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March 26, 2021

Mr. Stuart Altman, Chair
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Senator Cindy Friedman
Chair, Joint Committee on Health Care Financing
State House, Room 413-D
Boston, MA 02133

Representative John Lawn
Vice Chair, Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

Submitted Electronically

RE: Health Policy Commission's Modification Hearing on the 2022 Health Care Cost Growth Benchmark

Dear Chairman Altman, Senator Friedman and Representative Lawn:

Thank you for the opportunity to offer comments as you consider potential modification of the state's health care cost growth benchmark for the average growth in total health care expenditures for calendar year 2022.

As we all understand, no one has been immune to the devastating impacts of the COVID-19 pandemic. Atrius Health has experienced first-hand the consequences for our patients, our staff and our communities – as well as on our organization. In 2020, as a result of the pandemic, we saw a decrease of almost 22% in patient encounters as compared with 2019. We believe that the repercussions of the pandemic on health care providers warrants a careful and serious assessment by the Health Policy Commission (HPC) in determining the appropriate health care cost growth benchmark for 2022.

Although since the enactment of Chapter 224, Massachusetts has seen growth in health care costs trend below the national rate, we believe that the pandemic and resulting public health emergency have resulted in **significant** financial pressures and additional costs to all health care providers in 2020 that will continue and will be reflected in upward overall health care cost trends well into 2022 and possibly beyond due to pent up patient demand. According to the Division of Insurance, health insurance premiums are expected to increase statewide in 2021 by an average of nearly 7% with increases from 4.3% to as much as 11.5%, significantly higher than the state's current healthcare cost benchmark of 3.1%. Accordingly, we fear the trend will be higher in 2022, although we support working toward a 3.1 % health care cost growth benchmark for 2022. To meaningfully impact trend, unit price (provider fee schedule changes) will need to be moderated because pent up demand will

increase utilization. However this does not change Atrius Health's commitment to working to control total medical expense.

Over the past several years Atrius Health has excelled in being an exceptional high-value provider, with one of the lowest total medical expense rates in the Commonwealth. However, the pandemic and the emergency orders requiring businesses to temporarily close and all but essential workers to stay home, while necessary, resulted in an immediate and drastic reduction in Atrius Health's patient visits and in an associated dramatic and unsustainable loss of revenues. These events led to Atrius Health having to temporarily close a number of its clinical sites and to furlough a significant number of staff in order to stay afloat. During this time many of our fixed operating costs remained unchanged and we also experienced considerable cost increases, primarily in **prescription drug costs** and **hospital inpatient department spending**.

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Among the serious, profound impacts of the pandemic on the healthcare system that we believe will and have already begun to translate into negative financial consequences for healthcare providers include the following:

- A precipitous drop in patient visits resulting in a significant loss of revenue which will now be recouped;
- Pent up patient demand for medically necessary and elective care that has been delayed;
- Patients with long-term clinical issues associated with COVID-19 requiring increased attention and services;
- Increased need for behavioral health services amid an ongoing shortage of behavioral health providers;
- Fixed costs for which providers have not been able to be reimbursed; for example, establishing dedicated resources to handle COVID-19 concerns, testing and vaccination for both patients, communities and employees;
- Increased staffing costs driven by competition among providers for the limited supply, particularly for nurses;
- Increased technology and equipment, PPE and facility needs and expenses;
- Employee testing/screening and vaccination-related costs; and
- Human resource expenses, such as child care assistance for employees unable to return to work due to the reduced availability of child care as well as additional salary costs/overtime incurred due to staffing shortages.

While Massachusetts has much to be proud of in containing healthcare costs since the enactment of Chapter 224, continuing to meet any benchmark will still require considerable effort by all healthcare stakeholders along with strong partnerships with policymakers if we are collectively to achieve this goal, especially as we recover from the experience of the past year. The pandemic has also exposed other stark systemic issues related to racism and inequity in health care that we must address. These issues require rethinking how we allocate resources and warrant additional, dedicated funding.

The pandemic also did not erase – and in many instances actually amplified – the cost drivers identified year after year that hamper the ability to meet the established health care cost benchmark. Please see the list of issues (attached to this letter as Exhibit 1) that we believe continue to result in increased healthcare costs, that unchecked will lead to escalating healthcare inflation. Some of the primary examples include, pharmaceutical costs, expansion of AMCs (satellite facilities), administrative costs associated with lack of standardization in payer programs, and very slow growth in value-based insurance products.

This list of issues is not unique to this year, but the impact of COVID-19 on top of these ongoing cost drivers requires the consideration of the HPC as it determines the health care cost growth benchmark for 2022, as well as the Legislature and policymakers. Accordingly, we respectfully request that the HPC weigh these factors in setting the benchmark for 2022 as there will be extreme COVID-19 related pressures experienced by healthcare providers.

Thank you again for the opportunity to provide input on this important and timely matter. We welcome the opportunity to discuss these issues in more detail with you or members of your staff. If you have any questions or require further information, please feel free to contact me at (617) 559-8042 or contact Kathy Keough, Director of Government Relations at (617) 559-8561.

Sincerely,

DocuSigned by:
Steven Strongwater
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Steven Strongwater, MD
President and CEO, Atrius Health

EXHIBIT 1

Summarized below are matters (not prioritized) that Atrius Health believes warrant attention by both the HPC and the Legislature to help ensure the Commonwealth continues to meet its goal of lowering the cost of healthcare for our citizens:

1) **Planning**. Restore funding for the Health Planning Council originally established under Chapter 224. Atrius Health believes that the Health Planning Council created a unique opportunity to evaluate the availability of health resources statewide in order to ensure that healthcare services meet the needs of residents without duplicating or adding additional costs. We support the expansion and funding of a Health Planning Council or shifting those responsibilities with adequate funding to another entity.
2) **Workforce.** Focus on healthcare workforce planning and implement strategies to increase the availability of primary care providers, nurses, APRNs and medical assistants. Physician burnout and shortages of certain healthcare providers are affecting overall costs as providers compete for limited resources.
3) **Public & Employer Awareness**. Promote and create public awareness campaign of high-value providers. The Commonwealth should invest resources to showcase providers that demonstrate high quality and low total medical expense via a public awareness campaign aimed at both employers and consumers. Lack of brand-names disadvantages high value providers with limited marketing budgets; if consumers select their providers based on name recognition, we will continue to drive up costs.
4) **Primary Care.**
    a. Support for SD2017 "An Act Relative to Primary Care for You." Similar to the Governor's VALUES Act proposed last session, this bill recognizes the vital role that primary care plays in reducing overall healthcare costs by seeking to create a statewide and entity-specific primary care expenditure mandate that invests in primary care over several years with a goal of allocating more resources towards primary care.
    b. Primary Care Notification. Require the Department of Public Health to mandate that hospitals notify the patient's primary care provider upon the patient's admission to a hospital. Currently there is considerable variation among hospitals in providing this information. Lack of information results in poor coordination of care - and thus increased risk and reduced quality of care - both during the hospital stay and upon discharge.
5) **Telehealth**. Promote and support telehealth, such as SD2099/HD2533 "An Act Relative to Telehealth and Digital Equity for Patients", which builds on extremely promising telehealth legislation passed last session. Telehealth should be considered comparable to in-person visits and the health plans should be required to treat it as such. In addition, health plans should be required to develop uniform coding and documentation requirements for telehealth visits to decrease the administrative burden and costs for providers that results from the variation from plan to plan.
6) **Academic Medical Centers.**
    a. Control the expansion of high cost Academic Medical Centers (AMCs) and brand name oncology centers statewide into new outpatient facilities. While ostensibly less expensive than their downtown, tertiary counterparts, these entities are still able to charge facility fees and refer patients to higher priced hospitals, increasing the overall cost of care and resulting in higher out of pocket expenses for patients in many cases. Atrius Health supports the principle of "site neutrality" with respect to payment for certain outpatient health care services.
    b. Limit urgent care centers affiliated with AMCs. The impact of these entities on health care costs should be periodically reviewed by the HPC since they have the ability to refer patients to higher cost hospitals when more advanced care is needed.
7) **Pharmaceutical Costs.** Address the rise in pharmaceutical costs, including specialty drugs, biologics and generic drugs. These continue to be a major concern for patients, payers and health care providers in the state. Prescription drug spending continued to be one of the highest growth areas for Atrius Health in 2020, with a 13% increase in specialty drug costs during this period. These increases have made budgeting difficult; in addition, price increases impose significant hardships for our patients who

have co-pays and deductibles. We strongly support increased transparency of both pharmaceutical manufacturers as well as Pharmacy Benefit Managers (PBMs) is critical.

8) **Provider Price Caps.** Cap providers' pricing on expensive oncology drugs relative to market averages. A recent report by the HPC identified two large oncology providers that were pricing drugs at twice the cost of other providers. The HPC should closely examine the cost of oncology services by provider and setting. Some providers are paid twice what others are paid for the same services because of their brand or special Medicare exemptions. It is difficult to move patients away from the higher cost facilities that have very strong brands.
9) **On Site Management**. Require hospitals to allow onsite ED access to care/case managers associated with referring provider practices so patients can be directed to lower-cost settings when clinically appropriate. Without this requirement, primary care providers are unable to ensure that their patients are receiving care in the lowest acuity safe setting. This requirement would enable primary care providers to better manage cost and quality.
10) **Preferred Care Network.** Require hospitals and skilled nursing facilities to consult with the patient's primary care provider for the preferred referral to home health agencies (while continuing to give patients the choices that Medicare requires). Atrius Health tries to use its preferred home health agency, VNA Care, which is an integral partner in providing coordinated and more cost effective home health and hospice services to our patients; however, we frequently find that hospitals/skilled nursing facilities push patients to their own or other home health care providers which fragments care.
11) **Uniform Quality Metrics**. Require the implementation of uniform quality metrics across Massachusetts payers. The Massachusetts Quality Measurement Alignment Taskforce (of which Atrius Health is a part) has been trying to align the payers' quality metrics for the past several years. We believe this initiative has the potential to significantly reduce administrative burdens on providers and individual clinicians, however we believe this effort will be unsuccessful unless mandated by state law.
12) **Redefine Material Change Definition.** Amend the definition of "material change" to require notice to and review by the HPC to include the establishment of new outpatient centers in the community by Academic Medical Centers (AMC's) and cancer centers as well as the development of new freestanding urgent care centers. As noted in recent HPC reports, services provided at some outpatient facilities are more expensive than community-hospital based services. Fees in these new outpatient facilities should be limited to community hospital rates, or the facility fees should be eliminated as they have been with Medicare.
13) **Support Diversity, Equity & Inclusion in Healthcare**. Address diversity, equity and inclusion in healthcare. We believe there may be a way to reduce burden and TME if there are specific interventions targeted at underserved communities. Atrius Health found a 10 point difference in flu vaccine rates for underserved communities who use our Kenmore, Quincy and Braintree practices compared to other locations. Our hope is that by identifying these patients using a social vulnerability index (SVI) we can provide better preventive care. We believe there are opportunities for improving health outcomes as well as access to care if we expand and coordinate efforts such as these among providers, commercial payers, and MassHealth.
14) **Leverage GIC** to shift to Value Based Care. Require the GIC to offer products which differentially promote the use of high value providers as measured by HPC on the basis of cost of care and quality. This would grow market share for high value providers and lower the total cost of care while maintaining quality.
15) **Manage Market Share that drives up total costs.** Change criteria for CHIA's evaluation of providers and plans relative to Performance Improvement Plans to include not only trends above benchmark but also market share growth that increases total expense. This would recognize that prices can rise by virtue of high-priced providers taking additional market share, and not only by direct price increases.
16) **Stabilization Funds**. Permit the Community Hospital and Health Center Investment Trust Fund to be used to help stabilize independent, non-profit medical groups in addition to distressed hospitals and community health centers.

17) **Health Plan Design.**
    a. **Telehealth**. Health plans should be required to develop uniform coding and documentation requirements for telehealth visits to decrease the administrative burden and costs for providers and patients that result from the variation from plan to plan.
    b. **Cost Sharing**. Eliminate cost-sharing for certain preventative/maintenance medications that are required to manage common chronic conditions (e.g., diabetes medications).
    c. **Value Based Insurance Design**. Encourage health plans to adopt "value-based design" and introduce products with cost-sharing structures that lower cost care without compromising quality (e.g., no co-pay for a video visit; waived or reduced copays for preventive care medications.)
    d. **Plan Provider Recognition.** Encourage health plans to recognize and reimburse pharmacists and APRNs as providers, consistent with recent statutory recognition. Both pharmacists and APRNs can play a key role in filling certain service gaps, particularly in primary care, and help manage TME. Support for systems to move appropriate patients out of high cost academic medical centers to community hospitals and/or hospitalization at home. We believe financial weakness of community hospitals may discourage patients from seeking care there, and going instead them to AMC's, ultimately driving up costs.
18) **Interoperability.** Require hospitals to provide the interoperability that would allow community providers to view the medical records of their own patients, regardless of electronic medical record. Ensure that the Mass Hi-way is used more consistently.
19) **Reporting Requirements.** Require standard reporting practices for hospitals and health systems. As noted in a 2019 report on the financial health of hospitals commissioned by the Massachusetts Association of Health Plans, there is inconsistent data reporting by hospitals/systems that affects the ability to assess the financial health of hospitals, particularly community hospitals. Reliable data is critical to identifying which community hospitals need additional funding in order to remain viable.
20) **MassHealth.** As enrollment is expected to increase due to the pandemic-induced growth, ensure risk bearing ACOs are properly funded to cover expenses due to enrollment and utilization increases.