The principal teaching hospital for Tufts University School of Medicine

Tufts Medical Center

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September 19, 2016

VIA ELECTRONIC MAIL

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109
HPC-Testimony@state.ma.us

RE: Request for Written Testimony

Dear Mr. Seltz:

Please find attached Tufts Medical Center response to the request for written testimony submitted by the Health Policy Commission and the Office of Attorney General.

I am legally authorized by the Tufts Medical Center Board to represent Tufts Medical Center in this matter. I am informed and believe, and upon such information and belief declare under penalty of perjury, that the statements made herein are true and correct.

Sincerely,

Michael Wagner, MD
President and Chief Executive Officer

Encl. Exhibit B and C responses

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

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

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

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

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

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

1. **Strategies to Address Health Care Cost Growth.**
   Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
   a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Tufts Medical Center and Floating Hospital for Children remain one of the lowest cost providers among our Academic Medical Center peers. We continue to believe moving from volume to value is a trend the market should pursue rigorously, however the lack of a curtailing of prices and volume at the highest cost providers will prohibit the state from achieving meaningful cost savings in healthcare.
The ability of high priced providers to acquire physician groups throughout communities and in surrounding states continues to drive inpatient and outpatient volume to the highest cost providers, enhances their market and bargaining clout and exacerbates the cost problem.

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

The state should pursue increased transparency measures to understand the actions driving inpatient and outpatient volume to the highest cost providers, including a better understanding of referral incentives and risk arrangements within alternative payment arrangements. While Total Medical Expense has become an important measure of price and utilization, the current measure does not adequately capture the true picture. As the PPO sector grow continues to grow the state should consider revisiting what TME captures make certain it adequately represents the marketplace.

Tufts MC continues to believe that uniform application of the healthcare cost benchmark across all providers is not accurately portraying the trends in the healthcare or the drivers of cost increases or decreases for any particular provider. In its current form the benchmark is being used as a tool to further entrench the current healthcare pricing disparities. Tufts MC urges the HPC to revise the cost benchmark and consider application of the benchmark at a more stringent level for those providers with relative prices significantly higher than the relative price of their peer group and application of a higher benchmark for providers with a significantly lower relative price.

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

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.
    i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

    Currently Implementing

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

    Currently Implementing

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

    Currently Implementing

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

    Currently Implementing

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

    Currently Implementing

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

    Does NOT Plan to Implement in the Next 12 Months

    i. Other: Tufts MC utilizes an internal Pharmacy and Therapeutics Committee, a medical staff committee, to set the hospital's Formulary and oversee medication use policies and approve protocols and guidelines for prescribing.
    ii. Other: Insert Text Here
    iii. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

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

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

Tufts Medical Center has a strong commitment to behavioral health and to treating a broad spectrum of patients' behavioral health need a hospital and community clinic setting. Within the Medical Center we have a 20 bed secure inpatient unit for adult patients, many of whom have complex medical and psychiatric illness including substance use, and in the community the South Boston Behavioral Health Clinic provides services to adults and Youth with serious emotional disturbance, adults with serious mental illness, and persons with mental health and substance abuse disorders

We continue to support the integration of care between the Department of Psychiatry and the Primary Care practice for our outpatients, including all specialties that refer their patients the Department of Psychiatry. The Department of Psychiatry has regular consultations with physicians who are members of the Primary Care practice and New England Quality Care Alliance. The Department of Psychiatry is diligent in its efforts to include the primary care physician of our patients who do not receive their primary medical care at Tufts Medical Center. We also participate in the Massachusetts Child Psychiatry Access Project, which enables a child's doctor to access information and resources regarding mental health issues and treatment.

Tufts Medical Center's Department of Psychiatry has a highly qualified Consult Service which is utilized throughout the Medical Center to address patients in other departments who may seem to be having psychiatric emergencies, or to help address the needs of complex, comorbid, high-risk patients.

Within our primary care practice we have increased the presence of clinical social workers supporting our physicians to screen and address the behavioral health needs of our patients, we have also increased the community resource assistance provided to our primary care patients.

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

As we have stated in the past, the biggest barrier to the integration of services is the lack of services in the communities where our patients live, and the absence of payment mechanisms for telephonic consultation and case management. Specialty services continue to close due to lack of funding which leaves inpatient units and general clinics challenged in trying to care best for special populations.

In order to truly integrate care we must align the information and incentives across the system, which is particularly misaligned within the current BH construct. The state could assist behavioral health integration in several areas:

- Creating standards for data collection and sharing, transparent metrics around quality, utilization and costs
- Supporting and easing access to additional BH services

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

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

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

Tufts Medical Center and Floating Hospital for Children serve a highly diverse population, from geography, race, ethnicity, language and socio economic status. A majority of our patients are Medicare and Medicaid patients, many of whom face a myriad of complex challenges beyond their healthcare needs. The core values of our organization are to provide the highest quality of care to all of our patients and ensure that we treat all patients and families as we would want our own family members taken care of. This means thinking about the whole patient and determining what their needs may be beyond what can be provided by a care team within the hospital.

A part of this drive is captured in our desire to ensure equity of care for all patients. We rigorously capture and analyze our patient and quality data to understand our patient base and make certain that the highest quality is delivered uniformly to all patients, and assure that difference do not exist based on race, ethnicity, gender or socioeconomic status. To do deliver on this, hospital registration staff routinely and consistently collect information on the race and ethnicity for all patients at the point of registration. We have an external, third party report to us on our quality data segmented by race, ethnicity and language, searching for

differences between the care we give in certain abstracted measures (ED wait time, surgical care, stroke care, and VTE care) across gender, race, and SES. We have consistently found that no significant differences exist.

We also deploy dedicated case management and social work staff to work collaboratively with our care teams and in the transition to other care providers. Our clinical social workers collaborate with case management, the care team and community agencies, serving as advocates for patients and families in order to achieve the outcome of optimal health and well-being for patients.

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

We will echo what has been stated by our physician network, New England Quality Care Alliance, that one of the barriers to understanding, and addressing a patients' social needs is the lack of ability to retain that information throughout and across the continuum of care and support services. This also often leaves a gap in population health approaches. The lack of resources to provide additional social services support and the lack of a formalized connectivity and information sharing with community support services are also significant barriers to addressing the social determinants of health for patients.

5. Strategies to Encourage High-Value Referrals.

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

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

Tufts Medical Center has been a high quality, high value referral provider for many years. Our distributed academic medical center model has driven referral relationships with providers that have demonstrated outstanding results in care delivery, cost savings and in keeping as much care local as possible.
As the academic medical center partner of Wellforce, a collective of value-driven healthcare providers, we continue to strengthen our role as the high value provider, often exporting clinical teams to enhance the level of care that can be provided in the community setting.

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

No

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

ii. If no, why not?
38T

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

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

ii. If no, why not?
38T

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

Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

Type of Interface	Available Clinical Information	Description of Functionality	Status
Portal	Discharge Summaries CCDAs Outpatient Clinic Notes Oncology Notes ED Notes Operative Notes Lab Results	External physicians subscribed to this portal can use this portal to view patient clinical information and download as needed.	Available
Portal	Outpatient Clinic Notes Community Provider Notes Lab Results	Physicians in the NEQCA network can use this portal to view patient clinical information and download as needed.	Available
Direct Messaging	CCDs General direct messages	Physicians in the NEQCA network can send and receive direct messages from the eCW EMR.	Available
Direct Messaging	CCDAs General direct messages	Clinicians can send and receive direct messages from the Soarian EMR.	In development
Mass HIway	CCDAs CCDs	Clinicians who are connected to the Mass HIway can send and receive patient clinical information with Tufts MC.	Available to other providers upon request; Currently implemented with BPHC and Network Health

ii. If no, why not?

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

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

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

As a high quality, value provider Tufts MC and Floating Hospital for Children are dedicated to the move to value and more coordinated and collaborative care, ensuring that the right care is provided in the right setting. APMs have helped provide the data and funding to targeted quality programs that have resulted in marked quality achievements. APMs also provide the platform for better alignment of incentives and focused measurement and improvement around specific disease states and quality metrics. APMs that provide robust, timely and complete information about patients provide the best opportunities to truly coordinate care, whereas APMs that carve out specific areas of care, such as behavioral health and pharmacy, lack the funding and data to influence and improve upon some of the most critical areas of care.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs and all other payment methodologies continues to be a concern for Tufts Medical Center. APMs that provide robust, timely and complete information about patients provide the best opportunities to truly coordinate care, whereas APMs that carve out specific areas of care, such as behavioral health and pharmacy, lack the funding and data to influence and improve upon some of the most critical areas of care.

Relaible and consistent data sharing remains a key pillar of successful adoption and execution of APMs; the lack of such information remains a signficant barier to increased adoption of APMs. In praticular the contued lack of information on the PPO population is a significant hindrance to providing more coordinated patient care across a broader population and to better understanding trends in quality, variations in care and cost. Timely, accurate and complete data, along with sufficient payment to support the necessary infrasturcure, will be key components for successful implementation of APMs for the complex MassHealth population.

Another concern in the move to value arises in the strcuture of referral arrangements. The value and savings that can be realized by APMs is undermined when providers arrange pricing discounts between themselves. In these situations, the consumer is often referred to the high priced institution while the provider's incentive is not aligned to make the value decision.

c. Are behavioral health services included in your APM contracts with payers?
No

   i. If no, why not?
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7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs,

amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

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

Tufts MC is required to report on an innumerable amount of quality metrics. There is very little coordination across the various the reporting requirements and they do not always serve as informative and objective measures. The increasing breadth and variety of reporting metrics places a burden on our staff and resources, diverting time and critical funds away from patient care and into data collection, reporting and analysis.

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

While much of the quality reporting is helpful, reducing the administrative burden and creating metrics and processes that are uniform across organizations, payers and other entities requesting quality data reporting will go a long way to reducing the burden of reporting and strengthen the usability of the information, particularly for the general public.
Coordination of reporting requirements and processes, along with the adoption of an overarching and widely accepted set of common metrics would be very helpful to reducing the administrative burden required to meet the numerous and varied reporting requirements. The reporting metrics selected by agencies and third party rating groups should also constantly be evaluated for their scientific basis, objectivity and relevancy.

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

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

1. For each year 2012 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.
   38T

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

Since Chapter 224, we have complied with the requirement to provide cost estimates to our patients upon request. As we have seen those requests increase over the past couple of years we have created a more accessible, standardized process internally for requests to flow from our physicians' offices to the Financial Coordination Department. We are constantly seeking to improve the patient experience and continue to monitor ways to enhance this process for our patients and our care givers who are also fielding direct pricing requests from their patients.

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

The cost estimation process is constantly monitored by staff and leadership of the Financial Coordination Department, along with leadership from the Department of Physician Services. Because many of the cost requests are for highly complex care, cost estimates are often viewed by more than one department to determine the best accuracy. Case where a significant variance may have occurred are analyzed and discussed to determine why a variance occurred and how the process can be improved.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

One of the barriers to providing accurate and timely cost estimates lies in the time and amount of information with which a person inquires. Often patients do not have adequate information to provide a robust cost estimate and it can take cannot several days with numerous inquiries to their physician and insurer to fully and accurately compile a cost estimate. Educating consumers about the ability to request price estimates and encouraging requests well before a procedure, as well as a longer lead time to provide a request would greatly enhance the accuracy and usability of cost estimates.

Another difficulty in providing cost estimates is the nature of the highly complex cases treated at Tufts MC. Complex cases with the possibility of multiple procedures and quickly changing dynamics make it extremely difficult to provide an accurate cost estimate for patients, without a wide variation for several possible outcomes. Examples of these types of complex cases where circumstances can change once a procedure begins are hematology and oncology, neurosurgery and cardiology. Physicians often predict what they will

encounter in a patient and how a care plan may change based on the highly complex nature of this type of care.

Tufts Medical Center

2015

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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	32,090,627	62,226,012	1,406,896	2,728,072												98,451,607	
Tufts					46,494,350		-				-					46,494,350	do not distinguish HMO v. PPO, reported all as HMO
HPHC	39,326,927		365,167													39,692,094	do not distinguish HMO v. PPO, reported all as HMO
Fallon												4,446,047				4,446,047	no delineation by product, reprt as PPO
CIGNA												4,583,365				4,583,365	no delineation by product, reprt as PPO
United												12,069,478				12,069,478	no delineation by product, reprt as PPO
Aetna												8,049,660				8,049,660	no delineation by product, reprt as PPO
Other Commercial												28,087,527				28,087,527	no delineation by product, reprt as PPO
Total Commercial	71,417,554	62,226,012	1,772,063	2,728,072	46,494,350	-	-	-	-	-	-	57,236,077	-	-	-		
																-	
Network Health											19,333,416					19,333,416	do not distinguish HMO v. PPO, reported all as HMO
NHP											27,075,330					27,075,330	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											8,978,957					8,978,957	do not distinguish HMO v. PPO, reported all as HMO
Fallon											516,620					516,620	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											55,904,323						
																-	
Mass Health		50,128,867		1,159,434										3,000,000		54,288,301	classified all as PPO
																-	
Tufts Medicare Preferred					16,486,768		-									16,486,768	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											6,936,759					6,936,759	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											19,255,936					19,255,936	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					16,486,768						26,192,695						
																-	
Medicare												164,072,537				164,072,537	classified all as PPO
																-	
All Other Payors												25,197,614			8,779,500	33,977,114	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	71,417,554	112,354,879	1,772,063	3,887,506	62,981,118	-	-	-	-	-	82,097,018	246,506,228	-	3,000,000	8,779,500	592,795,866	