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.

November 5, 2021

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Dear Mr. Seltz,

Below, please find the pre-filed testimony of Dana-Farber Cancer Institute, signed under pains and penalties of perjury, in response to questions provided by the Health Policy Commission and the Office of the Attorney General.

As the President and Chief Executive Officer of Dana-Farber Cancer Institute, I am legally authorized and empowered to represent the organization for the purposes of this testimony.

If you have any questions, please contact Kate Audette, Director of Government Affairs at Kathryn_audette@dfci.harvard.edu.

Sincerely,

Laurie H. Glimcher, M.D.
President and CEO
Dana-Farber Cancer Institute
Richard and Susan Smith
Professor of Medicine
Harvard Medical School

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:

Dana-Farber Cancer Institute blends leading science and exceptional care into transformative medicine. Founded in Boston in 1947, Dana-Farber is a principal teaching affiliate of Harvard Medical School and federally designated as a Comprehensive Cancer Center that develops and disseminates innovative patient therapies and scientific discoveries throughout the world.

Dana-Farber cares for adults and children challenged with cancer, blood disorders, and related diseases. Our world-renowned specialists provide comprehensive and personalized care for each patient and support for their families. We don't just treat cancer; we treat the whole person. Our highly specialized, state of the art hospital facilities are staffed by teams of experts who work closely together to offer patients the latest therapies and strategies, including access to innovative clinical trials. Prior to the pandemic, per fiscal year 2019 data, Dana-Farber provided 187,664 infusion treatments and 359,519 in-person, outpatient visits for 74,084 unique patients. Our high-touch, specialized care is made possible by our 5,231 employees.

From our patients to our workforce, no aspect of the Dana-Farber enterprise has escaped the impacts of COVID-19. The pandemic has had tremendous effects on our research and our function as a teaching institution training the next generation of health care providers, researchers, and leaders.

Workforce

The health, safety, and wellbeing of the workforce at Dana-Farber is always a top priority and during the pandemic this became even more prevalent of a focal area. As part of a strategy to ensure the health and safety of our workforce, and patients, in the early days of the COVID-19 pandemic, Dana-Farber moved quickly to transition 80 percent of our workforce to a remote work, which became known internally as our 'dynamic work' environment. While initially anticipated to last just a few weeks, it gradually became apparent that dynamic work would be needed on a long-term basis. This new work environment necessitated extensive additional equipment and technical support for our employees at home, and Dana-Farber mobilized safe drive up and drop off equipment distribution locations for relevant members of our workforce.

While much of our staff moved to the dynamic work environment, our clinical staff, making up 20 percent of our overall workforce, has remained onsite throughout the pandemic. For our patient facing staff, who could not transition at least entirely to dynamic work, we faced a range of challenges from securing adequate supplies of personal protective equipment (PPE), developing testing and symptom evaluation protocols, contact tracing, and new workflows that incorporated social distancing to name a few. We also moved quickly to address the mental

health and wellness needs of our workforce who reported anxiety around potential exposure to COVID-19 in the workplace, the constant state of uncertainty, fatigue, and stress related to managing demands in their personal life, such as childcare in the changing pandemic environment. To that end, we have seen our workforce exhibit an increased utilization of resources and services provided by our Employee Assistance Program, and our Human Resources department.

Access to safe and reliable childcare has always been a challenge for the Dana-Farber workforce, especially for our patient facing staff and those who work outside of 'normal business hours'. These challenges were exacerbated by the pandemic and have not eased. We continue to see an increased demand for dependent care services and creative supports for parents/caregivers of infants and school aged children, especially for our early career researchers who have documented barriers to accessing reliable and affordable childcare and early education and care programs.

The pandemic also has taken a financial toll on our workforce. The creation of home offices and educational spaces for remote learning for school aged children created operational and financial burdens for many. Additionally, job loss within family systems, funeral expenses for loved ones who died due to COVID-19, and other financial challenges all impacted our workforce. Dana-Farber established a COVID-19 emergency fund to support our staff facing COVID-19-related financial hardship. Nevertheless, we know the mental, emotional, and social impacts of these stresses continue.

Finally, as an academic medical center, the Dana-Farber mission includes training the next generation. The pandemic disrupted and, in some cases, caused these students, trainees or interns to move into a remote learning experience or end their time at Dana-Farber prematurely. These disruptions were immediate and will affect these trainees and workforce pipelines over the long term.

Recruitment and Retention

Recruitment and retention of employees in the health care industry during the global pandemic has become challenging. Specifically, identifying talent to fill patient facing positions has become increasingly more difficult as area hospitals are all pulling from the same talent pool. This talent pool has decreased due to what is being called 'the great resignation' - which includes early retirements and some workers deciding to leave the health care workforce all together.

During the pandemic, Dana-Farber, like many organizations, realized that non-clinical staff can effectively take advantage of dynamic work, and to that end, currently have 40 percent of our workforce continuing to work either fully or partially remote, which is aiding retention efforts. However, we are finding that many new job applicants only wish to work remotely and are unwilling to come on-site or relocate, making hiring difficult for some positions that require presence onsite.

Dana-Farber has undertaken several strategies in response to the need to recruit new members for our workforce during the ongoing pandemic environment. For hard to fill positions, we have increased referral bonuses to current staff who refer a candidate who is successfully hired. For retention, we have announced a year-end thank you bonus, implemented several ongoing

employee appreciation events, and we are currently conducting an employee engagement survey with Press Ganey to gather data on how to continue to support our workforce.

Finally, while Dana-Farber supports the concept of the new Massachusetts Paid Family and Medical Leave for our patients, caregivers and employees, the implementation of the law during the pandemic has put a strain on the health care workforce both from a financial and staffing perspective. This may be an unintended outcome of the law that the Health Policy Commission should consider monitoring closely.

Occupational Health and Patient Safety

In order to protect our medically vulnerable Dana-Farber patient population and our workforce, Dana-Farber quickly moved to set up a robust COVID-19 testing, symptom checking, and vaccination infrastructure. We implemented a COVID-19 vaccine mandate for our entire workforce. In addition, Dana-Farber implemented several policies and protocols to ensure our campus remains safe for patients and staff including signage, daily COVID-19 attestations, limiting visitors, and moving non-patient facing staff offsite. As the pandemic continues, we continue to work with our workforce to provide strategies for safe employee commuting options, as well.

Research Impact

Dana-Farber is dedicated to discoveries in cancer research and, to that end, in fiscal year 2019, we had more than 1,100 open clinical trials led by 156 principal investigators, 620 research fellows, and 75 clinical fellows.

Research at Dana-Farber was greatly impacted by COVID-19. In the Spring of 2020, in-house research operations shut down for nine weeks. For the next approximately seven months, research operations functioned at a reduced capacity, with staff working in shifts spread out over seven days per week to allow for adequate physical distancing in laboratories. Countless hours of research were lost during this time.

Research cores are groups within Dana-Farber that provide lab services to Dana-Farber researchers, as well as to external researchers in the Longwood Medical Area. Research cores were forced to close for several months in 2020. They were slowly brought back on-line, in a limited capacity, when research activities began to return to normal levels; however, to limit the number of people on-site, we did not until recently allow external researchers access to our research cores. The closure of research cores to third parties resulted in a significant decrease in revenue and a need for Dana-Farber to cover an unanticipated deficit in 2020 and the first half of 2021.

Supply chain issues have continued throughout the pandemic. Initially, we encountered difficulty procuring gloves and masks, ultra-low temperature freezers, and deliveries of essential carbon dioxide gas. More recently, we are seeing shortages in basic supplies such as sterile pipette tips, tubes, and cell culture flasks. These supply chain challenges remain complicated and multifactorial; however, they need to be addressed in order to move us toward getting back to full research capacity.

In the summer of 2020, a hiring freeze delayed our ability to recruit research faculty members along with administrative staff. Student training was also greatly reduced because of the need

for physical distancing. Once the hiring freeze was lifted and we were able to fill open positions, we found that training of staff proved difficult. At the time, labs were still working in shifts and maintaining six feet of distance between each person. Faculty members were only allowed on-site up to a maximum of two days per week. This made on-boarding and training extremely challenging for everyone. So much of what happens in research is a result of the collaboration and conversations that happen between scientists. Faculty serve a critical role in the mentoring and development of postdoctoral and graduate students.

As a not-for-profit academic institution, we long have had to compete with for-profit biotech and pharmaceutical companies to attract and retain staff, particularly in research administration. The pandemic has only exacerbated these challenges. Many research staff moved out of Massachusetts during the pandemic and wanted to continue to work from another state, which Dana-Farber is not able to accommodate at this time. In addition, we did lose a small number of staff due to the vaccination mandate put in place to protect staff and patients.

Throughout these struggles, research has continued and thrived. During the nine-week shutdown, researchers quickly pivoted from working at a lab bench to working on research papers, writing grant applications, and reviewing science articles. Grant submissions in 2020 were up over 5 percent from 2019. Zoom enabled lab meetings and seminars to continue, and researchers were flexible to continue their research in shifts, seven days a week. Research administration transitioned seamlessly to a fully remote model without loss of productivity. Dana-Farber provided every possible resource from testing, vaccination, clear policies and communications, screening, and attestations to set the research enterprise up for success during an extremely difficult time.

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):

The COVID-19 pandemic has profoundly impacted the physical health, mental health, and economic stability of Dana-Farber patients, their families, and our staff. Our patients, who are already medically vulnerable, have experienced even greater challenges, including logistical changes in access to clinical care, delays in care and cancellations of procedures both at Dana-Farber and other health providers. In addition, patients faced isolation during treatment, challenges in learning how to navigate and use telehealth services, and experiences with complicated grief.

COVID-19 and the Impact on Cancer

Prevention, awareness, education, and early detection of cancer is at the heart of the services that Dana-Farber provides. Community outreach and education and routine cancer screenings such as colonoscopies, Papanicolaou (pap) smears, and mammograms, were abruptly halted at the onset of the pandemic. As a result, many individuals were unable to learn of abnormal findings or cancer diagnoses, thereby delaying treatment start. COVID-19 put a tremendous strain on the entire health care system; many routine exams and surgeries were canceled to prioritize resources for COVID-19 patients. Emergency departments were unable to provide the

same level of care to due to sheer numbers of patients. Many symptomatic or diagnosed patients avoided medical care or emergency departments altogether, due to the fear of contracting COVID-19.

In fact, the National Cancer Institute (NCI) estimates that because of these missed, skipped, or delayed screenings mortality rates for both colorectal and breast cancer will be increased by 10,000 deaths over the next decade. Those deaths represent about a one percent increase in the almost one million deaths expected from those malignancies in the next ten years. Furthermore, NCI estimated that the decrease in mammograms and colonoscopies during the pandemic might be 90 percent or more, creating disruptions of screening and care which may lead to more deaths. The NCI report goes on to indicate that while there has been a steep drop in cancer diagnoses in the United States since the start of the pandemic, there is no reason to believe the actual incidence of cancer has dropped. The result is that cancers being missed now will still come to light eventually, but at a later stage or 'upstaging' and with worse prognoses and greater costs associated with treatment.

Although we have seen cancer screening rates begin to recover since the early days of the pandemic, it is clear that COVID-19 has exacerbated the systemic disparities that are prevalent in historically excluded or exploited populations. Innovative strategies that bring services directly to communities in need like the Dana-Farber mammography van help to address barriers to screening across the Commonwealth. In partnership with community-based organizations and local federally qualified community health centers, the van is on the road three to four days per week year-round, serving all Boston neighborhoods as well as local towns including Natick, Waltham, Quincy, and Brockton. Skilled, registered mammography technologists from Dana-Farber perform the exams and films are interpreted by board-certified radiologists with extensive experience dedicated to mammography. During the appointment, patients are able to speak with a health educator about the importance of being screened for breast cancer and steps they can take to reduce their risk of developing the disease. By bringing Dana-Farber's high-quality services directly into neighborhoods and meeting people where they are at, the van help Dana-Farber to break down cultural, linguistic, financial, and logistical barriers to care and makes access to mammograms more equitable.

While delaying cancer screenings during the height of the pandemic may have been a prudent approach, it could lead to a cancer chilling effect over the long term which creates another public health crisis. While Dana-Farber is working hard to make patients feel comfortable about returning to hospitals, clinics and doctors' offices for essential cancer screening and treatment, this is an area where the Health Policy Commission and State Legislature can also support this important awareness and messaging.

For patients at Dana-Farber who received a diagnosis prior to the pandemic, they too experienced delays in accessing surgical interventions and scheduled inpatient care. Some patients were unable to afford to start their oral chemotherapy treatments due to delay in processing of drug manufacturer applications for financial assistance. In addition, the pandemic caused delays in patient care for patients who have needed to travel to Boston and arrange accommodations to access their care or participate in clinical trials.

Patient Safety

At the height of the COVID-19 pandemic, the Dana-Farber Department for Quality and Patient Safety identified an increase in the number of patient falls on our campus. The increase was suspected to be due in large part to the lack of visitors, caregivers and family members who typically accompany patients while attending in person appointments. There also has been an increase in the number of safety reports related to disruptive patient behavior, due to patients expressing frustrations with workflow and treatment delays, social isolation, anger about the loss of control of circumstances due to COVID-19, and fear and anger associated with job loss or increasing financial stress.

Telehealth

Since March 2020, a number of federal and state public health emergency declarations, executive orders, waivers, and regulatory changes have allowed Dana-Farber to broadly offer telehealth to our patients. We have now conducted over 160,000 telehealth visits by utilizing synchronous, virtual video visits, as well as audio-only telehealth, to reach our patients across the Commonwealth, the nation, and the globe.

Telehealth is of particular importance for cancer patients but will never replace needed in person visits that can include surgical interventions, chemotherapy infusions, radiation therapy and bone marrow transplants. However, often second opinions, treatment plan reviews, scan evaluations, monitoring and follow-up care can be safely and effectively delivered remotely. In addition, cancer patients are often severely immunocompromised and at higher risk of contracting infections and viruses, such a COVID-19, making telehealth a safer option for them to access certain aspects of their care, even in the post pandemic environment.

Now, Dana-Farber is advocating with Congress and our State Legislature to ensure there are no interruptions in access to telehealth services for cancer patients. Telehealth visits have been highly desirable and convenient for patients. They have been especially helpful for those patients who were fearful of traveling due to COVID-19. Visits with social workers and chaplains were often patients' lifelines when experiencing feelings of isolation. Social workers created two new virtual support groups to address mental health needs during COVID-19: "Managing Anxiety during COVID-19" and "Rest and Resilience" for patients who identify as Black Indigenous or People of Color (BIPOC). Because of their popularity, social work and spiritual care visits will continue via telehealth.

Out-of-state telehealth appointments were especially helpful for our patients located outside Massachusetts. Now that many states have discontinued emergency licensure for our providers, we can no longer conduct telehealth visits for out-of-state patients. This has been a significant source of frustration for these patients. This loss affects not only medical appointments but also social work, genetic counselors, and spiritual care visits. We currently are working on a strategy to license two providers per disease center in five states, but this will still not meet the demand of all patients wishing to access their care via telehealth. Interstate licensure compacts are essential in order to allow our providers to care for patients who need to receive treatment at Dana-Farber but who live out-of-state. For many of these patients, the subspecialized care they need is not offered in their local community, so our care or consultation at a comprehensive

cancer center such as Dana-Farber is greatly needed. Furthermore, many of these patients cannot afford to drive or fly to Boston or stay in hotels for routine appointments.

Adoption of telehealth at Dana-Farber brought to light many of the well documented challenges that exist due to the digital divide and disparate access to both devices and consistent and affordable broadband and Wi-Fi. We have seen firsthand that participation in telehealth visits was extremely difficult or impossible for patients who did not have access to the internet or technology to communicate virtually. This led to much uncertainty and worry regarding treatment plans. Other patients couldn't make phone appointments because they didn't have a phone, or voicemail for messages, or enough minutes to talk. Access to reliable cell phone and broadband services in Massachusetts is not a social determinant of health and imperative in ensuring patients who wish to access telehealth services can do so.

Our patients with limited English proficiency (LEP) were able to return to our campus before our interpreters were permitted to return, resulting in interpreters trying unsuccessfully to interpret via telephone. As a result of this challenge, the percentage of patients being seen without a qualified interpreter jumped to 34 percent. Interpreter Services partnered with nurse directors to roll out the use of iPads and Zoom for patients being seen in-person, with interpreters still in a remote setting, successfully lowering the percentage of patients seen without a qualified interpreter to two percent. Interpretation and translation services via telehealth continues to be a workflow challenge that Dana-Farber is addressing to ensure more equitable access to telehealth services for our LEP patients.

Patient Navigation

The new Dana-Farber Chestnut Hill satellite location opened during the pandemic. Because patients were unable to visit the site ahead of scheduled visits and were not able to bring caregivers or loved ones with them for appointments, Dana-Farber developed creative solutions to provide advance patient navigation and support to patients. Volunteers were trained to make pre-visit reminder phone calls in which they also provided wayfinding information and offered support. Volunteers also made follow-up calls post-visits to solicit feedback on the patient experience.

Similarly, Interpreter Services made over 2,500 outreach calls to inform LEP patients of process changes at Dana-Farber due to COVID-19, to reassure them that it was safe to come to Dana-Farber for care, and to support them as they prepared for their telehealth visits. In collaboration with social work and patient navigation, videos and tip sheets were created to highlight COVID-19 and visitor policies and Zoom telehealth instructions. They also arranged a forum for Spanish-speaking patients, during which Spanish-speaking faculty and staff provided information about vaccine safety and patients provided testimonials.

Mental and Behavioral Health

One of the most difficult aspects of the pandemic for Dana-Farber patients and their loved ones has been the impact on mental and behavioral health and overall well-being. Dana-Farber provides an interdisciplinary model of care for patients that centers on the whole patient, inclusive of their support systems. However, the COVID-19 pandemic forced many of our patients to receive care, including inpatient admissions, recovery from surgery, chemotherapy, and

radiation appointments with difficult news – alone. No visitors were allowed for an extended period of time; now patients are permitted to bring only one visitor. This has been a major stressor for patients, Dana-Farber staff, and clinicians. Many patients are reliant on their personal support systems for emotional support, but also for their day-to-day care.

Sadly, many Dana-Farber patients have felt unsafe generally, concerned that their loved ones or the larger community were not engaging in safe practices like social distancing or wearing masks. This made them feel even more isolated. In addition, patients with families living in different parts of the country or the world experienced an extreme sense of isolation. As a result, COVID-19 also exacerbated mental health, behavioral health conditions and substance use disorders, in large part due to isolation and lack of available support.

Many of these patients experienced complicated and/or devastating grief, due to the inability to be with family members dying in the hospital or who died of COVID-19, or the inability to ritualize or have memorials for those who died of COVID-19 or their cancer. It was difficult for many patients to access support from their families and communities because of social distancing requirements.

Delayed, deferred treatment and canceled surgeries have led to a tremendous amount of stress and anxiety – worry about when the procedure will take place; extreme stress and anguish about being diagnosed later than they otherwise would have; worry about not having childcare, or about the financial impact of both cancer and COVID-19.

Patient Financial Impact

A cancer diagnosis is already a financial burden to many patients and their families and in some cases can lead to job loss for the patient or a caregiver. Some Dana-Farber patients and caregivers who were able to continue to work during or after treatment, lost their employment as a result of pandemic shutdowns. As a result, many households with Dana-Farber patients experienced some sort of loss of income during the pandemic. Resource specialists observed a significant increase in food scarcity, particularly for pediatric patients and their families. Various community resources, such as lodging or transportation, were forced to close. Our partners in the philanthropic sector had to either close entirely or stop accepting new applications for assistance due to a lack of funding and an inability to fundraise. However, various government programs and moratoriums were established. To manage the changing landscape of access to public benefits for our patients during the pandemic, interdisciplinary teams partnered to catalogue available resources and a monthly 'Resource Rounds' huddle was launched with continuous updates on these programs.

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 forced leadership of local, national, and global health care systems to rethink many of our approaches to public health and health care access. In addition, the pandemic continues to highlight the systemic disparities in treatment of historically and

contemporarily exploited and excluded populations both in health care and our society writ large.

Looking forward, we anticipate that certain trends that emerged during the pandemic are here to stay, such as the increased adoption and scale of telehealth and efforts to create a more fair, just, and equitable health care system and society. Waivers and other regulatory changes that were rolled out during the pandemic have shown what is possible when we center equity and reduce administrative burdens that create access barriers for patients and drive-up costs. Finally, the pandemic provided an opportunity to look at credentialing, licensure and scope of practice workflows, all ideas that should be evaluated for the post pandemic environment.

Telehealth

As stated above, since March 2020, federal and state public health emergency declarations, executive orders, waivers, and certain regulatory changes have allowed Dana-Farber to broadly offer telehealth to our patients. Even prior to the pandemic, Dana-Farber was a proud member of the Massachusetts Telemedicine Coalition (tMED), working to advance telehealth access across the Commonwealth.

Now, Dana-Farber continues to work with tMED and the Division of Insurance to ensure implementation of Chapter 260 of the Acts of 2020, An act promoting a resilient health care system that puts patients first, in a manner that does not disrupt our patients who wish to access their cancer care via telehealth.

To continue to improve telehealth access, Dana-Farber has submitted testimony to the Joint committee on Financial Services in strong support of H1101/S678 - An Act Relative to Telehealth and Digital Equity for Patients (the "Proposed Telehealth Act") and have respectfully requested a favorable report on the bill as soon as possible, to ensure our patients have continued access to telehealth services.

The Proposed Telehealth Act builds on gains made in telehealth access after years of work by the Health Policy Commission, advocacy by tMED, emergency executive actions by the Governor during the pandemic and the passage of Chapter 260 of the Acts of 2020 by the Legislature. This bill, which was filed by the tMED Coalition, would ensure that cancer patients, and indeed patients across the Commonwealth, are able to continue to access telehealth services in Massachusetts now that the pandemic state of emergency has ended. In addition, the bill creates taskforces to assess the licensure barriers that prevent physicians, advanced practice nurses, physician assistants, behavioral health providers and other allied health professionals from providing telehealth services to patients outside of Massachusetts, something that has been an ongoing challenge for Dana-Farber since we began to offer telehealth.

As stated in the title of the Proposed Telehealth Act, this bill also has a strong focus on equity. Specifically, the bill ensures that patients who choose to use telehealth do not need a prior

authorization for medically necessary services that do not require a prior authorization for in-person services. The bill also seeks equity through language justice by ensuring that translation and interpreter services are covered when delivered via telehealth. Finally, the bill would improve transparency of benefit plans so that both patients and providers understand the patchwork of insurance coverage for telehealth services.

Licensure, Credentialing and Scope of Practice

As stated above, Chapter 260 of the Acts of 2020, An Act Promoting A Resilient Health Care System That Puts Patients First, contains many important provisions that codify innovations driven by the pandemic such as telehealth. In addition, we applaud the Legislature and Governor for including in Chapter 260 provisions which allow physicians to obtain proxy credentialing and privileging for telehealth services and the provision relative to expanding the scope of practice for advanced practice nurses. Dana-Farber would like to see continued streamlining of the throughput for licensure and credentialing in the Commonwealth and continued expansion of scope of practice for providers such as physician assistants.

In addition, Dana-Farber recently submitted written testimony to the Joint Committee on Health Care Finance in strong support of H1284 / S163 - An Act relative to nurse licensure compact in Massachusetts. Even prior to the pandemic, we strongly believed that joining the Nurse Licensure Compact (NLC) and granting nurses the authority to practice across state lines would be a welcome and common-sense policy change. Joining the NLC creates standardization and alignment of nursing licensure laws to quality-of-care standards. However, now in the ongoing pandemic and looking forward to the post pandemic environment we know the passage of this bill is both critical and urgent to address workforce and public health needs.

This bill would add the Commonwealth to the list of 38 states that participate in the NLC by directing the Board of Registration in Nursing (BORN) to enter into and administer the NLC while also authorizing BORN to impose a penalty for licensed nurses who violate regulations related the practice and registration of nursing.

The NLC acknowledges that the expanded mobility of nurses and the use of telehealth as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation. The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states. Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits and could help to address the current nursing workforce shortages.

The Department of Nursing and Patient Care Services at Dana-Farber is committed to excellence and to compassionate patient and family centered care. Our multidisciplinary team model ensures that patients and their families are cared for by highly skilled professionals who work together to craft individualized care for each patient and to facilitate access to clinical research

that is on the cutting edge. We have earned the Magnet Recognition Program® designation, which is conferred by the American Nurses Credentialing Center, the nation's preeminent accreditation organization for excellence in nursing service and practice.

H1284 / S163 - An Act relative to nurse licensure compact in Massachusetts would enhance nursing practice at Dana-Farber in many ways; two examples include enhanced continuity of care and access to telehealth for our patients. At Dana-Farber we believe that continuity of cancer care is a pillar of high-quality care. Nurses from registered nurses to our advanced practice nurses are a critical part of ensuring continuity of cancer care as they efficiently and effectively help navigate and guide the delivery of patient care across Dana-Farber. As the region's only comprehensive cancer center, we care for a population of patients who are permanent Massachusetts residents and spend winter months in warmer southern states, a population sometimes referred to as "snowbirds". For these patients, continuity of their cancer care between Dana-Farber and the other locations where they receive cancer care can be a significant challenge. Passage of this bill would allow Massachusetts to join the NLC with states such as Florida where many of our patients spend the winter months.

Telehealth is now an integral tool in our cancer care delivery model at Dana-Farber. We believe that access to excellent nursing care via telehealth is an essential element of our care model, during the ongoing pandemic and for the foreseeable future. Joining the NLC will help to reduce the administrative burdens and barriers that our nurses face in providing telehealth to care for our patients.

Another innovation in licensure compacts that we wish to highlight is that earlier during the pandemic, the United States Department of Defense, as part of an initiative to promote licensure portability for military spouses, awarded a $500,000 grant for the development of an interstate licensure compact for social workers. The compact, which is expected to take 12-16 months to develop, will be a legal agreement between states that will allow licensed social workers to practice in all participating states. Currently, licensed social workers must seek and receive licensure in each state in which they wish to practice. An interstate licensure compact for the social work profession is critically needed to address the ongoing mental, behavioral health and substance use disorder crisis in Massachusetts and around the nation. It will also improve continuity of care, access to tele-behavioral health and enhance the exchange of licensure verification, investigatory, and disciplinary information between member states. The Council of State Governments is currently overseeing the development of the social work compact in conjunction with the Association of Social Work Boards, the National Association of Social Workers, and the Clinical Social Work Association as partners. Once the national compact is created, model legislation will need to be filed and signed into law in order for states to participate. Dana-Farber looks forward to following the development of a national social work

licensure model and supporting legislation in the future to ensure Massachusetts joins the compact.

Administrative Burdens

Addressing and reducing administrative burdens such as prior authorizations, utilization review and step therapy or fail first protocols has been an equity driven policy priority for the Health Policy Commission that Dana-Farber applauds. During the pandemic, we greatly appreciated the passage of federal and state waivers and other regulatory changes that recognized the burdens placed on patients and hospitals, and barriers to care that these practices created and therefore, some were temporarily rescinded. Dana-Farber urges the Health Policy Commission and State Legislature to continue to evaluate opportunities to advance equity by reducing administrative burdens in health care, both to reduce barriers to care for patients and to reduce the costs associated with these administrative burdens born by both providers and insurers.

As shared in our Cost Trends Hearing pre-filed testimony in 2019, Dana-Farber is significantly impacted by the administrative complexity of health plan prior authorization requirements, especially for drug treatment within the clinical setting. The health plans continue to expand both the volume of drugs that require prior authorization and their use of vendors to manage this authorization process. The disconnects between the health plan and the vendor continue to be a very significant pain point; these delay patient care and are very resource intensive. We have worked directly with the health plans to demonstrate the evidence-based decision making and extremely low authorization denial rate for many drugs that continue to be on their list. At this time, the issue is further burdened by the labor shortage, increasing patient care delays; it is very disappointing that they are comfortable in pushing out their turn around time rather than updating their requirements. We would be happy to meet with staff with the Health Policy Commission to see how we can collaborate on approaching this issue, which could include additional information on our Pathways initiative and drugs that require authorization where we have a low rate of authorization denials.

On the issue of prior authorization, thanks to funding support from the Health Policy Commission, the Boston based Network for Excellence in Health Innovation (NEHI), through the Massachusetts Collaborative which includes the Massachusetts Medical Society, Massachusetts Health and Hospital Association, Massachusetts Association of Health Plans and Blue Cross Blue Shield of Massachusetts, just released a report on streamlining prior authorizations. One of the recommendations from this report includes reforms such as gold-carding through 'tests of change' in individual contracts. One example of a policy reform to consider is the new gold card law that was just passed in Texas. Under the Gold Card Law that took effect in September 2021, this first in the nation law, allows physicians who have a 90 percent prior authorization approval rate over a six-month period on certain services to be exempt, or 'gold carded', from prior authorization requirements for those services.

Gold carding is included in a set of prior authorization reform principles put forth by the American Medical Association (AMA) and 16 other physician, patient and health care organizations. Specifically, these principles state that health plans should restrict utilization management programs to outlier providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors. The principles further elaborate that health plans should offer a physician-driven, clinically based alternative to prior authorization, such as gold card programs. Importantly, health plans also agree that prior authorization reforms should include offering programs that exempt high-performing physicians from prior authorization requirements. The AMA, along with other national provider associations and the insurer trade associations, America's Health Insurance Plans and Blue Cross and Blue Shield Association, released the Consensus Statement on Improving the Prior Authorization Process in January 2018. In this landmark agreement, health care professional and insurer representatives agreed to encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine. The post pandemic environment presents an opportunity for the Health Policy Commission and the state legislature to resume their look into reforms like gold carding which can reduce administrative burdens and delays in care, which will be critical in addressing the delays in diagnosis of cancer and access to care which were driven by the pandemic.

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.**

Dana-Farber supports the comprehensive collection of patient data, including race, ethnicity, language, disability status, and sexual orientation/gender identity as part of its (pre)registration workflows. This data collection typically happens by phone, during a registration telephone call with new patients or via Dana-Farber's patient portal. In addition, Dana-Farber has a detailed clinical clearance process, during which patients are asked questions that help us understand their needs, including support needed in connection with a disability. It can be difficult for patients to prioritize providing detailed demographic data as they are managing their cancer diagnosis. As such, in early 2021, Dana-Farber implemented a cross functional team that included employees and patients, to improve the accuracy and specificity of patient demographic data. We are currently planning an employee retraining initiative, as well as a patient education

campaign, to highlight why this data is so critical. While not necessarily a barrier, our patient population may have changes to their disability status throughout their episode of care. As a result, we are always looking for opportunities to accurately capture changes in reporting of disability status as a result of a cancer diagnosis.

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 Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2019	**Q1**	0	16
	Q2	0	6
	Q3	0	2
	Q4	0	3
CY2020	**Q1**	0	2
	Q2	0	2
	Q3	0	2
	Q4	0	3
CY2021	**Q1**	0	5
	Q2	0	4
	TOTAL:	0	45