CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

September 1, 2016

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street
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 19, 2016.

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

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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, 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.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@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 Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, 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, and/or 2015 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 Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury 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 Cost 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. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Cambridge Health Alliance (CHA) understands the importance of achieving reasonable levels of health care expenditures within the context of the overall economy. Our most significant concerns relate to the inflexibility associated with establishing such a target. Commercial payers have not taken necessary steps to address relative price variation for health care providers paid below average in this context. As the overall economy is improving, market wages are increasing in many positions (both clinical and administrative) by rates which exceed the benchmark; we must recruit and retain qualified staff to remain competitive. In addition, the benchmark is not generally responsive to innovations and associated cost increases related to technology and pharmaceuticals. For the majority of these increases, there is an associated value proposition to which the benchmark (and any payer rates which are capped at or below the benchmark) is unresponsive. Finally, the implications of MassHealth payment reform will need to be adequately accommodated in the statewide target-setting process.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

Payment rate variation continues to drive decline in smaller, lower cost community providers with limited market power. 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. Despite well-documented and unwarranted price variation for the same types and quality of services, providers must continue to make investments in technology, meet regulatory requirements, and pay market wages, while still meeting the basic health access needs of their communities. Additionally, many governmental payment adjustments (Medicare rural floor, MassHealth MCO payment adjustments) disproportionally affect these disproportionate share hospitals and providers, further weakening their financial performance and creating a cycle of decline. The likely long term outcome of this cycle is reduced competition and higher overall cost, unless policy and other corrective actions are taken to address unwarranted relative price variation. While some initial steps were implemented in SFY2016 to establish a commission to review this issue, CHA urges a continued consideration of effective policy and regulatory initiatives in this area.

2. **Strategies to Address Pharmaceutical Spending.**

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Plans to Implement in the Next 12 Months

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Plans to Implement in the Next 12 Months

iv. Establishing internal formularies for prescribing of high-cost drugs

Plans to Implement in the Next 12 Months

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

3. **Strategies to Integrate Behavioral Health Care.**

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

Through a variety of initiatives, CHA has implemented multiple strategies to improve the integration of behavioral health care and outcomes for our patients. These strategies include Primary Care/Behavioral Health Integration (co-location of behavioral health providers in primary care sites, increased utilization of evidence-based behavioral health screening tools (depression, general well-being, anxiety, alcohol and substance use) across the primary care population, telemedicine psychiatric consult services), Behavioral Health Home (co-location of primary care in intensive mental health outpatient service, increased utilization of physical health screening tools, and population health approaches), and CHA's work to integrate training programs for future generations of clinicians and graduate medical education, such as through the Harvard Medical School clinical clerkship to increase the supply of physical health providers who are more knowledgeable of the tactics associated with successful care integration and managing care teams which include behavioral health resources such as care coordination staff.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

The lack of parity in reimbursement for behavioral health services remains a barrier for an organization such as CHA, which offers significant inpatient and outpatient behavioral health services and also has a high proportion of safety net patient populations with a high prevalence of behavioral health conditions. Screening has revealed a significant need for interventions, particularly for detoxification services and other substance use treatment, and there is an overall system-wide shortage of such services, especially for the safety net population.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)\

The top three strategies that CHA will be deploying to address the social determinants of health are as follows:

1. *Integration of a nationally validated screening tool within our electronic health record for the purpose of annual and repeated screening for social determinants;*
2. *Establishing a network of community providers that address social determinants and developing referral structures that allow CHA to connect patients to the appropriate services within the community; and*
3. *Developing with our community partners programs, services and outreach methodologies that target specific social determinants within our respective communities with the goal to improve health outcomes.*

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

CHA is committed to efforts to address social determinants of health (SDH) in our patient population that is comprised of large safety net population. Several top barriers to understanding and/or addressing SDH are as follows:

1. *As an emerging field without dedicated funding, the SDH screening and resource referral process can be intensive. The intensity and length of existing SDH screening tools, the efforts to address identified problems, and the lack of resources to address these problems within the community can add significant burden to primary care practices, clinicians and staff. Determining pathways to incorporate adequate screening for SDH and explore reasonable options for resolution of the social determinants is needed so that already busy care teams and clinicians are supported.*
2. *Patients may initially be reluctant to complete surveys and be forthcoming about SDH needs. Time may be needed in order for patients to feel comfortable to discuss these issues with their care team.*
3. *Advancing the adoption of efforts to address SDH is impeded by the current status quo in which there are limited, non-standardized community-based responses to issues that are uncovered through a SDH screening process. While there is a goal, especially among safety*

net providers, to work on SDH and transform from a medical care model to a health promotion model, the lack of policy and consistent financial support for a comprehensive community response to common SDH is a cause of concern for our providers and our patients and may cause ethical concerns and unintended consequences, as articulated in the August 23/30, 2016 Journal of the American Medical Association article, "Avoiding the Unintended Consequences of Screening for Social Determinants of Health."

5. **Strategies to Encourage High-Value Referrals.**

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

CHA has addressed the approach to high value specialty and ancillary care by establishing referral policies and protocols that outline the expectations for our providers, staff and patients who choose us as their primary care network. All referrals for clinical services, including ancillary and diagnostic testing, are preferentially referred to CHA providers to ensure clinical continuity with the primary care provider when appropriate. When necessary, CHA will refer patients to a preferred network of providers for services that CHA does not provide or in situations where clinical continuity with an existing provider is essential to achieving a positive outcome for the patient.

In the event that services are not offered within CHA, providers will utilize the Electronic Health Record (EHR) system, a referral coordinator, or a centralized support team aware of regional services and affiliations to identify "external preferred providers" or facilities that are preferred from a cost, quality, and access perspective. All CHA providers and staff are expected to educate patients about the value of using CHA specialists and or CHA's network to provide integrated care.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.

ii. If no, why not?

While CHA's EHR includes a module to make referrals to preferred providers, including providers within our own health system and other clinical affiliates, this module does not presently include cost and/or quality information. However, CHA has intentionally pursued preferred provider partnerships that are based on high value, including cost, quality, and accessibility. In certain cases, individual analysis has been performed to assess various aspects of these relationships. Upon completion of this type of analysis, CHA has incorporated new providers into our EHR with a designation of a preferred provider.

Current EHR tools are complex and require a significant amount of maintenance to address accurate provider and system affiliation directories. The introduction of cost and quality to these directories would require significant IT functionality and resource intensity to develop and maintain this type of sensitive information. Additionally, many of the existing EHR tools do not

have the capacity to effectively integrate information such as cost and quality. Furthermore, through currently available information via health care public policy arenas, there is not full industry cost/relative price transparency and quality data at a provider, system and/or service level.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.

ii. If no, why not?
Please see the response above in question 5.b.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?

Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

CHA's EHR has both the full access and view access to providers and organizations that are either credentialed at CHA or have executed the appropriate data security and privacy documentation as well as attend the necessary training. In some cases, CHA has been able to provide direct access to our EHR system from within an independent EHR structure of a referring partner. To date, CHA provides access to our EHR to individual providers and provider systems, Visiting Nurses Associations, Skilled Nursing Facilities, Hospice providers and other selected care managers.

ii. If no, why not?

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

1. *CHA continues to explore the appropriate use of alternative payment methods (APMs) in its portfolio and is actively participating in various forums to address and support the use of these models more comprehensively in the Medicaid population. CHA already participates in the following APM models which collectively result in greater than 42% of its patient population in APMs:*

- *Medicare: Pioneer ACO, Medicare Advantage, Senior Care Options and Elder Service Plans;*
- *Medicaid: Medicaid Primary Care Clinician Program (PCCP) Primary Care Payment Reform and Medicaid Managed Care Organization*
- *Commercial: Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan.*

2. *CHA will continue to expand its participation in APMs by selecting to participate in Mass Health's Medicaid ACO platform. By adopting APMs for a greater proportion of CHA's Medicaid population, this could result in approximately 58% of CHA primary care panel being covered by APMs.*

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The following barriers present challenges to the continued progression of alternative payment methods (APMs) for CHA:

1. *Methodologies for conversion of the remaining Medicaid fee-for-service and Primary Care Clinician Plan (PCC) to alternative payment models and adequate financing of such models, as Medicaid tends to reimburse below the cost of care.*
2. *With the progression of Massachusetts Medicaid ACOs and adoption by CHA, the majority of CHA's attributed patient population will be covered in APMs.*
3. *As APMs continue, there are uncertainties on how these models will work for Medicaid and related public payers, including populations with health complexities or social acuity that is not currently reflected in the risk adjustment methodology.*

In addition, per our previous testimony, there are underlying conditions that continue to be relevant and pervasive. In particular, the shift to APMs and global budget arrangements has not addressed the significant set of 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 and social acuity.

Furthermore, a shortage of primary care and mental health providers, a lack of uniform cost and quality transparency, measurement of SDH, and the impact on the ability to successfully manage populations are all still critical to overall success and financial stability of provider organizations in the Commonwealth.

c. Are behavioral health services included in your APM contracts with payers?

Yes

i. If no, why not?

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

CHA agrees with an objective of greater alignment of quality measure definitions across specific payer initiatives. It would be time and cost-effective to have the measures mirror or better yet consist of a subset of the CMS measures, including CMS Core Medicaid measures for adults and children. The burden of reporting on numerous metrics that are not aligned directs necessary analytic resources away from other needed efforts and increases administrative burdens and cost. Retrospective abstracting for quality data and manual reports are particularly time consuming.

As an example of the work efforts for misaligned definitions of similar quality metrics, the following are additional work steps that can be required:

- *understanding the different nuances of the variation in measure definitions;*
- *the development of separate reports for each variation of a similar quality metric;*
- *for some measures, new clinical components need to be built in the EHR to meet each definition;*
- *clinician and operations care team buy-in to the measure definition is essential to performance, as at times some measure definitions are not reflective of rapidly emerging evidence (a recent example of this were recent updates to the national definitions for hypertension control measures to reflect emerging guidance on good blood pressure control levels by age group);*
- *clinical and operational workflow review and changes related to the quality measures and their variations; and/or*
- *ongoing maintenance and review of annual changes in measure definitions.*

Utilizing nationally or state validated measure definitions that reflect the most recent evidence, where possible, helps CHA to address the variation in quality measure definitions, where possible. In order to drive practice change and results, it is most helpful to have a singular set of reports for providers and care teams on a particular quality measure. CHA addresses the changes by building reports that are flexible and allow for modifications, to the extent possible.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

Internally within CHA, we attempt to use one quality measure definition, typically aligned where possible with nationally or state validated measure definitions, across the organization. When possible, we use the same definition for external reporting. We also leverage external tools, including those available within our EHR to facilitate automatic reporting (for example: use of EHR Meaningful Use measure definitions or application of Snomed standardized groupers).

We either send database files to the payer or reports. Most data exchange occurs monthly.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

Related to Section 7. Strategies to Improve Quality Reporting, CHA notes that some of the quality measures within payer contracts are based on claims data, which can pose a range of challenges toward capturing complete information. Billing information can often present incomplete data needed for quality statistical reporting. For instance, MassHealth fee-for-service claims do not allow for certain hospital-based providers to include allied health provider claims, such as those provided in a primary care setting. Academic organizations, including organizations like CHA that provide substantial primary care residency programs, are unable to submit claims for services provided by residents under the primary care exception rule. Such resident services which may include those performed in an annual wellness exam, under the primary care exception rule, are not being billed on the claim although the service has been performed. Therefore, these associated visits and preventive screening activities are not counted toward the quality measurement, often resulting in an under-reporting of the quality indicator achievement. An area for recommendation is to allow informational claims submissions that count toward quality measurement, even though the bill is not adjudicated for payment purposes.

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 Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. For each year 2012 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 and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, 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 2011 through 2015.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

      CHA has created a price quote line within its Financial Assistance Department which is promoted both externally, via the CHA website, as well as internally, as a resource for patients to request a price quote for all services at CHA. Staff who answer the price quote line have been trained to gather relevant information to pass on to Customer Service staff who 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, then send the information back to Customer Service to complete and communicate back to the patient. Once the request is completed, the patient is called with the information and sent a confirmation letter as well, or the letter is e-mailed based on patient preference. The standard letter format includes both Facility and Professional pricing for the requested services as well as a link to the website of the payer for the patient to access the payer for information related to the required allowed amount by their insurance company.

   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 analyses.

      A tracking system has been established 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. The tracking system has been in place since February of 2016.

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 as well as additional training for staff processing the request has helped to improve service to patients in this area.

Attachment: Exhibit C, Question 1

Acute Hospital Financial Performance Trends

Hospital	City/Town	County	Hospital Type	Fiscal Year End	Number of Months Data
Cambridge Health Alliance	**Cambridge, Somerville, & Everett, MA**	**Middlesex**	**Teaching Hospital**	**06/30/15**	**12**

Financial Performance Indicators	FY11	FY12	FY13	FY14	FY15	MA Industry Median FY15	North East US Median FY14
PROFITABILITY							
Operating Margin	-8.6%	-6.5%	-4.9%	-4.8%	-0.5%	3.0%	2.2%
Non-Operating Margin	1.2%	1.1%	1.2%	1.2%	1.8%	0.1%	0.1%
Total Margin	-7.4%	-5.4%	-3.7%	-3.6%	1.4%	3.7%	3.1%
Operating Surplus (Loss)	($42,631,694)	($34,599,521)	($26,440,812)	($25,816,752)	($2,728,078)	--	--
Total Surplus (Loss)	($36,884,920)	($28,533,985)	($19,956,270)	($19,339,831)	$7,945,894	--	--
LIQUIDITY							
Current Ratio	0.6	0.9	0.8	0.7	1.3	1.6	1.6
Days in Accounts Receivable	18	26	26	27	27	38	49
Average Payment Period	51	54	58	57	107	58	64
SOLVENCY/CAPITAL STRUCTURE							
Debt Service Coverage (Total)	-1.4	-0.1	2.0	3.0	8.8	5.7	4.4
Cash Flow to Total Debt	-10.8%	-1.8%	9.3%	8.1%	18.4%	20.5%	12.4%
Equity Financing	31.6%	36.3%	29.0%	23.2%	26.6%	47.4%	46.6%
OTHER							
Total Net Assets	$81,342,424	$101,082,229	$74,744,931	$56,006,936	$103,584,834	--	--
Assets Whose Use is Limited	$14,702,691	$8,378,650	$8,045,061	$17,376,837	$24,287,050	--	--
Net Patient Service Revenue	$439,533,616	$474,396,724	$467,066,636	$445,982,150	$482,946,401	--	--

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

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