MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

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

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

Notice of Public Hearing

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

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 25, 2019, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit the Suffolk University website. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be available via livestream and video will be available on the HPC's YouTube Channel following the hearing.

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

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

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

On or before the close of business on **September 20, 2019**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

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

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

HPC Contact Information

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

AGO Contact Information

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

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a. What are your organization's top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

UMMHC's top priorities to reduce health care expenditures are:
• shifting care from high-cost settings to lower cost settings, as clinically appropriate,
• reducing unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions),
• reducing out-migration to higher cost providers, and
• reducing unnecessary utilization of institutional post-acute care.

UMass Memorial Health Care has been actively working for a number of years to provide the highest quality care in the lowest cost setting.

UMass Memorial Health Care includes two community hospitals (Health Alliance-Clinton Hospital and Marlborough Hospital) in addition to UMass Memorial Medical Center. We have been actively encouraging optimal use of our community hospitals to provide lower cost options for patients whose clinical needs can be met at these lower acuity hospitals. We also have a large network of community-based services including primary care, specialty care and an extensive behavioral health and substance abuse network which provide cost effective services outside the inpatient setting.

UMMHC has demonstrated its commitment to controlling healthcare costs through its voluntary participation in innovative models offered by both commercial and public payers at the State and Federal level. UMMHC has collaborated with EOHHS through participation in the PCMH, PCPR, and Medicaid ACO Pilot initiatives, with BCBS in the AQC and with CMS innovation models including Bundled Payments and Medicare Shared Savings Program. Each of these initiatives has been focused on performance based on a set of quality and utilization metrics. Reducing readmissions and preventing unnecessary emergency department and inpatient admissions is key to the success of these programs. Through participation in each of these innovative approaches to payment reform, UMMHC has invested in the infrastructure deemed necessary to succeed. Although that investment, and others made since, have not been fully realized, UMMHC remains committed to its approach with the understanding that changing payment models is not healthcare transformation. Changing how, where, to whom and by whom care is delivered will

transform healthcare and the process requires investments of time, resources and collaboration across the care continuum.

One of UMMHC's recent innovations in care management is its specialty pharmacy program which provides patients with an innovative approach to specialty pharmaceutical care to improve medication adherence, delivering better patient outcomes, and reducing total cost of care. Approximately 50% of prescriptions filled each year are not taken correctly. 33% of patients never fill their prescription and poor prescription adherence is the #1 reason for readmissions (from NEHI Research Brief, "Thinking Outside the Pillbox: A System-wide approach to improving Patient Medication Adherence for Chronic Disease." NEHI, 2009). Initial results from a focused study indicate post-transplant ER visits that result in an inpatient admission for patients enrolled in specialty pharmacy are 13.33% lower than for patients not enrolled in the program. This is one of UMMHC's many innovative approaches to reducing the cost of care while improving outcomes for patients.

Other initiatives include opening an ambulatory surgical center through a joint venture with Shields and Reliant, and expanding our telemedicine capabilities to include eICU, eNICU, teleDerm and most recently, teleSUDE, telemedicine-based Substance Use Disorder Evaluation, a program to evaluate patients who present in the emergency department after suspected overdose. Through a collaboration with community partners across greater Worcester, we launched Community HELP (Health and Everyday Living Programs), a cloud-based platform to connect our patients with resources in the community to address social determinants of health issues (http://www.communityhelp.net/).

UMMHC also developed a Post-Acute network of Preferred SNFs and Home Health Agencies who collaborate with our team of care managers to develop care transition plans prior to discharge and providing those Preferred Providers access to our instance of Epic to ensure timely access to critical patient data. This enables us to make sure our patients are receiving high quality post-acute care at the level most appropriate for the patient, to improve outcomes and reduce avoidable readmissions.

A major strategy to reduce TME for patients in Central Massachusetts is to keep care local and prevent leakage to the higher cost systems in Eastern Massachusetts. Overall the rate of outmigration of discharges from the UMMHC service area grew to 20% in FY2017 (approximately 21,000 out of a 106,000 discharges). The out-migration is disproportionately concentrated in commercial patients (outmigration of 30% of commercial patient discharges) and much of this outmigration goes to higher cost hospitals. The cost of treating patients in Boston is estimated at 25% higher than UMass Memorial Medical Center. Reducing outmigration to Boston is the single greatest opportunity for UMMHC to reduce TME for the people of Central Massachusetts, and thus for the State as a whole.

All of these initiatives, and dozens of others, contribute to our slowing the cost growth trend. We embody continuous improvement as demonstrated by our organization-wide commitment to Lean practices and the Visual Management Systems throughout the organization. It is the sum of these efforts that steadily

transforms the way we care for our patients, meeting them wherever they are and treating the cause, not the symptoms, of increasing health care costs.

However, as we continue to work to control cost growth through the initiatives described above, we have also recently been experiencing the impact of a very tight labor market in the area. This has, and will continue to lead to increases in salary expense in order to keep our salaries competitive with the market and attract high quality staff. UMMHC also has a heavily unionized staff, with approximately 80% covered under collective bargaining agreements that lock in negotiated increases to rates of pay.

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

1) We would suggest state policy development/intervention to control the costs of prescription drugs in Massachusetts. 2) Adequate and flexible behavioral health access and improved reimbursement need to be prioritized. 3) Appropriate payments for telemedicine to allow further expansion of telemedicine capabilities are necessary. 4) Policies are needed which allow for participation in Alternative Payment Programs for organizations in a relatively weak financial position who do not possess the reserves which would normally be required.

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

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

UMass Memorial Health Care has been committed to ensuring that primary care services are available to all of our patients throughout our service area. We are continuously reviewing the primary care services we offer to look for any potential gaps that need to be filled. UMass Memorial Health Care currently has over 50 primary care locations throughout Central Massachusetts. Since 2012, we have opened 5 new primary care locations in our service area. Also, several years ago, in order to supplement the availability of primary care, we entered into a joint venture with Carewell Urgent Care so our patients could have quick access to urgent appointments while allowing our primary care offices to open up slots for new patient appointments. We have found that the limitation in expanding primary care is often the lack of available primary care providers. UMass Memorial Health Care has seen recent improvements in both our commercial and Medicare

ambulatory quality scores which support the importance of having adequate primary care resources in our area. Our Medicare ACO has been able to limit the growth in total medical expenditures (based on per person per year spend) to 0.5% over the two year period from 2015 to 2017. Much of that success is due to the primary care resources we have made available to our patients. Additional expansion of primary care resources in our service area will require sufficient revenues and capital to support both the recruitment and retention of providers and investment in the necessary space and equipment.

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.

Our patients and families throughout Central Massachusetts count on UMass Memorial to deliver mission-based, high-quality psychiatric services in an affordable, convenient manner, particularly in Worcester where a large percentage of our adult psychiatric patients receive both inpatient and outpatient services.

Over the past several years, UMass Memorial has researched numerous alternatives for providing these services in an efficient, high-quality and most cost-effective manner for the region. All the while, ensuring that the future of this care is sustainable at a time of considerable financial challenges.

Given the current conditions faced by UMass Memorial in directly providing high-quality, financially sustainable behavioral health services to patients, and still wanting to play a role in serving the needs of these patients in our region, UMass Memorial invested a minority interest in Lola Development's new, 120-bed Hospital for Behavioral Medicine (HBM) located at 100 Century Drive in Worcester. The Hospital for Behavioral Medicine was built, developed and is operationally managed as a Hospital of Lola Development.

Our interest in the Hospital for Behavioral Medicine is less about a financial investment - the minimal financial return to UMass Memorial is being re-invested to offset financial losses in outpatient psychiatric services – and more importantly about insuring that UMass Memorial continues to have a role in behavioral health services in the region long into the future.

Separately, and in support of serving the continuum of care for behavioral health patients in Worcester County, as well as the greater Central Massachusetts region, the Hospital for Behavioral Medicine has leased 15,000 square feet of non-hospital space for UMass Memorial Medical Group to open a new, office-based outpatient psychiatry practice, which over time, is expected to support 40,000 patient visits/year.

The Hospital for Behavioral Medicine opened on February 11, 2019 and currently has 82 open and licensed beds (20 child/adolescent, 14 older adult and 48 adults). Based on volume and staffing, the remaining 38 beds will be opened. The average daily census has grown from 10 patients/day in February to 45 patients/day in August.

Our partnership has allowed for the opening of the first, child/adolescent unit in Central Massachusetts, while also providing for hospital-based outpatient services including Intensive (IOP) Outpatient and Partial Hospitalization (PHP) which are not currently offered at the Medical Center in Worcester.

See the attached outline of programs offered and the efficient design that supports cost management.

In addition, for many years UMMHC has supported Community Healthlink, a community-based low cost provider with comprehensive behavioral health, addiction and homeless services with locations throughout Central Massachusetts.

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?

Payers are recognizing these providers are underpaid relative to their specialist peers and have increased fee schedules (usually with offsetting decreases to other providers) and/or included incentive potential for meeting certain quality measures. While additional revenue opportunity is helpful to support these services, often the providers are required to make offsetting investments in order to earn incentives and incentives are designed by payers to enhance payer performance against HEDIS measures so are not always the best measure of quality of care.

This question starts well downstream of where the actual discussion needs to start. Traditional behavioral health reimbursement must be addressed first unless the costs of the behavioral health services are to be permanently subsidized by the patient's medical benefit. We have already allowed a cost shift to the medical benefit in the PCPR and this had a short-term positive benefit. However, in situations where the cross-subsidization from the medical risk were reduced or ended, the behavioral health services were either reduced or terminated.

No insurer, ACO, HMO or Massachusetts based Behavioral Health Managed Care Organization (BHMCO) develops their outpatient mental health rates with a recognition of the full cost for the provider or provider's organization to provide these outpatient behavioral health services.

Providers operate at significant and documented losses to meet the behavioral health needs of the communities they serve. Historically these losses are "cross funded" by either philanthropy, another form of internal support within the outpatient location's parent corporation or the agency's ability to develop offsetting contracts with state and federal agencies.

Given that EOHHS policies allows for or even encourage the bifurcation of the behavioral health benefit from the medical benefit, the reimbursement for behavioral health services must first increase to cover 100% of direct and indirect costs of the core behavioral health services.

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?

To the extent that there is recognition that more dollars need to be allocated to primary care and behavioral health, it can't be a zero sum game for the payers as providers are investing in population health in order to improve quality and access.

Payment regulation should recognize true costs, especially as they relate to specialty services. Access to outpatient care at the level and intensity needed to stabilize stressful situations is required. The major underlying problem with access to outpatient BH services is misalignment. There are other problems, but the system is not well organized to prioritize access to the right treatment based on clinical need, clinical risk, family concerns, or community priorities. Massachusetts has one of the highest per capita spend on behavioral health and we still have the same access problems as other states.

Many reasons have been identified that may contribute to this misalignment: as mentioned earlier, inadequate reimbursement schedules, particularly for outpatient care that does not conform to standard practices; the difficulty of regulations and regulators to alter or direct provider response; risk aversion; inadequacy of network panels, and so on.

The following are solutions that could reduce patient, family and community suffering while the Commonwealth tries to address this problem:

- **Create financial support (from payors and elsewhere) for specialty clinics to assess and stabilize patients with the more complex disorders.**
- **Bridging clinics available to patients in high-risk categories. These clinics would provide rapid access for high-risk patients and be prepared to offer both short-term stabilization and referral to community-based care and longer-term treatment for patients who are not able to transition due to clinical instability or lack of community resources.**
- **Consider bundling of psychiatric care with other DMH service contracts with clearly defined requirements for longitudinal care with no reject and no eject. Residential programs, respite programs and care coordination programs would include psychiatric services as part of the treatment package either through direct hiring or contractual arrangements with local providers and these providers should offer longitudinal care. Pilot programs with DDS clients has proven to be efficient with a decrease in no-shows and a significant decrease in transportation and staffing costs incurred in bringing patients to visits. Care coordination for individual patients can remain an option, but there should be ready access to well-integrated treating providers for all patients who may benefit.**
    - **Reimbursements for consultative and e-consultation work should be adequate to cover direct costs.**

- **Fast tracking tele-psychiatry services to clinical sites and targeted grant support efforts for expanding to non-clinical and home sites.**
- **Outreach programs in each region to target at-risk patients. Compensation to support care for patients with difficulty making appointments should be considered (right now we incentivize clinics to actively select patients who can conform to the business requirements of the clinic rather than modifying our practices to engage patients who may need help most).**

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Major Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Major Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Minor Contributing Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Patient acuity and risk score increases are also related to the addition/expansion of certain clinical programs, such as Stroke Center of Excellence, LVAD (Left Ventricular Assist Device), affiliation with Dana Farber leading to more acute cancer cases staying at UMass Memorial Medical Center. Another factor in the increase in risk scores has been an increased focus on provider education around documentation.	Major Contributing Factor

Note: To the extent the increase in the case mix index state-wide reflects improvements in coding practices, the current CMI is likely to be more rather than less accurate than it was historically. Providers do not up-code because it is illegal to do so. There are significant penalties associated with up-coding and governmental and commercial payors invest enormous resources, including regular auditing, to validate accuracy and identify and respond to inappropriate coding. Providers have incentives to code correctly not only to

avoid payor refunds and enforcement actions but also primarily because it is necessary for quality improvement, population health and continuity of care.

☐ 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	Low
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Low
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Medium
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	High

Area of Administrative Complexity	Priority Level
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Medium
Other, please describe: **Payer Denials – carrying and arbitrary criteria used by payers to deny payment for services identified as medically necessary by health care providers**	High
Other, please describe: **Large amount of reporting required to state agencies**	Medium

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 – see notes under Other
- ☐ 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:

Related to the first bullet (Expanding APM's…): Provision of infrastructure funding and payer financial support in case of a loss to cushion the negative impact for those with less financial reserves; better and more transparent benchmark methodologies to recognize unique health communities

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   See attachment

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**	12	79
	Q2	18	89
	Q3	10	81
	Q4	15	42
CY2018	**Q1**	13	78
	Q2	12	62
	Q3	14	80
	Q4	5	97
CY2019	**Q1**	11	85
	Q2	14	86
	TOTAL:	124	779

   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.
   All estimates are logged and monitored to ensure that Financial Counseling is responding to consumer requests timely. Financial Counseling has been successful in providing timely estimates upon receiving all necessary information to complete an estimate.

c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
The most significant barrier to providing a timely and accurate price estimate is to have the sufficient information at time of initial requests. As the CPT, procedure and ICD 10 codes are necessary to determine the initial requests. Financial Counseling works with the health care providers to obtain all necessary information to provide an accurate estimate.

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

   a. For each year **2016 to present**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

      See attachment

   b. For **2018 only**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

      See attachment