Baystate Health

ADVANCING CARE. ENHANCING LIVES.

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October 24, 2022

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street
Boston, MA 02109
Via Electronic Submission to HPC-Testimony@mass.gov

Re: Annual Health Care Trends Testimony

Dear Mr. Seltz:

This letter transmits Baystate Health's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General as part of the 2022 Annual Health Care Cost Trends Hearing.

Please find attached Baystate Health's responses to the questions in the 2022 Pre-Filed Testimony for Providers. We hope our responses are helpful to you as we all seek to understand more about Massachusetts's dynamic healthcare environment, particularly amidst the unprecedented challenges we are all facing due to the ongoing impact of the COVID-19 pandemic.

As CEO of Baystate Health, I attest, to the best of my knowledge, that the attached testimony is accurate and true, and I sign this testimony under the pains and penalties of perjury.

Please feel free to contact me should any questions arise.

Thank you for your consideration.

Sincerely,

MKeroack MD

Mark A. Keroack, MD, MHA
President & Chief Executive Officer
Baystate Health

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 (except for 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

COVID-19 has governments and organizations operating in a context of radical uncertainty. The regional and local impact of the COVID-19 crisis is highly heterogeneous, with significant implications for crisis management and policy responses. Baystate Medical Center's response aims to take an in-depth look at the territorial impact of the COVID-19 crisis in its different dimensions: health, economic, social, and fiscal. It provides examples of challenges our organization faces while helping to mitigate the territorial effects of the crisis and offers takeaways on managing COVID-19's territorial impact. Finally, the responses provide a forward-looking perspective to discuss the crisis' implications for multi-level governance and points for policymakers to consider as they build more resilient regions.

a. Reflecting on the past ten years of the Massachusetts healthcare 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 healthcare cost growth, promoting affordability, and advancing health equity in future years.

**Workforce & Financial Challenges**

Labor shortages related to COVID-19, coupled with an increased demand for services, have led to a dramatic increase in cost during FY2022.

Throughout the pandemic and continuing today, Baystate Health (BH) has experienced staffing challenges at all levels. Similar to our 2021 report, Baystate continues to be confronted with high levels of vacancies and turnover. Overall vacancy rates have declined slightly (17% to 15%) in the past year, but recruitment and retention continue to be challenging, with vacancies over 20% for physicians, registered nurses (RNs), behavioral health clinicians, and in the areas of trades and hospitality. As the sole provider of certain essential services in Western Massachusetts, BH has committed to keeping quality care available in our region despite increasing demands. We have kept our facilities running at acceptable ratios despite occupancy of 110-120% of licensed bed capacity, resulting in labor costs that have skyrocketed in the last nine months, accounting for $125M of unanticipated expenses in the first ten months of the year. About $50M of these costs are related to bonuses and overtime pay for our staff, while $75M refers to payments to contract workers, who typically command 150-200% of former market pay rates.

After beginning the year on budget during the first quarter, losses began to mount in January due to the surge of the COVID-19 omicron variant and have continued at a concerning pace. In addition to the inpatient burden of COVID-19, inpatient census began to climb beyond BH's licensed bed capacity and has remained at 110-120% for most of the year. Cost of care is being impacted by the increase in inpatient cases, driven by

- Prolonged length of stay (LOS) due to a shift from surgical to medical cases;
- Reduced ability to discharge patients to understaffed nursing facilities and home care agencies;
- Increased arrivals related to deferred care, often with increased severity of illness;
- Increased ER boarder/observation cases among patients with behavioral health needs; and
- Volume shift from other systems in our region that have not increased staffing to offset increased demand.

Finally, Baystate is experiencing increased supply expenses and lowered reimbursement related to the shift toward medical cases and government payers. However, all other factors pale in comparison to labor costs as the major driver of overall cost of care.

BH is part of the larger healthcare ecosystem including post-acute providers (skilled nursing facilities (SNFs), assisted living facilities (ALFs), rehabilitation facilities and homecare agencies), with interdependencies necessary for our success. Post-acute labor shortages, a pre-pandemic issue, have now reached critical levels. Up to 15% of the nursing home workforce has left, coupled with unrelenting wage competition with other health sectors for critical roles such as RNs, Certified Nursing Assistants (CNAs), and Patient Care Technicians (PCTs). As noted above, the labor shortages among our post-acute partners resulted in delayed hospital discharges and increased avoidable patient days due to lack of access to appropriately staffed SNF beds and home services. We do not expect the fierce competition for labor at all levels to abate any time soon, and thus costs to provide basic care will remain elevated for the foreseeable future. Additionally, health equity comes into question as escalating labor costs force post-acute providers to scrutinize their payor-mix to remain solvent.

Despite these challenges, Baystate Health is committed to our mission and continues to fulfill our role as the trusted healthcare partner to the communities we serve. We are proud of our team members and their resilience and dedication as they continue to care for patients through surges of COVID-19 and its variants. Thanks to their commitment to patient care excellence, compassion, innovation, teamwork and clear communications, our teams continue to overcome considerable challenges. These qualities enable us to do work that saves many lives

and prevents the pandemic from taking an even greater toll on our colleagues and our communities.

## Turnover & Vacancy by Company

| | FY21 Turnover Rate | FY22 Turnover Rate | FY22-*ADJ*$_1$ Turnover Rate | FY21 Vacancy Rate | FY22 Vacancy Rate |
|---|---|---|---|---|---|
| Baystate Health - ALL | 18.0% | 21.2% | 20.6% | 10.4% | 11.7% |
| Baystate Medical Center | 18.1% | 21.3% | 21.1% | 10.9% | 12.5% |
| Baystate Medical Practices | 11.4% | 15.0% | 14.9% | 4.4% | 4.3% |
| Baystate Franklin | 26.3% | 27.4% | 25.5% | 14.2% | 14.9% |
| Baystate Wing | 23.8% | 28.7% | 27.2% | 13.8% | 19.9% |
| Baystate Noble | 27.8% | 33.2% | 29.7% | 16.0% | 13.8% |
| Baystate Home Health | 17.7% | 23.1% | 19.8% | 6.6% | 6.7% |
| Baystate AdministrativeSvs. | 9.2% | 11.0% | 10.6% | 8.7% | 7.6% |

Benchmark - Advisory Board 2021 hospital turnover and vacancy benchmarks released Feb-2022
All Turnover Rate 50$^{th\ percentile}$ = 23.0% (206 Hospitals Reporting)
All Vacancy Rate 50$^{th\ percentile}$ = 10.1% (142 Hospitals Reporting)

$_1$*Annualized turnover with Q1 data (vaccine mandate) removed, turnover Q2-Q4 annualized*

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## Turnover & Vacancy in Critical Jobs

| | FY21 Turnover Rate | FY22 Turnover Rate | FY21 Vacancy Rate | FY22 Vacancy Rate |
|---|---|---|---|---|
| Adv. Practitioners | 12.7% | 14.7% | 9.1% | 8.9% |
| Allied Health | 16.1% | 16.7% | 9.7% | 11.2% |
| Behavioral Health | 27.5% | 30.6% | 14.0% | 16.9% |
| Clinical Support | 28.8% | 37.0% | 17.9% | 17.3% |
| I&T | 7.6% | 9.5% | 6.2% | 6.0% |
| Medical Assistants | 16.3% | 21.0% | 15.1% | 10.2% |
| Physicians | 8.0% | 12.2% | 8.1% | 9.8% |
| RN (Direct Care) | 17.4% | 18.2% | 11.5% | 14.7% |
| Trades/Hospitality | 21.6% | 26.0% | 13.0% | 16.0% |

Benchmark – Advisory Board 2021 "Hospital turnover and vacancy benchmarks" released Feb-2022
Direct Care RN Turnover Rate 50$^{th\ percentile}$ = 22.2% (198 Hospitals Reporting)
Direct Care RN Vacancy Rate 50$^{th\ percentile}$ = 11.7% (143 Hospitals Reporting)

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**Prescription Drug Prices**

The continued growth in specialty drug costs, including costs for oncologic and autoimmune disease management, represents a critical step forward for health but at an alarming cost. At the same time drug manufacturers, pharmacy benefit managers, and payers are implementing

procedures that threaten the availability of affordable pharmaceutical products for health systems like BH that provide a high level of services to low-income individuals or that serve isolated rural communities.

**Access to Post-acute Care**

Western Massachusetts's population will age between 2020 and 2030; it is estimated that the population aged 70 years and older will increase by 5%. Therefore, managing the bundle of costs associated with acute medical hospitalizations will become even more critical for cost containment (hospital and post-acute costs). Building a model where our patients can "age in place" and receive more care in their homes will require a significant investment that is not feasible with current fee-for-service or value-based reimbursement. Care models concordant with "care at home" (i.e., "Hospital at Home", "SNF at Home", "Primary Care at Home") can likely help marry consumer desires, quality outcomes, and reduced total cost of care, but these models will require multiple complementary advances to make them a scalable reality. These include:

- Across payor payment methodologies for real-time financial support.
- Workforce development for care-at-home models, including non-skilled caregivers.
- Affordable technologies supporting geographic supply chain management; and
- Integrated telehealth modalities enabling seamless, equitable care between patients and providers.

Care at-home care models could help bend the cost curve but cannot be implemented, sustained, or scaled without addressing these barriers.

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

**Supporting the Workforce**

Entering the third year of a world-changing health disaster, COVID-19, healthcare providers are confronting a landscape profoundly altered by its effects as health systems have rapidly adapted to meet the needs of patients and care for their caregivers.

Baystate Health workers have been on the front lines of this global crisis since the outset, putting their health and well-being at risk to care for patients and save lives. While Baystate Health initially struggled with insufficient protective equipment and a lack of information, the focus has increasingly turned towards workforce-related challenges among the most critical roles.

Even before the pandemic, the shortage of healthcare workers in Massachusetts was foreseen. Governor Baker began the Massachusetts Healthcare Collaborative in 2018 based on a Boston Consulting Group analysis forecasting a shortage of 43,000 healthcare workers by 2024, particularly affecting nurses, direct caregivers, and behavioral health workers. These challenges have only grown more acute during the pandemic. In addition, the tremendous and unprecedented physical and emotional toll that healthcare workers have endured in caring for patients during the pandemic has increased departures as part of "the Great Resignation."

Because our workforce is our most invaluable resource, Baystate Health is committed to supporting them. Accordingly, Baystate Health has pursued aggressive initiatives to reduce our dependency on contract labor and replace it with our employees.
We have created programs and developed resources to increase staff recruitment and employee health to promote caregiver well-being and resiliency. *Strategies include:*

- Increasing salaries and benefits, particularly for entry-level employees.
- Increasing scheduling flexibility.
- Enriching onboarding programs to improve retention
- Providing referral and retention bonuses.
- Strengthening pipeline programs with local colleges and universities
- Expanding apprenticeships and certification programs
- Exploring alternative sources of potential employees, including disabled individuals and justice-involved individuals
- Initiating grant-enabled educational partnership with regional colleges, skilled nursing providers, and BH to train and retain PCTs and CNAs collaboratively.

We are recruiting in new ways and believe fiercely and purposefully in advancing diversity, equity, and inclusion efforts that offer deep meaning in the recruitment and retention of minorities into the health professions to build a more diverse and culturally competent healthcare workforce.

All these efforts have had only modest effects to date, and we have had to embark on a program of severe cost-cutting in support departments, as well as selective divestitures to achieve a positive operating margin in our 2023 budget. Many hospitals in our area have chosen not to employ as many contract workers and instead have curtailed services, including reducing basic med/surg and behavioral health bed capacity. Baystate Health has tried to avoid these measures, but we may ultimately succumb to economic realities.

We believe the HPC needs to recognize the unprecedented increase in basic labor costs at all levels. Its members must grapple with the difficult choice between achieving the cost benchmark and having adequate capacity to care for patients' basic needs.

We need to invest in our workforce, promote a positive culture to prevent burnout, and ensure the well-being of our providers because the truth is, we cannot improve health care without the talent and workforce to deliver that compassionate care every day.

**Value-based Care**

BH and its physician network hospital organization, Baycare Health Partners, Inc. (Baycare) have been leaders in the state in controlling costs over the last ten years. Our goal is to keep patient care local and in the appropriate setting, which helps in managing total medical spend for members. In general, we keep more than 70% of care in our region. BH hospitals and Baycare physicians have consistently been good stewards of healthcare resources, often posting the lowest rates of total medical expense per capita in the state according to CHIA reports. This reflects ongoing cost discipline, coupled with a solid commitment to investing in value-based approaches to care. The system also leads the state in the percentage of primary care patients in these population health arrangements, with over 170,000 members covered by commercial, Medicare and Medicaid globally budgeted alternative payment models committed to patient safety, quality of care, patient experience, and cost-efficiency.

Since 2009, Baycare has been at the forefront of payment transformation and the population health journey with the development of ACOs and our successful participation in alternative payment contracts with commercial payers, including Blue Cross Blue Shield of Massachusetts AQC, Health New England, and Unicare-GIC. Baycare's wholly owned subsidiary, Pioneer Valley Accountable Care (PVAC), participated in the Medicare Shared Savings Program from 2013 through 2015 and was one of the original 18 ACOs in the country participating in CMS' Next Generation ACO (NGACO) 2-sided risk model from 2016 and continuing through 2021. PVAC is continuing its participation in CMS alternative payment models in the Medicare Shared Savings Program Enhanced Track, which is also a 2-sided risk arrangement.

Since 2018, as a further indication of Baycare's commitment to our population health journey and in conjunction with the MassHealth payment reform ACO initiative, the BeHealthy Partnership has been participating in the MassHealth ACO program in the 5-year contract with EOHHS (Executive Office of Health and Human Services). The partnership is a collaborative effort between Baycare's wholly owned subsidiary, Baystate Health Care Alliance (BHCA), Caring Health, and Health New England. The Model A partnership is a two-sided risk contract,

accountable for the total cost and quality of care for over 48,000 members in the Springfield area. The BeHealthy Partnership intends to expand its model beyond Springfield under the recently approved 1115 waiver.

Baycare and BH have made significant Investments in the following areas that are critical to the success of medical cost management, improvement of quality care and patient experience for our patients.

- Baycare's Integrated Health Care (IHC) Program is one of our key foundational strategies and is at the heart of our organizational mission to improve quality of care while controlling costs. The overarching goals of the program are to assist patients in navigating our complex health care system, improve health outcomes, reduce unnecessary utilization/cost as well as enhance the patient experience. Our program consists of approximately 45 embedded nurse care managers and care coordinators that work directly with patients on health outcomes, processes, and transitions of care, which consider the patients' needs, preferences, values, and priorities. The main activities of the program include complex disease management, transitions of care and quality management. Care management activities continuously improve our population's health literacy through activities such as one-on-one patient counseling sessions concerning disease states and self-management skills. Clinical information is disseminated to patients in a manner and format they can understand and readily use to assist with health management skills, including a standardized library of patient education materials. Our ability to create individual care plans respects patient diversity and addresses ethnic and cultural needs.
- Baycare has developed an extensive post-acute program focused on controlling length of stay and improving the quality of care our patients receive at skilled nursing facilities. levels. Baycare collaborates closely with non-BH hospitals to ensure we develop aligned strategies and goals regarding our common post-acute partners.
- Partnership/Collaboration with DispatchHealth, a mobile urgent care company providing advanced urgent care services to patients in their own homes who would otherwise go to a hospital emergency department.
- Baycare and Baystate Home Health and Hospice have developed a collaborative Community Palliative Care program to bridge the gap between Palliative Care and Hospice and allow patients to receive enhanced symptom management in the comfort of their own homes.
- Pharmaceutical management in the Baystate specialty and retail pharmacies that promotes quality, positive provider and patient experience, cost avoidance through improved time to therapy, medication adherence, and improved clinical outcomes.

- Investments in behavioral health to address critically needed services in our region, including
    - Joint venture development of a new Behavioral Health hospital in western MA bringing 120 beds (30 new beds)
    - Collaboration with the Center for Human Development (CHD) for in-home behavioral health services provided to complex patients
    - Integrated Behavioral Health Program that embeds Behavioral Health staff in primary care and specialty practices to improve access to care
- Encouraging care in the outpatient setting through joint venture ambulatory surgery centers.

c. **Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including specific metrics and results. Please also describe measurable results in other activities your organization has undertaken to advance health equity.**

Collecting data to advance health equity is a focus at Baystate Health. Baystate has a formal data governance program, Clinical Health Equity (CHE), that is supported by multiple departments and overseen by a dedicated project manager. Three tracks have been created to support the CHE work within Baystate Health – a System Upgrade Workgroup, a Training and Education Workgroup, and a Reporting/Analytics Workgroup. Workgroup activities and milestones are shown in Tables 1 and 2 and described below.

Table 1 – Clinical Health Equity Workgroup Activities Timeline

| | 2022 – Baystate Health Clinical Health Equity (CHE) activities | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Phase1- HCAHPS, Inpatient Quality Measures Reports w Stratified Data | COVID SURGE ON HOLD | | *Reports Analysis* | | | | | | | ★ | | |
| Phase1 Update REaLL | | | | | | | | | | | | |
| Phase2 Update SOGI and Disability | | | | | | | | | | | | |
| Training and Education | | | | | | | | | | | | |
| Policies and Procedures | | | | | | | | | | | | |

Table 2- Clinical Health Equity Workgroup Milestones

| Baystate Health CHE System Upgrade & Training and Education Project Milestones (complete and remaining) | % Complete | Estimated Start Date | Planned or Actual End Date |
|---|---|---|---|
| Project Discovery | 100% | 10/1/21 | 11/30/21 |
| Design Complete | 100% | 12/1/21 | 5/31/22 |
| Non-PROD Build | 100% | 6/1/22 | 8/19/22 |
| Unit Testing | 100% | 8/22/22 | 9/16/22 |
| Integrated Testing | 99% | 9/18/22 | 9/30/22 |
| Communication/Training ★ | 50% | 10/1/22 | 10/30/22 |
| PROD Build | 0% | 10/10/22 | 11/1/22 |
| System Go-Live | 0% | 11/1/22 | |
| Go-Live Support | 0% | 11/1/22 | 11/30/22 |

During the past year, the System Upgrade Workgroup completed a gap analysis of the current state of Baystate data collection for race, ethnicity, language, disability (RELD), sexual orientation and gender identity (SOGI) and age compared to requirements of external regulatory bodies (CMS, TJC, MassHealth). Baystate data capture systems were updated to match the CMS and HHS standards and will be going live November 1, 2022.

The Training and Education Workgroup completed activities including updating patient interview guidelines and education materials related to the interview changes. Staff is receiving guidance on the purpose for collecting the patient demographic data, the importance of asking the questions, and training on new options within certain data fields. The registration workflow has been modified to query any 'unknown' or 'blank' entries every 30 days. Of note, there has been improvement in the data collection, with fewer than 3% of patients having an 'unknown' response to race in the data measured for ambulatory encounters compared to 5% in the prior year. Finally, work continues to standardize documentation across the organization, regardless of where a patient checks in (hospital, clinics or contact center), and policies and procedures pertaining to these workflows have been identified for review and update.

The Reporting/Analytics Workgroup identified a number of reports that stratify data by patient demographics. The reports are routinely prepared and distributed to senior leaders within Baystate Health and, for some reports, to the Board of Trustees. Clinical goals to measure and address basic disparities by race and ethnicity now form part of the variable compensation plan for 220 BH senior leaders.

Quarterly inpatient quality outcome reports provide data on 1) sepsis mortality; 2) unplanned readmissions; 3) complications; and 4) length of stay. These reports are risk-adjusted and stratified by race and Hispanic identifier. During the past year, specific focus was placed on sepsis mortality. Analysis of the observed-to-expected sepsis mortality showed the following:

- Despite differences in risk-adjusted mortality rates, the numbers did not represent a true difference in mortality for White patients with sepsis compared to Black patients with sepsis.
- Detailed analysis identified differences in coding, palliative care, and average patient age – all factors that are highly weighted in the risk-adjustment methodology.
- A blinded audit which detailed chart reviews completed on matched patient pairs (matched on age and gender where one patient was White and the other Black) did not identify a clear disparity in care.

A monthly COVID-19 quality outcomes report provides data on risk-adjusted mortality, readmissions, and length of stay for inpatients. The mortality data is additionally stratified by age, race, Hispanic identifier, and language. Analysis of the data identified small differences by race and Hispanic identifier, but no large differences.

On the ambulatory side, three priorities were established during the past year where data was stratified by race and Hispanic identifier: 1) hypertension control; 2) breast cancer screening rates; and 3) percentage of patients with an unspecified depression diagnosis. The data showed the following:

- Small differences between Black and White patients for hypertension control and unspecified depression diagnosis.
- Breast cancer screening percentages were identical for Black and White patients.
- Small differences between Hispanic and non-Hispanic patients for hypertension control and breast cancer screening.
- Hispanic patients were more likely than non-Hispanic patients to have a diagnosis of unspecified depression.

During the past year, the BeHealthy ACO also stratified certain ambulatory health metrics by race, including patients with controlled hypertension. For this metric, the ACO's data analysis showed a higher percentage of its White patients with controlled hypertension compared to its Black patients. As a result, the BeHealthy ACO developed a state-approved program focused on improving hypertension control among Black ACO members through direct outreach and community-based messaging. The program is in its initial stages of implementation.

In addition to the efforts noted above, Baycare Health Partners (Baycare), the Physician Hospital Organization of Baystate Health, has been working diligently with our member practices, both primary and specialty care practices, related to the collection of race, language and ethnicity data. Baycare was awarded grants from Blue Cross Blue Shield of Massachusetts and the Institute for Healthcare Improvement (IHI) totaling $1.5M to advance Health Equity in Western Massachusetts. This funding will be utilized to provide training, educational materials, and toolkits to assist in standardizing the data

collection within clinical practices. Once this data is collected in a consistent manner, our efforts will be turned to identifying health disparities as it relates to hypertension and diabetes quality measures and developing/implementing interventions to address disparities. To help move these efforts forward, Baycare has been participating in learning sessions and monthly individual consultation sessions with the Health Equity Action Community through IHI.

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

Baystate Health recommends and/or cautions policy makers in the following ways:

- Support workforce stabilization and development, through initiatives such as:
    - Nursing Pathways and Interstate Nurse Licensure Compact
    - Ease transition of licensure for nurses from Puerto Rico and displaced nations; this is a particularly unique opportunity for Baystate Health since Springfield has one of the largest Puerto Rican populations in the state
    - Relax immigration policies to permit in-migration of additional workers at all levels of employment
    - Eliminate scope of practice barriers

- Encourage the adequate funding of population health strategies including the creation of "Health Empowerment Zones", aimed at addressing social determinants of health
- Allow the new 1115 Medicaid waiver with its emphasis on health equity to be operationalized by providers over the next five years. For systems like BH, allow us to build on the progress we have seen with the 2018 waiver and our commitment to value based care through the Medicaid ACO
- Ensure rate adequacy for public and private payors that reflects current inflation pressures and market basket challenges
    - forgo policy development on site-neutral payments and arbitrary provider price caps which do not recognize the complexities of provider price variation, including payer mix, patient complexity, availability of services, etc.
    - devote more resources to support payment mechanisms, infrastructure funding and incentives that encourage continued adoption of value-based care, including capitated arrangements
- Recognize efforts for those providers who are committed to health equity strategies with appropriate financial and strategic incentives in regions where certain providers are cutting back on their safety net missions
- Commit to strategies that promote digital literacy and improved access for patients and citizens, particularly within the broad geography served by our health system (the most digitally challenged region in the Commonwealth)
    - Use telehealth utilization and access as a health equity imperative, including payment parity with in-person services

- Forgo state implementation strategies that encroach on 340B savings that are aimed at supporting disparate populations (particularly given cutbacks in the program from the federal government and pharmaceutical companies).
- Add pharmaceutical companies to HPC oversight. The legislature should require pharmaceutical manufacturers be held accountable to the state's Cost Growth benchmark just as health plans and providers are today.
- Create incentives and reward (not penalize) provider systems that have committed to growth strategies for primary care and behavioral health in advance of further mandates in this space
    - Support behavioral health reimbursement parity and reimbursement for wrap-around services
    - Remove barriers to patient access to care such as restrictive prior authorization and referral processes

## 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<br>Calendar Years (CY) 2020-2022 | | | |
|---|---|---|---|
| Year | | Aggregate Number of Written Inquiries | Aggregate Number of Inquiries via Telephone or In-Person |
| CY2020 | Q1 | 3 | 149 |
| | Q2 | 2 | 60 |
| | Q3 | 3 | 80 |
| | Q4 | 4 | 109 |
| CY2021 | Q1 | 11 | 118 |
| | Q2 | 3 | 72 |
| | Q3 | 5 | 65 |
| | Q4 | 22 | 54 |
| CY2022 | Q1 | 5 | 72 |

| | | | |
|---|---|---|---|
| | Q2 | 6 | 73 |
| | TOTAL: | 64 | 852 |

Appendix 1 to Item (c) Baystate Health
Pre-filed Testimony-2022 Health Care Cost Trends Hearing
Clinical Health Equity Workgroup Activities Timeline

| | 2022 – Baystate Health Clinical Health Equity (CHE) activities | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| **Phase1- HCAHPS, Inpatient Quality Measures Reports w Stratified Data** | COVID SURGE ON HOLD | | *Reports Analysis* | | | | | | | ★ | | |
| **Phase1 Update REaLL** | | | | | | | | | | | | |
| **Phase2 Update SOGI and Disability** | | | | | | | | | | | | |
| **Training and Education** | | | | | | | | | | | | |
| **Policies and Procedures** | | | | | | | | | | | | |

Appendix 2 to Item (c) Baystate Health
Pre-filed Testimony-2022 Health Care Cost Trends Hearing
Clinical Health Equity Workgroup Milestones

| Baystate Health CHE System Upgrade & Training and Education Project Milestones (complete and remaining) | % Complete | Estimated Start Date | Planned or Actual End Date |
|---|---|---|---|
| Project Discovery | 100% | 10/1/21 | 11/30/21 |
| Design Complete | 100% | 12/1/21 | 5/31/22 |
| Non-PROD Build | 100% | 6/1/22 | 8/19/22 |
| Unit Testing | 100% | 8/22/22 | 9/16/22 |
| Integrated Testing | 99% | 9/18/22 | 9/30/22 |
| Communication/Training ★ | 50% | 10/1/22 | 10/30/22 |
| PROD Build | 0% | 10/10/22 | 11/1/22 |
| System Go-Live | 0% | 11/1/22 | |
| Go-Live Support | 0% | 11/1/22 | 11/30/22 |