MASSACHUSETTS
HEALTH POLICY COMMISSION

2023 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 2023 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 27, 2023**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2022, if applicable. If a question is not applicable to your organization, please indicate that in your response.

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

You are receiving questions from both the HPC and the Office of the Attorney General (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC CONTACT INFORMATION

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

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INTRODUCTION

This year marks a critical inflection point in the Commonwealth's nation-leading journey of health care reform. As documented in the Health Policy Commission's 10th annual Cost Trends Report, there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses, including:

- Massachusetts residents have high health care costs that are consistently increasing faster than wages, exacerbating existing affordability challenges that can lead to avoidance of necessary care and medical debt, and widening disparities in health outcomes based on race, ethnicity, income, and other factors. These high and increasing costs are primarily driven by high and increasing prices for some health care providers and for pharmaceuticals, with administrative spending and use of high-cost settings of care also contributing to the trend.
- Massachusetts employers of all sizes, but particularly small businesses, are responding to ever-rising premiums by shifting costs to employees through high deductible health plans. As a result, many employees are increasingly at risk of medical debt, relying on state Medicaid coverage, or are becoming uninsured, an alarming signal of the challenges facing a core sector of the state's economy.
- Many Massachusetts health care providers across the care continuum continue to confront serious workforce challenges and financial instability, with some providers deciding to reduce services, close units (notably pediatric and maternity hospital care) or consolidate with larger systems. The financial pressures faced by some providers are driven, in part, by persistent, wide variation in prices among providers for the same types of services (with lower commercial prices paid to providers with higher public payer mix) without commensurate differences in quality or other measures of value.

The HPC report also contains nine policy recommendations that reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 and 2024 prioritize modernizing and evolving the state's policy framework, necessary to chart a path for the next decade.

This year's Cost Trends Hearing will focus these policy recommendations and on the efforts of all stakeholders to enhance our high-quality health care system in Massachusetts to ensure that it is also affordable, accessible, and equitable.

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

a. Reflecting on the findings of the HPC's 2023 Cost Trends Report showing concerning trends of high and increasing health care costs and widening health disparities based on race, ethnicity, and income, please identify and briefly describe your organization's top 2-3 strategies for reducing health care cost growth, promoting affordability, and advancing health equity for residents of the Commonwealth.

Berkshire Fallon Health Collaborative ACO

Berkshire Medical Center (BMC), a member of Berkshire Health Systems (BHS), has renewed its partnership with Fallon Health to jointly operate the Berkshire Fallon Health Collaborative (BFHC), a MassHealth Model A ACO. Having learned from our work over the last five plus years, we are excited to build upon this foundation to enable high quality outcomes for members while simultaneously advancing health equity and striving to reduce healthcare costs.

As background to provide context for the challenges our ACO faces when delivering care, Berkshire County is a rural community covering 946 square miles with a population of approximately 128,000 and a density of roughly 135 people per square mile. Massachusetts, with a density of 900, is almost 7 times Berkshire County. The county is also older, poorer and less educated:

- Berkshire county's average age is 47 vs. 40 for Massachusetts with 25% of residents being 65 years or older, which is 1.5X the state and national rate of 17%;
- Median income is 30% lower than the state
- Community health needs assessment shows that 60% of people of color live below the poverty level
- Only 19% of the population aged 25 or over has a bachelor's degree compared to 45% for the state

These demographics have impacted health outcomes resulting in the county rate of premature deaths (before 75) exceeding the state average by 48% with 8,500 lost years per 100,000 population compared to 5,700 for the state.

Substance abuse is also more prevalent in the county with Opiod related overdose deaths per 100,000 of 49 compared with 34 for the state. Opiod related deaths have increased 65% since 2014.

Through the work of BMC, BHS and our ACO, we are striving to address the lower health outcomes and health inequities caused by these social determinants of health. Our model of care has been restructured to bring care closer to our patients by embedding baseline and enhanced care team members within primary care practices. This is further supported by care coordination at the ACO level to assist with referrals for the most complex patients. We have built a more robust data warehouse to capture patient activity across all members of the ACO. This will better enable care by supporting data driven decision making such as the early identification of at-risk patients through data stratification.

The data warehouse will support the attainment of our goals for high quality outcomes, health equity and reduced costs by allowing performance to be measured at the provider level. We have set goals in the following broad categories:

- reducing cost by decreasing unnecessary utilization (avoidable admissions and emergency department visits and readmissions),
- improving quality/outcomes (Appendix Q ACO goals)
- member experience (communication, integration of care)
- care coordination (transitions of care, outreach and engagement rates and assessment completion)
- health equity (screening rates)

To further support the commitment of the ACO and our organization around diversity, equity and inclusion, we recognized we needed a leader entirely focused on this work. In August of 2022, we hired a Diversity, Equity and Inclusion (DEI) Officer. His responsibilities encompass the ACO objectives for health equity and moving forward the BHS vison "to advance health and wellness in our community in a welcoming, inclusive and personalized environment and to be a partner in healthcare within our community". In his role, the DEI Officer has been actively partnering with community stakeholders across the county to strengthen collaboration. These stakeholders represent the diversity of the county demographics and encompass the breadth of ethnic populations, sexual orientation, and gender identity. Organizational missions are equally diverse and cover services such as providing healthcare for immigrants, economic opportunities for people of color, substance use, housing, LGBTQIA+ support, and hate and bias prevention. The DEI officer also took the lead rolling out the community code of conduct, a guide for respectful interactions.

Patient Throughput

Over the course of the pandemic and since, BMC has been faced with a multitude of throughput challenges. In response, we have created a multidisciplinary, multidepartment throughput team. This team has identified several opportunities to improve ED wait times, the admission and discharge process and create improved communication with patient families and the multidisciplinary team to ensure admission length of stay and treatments provided are appropriate. The team instituted a more efficient process for ED registration, triage and work up. If appropriate, patients in the waiting area to be seen by a provider are worked up so treatments and care decisions can be expedited, reducing the ED visit duration. A nurse and a patient advocate have been added to the area to ensure timeliness of care, communication and safety of the patient reducing the rate of patients leaving without being seen. The team is also addressing the admission process and has developed overall improved communication among ED provider, admitting provider, patient placement director and admitting. These actions continue to reduce ED wait time supporting BMC's goal to improve access.

BMC has created a Short Stay Observation unit in the ED area to support rapid assessment treatment and discharge. This six-bed unit has an average length of stay under 24 hours (about half of what it might be if placed on an inpatient unit) and has provided patients that meet inpatient criteria increased bed availably on inpatient units.

To address inpatient care and throughput, the acute care team has instituted Structured Interdisciplinary Bedside Rounds (SIBR). This initiative promotes communication and alignment of care, treatment and progress amongst the team. Daily, multidisciplinary team members discuss patient progress and transitions of care at the bedside with patient and family participation. Discharge plans are reviewed and solidified at this time ensuring the team and patient expectations are aligned. There has been a reduction in length of stay and improved patient experience, as well as improved patient outcomes. CAUTI, C-Diff, falls have all decreased with the implementation of this initiative.

In addition to improving patient experience and outcomes associated with improved throughput, BMC has been able to decrease its length of stay over the last year. The decreased length of stay in both the ED and on inpatient units translates into fewer needed care hours, which in turn means lower salary and contract labor costs.

Employee Pipeline Investments

As BMC faced historic staffing shortages and rising turnover, we determined that, given the limited population in the region, the supply of qualified skilled staff in our market would be insufficient to meet the healthcare needs of the community. For example, a lack of Medical Assistants was limiting patient access to physician practices but there were not enough Medical Assistants in the region to meet our needs through aggressive recruitment. BMC needed to take an unprecedented proactive role in building the supply of skilled staff.

We concluded that the primary obstacle to recruiting sufficient students into training was the students' need for full-time employment income during education. One of our local education partners, Berkshire Community College, conducted a survey to determine why a low percentage of students who completed the pre-requisites for the Nursing program actually moved on from the program. The primary reason was that the students would have been unable to support themselves and their families without full-time employment while completing the rigorous training program.

In response, BMC developed its Talent Pathways program. The program covers the cost of tuition, books and fees for specific healthcare training and education programs. What sets these programs apart is that it also provides each student with full-time salary and benefits for the duration of the program while requiring limited hours of work at BMC (as little as 8 hours per week, depending on the demands of the academic program a student is enrolled in). Students have an obligation to remain employed with BMC after the program for a fixed period depending on the investment (e.g. 2 years for a Medical Assistant, 3 years for and RN). Following are the specific Pathways:

	Program Start	Education/ Training Time	Students to Date	Completed the program and remain employed
Medical Assistant	Apr 2021	6 months	115	87
LPN	Jan 2022	1 year	27	23
LPN to RN	Sep 2022	1 year	20	15
RN	Sep 2022	2 years	48	n/a

Nursing Assistant	Sep 2020	4 weeks	157	85
Bio-Med Tech	Jan 2022	15 months	7	3
Surgical Tech	Sep 2021	2 years	2	1
Respiratory Therapist	Sep 2023	2 years	1	n/a
MRI Tech	Jul 2023	1 year	1	n/a

We believe this program will ultimately yield an increase in the number of trained employees able to fill vacant positions for which there will be an overall reduction in cost for some positions. For Medical Assistants, BMC generally does not engage agency or traveler staffing, so the program will not decrease costs, but rather improve patient access. Where travelers are engaged, ROI is easier to estimate. For example:

	Agency Cost 1 FTE (annual)	W-2 Cost incl. fringe (annual	Difference (Agency – W-2)	Pathway Program Cost (Wages and all expenses) per learner, full length of program	ROI per Student
RN	249,600	135,200	114,400	50,168	64,232
Allied Health	193,440	117,000	76,440	51,667	24,773

b. Please identify and briefly describe the top state health policy changes your organization would recommend to support efforts to advance health care cost containment, affordability, and health equity.

<u>Employee Pipeline</u>

As noted above, BMC and BHS have invested in the development of staff by supporting not only their cost to attend school, but by also providing full- salary and benefits. We are investing almost $7 million per year and this number is expected to grow as we need to consider other positions experiencing shortages such as certified registered nurse anesthetists and the growth in programs where cohorts are multi-year. Though we believe there is a payback for this program, it is a significant investment representing the equivalent of almost 1% operating margin. With many other competing financial priorities, an expected growth in the program's cost and the likelihood that the availability of workers will remain insufficient for the foreseeable future, it will be very difficult to sustain this necessary investment. It is even possible, that in spite of this program, employee attrition will exceed the number of new staff trained. Support for the pipeline program would allow us to continue the development of a healthcare workforce in the county. We recommend the state consider partnering in a similar program across Massachusetts.

In running it's Talent Pathway programs, and in recruiting into entry-level positions, BMC has been able to increase hiring among under-represented populations. In doing this we've had inconsistent success in creating lasting employment relationships with individuals who have not had a consistent employment history, or have not been employed at all. This is a problem both for recent high-school graduates and individuals in their 20s and 30s. Even with additional counselling and corrective action, the failure rate among these groups is far too high. If this problem could be addressed, our workforce development efforts would be substantially more effective and more efficient.

It is important to note that this problem presents at every effective workforce development program across the Commonwealth that reaches out to individuals without a successful employment track record.

Additional training (in schools, or at BMC) has been, and research says will continue to be, ineffective. Addressing this problem requires a mind-set change that can best be accomplished through frequent coaching and mentoring interactions with an individual who is not the supervisor. BMC's proposed solution would be to develop best-practice, evidence-based approaches to coaching and mentoring, and attract peer employees to be trained as coaches/mentors for one peer employee at a time. Given the additional commitment of time and attention to the training and coaching, BMC would need to invest in compensating these peer coaches.

If State funds were available to help offset the cost of this coach compensation, such a program could be within reach for BMC. Additionally, if the State were in a position to facilitate the development of solid, high-quality training in coaching and mentoring, it would help ensure effective delivery of this service and improve the effectiveness of almost all employer-based workforce development programs.

<u>340B</u>

The 340B program was created in 1992 to allow covered entities "to stretch scarce federal resources as far as possible reaching more eligible patients and providing more comprehensive services". The intent of the program was to support patient access to services through financial support to providers considered most vulnerable due to their location and patient demographics (e.g. rural and/or high Medicaid patient mix). Providers in the 340B program are able to purchase outpatient drugs at discounted prices for covered patients (under the care of an entity provider) for prescriptions filled at hospital owned retail and specialty pharmacies and community retail pharmacies. The community and BHS have benefitted from this participation in 340B and the services available would likely look very different if it were not for this support. Beginning in 2020, drug manufacturers (26 to date) have been increasingly restricting access to 340B pricing for prescriptions filled at community pharmacies resulting in a $10 million plus decrease to BMC. In the absence of national legislation to address this issue, several states have passed their own laws to ensure manufacturers do not restrict providers' access to 340B pricing. Specifically, Arkansas and Louisiana passed laws in 2021 and 2022, respectively prohibiting discriminatory payment policies against 340B providers. We recommend the state pass similar legislation and take other actions to protect 340B program revenue for covered entities in Massachusetts.

Another component of the 340B process for which recent changes have negatively impacted BMC relates to services provided by pharmaceutical benefit managers (PBM) on behalf of insurer pharmacy benefit plans. PBM's charge pharmacies/340B providers direct and indirect remuneration fees (DIR fees) based on measures such as generic drug dispense rates, medication adherence rates and net promoter patient satisfaction scores. These measures are often not openly shared and typically designed so that 100% achievement is not possible resulting in significant lost dollars to pharmacies/340B providers. These fees have grown substantially over the last several years and have tripled between 2019 and 2023 resulting in increased costs of $2.8 million to us shifting funds away which could have been directed to patient care. We recommend the state require full transparency for PBM fees and rebates and to review the significant increase in DIR fees over the last 5 years and limit them to no more than historical levels prior to their rapid growth. To promote full transparency, PBM's should be subject to review by the HPC.

Rural Healthcare

As noted above, Berkshire county is a rural county with low population density and a relatively large geographical footprint (roughly 50 miles by 20 miles). Providing equitable access to services across the entire county is extremely challenging as it is not economically feasible to staff services in close proximity to all residents. There is simply not the population density necessary to support the physical and human resources required. We have challenged ourselves to provide consistent access to services across the north, central and south portions of the county, though at times this may not always be possible. As a result, patients may need to drive long distances to access services. And worse yet, some patients may not have ready access to transportation making access even more challenging. Additionally, the county's only non-medical transportation service offering stretcher transportation for stable patients needing transportation for medical appointments recently closed due their inability to find staff. We recommend the state consider how to make non-medical transportation more available within the county.

Physician recruitment is also impacted by the lack of population density. Patient volumes are often insufficient to support groups large enough to offer equitable call. With smaller practice sizes, providers must cover more nights/weekends than their counterparts in larger practices in more urban/densely populated areas. In the Berkshires, coverage must also span multiple facilities stretching 50 miles shared among these same practices. Providers are often not interested in this higher call burden and opt to practice in more populated areas. The economics of recruiting sub-specialist providers is even more challenged as patient volumes may only support a limited number or partial provider, which does not appeal to most specialists. From the hospital perspective, supporting the higher salaries of sub-specialists is also not economically viable due to the limited volumes. We recommend the state consider ways to promote specialist and sub-specialists to provide care in lower population settings, such as Berkshire county.

As noted earlier, our community is older and poorer than Massachusetts as an average with a governmental payer mix of 77% and just 22% covered by commercial insurance (and 1% self-pay). As such, our patient profile resembles the high government concentration typical of a community health center or federally qualified health center. Community health centers, in recognition of the patients they care for, are at times eligible for funding not available to other providers such as loan forgiveness and residency training through GME. We recommend the state consider ways to offer similar support to

sole community hospitals, who have patient populations resembling those served by community health centers.

The pandemic required providers to change the way care was provided to patients. The acceleration of telemedicine was one of those changes. Telehealth removes some of the access barriers associated with the rural nature of Berkshire county and is even more important for the rendering of care by certain specialties, such as neurology where consults and visits are performed by providers on the eastern part of the state, while patients are at BMC. Telemedicine has become a tool to ensure patient access to care. MassHealth, in recognition of the benefits of telehealth for patients and their medically necessary care, provided reimbursement parity with in-person visits. We recommend the state continue this practice.

Expansion/support for Behavioral Health and Substance Use Disorder

Berkshire County has experienced an increase in suicide as well substance use disorders (SUD). To address this concern, the county needs a more comprehensive focus on outpatient care and the ability to identify community members in need of support. Schools, workplace and primary care providers, must have the ability and resources to identify those in need of help. Proactively identifying those in need will curtail acute cost of care, as well as save lives. The ability to identify and manage this population can be addressed with outpatient services. We recommend the state consider ways to expand outpatient behavioral health in Berkshire county and other underserved communities across the Massachusetts. We would also recommend the state promote careers as Community Health workers, clinicians, social workers and nurses to work in behavioral health as one of its workforce priorities.

Berkshire Medical Center has a SUD unit as well as a Crisis Stabilization Service (CSS), however a Transitional Stabilization Service (TSS) does not exist and is needed in Berkshire County. There is no treatment/support for those leaving BMC CSS that may need more supervision and support. Many of our patients discharging from CSS refuse to transfer to a TSS in the eastern part of the state due to the long distance from home and family.

Community members are unwilling to travel for support services such as these. The distance prohibits the client from moving forward with their life while remaining in their community, so they choose not to participate in further treatment, sometimes leading to poor outcomes. SUD patients would have greater success and outcomes if the county had a TSS service. We recommend the state consider supporting Transitional Stabilization Services in Berkshire county.

c. Many Massachusetts health care providers continue to face serious workforce and financial challenges, resulting in the closure and reorganization of care across the Commonwealth. How are these challenges impacting your organization today? What steps is your organization taking to address these challenges?

Similar to many other healthcare providers and employers, we have experienced historically high turnover since the pandemic:

	2017	2018	2019	2020	2021	2022
Turnover rates - BMC	13.7%	15.6%	16.1%	18.6%	21.9%	22.0%

Turnover has been driven by many factors including:

- an aging workforce with insufficient new employees choosing healthcare as a career, who instead are seeking options not previously available for past generations
- the burnout and uncertainty created by providing care during the pandemic
- leaving to pursue traveling contract work
- a preference for weekday work hours
- higher compensation offered by competing providers or in other industries, due to rapidly escalating wages

This turnover is placing a significant burden on our ability to employ enough staff to meet patient demand. In order to continue offering access to services, we have had to utilize contract labor at levels three times higher than just a few years ago with costs going from $14 million to $50 million. Contract labor rates paid to agencies are typically 2.5 times higher than what we would pay if we could hire for these positions, so the increased fees we are now paying represents an incremental premium of $22 million. Increases in contract labor are spread across all categories with nursing increasing $14 million, physicians by $4 million, CRNA by $8 million and ancillary/support increasing by $14 million. These significant cost increases are not sustainable.

At times, we have had to restrict patient access by limiting appointments or scheduling out with longer than desired wait times due to staffing constraints in areas like medical imaging, elective surgery, endoscopy, and our physician practices. We were forced to temporarily close/consolidate MRI, CT scan and x-ray services.

Given the low population in our county, we often don't have sufficient volume to financially support certain services. As an example, we deliver about 800 babies per year across the county at our two hospitals. Obstetrical care requires obstetricians, anesthesiologists, pediatricians and staff be available 24/7. To ensure the availability of the providers and staff necessary for this 24/7 service, we are required to pay premium costs for coverage. Nationally and locally, many pediatricians have opted out of call coverage requiring hospitals to find other solutions. We are similarly challenged and have been forced to contract at a significant premium with hospitalists who can care for both adult and pediatric

patients. At 800 deliveries per year and only one to two inpatient pediatric patients per day, there is not sufficient volume to support core program costs let alone these additional premium costs.

Other services where there are significant disparities in program revenue compared to costs are psychiatric care and renal dialysis. These programs are challenged by reimbursement rates rather than demand, though inpatient psychiatric demand has fallen since the pandemic and has not rebounded.

Post acute care providers are experiencing similar staffing shortages resulting in a direct impact to BMC's ability to transition patients to the next level of care. When reviewing data related to patient average length of stay within the same diagnosis related group (DRG), patients discharged to post-acute providers vs. going home, have a one day longer length of stay, which is in part driven by their limited staffing. Also contributing to a higher length of stay for discharges to post-acute providers lack of beds for dementia and behavioral diagnosis within a 50-mile radius, reflective of their financial challenges caring for these residents. Skilled nursing facilities are also reluctant to take patients with substance use disorders due to higher staffing requirements and the related cost resulting in lengthy hospital stays.

Similarly, ambulance squads and other medical transporters often have the inability to transport emergent and non-emergent patients due to their own staffing deficiencies. The County is in dire need of EMS staff, paramedics in particular. BMC has held multiple patients for hours in the ED needing transport to a tertiary facility. This not only impacts patient outcomes but also access for those waiting to be seen. BMC staff, respiratory therapist and registered nurses have actually volunteered to care for these patients during transport to expedite the transport supporting patient care needs.

Transport issues also arise when attempting to transport discharged patients to the next level of care. Length of stay has been impacted negatively due to patients waiting in Acute Care for transport by ambulance or cabulance to SNFs.

The county's only non-medical transportation service offering stretcher transportation for stable patients needing to return to their homes or their skilled nursing facilities closed due their inability to find staff. EMS squads have attempted to step in to fill this void where possible, but it has further exacerbated delays transporting patients and in turn extended hospital lengths of stay.

What we are doing:

As noted above, we have made a significant investment in our employee pipeline program which we expect will increase the number of trained staff available to fill vacant positions improving both access to care and reducing our reliance on agency costs.

We have a tradition of partnering with local colleges and schools to create the region's healthcare workforce. Recent support and collaboration includes:

- partnering with Massachusetts College of Liberal Arts (MCLA) in North Adams to begin a RN-Baccalaureate program. BHS committed to funding $220,000 to fund start up costs associated with the program. The commitment can be used over a five-year period. BHS paid $44,000 in May 2022 and an additional $44,000 in November 2022

- Providing clinical training space for the MCLA RN program and the Radiology Technician program on the northern Berkshire campus in North Adams
- partnering with Berkshire Community College to re-establish the respiratory therapy program at the college. The program requires two respiratory therapists as educators supported by the hospital

To meet our workforce needs, we have even extended our recruiting efforts beyond our typical catchment area for employees and have sponsored international workers for lab technicians.

Healthcare wages and those in other industries have been rapidly escalating since the onset of the pandemic and to stay competitive we have provided for pay increases above inflation and reimbursement rates.

It has been well documented that fully engaged employees are much more likely to stay with an organization. We have always been committed to ensuring our employees feel valued, but given the changes in the labor market, we realized we needed to differentiate ourselves to fully engage our employees. One of the ways we are doing this is by encouraging frequent touchpoints among managers and their teams. This work is supported through weekly "check-ins" between staff and their managers highlighting current projects, barriers to success and things that motivate or discourage team members. Quarterly engagement surveys measure how employees feel about their work, their manager and the organization. We believe this focus will improve staff engagement and retention.

Hospitals across the state and nationally have experienced a dramatic increase in the number of patient and visitor incidents directed at hospital staff. The BHS Community Code of Conduct, adopted in October 2023, was created in response to this increasing number of dangerous and volatile situations arising in healthcare settings nationwide. The Community Code enforces the expectation of all people to be respectful and courteous while refraining from behaviors that are not welcome in BHS care environments. BHS is dedicated to the safety and wellbeing not only of patients, but also of employees and of front-line staff.

BHS's Community Code of Conduct was the product of months-long discussions and collaboration that combined the insights and experiences of BHS leaders and employees, community members, partners, and the BHS Community Code of Conduct Task Force, ensuring that all who interact with the system would be well- represented and understood.

Initiatives like the Community Code of Conduct, along with our internal communication strategy that encompasses a mix of town hall meetings, emails, employee portal updates, and in-person rounding by all levels of leadership, help to create an environment of trust, accountability, and respect that reinforces employee engagement and supports workforce retention.

Cost containment is consistently at the center of our actions and remains vital to protecting our future so we can reinvest to meet the healthcare needs of our community. We diligently monitor various labor and cost metrics to ensure there is an appropriate balance between paid work effort and volume. This work has recently been further supported by external consultants to ensure we benchmark favorably with other similar organizations. Supply chain pricing and utilization variations are also a constant focus with annual targets for year over year price decreases. More recently, we have targeted our purchased service spend for year over year decreases.

d. Please identify and briefly describe the policy changes your organization recommends to promote the stability and equitable accessibility of health care resources in Massachusetts?

Starting January 1, 2021 employees in Massachusetts are eligible for between 12 and 26 weeks of paid family medical leave (PFML) for certain qualifying reasons including a worker's own health conditions, caring for a family member with a health condition, and bonding with a child. The program is structured so that both extended and intermittent (time off is not continuous) leaves are permissible and can be taken with limited/no notice. The program is also structured such that a wide range of reasons for leave are permitted. Given that BMC operates around the clock caring for patients, the majority of these leave hours must be filled and often requires premium costs to do so. When comparing current leave hours prior to the start of PFML to this most recent year, we have seen an annual increase in leave hours of 100,000 or the equivalent of 55 FTE's. The incremental cost of backfilling staff leaves for this new benefit after deducting employee contributions is $4.4 million per year. Though we support the concept of Paid Family Medical Leave, we recommend the state review the cost of the program to employers to identify ways to decrease the significant financial burden to employers.

The cost of providing care has been significantly impacted by contract labor as discussed earlier. Massachusetts has attempted to cap the hourly wage of contract staff, in particular, Registered Nurses. However, this initiative was unsuccessful due to the fact that no other State in the country joined in the effort. To be effective in reducing the cost of contract labor, a policy must be developed at a notional level. The policy should place a cap on wages paid to caregivers and charged to provider organizations limited to a reasonable mark-up when compared to provider average rates of pay. The policy should also require any travelers to work a designated number of miles away from their primary residence, such that a daily commute would not be possible.

In order to be considered for Licensure, a registered nurse applicant must fulfill the Good Moral Character requirement for the State of Massachusetts and Board of Nursing. Currently, BMC RN and LPN hires have seen a significant increase in licensure applications being denied due to this regulation. The applicant must prove to the State via written submission that they have corrected the offense noted when denied licensure. Most applicants are able to satisfactorily demonstrate the issue has been resolved (or never was an issue at all), but experience long delays waiting for license approval. We recommend the state allow the applicant the ability to address these offenses well before they apply for licensure and that nursing students be made aware of this requirement upon applying to nursing school.

We request the state take legislative action to protect health care workers from workplace violence by passing a measure such as "An Act Requiring Health Care Facilities to Develop & Implement Programs to Prevent Workplace Violence (H.2381 / S.1538)."

We are in support of the interstate licensure compact and request the state adopt.

We understand Governor Healey has established a Director of Rural Affairs to address the unique concerns of rural communities. Among the issues impacting healthcare and patient outcomes are social determinants of health such as affordable and available housing and employment. Housing is also a limiting factor for some workers looking to join the BHS team due their inability to find affordable housing. We would enjoy the opportunity to share our experiences and offer recommendations most likely to be successful in Berkshire County.

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) 2021-2023			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2021	Q1	23	0
	Q2	33	0
	Q3	23	8
	Q4	35	10
CY2022	Q1	7	12
	Q2	12	1
	Q3	0	2
	Q4	14	1
CY2023	Q1	14	3
	Q2	10	0
	TOTAL:	171	37