Caring Health Center, Inc.
Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:
   Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced 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 strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

The participation of Caring Health Center (CHC) in the BeHealthy Partnership Accountable Care Organization (ACO) represents CHC's primary strategic priority for reducing health care expenditures. As an ACO member, CHC is moving toward a value-based care model that encompasses considerations such as alignment around metrics and goals, utilization of data to measure progress and manage population health, stratification of patients by risk, enhanced care management and coordination systems, and approaches to ensure standardization of care across the ACO's patient population. Founded in 2018, the BeHealthy Partnership is working through the initial stages of its development. Accordingly, it is too early to assess the ACO's success in reducing the growth of health care spending.

An additional strategy to limit health care costs include the programs offered at CHC's 1,700 square-foot Wellness Center. Under the direction of the Vice President of Research and Population Health, the Wellness Center provides programs to reduce health disparities and health care costs through healthy cooking classes, pediatric obesity prevention interventions, diabetes education, clinical services in a shared medical appointment format, group exercise classes, and chronic disease group education classes. In the Wellness Center, culturally-based support for lifestyle changes that support diabetes prevention and treatment goals are provided by CHC's team of Community Health Workers (CHWs).

Quality management (QM) and long-range strategic planning provide additional examples of CHC's efforts to reduce health care costs. Following the outline established through CHC's Board-approved QM Plan, monthly QM Team meetings co-chaired by the QM Director, Risk Manager, and Corporate Compliance Officer provide a forum to examine key quality issues through progress updates, problem solving, recommendations and solutions. Training, policy development and audits are on-going, as implemented in response to identified quality or risk management issues, and to assure accountability and corporate compliance. CHC operates according to a detailed, time-framed, and measurable 5-year Strategic Plan that includes specific objectives related to increased efficiencies and sustainable cost savings.

   b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

CHC's efforts to reduce health care expenditures would benefit from: The integration of care coordination costs into global payment structures, in a manner that accounts for workforce expenditures that are needed to address the extensive social determinants of health (SDOH)-related factors being experienced by those populations that are traditionally served by federally qualified health centers. The incorporation of population health data integration costs into global payment structures, in a manner that accounts for a corresponding growth in the data integration workforce; this feature is particularly important, given the difficulty of providing health services that are efficient, timely, and appropriate without the benefit of high quality population management data. The integration of SDOH-related costs into global payment structures, as well as related policy changes to address upstream factors that impact those populations served by federally qualified health centers, such as housing and transportation needs, behavioral health/substance use, etc.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

CHC's strategies to increase investment in primary care include:

- The utilization of Pharmacy Benefit Managers (PBMs) to reduce drug costs and increase access to drugs for patients through home delivery, the use of generics and more affordable brand medications, manufacturer rebates, management of high-cost specialty medications, reduced waste, and improved drug adherence among patients.

- Employment of Medication Therapy Management (MTM) pharmacists to increase access, reduce return-to-stock rates, and cut overall primary care costs through improved drug adherence, ongoing disease management support, and medication therapy planning.

- CHC's recognition as a Patient Centered Medical Home increases efficiency through streamlining of care coordination and care management services, increased reimbursement rates, and the achievement of core competencies that enhance benefits associated with value-based care models.

b. Please describe your organization's top strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization

is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

CHC has increased its investment in behavioral health (BH) care through an ongoing effort to aggressively pursue grant funding that is targeted to support BH services. CHC has successfully obtained increased BH funding through grants submitted to the U.S. Health Resources and Services Administration (HRSA), including CHC's original Behavioral Health Services grant in 2014; a Substance Use Services Expansion grant in 2015; an Access Increases in Mental Health and Substance Abuse Services (AIMS) grant in 2017; an Expanded Access to Quality Mental Health and Substance Use Services Supplemental grant (2018); and an Integrated Behavioral Health Services (IBHS) grant (2019). Increases in staffing that have resulted from increased HRSA funding serve as evidence that these activities have represented a successful strategy to increase access to care. For example, BH staffing increased by 1.5 FTE through funds awarded through the Expanded Access to Quality Mental Health and Substance Use Services Supplemental grant in 2018. Steadily increasing numbers of BH patients also provide evidence of increased access to care. For example, during the period from May through August of this year, an average of 8 new BH patients were seen each month.

c. Payers may also provide incentives or other supports to provider organizations to deliver high-functioning, high-quality, and efficient primary care and to improve behavioral health access and quality. What are the top contract features or payer strategies that are or would be most beneficial to or most effective for your organization in order to strengthen and support primary and behavioral health care?

We have no response to this question.

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

Barrier #1: The high staff costs associated with identifying, assessing, and addressing the range of SDOH-related factors that impact patients served by federally qualified health centers.

Response to mitigate this barrier: Changes in existing global payment systems to provide a realistic level of reimbursement for the staff hours that are required to address the range of SDOH-related factors that impact patients.

Barrier #2: "Upstream" costs of addressing SDOH, such as housing, transportation, safe environments, literacy, employment, education, and nutrition.

Response to mitigate this barrier: Policy changes to target significantly increased resources to creating and sustaining the services and infrastructure that are needed to reduce the impact of inadequate housing, transportation, education, etc.

Barrier #3: The cost of conducting detailed and systematic Quality Management (QM) programs in a federally qualified health.

Response to mitigate this barrier: Changes in existing payment systems to allow a realistic level of support for QM costs.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Extent of Impact
Increased prevalence of chronic disease among your patients	n/a
Aging of your patients	n/a
New or improved EHRs that have increased your ability to document diagnostic information	significant
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	significant
New, relatively less healthy patients entering your patient pool	significant
Relatively healthier patients leaving your patient pool	n/a
Coding changes (e.g., shifting from ICD-9 to ICD-10)	significant
Other, please describe: Click here to enter text.	n/a

☐ Not applicable; neither risk scores nor acuity have increased for my patients in recent years.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed. Please note that I could not modify the **Priority Level** column in this version – so I have indicated the priority levels in the **Areas of Administrative Complexity** column (#1, #2, #3)

Area of Administrative Complexity	Priority Level

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	Priority Level
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Priority Level
#2 **Clinician Licensure –** seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Priority Level
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Priority Level
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Priority Level
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Priority Level
#1 **Provider Credentialing –** obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Priority Level
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Priority Level
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Priority Level
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Priority Level
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Priority Level
#3 **Variations in Payer-Provider Contract Terms** – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

5. STRATEGIES TO SUPPORT ADOPTION AND EXPANSION OF ALTERNATIVE PAYMENT METHODS:

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.** Please note that I could not modify the boxes in this version – so I have indicated the priority levels with **X, X, X.**

- ☐ **X** Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☐ **X** Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☐ Encouraging non-Massachusetts based payers to expand APMs in Massachusetts
- ☐ Identifying strategies and/or creating tools for overcoming problems related to small patient volume
- **X** Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)
- Aligning payment models across payers and products
- Enhancing provider technological infrastructure
- Other, please describe: Click here to enter text.

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 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 Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	n/a*	n/a*
	Q2	n/a*	n/a*
	Q3	n/a*	n/a*
	Q4	n/a*	n/a*
CY2018	**Q1**	n/a*	n/a*
	Q2	n/a*	n/a*
	Q3	n/a*	n/a*
	Q4	n/a*	n/a*
CY2019	**Q1**	n/a*	n/a*
	Q2	n/a*	n/a*
	TOTAL:	n/a*	n/a*

* All services are provided according to a Board-approved sliding fee scale that is based on current Federal poverty level guidelines. CHC does not track price inquiries.

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.

As noted, all services are provided according to a Board-approved sliding fee scale that is based on current Federal poverty level guidelines. CHC responds to all requests for pricing and other

information in a timely manner. However, we do not conduct monitoring or analysis of our responses to consumer requests for price information.

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?

As noted, we respond to all requests for pricing and other information in a timely manner. Information on pricing and other relevant topics is provided regularly to staff by supervisors. Staff are trained to respond to requests for information promptly and accurately, or to refer questions requiring more detailed information to their supervisors. We have not encountered barriers to providing accurate, timely responses to consumer inquiries for price information.

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

    a. For each year **2016 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.

    b. For **2018 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.

Exhibit 1 AGO Questions to Providers

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. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **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.
5. **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.
6. **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.
7. **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).
8. **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.
9. **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.
10. **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.
11. **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.

2015	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	X	X	X	X	$30M	X	($0.50)	X	$0.50	X	X	$40M	X	X	$10M
Tufts Health Plan	$15M	$7M	$0.3M	0	X	X	X	X	X	X	X	X	$0.25M	X	X
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial															
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth															
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare															
Other															
GRAND TOTAL															

2016	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	X	X	X	X	X	X	X	X	X	X	$37,954.00	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$62,687.00	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	X	X	X	X	$4,112.00	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$10,416.00	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$17,525.00	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$8,480.00	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$5,175.00	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$117,288.00	X	X	X	X
Total Commercial	X	X	X	X	X	X	X	X	X	X	$263,637.00	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$332,849.00	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$637,943.00	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$895,398.00	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	##########	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$132,102.00	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	##########	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	##########	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$16,279.00	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$16,279.00	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	##########	X	X	X	X
Other											$209,159.00				
GRAND TOTAL											##########				

2017	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	X	X	X	X	X	X	X	X	X	X	$50,578.00	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$52,313.00	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	X	X	X	X	$3,467.00	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$9,190.00	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$17,592.00	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$20,287.00	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$5,848.00	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$289,103.00	X	X	X	X
Total Commercial	X	X	X	X	X	X	X	X	X	X	$448,378.00	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$343,784.00	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$491,725.00	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$914,632.00	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	$1,109,388.00	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$71,336.00	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$2,930,865.00	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	$2,331,777.00	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$19,181.00	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$19,181.00	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$1,268,618.00	X	X	X	X
Other											$74,955.00				
GRAND TOTAL											$7,073,774.00				

AGO Provider Exhibit Caring Health Center

2018	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	X	X	X	X	X	X	X	X	X	X	$85,350.00	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$50,001.00	X	X	X	X
Harvard Pilgrim Health Care	X	X	X	X	X	X	X	X	X	X	$2,582.00	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$55,829.00	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$14,806.00	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$24,426.00	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$8,309.00	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$353,039.00	X	X	X	X
Total Commercial	X	X	X	X	X	X	X	X	X	X	$594,342.00	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$110,271.00	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$96,641.00	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$280,111.00	X	X	X	X
Health New England	X	X	X	X	$3,717,302.00	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$21,776.00	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$508,799.00	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	$1,382,396.00	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$11,340.00	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	$11,340.00	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$1,397,439.00	X	X	X	X
Other											$236,323.00				
GRAND TOTAL					$3,717,302.00						$4,130,639.00				