior Options											2,196,319				
Other Comm Medicare											6,886,113				
Commercial Medicare Subtotal	-		-								17,915,689		-		
Medicare													132,720,478		
Other											66,595,457				
GRAND TOTAL	245,449,885		4,897,253								203,369,998		132,720,478		

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	135,979,546		2,620,297												
Tufts Health Plan	40,176,243		985,124												
Harvard Pilgrim Health Care	79,774,516		1,171,075												
Fallon Community Health Plan											14,063,729				
CIGNA											8,192,369				
United Healthcare											26,819,928				
Aetna											23,996,470				
Other Commercial											2,414,460				
Total Commercial	255,930,305		4,776,496								75,486,956		-		
Network Health											5,396,025				
Neighborhood Health Plan											19,198,149				
BMC HealthNet, Inc.											941,056				
Health New England											1,266,597				
Fallon Community Health Plan											306,508				
Other Managed Medicaid											1,282,214				
Total Managed Medicaid	-		-								28,390,549		-		
MassHealth											13,869,577				
Tufts Medicare Preferred											11,163,318				
Blue Cross Senior Options											4,037,070				
Other Comm Medicare											7,907,746				
Commercial Medicare Subtotal	-		-								23,108,134		-		
Medicare													144,875,875		
Other											63,055,524				
GRAND TOTAL	255,930,305		4,776,496								203,910,739		144,875,875		

2014

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	143,972,021		2,816,695												
Tufts Health Plan	42,114,413		1,209,361												
Harvard Pilgrim Health Care	83,632,764		2,686,472												
Fallon Community Health Plan											11,565,322				
CIGNA											11,802,452				
United Healthcare											25,305,872				
Aetna											25,787,878				
Other Commercial											3,060,836				
Total Commercial	269,719,198		6,712,528								77,522,360		-		
Network Health											3,861,959				
Neighborhood Health Plan											28,850,897				
BMC HealthNet, Inc.											702,055				
Health New England											1,228,491				
Fallon Community Health Plan											54,336				
Other Managed Medicaid											1,119,365				
Total Managed Medicaid	-		-								35,817,104		-		
MassHealth											16,124,919				
Tufts Medicare Preferred											11,556,932				
Blue Cross Senior Options											4,176,214				
Other Comm Medicare											9,875,174				
Commercial Medicare Subtotal	-		-								25,608,320		-		
Medicare													149,405,480		
Other											60,251,524				
GRAND TOTAL	269,719,198		6,712,528								215,324,227		149,405,480		