MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 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 (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines 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.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 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 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, 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 25, 2019, 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 the Suffolk University website. 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 available via livestream and video will be 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 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 page on 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 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 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.**

On or before the close of business on **September 20, 2019**, 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.

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 or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

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?
Reduce ED Visits, Increase Treatment Engagement in SUD, Reduce Tobacco Use among patients and staff

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?
Better information sharing/timely feedback on overall utilization and costs by our patients

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.

b. Use of DSRIP funds to improve our EHR and IT infrastructure and data analysis.
Our integrated model of primary care, mental health, SUD services including all forms of MAT improves treatment engagement and care coordination . Patients -especially those with complex lives – need easy access to these services and it's much more convenient to be able to access at one location with navigators, recovery coaches, care coordinators, to facilitate hand-offs. We have dramatically reduced waits for BH services through a walk-in open access model and our Opioid Urgent Care Center. Our FQHC strives for a more open access model. Our Behavioral Health Community Partner services have significantly reduced unnecessary ED visits by the high utilizers and improved coordination with primary care. Coordinating with Southcoast Hospitals ED to offer a "bridge clinic" for patients who go to the ED for opioid use disorder. The ED physician gives them one dose of Suboxone and sends them to SSTAR FQHC/MAT clinic, where we will titrate, provide a 'bridge' script and make a warm hand-off to our MAT clinic to go through the full admission as soon as possible. The bridge clinic is also used for

patients leaving our ATS detox, Dual Diagnosis inpatient, and CSS who wanted to be initiated on MAT while on the inpatient unit but need immediate access to MAT services on the day of discharge. They can walk across the parking lot and use the Bridge Clinic until they can be formally admitted into our or another MAT provider. We also have a MAT Case Manager on inpatient who negotiates the often very complicated aftercare arrangements for discharging patients on MAT. Successfully linking with a community MAT provider without disruption in medication regime is key to avoiding relapse and readmission (and overdose deaths).

c. 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.
d. Obtained SAMHSA CCBHC grant that allowed for increasing pay rates to recruit psychiatric prescribers. This is a temporary fix – it needs to become financially sustainable after the grant. Prior to this, we had months wait for new psychiatric patients. Now it is almost at same day. This kind of access – especially in a setting like SSTAR with a full range of wrap-around services and supports – reduces utilization of inpatient psychiatric and other acute levels of care.
e. The CCBHC grant is also allowing us to introduce two new types of services that we believe will improve treatment outcomes and reduce costs. 1) family peer recovery coach for people with loved ones affected by addiction. 2) "enhanced" partial hospital program for people with co-occurring psychiatric and opioid use disorder that includes as part of the daily program, psychiatric assessment and treatment, acupuncture, primary care, Medication Assisted Treatment for OUD – Buprenorphine and Vivitrol
f. We are developing a medical residency program for Family Practice with a strong addiction medicine component.
g. Click here to enter text.

h. 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?
Adequate reimbursement of course.
Timely and meaningful utilization and outcome data. Beacon and MBHP have been helpful in providing some such feedback over the years but it lacked some key data points- primarily utilization of non-BH services such as ED and inpatient acute care hospital utilization. Getting rid of unreasonable and unproductive EIM ESM demands would help improve the admission process. We have too many forms for patients to complete.

i. 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?

Single Payer would eliminate an enormous amount of administrative complexity and reduce access barriers. Massachusetts leads the nation in creative strategies to reduce healthcare costs while improving outcomes and patient satisfaction. The side effect has been costly administrative complexity for providers that has not been fully acknowledged.

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	Level of Contribution
Increased prevalence of chronic disease among your patients	Major Contributing Factor
Aging of your patients	Not a Significant Factor
New or improved EHRs that have increased your ability to document diagnostic information	Minor Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Major Contributing Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant Factor
Other, please describe: **Increasing acuity of mental health symptomatology and declining availability of DMH services**	Major Contributing Factor

☐ 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.

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	High

Area of Administrative Complexity	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	Low
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	High
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	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	High
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Low
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	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
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	Medium
Other, please describe: EIM-ESM requirements. They affect our SUD programs which are an integral part of our services. The data collection and entry seem unreasonably onerous for staff and patients with very little in the way of usable reports and data analysis. It becomes a major business disruption when there is staff turnover among data entry staff. No forms can be entered until we can send someone else to a BSAS EIM/ESM in-person, day long, training somewhere in the state. It just seems ridiculous that the data entry staff can't be trained and approved for data entry through some on-line trainings.	Medium
Other, please describe: Click here to enter text.	Priority Level
Other, please describe:	Priority Level

Area of Administrative Complexity	Priority Level
Click here to enter text.	

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.**

- ☒ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments. (So long as rates are adequate)
- ☐ 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
- ☒ 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 – state leadership re interoperability including state agencies and MassHealth
- ☒ Other, please describe: We continue to be concerned that payors underfund the cost of care and push those costs down on small community-based organizations that are least ab1le to absorb them .

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**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	Q3		
	Q4		
CY2019	**Q1**		
	Q2		
	TOTAL:		

    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.
    Click here to enter text.

We have not been tracking this. We don't believe we get many such requests but will begin to track this by letting staff know to direct these inquiries to the billing department where they will keep a record.

    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?
    Click here to enter text.

3. For hospitals and provider organizations corporately affiliated with hospitals: N/A

    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											14,024.91	399,007.69			
Tufts Health Plan												95,197.89		9027.89*	
Harvard Pilgrim Health Care												18,715.25			
Fallon Community Health Plan															
CIGNA												7,530.92			
United Healthcare												78,562.61			
Aetna															
Other Commercial												52,654.24			
Total Commercial												651,668.60			
Network Health											1,467,746.21				
Neighborhood Health Plan											1,732,114.42				
BMC HealthNet, Inc.											4,251,307.42				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											596,767.61				
Total Managed Medicaid											8,047,935.66				
MassHealth											2,187,718.32	1,695,295.26			
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare											13,822.50	438,662.87			
Other												614,478.95			
GRAND TOTAL											10,249,476.48	3,400,105.68		9,027.89	

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											13,174.78	459,866.83			
Tufts Health Plan												103,894.24		6855.09*	
Harvard Pilgrim Health Care												25,814.18			
Fallon Community Health Plan															
CIGNA												8,380.80			
United Healthcare												105,775.47			
Aetna															
Other Commercial												57,575.84			
Total Commercial												761,307.36			
Network Health											1,450,433.89				
Neighborhood Health Plan											1,941,561.50				
BMC HealthNet, Inc.											4,774,957.65				
Health New England															
Fallon Community Health Plan											405.96				
Other Managed Medicaid											687,142.81				
Total Managed Medicaid											8,854,501.81				
MassHealth											2,144,118.75	1,345,168.41			
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare											16,406.22	622,966.96			
Other												745,568.76			
GRAND TOTAL											11,015,026.78	3,475,011.49		6,855.09	

*PCP management

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											10,671.02	448,108.29				
Tufts Health Plan												81,481.96		909.96*		*PCP management
Harvard Pilgrim Health Care												18,956.68				
Fallon Community Health Plan																
CIGNA												9,372.73				
United Healthcare												145,881.92		7.82*		*PCP management
Aetna																
Other Commercial												108,636.44		483.15*		*PCP management
Total Commercial												812,438.02		1,400.93		
Network Health											1,503,062.00					
Neighborhood Health Plan											1,706,507.43					
BMC HealthNet, Inc.											5,475,856.26					
Health New England																
Fallon Community Health Plan																
Other Managed Medicaid											695,389.92					
Total Managed Medicaid											9,380,815.61					
MassHealth											2,020,141.04	1,541,770.71				
Tufts Medicare Preferred																
Blue Cross Senior Options																
Other Comm Medicare																
Commercial Medicare Subtotal																
Medicare											19,859.90	681,583.86	2317.00*			*PCP management
Other												447,814.01				
GRAND TOTAL											11,420,816.55	3,483,606.60	2,317.00	1,400.93		

AGO Provider Exhibit 1

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											12,149.15	445,099.93	7910*			*PCP management
Tufts Health Plan												97,134.27		642*		*PCP management
Harvard Pilgrim Health Care												12,334.64				
Fallon Community Health Plan																
CIGNA												9,685.92				
United Healthcare												310,738.34		2150*		*PCP management
Aetna																
Other Commercial												181,803.97		2391.99*		*PCP management
Total Commercial											12,149.15	1,056,797.07				
Network Health											1,431,722.82					
Neighborhood Health Plan											1,025,286.94					
BMC HealthNet, Inc.					779,517.64				221,200.26		7,008,521.57					
Health New England																
Fallon Community Health Plan											84.56					
Other Managed Medicaid											575,654.77					
Total Managed Medicaid											10,041,270.66	0.00				
MassHealth											2,065,323.82	1,692,281.83				
Tufts Medicare Preferred																
Blue Cross Senior Options																
Other Comm Medicare																
Commercial Medicare Subtotal																
Medicare											23,741.41	707,649.02	1456*			*PCP management
Other												803,297.88				
GRAND TOTAL					779,517.64				221,200.26		12,142,485.04	4,260,025.80	2,366.00	5,183.99		