MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 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 2022 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, October 24, 2022**, please electronically submit testimony 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 2021, 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 Attorney General's Office (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.

INTRODUCTION

This year marks a milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and unwarranted variation,
- Increased market consolidation and expansion of high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the state's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the past ten years of the Massachusetts health care cost containment effort, and the additional context of ongoing COVID-19 impacts, please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth, promoting affordability, and advancing health equity in future years.

Workforce shortages, especially for nursing but also for other clinical and non-clinical staff, has quickly become the major challenge our organization is facing. The expense of recruiting (through sign-up bonuses) as well as retaining staff (through pay-raises and incentives) is only dwarfed by the extremely high cost of filling open positions with contract staff. These expenses negatively impact the healthcare cost growth benchmark and affordability of services.

The main barrier to advancing health equity in future years is the continuing disparity in unwarranted price variance which is inflicted upon the hospitals serving the most diverse and the most disadvantaged populations in the Commonwealth. It is actually ironic, that in an area of heightened sensitivity to existing inequities, institutional racism and other barriers to advancing health equity, the recommendations of the State commission on unwarranted price variance have been completely ignored. That, despite the fact that the hospitals who are victims of the private insurers practice of sub-par payments and unwarranted price variance are located in the poorest and most diverse communities in the Commonwealth. **While EOHSS and MassHealth, to their enormous credit, have consistently strived to support and reinforce those hospitals located in poor and racially diverse areas, the private insurer lobby has successfully pushed back time and time again on any legislation that seeks to end their institutional racism by mandating fair payments to hospitals in poor and racially diverse areas of the Commonwealth.**

Lest anyone believes this to be anything else than a blatant manifestation of institutional racism by the private insurers, here is a concrete example: Holyoke Medical Center shares many things with one of its closest neighbors, Cooley Dickinson Hospital. Our size, labor market and quality metrics are almost identical. We actually even share geographic location: Western Massachusetts (we are only 9 miles apart as the crow flies). What we do not share is a zip code, and with that, median household income, racial make-up of the population, education level, etc. Here are some quick facts:

	Holyoke	Northampton
Median Household Income (2020)	$42,537	$71,866
Percent White Non-Hispanic or Latino Population	41.1%	82.1%
Hispanic or Latino Population	54.6%	9.1%
Bachelor's degree or higher education	22%	60.8%
Persons In Poverty	27.5%	10.9%

So what does a mostly white, college educated, and affluent community get that a mostly Latino, poorer community doesn't? Their hospital in the white and affluent community gets paid very well with plenty of funds to invest in their facilities, equipment and programs, while the hospital in the racially diverse and poorer community gets paid significantly less for the exact same services. Institutional racism in its fullest expression! Solely based on the very different demographic of the two communities: Holyoke Medical Center Price Variance Index: 0.73, Cooley Dickinson Hospital Price Variance Index: 0.98. That is a 0.25 spread in private insurer payments for the exact same services. Given that the labor and supply cost at Holyoke Medical Center is identical to that of Cooley Dickinson Hospital, this is nothing else than institutional racism at its worst. One community hospital is reimbursed significantly lower than its neighboring facility, only because the population it serves is poorer, less white, less educated, less likely to speak English. The oxymoron of this discrimination is that the funds are mostly needed in the exact areas from which they are being deprived.

The loss of revenue to Holyoke Medical Center due to this institutional racism is at least $10-$12 million per year. It is an enormous price the community pays, year in and year out, because it doesn't fit the demographic and racial profile the private insurers prefer. In several decades of this practice, Holyoke Medical Center and its community have been deprived of hundreds of millions of dollars that could have been invested in new services, equipment, outreach programs, etc. to benefit the very people our Commonwealth is presumably caring to elevate to a better, and more importantly, equal quality of life and health status as their neighbors in privileged communities.

NOTE: The **factually unfounded excuse** the private insurers have for perpetuating their institutional racism is that paying Holyoke Medical Center the same amount of money as Cooley Dickinson Hospital for the exact same service would force them to increase premiums and raise the cost of healthcare in the Commonwealth. **Holyoke Medical Center represents only 0.2% of the total private health insurer payments in the Commonwealth.** This is not a typo, it is 0.2% (zero point two) percent. And the percentages are similarly small (under 1%) for essentially all the hospitals located in poor and racially diverse communities who are being discriminated against. The private insurers could rectify this discrimination immediately with zero impact on premiums or overall healthcare costs. Frankly their huge reserves and large margins, which only increased during the pandemic, would reduce the fix to essentially a rounding error on their books. Yet they steadfastly refuse to do it, managing through their powerful lobby to kill every bill that comes close to addressing the issue, while at the same time claiming to work hard to reduce racial inequities in the healthcare system.

b. Please identify and briefly describe the top strategies your organization is pursuing to address those concerns.

b. Holyoke Medical Center has and will continue to advocate for the elimination of institutional racism of private insurers expressed as “unwarranted price variance”, by legislation and DOI regulation. This discriminatory practice deprives our community form much needed funds to improve the lives and health outcomes of the population we serve.

On the workforce shortage issue, Holyoke Medical Center is continuing to support staff who wish to pursue careers in nursing and in other much needed careers by providing significant tuition reimbursement. We have had a policy of setting our lowest wage at $2 above the state minimum at all times and have recently increased all our rates including the entry level pay rates. We have developed strategies for recruitment and retention of staff, such as a RN residency program, mentoring programs, and significant collaboration with colleges and universities. Of course, all this requires significant amount of funds. We have been able to fund these initiatives largely thanks to CARES ACT and ARPA funding, however we are very concerned about future investments as these funds are coming to an end.

c. Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including specific metrics and results. Please also describe other specific activities your organization has undertaken to advance health equity.

Holyoke Medical Center currently collects race, ethnicity, birth gender, and legal gender, language, and disability status from patients. The hospital has added the capability to collect data on sexual orientation and gender identity (SOGI data). We are currently working on developing a process to consistently collect SOGI data on all our patients. Holyoke Medical Center participates in MassHealth initiatives to promote health equity, especially as it relates to the new 1115 waiver. Currently, we report data to MassHealth on Health disparity measures.
On the MassHealth Health Disparity Composite (HD-2), Holyoke Medical center has made steady improvements. The Final Between Group Variance (BGV) index has improved from 0.003640 in 2019, to 0.001975 in 2020, and further to 0.000440 in 2022.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

The most important policy change is to pass legislation, followed by DOI enforcement, which requires the elimination of unwarranted price variance in private insurance reimbursement, a manifestation of institutional racism by the industry that is depriving Holyoke Medical Center and the people it serves of much needed resources.

We also believe that the Attorney General’s office can and should have done more to address this institutional racism. The office is certainly aware and has certainly shown to

be capable of action and results in other major issues. We call upon the Attorney General to immediately turn her attention to this matter.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

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) 2020-2022			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2020	Q1		23
	Q2	3	8
	Q3		24
	Q4		17
CY2021	Q1	1	19
	Q2		9
	Q3	1	8
	Q4		8
CY2022	Q1		13
	Q2	1	14
	TOTAL:	6	143