

2025 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 [2025 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document 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 2024, 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. All submissions are public record and will be posted to the [HPC's website](#).

You may receive questions from both the HPC and the Office of the Attorney General (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 relevant 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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For any inquiries regarding AGO questions, please contact:
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THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging the stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), and residents paying \$5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark](#) and the status of public and industry-led health care policy reform efforts.

1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on health care workers, patients, and patient care? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

Boston Health Care for the Homeless Program (BHCHP) is a federally qualified health center whose mission is to provide the highest quality of health care for all individuals experiencing homelessness in our community. We accept all patients regardless of their ability to pay or insurance status. Nearly all (99%) of our patients are at or below the 100% federal poverty level. Insurance mix is 67% Medicaid only; 17% Dual Medicaid/Medicare; 1% Medicare only; and 11% uninsured (includes Health Safety Net). Current federal Section 330 funding only covers a fraction of our operational revenue. Medicaid is 75% of our revenue and therefore any federal actions that significantly change Medicaid eligibility and coverage may result in reducing our hours of operation, sites of care, and services offered. In addition, with the rise in homelessness in Massachusetts and loss of tax credits for Affordable Care Act marketplace, we anticipate a significant increase in uncompensated care, further exacerbating our ability to sustain our current model of care.

For homeless individuals who are struggling to meet the basic necessities of life including shelter, food, clothing, and safety, new Medicaid work requirements would place an undue burden for not only meeting the 80 hours/month requirement, but having the means to submit the paperwork, receive timely communications about eligibility redeterminations, and more. Effectively, this federal action will result in our patients losing their coverage and losing connection to providers who have worked to develop relationships with patients who have historically been hard to engage. The medical and behavioral health care services that we provide in the outpatient setting are the keys to preventing expensive hospital and emergency department care.

We request that the Commonwealth explore requesting an exemption for work for homeless individuals requesting the Secretary of HHS to allow homelessness as a “short-term hardship event”, being part of the “medically frail” exemption, or as its own standalone work exemption. This exemption policy could be supported by identifying those that have a Z59.0 code in health claims data and/or leveraging data from state and local Homeless Management Information Systems (HMIS) as MassHealth does for determining timelines for eligibility redeterminations.

We are grateful to MassHealth for setting policies for 24 months of continuous eligibility for those individuals who meet the definition of chronic homelessness. We strongly advocate to expand this policy to include a broader set of homeless individuals. This includes those that are street homeless or rough sleepers and not accessing shelters, and therefore not in HMIS. Using Z59 codes or HMIS data to verify homelessness would better ensure that vulnerable populations maintain MassHealth eligibility for 24 months and uninterrupted care. It could offer some flexibilities such as a grace period if they miss a communication about a deadline to fill out renewal paperwork, while reducing significant administrative work that our staff must do now to keep coverage intact. We also advocate for MassHealth to continue to employ a wide array of methods (email, text, mail, etc.) to communicate with individuals about time-sensitive eligibility issues including allowing mail to be sent to providers when someone does not have a permanent address.

Other federal actions that threaten core program revenue include new pharmacy 340B program changes. The funds obtained from the 340B program are reinvested back into BHCHP to enhance and support vital services and staff that assist patients, which would not be possible without this program. This program enables BHCHP to optimize their resources and offer additional services to our patient population, many of which do not receive reimbursement from health insurance.

In the existing 340B framework, we buy medications at a reduced rate initially. The suggested rebate model would impose the following requirements on us:

1. Acquire pharmaceuticals at the standard, non-discounted rate.
2. Await the manufacturer’s processing and return of the rebate, a task that may come with significant administrative challenges and unforeseen delays.

This rebate approach jeopardizes the essential goal of the 340B program, which is to establish the financial support crucial for delivering comprehensive care to the nation’s most at-risk populations. BHCHP has conducted a cost analysis on ten medications planned for the rebate initiative in 2026. According to the existing

model, the initial expense would be \$30,000, whereas with the rebate model for these identical ten drugs, we would face an upfront cost of \$950,000 at retail price, reflecting an approximate increase of 3066%.

More specifically, the 340B savings are reinvested to support:

- Free or discounted medications for our uninsured and underinsured patients.
- Behavioral health staff and programs (e.g., substance use disorder and mental health counseling).
- Our Sliding Fee Scale, making all services affordable for low-income patients.
- Enabling services such as transportation and translation that break down access barriers.
- Specialty care and chronic disease management programs.

With the loss of 340B revenue will be faced with extremely difficult choices on cutting core services for our population.

2. Many Massachusetts health care providers continue to face significant workforce challenges. What strategies has your organization successfully implemented to improve recruitment and retention of clinical and/or non-clinical workers? What policy, payment, or health care system reforms does your organization recommend to better sustain, strengthen, and diversify the health care workforce more broadly in Massachusetts?

Many Massachusetts health care providers, including Boston Health Care for the Homeless Program (BHCHP), continue to experience significant workforce challenges in the wake of inflation, rising costs of living, and a tightening labor market. As a mission-driven organization, we are committed to offering competitive compensation to retain highly skilled staff who care for some of the most medically and socially complex patients in the state. However, payroll now accounts for approximately 65–70% of our overall operating budget, creating sustained financial pressure. These challenges are compounded by burnout across both clinical and non-clinical roles, particularly in settings that require high emotional resilience and deep trauma-informed practice.

To strengthen recruitment and retention, BHCHP completed a comprehensive market compensation analysis and implemented targeted market adjustments for

key clinical roles, including registered nurses and behavioral health clinicians. These adjustments were essential to remain competitive with larger health systems and to reduce turnover among experienced and specialized clinical staff. At the same time, to meet growing service needs, BHCHP has recruited a higher proportion of early-career and less experienced workers across the organization. While this has expanded opportunities for workforce entry, it has also contributed to increased turnover, as newer staff may require more support to manage the intensity of street-based care, shelter-based care, and complex primary care settings.

Given statewide workforce shortages, BHCHP recommends expanded public investment in health care training pipelines, particularly for nursing, behavioral health, and other clinical roles critical to community-based care. The Commonwealth should increase funding for workforce development grants that are accessible to community-based and safety-net providers—not just large systems—so that organizations like ours can strengthen clinical supervision, residency-style training, and advancement pathways. Additionally, expanded tuition support, loan repayment, and scholarship programs for individuals entering nursing and behavioral health fields would help diversify the workforce and create sustainable pathways into long-term health care careers. Increased, predictable payment structures for community-based care would further support providers in offering competitive wages while maintaining access to high-quality care for vulnerable populations.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs of providing care?

Boston Health Care for the Homeless Program recognizes that administrative complexity places a significant burden on our organization, our clinical providers, and—most importantly—our patients. Our work serving homeless individuals is supported through value-based payment arrangements with MassHealth, including ACO/MCO capitation rates adjusted for social determinants of health. While we are grateful for MassHealth's recognition of the service intensity required to care for this vulnerable population, the adjusted payment model creates significant unintended administrative consequences.

First, eligibility redeterminations frequently remove patients from MassHealth coverage, interrupting payment and requiring substantial case manager and front desk staff time to reinstate coverage—sometimes taking days or months. This administrative churn directly reduces our payment stream while increasing staff workload.

Second, capturing and coding social determinant of health assessments requires extensive cross-checking of claims, health encounter data, and care plans across multiple systems. Resources that would be better invested in frontline clinical staff or innovative technology are instead consumed by administrative personnel ensuring proper code capture and documentation compliance.

Our clinical providers are also facing significant documentation and coding burdens. Payers require that chronic conditions be re-coded at least once per calendar year, even when conditions do not resolve with treatment (such as amputations or HIV status). While re-coding is necessary to ensure accurate risk adjustment, this annual documentation requirement places additional burden on providers to re-document conditions that may never change. This represents documentation work that does not advance clinical care but is mandated by payment rules.

For nurses, social workers, and case managers providing complex care management for homeless individuals, requirements to update care plans with patient input every six months—and each time a patient accesses an emergency room—create

tremendous documentation burden. For our homeless population, ER access can be frequent, resulting in continual care plan updates that occupy staff time that could be directed toward direct patient care engagement.

In response to these administrative requirements, we recommend consideration of the following strategies:

First, it would be helpful to support AI-based clinical documentation tools for practices like ours. BHCHP is piloting an AI tool (Abridge) integrated with our Epic EHR that uses ambient clinical recording and natural language processing to automatically generate draft clinical notes. Early results show this tool significantly reduces provider documentation time while enhancing coding precision and improving provider satisfaction and burnout metrics. The cost—approximately \$250 per provider per month—is significant for community health centers. We recommend that policymakers consider funding mechanisms or reimbursement models to support the adoption and scaling of AI-based clinical documentation tools, which can simultaneously reduce provider burden, improve care quality, and enhance coding accuracy.

Second, we require sustained telehealth reimbursement. Telehealth has proven particularly valuable in our Behavioral Health department, supporting increased provider productivity and reduced patient no-show rates. For geographically diverse patients and staff, telehealth visits provide critical access options. We urge continued support for robust reimbursement of telehealth visits for both medical and behavioral health services, ensuring that organizations like BHCHP can maintain continuity of care and provider efficiency.

Additionally, policymakers should work with payers to review and streamline chronic condition re-documentation requirements in value-based payment models. Where clinical conditions do not change, annual re-documentation should not be mandated solely to maintain accurate risk scores.

We also recommend that MassHealth explore policies that reduce coverage gaps due to eligibility redeterminations, such as streamlined reinstatement processes. This would reduce administrative costs for both the program and providers while ensuring uninterrupted coverage for vulnerable populations.

These administrative burdens are not trivial. They consume resources and provider attention that could be directed toward vital clinical care and patient engagement. Targeted policy changes, coupled with support for technology solutions and

continued telehealth reimbursement, can meaningfully reduce administrative complexity for health centers like ours while improving both provider satisfaction and patient outcomes.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. If your organization includes primary care providers, what activities or investments are you pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your patients? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms does your organization recommend to enhance equitable access to high-quality primary care services?

For 40 years, Boston Health Care for the Homeless Program has been demonstrating what comprehensive, person-centered primary care looks like when designed for one of the most complex and vulnerable populations in Massachusetts. Today, our team of over 500 staff members provides integrated, continuous primary care to approximately 11,000 unique patients annually. We believe our experience offers important insights into what is needed—both organizationally and systemically—to enhance equitable access to high-quality primary care.

BHCHP's primary care model is built on the foundation of continuous, multidisciplinary care that addresses the full spectrum of our patients' health needs. Our services include:

- Adult & pediatric primary care
- Integrated behavioral health services
- Substance use disorders treatment and support
- Street team outreach and engagement
- HIV testing, counseling and treatment
- Hepatitis C testing and treatment
- Medical respite care (103 beds)
- Case management
- Dental care
- Family and youth services
- Public health interventions
- Meal services

A defining feature of BHCHP's primary care model is the deep integration of behavioral health with primary medical care. This integration is not simply co-location—it reflects a

fundamental organizational commitment to treating mental health, substance use, and medical conditions as interconnected aspects of whole-person health.

Our integrated care model includes, for instance: on-demand (same-day, walk-in) behavioral health access for primary care patients, eliminating referral delays; co-located primary care and behavioral health providers who share the same electronic health record and care coordination infrastructure; unified care planning that integrates primary medical goals with behavioral health and substance use treatment goals; and care conferences that include both primary care and behavioral health members of patients' care teams. This level of integration is essential for our unhoused patient population, for whom untreated mental illness, trauma, and substance use disorders are prevalent and deeply intersect with medical conditions. Integrated care improves treatment adherence, reduces fragmentation, and leads to better health outcomes.

BHCHP maintains a robust quality program that monitors core clinical quality metrics, as well as patient satisfaction, to monitor the effectiveness of our care model. Our quality metrics include, for instance, outcomes related to hypertension and diabetes control; screenings for illnesses like cancer, HIV, and TB; depression screening and follow-up; patient retention in office-based addiction treatment (for patients with opioid use disorder); inpatient hospital readmission, follow-up after hospitalization for mental illness; among others. Our interdisciplinary Quality and Efficiency Committee brings primary and behavioral health care staff together to collaboratively strategize around quality care gaps.

Beyond this foundation of our integrated care model, BHCHP is pursuing specific initiatives to further enhance access to affordable, high-quality primary care. For example, our medical respite program has recently added a satellite opioid treatment program to offer on-site access to daily methadone dosing for the many Respite patients in need of this service.

While BHCHP has invested significantly in primary care infrastructure and integration, systemic barriers prevent many organizations—especially safety-net providers like BHCHP—from sustaining high-quality primary care. We applaud the Health Policy Commission and the Commonwealth's Primary Care Task Force for their commitment to rebalancing payment in the health care system to support primary care. However, these efforts are often offset by concurrent value-based payment models that penalize or create downside risk for primary care providers who do not meet certain performance targets—such as inpatient or emergency department utilization targets—especially when those targets are not adequately adjusted for case complexity and patient risk. For providers serving high percentages of homeless and other complex populations, these

utilization targets are particularly problematic because they often reflect unmeasured clinical and social complexity rather than quality of care.

We support efforts such as those in California to establish a goal of reaching 15% of total health care spending on primary care by 2034—a target that would require substantial rebalancing of payment in Massachusetts. We also advocate for mandatory public reporting of health plan investments in primary care, enabling transparency about whether payers are actually shifting resources toward primary care as intended. Primary care clinician shortages are a critical barrier to expanding access to high-quality care. BHCHP supports investments that attract and retain primary care professionals, including:

- Enhanced compensation for primary care physicians, nurse practitioners, physician assistants, and other primary care clinicians
- Medical school tuition reimbursement programs for students committing to primary care careers
- Enhanced graduate medical education (GME) payments to teaching hospitals for each primary care residency slot
- Loan forgiveness programs for primary care providers serving underserved populations

Community health centers and other safety-net providers serve the most complex, resource-intensive patients in the health care system. Payment models and system investments must reflect this reality. Like many other community health centers across the state, BHCHP has struggled with several years of deficit budgets have resulted in recent actions to reduce programs, services, and workforce. With looming Medicaid cuts, we are likely to face further cuts.

5. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out of pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

BHCHP's payer mix includes almost no private health care coverage for our patients. We would be ready and willing to work with the state and other provider and community-based partners to preserve access for the growing uninsured population to critical

services and ensure that the funding is viable, both today and in the future, in ways that are efficient, equitable, and sustainable.

We are in the early stages of planning for the new Medicaid and marketplace changes that will likely result in increasing the amount of uninsured seeking care from us.

Regarding health insurance costs, BHCHP manages rising health insurance costs by balancing affordability with comprehensive coverage and minimizing financial burden on lower-wage staff. We maintain a tiered premium structure in which the lowest-paid employees contribute the least, and we regularly refine plan design to maximize value, including introducing high-deductible options to expand choice and control cost growth. We work closely with our broker and carrier partners to negotiate favorable rates, monitor plan performance, and provide wellness programs, preventive care incentives, and health education resources to support employees' ongoing health. By promoting early engagement in care and offering benefits that are both equitable and sustainable, we aim to preserve access to high-quality coverage while responsibly managing organizational expenses.

QUESTIONS 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) 2023-2025 | | |
|--|---------------------------------------|--|
| Year | Aggregate Number of Written Inquiries | Aggregate Number of Inquiries via Telephone or In-Person |
| CY2023 | Q1 | |
| | Q2 | |
| | Q3 | |
| | Q4 | |
| CY2024 | Q1 | |
| | Q2 | |
| | Q3 | |
| | Q4 | |
| CY2025 | Q1 | |
| | Q2 | |
| TOTAL: | | |

BHCHP does not have sufficient data to complete this chart.