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.

1. Health-related social needs and behavioral health needs continue to drive medical spending and impede efforts to address health inequities.

Boston Medical Center (BMC) serves a unique and diverse patient population, with approximately 70 percent of patients identifying as people of color and nearly half of patients living at or below the federal poverty line. Through caring for this population, BMC has learned that social needs outside the hospital's walls greatly impact health outcomes and often lead to increased health costs. At BMC, we see the short and long-term health impacts of housing instability, eviction, and homelessness in our clinics, emergency room, and inpatient services daily. An average of 70 (~12%) of BMC hospital inpatients on a given day are homeless. Further, within the Boston Medical Center Health System (BMCHS), the Boston Accountable Care Organization serves nearly 8,000 members experiencing homelessness (5% of members) and nearly 20,000 members at risk of homelessness (13% of members). Medical interventions can only go so far when patients have other, pressing social needs. For instance, when patients do not have a safe, affordable place to call home, they cannot be discharged from inpatient care, they may not be able to manage a chronic disease outside of clinic, or they may struggle to provide a place for their children to grow and thrive. Research has consistently shown that when adults and children live in stable, affordable homes, they have better physical and mental health outcomes and are at lower risk of hospitalization. In order to better control costs and improve care, the healthcare system must address the social needs of patients.

Economic status is another important health-related social need that can exacerbate existing racial inequities in health outcomes. BMC internal data has shown that when adjusted for prematurity, Black babies are born too small for gestational age at a rate 1.5 times higher than white babies. Further analysis revealed these inequities in baby weight are driven by Medicaid status, showing that economic factors may play a role in racial disparities in birth outcomes. Economic status, health outcomes, and health inequities are often interconnected. Therefore, addressing health-related social needs should be a central focus of health equity efforts.

In addition, unmet behavioral health needs increase medical spending. When patients' behavioral health issues go untreated, they utilize the emergency department at higher rates - a high cost setting that often does not provide care that matches the needs of patients. In 2021, BMCHS conducted a comprehensive needs assessment of its members and found particularly acute behavioral health needs. The MassHealth members in our ACO program

have higher needs (48%) compared to the average Medicaid population (~35%). Unfortunately, significant gaps in outpatient and inpatient behavioral health care drive increased medical and behavioral health costs. Until there is a robust continuum of behavioral health services, medical spending on behavioral health patients will continue to be costly.

2. Safety net providers who serve the most diverse patient populations suffer from systematic underpayment, threatening efforts to advance health equity.

Due to an over-representation of Medicaid patients and consistent underpayment by commercial insurers, safety net providers face and will continue to face financial peril. MassHealth and Health Safety Net rates are low and inflate less than costs annually. This creates an unsustainable reimbursement model, especially when the majority of a providers' care is delivered to this patient population. Further, safety net providers are generally paid less by commercial insurers than peer hospitals, even if they provide similar quality of care. Center for Health Information and Analysis (CHIA) data shows that safety net hospitals are often among the lowest when comparing statewide relative price. According to the most recent CHIA data available, as a group, high-Medicaid, low-commercial hospitals are relatively underfunded by Blue Cross Blue Shield (BCBS), especially safety net facilities. Data show hospitals with the highest percent of non-white patients are funded lower than BCBS Relative Price.

Systemic underpayment of safety net providers threatens health equity efforts as these providers typically care for the most diverse patient population. When safety net providers are not adequately paid, it becomes challenging to provide quality care to this important population. It is also difficult to research existing racial inequities among patients, implement new interventions, or create new initiatives targeting equity when safety net providers are already financially strapped.

3. Rising labor costs and continuing workforce shortages are making the cost of providing health care more expensive.

Like other sectors, the healthcare industry is facing severe workforce shortages. However, given the challenges of the pandemic and its toll on workers, the situation is even more acute and is projected to continue for the next decade. The registered nurse (RN) workforce shortage is the most critical due to a large number of early retirements, high burnout, and nurses leaving the field. Nurses remaining in the profession are taking longer periods of time off or are moving from hospital settings to less acute settings, creating additional staffing challenges. This RN shortage requires the use of a large temporary RN labor pool (travel nurses), which is costly. While traveler pay rates are trending downward, they remain high and are increasing costs for all hospitals. According to the Massachusetts Health and Hospital Association, hospitals were spending around $181 million annually on temporary staffing at the beginning of the pandemic. This increased by 81% to $328 million in fiscal year 2021 and grew to $445 million in the first half of fiscal year 2022 alone.

Since the pandemic began, BMC, like other hospitals, has seen a higher than normal vacancy rate as well as a higher turnover rate than before the pandemic. As a safety net institution, BMC cares for a patient population with complex health and social needs and does not have the financial security of other academic medical centers. With all hospitals experiencing workforce shortages at the same time, hiring and retaining staff has been even more challenging.

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

1. Health-related social needs and behavioral health needs continue to drive medical spending and impede efforts to address health inequities.

BMC has long recognized the impact social needs have on the overall health of our patients and community. We have developed a number of programs and initiatives to support our patients' wellbeing. For example, to address housing insecurity, our Elders Living at Home and Housing Rx programs assist homeless patients with housing navigation and prevention support, as well as post-move-in supportive services. Additionally, BMC has employed housing navigators in outpatient pediatrics and the emergency department to assist patients. Further, we have invested in the creation of more affordable housing through Determination of Need investments and partnered with local non-profits to increase the supply of supportive housing units.

To address the economic challenges our families face, our clinicians launched Street Cred, which provides free tax prep services to families receiving pediatric care at BMC. Further, BMC has created a number of innovative food and nutrition initiatives to address hunger. BMC's Preventive Food Pantry distributes over one million pounds of food annually (including fresh vegetables from the Rooftop Farm) to BMC patients and families facing food insecurity. Our Rooftop Farm plays host to more than 25 crops, which yield 5,000 to 7,000 lbs. of produce annually. The farm provides fresh, local produce to hospitalized patients, cafeterias, the Preventive Food Pantry, our in-house Teaching Kitchen, and a weekly in-hospital farmers' market. In addition, the Grow Clinic for Children is an outpatient Pediatrics subspecialty clinic at BMC that provides specialty medical, nutritional, developmental and social services and dietary assistance to children who do not gain weight or height at rates comparable to other children their age.

In order to be more intentional in addressing health injustice, BMCHS launched the Health Equity Accelerator in fall 2021 after more than a year of research and development. The Accelerator's goal is to eliminate gaps in life expectancy and quality of life among groups of different races and ethnicities. The Accelerator's approach is to incorporate three foundational vectors that are often siloed in healthcare: research, clinical care, and community, including social determinants of health. After a deep review of Boston's Community Health Needs Assessment as well as our own data, we have identified clinical areas with the largest gaps in health outcomes among people of different races and

ethnicities: pregnancy equity, infectious diseases, behavioral health, chronic conditions and oncology & end-stage renal disease (ESRD). For each of these areas, BMC is investigating and will address both the upstream and the clinical factors that contribute to inequities in health access, patient experience, and outcomes. In our first deep dive into pregnancy equity, we have used analytics to uncover racial inequities among patients' health outcomes, discovered insights on factors related to these disparate outcomes, and launch targeted interventions (described in detail below in response to question c). We are introducing parallel efforts in the other selected clinical areas and look forward to the Accelerator's continued work. Further, many of the new 1115 waiver equity initiatives focus on similar issue areas, aligning our health equity work with the state's goals.

Focusing on behavioral health, after recognizing shortfalls in the overall system, BMC has built missing pieces of the behavioral health continuum of care. BMC data found a lack of inpatient behavioral capacity and difficulty in obtaining appropriate access to ambulatory appointments inhibited care for patients. Further, BMC continues to experience patients boarding for behavioral health needs. In order to address this gap in care, BMC recently opened the Brockton Behavioral Health Center to increase capacity and ensure a continuum of care for patients. This new facility has 56 inpatient psychiatric beds and 26 clinical stabilization service beds to treat substance use disorder (SUD). Our hope is this facility can better serve patients, especially those with both mental health and SUD needs, as there is a lack of facilities statewide that can treat dual diagnosis patients. By providing additional inpatient capacity, BMC hopes this will reduce the amount of patients boarding in the ED which is costly, does not provide appropriate patient care, and impedes hospital workflow. As a system, we also hope this new facility will improve the care of our ACO members.

2. Safety net providers who serve the most diverse patient populations suffer from systematic underpayment, threatening efforts to advance health equity.

BMC actively partnered with the Massachusetts Health and Hospital Association and Baker-Polito Administration to shape the newly approved 1115 Medicaid waiver and ensure sustainable support for safety net providers. We are grateful the new waiver includes substantial increases in funding for safety net providers with a continued link to accountable care. The waiver also focuses on advancing health equity, particularly through the groundbreaking new incentive initiative for ACO-participating hospitals that make demonstrated progress in reducing health care disparities. This incentive program will allow safety net hospitals who care for diverse patient populations the opportunity to earn additional revenue if they can reduce health inequities among patients. While these incentive dollars are not guaranteed, they have the potential to boost safety net providers while simultaneously working to address health equity. BMC will continue to partner with the Administration to help implement the new waiver and ensure its success.

BMC is also actively working to negotiate higher rates from commercial payers to be more aligned with other academic medical centers. While we appreciate the additional support from the 1115 waiver, in order to keep up with rising costs and ensure we can provide our

patients quality care, we must pursue additional revenue streams. It is important for safety net institutions to receive adequate resources from commercial payers to address equity, as underpayment perpetuates inequity.

3. Rising labor costs and continuing workforce shortages are making the cost of providing health care more expensive.

Above all, BMC continuously strives to provide a working environment that supports staff and allows them to grow professionally. For example, after years of preparation, in 2021, BMC was awarded Magnet Recognition by the American Nurses Credentialing Center (ANCC), the highest national credential for nursing excellence, quality patient care and innovation in professional nursing practice. With this recognition, BMC joins a select Magnet community, with fewer than 10 percent of hospitals nationwide achieving this status. Magnet designation shows current and potential nursing staff that our hospital is a professional practice environment that values nurses and their integral role in the care team.

In order to try and address labor shortages and reduce reliance on temporary staffing, BMC has implemented a number of new initiatives to retain and attract new nurses. These include: new pre-tax benefits for tuition repayment, launching specialty RN residency programs, developing a nurse leadership council to develop unique retention ideas and assist with recruitment initiatives, and broadening a diverse portfolio of advertising channels and education to directly target RNs nationally. Additionally, as labor shortages and the rise of travel nurses change market dynamics, BMC will move towards these new market adjustments for staff.

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.

Analytics has played a key role in the work of our newly launched Health Equity Accelerator. We cannot fix what we cannot see, so investments in data collection, standardization, and stratification of all our core dashboards and reports have been essential to identify clinical areas to prioritize. BMC has invested significantly in utilizing our analytics capabilities for root cause analyses to identify drivers of inequities and inform Quality Improvement projects. For example, BMC was able to identify that our Black patients have 1.7x more severe complications during pregnancy than our white patients (in line with other national data). After much research, a group of multidisciplinary experts were able to uncover a new insight: the majority of this gap is driven by differences in preeclampsia prevalence and treatment. This internal data has helped shaped new interventions, including providing remote monitoring of hypertension during pregnancy and providing more information about preeclampsia to our pregnant patients through culturally inclusive channels and in many languages. Given the program’s recent launch, we do not have results data at this time,

however patient feedback and stories have been extremely encouraging. We know that it will take time to reduce the health outcomes gap given the upstream nature of the barriers we need to dismantle. We are committed to continue investing in this work in the long term, accelerate the impact in outcomes as much as we can, and measure intermediary progress through process measures and indicators such as patient experience.

BMC currently has valid race data for 84% of patients with a clinical visit in the past 18 months. The vast majority of the 16% of the population blank are patients who reported their race as Hispanic/Latino, which is not a valid Office of Management and Budget category under the new data standards developed by the Executive Office of Health and Human Services. This means BMC collected data from that large group of patients but that selection did not qualify for completion. BMC plans to collect this data from patients in future clinical visits, with an option for choosing not to answer. BMC currently has valid ethnicity data (Hispanic/Latino indicator) for 98% of patients.

We continue to have robust discussions surrounding the best way to collect sexual orientation and gender identity data as well as disability data. BMC is currently collecting SOGI data in specific clinical areas and is evaluating best practices for what to collect and when, how to collect data, and who should ask the questions going forward. Disability status remains difficult to collect as there is no single definition for a disability. Further, the definition can differ when speaking in the context of insurance status as compared to patient care in the clinical setting.

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

1. Health-related social needs and behavioral health needs continue to drive medical spending and impede efforts to address health inequities.

Healthcare systems can and should play a role in supporting the health-related social needs of patients, but the state must continue to invest in affordable housing, transportation systems, food policy and economic empowerment for low income families. As providers, it is challenging to care for patients' social needs without reimbursement for these services. Innovative initiatives like housing navigators, care coordinators, and food-access programs are often not covered, even when they reduce healthcare costs overall. Global payment models allow flexibility so that providers are able to care for the whole patient in a way that is more financially sustainable. Massachusetts should continue to move towards this model of reimbursement.

Recent policy changes through the Legislature's mental health reform legislation, the Baker-Polito Administration's Roadmap for Behavioral Healthcare, and reimbursement at parity for telehealth services will help expand access to behavioral healthcare care. However, continued investment in the behavioral healthcare continuum is needed, particularly rate increases. As we work to expand access to behavioral health services, staffing these programs will become challenging without additional state support. Additional focus should

be placed on workforce development for behavioral health providers, especially providers of color and clinicians who can provide care in languages other than English.

2. Safety net providers who serve the most diverse patient populations suffer from systematic underpayment, threatening efforts to advance health equity.

While the new 1115 waiver will help boost safety net providers, additional supplemental support will still be needed as inflation and labor costs continue to grow faster than Medicaid reimbursement rates. Safety net institutions need to be able to grow their revenue base within statewide cost containment parameters. When considering statewide cost containment, a one size fits all approach for limiting price growth is not appropriate as not all providers are the same. Underpayment of safety net providers perpetuates inequities. Treating providers equally does not treat providers equitably, so care should be taken when analyzing individual provider's growth to consider historic underpayment, their overall cost compared to other providers, and the diversity of the patient population served. This approach will help address provider price variation and ensure that safety net providers are able to become more financially sustainable. Further, if price increases within the system are targeted to providers caring for patients experiencing the largest health inequities, we can more quickly advance the state's goal of achieving health equity.

3. Rising labor costs and continuing workforce shortages are making the cost of providing health care more expensive.

Allowing Massachusetts to enter into the Nurse Licensure Compact would help address our current nursing shortage crisis by making it easier for nurses from other states to work in our hospitals. The ability to expedite licenses from out of state nurses throughout the pandemic has not impacted quality of care but has reduced barriers to entry and allowed us to sustain our nursing workforce. Further, the state should continue to invest in workforce development by providing additional funding to expand loan repayment programs for clinicians at all levels. Additionally, state support is needed for innovative approaches like paid apprentice-type programs or career ladder programs which allow existing staff to grow within the field.

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**	N/A	N/A
	Q2	N/A	N/A
	Q3	N/A	N/A
	Q4	N/A	N/A
CY2021	**Q1**	N/A	N/A
	Q2	N/A	N/A
	Q3	N/A	N/A
	Q4	N/A	N/A
CY2022	**Q1**	66	N/A
	Q2	85	N/A
	TOTAL:	151	N/A

Note: Boston Medical Center is committed to price transparency and provides price information to patients upon request. Unfortunately, BMC had a lapse in collecting the number of these requests for a period time. At the end of 2021, BMC implemented an electronic health record system update which provides a central way to track these requests. This ensures we are able to now easily report data on price inquires, as reflected in CY2022.