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.

Beth Israel Lahey Health (BILH) is proud to care for over a million patients each year in settings throughout Eastern Massachusetts from hospital operating rooms, outpatient clinics, primary care offices, outpatient behavioral health treatment centers and in various virtual modes. A number of highly consequential cost drivers are impacting BILH, as they are for providers across the country. Unprecedented rise in labor, drug and medical supply costs are driving hospital expenses up. Staffing vacancies and inflationary pressures have driven salary and wage increases that are contributing to increased operating costs. Significant staffing vacancies are resulting in a much higher need for contract labor staff and a sharp increase in prices charged by staffing agencies have exponentially increased BILH's labor costs; in FY22 BILH incurred more than $230m in contract labor expenses over the prior year. Additional factors increasing the cost of care are the need to care for sicker patients and longer lengths of stay in hospitals. Across the BILH system we saw a 3.1% rise in patient acuity levels and a 6.7% increase in the average length of stay for a patient. The workforce challenges faced by other providers in healthcare, particularly in behavioral health and post-acute care settings are affecting hospitals' ability to discharge patients to the next level of care, requiring patients to remain in a higher cost hospital setting longer. Additionally, BILH is concerned about the widening health disparities exacerbated by the pandemic's outsized impact on low-income, underrepresented communities and believe concentration and resources are warranted to address these systemic inequities.

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

Beth Israel Lahey Health has brought greater value to the healthcare market since its inception. The convening and alignment of hospitals with lower relative prices than other providers has allowed us to build upon an ethos of quality and efficiency in care delivery. Additionally, BILH's price cap makes it unique among all other providers in the state in helping to meet the state's cost control benchmark. Conversely, BILH is uniquely challenged compared to other providers in the state in how it can respond to the expense increases noted above. In the face of steep financial challenges, BILH has worked hard to find efficiencies across the system to drive down costs in areas such as supply chain and contract synergies. BILH continues to drive efforts to meet the needs of our communities by increasing access to care in our community settings – 55% of the care delivered by BILH is in community settings, continuously investing in services such as behavioral health integration and substance use services, and efforts to address health equity. One of the greatest concerns BILH leaders face is ensuring a supported and robust workforce to

provide the care our patients need. BILH is focused on supporting our existing workforce by creating a culture of wellness and support, realigning and automating the workload where possible and optimizing workflows to support a top of license approach. In an environment where violence against healthcare workers is increasing BILH is intent on ensuring the highest level of safety possible through transparency and reporting, training, improvement and support programs for our employees and patients. Our workforce is facing unprecedented levels of burnout and seeing an increased need in temporary staff to fill roles at all levels. As reliance on temporary staff increases, the burden on our full-time staff also increases. To address some of the administrative burden on staff we would encourage government agencies and payers evaluate opportunities to pause or eliminate any administrative processes or reporting requirements that are not providing value to patients. In the face of increasing labor costs BILH is focusing efforts on growing the pipeline and advancing the next generation of caregivers. We are building upon partnerships with government agencies, higher education and training/certification programs to train, recruit and retain healthcare employees across all positions. Government can assist healthcare employers in retaining our existing employees and enhancing the pipeline by investing in nurse educators, continuing to support programs like loan forgiveness, incumbent worker training supports and benefits, and childcare and transportation subsidies.

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.

Addressing health equity is among BILH's strategic priorities. BILH's long-term aim is to eradicate health disparities across BILH's patient population. Through engagement and accountability across leadership levels, we have established concrete goals and are transitioning from processes to outcomes with early signs of efforts having positive impacts in hiring and infrastructure development. We have taken a number of deliberate steps to address health disparities across the system.

(1) Infrastructure: In 2021, we established BILH-wide Quality Health Equity Committee (QHEC), co-led by BILH's Chief Diversity, Equity & Inclusion Officer and BILH's Chief Medical Officer. We hired a health equity leadership dyad, comprised of a Vice-president of Health Equity who is paired with a Health Equity Medical Director to staff QHEC and to manage health equity efforts across the system. The QHEC committee has wide and diverse representation of subject matter experts across the system, including population health, primary care, hospital and behavioral health representatives, as well as Patient & Family Advisory Committee members.

(2) Data Collection: In 2021 we conducted a robust process to standardize and enhance collection of patient demographic data across our multiple electronic health records within BILH. We disseminated job aids for front-line registration staff to work with patients to collect missing demographic data, using culturally-appropriate approaches, informing patients of the importance of such data for purposes of improving health outcomes for all patients. Our capture rate for completeness of race is 92% and ethnicity is 88%, across BILH

patients. We are continuing to validate the accuracy of data, particularly as we embark in migrating data to a single EHR system. Data on capture rate for language, disability status, sexual orientation, gender identity is not currently available but are important elements we plan to expand upon in the upcoming years.
(3) Analysis: we conducted disparity analysis starting with diabetes and hypertension and found that Black and Hispanic patients, across our patient population, have a higher prevalence of diabetes and hypertension outside of the goal for well-managed control.
(4) System-wide Goal: we established a system health equity goal in 2022 to reduce diabetes disparity by 20% for our Black and Hispanic patients and have expanded that goal to include hypertension for 2023. These goals are monitored throughout the year and reported to QHEC, BILH's Executive Team, Hospital and Business Unit Presidents and BILH's Board of Trustees, as one of three DEI system goals (with additional DEI goals for workforce representation and supplier diversity spend).
(5) Interventions: practice level interventions and best practices have been deployed, with a focus on patient practices that have a larger share of Black and Hispanic patients throughout BILH's network. Interventions include (a) integrated clinical pharmacists to increase access to proven and effective medications for managing diabetes, hypertension and obesity; (b) multicultural/ multilingual health navigators to assist patients with health-related social needs (e.g., nutrition, affordability of medication, etc.); (c) enhanced technology to outreach to patients using multilingual texting and phone outreach; and, (d) continuous glucose monitoring devices.
(6) Expanded Infrastructure: While we have established initial priorities for health equity, we have significant additional investment required to establish a more mature and robust infrastructure. We are transitioning to a single electronic health record system across BILH, which will enable expanded collection and standardization of patient demographics (e.g., race, ethnicity, language, sexual orientation, gender identity, preferred name, disability status, etc.) and system-wide ability to screen for health related social needs (e.g., food insecurity, housing insecurity, etc.) while expanding on our system's ability to impact social and racial disparities in health outcomes.

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

Areas that we believe would support health system efforts for continuing to advance health equity include: (1) sustainable reimbursement for resources to help address health-related social needs, which includes, but is not limited to community social workers, health navigators, and robust interpreter services, (2) support to stand up health equity infrastructure, including but not limited to: (a) data collection (system changes to standardize expanded collection patient demographic data, SDoH screening), (b) infrastructure to analyze health disparities, (c) culturally and linguistically oriented health care interventions and innovations, and (d) social services platform, integrated with EMRs.

## 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 | 279 | 205 |
| | Q2 | 86 | 71 |
| | Q3 | 254 | 202 |
| | Q4 | 254 | 158 |
| CY2021 | Q1 | 265 | 199 |
| | Q2 | 284 | 168 |
| | Q3 | 134 | 150 |
| | Q4 | 300 | 205 |
| CY2022 | Q1 | 250 | 235 |
| | Q2 | 185 | 219 |
| | TOTAL: | 2,312 | 1,812 |