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?
      Click here to enter text.

Reduce emergency department use. As part of a larger effort to provide more efficient, timely and cost-effective care to patients, Dana-Farber established an acute care clinic in September 2018 to manage patients with cancer-related symptoms. The objective has been to change the site of care for patients who would otherwise be seen in the ED and discharged home as well as to decrease the frequency of hospitalization following ED evaluation by providing oncology subspecialized outpatient care.

The model for the clinic was informed by significant external research of similar clinics at other hospitals. It is overseen by medical oncologists and staffed by a multi-disciplinary team including oncology trained nurse practitioners and physician assistants. The clinic offers the same services that are generally available within Dana-Farber's outpatient clinics, including ultrasound, CT, MRI, x-rays, standard labs and ECG.

Since the inception of the clinic, over a 9-month period, Dana-Farber has seen 544 patients with the highest volume being in breast oncology followed by gastrointestinal and thoracic oncology. Some of the reported symptoms for patients have been nausea, fever/chills, and dehydration. 72% of these patients have been discharged home from the acute care clinic. A preliminary analysis has revealed a reduction in ED visits and it is proving to be effective in safely treating oncology patients for several cancer-related symptoms by changing the site of care.

Reduce practice variation. Cancer care has exponentially increased in complexity over the last decade. The introduction of genomics, proteomics and molecular-targeted therapies has dramatically increased the treatment options for most cancer conditions, resulting in a crowded field of treatment options for clinicians. As the speed of the evolution of cancer care increased, the concept of Dana-Farber pathways emerged in 2012 with the goal to provide optimal patient care and treatment and to disseminate these best practices throughout community settings. The identification of this treatment is based on the most up-to-date published evidence, lowest symptom burden, and that which is most cost-effective.

The output of this program is the construction of medical oncology and radiation oncology clinical pathways built into an electronic platform that provides decision support. The effort has continued to evolve and provides enhanced integration with EMRs. This new platform through data capture and analytics is a novel method for enhancing the delivery and ability to learn from the provision of cancer care. We will be able to better partner with our collaborating institutions

to more effectively manage our cancer population clinically, operationally and with financial sensitivity.

Dana-Farber's payers have been extremely supportive of this initiative and are working with us to understand factors affecting treatment choice and how this information can be used to identify patients at high risk, including identifying the need for symptom triage pathways, supportive care, care coordination, and other services.

Shared care model. Another effort Dana-Farber is pursuing is to reduce hospitalizations and provide shared care in a community setting for patients receiving hematopoietic cell transplantation (HCT), commonly known as bone marrow transplantation. HCT is the only potentially curative treatment for many advanced hematologic malignancies and is a highly technical procedure that is only available at select centers in the U.S. For this reason, many patients who undergo HCT live at great distances from their chosen HCT center. Moreover, after hospital discharge, the first 180 days post-HCT are critical. Patients must be watched closely for infections and/or the development of graft-versus-host disease (GVHD) and specialized anti-rejection medications must be tightly managed. For those who live far away, the need for close follow-up for such a long period can cause a great burden in terms of familial finances, impact on caregivers, and compromised quality of life.

Dana-Farber has partnered with the Patient-Centered Outcomes Research Institute (PCORI) to help patients who live far away from our Boston location. In the context of a large randomized clinical trial, we aim to assess the effectiveness of a Shared Care program which allows patients to receive the first half of their post-HCT care at our Boston location and the second half of their post-HCT care with a designated local oncologist who practices closer to where the patients live. Designated local care teams receive intensive training on HCT follow-up care through various mechanisms including a yearly educational symposium. Accrual to the study began in January 2018 and will continue until May 2021. It is expected that 324 patients who live greater than thirty minutes from Boston will participate. The study team follows patients using required data repository outcomes and patient-reported outcomes instruments.

We anticipate that in addition to improving patient and caregiver quality of life and satisfaction, the Shared Care model will potentially reduce the cost of care, as some care may be provided at a lower cost at the local health care facility, and patients will not need to spend as much money out of pocket travelling to our Boston location. This program is part of a greater effort to develop a sustainable and patient-centered long-term follow-up care model for patients and caregivers post-HCT.

Transferring care to the ambulatory setting. Dana-Farber has established an ambulatory HCT service, with our first patient having received reduced-intensity HCT in the outpatient setting in July 2019. Instead of spending an average of 8 days in the inpatient setting, patients who are eligible for an ambulatory HCT visit Dana-Farber's outpatient clinic daily for their chemotherapy and HCT, which we believe is equally as safe as HCTs performed in the inpatient setting. We estimate that in the first year, up to 45 patients may be eligible for this service, amounting to 360 inpatient days avoided. Beyond the benefit of reducing inpatient days, patients benefit from being able to sleep in their own housing.

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

A significant barrier to Dana-Farber's ability to reduce health care expenditures is managing prior authorization requirements for unscheduled clinical services such as imaging or administration of supportive care medications. This creates reimbursement risks for providers, increases administrative costs and introduces potentially unnecessary delays in delivering patient care. As a result, we recommend that health plans waive any prior authorization or referral requirements for established patients to utilize these critical clinical services during an unplanned, urgent visit to Dana-Farber. This is addressed further in section 4.

Dana-Farber also restates its support for passage of the telemedicine bill which would significantly improve our ability to enhance the shared care model.

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

As a specialty cancer hospital, this question is not applicable to Dana-Farber.

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.
Click here to enter text.

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.
Click here to enter text.

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?
Click here to enter text.

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?
Click here to enter text.

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	Level of Contribution
Aging of your patients	Level of Contribution
New or improved EHRs that have increased your ability to document diagnostic information	Level of Contribution
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Level of Contribution
New, relatively less healthy patients entering your patient pool	Level of Contribution
Relatively healthier patients leaving your patient pool	Level of Contribution
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Level of Contribution
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	High
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Priority Level
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Priority Level
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	High
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	High
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Priority Level
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Priority Level
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Priority Level
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

Dana-Farber continues to be significantly affected by the growing burden of administrative costs associated with health plan utilization control requirements. Over the past few years, we have seen health plans continue to add and expand prior authorization requirements. We are currently considering the impact of the new MA Health drug authorization requirement, which includes over 60 drugs that are regularly utilized at Dana-Farber. Given the cost and complexity of services required to treat cancer, and the volume of new/innovative therapies and services we provide on a regular basis, extensive resources are expended at DFCI to ensure patients have appropriate health plan approvals in place to ensure coverage.

We recommend that the Health Policy Commission, in partnership with the Division of Insurance, convene a workgroup of stakeholders to evaluate prior authorization programs with the goal of increasing transparency and reducing unnecessary administrative burden. Specifically, the workgroup should consider and develop guidelines to address the following key issues:

- **Developing streamlined approval for treatment plans that follow established clinical pathways:**
    - Clinical pathways designed by an NCI-designated comprehensive cancer center are an evidence-based, consensus-driven approach to treating cancer. Instead of creating additional steps to authorize care for a patient's treatment on a defined pathway, adherence to the pathway should warrant approval in lieu of prior authorization.
- **Increasing transparency, improving accountability, and simplifying administrative steps of health plan prior authorization programs:**
    - The criteria by which prior authorization requests are evaluated should be clear and transparent, with up-to-date metrics available to all parties. Increasingly, utilization management vendors develop and manage these programs on behalf of health plans. The vendors have developed authorization processes that cannot reasonably be managed within a clinical setting. The vendors regularly deny approvals which are subsequently overturned after time-intensive peer-to-peer discussions with clinicians. Discrepancies between the health plan and vendor lead to unnecessary denials, placing additional burden on the provider to resolve in order to be paid.
    - Some health plans are very limited in utilizing technology-enabled tools to support their prior authorization programs. In these cases, requests are especially onerous and require many manual steps, including printing and faxing. Other health plans have developed web portals, which support a streamlined approach to entering prior authorization requests and typically provide more timely responses. We understand that the upcoming MA Health prior authorization process will be manual and further burdened by drug-specific forms and a separate signature from

the ordering physician (providers order treatments in the electronic health record including an electronic signature).
    - Obtaining health plan approval for a patient coming to Dana-Farber for treatment has become increasingly resource intensive as health plans have developed policies related to drug coverage based on site of service or step therapies which do not take into account the clinical and treatment complexities of cancer patients.
    - The performance/results of health plan prior authorization programs should be made available to providers and to the Health Policy Commission. These metrics could help identify which types of radiology, drug, and lab authorization programs add value, and which programs add administrative cost to the system without demonstrable benefit.
- **Health plan requests for medical records**
    - Health plans regularly request medical records for the same patient receiving the same service on different dates of service (e.g. for multiple courses of chemotherapy, which is typical for our patient population) requiring that we send the same information over and over again. This is administratively onerous and delays payment for care.
- **Ensuring appropriate expertise for review of specialty service authorizations:**
    - Many reviewers of authorization requests have general medical expertise but lack the necessary background to evaluate care for oncology cases that include highly complicated medical histories and treatment plans. As an example, specialized molecular and genetic pathology laboratory testing is rapidly evolving and authorization programs and reviewers are not updated regularly enough to result in an efficient or appropriate exchange between the vendor and provider seeking approval. This increases the administrative burden on specialty providers to provide the relevant evidence base, which may not yet be reflected in health plan guidelines and algorithms.
- **Health plan review of all diagnoses submitted on a claim.**
    - Oncology patients often receive many, many services on the same day. Consistent with hospital billing rules, all ambulatory services performed on a single day are billed on a single claim. There are many different diagnosis codes that are relevant to describe the clinical rationale for services rendered. Payers do not always read all the diagnosis codes, which leads to denials. This administrative burden delays payment for care and can impact a patient's out of pocket responsibility.
- **Understanding the impact on patients and consumers:**
    - Insurance denials and appeals can lead to significant stress and anxiety for patients with cancer. Payers and provider organizations must partner in an ongoing way to be certain that utilization management protocols do not interfere

with the core mission of providing timely, medically necessary care to our patients.

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.

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**	0	17
	Q2	0	15
	Q3	0	10
	Q4	0	10
CY2018	**Q1**	0	16
	Q2	0	7
	Q3	0	0
	Q4	0	8
CY2019	**Q1**	0	11
	Q2	0	4
	TOTAL:	0	98*

*Note: 7 of the 98 requests were ultimately cancelled. Reasons included that the requester was planning to obtain care at another facility, or the requester was interested in other information related to their insurance coverage, which was addressed during a discussion with our Financial Counselors.

    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.

Dana-Farber continues to evaluate and pursue improvements to our price estimates. Examples of such improvements include adjusting estimated charges for treatment regimens based on the patient's weight and height for dosing purposes, accounting for varied dose/cycles of treatment being requested, as well as adjusting the physician treatment request template to query if specific services are likely to be provided as part of the treatment plan, such as supportive agents, diagnostic radiology, and/or radiation therapy.

Dana-Farber tracks all Chapter 224 price estimate requests in a Price Estimate Request Tracker. This tracker includes the patient demographic and insurance information, the date of the request, a summary of the specific request, and the date a Financial Counselor provides a written estimate to the patient. A manager provides feedback to staff on a regular basis and reviews the tracker periodically to ensure estimates are presented within the targeted timeframe of 2 business days from receipt of the request. Forty-two percent (42%) of estimates from Q1 CY2017 through Q2 CY2019 were provided on the same day as the request was received. Eighty-five percent (85%) of estimates were completed within 2 business days. In instances where we were unable to provide an estimate within the targeted 2 business day timeframe, delays are often the result of staff not being able to reach the patient or provider for additional information regarding the request or complicated estimates that require input from other resources (e.g., clinical trial considerations, retail pharmacy).

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 are several barriers to effectively responding to patient inquiries. Patients or potential patients contacting us for price estimates are often ultimately looking for other types of information, such as his/her out of pocket expenses (e.g., outstanding balance based on the time of year or coverage for specific services). Dana-Farber's Financial Counselors explain verbally and in writing that the estimate provided does not represent the patient's actual personal financial responsibility, which often is the key information patients are seeking.

Additionally, while consumer inquiries regarding individual services such as high-tech radiology (e.g., MRI, PET/CT) often can be easily and accurately addressed at the time of inquiry by referencing Dana-Farber's charge schedule, there are complexities to producing an accurate and timely estimate for a course of treatment. Due to varied duration of oncology services, Dana-Farber typically produces treatment estimates based

on charges incurred for comparable patients who have previously received a similar regimen. Variations exist in the charges incurred among cancer patients based on the duration of treatment, the doses of medications prescribed, comorbidities, as well as side effects of treatment that require supportive care. As cancer treatments become increasingly personalized, these complexities all factor into our ability to accurately provide a comprehensive estimate of all services a patient might receive here at Dana-Farber. Dana-Farber does its best to educate patients about the estimate process and the information provided, and additionally shares information regarding any resources available for those who are under or uninsured, consistent with our Financial Assistance Policy.

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.

    The data requested on margin and payor mix, and the list of carriers/programs, are provided in excel format as Attachment B.

    Dana-Farber does not have any payor contracts that incorporate a per member per month budget. We do not look at revenue or margin based on HMO or PPO business. In general, there are very few payor contracts where there is a reimbursement impact based on HMO or PPO business and, in cases where there are, there is a very small difference between the two.

    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.