MASSACHUSETTS
HEALTH POLICY COMMISSION

2024 Pre-Filed Testimony
PROVIDERS

As part of the
Annual Health Care
Cost Trends Hearing

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

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 2024 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, November 4, 2024**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed 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 pre-filed testimony responses from 2013 to 2023, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission 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.

You are receiving questions from both the HPC and the Office of the Attorney General (AGO). 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 Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

AGO CONTACT INFORMATION

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.

THE 2024 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2024 Health Care Cost Trends Hearing will take place in a period of significant upheaval and reflection for the Commonwealth's health care system. The bankruptcy and dissolution of Steward Health Care, previously the third largest hospital system in Massachusetts, led to substantial disruptions to the state's health care market and has taken a significant toll on communities, patients, provider organizations, and health care workers across the region. This market instability is occurring while many providers across the health care continuum are still struggling to adapt to a post-pandemic "new normal" state, wrestling with capacity constraints, financial volatility, administrative burdens, and workforce recruitment and retention challenges.

At the same time, an increasing number of Massachusetts residents are struggling with health care affordability and medical debt. Massachusetts has the second highest family health insurance premiums in the country. The average annual cost of health care for a family exceeds $29,000 (including out of pocket spending). Recently, more than half of residents surveyed cited the cost of health care as the most important health care issue, far surpassing those that identified access or quality. Due to high costs, 40 percent of survey respondents said they are putting off seeing a doctor or going to a hospital. These affordability challenges are disproportionally borne by populations of color, and those in Massachusetts with less resources, contributing to widening disparities in access to care and health outcomes. The annual cost of inequities experienced by populations of color in Massachusetts is estimated to exceed $5.9 billion and is growing every year. These challenges require bold action to move the health care system from the status quo to a new trajectory.

This year, in the wake of the considerable harm caused by the bankruptcy of Steward Health Care and other recent market disruptions, the HPC is focusing the 2024 Cost Trends Hearing on moving forward, from crisis to stability, and building a health care system that is more affordable, accessible, and equitable for all residents of Massachusetts.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the annual public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the Health Care Cost Growth Benchmark and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Reflecting on the health care market disruptions in Massachusetts in recent years, including the bankruptcy of Steward Health Care and related closures, what have been the most significant impacts of these disruptions on the patients and communities your organization serves, particularly with regard to equitable and affordable access to care? What have been the most significant implications for your organization and workforce?

At our core, UMass Memorial Health (UMMH) is committed to improving the health and well-being of the diverse communities in central Massachusetts. Our flagship academic medical center in Worcester and our four community hospitals primarily serve residents of the commonwealth living from MetroWest to the Quabbin Reservoir, from the top of the state to the bottom. Even in times of turbulence and market disruptions, we've maintained our commitment to provide quality and accessible services in central Massachusetts, one of the fastest growing and most under bedded regions of the commonwealth.

In the days leading up to the closing of Steward's Nashoba Valley Medical Center (NVMC) on August 31, we began to see increases in the numbers of patients showing up at our emergency departments and being admitted for observation and inpatient stays, particularly at UMMH - HealthAlliance-Clinton Hospital. We are currently seeing about 10 additional emergency department visits and 2 additional hospitalizations each day from people living in the NVMC area, and we anticipate that this will continue to increase as we move into the busy winter season.

In an effort to deal with already high ED and inpatient volumes, we've instituted several new initiatives that have been helpful for dealing with further volume increases from the NVMC closing. We've made significant workflow changes in our Emergency Departments to improve patient experience and flow. We've staffed a surge unit—largely with travelers—that is able to provide care to 25 additional patients at UMMH - HealthAlliance-Clinton Hospital; we've submitted a request to DPH to convert this unit into a permanent telemetry and med surge space to help us deal with this increased volume in the long term. Furthermore, we've hired more than 20 caregivers from NVMC to fill critical vacancies within our system, with a majority now working at UMMH - Health-Alliance Clinton Hospital. We've been supporting primary care providers formerly associated with NVMC in multiple ways. UMMH is offering the resources of Physician Concierge Service to facilitate access to specialist services for their patients, in particular to meet the growing need for cardiology, gastroenterology, and endocrinology specialty services resulting from the NVMC closure. We've been able to meet some of this need through our new 6-physician cardiology suite at the Leominster Campus, planned before the closure but fortuitous for the current situation.

Some patients formerly seen at NVMC, particularly oncology patients, have reported issues accessing their Steward health records. UMMH proactively reached out to Steward providers and practices to provide access to Epic Care Link, allowing for improved communication and connection.

Additionally, the NVMC service area includes one federal and two state prisons leading to an increase in the need to provide medical services to this vulnerable population of incarcerated individuals. Many of these patients require 1:1 supervision, further straining our already overstretched clinical team, along with the small security team at the UMMH HealthAlliance Clinton Hospital.

Even before the closure of the Steward Hospitals, UMMH has been driven by our mission to serve as a stabilizer in the region. In 2021, we welcomed Harrington Hospital into the UMMH family, followed by Milford Regional Medical System on October 1st of this year. As a result of these acquisitions, we are able to provide Harrington and Milford with improved access to clinical resources and capital, and our 10 star Epic electronic health record and state-of-the-art Workday ERP system and promote their long-term financial stability, allowing them to continue to provide high quality and cost effective care in their local communities.

2. Please identify and briefly describe any policy, payment, or health care market reforms your organization would recommend to better protect the Massachusetts health care system from predatory actors, strengthen market oversight and transparency, and ensure greater stability moving forward.

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Regional Health Planning: UMass Memorial Health commends both chambers of the Massachusetts legislature for including provisions in their respective healthcare bills to create a statewide health planning process; we also support the policy recommendation in this year's Cost Trend Report to "revitalize health planning to ensure that the supply of health services aligns with community health needs." UMMH recommends that this recommendation for statewide plans be expanded to include linked state-led planning at the regional level given the different needs, assets, challenges, and solutions present in different areas of the Commonwealth. Further, this regional and state level planning should develop solutions in relation to a comprehensive plan rather than implementing one-off, project-by-project based analyses of needs and impacts. Finally, all plans should include setting goals and developing strategies for meeting key capacity, access and equity needs, rather than solely focusing oversight on constraining and limiting expansion and growth.

Central Massachusetts—with Worcester County as a proxy—is one of the fastest growing regions in the state and one of the more under bedded regions. Between the 2010 census and the 2020 census, there was an 8.2% increase in the Worcester County population, outpacing most other counties in Massachusetts, particularly those in the eastern part of the

state like Suffolk and Middlesex Counties. Worcester County has only continued to grow in the years since 2024. Even with a growing population, the central Massachusetts region has 40% fewer staffed beds per-1,000 residents than Metro West and Metro Boston and 15% fewer than the Commonwealth as a whole. It would take about 175 additional beds for our region to meet the state average and even more to meet the national average (see Table 1).

Table 1: Staffed Med/Surge Beds by Region

HMCC Region	Description	Med/Surg Staffed Beds	Population	Adult Med/Surg Staffed Beds per 1,000 Population
Region 1	Western	1,012	803,886	1.26
Region 2	Central	999	991,310	1.01
Region 3	Northeast	934	1,371,264	0.68
Region 4	Metro West and Metro Boston	3,997	2,410,149	1.66
Region 5	Southeast	1,374	1,424,867	0.96
Statewide Aggregate		**8,316**	**7,001,476**	**1.19**

Sources: Adult Med/Surge staff beds reported to DPH between 10/20/2024 - 10/26/20/24. Census data from 2020 census: https://www.census.gov/data/tables/time-series/demo/popest/2020s-total-cities-and-towns.html

In the absence of a robust state-led regional health plan for central Massachusetts, UMMH has taken on the challenge of better understanding and meeting the needs of the diverse communities we serve. Our 72-bed North Pavilion at the UMass Memorial Medical Center is scheduled to open in January 2025, helping to address the bed shortage and better meet the acute hospital bed needs of our region.

Looking back to the COVID-era, EOHHS, local health departments, and stakeholders participated in thoughtful regional planning to determine our pandemic response. We did well in the time of crisis. Now we need to reinvigorate a process to develop regional health plans that thoughtfully consider the unique needs and assets of a region, that see the whole ecosystem rather than one-off analyses, and that set thoughtful goals both about constraint and expansion as the need dictates.

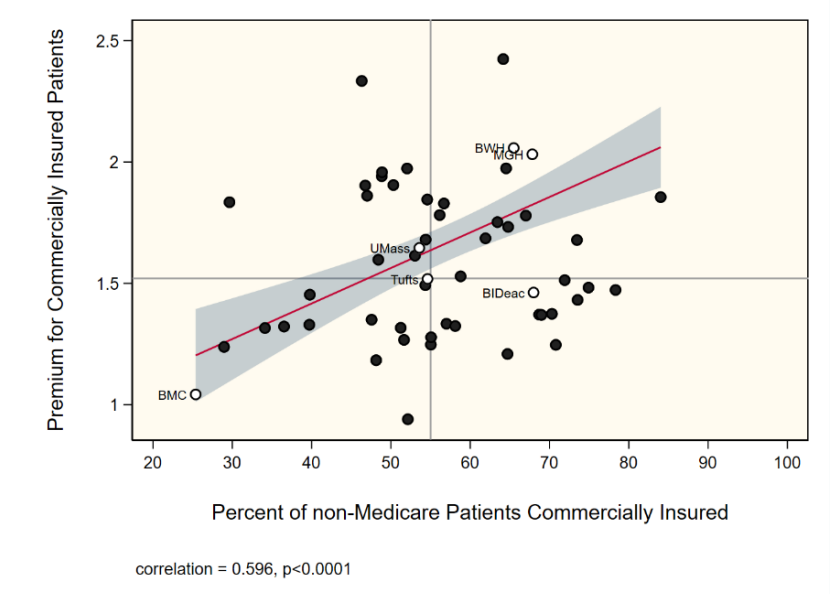
Updated Cost Containment Oversight and Provider Price Inequities: We strongly recommend an amendment to the Health Policy Commission's (HPC) current cost containment approach, which focuses only on year-over-year percentage changes in specific commercial plan prices relative to the State-wide benchmark, without taking into account difference in payer mix (particularly for safety net providers such as UMMH), relative absolute prices, and any other statutory obligations unique to a provider system. The current HPC one-size-fits-all benchmark analysis disadvantages provider organizations with lower baseline reimbursement rates and a higher public payer mix, and it does not include

an analysis of health plan margins, administrative overhead costs, or other added costs such as brokers fees and commissions.

UMass Memorial Medical Center remains one of the lowest cost academic medical centers in the Commonwealth, and the UMMH community hospitals are categorized as lower cost community hospitals. UMMH remains a cost-effective option on a relative absolute basis notwithstanding our high public payor mix and our unique statutory obligations to support the Commonwealth's only public medical school.

UMMH strongly recommends that HPC and CHIA be given the authority to monitor affordability and access to care with more nuanced tools to addresses the "long standing inequities in provider prices" as stated in this year's Cost Trend recommendations. In order to ensure financial stability, all hospitals need to ensure revenue across all lines of business is adequate to cover the cost of providing the care across all patients they serve. When funding under government programs is cut, there is nowhere else to make up this revenue than through commercial insurance contracts. Common knowledge suggests that higher commercial prices help offset losses for public payer patients (especially patients covered by Medicaid)—however, an analysis of CHIA data shows the certain providers with higher commercial prices actually see fewer public payor patients (see Figure 1).

Figure 1: Graph of commercial prices (standardized to Medicare PAF) vs. Payor Mix



Rather than only focusing on commercial payments, the HPC should consider average prices across all payers in a system. When factoring in lower Medicare and Medicaid reimbursement, providers treating a disproportionate share of public payor patients look more favorable from an overall cost trend perspective. Alternatively, HPC could take into

consideration the payer mix when analyzing commercial prices to establish cohort-specific benchmarks which recognize the additional cost challenges of disproportionate share hospitals, safety net hospitals, and hospitals with statutory obligations to the state.

Additionally, we encourage a longer measurement period than a single year to account for variation in contract terms which may provide for greater increases in one year and less in another. More importantly, any cost containment measure should take into account relative absolute prices (as some providers are starting at a significantly lower base cost and need greater increases to catch up to what is fiscally sustainable) and overall payor mix (as it is not reasonable to compare a hospital that has a payor mix with less than 30% commercial to one that has 70% commercial patients).

3. Reflecting on consistent HPC findings showing increasing health care affordability challenges, growing difficulties accessing needed care, and widening health disparities based on race, ethnicity, and income among Massachusetts residents, what are your organization's top two to three strategies for addressing these trends? What are the most significant challenges to implementing these strategies?

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Strategy 1: Innovative Approaches to Care Delivery to Reduce Costs in the Long Term
UMMH and its leaders share a desire to be a part of the solution to make health care more affordable, accessible, and equitable. As a Lean organization, we are constantly looking for new ways of delivering care, reducing waste, and improving outcomes. We've made upfront investments to test out new models of care delivery—with some initial data showing their effectiveness.

- **Hospital at Home (HAH):** Described in our 2022 and 2023 testimony, we have continued to implement the HAH program that launched in the summer of 2021. New data from this program show that while the acute care costs are about the same as a brick and mortar hospital stay, HAH lowered overall costs by reducing 30 day readmissions and the need for sub-acute rehab/skilled nursing facility rehabilitative care. Patients enrolled in HAH also had better outcomes (lower mortality and fewer safety events) and higher patient satisfaction than patients with stays in the brick and mortar hospital – and the greatest improvements were among the most vulnerable patients, including those insured through Medicaid or dually insured through Medicare and Medicaid.

- **Mobile Integrated Health (MIH)**: Described in our 2022 and 2023 testimony, our MIH program was also launched in June 2021. So far, more than 450 patients have been served by the program. This program has been effective at keeping patients out of the emergency department, with more than 93% of patients who receive a visit from a Paramedic not needing to go to the ED within the next 72 hours (and more than 75% not going within the next 30 days). We've leveraged the MIH

platform to implement the PACED (Paramedic Assisted Community Evaluation After Discharge) Program, a non-randomized clinical trial testing the effectiveness of paramedic home visits within 48 hours of discharge for frail patients. Initial data show that when controlling for confounding factors, patients enrolled in the PACED intervention had a 60% lower risk of re-hospitalization within 30 days compared to the control cohort, reducing total medical expenditures over time.

- **Remote Patient Monitoring (RPM)**: UMMH leverages wearables and a virtual platform to allow providers to more closely manage and improve chronic conditions such as hypertension, diabetes, COPD and heart failure. RPM can support providers' efforts to work with patients and their families to avoid unnecessary hospitalizations and ED visits, which will both improve overall health status and reduce total medical expenses. Our early results suggest that patients placed on RPM after discharge from the hospital are significantly less likely to be readmitted in the 30 days following discharge.

- **Electronic Intensive Care Unit (eICU):** With 24/7 visual and electronic monitoring of critical care patients in our community hospitals, our interdisciplinary team of intensivists can supervise care of critical care patients at our lower cost community hospitals to prevent transfer to our higher cost AMC.

Strategy 2: Improving access to primary care and chronic disease specialty services
The HPC has noted the multiple challenges related to the accessibility of primary care and specialties that maintain the stability of patients with chronic diseases. UMMH is committed to ensuring that patients can access primary care and other services within their communities. To support this effort, we've launched several specific interventions:

- **Patient Access Center:** This year, we fully stood up our Patient Access Center (PAC) for all our hospital-based clinics, designed to transform the way patients access care by creating a centralized infrastructure for scheduling and financial clearance. The PAC helps deal with the patient challenge of finding available appointments and the administrative challenge of processing prior authorizations, while also reducing the burden on individual clinics and practices, improving patient experience, and reducing overhead administrative costs. This year we'll integrate all of our Medical Group's remaining practices into the PAC's workflow.

- **Medical assistant staffing and training:** Due to the changing labor market and the growth in wages outside of healthcare in the years since COVID, our primary care practices have faced significant challenges recruiting and retaining medical assistants and office-based support staff. In response, UMMH has heavily invested in market adjustments and annual cost of living adjustments to help make these positions competitive with other industries. Additionally, we've expanded opportunities for interested medical assistants and office-based employees to move through a

professional ladder by developing more tiered positions and steps for advancement. We've also leveraged the use of float pools to support practices with vacancies or staff out on medical and family leave.

- **Bridge Clinic:** Given the short supply of primary care providers (PCPs) in the commonwealth, patients can sometimes wait for months to see a new PCP. To meet this challenge, UMMH established a new virtual clinic in March 2024 to provide patients awaiting a new PCP visit with a virtual bridging provider who can provide medication refills, referrals, and acute medical condition assessments. So far, we've provided bridging appointments to 155 patients and hope to expand as we recruit and onboard additional providers and staff.

- **Multi-Disciplinary Clinics:** UMMH invested in multi-disciplinary clinics located in Leominster at HealthAlliance-Clinton Hospital and in Sturbridge at Harrington Hospital, that allows patients to access specialty care they need, closer to home. Last year, more than 12,000 patients received specialty care (audiology, cardiology, dermatology, diabetes, endocrinology, infections disease, neurosurgery, oncology, rheumatology, spine, and thoracic surgery) at the Leominster clinic, a 20% increase from the previous year. Similarly, our Sturbridge Multidisciplinary Clinic served more than 7,500 patients. We've invested $1.6M to expand the current services in the coming years at Leominster, and our board just approved standing up a new multi-disciplinary clinic at Marlborough Hospital.

Strategy 3: Health Equity Scorecard

UMMH is committed to ensuring that our patients receive the best care possible no matter their skin color, ability level, cultural background, sexual orientation, gender identity or any other identity they hold. This means investing in and developing a robust health equity scorecard for understanding the populations we serve, setting meaningful targets and goals to reduce disparities in access and outcomes, and addressing upstream drivers of health by using our assets and resources thoughtfully and strategically. In the last year, we've launched the 'We Ask Because We Care Campaign' to help our patients and staff understand the new expanded demographic data we are collecting from all the patients who come to our system for care. This year we also launched a new SDOH screening and referral effort in our inpatient and primary care settings, leveraging a patient experience company that is ensuring that all patients who request help finding community resources to address SDOH receive a text message or phone call from a virtual navigator with resource information. We've also continued to build and expand dashboards to stratify our outcome and access data by the new demographic variables we have available—and we've continued to track our progress on closing disparities related to colorectal screening, well-child visit adherence, and (new this year) follow-up after an ED visit for substance use. Finally, we've moved an additional $1M from our long-term financial reserves into local, place-based investments that address upstream social drivers of health.

Challenge 1: Limited reimbursement for innovative approaches to care delivery.
In Strategy 1, we laid out several programs that we've invested in to help improve outcomes, reduce disparities, improve access, and lower costs (which accrue to the benefit of payers and patients, not the hospital). In many cases, the impacts—and the ability to further scale and test these programs—are limited when commercial payers require discounts off standard rates or fail to reimburse us at all for these service that could help reduce total health care expenditures over time. For some programs (for example the MIH program), the lack of standardization across claims platforms and absence of existing applicable billing codes requires custom implementation which slows down progress and creates further administrative burden for our already overstretched staff.

Challenge 2: Capacity at Post-Acute Facilities and Social Service Organizations
A major contributor to the crisis in the emergency departments across our health system—and the Commonwealth as a whole—is the availability of staffed skilled nursing facility beds and home health services that patients can be discharged to. To its credit, the Massachusetts legislature is working to tackle the administrative parts of this issues, recently passing a bill to speed up the prior authorization process for discharging patients to post-acute care facilities. In addition, discharges to post-acute facilities are delayed by lack of coverage for patients with MassHealth Limited and by the lengthy court processes for securing guardianships for patients without authorized decision makers.

Similarly, with the push from regulators to more consistently screen patients for their social drivers of health (SDOH) needs, the stream of patients we are sending to already overstretched community organizations is increasing substantially. Since we launched our updated SDOH screening in April, we've identified more than 8,000 patients who asked to be connected with community resources. The need for well-resourced social service organizations in the community is now more important than ever.

4. Please identify and briefly describe any policy, payment, or health care system reforms your organization would recommend to achieve a health care system that is more affordable, accessible, and equitable in Massachusetts.

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In addition to the suggestions highlighted in Question 2, we recommend several reforms that promote a more affordable, accessible, and equitable health system in Massachusetts while promoting long-term financial stability for the health care system.

Better Prices for Medicaid
As noted above, Medicaid reimburses hospitals at rates that very rarely cover the costs of providing healthcare to members. If Medicaid prices were increased to cover the actual cost of care, there would be less need to augment the hospital balance sheet with higher commercial rates, lifting the burden on employers to cover the gap between the actual cost of service provision and the Medicaid approved rates. This could decrease upward pressure

on commercial insurance rates, thus easing the cost burden on businesses and commercially insured patients.

Administrative Simplification
As stated in past cost trend testimony, we strongly recommend that the State take action to align administrative requirements and systems across payers to decrease the burden placed on providers. Whether this burden comes from obtaining pre-authorizations, managing denials for payments, excessive documentation to get reimbursed by payers, or more recently tracking dozens of quality metrics (many of which differ slightly by payer and few of which result in actual higher quality care).

One of the biggest drivers of burnout of primary care providers—and therefore the shortage of primary care providers in the Commonwealth—is the excessive administrative requirements that seem at odds with providing personal, quality care to patients. If we don't take action now to give our primary care providers the ability to actually practice medicine and focus on their patients rather than on satisfying payers' administrative requirements, the chances of us emerging from our primary care shortage are slim to none.

Specifically, we recommend three key reforms related to administrative simplification:

- Legislatively require insurers to reduce the administrative burden on providers by making payers pay for prior authorizations and denials that are later overturned. Alternatively, ban prior authorizations altogether. This will improve primary care access by freeing up primary care providers to be . . . primary care providers.

- Reduce the number of quality metrics that a primary care practice must track and report on to the 10 most important indicators—and ensure that all payers utilize this same slate of measures. By focusing on a smaller number of metrics, primary care providers will have more capacity to care for patients, as well as focus on the quality and safety of the care they provide.

- Ensure that payers reimburse for new, innovative approaches—like MIH, HAH, RPM and eICU. This will strengthen our ability to test out and implement efforts that can reduce total medical expenditures (TME) and improve outcomes, access and equity over time, particularly for the most vulnerable residents of the Commonwealth.

Expand the capacity of SNF, BH, and Social Service Organizations.
As noted in question three, a major challenge to our crowded emergency departments and long inpatient stays, along with our ability to meaningfully implement a new social driver of health screening and referral program, is the limited capacity of skilled nursing facilities, home health agencies, behavioral health providers, and social service organizations. We recommend a few reforms to address this challenge.

- Provide hospitals with funds to pay skilled nursing facilities to take patients that still require medical care, but don't need to be in the hospital. This will free up inpatient beds and take pressure off emergency departments.

- Increase funding to social service agencies to expand capacity to deal with increasing referrals from healthcare-implemented Social Driver of Health Screening. In addition, build the systems and create the incentives for reporting back to the providers the status of services received. This will help ensure that our newly mandated efforts to ask about patients' social driver of health needs can be delivered without leading to further harm and distrust of the health system.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request. In the table below, please provide available data regarding the number of individuals that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2022-2024			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2022	**Q1**	18	130
	Q2	19	119
	Q3	9	118
	Q4	10	122
CY2023	**Q1**	19	142
	Q2	15	129
	Q3	9	151
	Q4	18	156
CY2024	**Q1**	47	177
	Q2	18	160
	TOTAL:	183	1404

2. Please describe any steps your organization takes to assist patients who are unable to pay the patient portion of their bill in full.

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In accordance with our Credit & Collections and Financial Assistance Policy, patients unable to pay the patient portion of their bill in full are screened for MassHealth, Health Safety Net or Medical Hardship programs eligibility. Balances not covered under these programs are also considered for eligibility under the hospital's Financial Assistance Program where eligible patients may receive a sliding scale discount. Patients choosing not to apply for any of the aforementioned programs are offered a payment plan as another option.

3. Do any of your commercial global risk arrangements adjust your final settlement for bad debt? Please provide details on any commercial arrangements that make accommodations for uncollectable patient payments.

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UMMH does not currently have any commercial global risk arrangements or any commercial arrangements that specifically include accommodations for uncollectable patient payments.

4. For each year **2022 to present**,
    a. For **HOSPITALS**: please submit a summary table for your hospital showing the hospital's operating margin for each of the following four categories, as well as revenue in each category expressed as both NPSR and GPSR): (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.

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b. For **HOSPITAL SYSTEMS**: please submit a summary table for each hospital corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, as well as revenue in each category expressed as both NPSR and GPSR): (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.

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