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.

Community 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. 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 - 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. Capital - We also need capital to expand our facilities to meet patient demand. We firmly believe that overall reductions in healthcare costs as well as improvements in health equity require increased investments in primary care and especially in community health centers. CHCs have demonstrated success and reducing upstream costs when we have the resources to meet the needed of our patients. The state has made great strides in increasing resources for CHCs with the introduction of federally required Prospective Payment System (PPS) rates. We have been able to increase wages modestly but we still lag far behind hospitals, which limits our recruitment capacity. Without adequate salaries to recruit and retain staff, our capacity to serve more patients and provide more intensive services is a huge challenge and often leads patients to seek care in more expensive settings, such as emergency departments. These more expensive settings also do not always have the cultural and linguistic supports we do, so it is more challenging for our patients to seek care there. We need continued policy changes to shift resources to community health centers to enable us to compete with hospitals for staff so we provide more care in our lower cost setting.

CHCs have been leaders in health equity for years and we struggle with the financial challenge of making that happen. For example, BNHC spends nearly $2.4 million on interpreters, $1 million on enrollment staff, and $2.2 million on community health workers. All of these positions and many others are dedicated to removing barriers to care, helping assess and address social determinants, and creating a health care environment where patients understand their care, can access care and health education without barriers, and have help navigating the complex system. Most private practice do not incur these health equity costs at the same level as CHCs and we need the resources to maintain and enhance these services.

PPS rates are a game changer for CHCs but not the entire solution. BNHC and other CHCs remain fragile after decades of underfunding. One-time pandemic funding has strengthened us but our budgets without the one-time funding remain razor thin. We are spending all of our PPS rate increases and even more on workforce, just trying to keep up with rapid

increases in salaries. We had hoped PPS rates would enable us to be more competitive in the workforce market but labor shortages leave us challenged just to keep up with the market. Over the past year, we have had more positions open than ever in our history. We are deeply worried about state requirements for us to add positions in value-based care when we can't keep our current positions staffed.

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

BNHC has been deeply involved in advocacy for PPS rates. 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, has enabled some market adjustments, which we hope will help us fill open positions to increase patient access to services. We have made two rounds of market adjustments to salaries over the past year.

The increases were more than we could easily afford but did not get us to the level needed to make us competitive in the market. We have also promoted loan repayment programs as a recruitment tool make up for lower than market salaries. The pitfalls of the loan repayment strategy is that we can't guarantee loan repayment when we hire and staff often leave for higher paying positions when the loan repayment ends.

We're writing lots of grant applications. Our community health workers are mostly grant funded and some of our interpreters are grant-funded. Programmatic planning with these staff is difficult as we're constantly shifting staff from grant to grant as one ends and another begins, often with different programmatic requirements.

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.

BNHC has collected race, ethnicity and language for many years and has a very complete data base for these metrics. According to C3 and federal data, BNHC is able to report race data for 99% of our patients. Our data on ethnicity and language is complete for at least 90% of our patients. According for our federal Uniform Data System (UDS) report for 2021, BNHC reported SOGI for 58% of our patients. This percentage has been increasing steadily each year since we started collecting this data in 2016. Disability status is documented within individual medical records but we can run reports by diagnosis code so could get at some of the data that way. Incorporating disability status is challenging as there is not a standard definition or a standard way to document disability in EMRs so there would be a lack of consistency CHC to CHC or EMR to EMR. To enhance our reporting capacity, BNHC, along with C3 and 11 other CHCs, is in the process of transitioning to Epic electronic medical record. BNHC is working with C3 to develop reporting through C3's data warehouse to identify in equity for specific conditions.

BNHC is working hard to advance health equity. Our workforce is incredibly diverse with more than 2/3 of our staff from diverse backgrounds, most with language capacity in the languages prevalent in our community. We remove barriers to care by providing live and virtual language interpreters to more than 55% of our patients. We have more than 25 live interpreters fluent in the primary languages we serve. We use Pacific Interpreters for phone interpretation and Stratus for video language and ASL interpretation. We also remove financial barriers for our patients through our robust enrollment team of 13 staff who assist patients with enrollment and redetermination and qualify them for the Health Safety Net if needed. Our community health worker team helps patients understand and navigate the complex healthcare system by providing them with guidance and support in their native languages.

BNHC hired a Health Equity and Engagement Manager a year ago to guide us in our health equity journey. We formed a Board-level Health Equity Committee that is in the process of becoming a standing committee through a change to our bylaws. We have had an internal health equity committee that has been actively working on health equity for several years. Currently the committee is focused on staff and Board education. We engaged Face Race to provide organization-wide foundational training about health equity as well as deeper, more interactive training for some of our clinical teams.

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

We firmly believe that overall reductions in healthcare costs as well as improvements in health equity require increased investments in primary care and especially in community health centers. CHCs have demonstrated success and reducing upstream costs when we have the resources to meet the needed of our patients. The state has made great strides in increasing resources for 8 io9p;/'CHCs with the introduction of federally required Prospective Payment System (PPS) rates. We have been able to increase wages modestly but we still lag far behind hospitals, which limits our recruitment capacity. Without adequate salaries to recruit and retain staff, our capacity to serve more patients and provide more intensive services is a huge challenge and often leads patients to seek care in more expensive settings, such as emergency departments. These more expensive settings also do not always have the cultural and linguistic supports we do, so it is more challenging for our patients to seek care there. We need continued policy changes to shift resources to community health centers to enable us to compete with hospitals for staff so we provide more care in our lower cost setting.

In addition to workforce, CHCs need support for growth and renovation of our facilities. BNHC is beyond capacity as far as space. We know that value-based care will require us to add staff and we need space for them. BNHC leased office space in March 2022 and has moved many non-clinical staff to that space. Our architect is working on plans to convert the vacated administrative space to clinical use but we have not identified a funding source for the renovation needed.

We are excited about the transition to value-based care but anxious that there needs to be adequate resources provide to enable us to make the transition effectively. We are hearing that we may need to be at Tier 3 to be eligible for rates that match the PPS rates we are already receiving. Tier 3 will require us to make new investments in staff and space so we will need resources beyond PPS rates to make that possible. Since PPS rates are federally required, CHCs need to be paid at least PPS for Tier 1 services with increased resources provided for services at the higher tiers. We truly believe that value-based care can result in improved quality and outcomes and lower overall cost but we need the resources to make that happen.

Testimony submitted by:

Sue Joss, CEO

Sue Joss

Brockton Neighborhood Health Center

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	0	0
	Q2	0	0
	Q3	0	0
	Q4	0	0
CY2021	Q1	0	0
	Q2	0	0
	Q3	0	0
	Q4	0	0
CY2022	Q1	0	0
	Q2	0	0
	TOTAL:	0	0

NOTE: BNHC does provide cost information to patients upon request but we are not tracking requests. It is documented within individual medical records but we don't have a report that summarizes this data.