MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

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

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

Notice of Public Hearing

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

Scheduled hearing dates and location:

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

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

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

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

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, and/or 2017 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

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

If you have any difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

HPC Contact Information

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

AGO Contact Information

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

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

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

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

1. Mandated nurse staffing ratios ballot question ("Question #1")

Of great concern is ballot Question #1, which, if passed, would mandate all Massachusetts acute care hospitals meet strict minimum nurse-to-patient staffing ratios beginning January 1, 2019. As written, the one-size-fits-all approach to staffing would result in dramatically increased costs to consumers, providers, and the state, estimated in the first year alone to add $1.3 billion to the state's overall healthcare spending. The increased costs would overburden hospitals across the state, setting off a vicious cycle of hospital closures, service reductions and decreased access. Increased cost pressure on providers may also lead to payers having to increase provider rates. In effect, Question #1 would significantly impede the state's efforts to promote cost containment and meet the 3.1% benchmark in future years.

2. Pharmaceutical spending

Growth in pharmaceutical spending consistently far exceeds the benchmark, growing at an annual rate of 7.2% and 6.1% in 2015 and 2016, respectively – the highest rates of any spending category in each year. Complicating matters further, the drug pricing debate underway at the Federal government has put the 340B drug discount program under increased scrutiny under the claim that it contributes to drug price inflation. Quite to the contrary, Boston Medical Center (BMC) and other providers who serve a disproportionate share of low-income patients depend on the government-mandated drug discounts provided through the 340B program in order to bring costs down and provide high quality care for patients. Putting this essential program at risk would only serve to exacerbate spending growth in pharmaceuticals, further jeopardizing the state's ability to achieve the benchmark.

3. Opioid crisis

Massachusetts continues to be one of the states hardest hit by the opioid crisis. While the state's opioid-related death rate decreased (by 4%) in 2017 for the first time since 2010, the effects of the opioid crisis on patient care and healthcare costs going forward remains of grave concern. Of particular importance to cost is the increasing burden placed on resource-intensive emergency services to care for overdose victims, which comes at a significantly higher cost to the system than prevention or outpatient treatment, and puts a strain on already limited resources.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
Required Answer: Click here to enter text.

1. Mandated nurse staffing ratios ballot question ("Question #1")

BMC supports the Coalition to Protect Patient Safety in opposition of Question #1 in an effort to avoid the potential detrimental impacts its passing would impose on the healthcare system. As it is currently written, Question #1 would cause BMC to lose an estimated $28 million – through a combination of increased labor costs and decreased patient service revenue – in order to meet the stringent nurse-to-patient staffing requirements. For reference, this amount is about equal to our total margin for fiscal year 2017. To make matters worse, the effective date of January 1, 2019, leaves providers and lawmakers with little-to-no time to prepare for implementation (the state Legislature will not be resuming session until the law is already in effect).

2. Pharmaceutical spending

We strongly urge the state in partnership with the Federal government to preserve the 340B drug pricing program, which provides BMC with discounts on nearly three-quarter of a million prescriptions per year. The savings accrued through 340B in turn support our highly successful Specialty Pharmacy Program that provides comprehensive, high-touch services for thousands of patients receiving treatment for cancer, HIV, hepatitis C, and many more specialty conditions. The program has achieved impressive results for our patients including: increased medication adherence to 90-99%, reduced waiting times for cancer patients to receive their medications from an average of 11 days to same day pick-up, and decreased hospital readmissions rates by 60% for patients with acute myocardial infarction (AMI or "heart attack"). Any scaling back of the 340B program would undermine these efforts to lower healthcare costs and improve quality of care for our patients. We therefore recommend the state Medicaid program continue to allow 340B-eligible providers to fully utilize the program. In addition, we recommend the state explore value-based purchasing options that enhance payments for desired outcomes and reduce or eliminate payments for ineffective therapy. For example, limit payment for cancer drugs when used for indications where there is no evidence for effectiveness. Identify centers of excellence for conditions based on ability to provide exceptional outcomes in treatment of hepatitis C, HIV, and addiction. Significant changes are needed in order to control skyrocketing drug prices and prevent pharmaceutical spending from crowding out other important healthcare services. Given the complexity of the pharmaceutical supply chain, any changes should be thoroughly vetted to avert any unintended consequences that could disproportionately impact safety-net providers.

3. Opioid crisis

Despite the recent turnaround in the state's opioid-related mortality rate, there remains much to be done in order to reach more vulnerable patients with opioid use disorder and effectively stop the epidemic. We commend the Governor and state Legislature for their recent efforts in passing the Opioid 2.0 bill, which includes many provisions that will advance treatment for opioid use disorder (OUD) across the Commonwealth. We are particularly encouraged by the measures that seek to make Medication for Addiction Treatment (MAT) more available in emergency departments and correctional facilities, as well as language authorizing a HPC grant program to support programs studying and treating the long-term effects of neonatal abstinence syndrome (NAS) on children as they grow. An area that remains a concern across the Commonwealth is the low number of providers with waiver authority to prescribe MAT. More can and should be done to incentivize greater provider participation to address the low number of prescribers that poses

a significant barrier to individuals with OUD accessing MAT. BMC, through its Grayken Center for Addiction, has long served as a testing ground for many pioneering initiatives in addiction treatment, prevention, training, and research, and will continue our work of spreading best practices.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.
Required Answer: Click here to enter text.

The BMC Health System partners with four hospital system-led ACOs across the state – Signature, Southcoast, Mercy, and the Boston Accountable Care Organization (BACO). BMC is the anchor institution of BACO. BMC and other BACO-affiliated providers are directing tertiary volume to low cost, high-quality institutions, like BMC. Redirecting clinical services to lower cost providers will play a role in driving down overall healthcare costs. BMCHP also minimizes costs by maintaining a low administrative rate and leveraging the plan's multi-product, multi-state (Massachusetts and New Hampshire) operations to generate economies of scale.

Over recent years, our system has increased use of alternative payment methodologies – assuming full risk in the aforementioned Medicaid ACOs – and decreased unnecessary hospital utilization. Going forward, these areas remain high-level system priorities, which drive system-wide strategies aimed at reducing health care expenditures. These strategies, which in many ways are complementary and not mutually exclusive, include: high risk care management, strengthening the care continuum, and addressing social determinants of health (or root causes) of high health care utilization.

i.) High risk care management – i.e. management of the top 2-3% of highest cost patients that account for a disproportionate share of overall cost. Our overarching goal for our high risk care management program is to decrease unnecessary healthcare utilization and improve the relationship patients have with the healthcare system, which together, ultimately aim to improve the health of the population. Specifically, the program aims to reduce costly inpatient and emergency department (ED) visits and increase engagement with outpatient primary and specialty care. As part of these efforts, we are monitoring important clinical indicators, such as readmission rates, low acuity ED visit rates, and medication adherence rates – the latter of which also happens to be an area where our system has a strong track record of success through our Specialty Pharmacy Program; refer to Question 1b) "Pharmaceutical spending" for details.

ii.) Care continuum – Maintaining a robust continuum of care across the system, including primary care provider (PCP) sites and community health centers (CHC), has long been a strategic priority. BMC is a founder of Boston HealthNet, a network affiliation of BMC, Boston University School of Medicine, and fourteen community health centers across the Boston area. Our efforts to strengthen the care continuum dovetail with the state's Community Partner (CP) integration through the MassHealth ACO program, bolstering capacity for community-based care. In order to achieve desired cost savings, improving transitions of care between sites of care is a key system goal.

iii.) Pathways to address root causes – Social determinants of health are a key driver of high cost and are targeted through numerous system interventions. As an example, we have identified lack of stable and affordable housing as a major strategic area for our system to address in order to positively impact patient and community health. Our system has increased our

investment in affordable housing and community housing organizations through our $6.5 million Determination of Need initiative. Through this initiative and others, like the Housing Prescription (Rx) Project, we are increasingly partnering with community-based housing programs to address this structural issue for our patients – refer to Question 3b) for details.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

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

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

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

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

N/A

Number of unique patient visits	
Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	
Percentage of patient visits where the patient is referred to a more intensive setting of care	

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

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

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

BMC is optimizing primary care access and scheduling protocols to support diversion of low acuity ED visits to primary care. These efforts include incorporation of extended evening and weekend hours, addition of mid-level providers, and optimization of scheduling protocols to support more real-time access to primary care providers.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.
Required Answer: Click here to enter text.

At BMC, we are very much in support of increasing access to care to reduce unnecessary and avoidable utilization of emergency and inpatient services. In addition, this shift in site of care allows our clinical staff to work at top of license in attending to higher order care. While the growth in alternative care sites in Massachusetts has positive implications for patient access to care in community and after-hour settings, we have faced issues with receiving timely and accurate patient encounter data from these sites, which interferes with our ability to adequately coordinate care for our patients who receive care at these alternative sites. As we transition to assuming greater risk for our patient population, this information gap becomes increasingly consequential.

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

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

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

- ☒ Legal barriers related to data-sharing
- ☒ Structural/technological barriers to data-sharing
- ☒ Lack of resources or capacity of ~~your organization or~~ community organizations
- ☐ Organizational/cultural barriers
- ☐ Other: Click here to enter text.

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?
Required Answer: Click here to enter text.

At BMC, we have an ambitious goal – to make Boston the healthiest urban population in the world by 2030. Long at the forefront of institutions addressing health-related social needs, BMC is making renewed strategic investments in this area to standardize and scale our efforts system-wide in order to alleviate social burdens in service of our goal.

One such example is our THRIVE universal screening and community resource referral program, which BMC has developed and employed to systematically identify, document, and address patients' social needs – and through support from a HPC SHIFT-Care grant is testing via an experimental study. Since September 2017, we have screened more than 38,000 unique patients, of which 24% screen positive for at least one social need and 10% screen positive for three or more social needs. With these data, which more accurately represents the social acuity of our patients, we are better able to coordinate care across providers and connect patients to resources both at BMC and in the community to ensure needs – like food and housing – are met.

- *Since program launch, our food pantry, stocked with fresh vegetables from our rooftop garden, has served over 600 patients who identified food as an "emergency need – meaning they didn't have food for that night.*
- *13% of patients in our Emergency Department and 25% of patients admitted to the hospital are homeless – indicating that lack of stable housing is one of the main upstream factors that cause our patients to get sick in the first place. In December 2017, in recognition of this unmet need, BMC dedicated $6.5 million to affordable housing and community-based housing programs in neighborhoods where our patients live. In doing so, we became the first Massachusetts hospital to put all of our required Determination of Need community health investment into one social determinant of health. BMC is making a long-term commitment to housing for health, and will reinvest loan repayments, equity fund returns and tax credits from this initiative back into affordable housing.*

BMC has also partnered with other local healthcare provider systems in addressing the social determinants of health. As a member of the Boston Area Collaboration on the Social Determinants of Health, BMC is involved in coordinating efforts across healthcare provider

systems to create mutual learning opportunities, develop best practices, and employ effective strategies to maximize the impact of our collective investments.

Based on the breadth and depth of our experience in this area, we recommend the state explore the following proposed policies and resources in order to address data-sharing issues that we've encountered in caring for our patients' health-related social needs:

1) *Provide funding and technical assistance to community-based organizations to build additional capacity (IT infrastructure, staff, etc.) to accommodate increased demand. The state should utilize hospital data on health-related social needs and community referrals to create a statewide clearinghouse on social issues and the resources available to address them. This data can be leveraged to identify social determinants of health domains where community resources are lacking and target funding and technical assistance accordingly.*

2) *Clarify HIPAA regulations – i.e. make it easier to share certain patient data with community resources when it will help address their social needs. We suggest:*
    a. *Allowing name, email, phone number to be shared for referral purposes with patient's verbal consent.*
    b. *Publishing a guideline or form that lays out what it means to follow HIPAA and prompts community agencies to consent to responsibly manage patient data – and making the list of community organizations that signed this agreement public.*

3) *Support interoperability of referral platforms (e.g. Aunt Bertha, Healthify, NowPow, HelpSteps, etc.) or development of universal referral platform in order to streamline system for managing client referrals and communication between patients, community-based organizations, and healthcare provider systems. Not doing so could result in unnecessary administrative burden for all parties and increased healthcare costs.*

AGO Pre-Filed Testimony Questions

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

   Included in accompanying Excel file labeled "2018-AGO-provider-exhibit-1-BMC-final."

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

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

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	25	84
	Q2	24	115
	Q3	33	90
	Q4	17	71
CY2017	**Q1**	21	114
	Q2	26	130
	Q3	42	252
	Q4	15	97
CY2018	**Q1**	25	102
	Q2	23	131
	TOTAL:	**251**	**1186**

   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.
   Required Question: Click here to enter text.

   Daily price inquiries are logged by BMC Patient Financial Services to track by caller/patient, type of service and call back number or email. Response typically given within 24-48 hours of inquiry.

c) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
Required Question: Click here to enter text.

Barriers encountered include the caller not having the proper name of procedure or correct CPT code at time of inquiry. If it's an internal request, we follow-up with clinical area to secure information needed to be able to provide timely response. For external requests, we will follow-up with caller to secure more information.

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

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

Included in accompanying Excel file labeled "2018-AGO-provider-question-3a-BMC-final."

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

Included in accompanying Excel file labeled "2018-AGO-provider-exhibit-2-BMC-final."

Service Category	Commercial				Medicare				Medicaid			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
2015 GRAND TOTAL	63,122,099	(9,526,610)	81,209,486	(14,509,997)	155,720,520	9,575,227	81,910,303	(35,658,143)	154,441,902	(54,053,139)	196,188,733	(35,446,642)
2016 GRAND TOTAL	68,670,157	(1,042,351)	88,900,631	(15,018,731)	167,287,004	11,427,411	93,643,864	(40,037,072)	169,002,543	(48,412,527)	207,900,377	(45,495,557)
2017 GRAND TOTAL	76,176,855	(2,603,429)	115,055,564	(5,784,659)	182,058,993	14,381,048	102,866,421	(35,359,653)	173,323,474	(53,940,660)	220,208,680	(40,197,047)

Based on 2017 Revenue

Payer Mix	Inpatient	Outpatient	Total
Commercial	18%	26%	22%
Medicare	42%	23%	32%
Medicaid	40%	50%	45%
All Other	1%	1%	1%
Total	100%	100%	100%

All Other				Total			
Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
2,632,414	(1,830,562)	3,772,684	(6,563,646)	375,916,934	(55,835,083)	363,081,205	(92,178,428)
3,821,169	(1,149,594)	4,255,348	(5,780,757)	408,780,873	(39,177,060)	394,700,221	(106,332,117)
3,589,159	(2,948,112)	5,737,287	(8,854,271)	435,148,480	(45,111,152)	443,867,952	(90,195,629)

803,481,094