MASSACHUSETTS
HEALTH POLICY COMMISSION

2023 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 2023 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 27, 2023**, please electronically submit testimony as a Word document 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 2022, 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 Office of the Attorney General (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.

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INTRODUCTION

This year marks a critical inflection point in the Commonwealth's nation-leading journey of health care reform. As documented in the Health Policy Commission's 10th annual Cost Trends Report, there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses, including:

- Massachusetts residents have high health care costs that are consistently increasing faster than wages, exacerbating existing affordability challenges that can lead to avoidance of necessary care and medical debt, and widening disparities in health outcomes based on race, ethnicity, income, and other factors. These high and increasing costs are primarily driven by high and increasing prices for some health care providers and for pharmaceuticals, with administrative spending and use of high-cost settings of care also contributing to the trend.
- Massachusetts employers of all sizes, but particularly small businesses, are responding to ever-rising premiums by shifting costs to employees through high deductible health plans. As a result, many employees are increasingly at risk of medical debt, relying on state Medicaid coverage, or are becoming uninsured, an alarming signal of the challenges facing a core sector of the state's economy.
- Many Massachusetts health care providers across the care continuum continue to confront serious workforce challenges and financial instability, with some providers deciding to reduce services, close units (notably pediatric and maternity hospital care) or consolidate with larger systems. The financial pressures faced by some providers are driven, in part, by persistent, wide variation in prices among providers for the same types of services (with lower commercial prices paid to providers with higher public payer mix) without commensurate differences in quality or other measures of value.

The HPC report also contains nine policy recommendations that reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 and 2024 prioritize modernizing and evolving the state's policy framework, necessary to chart a path for the next decade.

This year's Cost Trends Hearing will focus these policy recommendations and on the efforts of all stakeholders to enhance our high-quality health care system in Massachusetts to ensure that it is also affordable, accessible, and equitable.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the findings of the HPC's 2023 Cost Trends Report showing concerning trends of high and increasing health care costs and widening health disparities based on race, ethnicity, and income, please identify and briefly describe your organization's top 2-3 strategies for reducing health care cost growth, promoting affordability, and advancing health equity for residents of the Commonwealth.

UMass Memorial was created by an act of the legislature 25 years ago and has a legal obligation to support the state's only public medical school (UMass Chan Medical School), provide care to the indigent populations of central Massachusetts, and provide services otherwise not available to the people of Central Massachusetts. We meet these obligations by making significant payments to UMass Chan, providing free clinical education and faculty to UMass Chan medical students, serving as the safety-net provider for central Massachusetts, serving as the only tertiary referral center and only academic medical center outside of Boston, and serving as the only level 1 trauma center with pediatric designation outside of Boston. Funding from the state to UMass Memorial primarily comes to us in the form of MassHealth payments and Medicaid Supplemental Funding. In fiscal year 2022, our last audited fiscal year, these payments totaled $741 million. The cost associated with providing care to Mass Health beneficiaries and supporting UMass Chan was $1,063,061 leaving a shortfall of over $300 million. This does not include the cost of supporting faculty time to educate medical students, which is estimated to be another $80 million. In addition to losses on state programs, we also lose money on federal programs, albeit to a much lesser extent.

Our goal in setting our commercial rates is to make up for the shortfall between the cost of meeting our obligations to the state and losses on federal programs while assuring the long-term viability of central Massachusetts' safety-net health care system and the state's only public medical school. Over the course of our 25 years of existence, we have been able to break even on our core operations ~ 50% of the time. In FY 2022, our loss on core operations was ~$220M. Liquidity was maintained by selling equity in one of our joint ventures which, unfortunately, will significantly affect our distributions and the ability to support the losses on state programs in the future.

Despite the hefty obligations placed on us—and only on us—by the state of Massachusetts as well as the immense challenges facing health care systems today, UMass Memorial remains committed to reducing costs and reducing health disparities by leveraging the tactics described below.

1. **Investments in Administrative Simplification:** UMass Memorial Health (UMMH) has made significant investments this year to simplify administrative processes and leverage technology for improved efficiency and reduced costs. Some investments include:
    - Consolidating administrative systems through Workday: In 2022, we embarked on a transformational journey to modernize our human resource, finance, supply chain and data/reporting systems by transitioning to a best-in-class, cloud-based

enterprise resource planning platform called Workday. With a planned go-live at the start of calendar year 2024, this new integrated system simplifies our way of working and replaces more than 40 of our current systems. The platform will enable us to streamline and automate many administrative processes, allowing us to deliver more value to our caregivers, patients, and community. Workday will become our home for all caregiver personal and job-related information, expense reporting, fiscal management, as well as purchasing and inventory activities. This effort joins various corporate functions into single teams to support the enterprise. We expect the combination of team consolidation and standardization of work to free administrative resources up for more advanced analysis and consultative support to our caregivers.

- EPIC and AI Efficiencies: UMMH invested in Epic as core electronic medical record system in 2017. Since then, UMMH has maximized this investment by creating an environment whereby new features and functionality can be selected and adopted rapidly. In October of 2023, we extended EPIC to Harrington Hospital, the newest addition to the UMMH system—allowing this group of providers and caregivers to leverage the same tools as others in our system. Our continued focus on optimizing the UMMH Epic environment has led to patient care and provider productivity enhancements. For a second year in a row, UMMH has been recognized by Epic as a "Gold Star 10." The Epic Gold Stars Program measures how effectively an organization is using the EMR and provides a road map for improving clinical and financial outcomes. Organizations that achieve the highest level (10) are deemed cutting-edge and leaders in EMR use.

  At the same time, UMMH has purposefully invested in AI technologies to improve care and allow providers to maximize time with patients. Some examples include:
  - Dragon Ambient Experience (DAX) captures the audio of a patient/physician interaction, then uses AI to generate a provider note. This process creates draft physician documentation for edit/review instead of the provider pulling information together to create the note.
  - Epic AI creates draft inbox responses to patient inquiries. Providers can then edit messages rather than creating a full response, saving time for providers and allowing for faster responses to patients.
  - Chat GPT summarizes activities and changes to the patient record since last visit, which consolidates information for the provider and frees up time to focus on the patient.
  - AEYE, aidoc, and other programs read images to detect conditions that may or may not be recognized by humans.

- Using AI and data analytics from Epic helps identify patient conditions – discharge readiness, deterioration, need for advanced therapeutics, etc. – to facilitate quicker provider intervention.
- Remote patient biometric monitoring via a virtual platform allows providers to more closely manage and improve chronic conditions such as hypertension, diabetes, COPD and heart failure.

2. **Investments in Value-based Care and Innovative Care Delivery Models:** In the last few years, we've made significant investments in new value-based programs and innovative care delivery models with a goal of reducing total medical expense and increasing quality of care and overall health, particularly among underserved populations. Some of these include:
    - **MassHealth ACO:** In April of this year, in partnership with Point32 Health/Tufts Health Public Plans, UMass Memorial launched the Tufts Health Together with UMass Memorial Health ACO, which provides health coverage to about 50,000 MassHealth members in central Massachusetts. Through this new program, we've been able to provide more comprehensive and coordinated care to members with behavioral health and other complex conditions through partnerships with Point32 Health's team of complex care managers, flexible spending program partners, and behavioral health (BH) and long term supports and services (LTSS) community partners. Embedded in each of these programs and partnerships is a goal of keeping patients out of the emergency department and reducing readmissions.
    - **Medicare Value-Based Programs:** We've continued to invest in a range of value-based Medicare programs. We have participated in the Medicare Shared Savings Program since 2015 which now covers 46,000 members; we've achieved net total medical expense savings of $45 million through reducing our cost growth at a greater pace than those in our region. In 2021, UMMH became one of the largest participants in the Primary Care First Program, a voluntary five-year Medicare value-based program, with 52 practices and 26,000 Medicare beneficiaries participating. We continue to participate in the Medicare Bundled Payment Program, the expansion of a voluntary program, which we originally joined in 2015. This program provides longitudinal care for patient in orthopedics, spine, neurology and gastroenterology for 90-day periods following a patient's qualifying acute health care event and has consistently achieved net savings in total medical expense of an average of $1million annually. Finally, UMMH invested in a MassAdvantage Plan, now in its 2nd year with close to 2,000 members. This program, while new, has already reported high, star quality of care and patient satisfaction scores as well as meeting health plan spending targets; the goal of UMMH's investment is to achieve both optimal care options

for Medicare beneficiaries in the region and administrative simplification for our providers.

- **Urgent Care Partnerships:** In 2015, UMass Memorial Health launched a collaboration with Carewell Urgent Care to open two UMass Memorial-affiliated Carewell Urgent Care Centers in Worcester. Today, we support 7 urgent care locations across our service area. With more than 8,000 Urgent Care encounters each month, these investments have helped reduce the number of Emergency Department Visits—and their associated costs—within our system. All these urgent care centers accept patients enrolled in coverage through MassHealth, and four centers are located in low-income neighborhoods where many MassHealth enrollees live.
- **Ambulatory Surgical Center:** In 2018, UMass Memorial Health—in partnership with Shields and Reliant Medical Group, launched the Surgery Center in Shrewsbury, MA. In 2022 alone, nearly 4,000 surgeries were conducted in this lower-cost setting. We continue to identify new ways to maximize this lower-cost facility to improve surgical efficiency and ensure the right acuity cases are receiving care in the most appropriate setting.
- **Hospital at Home (HAH):** Described in our 2022 testimony, we initiated the HAH in the summer of 2021 as a key part of our strategy to expand our patient capacity, reduce costs and improve outcomes for low-income patients. We are learning that this program has successfully reduced total costs, with 20-30% reductions in 30-day readmissions and 80-90% reductions in transfers to skilled nursing facilities (SNFs) when comparing the HAH program relative to hospitalist service benchmarks, noting that both findings are supported by randomized controlled trials. Additionally, the program has had impressive outcomes for our most disadvantaged patients. For example, while the average 30-day readmissions were reduced by 20-30% across the HAH patient population, when you look just at Medicaid and dual-enrolled patients, the reduction in 30-day readmissions is closer to 50-60%. This unique model for delivering lower acuity hospital-level care positions our staff to more readily identify social needs and other challenges facing patients—and find ways to address them.
- **Mobile Integrated Health (MIH):** Described in last year's testimony, our MIH program was launched in June 2021 as a strategy to reduce ED and hospital admissions by sending paramedics into patients homes to provide services and interventions. During 2023 we utilized this service for 264 visits to over 160 patients' homes. These patients are part of our value-based programs and have consented to this service whereby they call a triage line rather than going to the emergency department when care is needed. In cases where the trained paramedic triage provider assesses that the MIH paramedic team can be deployed, an emergency department visit is avoided. 77% of the patients

enrolled in this service have had no emergency visits within the 30 days following the MIH visit and 54% have had no visit with the following 3 months.

- **Road to Care:** Described in last year's testimony, the Road to Care program provides mobile addiction services to central Massachusetts residents and is designed to provide more coordinated and accessible behavioral health services to the most at-risk (and high cost) patients. In addition to providing behavioral health services, the road to care team supports preventive and wound care and coordinates referrals to a number of primary care and specialty programs. While the program aims to help reduce the barriers to accessing behavioral health services for marginalized populations, we still see fewer African American and Hispanic patients accessing this service compared to the greater Worcester population.

3. **Prioritizing Health Equity:** UMMH has garnered wide commitment—from our Board of Trustees to frontline caregivers—for health equity investments with meaningful results. Over the next few months, we'll be working to better align the many ongoing efforts to ensure long-term sustainability and progress. These investments help address the disparities that cost our system money in the long term. The following provide some updates on our health equity efforts, building off the longer list submitted in our 2022 testimony:
    - **Equity and Inclusion Seed Fund:** UMMH is committed to innovation, process improvement, and LEAN management—acknowledging the best ideas come from caregivers at all levels within our organization. Last year, we launched a 'health equity and inclusion seed fund' to provide funding for caregiver ideas that drive health equity improvements in our system and community. So far, we've provided $360,858 to implement 25 caregiver ideas including translation of patient materials into more languages, hiring a pilot community health worker to support clinics in social need follow-up, the addition of inclusive artwork for the community women's care clinic, and the provision of wigs and head coverings to oncology patients.
    - **Anchor Mission and Place-based Investments:** Five years ago, the UMMH Board approved the system's 'Anchor Mission', a commitment to leverage our power and resources to drive upstream changes in social determinants of health and equitable community development. So far, we've invested more than $4M into local projects across central MA to address the growing housing crisis, support small business, and provide needed social services. This spring, our first investment was paid off when two low-income, Worcester families moved into their new homes as first-time homeowners. We've also doubled the amount of money our organization has spent with minority and women-owned businesses—one small step in leveling the racial wealth gap in the Commonwealth. These investments and have a direct impact on the financial

stability of individuals directly receiving the benefits and a more broad-based impact by stabilizing and reducing disparities of the communities we serve.

- **1115 Waiver Equity Incentive Program:** In the last year, we've shifted several staff members to focus on the implementation of the 1115 Waiver Equity Incentive Program and the corresponding requirements from the Joint Commission and CMS. We've benefited from a talented group of health equity experts across our system as we've put plans into action. We've convened teams to explore how we can improve the delivery of care to be more linguistically and culturally appropriate, how we can better train our caregivers on implicit bias and health equity, and how we can update our approach to providing meaningful accommodations to our patients with disabilities. We've also made significant investments to collect more demographic data from our patients—to help us identify and dismantle disparities in care provision and health outcomes—and to identify patients with social needs and link them to resources.
- **Disparity Improvement Projects:** Over the last three years, we've identified a 'True North' Metric—one of the 10 metrics tracked most regularly by our senior leadership—focused on reducing the racial/ethnic disparities in health outcomes. Our 2023 metric focused on colorectal screening. While we increased the screening rate among our BIPOC patients over the last year, we still have more work to do to further reduce the disparity, an effort that will continue through the equity improvement plans submitted to the Joint Commission for each of our hospitals. Our planned ACO-hospital partnered health equity performance improvement plan will bring together caregivers in care management, the emergency department, and behavioral health to improve and reduce disparities in follow-up after ED behavioral health visits over the next three years.

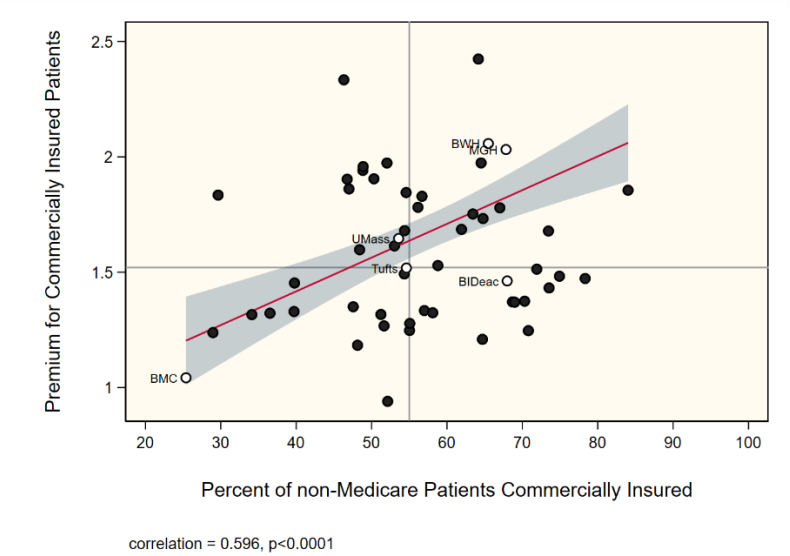
b. Please identify and briefly describe the top state health policy changes your organization would recommend to support efforts to advance health care cost containment, affordability, and health equity.

1. **Modernize cost containment policies:** While in general, UMass Memorial Health supports the policy recommendations to modernize the Commonwealth's benchmarks framework and constrain excessive provider costs (the HPC's first and second policy recommendations), we believe this must be done in a nuanced and thoughtful way. Under the Commonwealth's cost containment law, the Massachusetts Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA) currently monitor commercial reimbursements relative to a percentage-based, year-over-year benchmark that does not take into account governmental payor mix. This cost containment strategy favors systems with higher baseline costs, while disadvantaging those that serve low-income and underinsured residents. For a system like UMass Memorial Health, our higher cost competitors can afford lower rates of increase to their commercial rates because they are starting at a higher commercial base rate and they

have a higher percentage of commercially-insured patients. Disproportionate share systems like UMMH with a high public payor mix have a lower commercial payor base to which any rate increase is applied, resulting in lower total revenue.

Further, common logic suggests that higher commercial prices help offset losses for public payer patients (or at least patients covered by Medicaid)—however, an analysis of CHIA data shows the opposite. Providers with higher commercial prices actually see fewer public payor patients (see Figure 1).

Figure 1: Graph of commercial prices (standardized to Medicare PAF) vs. Payor Mix



With this in mind, we believe the HPC should not rely solely on commercial prices for determining cost containment strategies, but should also consider average prices across all payors in a system. By adding this metric to the HPC's cost containment analysis, the Commission can ensure that new cost containment strategies don't further disadvantage systems providing safety-net care to the Commonwealth's most disadvantaged residents. We recommend another strategy that would promote health equity while also containing costs—the addition of an absolute 'floor' along with an absolute 'cap' on prices. A floor would prevent hospitals from falling below price levels that enable delivery of quality and safe services while supporting long-term financial solvency—a key contributor to the ongoing availability and affordability of care across the Commonwealth.

2. **Reduce Pharmaceutical and Administrative Costs:** In line with many of the findings of the 2023 Cost Trend Report, a 2018 JAMA article examined the disproportionately high costs of health care in the U.S. compared to other high-income countries around the world—finding that despite similar utilization rates, the U.S. spent twice as much as others on health care. The authors found that the major drivers of this cost differential can be linked to administrative costs, workforce costs, and pharmaceutical costs.[1]

[1] Papanicolas I, Woskie LR, Jha AK. Health Care Spending in the United States and Other High-Income Countries. *JAMA.* 2018;319(10):1024–1039. doi:10.1001/jama.2018.1150

We support the full range of recommendations provided by HPC for enhancing oversight of pharmaceutical spending (policy recommendation 3)—and even recommend that the Commission and legislature go further in setting pharmaceutical prices to ensure affordability for all.

Administrative complexity contributes to higher costs within our system — costs that can't be avoided until and unless the system changes. This means the state should require greater standardization in payer process, automate prior authorizations, and mandate adoption of aligned quality measure sets, as stated in the Commission's sixth policy recommendation. Our system's administrative staff spends significant time on prior authorizations and different requirements among payers. Similarly, our quality and clinical integration teams spend time making sense of slightly different quality metrics, building slightly different versions of dashboards, and implementing nuanced programs that could have a broader reach if implemented in a payor agnostic way if metrics and requirements were standardized across payors.

While our system supports the increasing focus from the 1115 waiver on health equity and the ability of the new incentive program to provide funds and accountability for health equity activities, the new administrative requirements for this program have required substantial staff time that could have been repurposed to the actual implementation of health equity initiatives to reduce disparities and promote a culturally and linguistically welcoming environment for our caregivers. As an example, our system will have submitted 23 deliverable documents by the end of the year describing our planning and key contributors to our hospital-ACO partnered Performance Improvement Plan for reducing disparities in follow-up after an ED behavioral health visit. While we've assembled a skilled team across our 4 hospitals and ACO, the time spent filling out duplicative forms that easily could have been submitted together has reduced our ability to think creatively and advance meaningful change within our organization.

3. **Increase state investment in whole-person health and social services outside the clinic:** In the 2018 JAMA article referenced above, the authors identify that the U.S. spends on average less on social service when compared to other high-income countries (16.9% GDP for the US vs. 19.4 for all 11 countries in the analysis). The biggest challenge to meeting the requirements regarding social drivers of health screening is not in our system's internal ability to screen patients or even to provide referrals or information on programs in the community—it relates to the quality of the referral if no organizations have capacity to take on more clients. The need for well-resourced social service organizations in the community is now more important than ever.

   Additionally, the meaningful tracking of success in linking patients to social drivers of health resources depends on a platform that provides an interface been healthcare and social service organizations. UMass Memorial Health has invested in the findhelp.org platform (previously Aunt Bertha) since 2018 in partnership with Reliant Medical Group to create a central Massachusetts resource repository. While this platform has been vital to our ability to share resource information with patients and caregivers, we've had minimal success in tracking whether referred patients receive services. This is largely due to the limited capacity of organizations to use the platform and update the status of

referrals. Without incentivizing community service organizations to share information back with hospitals, our ability to create a closed loop referral will remain limited. One solution is a state-supported system that includes incentivizing community service organizations to participate and use the system—as several other states are implementing now.

In addition to social service supports, the state must find more ways to increase the availability and accessibility of behavioral health services and post-acute care. As the Commission pointed out, one key driver of health care costs is the unnecessary ED visits and longer than needed hospitalization; without capacity in community-based behavioral health and post-acute organizations, our ability to decrease the length of hospital stays and ED visits will be severely hampered.

Finally, addressing structural racism and growing inequities in our communities requires innovate and creative solutions. Burdensome and inflexible processes stifle innovation. We encourage EOHHS to continue to find creative ways to leverage existing processes for meaningful and innovative solutions—like the Determination of Need Process associated with major capital expansion projects. We've been encouraged by EOHHS's willingness to consider innovative funding arrangements such as long-term, place-based investments that address social determinants of health further upstream, in addition to grants. We believe that only with concentrated long-term investment in partnership with local residents can we begin to turn the tide of inequities outside and inside the clinic.

4. **Provide state support for the Commonwealth's only medical school:** The state of Massachusetts is blessed to have a world-class public medical school. UMass Chan is an amazing state asset that has generated significant economic, scientific, and educational benefits to the state. We believe in public education, and we believe UMass Chan is worthy of the state's support. Medical students from across the Commonwealth and now from states outside of Massachusetts greatly benefit from the outstanding education provided at UMass Chan. Unfortunately, rather than spreading the cost of educating the next generation of doctors, nurse practitioners, scientists across the state, the enabling legislation (described above) puts this responsibility primarily on UMass Memorial Health and the citizens of central Massachusetts. Even if this made sense 25 years ago, it makes little sense now that the school has expanded to three campuses located in eastern, central and western Massachusetts. The state's assets, which were given to UMass Memorial 25 years ago, have been repaid several times over with interest. We believe it is time for the state to take a close look at the obligations placed on UMass Memorial at that time and assure that the cost of supporting the state's only public medical school is spread across the entire state rather than inequitably placing it on UMass Memorial Health and the communities we serve.

c. Many Massachusetts health care providers continue to face serious workforce and financial challenges, resulting in the closure and reorganization of care across the Commonwealth. How are these challenges impacting your organization today? What steps is your organization taking to address these challenges?

The workforce and financial challenges for our healthcare system have had profound impacts on our hospital operations and decision making over the last year. We began our 2023 fiscal year with 1,889 vacancies across our system (not including physician, CNRA, NP or PA positions) and spent $149M during calendar year 2022 on traveler positions to fill priority vacancies across our system—up from $62M in calendar year 2021. In fiscal year 2022, our core medical costs outpaced revenues by over $200 million, largely driven by the high costs of labor and supply chain purchases.

We've had to make several tough decisions over the course of the year resulting from the workforce realities impacting the healthcare industry. At the top of the list was the closure of inpatient maternity services at our Health-Alliance Clinton Hospital in Leominster, MA on September 23rd, 2023. Because maternity care is highly specialized, it has been difficult to maintain adequate physician and clinical staffing during and following the pandemic. This, along with the steadily declining number of births at the hospital, significantly impacted the sustainability of this inpatient service and ultimately threatened our ability to staff the unit sufficiently to continue to provide safe care. To minimize the negative impacts in the local community, we held numerous listening sessions and stakeholder meetings, created a transportation solution for birthing people with transportation barriers, and committed nearly $600,000 to support access and resources for birthing people and infants in the region. To be clear, this decision was not a financial one, but a matter of ensuring our ability to provide high-quality and safe care for all birthing patients in the region.

With significant effort and many difficult decisions, our fiscal situation improved over the course of the last 12 months, we ended the 2023 fiscal year with only 832 vacancies (well below half of the vacancies at the beginning of the year). In the first six months of calendar year 2023, we've only spent $7.2M on travelers in priority positions (about 10% of what we spent in 2022). This year, our new hires outpaced those who left the organization, a welcomed trend after the last few years of sluggish retention. Additionally, we plan to report our financial status for FY 2023 to be much improved over the prior year. To accomplish and maintain these improvements, our system is implementing numerous efforts to address our workforce challenges—both with a goal of promoting diversity and equity within our caregiver population and moving toward a sustainable financial future for both our system and the families of our caregivers. These strategies include:

- Launching a new workforce development function to grow our own talent and expand our pipelines for untapped talent in our local communities. We are investing in our own caregivers using 'earn and learn' models like registered apprenticeship programs. We are starting with three career pathway programs that will upskill our lowest wage earners into higher paying jobs while at the same time filling critical vacancies for medical assistants, surgical technologists, and patient care associates.
- Executing a staffing management plan that addresses the evolving workforce marketplace and optimizes our talent acquisition practices to recruit the best talent for roles at all levels and to further develop a more diverse workforce. This means—in addition to other tactics—exploring how we can attract applicants from talent pools like young adults and new Americans—and finding ways to support and encourage their success.

- Delivering Benefit and Wellness programs that provide greater flexibility and equity to serve the needs of our entire workforce and help caregivers and their family members access, understand, and maximize the use of their benefits.
- Investing in union collective bargaining agreements that resulted in new contracts that increased wages, a key action for attracting and retaining employees and reducing our reliance on agency and temporary staff. We partner with our unions in non-traditional ways, too. For example, in partnership with the SHARE Union, we've exponentially increased the number of unit-based teams—frontline-led, department level improvement systems that enable caregivers to work on the process problems that make it hardest for them to feel proud of the care they deliver.
- Aligning and communicating more about our mission. There's strong evidence that purpose at work impacts retention. We are working to help our caregivers see the value and importance of their work in leveling disparities and promoting health for the people of central Massachusetts.

d. Please identify and briefly describe the policy changes your organization recommends to promote the stability and equitable accessibility of health care resources in Massachusetts?

- **Thoughtful policies to support workforce needs:** There are several state and national policies that could help ease the workforce shortage while still ensuring quality standards for healthcare professionals. Our recommendations include:
    - Reversing the associate degree requirement for surgical technologists—or at a minimum allow entry into practice after 1 year of training (similar to a certificate for other technologists). This would help us train and recruit new caregivers into this vital position.
    - Ensuring community college clinical faculty are compensated at a level that is attractive to working clinicians. This could be accomplished by the state providing seed money to establish joint appointment models.
    - Leverage state relationships to advocate for reimbursement for Community Health Workers (CHWs) or patient navigators so that we can fill and pay for this vital skill set within our facilities given the increasing requirement and focus on social drivers of health screening and navigation.
    - Create stronger linkages between state labor and healthcare to ensure that healthcare and workforce development policy makers are sitting at the same table and finding creative solutions together.

- **"Monitoring" as a partnership:** While we agree that the Health Policy Commission can play an important role in understanding the provider market and aligning the supply and distribution of services to match community needs, we hope that this effort can be done in close partnership with the healthcare providers living the reality of care delivery in this challenging and unprecedented environment. Ensuring that our Commonwealth's hospitals and health systems collectively are providing equitable and accessible services is a shared goal of both the state and its hospitals. This is certainly true of UMass Memorial Health which serves as a regional health system committed in our mission to advancing the health of diverse patients across central Massachusetts.

We encourage the Commission to create opportunities for meaningful partnership with hospitals who are making thoughtful decisions about how to best meet the community's access needs while maintaining our long-term financial health. Burdensome processes without partnerships will stifle our ability to adapt easily to changing conditions and still meet the needs of our communities. Examples of opportunities for more meaningful collaboration may include ad hoc conversations with hospital leaders or a more formal partnership with a convening entity like the Massachusetts Health and Hospital Association.

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) 2021-2023			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2021	Q1	24	104
	Q2	21	145
	Q3	14	128
	Q4	14	97
CY2022	Q1	18	130
	Q2	19	119
	Q3	24	92
	Q4	21	94
CY2023	Q1	38	108
	Q2	19	112
	Q3	42	113
	TOTAL:	254	1242