



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
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AGO CONTACT INFORMATION

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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.

Tufts Medicine's Mission is to empower people to live their best lives by reimagining healthcare, advancing knowledge, pioneering discovery, and creating the most equitable and frictionless healthcare experience in the world.

Tufts Medicine strives to be a leader in reducing healthcare costs, providing affordable care, and advancing health equity for all patients and consumers. Yet for nearly three years, our health system has faced continuous and unprecedented challenges from supply chain disruption, altered hospital operations, staffing shortages like never seen before and the resulting significant financial distress. We urge all of our governmental leaders to keep our clinicians and care providers – true heroes of this prolonged crisis – top of mind as they make decisions directly impacting our industry.

Workforce Challenges Have Created Negatively Impacted Patient Access

Frontline healthcare workers and clinicians who have been battling COVID-19 for nearly three years have shouldered a heavy toll professionally and personally. They have experienced enormous strain during the surges of COVID-19 and continue to suffer from burnout, resulting in rising numbers of staff leaving the healthcare workforce. The emotional and physical burnout, coupled with ongoing COVID-19 surges, and other existing workforce pressures, have left us with a critical staffing shortage.

Staffing shortages existed before the COVID-19 crisis based on an aging workforce and population that has driven up the demand for healthcare. The pandemic created a domino effect in the medical community, prompting older workers to leave their jobs sooner and creating a boom in the travel medical professional industry that lured people away from their jobs to make significantly higher wages. We are now left with a large number of vacancies that we must fill urgently to maintain patient care services, particularly in areas that require experienced, specialized clinicians such as the emergency department, intensive care units, and operating rooms.

As of August 2022, Tufts Medicine had more than **1,500** open positions, with our total headcount of employees holding steady at around **13,000**. Tufts Medicine's year-to-date (YTD) average fill-to-open ratio was **99.53%** and the **YTD Average Time to Fill** was **76.3** days, **38.7%** higher than our goal. Our projected turnover has increased slightly to **20.8%** (+.05%), based on the continued increasing pressures on our workforce.

The current staffing crisis also affects the patient experience, resulting in longer waiting times in emergency rooms, hospitals, ambulatory clinics and post-acute venues of care. Tufts Medical Center alone was forced to turned away 2,740 patient transfers from other hospitals just this fiscal year (FY22), because of an inability to staff more beds. Improved staffing will help the system see more patients in need of complex tertiary care.

Financial Setbacks

The staffing crisis hit a peak in January 2022 and, like many other health systems, we have increasingly relied on contract labor to care for patients. Tufts Medicine had to hire an unprecedented number of contract nurses, technicians, and call center staff, to ensure our patients had safe access to care. In fiscal year 2022, contract labor accounted for 4% of hospital staff, but comprised 15% of salary expenses.

Like many other hospitals, we deferred elective procedures at certain times during the pandemic, which resulted in many of our patients falling behind in both urgent and proactive care and testing. These factors are contributing to an increased level of acuity in our patients seeking care. Our providers have found patients are arriving or being admitted sicker than they were in the past, causing more expensive levels of treatment than primary preventative care and mandatory closure of elective procedures at multiple points during the 2022 fiscal year have had a serious negative impact on our financial performance.

COVID-19 continues to negatively affect the lives of our patients and providers, as well as our financial outlook. Despite a decline in revenues and increased contract labor expenses throughout the Public Health Emergency (PHE), Tufts Medicine has continued to carry out our mission to support vulnerable populations by investing in community benefits and providing high-quality care to all of our patients.

In addition to increased labor costs and lost revenue due to deferred elective procedures, we continue to absorb costs related to inflation in our facilities, especially in relation to the supplies needed to serve our patients.

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

Recruitment and Retention

Tufts Medicine has launched a series of strategies to address retention, resiliency, and wellness for our workforce. We are making progress on initiatives to foster a supportive work environment built on a culture of inclusion and collaboration where our people can thrive.

We have launched retention initiatives expanding certification reimbursement, and reimagined ways to improve onboarding programs, employee recognition, and flexible work policies. We have developed more professional development opportunities for employees and are offering well-being and resilience-building program benefits to all Tufts Medicine employees. All of these strategies are aimed at increasing retention and growing resiliency across our teams.

Tufts Medicine continues to promote a robust and diverse recruitment strategy. Our system has worked to renegotiate contracts with some contract labor companies to reduce its spending and has aggressively worked to hire more staff to reduce its temporary labor expenses. We have hired more than 4,000 people since December, decreasing spending on contract labor from \$20 million for the month of March to \$8.5 million for the month of July. We have also developed a comprehensive nursing workforce dashboard, allowing us to create targeted retention strategies for nurses with the highest turnover risk. Tufts Medicine has launched a new nursing recruitment strategy, and launched a marketing campaign featuring our "Why Representation Matters" series, which gives individuals an opportunity to speak to their unique identities, cultures, experiences, and perspectives within the broader context of celebrating our differences year-round.

Utilize Other Healthcare Delivery Methods

In spite of the many here-and-now challenges confronting us, Tufts Medicine continues to focus on the future, and how we can deliver a better experience and outcome for patients, while also helping to reduce expenses and address long-term, structural financial constraints. We continue to invest in and grow other healthcare delivery methods, such as value-based care, care at home, hospital at home, and telehealth.

Value Based Care

Tufts Medicine is pursuing a value-based care strategy of growth, alignment, and equity. We are proponents of moving towards value across all payers and patients, but it requires commitment and resources from our government and private payer partners to implement. Models must empower providers to deliver the “right care in the right place”, free of regulatory constraints that run the risk of wasteful spending.

The traditional fee-for-service system only compensates for specific medical services provided. Yet many of the health issues experienced by Medicaid beneficiaries have a connection to social determinants of health (SDOH). Activities and services offered to effectively address SDOH, not typically compensated under the traditional fee-for-service system, are made possible under risk-based value methodologies. Advanced Payment Methodologies are less restrictive in their use since they are focused on outcomes, not procedures. For example, SDOH are a big driver of unnecessary and more costly use of the emergency department and places pressure on already constrained resources. These costs are often greater than the payment we receive from government payers on their health plan contracts.

Our Tufts Medicine Medicare ACO has many innovative value-based programs and in 2021 we had a shared savings of \$6M. One of the programs is Mobile Integrated Health, where we utilize mobile resources to deliver care and services to patients in coordination with healthcare providers, via scheduled in-home or community visits, to prevent avoidable emergency department and inpatient utilization. We also provide a series of clinics through our Care Connect Hub (CCH) in Lowell; CCH Transition clinic, CCH Heart Failure Clinic, CCH Palliative Care Clinic and Lowell General Bridge Clinic. These programs help patients manage their care and prevent avoidable hospitalization.

Care at Home and Hospital at Home

Over the last five months at Tufts Medicine, approximately 700 patients a month left the Emergency Department without being seen due to long waits and hospital access issues. One of the drivers of overcrowded emergency departments is the lack of access to inpatient beds (again, driven primarily by staff shortages and workforce challenges), as well as increased inpatient lengths of stay due to the difficulty in discharging patients to post-acute settings, particularly skilled nursing facilities.

In December 2022, we will launch a Hospital at Home (HAH) pilot at Lowell General Hospital (LGH) and if all goes well, we will roll it out to Tufts Medical Center (TMC) and MelroseWakefield Hospital (MWH) in future years. We are hopeful that the Centers for Medicare & Medicaid Services (CMS) and other payers continue to reimburse for this more innovative care delivery. By moving the lower acuity patients from the hospitals to home, we will free up beds for many of the Emergency Department patients who could not gain access to much-needed inpatient care.

In addition to securing Medicare reimbursement rates for HAH cases with a CMS waiver, Blue Cross Blue Shield (BCBS) announced they too will reimburse the inpatient diagnosis-related group (DRG) payment at a partial rate. As a result of this pilot program, we expect health outcomes to improve and readmission rates to decrease. As we evaluate the success of this program, we hope to scale it over time, but continued reimbursements at similar levels will be necessary to make it sustainable.

Tufts Medicine also has a robust and growing Care at Home enterprise that provides essential home health and hospice care in all the places patients call home. Together, our agencies form a comprehensive continuum of the highest quality home health and hospice care for infants, children, adults, and elders, in both home and community settings.

Telehealth

The use of telehealth (both audio-only and audio-visual), prior to the COVID-19 pandemic – which grew exponentially during the public health emergency – has enabled our patients to obtain medically necessary treatment without being exposed to COVID-19 and allowed our hospitals and primary care providers to focus in-person services for individuals who need physical assessment and treatment. Providing care via electronic formats has improved access to care by helping patients safely overcome many of the traditional barriers to obtaining care.

Without telemedicine availability, patients who still are apprehensive about coming for in-person visits (due to COVID) or who have SDOH that impact access to in-person care (e.g., work hours, lack of transportation) will not be seen. Many of our immigrant patients, for whom English is not their primary language, have significant barriers to setting up an optimal telemedicine visit (e.g. lack of video capability). The same is true for our elderly patients who might not be as tech-savvy. The availability of audio only and our language services is critical for our patients. For many patients, hospital staff coordinate the telehealth encounter by assisting patients with the necessary visit components (e.g., coordinating language services and guiding patients on the check-in and visit logistics). Efforts to expand these services and appropriately reimburse for them are important for the health of our community to manage patients care and prevent avoidable hospitalization.

Continued reimbursement for telehealth services at the same rate as in office visits for primary care services and chronic disease management beyond the December 31, 2022 expiration date included in Chapter 260 of the Acts of 2020, is crucial to allow us to continue to provide the broadest access to telehealth services for our patients. Along with payment parity, facility fees are crucial to our health system to support the services provided to our patients through telehealth.

- 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.

In keeping with our academic mission, Tufts Medicine has started a journey to become a learning health system, where we learn from every patient encounter. We are committed to analyzing and integrating clinical data, experiences, teaching, and research to improve the health of our patients, our consumers, and our physicians, students, residents, fellows and

staff. Tufts Medicine has prioritized advancing health equity and is committed to serving our local communities in a meaningful and patient-driven way, to improve patient outcomes and reduce hospital admissions.

Epic Electronic Health Record

Tufts Medicine implemented the first-ever, fully cloud-based Epic electronic health record simultaneously at each of its three hospitals, Tufts Medicine Care at Home, and roughly one-third of private practices in the Tufts Medicine Integrated Network in April of this year. As part of this launch, Tufts Medicine built a health equity dashboard and we are leveraging a grant to educate providers on data collection. We are working to develop a standard set of descriptive criteria to be employed across our system for our health disparities metrics. Once a data set is developed, we will have the capability to compare information across subgroups on areas such as utilization/access to primary care, urgent care, and behavioral healthcare, as well as the average length of stay and readmission rates across medical/surgical and behavioral health service lines. Our health disparities metrics will be used to better understand the needs of our patient populations and improve patient outcomes.

We are also currently rolling out two digital platforms to improve patient access to information and community resources intended to take the next step of addressing issues of equity and social determinants of health:

- **MyChart** – is an application that provides patients access to all of their medical information in one place. Our *myTuftsMed* patient application is embedded with cultural competence functionality, and includes a multilingual chatbot allowing patients to dictate their questions using their chosen language, supporting the integration of interpreters in telehealth, and enabling the collection of social determinants patient data with to connect them to community resources.
- **Findhelp** – a social service referral platform that will allow our clinical care teams to connect vulnerable patients to community resources and/or services they may need such as food, housing, transportation, or other needs.

Serving Our Communities

During the height of the pandemic in 2020-2021, Tufts Medical Center (TMC) responded to urgent COVID-related needs to provide resources and support to our most vulnerable communities in Boston, primarily residing in Dorchester, South Boston, South End, and Chinatown. TMC also partnered with organizations that serve the Chinatown area in a collaborative effort called the Asian Health Initiative (AHI) to provide education on the negative health implications of smoking. In addition, TMC created the Dorchester Health Initiative (DHI), which funded six community organizations focused on promoting behavioral health and social-emotional wellness for Dorchester community members.

MelroseWakefield Hospital convened the Mystic Valley Regional Behavioral Health Coalition, which provided four-year community grants to address behavioral health needs to 1) promote strategies for improved behavioral health and wellness for school-age children, 2) reduce social isolation for older adults, and 3) build community awareness and reduce behavioral health stigma in high-risk populations. As of 2022, two years of funding totaling \$280,000 has been distributed to fund nine organizations and programs.

Lowell General Hospital has partnered with Lowell's Mill City Grows, food justice and access organization, and with Lowell General Hospital's cardiac patients to participate in a "Veggie RX" program. Patients from the cardiac rehabilitation program could talk with their physicians about healthy eating and then go right to a mini-farmers market provided right inside the hospital to pick out fresh vegetables and get information from the Mill City Grows staff on the nutritional value and how to prepare the vegetables at home.

These are some of the many programs implemented across the Tufts Medicine entities to advance health equity. Initiatives like these make for a healthier patient overall and will reduce readmissions in our hospitals. Tufts Medicine released our 2022 Community Health Needs Assessments for each entity, where we have laid out new and ongoing priorities for each community in the coming years.

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

The COVID-19 pandemic created immense challenges for health systems across the country that will likely take years to overcome but that also fostered an unprecedented amount of communication and cooperation among healthcare providers, governmental agencies and key stakeholders. We applaud the work of the HPC among other state agencies for facilitating this communication and collaboration.

We applaud the Legislature for pushing financial relief funds for hospitals. The Public Health Emergency allowed for many flexibilities, which has helped our healthcare ecosystem adapt to the rapidly evolving needs of the community. In particular, the telehealth regulatory and reimbursement flexibilities have had an ongoing benefit in streamlining unwarranted differences in the clinical and payment rules across payers. Rate parity for telehealth and behavioral health services is key to ensuring the broadest access to services for our patients. We support extending access to telehealth and other key flexibilities after the public health emergency concludes.

The increased use of alternative care sites such as home care and telehealth during the pandemic has laid the groundwork to build a more flexible, modern care delivery model that better meets the needs and preferences of patients. We believe health systems should have the flexibility to manage the treatment of patients in lower-cost settings, but these efforts are often frustrated by the need to have multiple clinical and financial conversations with each health plan in order to be reimbursed. This dynamic is an obstacle to the delivery of fair and equitable healthcare. We believe in accountability for total health expenditures and the quality of patient care. We support policies that are aligned with value-based care and that provide the flexibility required to help the healthcare ecosystem evolve from the fee for service delivery model. We similarly support policies that provide reimbursement for Hospital at Home programs and extend support of these programs beyond the Public Health Emergency.

Building capabilities to access additional staff, especially in nursing, will allow the Commonwealth to adapt more quickly to meet the challenges of an evolving health delivery landscape. It is important to build a robust healthcare workforce pipeline that partners with community colleges, feeder schools, adjacent industries, and prioritizes diverse candidates. The Lawrence Memorial/Regis College School of Nursing is part of Tufts Medicine. We welcome programs and funding opportunities that would bolster a pipeline of nurses within our system, and throughout Massachusetts

Tufts Medicine strongly supports the mutual recognition model enabled by the Nurse Licensure Compact. Time to hire is important during this shortage. Being a Compact state could decrease the wait time as nurses transition to new roles. By joining the Compact, Massachusetts would increase access to experienced nurses and improve the Commonwealth's response to an evolving healthcare delivery landscape that has been strained by recent public health emergencies¹.

In addition to building our workforce pipeline, we support policies to improve workplace safety and violence prevention, as we are seeing a higher level of acuity patients daily. In a poll conducted by the American College of Emergency Physicians (ACEP) and Marketing General Incorporated (MGI), more than eight in 10 emergency physicians reported that the rate of violence in their workplaces has increased, with 45% noting a spike in incidents in the past five years². Violence against healthcare workers is rising and we support policies that protect our healthcare workforce.

¹ "Nurse Licensure Compact Gets Important Hearing on Tuesday." Nurse licensure compact gets important hearing on Tuesday. Massachusetts Health and Hospital Association, October 18, 2021. <https://www.mhalink.org/MHA/MyMHA/Communications/MondayReportItems/Content/2021/10-18/Items/Nurse-Licensure-Compact-Hearing-Tuesday.aspx?WebsiteKey=4749f948-ab0e-4978-a199-d93433f790dc>.

² Mensik, Hailey. "Violence against Emergency Room Physicians Is on the Rise, Survey Finds." Healthcare Dive, September 23, 2022. <https://www.healthcaredive.com/news/healthcare-worker-violence-emergency-rooms-pandemic-worsened/632475/>.

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	10,240	11,359
	Q2	10,194	11,308
	Q3	10,217	11,334
	Q4	10,243	11,363
CY2021	Q1	10,221	11,339
	Q2	10,238	11,357
	Q3	10,258	11,379
	Q4	10,275	11,398
CY2022	Q1	10,283	11,407
	Q2	13,313	14,769
	TOTAL:	105,481	117,014

Note: The table above reflects Tufts Medicine's total estimate inquiries for all three years. Our prior 2021 testimony reflected a per-day average per the information we had available to report on at the time of our submission. Please note, the increase in 2022 volume reflects Tufts Medicine's transition to a new and unified electronic health record.