Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

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

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

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

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

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

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

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

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

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

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

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

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

1. **Strategies to Address Health Care Cost Growth.**
Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
    a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)
    There is a need to better address the commercial price disparity across hospitals in the Commonwealth. Boston Medical Center is paid less by commercial payers than other teaching hospitals for the same care. This funding disparity ultimately supports expanding market share for high cost hospitals and hampers lower cost institutions.
    Planned Medicaid ACO reform is the right policy direction. To be successful, significant Medicaid providers need to be supported with adequate infrastructure funds and disproportionate share funding to make the needed investments in population health. ACO budget setting needs to be actuarially sound and supportive of the long term financial stability of essential providers.
    There is a need for socioeconomic adjustment of cost and quality outcomes across all payers so that institutions and providers who care for the underserved are not unfairly penalized in quality and cost contracts.

    b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)
    BMC supports legislative efforts to bring commercial payer rates more in line across providers. As indicated in the answer to 1.a. above, the gap in commercial insurance reimbursement rates is significant. Additionally, holding all hospitals to the same growth cap allows that inequity to continue.
    We also support all efforts to streamline the administrative burdens placed upon hospitals by new and ongoing regulations. Much of the information that is requested of hospitals to support these efforts already exists in various state filings. Better coordination across all state and quasi-state entities to access and use such information would help reduce administrative costs.
    Finally, BMC believes that expanded use of fully accountable care models of patient care and reimbursement can greatly benefit both patients and cost trends. We are pleased that the Commonwealth is moving in that direction with MassHealth, our largest payer, and anticipate that it will allow us to better use the health care dollar to most effectively and efficiently provide quality care.

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

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

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

Plans to Implement in the Next 12 Months

vii. Other: *At BMC, we have implemented many of the best practices highlighted above, as well as many more. The reality, however, is that drug prices are increasing because pharmaceutical manufacturer are raising prices for individual prescriptions by hundreds and thousands of percentage points each year. The overall inflation rate (price for the same quantity of the same drug) for drugs at BMC's inpatient pharmacy was over 15% for 2015-2016. This is the third consecutive year where inflation (price per unit of drug) has risen by double digit percentages. BMC has worked diligently to offset some of that growth with excellent clinical programs and focused quality improvement projects to reduce utilization. However, there are limits on how much utilization management can contain the growth. In the outpatient space, Boston Medical Center does more than most to ensure medications are available to patients at an affordable cost and to ensure patients are adherent to the regimens their clinicians have prescribed. Using the federal 340B program, we are able to provide drugs to uninsured and under-insured patients for reduced costs and used the savings to provide strong pharmacy management programs. Over half of the nearly 1 million prescriptions we dispense are given away below cost or for free. We have unmatched clinical quality programs that achieve unparalleled medication adherence and are documented to improve clinical outcomes. For example, we operate "pharmacy care management" programs that have led to dramatic improvement in the percentage of HIV patients who have their life saving medications in hand - nearly doubling from 50% of the time to more than 95% of the time. This means the percentage of patients who are "virally suppressed" (have so little of the virus in the system it is "undetectable") at BMC is an astounding 80% vs. only 55% in other settings. BMC has hired special staff to help ensure our discharging patients have their medications in their hands before they leave the hospital and understand how to take the medications, as well as providing support after discharge, including phone calls, office visits and more. We have shown that in many cases, these pharmacy-driven interventions have had a corresponding and significant impact in also reducing readmissions. We provide that level of support and success for over a thousand patients with a variety of difficult to manage and expensive medications (sometimes called "specialty medications"). We believe BMC's model is the model for excellent care.*

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

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

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

- ***Standard process for screening primary care patients for BH conditions and substance use disorders:*** *Behavioral health conditions are under-diagnosed and under-treated in primary care settings, despite their substantial contribution to patients' physical health and well-being and healthcare costs. We have implemented a systematic behavioral health screening program in which all primary care patients at BMC are offered annual screening for depression and unhealthy alcohol and drug use. Patients who screen positive receive further diagnostic testing. Results of the screenings provide PCPs with the information they need to educate, counsel and begin treatment for patients during their primary care visit, and match them with additional behavioral health resources as needed.*
- ***Embedding Behavioral Health teams into our Primary Care Practices:*** *Primary Care practices at Boston Medical Center have co-located and integrated behavioral health services. Approximately 32,000 current primary care patients at those BMC practices have access to integrated behavioral health teams and that number will grow to 45,000 patients by the end of the calendar year as we expand the capability to all of BMC's adult and family medicine practices.*
    - *Each practice's Integrated Behavioral Health Team consists of social workers for crisis intervention, short-course psychotherapy and substance use counseling; psychiatrists and psychiatric NPs for medication management and PCP education; and Care Coordinators to address social determinants of health and other resources needs that impact health outcomes. With this model, patients can receive care in their primary care practice for short-term needs, and they can be referred to the Department of Psychiatry or community resources for long-term follow-up if needed. The social workers, psychiatrists, and psychiatric NPs work collaboratively with primary care providers via face-to-face case consultation, case discussion rounds, and a systematic, evidence-based approach to depression care called depression care management.*
    - *Since 2003, BMC's Office-Based Addiction Treatment (OBAT) Program has provided medication treatment and support for primary care patients with opioid and alcohol use disorders. The OBAT model includes a full-time nurse program director, nurse care managers, a program manager and generalist physicians with part-time clinical practices who are waivered to provide buprenorphine. The Integrated Behavioral Health and OBAT teams coordinate closely on patient care.*

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

- ***Resources:*** *Current reimbursement, and in particular low Medicaid rates, do not incentivize increased investment in Behavioral Health resources. We have been able to make initial investments in behavioral health staff in primary care practices, but we have not been able to spread integrated behavioral*

resources across our entire ambulatory operation, and achieving the staffing ratios needed for optimal patient access and coordination of care requires a significant investment.

- ***Workforce and workforce development:*** *Integrated behavioral health is a new field that will require a workforce of behavioral health clinicians of diverse cultural backgrounds, linguistic abilities, and specific clinical skills relevant to the primary care setting. Recruiting a behavioral health team that reflects the diversity of our patient population, and ensuring ongoing training and support for our behavioral health clinicians is an ongoing focus for BMC.*
- ***Integration with BH providers across the continuum:*** *Lack of formal partnerships with community-based BH programs make it difficult to coordinate care for patients receiving multiple different services from multiple providers.*
- ***Lack of outcomes data*** *While we regularly track process data, including screening rates and patient access, it has been more challenging to track patient outcomes in a regular fashion. Doing so requires synchronization of EMR capabilities with our Analytics program and presents a considerable undertaking and investment.*

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

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

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

The issue of social determinants of health is so very important to the patients at BMC that we continually develop and implement numerous strategies to assist in that area. We share all of our top strategies below.

1. *BMC systematically screens and refers for social determinants of health at primary care visits for all patients. The pediatric primary care clinic has recently implemented the WE CARE model at all health supervision visits from birth to adolescence. This evidence-based intervention systematically screens for these needs at pediatric health supervision visits and refers families to existing community-based services via an Electronic Medical Record (EMR) platform. Recent data found that over 60% of families screened positive and wanted help with unmet basic needs such as food, housing, utilities and employment. This previously tested model has been demonstrated to increase parental receipt of community resources. The WE CARE model is currently being adopted to tailor the needs of adult populations and will be implemented in the BMC primary care clinic in the near future. Additional strategies include substance abuse programs, Medical Legal Partnership program and Health Leads. A team of community health workers are embedded in the department of Pediatrics clinics to facilitate coordination of care and services. Development of a social determinants of health screening tool for adults is in process for implementation in the EMR. BMC has increased staffing in the adult primary care clinic areas with care coordinators, navigators, community health workers and social workers to identify social barriers to stable health and wellness and refer patients for services. BMC has developed a database of community based service providers for staff to access social services to provide referrals for patients. The database provides vetting through GuideStar rating.*
2. *BMC has developed a case-management program for in-patients with complex disease states and high utilization. The program consists of a physician, nurse care managers, care coordinators, social workers*

and community health workers to identify social drivers of disease instability and adds high level patient engagement during admission, at discharge and post discharge to address potential barriers to stable health along the care continuum. An in-patient addiction consult service was established 1 year ago for the purpose of addressing and treating substance use disorders and other social barriers to mitigate cycles of disease instability. The consult team is a multidisciplinary team.

3. *BMC has just established an Urgent Care Substance Use Center in the hospital. In addition to providing out-patient treatment for substance use disorders, the center screens and refers for social determinants of health such as food, housing and out-patient Behavioral Health services. It provides assistance with establishing health insurance and a primary care physician and appointment at the first visit. The center is staffed by physician and nurse addiction specialists.*
4. *In June 2016, BMC integrated a Social Determinants of Health didactic and simulation in the hospital wide orientation curriculum for new interns. Social Determinants of Health was included among general competencies, Quality and Patient Safety and Infectious Disease. BMC is presently planning development of a longitudinal social determinants of health curriculum for all levels of trainees as part of a required Graduate Medical Education's Clinical Learning Environment Review. BMC is also discussing an integrated SDOH longitudinal curriculum with Boston University School of Medicine for medical students.*
5. *BMC's Violence Intervention Advocacy Program (VIAP) reaches out to connect with every victim of penetrating trauma who is brought to BMC. The program intervention is targeted towards the physical, emotional, and social needs of violently injured youth. Based on a peer advocate model and Trauma Informed Care approach, VIAP's program goals are to: assist in emotional and physical recovery from violent trauma; empower victims of violence with skills, services, and opportunities. Each victim of violence is assigned a VIAP advocate and a Behavioral Health clinician from the Community Violence Response Team (CVRT) who work in tandem to address social determinants of health and provide services such as housing, job readiness skills, employment, education, food security, and behavioral health services for victims and their families. The staffs (VIAP and CVRT) consist of 2 Licensed Clinical Social Workers, 3 case managers, 1 family support Advocate, a career specialist, 1 data research manager and 4 behavioral health clinicians (1 child, 2 adult and 1 family clinicians). VIAP has a new housing and employment track focusing on job readiness skills, employment and housing. The program is funded by a grant from the Department of Justice. The employment track is a partnership with BMC Human Resources. Clients are enrolled in the program, immersed in a job readiness curriculum and apply for employment at BMC. Some clients are referred for employment outside of BMC. Enrollees receive ongoing support from VIAP advocate staff. VIAP has a partnership with a real estate management company who will provide housing.*
6. *BMC was recently awarded a grant from the HPC that focuses on Social Determinants of Health and is intended to improve patient health and reduce health care costs. BMC will pilot a Community Health Advocate-driven intervention in the BMC emergency department. The intervention will focus on medically complex disenfranchised patients, screening for social determinants of health, referral to services and community health workers to support and facilitate patients facilitate service.*

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

1. *Availability of funding to provide a sufficient number of community health workers and other trained advocacy staff to coordinate services, referrals and support between the hospital and communities to address population health in its broadest sense. To impact quality, care and cost across the care continuum requires integration and coordination between hospitals and community services. Navigators, care coordinators and community health workers can then execute seamless transition of service referrals from hospital to completion in community and report outcomes and impact. People in*

these roles are also able to coordinate and provide community based services that can prevent unstable costly hospitalizations.

2. *The top barriers for addressing the social determinants of health in our patients at BMC include: lack of physician time, training dissemination, and sense of efficacy. Although BMC has expanded the use of patient navigators and has additional support staff such as social workers and community health workers there is still a lack of support staff to adequately assist the medical team and patients in adequately addressing the social determinants of health.*
3. *Lack of reimbursement for addressing social determinants which is time consuming is also a critical barrier.*

5. Strategies to Encourage High-Value Referrals.

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

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

We are active members of the University Health Consortium which allows us to compare our performance at the hospital and clinical department level to other teaching hospitals across the country. Our clinical leadership has access to and makes robust use of this data. Wherever feasible, our formal relationships with community providers include review of quality metrics and shared commitment to quality improvement.

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

No

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

38T

ii. If no, why not?

Cost and quality information, even for our affiliated providers, comes from multiple sources including payer claims, hospital information systems, credentialing systems, etc. We do not yet have the ability to integrate that information in an actionable way into our provider's referral workflow.

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

No

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

38T

ii. If no, why not?

Relevant information would either be from the public domain or for payers. In general, it is not detailed or comprehensive enough to make decisions as to where to refer a specific patient for a specific service or evaluation.

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

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
Our Epic EMR has the ability to exchange information with other systems. Outside users must attest to having appropriate patient permissions and have appropriate patient identifying information. Outside access is currently read only.

ii. If no, why not?
38T

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

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

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)
We carefully evaluate opportunities to enter appropriate risk based contracts with commercial payers and opportunities to enter public programs incorporating population health targets and/or bundled payments.

We continue to invest in our population health infrastructure to improve performance in population health arrangements.

We continue to strengthen our population health analytics capability both to evaluate potential new risk based contract and arrangement and support performance improvements within these arrangements.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)
A challenge is fragmentation of these arrangements across multiple payers. That creates unclear incentives and separate settlements, which are actuarially sound then consolidated settlements. Some standardization of contract terms across payers would be helpful.

We are also challenged by the need for infrastructure support for needed investments upfront to drive successful outcomes in these arrangements. Recognition across all payers of this need would help encourage more rapid adoption of these agreements.

Underlying payment rates still need to be adequate. Correction of rate disparities in the commercial markets would help address this.

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

i. If no, why not?

They are, in general, carved out by the payers. We are quite open to inclusion in APM contracts if we are given appropriate management control.

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.
    a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.
    We track over 400 metrics across our system and are held accountable for and report on different subsets of these metrics to various payers and agencies. This fragmentation makes it difficult for us to focus on a manageable number of quality metrics and direct appropriate resources to them.

    b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).
    We seek to negotiate payer arrangements that have consistent reporting and quality incentives with current contracts and reporting requirements. Statewide determination of annual quality priorities and reporting requirements for payers and provider would provide a helpful framework for this.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
38T

Exhibit C: AGO Questions for Written Testimony

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

1. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.
   The summary tab of BMC's attached spreadsheet describes the revenue and margin differences for the HMO, PPO and PMPM contracted business.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.
      Price inquiries are currently logged. Price analysis process is used to create an estimate and are compiled by using values provided in our Charge master, and payment history on the procedure. Since 2014, BMC has provided responses to a patient or clinic within 48 hours by members of our Patient Outreach staff.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.
      Calls received by customer service or Financial Counseling are recorded on a price transparency log and we've established a specific email distribution group who is notified of inquiries. They are then added to central tracking document for timely response to patient or clinic. Our process is to check the log daily to promote timely responses. The central document and email distribution group records detailed information about the request and assigns responsibility / accountability for follow up. We also document the CPT and price equivalent to the code provided.

   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?
      There is some level of difficulty in obtaining the clinically appropriate CPT codes which are not always readily known or available.
      To solve this, we created a Self-Pay Inquiry form for clinics to complete and send to Patient Outreach to further document the process.
      Price inquiry emails and logs are saved in Outreach price inquiry folder for future reference.
      Additionally it is difficult to understand the application of benefits from respective payers. Sometimes this is conditional based on specific diagnosis codes and as a provider, we don't always understand the contract exclusions which make is difficult to provide estimates. we will

explain the situation to the patient and ask them to contact their insurance company as well, to ensure that they are getting a complete and accurate answer.

Service Category	Commercial				Government				All Other			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
2012 GRAND TOTAL	63,756,248	(8,120,776)	73,953,156	(27,933,575)	297,394,087	(3,336,636)	231,159,390	(72,298,028)	4,153,179	(3,251,837)	4,304,804	(6,607,502)
2013 GRAND TOTAL	60,740,913	(7,633,231)	71,745,194	(27,709,793)	304,667,476	(14,893,619)	250,480,976	(67,522,127)	4,691,697	(5,120,048)	4,164,320	(7,678,611)
2014 GRAND TOTAL	57,892,366	(7,197,226)	71,335,306	(20,809,900)	300,837,042	(36,859,410)	281,412,467	(49,478,887)	5,828,389	(5,533,000)	4,603,932	(6,734,510)
2015 GRAND TOTAL	53,194,144	(8,474,657)	72,731,558	(19,363,479)	315,696,203	(41,776,889)	295,750,615	(54,614,965)	5,631,558	(6,250,578)	4,807,643	(8,727,174)

Payer Mix	Inpatient	Outpatient	Total
Commercial	14%	20%	18%
Government	83%	77%	79%
All Other	3%	3%	3%
Total	100%	100%	100%

Total			
Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
365,303,513	(14,709,249)	309,417,349	(106,839,105)
370,100,086	(27,646,899)	326,390,490	(102,910,531)
364,557,797	(49,589,636)	357,351,705	(77,023,297)
374,521,905	(56,502,124)	373,289,816	(82,705,618)

Payor rollup	Payor Type	Payor	Net Revenue	Margin
Government	Indigent	Free Care	31,001,228	(1,660,802)
	Medicaid	Comm Care BMCHP	11,036,571	2,968,931
		Comm Care Other	9,660,093	(6,551,810)
		HMO Medicaid BMCHP	108,981,731	19,285,610
		HMO Medicaid NHP	34,393,604	(11,331,322)
		HMO Medicaid Other	24,260,417	(12,943,850)
		Medicaid	156,304,441	(60,740,133)
		Other	607,552	(817,418)
	Medicare	BCBS	2,475,284	(178,193)
		EverCare	727,700	(113,846)
		HMO HPHC	-	(537)
		HMO Medicare	41,596,145	(10,290)
		HMO Tufts	7,464,179	(2,824,961)
		Medicare	180,741,282	(20,991,019)
		Other	2,196,591	(482,214)
	Government Total		**611,446,818**	**(96,391,854)**
Commercial	Commercial	BCBS	45,171,398	(10,011,469)
		Comm	20,581,430	(2,969,567)
		HMO HPHC	29,546,435	(5,667,609)
		HMO NHP	7,366,556	(468,366)
		HMO Other	12,749,933	(3,238,274)
		HMO Tufts	7,116,635	(4,289,726)
		Other	3,392,297	(1,191,713)
	Medicare	BCBS	1,018	(1,412)
Commercial Total			**125,925,702**	**(27,838,136)**
All Other	Other	Comm	358,422	(314,994)
		Other	3,926,634	(6,184,291)
		Work Comp	4,219,798	(1,699,225)
	Self Pay	Other	187	(1,795)
		Self Pay	1,934,160	(6,777,447)
All Other Total			**10,439,201**	**(14,977,752)**
Grand Total			**747,811,721**	**(139,207,742)**