MASSACHUSETTS
HEALTH POLICY COMMISSION

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.

Private Insurer	Blue Cross Blue Shield	Tufts	Harvard Pilgrim	Unicare	Cigna	Aetna	Allways	Fallon
% of Statewide Relative Price	77%	80%	82%	72%	76%	84%	63%	67%
Statewide Average Relative Price	100%	100%	100%	100%	100%	100%	100%	100%
Difference	23% below avg	20% below avg	18% below avg	28% below avg	24% below avg	16% below avg	37% below avg	33% below avg

	% People of color	% White Alone	% Hispanic / Latino	Living in Poverty	Graduated High School
City of Lawrence	88%	12%	82%	21%	13%
Massachusetts	8%	68%	13%	10%	47%
Difference	80%	-56%	69%	11%	34%

Source US Census Bureau

---The threat of diminished access and inequitable care for our socially vulnerable community. Despite high interest in health equity, hospital services provided in lower income cities that rely on MassHealth cannot cross subsidize large Medicaid shortfalls with low commercial rates. As the most recent CHIA data above illustrate, private commercial insurers pay Lawrence General 63% to 82% of the statewide average. These lower prices are paid to Lawrence General and other hospitals who provide a substantially higher share of health care to the highest concentrations of non-white, Latino and populations of color, as demonstrated by the Lawrence and Massachusetts census data above. Unwarranted, dramatically lower payments warrant policy changes. Lower payments paid to urban safety net stand-alone hospitals is threatening access and services. They reduce the opportunity for the lowest paid and most cost-effective providers to invest in staff, equipment, and technology. Higher payments paid help providers grow stronger, expand capacity and gain volume by making investments in physical expansions and by paying higher wages to attract clinicians and staff.

---Medicaid cost containment, as evidenced by HPC charts showing the most modest cost growth in recent years in Medicaid spending, is noteworthy. Medicaid rates, which are set annually, are lower today overall and for many basic services now than they were several years ago. Hospitals can no longer negotiate rates with Medicaid Managed Care Organizations, who used to pay a premium above Medicaid fee for service rates to high Medicaid hospitals. The Medicaid Model A ACO in this community did not yield adequate surpluses over the past 4 years as the budgets were reduced for expected savings and were tied to risk scores which aren't reflective of the community reality and are more related to non-EPIC providers less successfully capturing important information. Lower Medicaid rates, the inability to negotiate Medicaid Managed care rates, and Medicaid ACO deficits reduce essential financial support and important financial resources that allow for the provision of critical access for hospital care for the City of Lawrence. The weakening of Lawrence General

will clearly exacerbate healthcare disparities.
---Dramatic differences between commercial rates and Medicaid rates for the same service is at the heart of the double disadvantage for higher than average Medicaid providers who also have lower than average commercial volume. Rates paid for high volume Medicaid outpatient services like imaging have been reduced substantially since 2018. For example, Medicaid paid $208 for a mammogram in 2018 but pays $115 in 2022. Meanwhile, a 2021 CHIA report found the average reimbursement for a mammogram in Massachusetts was found to be $315. There is no difference in the qualifications of the staff, nor the equipment, nor the radiologist's credentials for reading the mammogram. But the average is 2.7x more than the Medicaid payment of $115 and the Medicaid payment is only 36% of the average. This kind of difference for a high volume service does achieve cost savings but it impacts the viability of the high Medicaid providers who are providing care for less today than years ago. This ultimately contributes to inequities in access, and a deterioration of the financial strength of low commercial rate, high Medicaid volume providers – the providers who have the greatest opportunity to reduce disparities for the populations the CDC and other authorities have designated as having poor health and who are socially vulnerable.

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

We hired two national performance improvement firms to wring savings from our hospital in order to preserve access and services in the City of Lawrence.

We have aligned with an in-market competitor provider and plan to jointly recruit physicians. We continue to advocate for equity and hospital relief by sharing our dire financial outlook and insufficient cash to maintain acute care hospital services in the city that has the Commonwealth's largest community of color - 89% according to the census.

We sought and successfully grew top line revenue pre-pandemic by expanding services, and in 2014 and 2017 went to the public debt market and borrowed $100M to improve our ICU capacity and built a new state of the art surgical building to replace 50 year old operating rooms and post anesthesia care units, and recruited specialist physicians such as orthopedic trauma to support our high volume Level III American College of Surgeons accredited Trauma Center.

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 measurable results in other activities your organization has undertaken to advance health equity.

We continue to make progress and embrace the new standards that the Commonwealth is advancing currently. The opportunity to earn 15% of our health equity incentive payments

from the Medicaid Waiver for capturing 80% completeness by year 3 will provide new resources for training and IT data capture that will accelerate robust data collection.

We have engaged the community in listening sessions organized in conjunction with our elected representatives, we have an active and highly engaged DEI Committee of the Board of Trustees and DEI leadership that represent the community and who serve in clinical roles at the Hospital. Health equity has been our mission for 147 years.
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d.Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

Require commercial insurers to pay the five remaining, independent, high Medicaid community/teaching hospitals, each of which serves a large community of color, the average statewide relative price, and require Medicaid to pay higher rates than they do to preserve access.

Lawrence has been hit the hardest by COVID-19 of any Massachusetts City or Town

City	Total confirmed COVID-19 cases	Rate (per 100,000)	
Lawrence	40,800	46,419	***#1 rate by every measure - City of Lawrence***
Chelsea	16,770	45,341	
Boston	207,201	29,815	
Springfield	65,517	41,791	
Worcester	63,382	32,984	

Source: Boston Globe Town-by-Town COVID-19 Data Jan 1, 2020 - Oct 15, 2022

The unmitigated cost impact of the pandemic in Lawrence, followed by the daunting operational and financial impact of workforce shortages, has left Lawrence General in an untenable financial position that will clearly impact vital services. We face the specific challenge of anticipating and projecting for policy makers that we have will have insufficient cash to continue services without a remedy this year. It is a significant market failure that the predictable weakening of safety net hospitals over the course of the last five years will result in reduced access to healthcare in cities like Lawrence where it is needed most to advance health equity. Given the volume of care provided by LGH to the entire Merrimack Valley, the inability of other providers to absorb our volume, and unavoidable reduction in access to key services, this will be a public health crisis.
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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	5	13
	Q2	3	13
	Q3	5	10
	Q4	5	8
CY2021	Q1	16	15
	Q2	11	21
	Q3	10	4
	Q4	6	6
CY2022	Q1	10	0
	Q2	4	0
	TOTAL:	75	90