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?

Beth Israel Lahey Health ("BILH") was created with the goals of transforming how health care is delivered and improving the lives of patients throughout Eastern Massachusetts. The system was created out of a commitment to finding bold and innovative market-based solutions to deliver the health outcomes patients and their families deserve, expanding access to care, and being part of the solution that addresses the high cost of health care.

In support of this commitment to high-quality, high-value care that addresses the growth in health care expense, BILH has pursued a range of early priorities. Examples include:

Shifting services to lower-cost community settings. For BILH, achieving "right site of care" for our patients means strengthening and expanding high-quality care close to where patients and their families live and work. For a range of services, BILH is actively pursuing initiatives to strengthen community hospital capabilities and reduce the use of higher-cost facilities such as Beth Israel Deaconess Medical Center ("BIDMC") and Lahey Hospital and Medical Center ("LHMC") where equivalent or higher-quality care is available in local settings. One example is an ongoing program between LHMC and Winchester Hospital under which patients presenting with community-appropriate conditions in the LHMC Emergency Department and certain LHMC primary care practices receive accelerated direct transfer and admission to Winchester Hospital. To date, this program has resulted in approximately 500 patients accommodated annually at Winchester Hospital who would otherwise have been admitted to a substantially higher-cost setting for care. Similarly, BILH has recently initiated a regional planning effort between BIDMC, Mount Auburn Hospital, and Cambridge Health Alliance ("CHA") to identify and implement strategies to ensure that a growing proportion of community-appropriate care currently provided to CHA patients at BIDMC can be accommodated at Mount Auburn Hospital - in order to enhance patient convenience, improve timeliness of care, and reduce avoidable use of higher-cost settings.

Enhanced retention of care. Reducing "out-migration" of care – those services that currently leave our combined referral network and go to competing, higher-cost providers – is a central goal for BILH. BILH is working to explore and adopt a range of access and referral management strategies - including initiatives within Beth Israel Lahey Performance Network

("BILPN"), primary care, and select service lines such as Orthopedics - to achieve this goal, with the potential to improve patient convenience for in-system services, enhance continuity of care, and achieve savings through reduced utilization of higher-cost settings.

Reduced avoidable use of emergency departments. BILH recognizes that a significant proportion of patients who receive care within its Emergency Departments could be appropriately treated in an urgent care or physician office setting, resulting in reduced ED boarding, improved patient experience, and cost avoidance. BILH has been investing in the expansion of urgent care - including existing centers in Chelsea, Chestnut Hill, Danvers, Gloucester, Lynnfield, Wilmington, and Woburn, as well as a new site in Quincy opening in 2020 - conveniently located across Eastern Massachusetts so that patients can easily access care in a lower-cost setting when they need it. In addition, BILH Primary Care is exploring the expansion of multiple models for enhancing urgent patient access to primary care through walk-in clinics, same-day appointments, and after-hours nurse triage, among other initiatives. All of these efforts have the potential to shift non-emergent and primary care-treatable ED visits to more appropriate provider settings throughout the BILH system.

Primary care - behavioral health integration. One of the largest contributors to high health care expenses is the failure to adequately treat mental health and substance use disorders. Among Massachusetts commercial and Medicare patients, those with both a behavioral health and chronic condition co-morbidity have an average total medical expense (TME) that is 4.2 times and 7.0 times the average patient, respectively. This has prompted BILH and many other health care providers to seek evidence-based solutions to improve health outcomes while reducing health care expenses. One such initiative is the integration of primary care and behavioral health care through the Collaborative Care Model (described in greater detail in response to question 2.b.), which BILH is in the process of implementing across all of its employed primary care practices. Multiple national studies, including the IMPACT study, have demonstrated that access to Collaborative Care results in substantially reduced per member per month (PMPM) health care expenditures over a sustained multi-year period.

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

BILH's formation itself presents an important opportunity to reduce health care expenditures by driving changes in market behavior and by creating a more competitive health care market. These efforts can be supplemented and augmented by changes in policy, regulation, and statute that aim to lower state health care costs.

Market-based solutions. The state has often recognized that certain components of health care delivery in Massachusetts are dysfunctional and unsustainable. For example, state policymakers have long sought to address the need for enhanced competition in the health care market, and no market-based solution had emerged prior to the formation of BILH to provide this balance. BILH represents the opportunity to create such competition by offering the geographic coverage, scale, reputation, and value proposition (lower-cost and higher-quality providers) to exert pressure on competitors and provide enhanced value to purchasers. BILH will accomplish this by building a recognized brand that will be attractive to patients and

purchasers for its commitment to a superb patient experience, high-quality care, and effective management of cost growth.

Insurance product design. BILH encourages policymakers and the market to continue to prioritize initiatives that enable consumers and purchasers to make informed and educated health benefit decisions based on provider cost and quality. While the state has made some progress in the adoption of high-value network designs, such as tiered and limited networks, the state should continue to push the market to adopt these types of designs. For example, increasing the price differential among tiers for point of service products or implementing tiered products based on provider affiliation at the point of enrollment would enhance value-based purchasing and create the economic incentives to shift more care to higher-value settings.

Reduce unwarranted provider price variation. Unwarranted provider price variation continues to obstruct efforts to achieve a higher-functioning health care market. As has been identified in prior Cost Trends testimony by legacy BILH entities, the Cost Growth Benchmark tends to lock in and exacerbate unwarranted price disparities by allowing high-priced providers to grow at a higher actual rate than lower-priced providers among relevant peer groups. The practical effect of this dynamic is that under-resourced providers will continue to be financially disadvantaged and well-resourced providers will continue to be financially advantaged. While the infusion of market competition can assist in addressing unwarranted price variation, BILH suggests that policymakers continue to explore strategies to reduce unwarranted price variation among hospitals relative to each of their relevant market-level peer groups.

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.**

BILH is implementing various strategies to support and increase investment in primary care with the goal of creating a superior patient experience, facilitating convenient access, improving provider work life, and leveraging population health infrastructure to enhance quality and lower costs. BILH recognizes that the scale, quality, and geographic distribution of its primary care provider network will enable patients to benefit from demonstrably improved access.

One of the initiatives BILH is pursuing to expand timely and proximate primary care access for new and existing patients is the adoption of a system-wide nurse triage program.

Through this program, patients will have immediate telephonic access post-business hours and on weekends to a triage nurse (with a physician on call) to address a wide range of patient questions. This program will improve timely access to appropriate care, reduce avoidable ED utilization by redirecting patients to the appropriate care setting, and enhance physician satisfaction. Additional access enhancements that are aligned with primary care strategies include the creation of a central service center, formation of system-wide access standards, and implementation of alternative visit modalities such as telemedicine.

These efforts will be supported through the establishment of a unified primary care administrative structure. A leadership council of this new structure has established 23 work streams to implement its plan. Its work will be guided by various key objectives, including decreasing administrative workload, promoting top-of-license practice, more efficiently distributing patient care responsibilities, and establishing a continuous learning and development environment.

BILH primary care will also be collaborating and partnering with BILPN to leverage its population health management resources and expertise. BILPN will support BILH primary care in areas such as care management and data analytics to assist with the management of chronic disease and to ensure appropriate and seamless care transitions. Each of these functions will further BILH's primary care goals of delivering a superb patient experience and high quality care at a lower cost.

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.**

BILH is implementing various strategies to create a population and evidence-based system of behavioral health care with multiple access points to a broad spectrum of comprehensive services.

BILH's strategy in this space will be achieved in part through the implementation of the Collaborative Care Model, which integrates behavioral health and primary care. Under this model, patients identified through the use of screening tools and direct PCP referral are introduced to a behavioral health clinician who works collaboratively with a PCP and consulting psychiatrist to deliver evidence-based behavioral health treatments. The strategy also involves proactive follow up and coordination, ensures close patient contact, and facilitates referral to more intensive treatment for more complex patients. In multiple peer-reviewed studies, this model has demonstrated improved clinical outcomes, patient experience, and provider satisfaction, as well as reduced costs. BILH intends to phase in implementation of the model at each employed BILH primary care site (approximately 100 practices) and plans to hire additional behavioral health clinicians, consulting psychiatrists, and program supervisors over the course of implementation.

BILH is also creating a centralized bed management and placement system to facilitate access to behavioral health services across the health system, which includes 185 inpatient

psychiatric beds and 146 inpatient detoxification beds at 11 locations across the BILH system. This centralized function will monitor behavioral health patient progress through the Emergency Department and coordinate patient intake to the inpatient unit best suited to treat the patient based upon clinical presentation and geographic location. This capability serves to expedite patient admission to all BILH behavioral health beds, reduce ED boarding for behavioral health patients, maximize bed utilization, support population health goals, and enhance provider and patient experience.

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?**

BILH supports the expansion of payment models and payer strategies that facilitate primary care innovation and enhancement of behavioral health services, both of which are not effectively addressed by most current models of fee-for-service reimbursement.

Within primary care, these alternative models include enhanced PMPM payments to support the adoption of more advanced medical home practices, including prospective risk-adjusted payments per beneficiary, global per-visit payments, and enhanced quality incentive payments, among others. Additionally, health plan products that reward primary care providers for high performance, based on quality, access, and cost, and incent patients through plan design to select high-value primary care providers at the point of enrollment or point of service can materially improve efficient health care delivery. Tiered network products are a strong example of this.

Within behavioral health, payment reforms by CMS have allowed providers to bill for Collaborative Care using CPT codes for psychiatric collaborative care management services and general behavioral health integration services. Adoption of these codes by all commercial and public payers would assist in strengthening this care delivery model. Given heightened attention to behavioral health, policymakers should continue to assert a focus towards supporting payment for innovative delivery models, like Collaborative Care, that have proven efficacy. These efforts could also be reflected in expanded grant opportunities and sharing of best practices.

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?**

Primary care. In addition to the opportunities identified in question 2.c., BILH supports changes in payment that increase reimbursement for primary care services and provide sustainable reimbursement for alternative modalities such as virtual visits and telemedicine, both

of which would assist in correcting the economic forces that have led to shortages in the primary care workforce and underinvestment in digital health services. Alternative modalities are becoming more prevalent given continuing and expanded innovations in technology and can afford patients greater access in terms of timeliness and convenience. Establishing payment parity for these types of modalities would also enhance efforts to manage total medical expense by removing access barriers to care and ensuring that care is delivered in the most clinically appropriate setting.

BILH also supports efforts outlined in Question 4, Reducing Administrative Complexity, to allow primary care clinicians to devote more time to patient care instead of administrative work.

Behavioral health. BILH supports changes in payment that increase rates for behavioral health services, which have historically been under-reimbursed across payers, as well as adoption of new payment mechanisms as outlined in response to question 2 c. While reimbursement for medical services is generally higher for commercial payers than government payers, the inverse can be true for behavioral health. Establishing payment parity is an important step towards ensuring that behavioral health services are sufficiently resourced.

BILH is supportive of efforts to enhance workforce development in the behavioral health space, including state legislation that would create a commission to identify reasons for behavioral health workforce shortages in inpatient and community-based settings and make recommendations to address such shortages.

BILH also supports strategies to modernize and streamline regulatory oversight of behavioral health providers to align with integrated community-based care models. Licensing regulations are important to ensure minimum standards of care and provide patient protections, but in certain cases these regulatory structures can be redundant and contradictory. For example, not all provider types are eligible for reimbursement in a mental health clinic, which in turn limits the type of psychiatric and addiction medications that can be prescribed at that location. Policymakers could convene private and public stakeholders to engage in a regulatory review that promotes integrated behavioral care and responds to the modern needs and circumstances of multiple provider types and populations.

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

Factors	Level of Contribution
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Major Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	Level of Contribution

☐ 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	Medium
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	High
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Low
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
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

Area of Administrative Complexity	Priority Level
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	Medium
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	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	High
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: 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.

- ☐ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☒ 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
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.**

See attached AGO Provider Exhibit 1 for BILH.

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**	329	240
	Q2	403	269
	Q3	326	284
	Q4	438	296
CY2018	**Q1**	510	239
	Q2	456	221
	Q3	324	254
	Q4	329	251
CY2019	**Q1**	350	337
	Q2	392	506
	TOTAL:	3,857	2,897

*Question 2.a. only includes information for the following BILH hospitals: Anna Jaques Hospital, BIDMC, LHMC, Northeast Hospital Corp., and Winchester Hospital. The following hospitals are not included: BID-Milton, BID-Needham, BID-Plymouth, New England Baptist Hospital, and Mount Auburn Hospital.

Mount Auburn Hospital tracks price inquiries but not by the number of individuals that request this information. Instead, it tracks inquiries by counting the number of times its price estimator software is

queried. These counts are excluded from the table to ensure consistency of the data reported for BILH hospitals.

For the purposes of this table, because Anna Jaques Hospital does not track whether such inquiries are written, via telephone, or in-person, all inquiries are counted as written 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.

BILH's processes concerning consumer requests for price information are primarily managed at the local level. While processes and workflows vary across BILH entities, in general, inquiries are monitored and tracked for timeliness and completeness. The goal is to ensure that any inquiry is responded to within 2 business days. If additional information is needed to complete the response, the requestor is generally notified within that 2 business day window that more time is necessary to complete the response. Responses that occur after 2 business days may be reviewed to determine the reason that the response occurred after 2 business days. Most often, responses that occur after 2 business days are because the original inquiry lacked sufficient specification to provide an accurate estimate within the 2 business day window.

Responses are also reviewed for accuracy when the original request was made by an identified patient with a scheduled date of service and that service was delivered. In these instances, the estimate can be compared to the billed charge. These cases may be reviewed to better understand the reason for any discrepancy and to improve the accuracy of providing future estimates.

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?

The main barrier to providing timely and complete responses occurs when the requested estimate lacks sufficient specification to determine an estimate. Staff may work with the requestor to further understand the nature and scope of the service and obtaining a sufficient understanding of this information may not always occur within 2 business days.

With respect to accuracy, the most significant barrier is determining the correct CPT code to perform the estimate. Patients may provide only the name of a service, which then requires collaboration with the Coding Department to translate the description into the appropriate code to generate an estimate. This scenario may occur when the requestor is not a future patient with a scheduled service (e.g., staff cannot rely on the patient's provider, for example, to better understand the nature of the service). Ancillary codes and supplies are also challenging to determine as those codes are not necessarily uniform for each patient. Similarly, the accuracy of the estimate is also dependent on whether other medical conditions are discovered or other tests are required during the actual visit or service. Lastly, the potential for inaccuracies is greater when the requestor is not a patient because issues such as medical history and consultation with the provider performing the service cannot help inform the estimate.

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.**

See attached summary table for BIDMC and LHMC.

    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.**

See attached AGO Provider Exhibit 2 for BIDMC and LHMC.