MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, 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. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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, 2015, 2016, and/or 2017 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 templates, 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@mass.gov or (617) 979-1400.

HPC Contact Information

For any inquiries regarding HPC questions, please contact HPC-Testimony@mass.gov or (617) 979-1400.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@mass.gov or (617) 963-2030.

HPC Pre-Filed Testimony Questions
Answers Provided by LAHEY HEALTH SYSTEM, Inc.

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

1. Government mandated nurse staffing ratios: The estimated annual cost to Lahey Health System to fill the registered nurses deficit as defined in the proposed nurse staffing ballot question is $35 million.

Rigid ratios would have to be followed at all time, without exception, and would be identical for every hospital – teaching and community. The proposal impact on all hospitals would be devastating: Mass. Insight Global Partnerships and BW Research Partnership, found that mandatory ratios would cost over $1.3 billion in the first year and over $1 billion each year after that, including $100 million in additional state spending. Much of this increased cost would have to be passed onto patients and employers in the form of high insurance premiums, co-pays, deductibles, and taxes.

Setting arbitrary rigid ratios ignores the many variations in patient care, including difference in nurses' education and experience, every-changing patient conditions, the composition of the whole patient care team, and the varying technologies and physical attributes of different facilities. Mandated nurse ratios would override the professional judgment of qualified healthcare professionals, threaten the quality and increase the cost of healthcare in Massachusetts

2. Rising cost of prescription drugs: The price of prescription drugs has skyrocketed over the past several years and represents the fastest growing category of care in 2015 and 2016 in Massachusetts. Unchecked drug price increases are not sustainable, and are a serious economic threat to the patients and communities we serve. In 2015, total national spending on prescription drugs surpassed $457 billion. Spending on drugs rose 8.5% in 2015 and the cost of some drugs jumped as much as 3,600% over two years.

A recent study commissioned by the American Hospital Association (AHA) and the Federation of American Hospitals (FAH) found that between 2013 and 2015 hospital spending on drugs in the inpatient space rose 38.7% per admission. The primary driver behind increased drug spending is higher prices, not increased utilization. Pharmaceuticals were the fastest growing category in terms of pricing for every month of 2016 and for most months of 2017. A recent forecast suggests that drug prices will continue to increase by more than 7% from July 2018 through June 2019 with similar annual growth projections through 2026.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?

1. Massachusetts Needs a Market-based Solution. Recognizing the harmful effects of unwarranted price variation, the HPC has appropriately called for competition among healthcare providers to address this market dysfunction. Effective competition is exactly what Beth Israel Lahey Health (BILH) proposed merger will provide. BILH will represent the first time that a system will have the reputation, geographic coverage, and value position to challenge the dominant health system's market position, and pressure such system to reevaluate its pricing strategy. BILH has also planned specific initiatives to improve access to care and population health, and to achieve efficiencies that will benefit the citizens of the Commonwealth that cannot be realized by the Parties on their own. There are a variety of efficiencies with an estimated annual impact between $149 million and $270 million that will only be gained through this proposed transaction, most of which will directly benefit the Commonwealth and all of which will benefit our patients.
2. We need to Reward Patients for Making Value-based Provider Choices. LHS supports lower cost options for patients that require insurers to offer at least one plan with premium rate discounts resulting from products designed with select networks, lower cost sharing differentials, and/or premium based on primary care provider choice. Coupled with price and network transparency, these viable options will help keep health care affordable for many residents.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

1. Complete the BILH Transaction: Parties have experienced significantly reduced operating performance over the past three years (including a combined operating loss of $70.8 million in Fiscal Year ("FY") 2017), as well as reduced days cash on hand and increased capital needs due to aging infrastructure. Unless BILH is formed, many of the Parties in the transaction will be increasingly challenged to sustain their current level of investment in clinical services, behavioral health programs, and population health initiatives they provide to the communities they serve in Eastern Massachusetts.

2. Build a Collaborative Care Model for Behavioral Health Patients: A major cost saving opportunity for the proposed BILH system is a Collaborative Care Model that BILH will implement. A broad roll-out of this model will directly address improving access to care for patients needing behavioral health services by integrating behavioral health in primary care practices. Currently, there are approximately 400,000 patients at BILH that would directly benefit from this program's implementation. It is estimated that the model will produce annual TME savings of $23million to $58 million.

3. Continue to Provide Care in the Most Appropriate Setting: LHS actively manages patient care to keep low-acuity care in the community setting, thereby achieving savings. As the HPC has documented, LHS enjoys some success in redirecting appropriate inpatient cases from its Burlington's teaching hospital to its community hospitals located in Winchester, Beverly and Gloucester. We continue to build on this community model to increase our community hospitals' share of low-acuity, community-appropriated inpatient care. In addition we have significant operational plans in development for a high-level of system integration and accountable care as part of the formation of BILH. Our ACO models have a shared commitment to a strong

MassHealth ACO program. BILH is committed to growing service offerings to underserved populations to help communities that we serve stay healthy.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond normal weekday business hours. Information requested in question (a) below may be provided in the form of a link to an online directory or as an appended directory.*

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.

Winchester Hospital Urgent Care (all corporately owned)

- 500 Salem Street, Wilmington, MA 01887

- 7 Alfred Street, Woburn, MA 01801

Lahey Health Urgent Care (all corporately owned)

- 480 Maple Street, Danvers, MA 01923 (opened January 2018)

- 305 Gloucester Crossing, Gloucester, MA 01930 (opened February 2018)

- 1350 Market Street, Lynnfield, MA 01940 (opening Oct 2018)

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through a joint venture with another organization (information from non-owned affiliates should not be included):

Winchester Hospital Urgent Care - Wilmington Number of unique patient visits	15,577

Winchester Hospital Urgent Care- Wilmington Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	Commercial payers: 64% Medicare: 19% Medicaid: 12% Self-Pay: 2% Other: 3%
Winchester Hospital Urgent Care Percentage of patient visits where the patient is referred to a more intensive setting of care	3.86%
Winchester Hospital Urgent Care - Woburn Number of unique patient visits	6,135
Winchester Hospital Urgent Care - Woburn Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	Commercial payers: 60% Medicare: 20% Medicaid: 15% Self-Pay: 3% Other: 2%
Winchester Hospital Urgent Care Percentage of patient visits where the patient is referred to a more intensive setting of care	3.99%

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.

The three urgent care centers Lahey Health opened in 2018 utilize an MD and NP clinical staffing model. The physicians are board-certified in Family Medicine, and in some cases, board-certified in Emergency Medicine and/or with urgent care experience. For purposes of the urgent care centers, they are considered primary care physicians who do not carry a patient panel, but who are available to support the routine and urgent health care needs of Lahey Health patients, and the urgent health care needs of non-Lahey patients.

The Nurse Practitioners are family medicine and/or emergency medicine trained.

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?

Lahey Health corporately owned urgent care centers benefit from a fully integrated EPIC electronic health record. As such, providers in the urgent care centers have real-time and full access to the medical records of Lahey Health patients. And, primary care and specialty providers have complete access to the services provided to Lahey Health patients through the corporately owned urgent care centers.

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).

Lahey Health Cancer Institute patient navigators:

The Lahey Health Cancer Institute (LHCI) is the only health care system in the Boston area chosen to participate in the Oncology Care Model (OCM), designed by the U.S. Centers for Medicare and Medicaid Services (CMS) through the Innovation Center. The goals of OCM are to align financial incentives to improve care coordination, appropriateness of care, quality, and access for Medicare patients undergoing chemotherapy. The OCM incentivizes practices to improve quality of care and lower costs by focusing on preventing ER utilization and unplanned admissions.

The requirements of the OCM implemented by Lahey Health Cancer Institute include the following components:

- 24/7 access to providers who have real-time access to your medical records
- Use of a certified EHR technology and providing 24/7 access to an appropriate clinician who has real-time access to patients' medical records.
- An EHR portal that provides patients and their designated caregivers access to their medical record, including medications, laboratory and radiology results, appointment schedules, billing options, and more.
- A detailed care plan that includes diagnosis information, treatment goals, plan for treatment, expected response to treatment, treatment benefits and harms, and information on quality of life during treatment.
- Use of therapies that are consistent with nationally recognized clinical guidelines; Lahey has retagged all chemotherapy protocols in EPIC to report compliance with guidelines at the patient level.
- LHCI aligns a newly diagnosed cancer patient with a highly experienced nurse navigator who supports the patient and their family with the physical, emotional, and financial resources they need at the start of their treatment plan and on an ongoing basis throughout their treatment and survivorship.
- Patients are given cost estimates for out-of-pocket expenses during the chemotherapy regimen, and financial counseling to assist with drug costs.
- Assistance with coordinating care, such as appointments, radiology scans, forms, and more.
- A single phone number to call for symptom management and advice any time day or night.
- Advanced care planning to ensure that each patient's care reflects their decisions, personal values, and preferences as it relates to exploring options, completing essential documents, and designating a Health Care Agent.
- Depression screening and psychosocial health services to ensure that patients receive the emotional support they may need for concerns associated with depression or distress due to their cancer diagnosis.
- A Survivorship Plan at the end of treatment that includes a summary of treatment, surveillance schedule of visits and testing, and healthy living suggestions
- Survivorship Evaluation at Lahey (SEAL), which is a comprehensive cancer care program that proactively engages patients at the start of their treatment plan and on an ongoing basis throughout their survivorship. The SEAL program assesses how well patients are functioning and refers them to certain rehabilitation programs to improve their outcomes and satisfaction with treatment.

- Mandatory CMS Quality Reporting includes:
- All cause inpatient admissions within the 6-month episode.
- ER visits without an admission within the 6-month episode.
- Proportion who die who were admitted to hospice for three days or more
- Patient reported satisfaction
- Plan of care and pain intensity quantified.
- Screening for depression and appropriate follow-up care.
- Multiple disease-specific quality metrics for prostate, colon, breast patients.
- Medication documentation in EHR.
- Clinical data (cancer type, TNM stage, molecular and histologic marketers, relapse status, and progression status.
- Chemotherapy intent, an Advanced Care Plan, Closing the referral loop.

In addition to the core requirements, Lahey Health Cancer Institute has initiated the following innovations in cancer care delivery as part of OCM:

1) Controlling drugs costs: Decreased drug costs by ensuring appropriate utilization and reviewing formularies and protocols for least costly alternatives for equally efficacious drugs; aligning drug use with treatment goals to eliminate aggressive use of end-of-life care.

2) Ensuring Compliance with National Comprehensive Cancer Network (NCCN) treatment guidelines: Assessed all chemotherapy protocols for NCCN compliance.

3) Adopting Population Management Technique for Cancer Patients: Adopted a risk stratification methodology of patients undergoing chemotherapy (the Elder Risk Assessment from Mayo Clinic), to better manage patients who have multiple co-morbidities and would be likely to have complications during chemotherapy, thus preventing ER visits and unplanned admissions. High-risk patients are monitored by nurse navigators with increased monitoring and earlier intervention.

4) Nurse Triage System: Adopted 35 nurse triage protocols based on the COME HOME CMS Demonstration Project to systematically manage symptoms of patient undergoing chemotherapy, thus decreasing ER visits and unplanned admissions.

5) Palliative Care Services: Increased the utilization of Palliative Care consultations in the outpatient setting with chemotherapy patients. Patients are screened as appropriate for a Palliative Care consultation based on diagnoses and stage of disease.

6) End-of-Life Care: Assessed end of life care to ensure that chemotherapy is not over-utilized very near to end of life and does not increase ER visits and hospitalizations in the ICU for terminal patients; in addition, ensuring that Hospice services are not underutilized.

Integrated Medical and Behavioral Health

Lahey Health Primary Care in collaboration with Lahey Health Behavioral Services has implemented an innovative model of care that embeds behavioral health clinicians in 14 primary care practices. Integrated behavioral health services offer patients access to a behavioral health provider in the same setting where they receive their primary care.

This integrated approach provides for a more comfortable and routine setting for patients who worry about being judged for needing mental and behavioral counseling services. Patients already have a relationship with their primary care provider, so it's easier for them to open up about any behavioral health challenges they may be having in that primary care setting.

In Fall 2018, these two teams will pilot a reverse integration, in which Lahey Health Primary Care will embed medical care into one of Lahey Health's behavioral health settings. A medical

nurse practitioner will provide care for Lahey Health Behavioral Services clients in the Cape Ann Adult Behavioral Learning Center in Salem, MA.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.

Lahey Health supports the growth of quality alternative care sites in Massachusetts to the extent they are properly integrated with primary care and support a longitudinal medical care delivery model, in addition to meeting consumer demand for immediate care for non-emergent medical needs. Alternative care sites that are not formally aligned with one or more healthcare systems risk promoting fragmented and episodic care that is not in the best interest of patients of the Commonwealth.

Quality alternative care sites are technologically integrated to primary care providers and have a level of interoperability that ensures the safe and effective delivery of care to patients during their urgent care visit, and appropriate communication back to primary care or the medical home as the overall coordinator of all care provided to each patient. Quality alternative care sites collaborate, coordinate and communicate with primary care or the medical home to ensure the best possible outcomes for the patient.

Quality alternative care sites support the following:

Emergency Department (ED) avoidance

- Full service urgent care centers can treat ~75% of ED visits. By providing convenient, walk-in access to urgent care and educating patients to use the centers for non-life-threatening injuries and illnesses, quality alternative care sites have the opportunity to significantly reduce unnecessary ED visits;

- Educating patients to use a full service urgent care model staffed will dramatically reduce ED transfers compared to walk-in centers with narrower scope of care. Full service urgent care staffs with more experienced providers and is equipped with capabilities on-site to broaden the scope of care and reduce ED transfers.

Expand primary care capacity

- Convenient access for common illnesses and injuries when primary care practices are not available. This includes during normal business hours, but also during nights and weekends when offices are closed;

- Re-allocate more of PCPs time to chronic care management and wellness visits, utilizing urgent care for episodic injuries and illnesses. This provides greater access for patients with chronic injuries and illnesses, reducing the overall spend for this more expensive subset of patients;

- By providing these additional access points, there is the opportunity to expand primary care capacity.

Effectively manage Total Medical Expense

- Quality alternative care sites share electronic health records with primary care and the medical home and ensure strong communications, essentially becoming a component of the medical home for significantly more effective TME management.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

- ☐ Legal barriers related to data-sharing
- ☐ Structural/technological barriers to data-sharing
- ☒ Lack of resources or capacity of your organization or community organizations
- ☐ Organizational/cultural barriers
- ☒ Other: Fragmentation of services

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?

Lahey Health partners with community based organizations to address patients' and families' health related social needs. Community based organizations provide critical services to residents and do so in an accessible, culturally appropriate manner. However, community services can be fragmented and in many cases organizations are under resourced – both with staff training and technology. We need to have a variety of ways to support those organizations and to support our patients on an individual level.

Provider systems will adequately address social determinants of health if and when appropriately incented and equipped to do so, through risk contracts and reimbursement policies that allow providers to address upstream determinants of health outcomes. For example, care integration such as the integrated behavioral health model outlined in Section 2E of this response addresses health related social needs. While payment models are the primary driver of practice pattern change in this domain, technical assistance could accelerate transformation by facilitating communication between CBOs and providers with respect to how CBO services can be efficiently tapped, as well as by funding training initiatives that enable CBOs to interface with providers effectively in a time sensitive environment.

Additionally, it is recommended that the state offer telehealth visits with co-pay less than primary care provider visits. Virtual visits help with accessing providers (e.g., urgent care, chronic disease management, well-being, patient engagement, pediatrics, lactation/pregnancy support), and avoid higher cost places of service (ED). There are lower cost co-pays with high quality care. Market data shows that regardless of income, many people have access to some kind of smart device that can connect to virtual visits.

Lahey Health will continue to use its community health needs assessment to fully understand and address the health and social needs of our patients. Timely and reliable data from state agencies will continue to inform and guide our health interventions.

AGO Pre-Filed Testimony Questions

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	0	251
	Q2	0	343
	Q3	0	396
	Q4	0	430
CY2017	**Q1**	0	493
	Q2	0	513
	Q3	0	428
	Q4	0	430
CY2018	**Q1**	0	428
	Q2	0	460
	LHS TOTAL:	0	4,172

   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 analysis.

The monitoring consists of tracking the request date and response date on a spreadsheet and review the reasons for responses that are over 48 business hours. While the final estimate may take over 48 hours, the process is to contact the patient within 48 business hours with an update.

Past estimates are periodically reviewed where the service actually took place and compare the estimate to the actual charges. When required, the Revenue Finance Team reviews the estimates to further refine the process.

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?
Required Question:
The most significant barrier is determining the CPT codes for the services on the estimate. Frequently patients will give us the name of a service and we must get input from our Coding Department to translate it into likely codes. Ancillary codes and supplies are difficult to determine, as these codes vary greatly among patients. Finally, those services that will vary and change during the service are challenging. The examples we see frequently are colonoscopies. It is not possible to know if polyps are found that may need to be removed, how many and the location until the test takes place. These factors all contribute to the final charges.

3. For hospitals and provider organizations corporately affiliated with hospitals:

a) For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

See attachment

b) For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

See attachment

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Trends | 2014 - 2017

Contract Type

	2014		2015		2016		2017	
	$	%	$	%	$	%	$	%
P4P	446,651,410	25.32%	447,098,400	24.59%	405,109,086	20.94%	423,787,479	21.53%
Risk	290,924,773	16.49%	299,765,919	16.49%	453,846,897	23.45%	465,681,680	23.66%
FFS	1,004,252,203	56.93%	1,053,756,508	57.95%	1,053,548,497	54.45%	1,043,691,289	53.03%
Other Revenue	22,090,400	1.25%	17,755,451	0.98%	22,516,329	1.16%	34,977,054	1.78%
Grand Total	1,763,918,787	100.00%	1,818,376,277	100.00%	1,935,020,809	100.00%	1,968,137,501	100.00%
Increase over Prior			3.1%		6.4%		1.7%	

Payor Group

	2014		2015		2016		2016	
	$	%	$	%	$	%	$	%
Total Commercial	833,029,537	47.23%	821,359,464	45.17%	862,113,098	44.55%	887,975,485	45.12%
Total Managed Medicaid	120,522,321	6.83%	139,500,272	7.67%	146,089,041	7.55%	131,184,296	6.67%
Mass Health	62,697,830	3.55%	50,694,136	2.79%	58,591,721	3.03%	71,914,733	3.65%
Commercial Medicare	150,262,324	8.52%	159,183,671	8.75%	188,538,390	9.74%	212,982,359	10.82%
Medicare	525,230,117	29.78%	573,107,834	31.52%	611,732,851	31.61%	603,261,798	30.65%
Other	72,176,659	4.09%	74,530,902	4.10%	67,955,708	3.51%	60,818,830	3.09%
Grand Total	1,763,918,787	100.00%	1,818,376,277	100.00%	1,935,020,809	100.00%	1,968,137,501	100.00%
Increase over Prior			3.1%		6.4%		1.7%	

Note: Winchester and Winchester Physician Associates included beginning in 2014

2015 & 2016 were restated. Some Claims revenue was originally reported as NHP & Network Health under Managed Medicaid but were reclassed to Other Commercial. HNE was pulled out of Other Commercial and reported under HNE.

Lahey Health

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

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 67,929,579	$ 190,405,032	$ 1,544,522	$ 3,923,568	$ 72,263,837	$ -	$ 490,937	$ -	$ 4,231,095	$ -	$ 4,170,732	$ -	$ -	$ -	$ -
Tufts	$ 8,783,628	$ -	$ 1,023,282	$ -	$ 23,906,902	$ -	$ (321,342)	$ -	$ 44,951	$ -	$ 19,988,428	$ 40,965,450	$ -	$ -	$ -
HPHC	$ 98,441,684	$ 31,393,906	$ 844,351	$ 105,703	$ 14,910,647	$ -	$ 124,582	$ -	$ 253,125	$ -	$ 2,009,424	$ 1,337	$ -	$ -	$ -
Fallon	$ 9,521,150	$ 2,158,807	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 298,734	$ 1,823,731	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,540,985	$ 35,809,141	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,495,942	$ 43,115,997	$ -	$ -	$ -
Aetna	$ 1,664,736	$ -	$ 75,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 323,027	$ 29,428,269	$ -	$ -	$ -
Other Commercial	$ 7,087,656	$ -	$ 19,911	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,630,967	$ 68,600,128	$ -	$ -	$ -
Commercial	$ 193,428,432	$ 223,957,745	$ 3,507,066	$ 4,029,271	$ 111,081,386	$ -	$ 294,176	$ -	$ 4,529,170	$ -	$ 72,458,238	$ 219,744,052	$ -	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 37,552,066	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 39,571,911	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,606,029	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,327	$ 2,780,534	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,446,889	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,275,948	$ 1,287,617	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 116,454,170	$ 4,068,151	$ -	$ -	$ -
Mass Health	$ 6,713,339	$ 14,921,665	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,764,817	$ 32,298,008	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 45,752,795	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 51,767,421	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,462,100	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ 93,658	$ -	$ 234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,571,306	$ 17,028,946	$ -	$ 211,789	$ -
Commercial Medicare Subtotal	$ 93,658	$ -	$ 234	$ -	$ 45,752,795	$ -	$ (1,625,925)	$ -	$ -	$ -	$ 88,800,827	$ 17,028,946	$ -	$ 211,789	$ -
Medicare	$ -	$ -	$ -	$ -	$ 127,893,170	$ -	$ 3,000,000	$ -	$ -	$ -	$ 750,593	$ 375,896,493	$ -	$ 17,689,861	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,727,442	$ 53,260,467	$ -	$ 4,188,750	$ -
Grand Total	$ 200,235,430	$ 238,879,410	$ 3,507,300	$ 4,029,271	$ 284,727,351	$ -	$ 1,668,251	$ -	$ 4,529,170	$ -	$ 301,956,086	$ 702,296,117	$ -	$ 22,090,400	$ -

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2015 - restated

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 67,626,263	$ 181,664,361	$ 831,769	$ 2,560,765	$ 78,604,605	$ -	$ 930,986	$ -	$ 4,606,196	$ -	$ 5,567,132	$ -	$ -	$ -	$ -
Tufts	$ 10,369,863	$ 2,150,780	$ 980,123	$ -	$ 18,630,227	$ -	$ (17,960)	$ -	$ -	$ -	$ 32,184,856	$ 35,562,571	$ -	$ -	$ -
HPHC	$ 104,438,445	$ 32,401,803	$ 521,082	$ 227,051	$ 14,049,339	$ -	$ 163	$ -	$ 154,037	$ -	$ 2,278,263	$ -	$ -	$ -	$ -
Fallon	$ 7,949,765	$ 3,796,279	$ 13,340	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 364,984	$ 399,443	$ -	$ -	$ -
Cigna	$ -	$ 1,967,563	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,591,078	$ 26,320,994	$ -	$ -	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,108,553	$ 41,194,476	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,351,720	$ 23,139,892	$ -	$ -	$ -
Other Commercial	$ 5,559,182	$ -	$ 17,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,055,325	$ 63,206,498	$ -	$ -	$ -
Commercial	$ 195,943,518	$ 221,980,786	$ 2,363,965	$ 2,787,816	$ 111,284,171	$ -	$ 913,189	$ -	$ 4,760,233	$ -	$ 91,501,912	$ 189,823,874	$ -	$ -	$ -
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,024,494	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 61,297,710	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,140,076	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,844	$ 2,516,019	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,207,747	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,399,627	$ 2,908,755	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 134,075,498	$ 5,424,774	$ -	$ -	$ -
Mass Health	$ 2,635,088	$ 12,181,075	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,525,951	$ 28,352,021	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 43,726,257	$ -	$ (2,981,213)	$ -	$ -	$ -	$ 58,684,560	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,386,364	$ -	$ -	$ -	$ -
Other Commercial Medicare	$ 9,202,599	$ -	$ 3,554	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,574,212	$ 16,241,366	$ -	$ 345,971	$ -
Commercial Medicare Subtotal	$ 9,202,599	$ -	$ 3,554	$ -	$ 43,726,257	$ -	$ (2,981,213)	$ -	$ -	$ -	$ 92,645,136	$ 16,241,366	$ -	$ 345,971	$ -
Medicare	$ -	$ -	$ -	$ -	$ 141,063,282	$ -	$ 999,999	$ -	$ -	$ -	$ 753,109	$ 414,470,682	$ -	$ 15,820,763	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,717,369	$ 57,224,816	$ -	$ 1,588,717	$ -
Grand Total	$ 207,781,204	$ 234,161,861	$ 2,367,519	$ 2,787,816	$ 296,073,710	$ -	$ (1,068,025)	$ -	$ 4,760,233	$ -	$ 342,218,974	$ 711,537,534	$ -	$ 17,755,451	$ -

Lahey Health

Health Policy Commission
AGO Provider Exhibit 1
Calendar Year 2016 - restated

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payor	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	$ 69,306,261	$ 109,482,663	$ 1,128,183	$ 1,852,324	$ 62,193,796	$ 76,833,852	$ 4,113	$ -	$ 2,084,155	$ 937,997	$ 11,910,102	$ -	$ 609,547	$ 119,390	$ -
Tufts	$ 7,885,008	$ 1,897,011	$ -	$ -	$ 21,878,508	$ 27,815	$ 421,864	$ -	$ 132,936	$ -	$ 22,910,916	$ 51,973,090	$ -	$ -	$ 319,415
HPHC	$ 127,175,713	$ 24,539,755	$ 403,565	$ 250,148	$ 18,421,740	$ 6,155	$ (2,515)	$ -	$ 443,926	$ -	$ 577,682	$ -	$ -	$ -	$ -
Fallon	$ 7,710,711	$ 2,779,756	$ 60,450	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,553,091	$ 195,240	$ -	$ -	$ -
Cigna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,422,955	$ 26,793,966	$ -	$ 83,872	$ -
United	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,317,697	$ 34,205,270	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,579,253	$ 30,364,307	$ -	$ -	$ -
Other Commercial	$ 4,517,120	$ -	$ 7,006	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 37,930,932	$ 62,799,443	$ -	$ 66,916	$ -
Commercial	$ 216,594,813	$ 138,699,185	$ 1,599,204	$ 2,102,472	$ 102,494,044	$ 76,867,822	$ 423,462	$ -	$ 2,661,017	$ 937,997	$ 112,202,628	$ 206,331,316	$ 609,547	$ 270,178	$ 319,415
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 34,946,170	$ -	$ -	$ -	$ -
NHP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 66,331,027	$ -	$ -	$ -	$ -
BMC Healthnet	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,200,419	$ -	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 533	$ 3,782,790	$ -	$ -	$ -
Fallon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,046,894	$ -	$ -	$ -	$ -
Other Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,525,450	$ 5,255,758	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 137,050,493	$ 9,038,548	$ -	$ -	$ -
Mass Health	$ 13,482,618	$ 21,102,499	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,995,830	$ 17,010,774	$ -	$ -	$ -
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 64,569,734	$ -	$ (3,039,843)	$ -	$ 73,078	$ -	$ 47,170,369	$ -	$ -	$ -	$ -
BCBSMA Sr	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,478,962	$ 12,437,155	$ -	$ -	$ -
Other Commercial Medicare	$ 11,108,472	$ -	$ 419,823	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 31,879,286	$ 19,209,023	$ -	$ 232,331	$ -
Commercial Medicare Subtotal	$ 11,108,472	$ -	$ 419,823	$ -	$ 64,569,734	$ -	$ (3,039,843)	$ -	$ 73,078	$ -	$ 83,528,617	$ 31,646,178	$ -	$ 232,331	$ -
Medicare	$ -	$ -	$ -	$ -	$ 204,242,085	$ -	$ 4,617,502	$ -	$ -	$ -	$ 562,027	$ 386,417,920	$ -	$ 15,893,317	$ -
Other and Self Pay	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,062,724	$ 47,701,442	$ 702,501	$ 4,489,041	$ -
Grand Total	$ 241,185,903	$ 159,801,684	$ 2,019,027	$ 2,102,472	$ 371,305,863	$ 76,867,822	$ 2,001,121	$ -	$ 2,734,095	$ 937,997	$ 355,402,319	$ 698,146,178	$ 1,312,048	$ 20,884,866	$ 319,415

Lahey Health

Health Policy Commission
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	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 70,076,423	$ 123,257,976	$ 1,317,829	$ 2,088,674	$ 62,600,854	$ 83,270,283	$ 558,856	$ -	$ 761,692	$ 1,062,011	$ 7,239,789	$ 6,576,122	$ 614,704	$ 254,556	$ -
Tufts Health Plan	$ 9,160,926	$ -	$ -	$ -	$ 21,152,499	$ 9,503,543	$ 626,981	$ -	$ 10,871	$ -	$ 23,605,781	$ 32,562,929	$ -	$ -	$ 353,411
Harvard Pilgrim Health Care	$ 123,423,782	$ 21,959,129	$ 279,799	$ 46,940	$ 18,488,070	$ 18,720	$ 92,597	$ -	$ 329,622	$ -	$ 4,399,371	$ 1,291,191	$ -	$ -	$ -
Fallon Community Health Plan	$ 7,053,821	$ 2,577,241	$ 34,666	$ -	$ -	$ -	$ 2,058	$ -	$ -	$ -	$ 197,515	$ 24,501	$ -	$ -	$ -
CIGNA	$ -	$ 1,324,226	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,904,525	$ 26,653,904	$ -	$ 14,278	$ -
United Healthcare	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,690,217	$ 41,080,459	$ -	$ -	$ -
Aetna	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,525,766	$ 31,348,713	$ -	$ -	$ -
Other Commercial	$ 3,424,197	$ -	$ 1,443	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 57,188,145	$ 51,867,153	$ -	$ 76,725	$ -
Total Commercial	$ 213,139,149	$ 149,118,572	$ 1,633,737	$ 2,135,614	$ 102,241,423	$ 92,792,546	$ 1,280,493	$ -	$ 1,102,185	$ 1,062,011	$ 130,751,109	$ 191,404,972	$ 614,704	$ 345,559	$ 353,411
Network Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,238,254	$ 896,082	$ -	$ -	$ -
Neighborhood Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 41,722,578	$ 9,459,736	$ -	$ -	$ -
BMC HealthNet, Inc.	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,636,217	$ 1,320,450	$ -	$ -	$ -
Health New England	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 344	$ 3,158,800	$ -	$ -	$ -
Fallon Community Health Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,102,491	$ -	$ -	$ -	$ -
Other Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,739,467	$ 4,909,877	$ -	$ -	$ -
Total Managed Medicaid	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 111,439,351	$ 19,744,945	$ -	$ -	$ -
MassHealth	$ 16,123,226	$ 21,695,626	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,798,015	$ 21,816,049	$ -	$ -	$ 5,481,817
Tufts Medicare Preferred	$ -	$ -	$ -	$ -	$ 62,480,521	$ -	$ (223,935)	$ -	$ 115,505	$ -	$ 51,120,989	$ -	$ 834,808	$ -	$ -
Blue Cross Senior Options	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,143,302	$ 13,298,963	$ -	$ -	$ -
Other Comm Medicare	$ 19,762,551	$ -	$ 179,004	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 42,030,995	$ 17,993,238	$ -	$ 246,419	$ -
Commercial Medicare Subtotal	$ 19,762,551	$ -	$ 179,004	$ -	$ 62,480,521	$ -	$ (223,935)	$ -	$ 115,505	$ -	$ 98,295,286	$ 31,292,201	$ 834,808	$ 246,419	$ -
Medicare	$ -	$ -	$ -	$ -	$ 204,830,932	$ -	$ -	$ -	$ -	$ -	$ 514,433	$ 373,585,693	$ -	$ 24,271,211	$ 59,529
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,870,033	$ 45,179,202	$ (702,501)	$ 2,709,146	$ 762,950
GRAND TOTAL	$ 249,024,926	$ 170,814,198	$ 1,812,741	$ 2,135,614	$ 369,552,876	$ 92,792,546	$ 1,056,557	$ -	$ 1,217,689	$ 1,062,011	$ 360,668,227	$ 683,023,062	$ 747,011	$ 27,572,335	$ 6,657,707