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.

Health Centers are affordable, lower cost providers that have been demonstrated to provide significant savings Medicaid programs and the health system overall when they are adequately resourced. We are culturally competent and center health equity in our work. However, in the high cost and competitive Massachusetts marketplace we struggle to be able to fully implement our proven model of care delivery when we can't secure or maintain adequate staff. Over the last few years, major strides have been made to improve investment and support for CHCs, but more work remains.
Specifically:

- Deferred care – getting patients back into care and remedying exacerbated inequities that emerged during COVID.
- Workforce – recruitment and retention of the full staffing we need for our integrated model of care, and growing the diversity of the workforce.
- (Lack of) affordable housing and impact on patients and health center workforce
- Capital needs – ability to expand our facilities to provide needed services to meet patient demand.

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

- Full implementation of June 2021 agreement for a new FQHC PPS methodology, launched in January 2022, including Change in Scope methodology which is nearing launch, should assist in:
    - Impact on reducing wait lists
    - Expansion of services, like BH and dental
    - Investments in providers and team-based care
- Workforce investments and supports – loan repayment, opportunities for training such as NP residency (several ARPA and 1115 Waiver programs coming) so CHCs can "grow our own" with training in community- and team-based settings.
- Enhanced work on Health Related Social Needs and Social Determinants of Health

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 other specific activities your organization has undertaken to advance health equity.

- CHCs have collected race, ethnicity, and language for patients for many years and documentation is straightforward in EMRs. These data are readily available in population health software as a filter, as well as on an individual basis, providing the ability to analyze care and outcomes within patient populations.

- For CY 2023 Uniform Data System (UDS) submission, FQHCs will be required to submit patient level detail, which would enable further analysis of clinical quality measures by race and ethnicity. In preparation for this upcoming change, the Mass League Health Center Controlled Network has been working with EHR vendors to ensure they will have the functionality available for CHCs to submit their UDS data with patient level detail.
- Disability status is documented with diagnosis codes by providers at patient encounters. However, incorporating disability status into analyses is more challenging at this point in time as there is not a standard way to document "disability" in general (overall) in EMRs. If CHCs are documenting a general disability field, it is not consistent CHC to CHC or EMR to EMR.
- CHCs have made efforts to collect SOGI data since the UDS requirement in 2016. Many have also attended learning sessions facilitated by the HCCN and given by The Fenway Institute to learn how to best implement and overcome implementation challenges.
- MassHealth ACO requirements – ACOs require CHCs to screen for SDOH annually, which has helped to improve screening rates across CHCs.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

- Payment: continue to ensure a move towards reimbursement that is adequate, fair and equitable.
  - Thanks to Baker Admin and strong legislative support, we have just had a major historic correction to years of gross underpayment in MassHealth. The Baker investment in Federally-Qualified Health Centers is deeply appreciated and has the potential to be transformative.
  - Recovering from the history of underinvestment will take time, however, and our new system is being launched in a time of unprecedented labor market tightness and provider shortages.
  - Even as we are still implementing this new payment methodology, a new one is being developed concurrently that will take MassHealth and likely FQHCs to a new primary care capitation.
  - Overall, we think PC cap will be a good thing for primary care providers, for workforce retention, and evolution of care delivery.
  - However, it will be essential that FQHC protections are honored and that we have a chance to validate that the new capitation will adequately finance the requirements of the new medical model, now and in the future. We also will want to ensure that the risk adjustments that are being refined provide protection for those serving high-need and diverse populations.
  - Additionally, as the Attorney General's Health Equity report[1] pointed out, no provider is a single-payer entity. So policymakers must be aware that those of us with high public payer mixes are also operating within a system in which we are competing on performance and for staff with entities that have much higher commercial reimbursement rates and patient mix and those resources are able to cross-subsidize the care provided to MassHealth patients and the staff who deliver care to them.

[1] download (mass.gov)

- Telehealth: Make permanent telehealth policies that provide primary care and chronic disease management coverage and reimbursement parity for both audio-video and audio-only visits- across all payers including MassHealth and Commercial.
- Workforce investments and pipeline programs: continue student loan repayment programs and expand/create pipeline programs to foster a diverse, representative provider and care team workforce in the state; expand health center-based residency programs like HRSA THCGME and Medicaid GME
- Capital and Deferred Care investments such as those in the pending state Economic Development bill (elaborate).

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		
	Q2		
	Q3		
	Q4		
CY2021	Q1		
	Q2		
	Q3		
	Q4		
CY2022	Q1		
	Q2		
	TOTAL:		