CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

September 8, 2017

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109
Via Electronic Submission HPC-Testimony@state.ma.us

Re: Annual Health Care Cost Trends Testimony

Dear Mr. Seltz:

This letter transmits Cambridge Health Alliance's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General in a letter dated July 26, 2017.

I am legally authorized and empowered to represent Cambridge Health Alliance for the purposes of this testimony. I attest, to the best of knowledge, that the attached testimony is accurate and true, and sign this testimony under the pains and penalties of perjury.

Please feel free to contact me should any questions arise.

Sincerely,

Patrick R Wardell

Patrick Wardell
Chief Executive Officer
Cambridge Health Alliance

Enclosure

MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Hospitals

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

Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

Monday, October 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

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

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

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

Exhibits B and C: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

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

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

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

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030.

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

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.
If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Spending Growth

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Increase the use of alternative payment methods (APMs)
   ii. **Priority 2**: Reduce over-utilization of institutional post-acute care
   iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?

Cambridge Health Alliance (CHA) continues to increase the use of alternative payment methods (APMs) in its portfolio and is currently accepted as a MassHealth Accountable Care Organization (ACO) through its Accountable Care Partnership Plan in conjunctions with Tufts Health Plan.

CHA is participating in the following APM models which collectively result in approximately 60% of its primary care patient population in APMs by March 2018:

- *Medicare: Medicare Shared Savings, Medicare Advantage, Senior Care Options and Elder Service Plans;*
- *Medicaid: newly launched MassHealth ACO, which builds on prior participation in Medicaid PCCP Plan Primary Care Payment Reform and a Medicaid Managed Care Organization APM; and*
- *Commercial: Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan.*

CHA has demonstrated success in delivering high value to patients and payers through its work to advance better health, better care coordination, and value.

CHA has been shown to more efficiently deliver and organize overall care for our patients, as evidenced, for example, through MassHealth's determination based on comparative total medical expenditures.

Between 2015 and 2016 for example, CHA achieved improvements in effective management of inpatient hospital and emergency department utilization for our attributed patient panel, including a:
- 6% reduction in the Medicare rate of inpatient hospital utilization;
- 20% reduction in the Senior Care Options rate of inpatient hospital utilization; and
- 6% reduction in the commercial insurance rate of emergency department utilization.

ii. What barriers does your organization face in advancing this priority?

The following barriers present challenges to the continued progression of APMs for CHA:

- *Current APM methodologies used by Massachusetts insurers incorporate payment disparities across ACOs, inclusive of unwarranted relative price differences by commercial payers and efficiency differences. More efficient ACOs and ACOs comprised of providers with lower relative price are often disadvantaged (versus rewarded) in APMs. More efficient ACOs would be supported through greater weighting of an average market rate in developing their APM total medical expenditure budgets.*
- *APM methodologies for Medicaid and public payer populations are constrained by historical funding and provider payment rates that are below the actual cost of care. As well, under the new MassHealth global payment arrangement, it is more challenging for more efficient ACOs to achieve savings in the initial years of the program. This is because the reimbursement model takes incremental savings upfront from an already more efficient starting place that is up to ten percent more efficient than the market average.*
- *The shift to APMs and global budget arrangements has not addressed underlying reimbursement conditions, which include relative price disparities across providers for the same quality and type of service, inadequate reimbursement in the most commonly adopted global budget models for primary care and behavioral health care, and the lack of current risk adjustment methodologies to adequately account for behavioral health complexity across all payers. MassHealth has importantly begun to address social acuity/social determinants of health in its risk adjustment methodology, which may have applicability to additional payer populations as well.*
- *Managing care at the population level requires substantial investments by ACOs that are not often recognized by financial models that are built on fee-for-service equivalents. For example, asynchronous care – telephonically or through digital means – may not be recognized as a cost in the global budget or capitation-setting models as currently constructed, but would need to be reflected going forward.*
- *There are access barriers for important levels of care such as mental health and substance use disorders, respite care, and dental care that present challenges to more efficiently organizing care. Some of these access barriers relate to shortage professions as well as reimbursement challenges by MassHealth, which is responsible for a great deal of this care.*

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

Unwarranted payment rate variation is a top priority for near-term policy action, particularly as it relates to low-relative price hospitals and providers. For many community and disproportionate share hospitals that are paid well below the average commercial insurer rate, this presents significant challenges in promoting access to a statewide, high value health care system. If inadequate commercial payment rates are not addressed, it endangers driving up statewide costs if community capacity is lost due to policy inaction. In addition, APM methodologies must create greater incentives for more efficient ACOs through greater weighting of the average market rate in developing their global budgets.

All providers must continue to make investments in technology, regulatory requirements, market wages, and health access needs of their communities, in addition to the investments required under APMs, all of which are hampered by the disparities in the payment system.

Adequate public payer APM rates are essential. As described in the barriers section above, ACOs that demonstrate value should not be subject to unrealistic short term savings expectations versus payment more aligned with the average market rate.

In addition, there is a need for policymakers to balance detailed programmatic requirements of ACOs against the shared goal of flexibility and innovation toward providing good access to high quality care.

c. Please complete the following questions for **Priority 2** (listed above).

i. What is your organization doing to advance this priority and how have you been successful?

CHA is actively working on effective post-acute care utilization and care, through in-depth clinical collaborations within defined preferred post-acute care provider partnerships, including home health and skilled nursing facilities (SNFs).

CHA is fostering collaborative relationships with selected post-acute care facilities over the last year and a half. As health systems and ACOs are increasingly held accountable for longer term patient outcomes, 30-day post hospital costs, and integration of care across the continuum, there is increasing recognition of the importance of cultivating more intentional networks with post-acute care providers.

CHA discharges approximately 15% of our patients to skilled nursing and/or rehabilitation facilities. Almost half of those patients are long term residents of those facilities, while the other half are discharged for short term stay in post-acute facilities. Available data from the Medicare Spending per Beneficiary report suggests that while CHA overall spending per beneficiary is at or below the state and national averages, CHA identified an opportunity to improve post-acute expenditures through clinical practices and partnerships with SNFs.

CHA is pleased that this work is beginning to yield results. Between 2015 and 2016, CHA reduced its Medicare Shared Savings Plan SNF days per thousand by 20% and reduced the readmission rate by 18%.

Prior to this initiative in calendar year 2015, CHA's inpatient acute care hospitals were discharging patients to a collection of 16 post-acute care facilities. Informed by available quality performance indicators and geriatric service provider input, CHA has narrowed the SNF network and engaged 10 preferred post-acute care facilities, to strengthen the clinical collaboration and to align these preferred facilities with the networks of payers in which CHA participates in ACO financial arrangements. Each of these 10 facilities has signed a contract agreeing to participate in data sharing with CHA to facilitate the work of improving care and care transitions. In nine of these ten facilities, CHA has geriatric physicians and nurse practitioners that assume responsibility for providing care to patients. Provider-to-provider collaboration, including warm hand-offs at the time of transition, is much easier when partnering providers are in the same health system and share access to the same medical record. CHA works collaboratively with a group of affiliated SNFs to improve communication post discharge. CHA's intent is to encourage a verbal patient handoff between members of the hospital team and the nurses and providers at the affiliated SNFs at the time of hospital discharge (with electronic medical record (EMR) documentation). CHA strives to reduce readmission rates by providing continuity of care across the continuum including post-acute facilities.

Since June 2016, a series of initiatives have strengthened the quality of our collaborative SNF relationships including: 1) development of a plan for data sharing; 2) regular meetings between CHA case management staff and multidisciplinary teams from SNFs to review patient cases; 3) targeted improvement initiatives emerging from case review; and 4) development of best practices in care transition communication. CHA is currently working on expanding EMR access to our ten collaborating post-acute care providers. In addition, we are mutually deploying an actionable decision support solution to permit data driven decision making for continuous improvement in care quality, safety, and cost, which will enable proactive care planning, inform quality improvement, and aim to reduce readmission rates and improve outcomes for post-acute populations.

ii. What barriers is your organization facing in advancing this priority?

Several barriers related to post-acute care and transitions of care from the acute to a post-acute care facility setting include:

- *effectively partnering to manage readmissions from the post-acute setting,*
- *addressing gaps in the continuum of care for respite care services and community-based post-acute psychiatric levels of care that could be utilized in lieu of SNF care in specific instances,*
- *greater opportunities to incorporate advance care planning, hospice, and palliative care use,*
- *lack of stability in SNF ownership and leadership, and*

- *the need to change clinical practice patterns regarding referrals to SNFs.*

There is an overarching provider culture barrier where SNF utilization may in certain instances be considered a safer option for patients with medical, behavioral health, and/or social complexity versus post-acute care delivered in a home-based setting. There are state and regional gaps in the availability of respite care facilities and options that may be suitable for patients with social acuity and other complexities. Furthermore, gaps in community-based post-acute psychiatric levels of care for patients with major mental illness can also result in usage of SNFs.

Frequent SNF ownership change and leadership changes (such as in the Executive Director and Director of Nursing positions) impacts clinical care collaborations that must be re-set amid frequent changes.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

There are a number of policy, payment, regulation and statutory recommendations that would be supportive of efficient usage of post-acute care options.

First, the current Medicare requirement of three consecutive hospital inpatient overnight days to qualify for skilled nursing facility level of care needs to be adjusted to be more flexible. While Medicare Pioneer and Medicare Shared Savings Program (MSSP) allow for a waiver of this rule, the traditional Medicare program would benefit from adopting this flexibility to allow for patient care in the most appropriate level of care. Without this flexibility, some patients have longer acute hospital stays than may be possible with greater flexibility.

Second, there is a need for additional short-term respite care capacity in Massachusetts, as a means of providing community-based alternatives to SNF care for patients that require an enhanced level of support after hospital discharge. This will be particularly helpful for patients with social acuity in addition to their physical and/or behavioral health conditions. In addition, there is a need to support the development of additional community-based post-acute psychiatric levels of care.

Third, there is an opportunity for greater policy alignment with post-acute facilities and ACOs. Current reimbursement policies for post-acute facilities still largely rely on volume.

As noted above, there is an opportunity for greater advance care planning, including palliative and hospice care. There can be a misalignment of payment incentives relative to hospice care in a SNF under the Medicare hospice benefit, which could be an area of federal policy focus. Palliative care and hospice care are patient-centered and can improve the quality of care for patients in a cost effective manner that respects a patient's wishes. However, electing to use the Medicare hospice benefit can be financially disadvantageous to both patients and the SNF. To enroll in hospice, Medicare requires patients to revoke their skilled SNF benefit, leaving the SNF room and board fees uncovered. The patient must then pay privately for the SNF room and board fees which can create financial challenges, if the patient is not MassHealth eligible. In addition, SNFs are generally reimbursed better for skilled Medicare days versus hospice care, which is an opportunity for further alignment.

Fourth, there is a need for greater stability for SNFs. The challenging reimbursement environment, particularly for public payers, can contribute to frequent ownership and leadership changes.

2. STRATEGIES TO REDIRECT CARE TO COMMUNITY SETTINGS

The HPC has identified significant opportunities for savings if more patients were treated in the community for community-appropriate conditions, rather than higher-priced academic medical centers.

a. What are the top barriers that you face in directing your patients to efficient settings for community-appropriate care rather than to more-expensive settings, such as academic medical centers? (select all that apply)

- ☒Patient perception of quality
- ☐Physician perception of quality
- ☒Patient preference
- ☐Physician preference
- ☐Insufficient cost-sharing incentives
- ☐Limitations of EMR system
- ☒Geographic proximity of more-expensive setting
- ☒Capacity constraints of efficient setting(s)
- ☒Referral policies or other policies to limit "leakage" of risk patients
- ☐Other (please specify): Click here to enter text.

b. How has your organization addressed these barriers during the last year?

CHA is actively implementing strategies toward appropriate care in community-based settings. Providing integrated care across the continuum of care through effective referral management and care coordination is foundational to the ACO model and APM arrangements with quality, cost and health care utilization accountability.

A significant focus is on advancing effective referral management and community-based specialty access improvement as part of the goals of better health and optimal, more coordinated and cost-effective care. CHA is cultivating preferred provider relationships with high value providers along the continuum of care, including for hospital services, specialty services, and post-acute care.

Recent CHA initiatives have resulted in increased patient access to high-quality care and promoted appropriate referrals and access (i.e. the right provider in the right setting) based on the complexity of the patient's needs. A measure of this success is CHA's reduction in overall out-of-network referrals by 2.3% compared to prior year performance.

CHA is also reinforcing care in its own community-based health care delivery system and with clinical affiliates. A core part of this work is to address access opportunities within CHA's high value community-based specialty care settings with an initial focus on three particular specialties of dermatology, gastroenterology, and orthopedics. The specialty access improvements implemented include: deploying physicians and physician assistants to expand community-based specialty access (along with expanded clinical exam rooms), increasing the use of innovative technology such as with tele-dermatology referrals, optimizing the appointment scheduling process, and a range of clinical operational improvements to facilitate access.

An ongoing focus is on:

- *educating providers and patients about our community-based specialty services,*
- *updating and distributing new patient-facing material to reflect new referral policies and procedures (at all campuses, the patient portal and website),*
- *educating staff on newly developed referral initiation workflows to support patients and providers with their referral needs,*
- *building information technology reporting to monitor the effectiveness of referral management interventions, leverage outmigration performance data, and reinforce the culture of accountability which is vital to successful referral management.*

These collective efforts are in furtherance of real-time actionable improvements in patient care, care coordination, and population health interventions.

3. INFORMATION ON PHYSICIAN COMPENSATION MODELS

Please answer the following questions regarding the current compensation models for your *employed* physicians. Indicate N/A if your organization does not employ physicians. ☐N/A

a. For **primary care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	5%
Salary	87%
Panel size	6%
Performance metrics (e.g., quality, efficiency)	2%
Administrative/citizenship	0%
Other	0%

b. For **specialty care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	0 – 6.9%
Salary	91.4 – 96.7%
Panel size	0%
Performance metrics (e.g., quality, efficiency)	0 – 6%
Administrative/citizenship	0 – 4%
Other	0 – 2.4%

Notes to Tables A and B above: Does not include Administration, Reimbursed and Teaching time or related stipends; incremental clinical earnings (e.g. excess on call) not part of compensation program; and any risk sharing distributions under alternative payment models.

c. Describe any plans to change your organization's compensation models for primary care and/or specialty care physicians that you employ.

CHA makes periodic adjustments related to physician compensation models for employed physicians. These often reflect elements that are in alignment with our further adoption of value-based payment methods, including those related to our ACO initiatives such as our MassHealth ACO.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030. **If a question is not applicable to your organization, please indicate so in your response.**

1. 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 CY2015-2017			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	N/A	
	Q2	N/A	
	Q3	N/A	
	Q4	N/A	
CY2016	**Q1**	17	All phone; Tracking began February 2016*
	Q2	46	All phone
	Q3	64	All phone
	Q4	49	All phone
CY2017	**Q1**	43	All phone
	Q2	82	All phone
	TOTAL:	301	301 via phone

** Tracking system in place since February 2016.*

   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.

CHA has created a price quote line within its Financial Assistance Department which is promoted both externally, via the CHA website, and internally, as a resource for patients to request a price quote for all services at CHA. CHA Customer Service staff manage the request internally, utilizing a standardized price quote request form to expedite the process in a timely fashion. Coding staff perform the necessary research and evaluation, following CHA and regulatory policies and procedures, and then send the information back to Customer Service staff to complete and communicate back to the patient. The patient is called with the information and sent a confirmation letter, or the letter is e-mailed based on patient preference, once the request is completed. The standard letter format includes both the pricing for the requested services and a link to the website of the payer for the patient to access information related to the required allowed amount by their insurance company.

A tracking system was established in February of 2016 to maintain a record of requests received and to monitor the turnaround time for such requests. Copies of confirmation letters are also scanned and kept on file for future reference. The average rate of turnaround within 48 hours is 95% of total requests.

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?

Obstacles to providing price quotes usually relate to a lack of accuracy as to the particular request. The implementation of a standardized price quote request form and staff training has helped to improve service to patients in this area.

2. For each year 2014 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain 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.

CHA is unable to complete this table because it does not have a cost accounting system in place at this time. While it may be possible to make estimates of the contribution margin by payer utilizing ratios from sources such as the Medicare cost report, these estimates would not be an accurate assessment of costs at the individual patient, and therefore aggregated payer, level. Given the level of assumptions necessary to develop this type of analysis, CHA has concerns that, even if it were able to submit information, the results would not be comparable across providers. We have provided the margin data at the total provider level. Please find attached the Center for Health Information and Analysis Acute Hospital Financial Performance Trends for CHA for FYs 2012 through 2016, which can be accessed at http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2016-annual-report/cambr-ha.pdf .

Attachment: Exhibit C, Question 2

Acute Hospital Financial Performance Trends

Hospital	City/Town	County	Hospital Type	Fiscal Year End	Number of Months Data
Cambridge Health Alliance	Cambridge, MA, Somerville, MA & Everett, MA	Middlesex	Teaching Hospital	06/30/16	12

Financial Performance Indicators	FY12	FY13	FY14	FY15	FY16	MA Industry Median FY16	North East US Median FY15
PROFITABILITY							
Operating Margin	-6.5%	-4.9%	-4.8%	-0.5%	-5.3%	2.6%	2.3%
Non-Operating Margin	1.1%	1.2%	1.2%	1.8%	2.1%	0.8%	0.1%
Total Margin	-5.4%	-3.7%	-3.6%	1.4%	-3.2%	3.1%	2.8%
Operating Surplus (Loss)	($34,599,521)	($26,440,812)	($25,816,752)	($2,728,078)	($31,030,361)	--	--
Total Surplus (Loss)	($28,533,985)	($19,956,270)	($19,339,831)	$7,945,894	($18,821,572)	--	--
LIQUIDITY							
Current Ratio	0.9	0.8	0.7	1.3	1.7	1.8	1.6
Days in Accounts Receivable	26	26	27	27	26	40	50
Average Payment Period	54	58	57	107	50	55	66
SOLVENCY/CAPITAL STRUCTURE							
Debt Service Coverage (Total)	-0.1	2.0	3.0	8.8	1.1	4.2	3.0
Cash Flow to Total Debt	-1.8%	9.3%	8.1%	18.4%	1.9%	20.8%	12.0%
Equity Financing	36.3%	29.0%	23.2%	26.6%	25.1%	50.3%	47.0%
OTHER							
Total Net Assets	$101,082,229	$74,744,931	$56,006,936	$103,584,834	$76,516,794	--	--
Assets Whose Use is Limited	$8,378,650	$8,045,061	$17,376,837	$24,287,050	$8,563,579	--	--
Net Patient Service Revenue	$474,396,724	$467,066,636	$445,982,150	$482,946,401	$498,485,822	--	--

For descriptions of the metrics, please see the Massachusetts Hospital Financial Performance Technical Appendix

For more information, please contact:
CENTER FOR HEALTH INFORMATION AND ANALYSIS
501 Boylston Street, 5th Floor | Boston, MA 02116
617. 701. 8100 | www.chiamass.gov

Publish Date: August 2017