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.

Steward appreciates the opportunity to provide testimony in connection with HPC's 2022 Cost Trends Hearing. The COVID-19 pandemic has caused an untenable path forward for the provider industry. Steward, like many other provider organizations in the state, is experiencing a massive workforce shortage, incurring expense growth that is unsustainable, and realizing reimbursement that is wholly inadequate. Put simply, the industry is on the precipice of significant and irreversible damage. The same partners that made Massachusetts a model for health care reform must come together with a sense of urgency to chart a sustainable path forward. All of Steward's recommendations concerning state cost containment efforts are necessary in order for our system to be viable– the status quo will only serve to accelerate the declining economic state of hospitals and providers organizations.

Internal and External Cost Pressures. The largest internal pressure to manage cost growth for Steward relates to labor expense. The significant staffing shortage across multiple provider types, which is particularly acute for nurses and behavioral health clinicians, has required us to use staffing agencies and temporary workers at costs that are approximately 2-3x higher than pre-pandemic levels. This trend is not sustainable for provider organizations and there is no indication these expense pressures are moderating or abating. At the same time, there are significant external economic pressures relative to managing cost, including historically high inflation, supply chain disruptions, and recessionary indicators, which continue to make the cost of goods and services necessary to operate hospitals more expensive. These challenges are compounded by clinician burnout and attrition and a sicker population requiring more intensive and costly resources due to the direct and indirect effects of the pandemic. These effects are even more acute for High Public Payer Hospitals as they have significant resource disadvantage – for example, many recently hired employees train and work at our hospitals for six to twelve months then leave for higher paying positions at other organizations that can afford above market wages because of their reimbursement advantage.

Promoting Affordability. The largest obstacle in promoting affordability for the market remains the unintended consequence of applying the Cost Growth Benchmark (CGB) uniformly to all provider organizations. High value providers, organizations with low to moderate prices and which manage total medical expense efficiently, have an inherent resource disadvantage – lower value providers (those with higher prices) grow at a greater absolute rate than high value providers. This dynamic has created a competitive disadvantage in areas such a physician recruitment and retention, investing in population health initiatives, and building a future health care infrastructure responsive to patient and community needs and demands. Eliminating this resource disadvantage, by indexing the Cost Growth Benchmark to allow for greater growth for high value providers, would create a more balanced and competitive marketplace. This change, coupled with greater uptake in insurance products that reward and incent patients for making high value choices, would

help facilitate a shift in a greater share of patients seeking care at higher value organizations, and over time, help making meaningful progress in moderating the state's cost trajectory.

Behavioral Health. The behavioral health crisis has been well documented by the media, in industry surveys, and in government reports. While there has been attention to and support for staffing initiatives from the state, there must be an even greater investment in reimbursement. As one of the largest providers of inpatient mental health in the state, Steward has been disproportionately disadvantaged as all of our acute care hospitals are dealing with a deluge of boarded patients – and many of these patients come from underserved areas where the prevalence of behavioral health comorbidities are the highest. The historic underfunding of these services coupled with the uptick in behavioral health presentations due to the pandemic has created the conditions for the current crisis. Behavioral health must be reimbursed at a level to cover the cost of care – providers can no longer be expected to subsidize the cost for government and commercial payers.

Advancing Health Equity. At the macro level, advancements in health equity can best be achieved through sustaining and supporting providers that serve vulnerable populations and disadvantaged communities. Hospitals in areas with higher rates of socio-economic disadvantages should be incented to make sustainable improvements and progress in advancing health equity – the state's recent 1115 Waiver is strong example of this type of construct. The state could consider convening stakeholders to determine if this type of model could be replicated in the commercial space in order to align incentives and models across payers. More specific Steward initiatives on this subject are described in section (b) and (c) below.

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

In 2020, Steward Healthcare Network (SHCN) started a health equity committee co-chaired by SHCN's President and Director of Health Equity. This committee is tasked with providing direction and recommendations to improve health equity across the network. A description of some of the clinical programming associated with the committee's work is described below.

Cancer Screenings. In September 2022, Steward received funding to support decreasing healthcare disparities for communities of color, and targeted programming will initially focus on hypertension, and breast and cervical cancer screenings. In order to create greater access for breast cancer screenings, Steward is planning to launch a mobile mammography unit in the Spring of 2023. This unit will visit housing projects, areas of worship, and identified workplaces in communities such as Haverhill, Worcester, Brockton, Fall River, Lawrence, Methuen, New Bedford, and Boston. We are also developing a text campaign to target black men as they have the highest colorectal cancer incidence and mortality rates of any race in the United States. The messaging for this campaign will educate and inform patients on: screening as a mode of prevention; the availability of non-invasive options; the importance of early detection; and educational information on the vulnerability of this racial group. Steward is also implementing direct booking for colonoscopy and mammography at

primary care sites so that the patient has a specialty appointment in hand prior to leaving the office visit.

Food Insecurity and Housing. To support with the skyrocketing cost of food and nutrition Steward will partner with produce vendors to provide free and discounted fruits and vegetables to underserved communities. This initiative will promote the "Food Is Medicine" model. In addition to these upcoming projects, Steward currently offers the Flexible Services program which works with eligible MassHealth members on key social determinants of health such as housing and food insecurity. We are stratifying these programs by race and ethnicity to ensure equity.

Medication Costs. Our physicians receive direct feedback on medication cost based on the patient's health insurance at the time of prescribing so that the physician can choose the most cost effective and clinically effective regimen for the patient. Shared decision making is a skill used in order to make realistic decisions about medications.

Language Barriers: Steward has deployed a Telehealth Platform that integrates interpreter services into the visit (three-way video call) to align with the patients preferred language for conversation. We provide most of our MassHealth materials in English and Spanish, and the member handbook can be requested in up to 13 different languages.

Behavioral Health Access: Steward has deployed therapists, Nurse Practitioners, and LICSWs into primary care offices in order to better integrate behavioral health services into medical care. Our affiliated Behavioral Health Community Partners (BHCPs) also work with our ACO's care managers in the communities they reside in order to support members' behavioral health needs, including scheduling a 7-day follow up after a mental health discharge.

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.

Data Collection and Usage. Steward plans to continue to build organizational data competencies to collect and report self-reported race, ethnicity, language, education, sexual orientation, gender identity and income data, and increase practice staff competencies in demographic data collection. Our methodology starts with educating practice leaders on the importance of demographic data and how that data can be utilized for care planning. We engage trainers both live and in our e-learning platform to develop and improve competencies. Steward follows up with a "call to action", including training staff on how to appropriately request patient demographic information and respond to questions in a culturally sensitive manner.

Patient Involvement: Steward monitors and analyzes feedback through our off-cycle patient experience survey and through other patient forums, including our Patient and Family Advisory Committee (PFAC). Steward believes in data democratization and leveraging patient voice and literature to interpret data as well as influence project design.

Project Evaluation: Steward measures the following leading indicators of success: (1) % of self-reported REL categories that are not "UNKNOWN" or otherwise not reported; and (2) Progress against Key Milestones. These milestones include: Establish REL data table; Establish REL data logic for handling conflicting data inputs (different EMRs with different REL categories associated with patient); Integration of REL into existing quality reports/dashboards; Creation of new reports, health equity index measures, and other advanced uses of the REL data; Establishment of organizational standard around collection of REL data; Development of training materials for practice staff with expectation that all practice staff are trained upon hire or once a year; and, Reports out to practices on completeness of REL data collection with percentage of unknown.

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 most meaningful means of achieving cost growth moderation are reflected in the HPC's 2022 Cost Trends Report, and include reducing unwarranted price variation, strengthening oversight for certain provider transactions, and applying the CGB in a more equitable manner. As the HPC has found, price growth has been a primary driver of cost growth in the state and significant unwarranted price variation still exists despite widespread recognition of the problem. Steward is supportive of establishing price caps for the highest priced providers in the state, whether that be accomplished by limiting service specific increases or by limiting the rate of growth by provider or by service. Any statutory or regulatory change to address price variation must be accompanied by safeguards to ensure that future price increases accrue to lower-priced providers, and particularly those with high public payer mixes. This recommendation is likely the strongest path towards bending the cost trend in a meaningful and systemic way, and absent action, the future viability of lower-priced hospitals (many of which are also designated by the state as Safety Net Providers or High Public Payer Hospitals) will remain in jeopardy.

Steward is supportive of legislative and regulatory changes that add additional oversight and accountability for high cost providers seeking to expand – particularly for expansions that could adversely impact high public payer hospitals located in underserved communities. High public payer hospitals, because of their comparatively lower reimbursement, are particularly vulnerable as it relates to the financial recovery from the pandemic as they are reimbursed by government payers at levels that do not cover the cost of care and their ability to cross-subsidize costs with commercial payers is limited. Furthermore, many high public payer hospitals are located in communities that have higher rates of health disparities and socio-economic challenges – a trend that has unfortunately been illuminated by the pandemic and is now the subject of significant policy attention in terms of advancing health equity. Expansions that could threaten these hospitals and the

communities they serve must be closely scrutinized. In addition, the state has already recognized the need and established regulatory structures to evaluate important market changes (e.g. the MCN/CMIR process). Conceptually, a threshold public policy question for any expansion by a high cost provider should contemplate the impact on high public payer hospitals and the populations they serve, regardless of the transaction type. The need for this type of oversight is even more urgent given the financial challenges of high public payer hospitals and the uncertain future of health care in a post-COVID environment.

Steward also recommends that adjustments be made to the Cost Growth Benchmark as described under section (a) – the rational is that it effectively locks-in unwarranted price disparities. Steward also recommends, either in conjunction or in tandem with other policies, that the HPC consider pausing the benchmark to allow for hospitals to recover financially from the effects of the pandemic. Hospitals continue to face an acceleration of costs due to staffing shortages, inflation, recessionary indicators, and supply chain disruptions. As an industry, margins remain depressed and expenses are significantly elevated from pre-pandemic levels. These market trends should be monitored closely and given significant weight as the HPC evaluates how to apply the CGB in future years – pausing it selectively for non high-cost providers should be given serious consideration.

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	100	300
	Q2	60	180
	Q3	60	180
	Q4	60	225
CY2021	Q1	100	339
	Q2	100	303
	Q3	41	77
	Q4	29	78
CY2022	Q1	27	81
	Q2	33	80
	TOTAL:	610	1843