MASSACHUSETTS
HEALTH POLICY COMMISSION

2021 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

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 2021 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, November 5, 2021**, 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 2019, if applicable. If a question is not applicable to your organization, please indicate that in your response.

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

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.

HPC QUESTIONS

1. UNDERSTANDING THE IMPACT OF COVID-19:

Please briefly describe how you believe the COVID-19 pandemic has impacted each of the following:

a. Your organization, including but not limited to the impact on your providers and other staff, and any impacts on your ability to recruit and retain staff:

Cambridge Health Alliance's (CHA) committed providers and staff responded swiftly to the COVID-19 pandemic and have persevered during the most challenging times. They have met the pandemic with resilience and courage, compassion and competency. Together they supported patients, engaged our communities and saved lives. While COVID-19 strained our capacity and endurance, CHA demonstrated its clinical and community responsiveness and is emerging as a more nimble organization, united in carrying our mission with an intentional focus on improving the health inequities which were exacerbated by the pandemic's disproportionate impacts on our communities and patient populations.

As part of response efforts, CHA created an innovative community care model to identify and treat COVID-19 patients; launched telehealth services; built a regional vaccine program which has delivered tens of thousands of doses for our patients, communities, and staff; and continued to address pervasive social determinants of health, such as food insecurity and housing stability, in our communities.

CHA played a leading role in responding to COVID and its impact on underserved communities, including those hardest hit by the pandemic. In March 2020, as COVID was spreading across Massachusetts, CHA took swift action to activate its incident command structure and reorganize its entire network, including redeploying 400 providers and staff within 48 hours to the front lines to meet the first patient surge. Among the steps CHA has taken include:

• Created an **innovative care model to manage COVID illness in the community** while preserving hospital beds for people with the most severe illness.[1]

- **A Dedicated Ambulatory Respiratory Clinic, which converted a large health center to a dedicated COVID-19 clinic,** to provide comprehensive services to thousands of sick patients, keeping patients out of the emergency department and hospital.

- **Intensive Longitudinal Community Management** model includes prevention, identification of COVID cases, early and ongoing management at home, escalated management in the respiratory clinic, and escalated management as needed in the emergency department and hospital.

• Set up **community testing** stations in Cambridge, Malden and Somerville, reducing spread by separating suspected COVID-19 cases from others. CHA launched the first drive-through COVID-19 testing site in the region at our Somerville campus.

[1] https://catalyst.nejm.org/doi/full/10.1056/cat.20.0181

- **Partnered with local Boards of Health to diagnose COVID-19, prevent spread, and provide support for housing-insecure populations during the pandemic:** In addition to its testing efforts, CHA worked with the City of Cambridge to provide a special shelter for the city's homeless population, including a 22-bed quarantine tent unit, a 50 bed isolation unit and a 100 bed expansion shelter with clinical space within this shelter. CHA's Healthcare for the Homeless program continued their clinic schedule providing their patients with face-to-face visits.

- **Patient and community vaccination efforts:** CHA is actively working to outreach to our own patients and in the community with the Metro North Vaccine Partnership, a collaboration of 9 cities (including 4 of the hardest hit) to advance tailored community initiatives for equitable COVID-19 vaccinations for youth and their families. Through these efforts, CHA is increasing COVID-19 vaccine distribution in historically under-resourced communities through dedicated community initiatives. We are working to address barriers, including language barriers, cultural differences, medical mistrust (which is higher in historically disenfranchised populations), socioeconomic and social factors in health. CHA has administered nearly 74,000 COVID-19 vaccination shots since December 2020. CHA's mobile vaccination clinics and outreach in neighborhoods, churches, over 10 schools, housing developments, and other community settings have included 66 events since late May with nearly 2400 vaccinations.

• **Launched telehealth services,** including being the first hospital in the U.S. to integrate the Epic Electronic Health Record with Google Meet.

• **Added hospital capacity with additional ICU beds, Comfort Care units, an inpatient psychiatry COVID unit and other services.**

- **An almost three-fold increase in CHA's critical care inpatient services and a 13% increase in medical inpatient staffed beds to meet the needs for COVID-19 critical care capacity in our hotspot area during the surge.** ICU bed capacity increased from 10 to 28 beds, opening an additional ICU in the Post-Anesthesia Care Unit (PACU) at our Cambridge campuses with another in the wings at our Everett campus PACU.

- **Opening two 8-bed Comfort Care Centers** to provide compassionate and supportive end-of-life care.

- **Providing essential inpatient and telehealth behavioral health services for children, adolescents, adults, and older adults** while managing COVID positive patients within cohorts of these admitted inpatient populations. Furthermore, CHA is expanding inpatient psychiatric care capacity in light of the intensive demand for services, adding 64 new beds of which 42 are for youth including those with specialized neurodevelopmental needs and 22 are for adults including those with intensive needs.

- **Organized outpatient pharmacies to access needed prescriptions and mitigate COVID exposure via:** mail order prescriptions, same day delivery for all patients, curbside delivery, free prescription services for COVID patients in transition or with no insurance, specialized packaging to organize doses for patients going to step down or alternative care sites, and assistance resolving copayments.

- **Supported Area Nursing Homes** through its geriatric care services and by providing technical support for nursing homes.

As outlined above, CHA's response to the COVID-19 pandemic has been comprehensive and community focused. We swiftly responded to the needs of our patients and families to provide access to the best possible acute and preventive care possible. This necessary response came at a high cost with **significant financial impacts.** In the first 4 months of the pandemic (March through June of 2020), CHA incurred incremental direct costs of $20M and, in the subsequent twelve months (through June of 2021) expended an additional $71M. These expenditures included additional staffing for more intensive inpatient services, an outpatient respiratory care center, and community testing and vaccination centers. CHA had additional costs to acquire PPE, obtain patient care equipment, and to address facility and IT enhancements to better serve our patients. During this same sixteen month period, CHA experienced $44M in lost net patient service revenue (as compared to baseline) as a result of service cancellations and disruption.

As we move into FY22, CHA continues to experience ongoing periodic disruptions in net patient service revenue and increased costs as a result of ongoing infection control precautions, supply chain disruptions, and various pressures on our workforce.

Impacts on providers and other staff and the ability to recruit/retain staff:
CHA is proud of the accomplishments of its workforce, and the sustained pandemic has impacted the healthcare workforce. As noted above, many staff were courageously redeployed to front line COVID-19 care, and there were no furloughs of any employees during the pandemic.

The demands on the workforce due to COVID-19, deferred healthcare related to the pandemic and increasing acuity particularly in emergency departments and inpatient behavioral health units, have taken a toll. It has also contributed to some healthcare workers reassessing their careers and hours worked. At the same time, we seek to grow the workforce with the expansion of inpatient psychiatric services to meet intensive needs. Our open positions are up 66% from pre-COVID times. As noted below in section 1.c., the ongoing partnership with the Commonwealth in addressing the workforce supports and needs will be highly valued. Key shortages of healthcare professions fuel wage increases, including base rates and sign-on and retention bonuses. Relocation costs are also being required. One strategy CHA is pursuing is "growing our own" workforce. We applaud the ARPA investments in supporting the workforce and developing pipelines for health professions, including opportunities to diversify the workforce to reflect the community served.

b. Your patients, including but not limited to the direct health effects of COVID-19 as well as indirect health effects, such as the effects of deferred or cancelled care, exacerbation of behavioral health and substance use conditions, and effects from economic disruption and social distancing (e.g., evictions, food security):

Direct and Indirect Health Effects: Our patient population is deeply impacted by the pandemic and its aftereffects, and specific diverse populations and immigrant communities had much higher than expected rates of severe disease. As demonstrated by national data, the pandemic within our walls at CHA caused disproportionate levels of suffering for patients coming from marginalized communities. Three quarters of the patients diagnosed with COVID infection at CHA have been people of color; only one quarter of patients diagnosed at CHA with COVID infection speak English as a primary language.

Though CHA's patient population is always diverse -- with approximately two-thirds of patients identifying as belonging to a racial group other than "white" and 44% speaking a language other than English -- the pandemic placed a disproportionate burden on a vulnerable subset of our patients.

Communities served by CHA like Chelsea, Everett and Revere were in the early epicenter of COVID-19, and had much higher COVID cases per capita than the state average. These cities were among the first to surge, and faced higher incidence rates for longer than other metropolitan areas.

As COVID was surging, CHA reconfigured its clinics to provide safe in-person visits and maintain a focus on routine and preventive care, particularly for frail elders in its PACE program and patients with chronic illness. Though we prioritized -- as per state mandates -- essential preventive care for children including vaccinations and chronic disease management for all patients, our ability to provide routine preventive care for healthy adults was severely reduced during the earlier stages of the pandemic. Due to social distancing and deferred care during the height of the pandemic, routine adult well being screening questionnaire completion fell from 67% to 30%. Many patients postponed routine cancer screening, leaving a backlog for mammography and colonoscopy that we are still working to manage. Similarly, we are actively focused on follow-up care for patients with diabetes and hypertension to ensure good control of these conditions. Only in this most recent quarter as the result of a significant amount of effort, we are making strides to pre-pandemic performance in these domains.

In light of the highly intensive demand for behavioral health inpatient services and elevated statewide emergency department boarding, CHA is currently working on an initiative to increase its behavioral health services by 64 new inpatient psychiatric beds for children and adolescents (44) including those with complex neurodevelopmental/autism needs and adults (22) including those with intensive psychiatric needs.

CHA's launch of telehealth services in March 2020 was a critical part of the COVID-19 response and remains integral to care delivery and patient access. Telehealth has been integral to CHA's COVID-19 response and subsequent reopening of services. It has enabled patient access to medical and behavioral health care. Top of mind for our organization is the digital divide and barriers to access to telehealth services for our diverse patient population. Since March 2020, CHA has provided about 570,000 telehealth visits for outpatient services out of over 1 million outpatient visits.

In earlier stages of the pandemic, the majority of ambulatory care was provided via telehealth. From June through September 2021, about 40% of ambulatory visits were provided via telehealth services. Only 43% of those telehealth visits are employed using video, which means 57% of our telehealth visits remain audio only. From the outset, CHA has integrated interpreter services into telehealth offerings. And we have continued to work to improve access. In the last 6 months, CHA provided over 22,000 interpreted or bilingual telehealth visits. Funding support for patient navigators is an area of recommendation to assist with digital literacy and access.

Social Factors in Health: There has been a dramatic increase in the health-related social needs of our patients, in areas like food and housing assistance, etc. Food security has long been a top need for our patient population, which has been exacerbated by COVID-19. Up to 40% of our patients who are screened experience food insecurity and need for food assistance which we seek to facilitate through referrals and other programs we offer. CHA participates in the Feed to Heal initiative. During a one-year period within the pandemic, 2050 households with 7125 family members were referred to free

food (two weeks of home delivered food). CHA organized "Know Your Rights" training to assist families with eviction prevention assistance, and our patient resource coordinators assist patients directly and through referrals to community partner organizations and services.

c. The health care system as a whole, including but not limited to how you think the health care system will change going forward, and any policies or innovations undertaken during the pandemic that you hope will continue (e.g., telehealth policies, licensure and scope of practice changes):

The COVID-19 pandemic has underscored how the public health and health care delivery systems are inextricably linked, which require investments and additional readiness to apply learning from the COVID-19 pandemic. Equitable and community-engaged planning must be integrated. There is tremendous learning, including unprecedented regional and statewide collaboration across the health care sector, that we suggest be captured in a statewide after-action-report undertaken with an equity lens and broad-based stakeholder engagement. Equity and health equity must ground the work ahead.

Critical areas of the health care delivery system - particularly the safety net hospitals, health centers and providers, behavioral health, home health and nursing home care - need funding and other investments to support their critical role and resilience.

Below we cover a few additional policy areas in greater depth.

Healthcare Supply Chain Readiness

The COVID-19 pandemic exposed significant gaps and risks to the healthcare supply chain which need to be studied and corrected. Shortages of PPE were well-documented during the course of the pandemic. Without adequate national and state stockpiles and centralized allocation and distribution systems, PPE and other critical supply and equipment items were subject to price gouging, counterfeiting, and disproportionate distribution relative to need. During the pandemic, CHA worked with over 200 vendors outside of its normal distribution chain to source adequate supplies. We had to rely on community donations and disinfection techniques while larger healthcare and governmental entities were gathering large supply quantities in their warehouses.

Programs to distribute government stockpiles and monitor misallocations demonstrated some fundamental misunderstandings of supply chain (including the long lead times) and infection control principles. Before the pandemic, CHA, like most hospitals, had access to the 3M 1860 respirators in two sizes for which our staff were routinely fitted to on an annual basis. These masks were depleted very early in the pandemic and were replaced by what was available. Alternatives require fit-testing (an expensive and inconvenient process), not to mention that it is a huge challenge to accomplish fit-testing during a pandemic with a contagious respiratory virus. The mere process poses risks. The alternative N95s we were able to source were quickly depleted.

CHA, like many hospitals, responded by adopting common sense and practical disinfection strategies based on UV disinfection and on sound principles at the time. We need to avoid adopting crisis standards in future pandemics. Healthcare organizations must have reliable and sustainable access to PPE that their staff have been fit-tested for going forward. Manufacturing and distribution channels

must be improved, and purchasing opportunities must be fair. Smaller organizations, particularly safety net hospitals caring for a disproportionate number of COVID patients, should have equitable allocation access.

CHA encourages Massachusetts agencies and provider groups to work together to advance efforts for better preparation and response tools in the future. The current data collection tools are not adequate to determine where shortages are most acute nor does there appear to be a strong focus on logistics to get the right supplies to the right place at the right time. Premier recently provided a road map of the detailed work that needs to be accomplished for a more coordinated supply chain response.[2]

Costs are increasing based on COVID-specific services, to obtain and warehouse appropriate PPE, and to meet ongoing higher levels of infection prevention to maintain staff and patient safety. During the pandemic, pricing for critical items ranged from five to twenty times higher than pre-pandemic levels. For example, isolation gowns previously cost $0.70/gown and were over $5/gown with uncertain delivery times, resulting in needs for reprocessed and launderable gowns at costs of $12 - $15/ gown. Prices have remained higher than pre-pandemic levels even as supply chain pressures have eased. In addition, the use of PPE remains high, as most patient interactions now require higher levels of precaution. Consequently, according to a recent Premier analysis, the cost of PPE per patient interaction is approximately 50% higher and this is consistent with CHA's experience.[3] FInally, CHA is incurring additional warehouse and inventory costs to maintain a much larger inventory of PPE items for current use as well as a larger stockpile for a future surge. Governmental and commercial payers should factor these costs, which are outside of the control of health care providers, into their rates in light of these trends.

Workforce Policies:

As has been widely reported and relayed to DPH in semi-weekly calls, a primary capacity constraint on health systems is staffing or lack thereof. During the state of emergency, the Commonwealth undertook several key strategies that, while not directly addressing the numerical shortage of healthcare professionals, removed unnecessary administrative hurdles and delays imposed upon healthcare providers seeking to add new staff. These strategies should continue or be reinstituted as the Commonwealth confronts an endemic shortage of healthcare professionals.

Specifically, The Board of Registration in Nursing should make permanent its Licensure Policy 10-03 to promote the expedited processing of nursing licensure applications. To allow for the most efficient deployment of staff resources, the March 18, 2020 Department of Public Health order allowing pharmacists to administer medications for the treatment of opioid use disorder should be statutorily authorized or promulgated as a permanent regulation by the Board of Registration in Pharmacy.

Over the course of the state of emergency, the Board of Registration in Medicine ("BORIM") was authorized to expedite the processing and approval of various categories of physician licenses. In the current environment, licensure processing delays at the BORIM and other professional licensing boards

[2] Premier Supply Chain Roadmap: https://www.premierinc.com/newsroom/press-releases/premier-inc-calls-for-national-stockpiling-standards-to-prevent-redundant-efforts-next-wave-of-product-shortages https://www.premierinc.com/images/icons/Supply-Chain-Improvement-Ideas-June-2020.pdf

[3] https://www.premierinc.com/newsroom/blog/the-current-state-of-ppe-costs-are-providers-out-of-the-woods-1

create avoidable backlogs that hinder the ability of healthcare providers across the Commonwealth to respond to patient demand. The BORIM and other professional licensing boards should be charged, and provided the resources to develop and implement processes for the timely review and, if appropriate, approval of licensure applications.

Telehealth Policies:

Continuing Parity: By enacting Chapter 260 of the Acts of 2020, the Legislature recognized, among other things, the reality that telehealth has become an essential element of the healthcare delivery system within the Commonwealth by continuing rate parity for services offered via a telehealth modality. Except for behavioral health reimbursement, however, these parity requirements will sunset, subject to future state policies. Healthcare providers have made large investments in telehealth technology in response to the pandemic. Permanent rate parity for all services will ensure that providers can continue this important modality that increases system capacity and thus access for patients.

Digital Equity and Inclusion: As noted, digital equity and inclusion is an area of ongoing opportunity. As promising telehealth and other virtual care modalities come on line, including remote patient monitoring (such as blood pressure cuffs, scales, glucometers, and pulse-oximeters that transmit data to the electronic health record), it is essential that state-supported policies and insurer practices provide assistance to diverse, low-income, and other vulnerable populations toward inclusion. This was a major recommendation of the legislature's Health Equity Task Force.

2. EFFORTS TO COLLECT DATA TO ADVANCE HEALTH EQUITY:

a. Comprehensive data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity is foundational to advancing health equity in the Commonwealth. Please describe your current efforts to collect these data on your patients. Please also describe specific barriers your organization faces in collecting such data and what policy changes or support has your organization identified as necessary to overcome such barriers.

Cambridge Health Alliance (CHA) believes that the collection and thoughtful reporting of data by race, ethnicity, language, disability status, and sexual orientation/gender identity is central to actional health equity initiatives. CHA collects data on these dimensions, the importance of which has been underscored by COVID-19's disproportionate impacts and vaccination efforts.

Race, Ethnicity and Language Data:

CHA established a task force with a goal of providing oversight for the organization's effort to use data for decision-making in reducing health disparities and ensure equity in patient care and services in alignment with institutional strategic priorities. This group has focused on the following:

1) Understanding institutional needs for demographic data [including but not limited to race, ethnicity, and language (REL)] to guide strategic commitments related to patient care outcomes and access.

2) Standardizing demographic data elements (including but not limited to REL) collected for patients, supported by a corresponding organizational policy.
3) Ensuring adherence to external standards and regulatory guidance regarding REL data from state and federal agencies.
4) Evaluating and monitoring demographic data integrity and supporting continuous improvement in REL data collection processes.
5) Organizing REL data within patient data tables to enable standardized reporting.
6) Determining standardized algorithms for demographic reporting filters for data analysis and display.
7) Engaging with internal and external stakeholders to understand different data use cases and enable use with stakeholders.

CHA plans to publish an organizational healthcare disparities report in the coming year, focusing on key health outcome measures.

Disability Status:

How disability is defined is a critical factor in collecting and potential reporting of health indicators. There are questions around how such patient information should best be provided based on patient query and/or clinical assessment, and how that should be differentiated from state disability status.

At present, it is difficult to extract discrete data from the electronic health record (EHR). While there are important interfaces between the EHR to identify patients with complex conditions for care management and for eligibility for disability coverage in the Medicaid program, the results of those assessments are not captured in a discrete field in the electronic health record. Some forms of disability, such as behavioral health conditions, may also involve protected health information. For example, the legislature's Health Equity Task Force heard testimony about the importance of understanding equity for persons with mental health conditions.

Sexual Orientation and Gender Identity Data Collection:

CHA is committed to inclusive practice and has the desire to standardize the current collection of SOGI information across the organization. There are dual aspects of SOGI data as collected in EHRs and associated patient care workflows:

- demographic fields, such as preferred name and pronouns (which may be collected by registration personnel) and
- clinical fields, such as sexual orientation, gender identity, and sex assigned at birth (which may be discussed with clinical personnel).

It will be helpful to have a statewide stakeholder process on how such data is collected and used in potential reporting of health indicators.

Barriers:

- **Standardized data definitions and collection across organizations (aligned with state and federal definitions).**
- For example, there are in the range of 130 fields on ethnic background, including "null", "declined to answer," "unknown/not specified," and "other ethnicity."

- Statewide standardization of the fields will be needed. **How to define and handle multi-racial, "other in the race and ethnicity fields, and multiple ethnic backgrounds so that the information is meaningful**
- Creating processes and workflows and trusted relationships so that consumers feel comfortable sharing sensitive personal information about REL, disability, and sexual orientation/gender identity. Informed by suggested stakeholder input, standardization and training will be key facets to successful data collection and design.
- **Reporting and use of the data:** An important issue is how data will be reported. For instance, what denominator size will be meaningful, and how data will best be rolled up. Understanding the importance of disaggregated data, there will also need to be state guidance on how to approach data reporting when specific patient population cohorts by ethnicity are small. A standard algorithm will be needed for comparison purposes and to be meaningful. For example, a current working premise within our organization is that 5% of CHA's own patient population would be a working parameter upon which an ethnicity would be reported individually with populations less than the working 5% threshold being rolled up.

Policy Recommendations:

A policy priority of the legislature's Health Equity Task Force recommendations (which CHA CEO Dr. Assaad Sayah was honored to chair) is the collection and reporting of data on health equity.[4]

CHA supports statewide policy recommendations and learning from other states like Connecticut that have statewide health equity dashboards, based on concepts of results-based accountability, and initiated standardized data collection and reporting efforts that involve the ongoing and extensive involvement of many stakeholders, including consumers, health care providers, etc.[5]

Massachusetts should similarly convene stakeholders to advance standardized collection and reporting of REL, disability, and SOGI data that includes standardized mechanisms for disaggregated data, so that it is meaningful for usage.

Furthermore, we encourage the development of opportunity-based dashboard framing (rather than focus on deficits), such as that incorporated by the Health Opportunity and Equity (HOPE) Initiative. HOPE tracks social determinants of health and health outcomes by race, ethnicity, and socioeconomic status.[6]

[4] https://malegislature.gov/Commissions/Detail/512/Bills

[5] Connecticut Open Data Portal for COVID-19: https://data.ct.gov/stories/s/COVID-19-data/wa3g-tfvc/
Connecticut Healthy People 2020 Dashboards: https://stateofhealth.ct.gov/HCT2020/HCT2020Index

[6] HOPE Initiative Website: www.HopeInitiative.org
HOPE Massachusetts Page: https://www.hopeinitiative.org/state/massachusetts
New England Journal of Medicine's interactive HOPE platform:
https://www.nejm.org/doi/full/10.1056/NEJMp2029139?query=featured_home

AGO QUESTION

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) 2019-2021			
Year		Aggregate Number of Phone Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2019	**Q1**	131	All Phone
	Q2	121	All Phone
	Q3	112	All Phone
	Q4	102	All Phone
CY2020	**Q1**	85	All Phone
	Q2	16	All Phone
	Q3	58	All Phone
	Q4	102	All Phone
CY2021	**Q1**	65	All Phone
	Q2	83	All Phone
	TOTAL:	875	