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:

The COVID19 pandemic has significantly impacted the daily work of our providers and staff. In March 2020, we responded to COVID-19 pandemic by making several fundamental changes. First, we focused our Urgent Care location and staff on caring for all patients with respiratory symptoms while using an integrated team spaces for patients with non-respiratory concerns. Secondly, we switched approximately two-thirds of our in-person primary and behavioral care visits to telemedicine. Even our Dental and Eye Departments delivered a percentage of care via telemedicine. Despite during some care via telemedicine, our Dental Department had to furlough 38 staff members. Lastly, with schools being closed, our school-based health centers shuttered. Nevertheless, many of our school-based health providers and staff led and worked in our COVID-19 testing and vaccination work. Currently, our primary care providers deliver 20% of patient care via telehealth, and our behavioral health providers 40% of care via telehealth. Staff, including nurses, medical assistants, and front desk staff, also did remote work throughout the pandemic when possible, including rooming patients and conducting appropriate screenings remotely, and doing follow-up on COVID-19 results. Currently, the majority of our staff have returned to on-site work. Other factors that impacted our providers and staff were the closure of schools and childcare centers, which made it very difficult for our staff to continue to work their regular hours. Remote learning also offered a unique challenge, as many providers and staff worked at home while also trying to manage households. Limited supplies of PPE at the beginning of the pandemic created sense of fear in some of providers and staff, and there are many who want to continue to work remotely. Our ability to recruit and retain staff and providers continues to be a daily struggle. The biggest gap currently is in recruiting and retaining nurses and medical assistants. Many, if not all, of the schools that trained Medical Assistants closed during the pandemic creating a gap in new entrants to this field. Many behavioral health providers have also left, as many organizations offer 100% of work remotely for behavioral health services. Providers and staff throughout our organization report feeling burnt-out from the long hours and rapid pace of change over the last 21 months.

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):

Deferred care during the height of the pandemic created increased current demand for primary and behavioral health care, and for the first time, we have long wait lists for all our services. We have growing wait lists for our patients with chronic illnesses who we need to get in for follow-up, for patients new to the health center, and for patients for behavioral health services. The increase in anxiety and depression-related referrals has been astounding. We have plummeted in our quality of care indicators in such areas as hypertension and diabetes management, as well as depression screening, but are recovering as we see more patients in-person. Throughout the pandemic we have prioritized our SUD treatment services, and so have been able to keep pace in this area. We have offered telephone and video services to our patients to maintain ongoing care in some form, but many or our patients lack the resources for video visits. A core group of patients have continued video visits for behavioral health, and for the most part our telehealth services are via telephone and not video. The number of patients that we have identified as food- or housing-insecure has grown and we intend to continue investing in support for these patients, and in establishing warm handoffs with other human services agencies.

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 exacerbated any disparity and inequity that existed prior. Going forward, issues of mistrust and of ambivalence will be more explicitly stated by various constituencies. There will be increasing demand for care teams that reflect the diversity of the population served (and in many different ways, not simply race or ethnicity). There will be increased demand for convenience, allowing patients to choose between email, text, video, phone or in-person. We intend on increasing our investment in the "convenience sector", which will include higher emphasis on walk-in capacity. We also expect our workforce to want increased flexibility in work hours and mode, more support in pursuing their career goals and concrete deliverables on paying living wages (everyone making in the $ 30/hour range). We also expect the non-licensed percentage of the workforce to increase, and to have decreased availability of all types of providers. Our percentage of advanced practice providers will continue to increase compared to that of physicians.

Throughout the pandemic, we had to keep a close eye on the specific changes the MA State Professional Licensing Boards instated regarding telehealth. First, there were significant policy implementation delays that impacted our behavioral health students and license-eligible behavioral health providers' ability to care for patients via telehealth. These delays in policies created anxiety and confusion among all of our staff, specifically our independently licensed

behavioral health providers who supervise our students and unlicensed providers. This anxiety and confusion caused, and to some extent still does, fear among unlicensed providers that they will not be eligible for licensure because of their work during this time and fear among the independently licensed providers that their license would be revoked if they were found not to be in compliance with Professional Licensing Board policies. Second, there were no clear policies for behavioral health students and unlicensed providers' requirement for what counted as "supervision." For example, there were significant delays in policies or guidelines stating whether supervision via phone or video would count towards the hours required for becoming independently licensed. If their supervision did not count, the hours of experience during this time could have been questioned as well. Given these uncertainties, our health center backed away from some opportunities to recruit new trainees, hindering our ability to build our recruitment and existing workforce pipeline efforts for behavioral health providers to work in a community-based setting. Lastly, we continue to struggle with significant delays in licensure applications processing, particularly for some applicants (Spanish speaking) being scrutinized and made to overcome additional hurdles, despite these providers filling a crucial gap in care at our community health center. Discrepancies among professional licensing Boards regarding requirements related to supervision and mode of service delivery (phone vs televideo) also create confusion when trying to develop the behavioral health workforce with providers from a range of disciplines.

Fortunately, per the state of the emergency, payors were required to reimburse behavioral health services provided via phone and/or teleconferencing. This allowance was hugely beneficial first and foremost for our patients, but also for our student trainees and unlicensed staff. Our show rates increased dramatically, meaning more patients were getting consistent care in a time of stress and uncertainty, while supervisees were getting more experience. Moreover, these folks were able to continue their training and professional development in the pandemic with the guidance of their supervisors to help them navigate best practice in the context of this new delivery model. In a short time, systems of remote communication for supervisees and supervisors became quite seamless, reducing the initial anxiety and concerns over working in separate locations. Now back in the office, it continues to be beneficial for supervised therapists to provide therapy via telehealth both to improve access for patients but also because it has become a standard model of BH care and important in professional development.

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.

Uniform Data System (UDS) information is collected at multiple access points for our patients. This information is collected as part of the creation of patient's record and is performed by our registration staff. Information is then regularly updated when patients call to schedule an appointment, present for an appointment, or when we complete the pre-registration process. Other entry points where this information is collected are the call center, front desk, referral navigators, and enrollment – all these being departments with direct patient contact. Past and present barriers which made it challenging for staff to collect information consistently were: (a) During pandemic we were short-staffed and most of the visits were conducted via phone, with a few being virtual video visits, making it difficult for staff to capture / update information as providers were calling patients directly; (b) Staff from multiple areas (other than registration), not familiar with the details of registration process, were registering patients; (c) Checking-in for an in-person visit through a plexiglass barrier, and with other patients waiting around, made it difficult for staff to obtain such detailed information via verbally communicating with the patient; (d) Staff turnover made it difficult to ensure consistent compliance; (e) Immigration policies in the past have caused patients to be more skeptical and to hold back their information. Our response: As part of our effort to collect information, some of the past and present measures are (a) Implemented indicators in our EHR as hard stops so staff could not bypass the required fields; (b) UDS collection specific training is provided to newly hired staff during onboarding; (c) Periodic training is provided to all support staff on the importance of UDS collection and creative ways to ask the patient for information; (e) Creating a Patient Registration Form in multiple languages and we are in the process of finalizing the workflow and making it mandatory to be given to the patients and filled out prior to the visit. Form will then be collected by front desk and information is updated accordingly in patient's record; (d) Reinstating weekly reports to audit compliance with UDS data collection and quality.

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.

No data available

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**		
	Q2		
	Q3		
	Q4		
CY2020	**Q1**		
	Q2		
	Q3		
	Q4		
CY2021	**Q1**		
	Q2		
	TOTAL:		

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	Number of Patients whose bill was discounted based on sliding fee
CY2019	**Q1**			108
	Q2			125
	Q3			117
	Q4			112
CY2020	**Q1**			155
	Q2			72
	Q3			67
	Q4			64
CY2021	**Q1**			42
	Q2			49
	TOTAL:			**911**