

2025 Pre-Filed Testimony  
PROVIDERS



As part of the  
*Annual Health Care  
Cost Trends Hearing*

Massachusetts Health Policy Commission  
50 Milk Street, 8<sup>th</sup> Floor  
Boston, MA 02109

Massachusetts Health Policy Commission  
50 Milk Street, 8<sup>th</sup> 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](mailto: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  
[HPC-Testimony@mass.gov](mailto:HPC-Testimony@mass.gov) or  
[lois.johnson@mass.gov](mailto: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](mailto:sandra.wolitzky@mass.gov) or (617) 963-2021.

## 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?

Recent federal policy changes are expected to have a profound impact on healthcare delivery in Massachusetts, with up to 300,000 losing coverage. As a result of the One Big Beautiful Bill's new work requirements and eligibility redeterminations, as many as 175,000 people are expected to lose MassHealth coverage. Similarly, changes to eligibility and redetermination, as well as the expiration of enhanced tax credits will result in up to 100,000 losing coverage for the Connector products. For Berkshire County this would mean approximately 5,000 individuals would lose coverage. We expect this will cause people to delay or forgo care, which will ultimately require more intensive, expensive treatment when they do reach the hospital. Emergency departments will become an even more prominent first and last line of defense for many. Assuming even just half of those individuals need services and are unable to afford the cost of their care, at an average annual cost of \$6,000, Berkshire Health Systems' unreimbursed cost would be \$15,000,000, absent any additional funding for the Health Safety Net Fund.

**To ensure stability and mitigate any negative impacts on our people, patients, and community, Berkshire Health Systems (BHS) is prioritizing and has recommendations around:**

#### Rural Healthcare

Berkshire County is a rural county with low population density and a relatively large geographical footprint (roughly 50 miles by 20 miles). Providing equitable access to services across the entire county is extremely challenging as it is not economically feasible to staff services in close proximity to all residents. There is simply not the population density necessary to support the physical and human resources required. We have challenged ourselves to provide consistent access to services across the north, central, and south portions of the county, though at times this may not always be possible. As a result, patients may need to drive long distances to access services. And worse yet, some patients may not have access to transportation making access to care even more challenging. **We recommend the state consider how to make transportation more available within the county.**

An important opportunity for bridging transportation gaps can be found in telehealth. Flexible telehealth services can improve healthcare access for rural residents who

often face long travel distances and provider shortages. By enabling timely consultations, chronic disease management, and mental health support, telehealth has the opportunity to improve overall health outcomes. Moreover, flexible telehealth options foster equity and sustainability in rural healthcare delivery. **We recommend that telehealth be a covered service, regardless of where the patient or provider is geographically located.**

The pandemic required providers to change the way care was provided to patients. The acceleration of telemedicine was one of those changes. Telehealth removes some of the access barriers associated with the rural nature of Berkshire County and is even more important for the rendering of care by certain specialties, such as neurology where consults and visits are performed by providers on the eastern part of the state, while patients are at BHS or at home. Telemedicine has become a tool to ensure patient access to care. **We recommend the state invest in making telemedicine more accessible through internet reliability throughout the most rural areas of the state and ensure that all areas have universal access to basic internet coverage.**

Physician recruitment is also impacted by the lack of population density. Patient volumes are often insufficient to support groups large enough to offer equitable calls. With smaller practice sizes, providers must cover more nights/weekends than their counterparts in larger practices in more urban/densely populated areas. In the Berkshires, coverage must also span multiple facilities stretching 50 miles shared among these same practices. Providers are often not interested in this higher call burden and opt to practice in more populated areas. The economics of recruiting sub-specialist providers is even more challenging as patient volumes may only support a limited number or partial provider, which does not appeal to most specialists. From the hospital perspective, supporting the higher salaries of sub-specialists is also not economically viable due to the limited volumes. Physician locums cost for specialists totaled \$20M in FY25, a premium of \$12M if able to employ.

Again, telehealth presents significant opportunities for improvement and efficiency in care delivery. By allowing telehealth providers to function as an extension of in-office visits, providers can offer continuity of care and allow the plan of care to be managed locally. For example, a BHS patient could be seen in a local office setting and be supported by an on-site MA or LPN, while a provider engages with the patient through telehealth. **We recommend the state consider ways to encourage specialists, sub-specialists, primary care practitioners to provide care in lower population settings, such as Berkshire County. Specifically, we recommend that rural healthcare systems, like BHS, be able to engage with sub-specialists as an extension of our provider practices and that provider groups be able to bill for these services as an extension of in-office care.**

Our community is older and poorer than Massachusetts as an average with a governmental payer mix of 76% and just 23% covered by commercial insurance (and 1% self-pay). As such, our patient profile resembles the high government concentration typical of a community health center or federally qualified health center. Community health centers, in recognition of the patients they care for, are at times

eligible for funding not available to other providers such as loan forgiveness and residency training through GME. **We recommend the state consider ways to offer similar support to sole community hospitals and critical access hospitals, both of which serve patient populations resembling those served by community health centers.**

#### Expansion/Support for Behavioral Health and Substance Use Disorder

Berkshire County has experienced an increase in suicide as well as substance use disorders (SUD). For reference, the rate of deaths of despair (defined as death due to intentional self-harm (suicide), alcohol-related diseases, or drug overdose) in Berkshire County was 80 per 100,000 in 2018-2022, the highest rate in Western Massachusetts (state rate: 56 deaths per 100,000). To address this concern, the county needs a more comprehensive focus on outpatient care and the ability to identify community members in need of support. Schools, workplaces, and primary care providers must have the ability and resources to identify those in need of help. Proactively identifying those in need will curtail the need for costly acute care, as well as save lives. The ability to identify and support this population can be addressed with outpatient services. **We recommend the state consider ways to expand outpatient behavioral health in Berkshire County and other underserved communities across Massachusetts. We also recommend that the state promote careers as community health workers, clinicians, social workers, and nurses to work in behavioral health as one of its workforce priorities.**

Berkshire Medical Center has a SUD unit as well as a Crisis Stabilization Service (CSS), however a Transitional Stabilization Service (TSS) does not exist and is needed in Berkshire County. There is no treatment/support for those leaving BMC CSS that may need more supervision and support. Many of our patients discharging from CSS refuse to transfer to a TSS in the eastern part of the state due to the long distance from home and family.

We find that many community members are unwilling to travel for support services such as these. The distance prohibits the client from moving forward with their life while remaining in their community, so they choose not to participate in further treatment, sometimes leading to poor outcomes. SUD patients would have greater success and outcomes if the county had a TSS service. **We recommend the State consider supporting Transitional Stabilization Services in Berkshire County.**

#### Career Pathways

A nationwide workforce shortage, increased patient demand, and record turnover rates threaten stability across the healthcare landscape. This is not a new problem – it has been evolving over the past decade. In response, BHS determined that, given the limited population in the region, the supply of qualified skilled staff in our market would be insufficient to meet the healthcare needs of the community. For example, a lack of Medical Assistants was limiting patient access to physician practices but there were not enough Medical Assistants in the region to meet our needs through aggressive recruitment. BHS needed to take an unprecedented proactive role in building the supply of skilled staff.

We concluded that the primary obstacle to recruiting sufficient students into training was the students' need for full-time employment income during education. One of our local education partners, Berkshire Community College, conducted a survey to determine why a low percentage of students who completed the pre-requisites for the Nursing program pursued a different career. The primary reason was that the students would have been unable to support themselves and their families without full-time employment while completing the rigorous training program.

In response, BHS developed its Career Pathways programs, which launched in 2022. BHS has focused on building pathways to the most immediately needed roles: nursing assistants, medical assistants, licensed practical nurses, and registered nurses. The program covers the cost of tuition, books and fees for specific healthcare training and education programs. What sets the program apart is that it also provides each student with full-time salary and benefits for the duration of the program while requiring limited hours of work at BHS (as little as 8 hours per week, depending on the demands of the academic program a student is enrolled in). Students have an obligation to remain employed with BHS after the program for a fixed period depending on the investment (e.g., 2 years for a Medical Assistant, 3 years for an RN). We have also developed additional pathways for bachelor's-prepared nurses, biomedical equipment technicians, practice manager apprentices, and radiology technicians like cardiac sonographers, CT technologists, and MRI technologists. As we begin our fifth year of Career Pathways, we have grown the program from supporting and training approximately 37 full-time equivalent positions (FTEs) in FY22 to a projected 109 FTEs in FY26.

We invest almost \$6 million per year, and this number is expected to grow as we continue to develop pathways in other positions experiencing shortages. Though we believe there is a payback for this program, it is a significant investment representing the equivalent of about ½ a percent (0.50%) operating margin. With many other competing financial priorities, an expected growth in the program's cost and the likelihood that the availability of workers will remain insufficient for the foreseeable future, it will be very difficult to sustain this necessary investment. It is even possible, that in spite of this program, employee attrition will exceed the number of new staff trained. Support for the Pathway program would allow us to continue the development of a healthcare workforce in the county. **We recommend the state consider partnering in a program to build the healthcare worker pipeline across Massachusetts.**

Through the Career Pathway Programs, and in recruiting into entry-level positions, BHS has been able to increase hiring among under-represented populations. In doing this we have had success in creating lasting employment relationships with individuals who have not had a consistent employment history or have not been employed at all. The lack of a work history means many of these individuals have not yet developed the skills necessary to be successful in their new roles. This is a problem both for recent high-school graduates and individuals in their 20s and 30s. Even with additional counselling and support, the failure rate among these groups is far too high. If this

problem could be addressed, our workforce development efforts would be substantially more effective and more efficient.

Additional training (in schools, or at BHS) has been, and research says will continue to be ineffective. Addressing this problem requires a mind-set change that can best be accomplished through frequent coaching and mentoring interactions with an individual who is not the supervisor. BHS's proposed solution is to develop best-practice, evidence-based approaches to coaching and mentoring, and attract peer employees to be trained as coaches/mentors for one peer employee at a time. Given the additional commitment of time and attention to the training and coaching, BHS would need to invest in compensating these peer coaches.

**If State funds were available to help offset the cost of this coach compensation, such a program could be within reach for BHS. Additionally, if the State were in a position to facilitate the development of solid, high-quality training in coaching and mentoring, it would help ensure effective delivery of this service and improve the effectiveness of almost all employer-based workforce development programs.**

#### 340B

The 340B program was created in 1992 to allow covered entities "to stretch scarce federal resources as far as possible reaching more eligible patients and providing more comprehensive services." The intent of the program was to support patient access to services through financial support to providers considered most vulnerable due to their location and patient demographics (e.g., rural, and/or high Medicaid patient mix). Providers in the 340B program are able to purchase outpatient drugs at discounted prices for covered patients (under the care of an entity provider) for prescriptions filled at hospital owned retail and specialty pharmacies and community retail pharmacies. The community and BHS have benefited from this participation in 340B and the services available would likely look very different if it were not for this support. Beginning in 2020, drug manufacturers have been increasingly restricting access to 340B pricing for prescriptions filled at contract pharmacies, resulting in a \$10 million plus decrease to BHS. In the absence of national legislation to address this issue, several states have passed their own laws to ensure manufacturers do not restrict providers' access to 340B pricing. **The Massachusetts House and Senate, respectively, have introduced legislation to protect 340B contract pharmacies, including House Bill H785 and Senate Bill S779, both aimed at prohibiting drug maker restrictions and safeguarding access for safety-net providers. We recommend support of both bills.**

Another component of the 340B process for which changes have negatively impacted BHS relates to a new rebate model pilot program. This new program is scheduled to be implemented by January 1, 2026. The 340B rebate model extends the timing for when providers are refunded for 340B discounts from the time of replenishment to an arbitrary timeline dependent on pharmaceutical manufacturer policies, reviews, and workflows. It is likely the pharmaceutical manufacturers will create administrative hurdles to prevent providers from ultimately receiving entitled reimbursements. This

change will shift financial risk, delay reimbursements, and undermine the upfront savings that safety-net hospitals rely on to serve vulnerable populations.

Maintaining a strong 340B program is vital to BHS's long-term sustainability and the health of Berkshire County. Like many hospitals and health systems, BHS is the safety net of our community. We serve any patient who comes to us for care – regardless of their insurance coverage. We are also Berkshire County's largest employer, making us an economic anchor for our region. A robust 340B program is essential to our organization's sustainability and our region's health, wellness, and economic strength. Any changes to or restrictions on the 340B program could result in difficult decisions negatively impacting our scope of services available to the community, reducing access to overall care. **We recommend that the State advocate to eliminate the rebate model and stop it from moving past the pilot stage.**

#### Patient Throughput

Over the course of the pandemic and since, BHS has been faced with a multitude of throughput challenges. In response, we have created a multidisciplinary, multidepartment throughput team. This team has identified several opportunities to improve ED wait times, the admission and discharge process and create improved communication with patient families and the multidisciplinary team to ensure admission length of stay and treatments provided are appropriate. The team instituted a more efficient process for ED registration, triage and work up. If appropriate, patients in the waiting area to be seen by a provider are worked up so treatments and care decisions can be expedited, reducing the ED visit duration. A nurse and a patient advocate have been added to the area to ensure timeliness of care, communication and safety of the patient reducing the rate of patients leaving without being seen. The team is also addressing the admission process and has developed overall improved communication among ED providers, admitting providers, patient placement directors, and admitting. These actions continue to reduce ED wait time supporting BHS's goal to improve access.

In March 2025, a dedicated short-stay observation unit was created at BMC with the expectation that the length of stay can be decreased by congregating similar patients where hours are impactful for length of stay, rather than full 24 hours. This has enabled short stay patients to be discharged more efficiently increasing bed availability on inpatient units.

To address inpatient care and throughput, the acute care team has instituted Structured Interdisciplinary Bedside Rounds (SIBR). This initiative promotes communication and alignment of care, treatment, and progress amongst the team. Daily, multidisciplinary team members discuss patient progress and transitions of care at the bedside with patient and family participation. Discharge plans are reviewed and solidified at this time ensuring the team and patient expectations are aligned. There has been a reduction in length of stay and improved patient experience, as well as improved patient outcomes. CAUTI, C-Diff, falls have all decreased with the implementation of this initiative.

Plans are also underway for the creation of a care coordination hub at BMC, which will go live in FY26. The hub will centralize many of the disparate processes across both BMC and Berkshire Health Systems to ensure patients are efficiently progressing to their next level of care and receive care as close to home as possible. We expect the hub will help to reduce length of stay and decrease patient transfers.

Our work around patient throughput described above are examples of our constant pursuit of process improvement to help drive cost out while improving patient experience and outcomes. This work is on-going and essential to Berkshire Medical Center’s ability to offset the impacts from the decreasing revenue resulting from the One Big Beautiful Bill.

**In addition to the recommendations shared above, the Commonwealth should remain focused on efforts that:**

- **Keep as many people on coverage as possible,**
- **Stabilize the Health Safety Net through creative funding solutions built between the state and hospital community,**
- **Invest in our nation-leading MassHealth program,**
- **Grow innovations like telehealth, hospital-at-home, remote patient monitoring, and mobile integrated health, and**
- **Empower, rather than further burden, healthcare providers and patients.**

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?

Similar to many other healthcare providers and employers, we have experienced historically high turnover since the pandemic:

	2020	2021	2022	2023	2024	2025
Turnover rates - BMC	18.6%	21.9	22.0%	18.6%	17.7%	15.8%

Turnover has been driven by many factors including:

- an aging workforce with insufficient new employees choosing healthcare as a career, who instead are seeking options not previously available for past generations;
- the burnout and uncertainty created by providing care during the pandemic;
- leaving to pursue traveling contract work;
- a preference for weekday work hours;

- higher compensation offered by competing providers or in other industries, due to rapidly escalating wages.

This turnover is placing a significant burden on our ability to employ enough staff to meet patient demand. In order to continue offering access to services, we have had to utilize contract labor at levels three times higher than just a few years ago with costs going from \$14 million to \$55 million in FY25. Contract labor rates paid to agencies are typically 2.5 times higher than what we would pay if we could hire for these positions, so the increased fees we are now paying represents an incremental premium of \$24 million. Increases in contract labor are spread across all categories with nursing increasing \$11 million, physicians by \$8 million, CRNA by \$8 million and ancillary/support increasing by \$14 million. These significant cost increases are not sustainable.

At times, we have had to restrict patient access by limiting appointments or scheduling out with longer than desired wait times due to staffing constraints.

Post-acute care providers are experiencing similar workforce shortages resulting in a direct impact to BHS's ability to transition patients to the next level of care. When reviewing data related to patient average length of stay within the same diagnosis related group (DRG), patients discharged to post-acute providers vs. going home have a one day longer length of stay, in part driven by their limited staffing. Also contributing to a higher length of stay for discharges to post-acute providers lack of beds for dementia and behavioral diagnosis within a 50-mile radius, reflective of their financial challenges caring for these residents. Skilled nursing facilities are also reluctant to take patients with substance use disorders due to higher staffing requirements and the related cost resulting in lengthy hospital stays.

Similarly, ambulance squads and other medical transporters often have the inability to transport emergent and non-emergent patients due to their own staffing deficiencies. The county is in dire need of EMS staff, paramedics in particular. BMC has held multiple patients for hours in the ED needing transport to a tertiary facility. This not only impacts patient outcomes but also access for those waiting to be seen.

Transport issues also arise when attempting to transport discharged patients to the next level of care. Length of stay has been impacted negatively due to patients waiting in Acute Care for transport by ambulance or cabulance to post-acute settings. The county's only non-medical transportation service offering stretcher transportation for stable patients needing to return to their homes or their skilled nursing facilities closed due their inability to find staff. EMS squads have attempted to step in to fill this void where possible, but it has further exacerbated delays transporting patients and in turn extended hospital lengths of stay.

#### What We are Doing:

As noted above, we have made a significant investment in our Career Pathways Program, which we expect will increase the number of trained staff available to fill

vacant positions improving both access to care and reducing our reliance on agency costs.

To meet our workforce needs, we have even extended our recruiting efforts beyond our typical catchment area for employees and have sponsored international workers for lab technicians.

Healthcare wages and those in other industries have been rapidly escalating since the onset of the pandemic, and to stay competitive we have provided for pay increases above inflation and reimbursement rates.

BHS is also on a journey to become a Magnet Designated Hospital, a prestigious recognition of nursing excellence, to support nurses. In addition to our system-wide strategic initiatives, BHS is also a proud advocate for advancing nursing practice across the state through our work with the Massachusetts Health & Hospital Association (MHA). BHS's Chief Nursing Executive works with a select group of CNOs from hospitals across Massachusetts, focused on guiding hospital leaders across the state to more effectively empower and support nursing staff to work to the top of their license and become more fully engaged.

It has been well documented that fully engaged employees are much more likely to stay with an organization. We have always been committed to ensuring our employees feel valued, but given the changes in the labor market, we realized we needed to differentiate ourselves to fully engage our employees. One of the ways we are doing this is by encouraging frequent touchpoints among managers and their teams. This work is supported through weekly "check-ins" between staff and their managers highlighting current projects, barriers to success and things that motivate or discourage team members. Quarterly engagement surveys measure how employees feel about their work, their manager, and the organization. We believe this focus will improve staff engagement and retention.

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?

Administrative responsibilities have become overwhelming for healthcare workers and patients particularly as it relates to patient access to care and revenue cycle activities:

- Access: At any given time, as many as [2,000 patients are "stuck"](#) in Massachusetts hospitals because they cannot access the next level of care they need. Insurance administrative barriers continue to be the top cause.

- Burnout: [According to the American Medical Association \(AMA\)](#), Physicians and their staff spend 13 hours each week completing prior authorizations (PAs) and 89% of them report that PA somewhat or significantly increases burnout. Other factors include the onerous tasks of facilitating eligibility and benefit verification, claims submissions and resubmissions, denials, audits, and navigating unilateral policy/contract changes.
- Costs: [Research shows](#) that administrative spending accounts for 15-30% of healthcare spending, at least half of which is considered wasteful. [Massachusetts Health and Hospital Association \(MHA\) estimates](#) that excessive administrative requirements are adding \$1.75 billion in cost waste to the Massachusetts healthcare system each year.

**Our state can look to several areas to make a difference:**

- Passing commonsense legislation to streamline the prior authorization process.
- Standardizing prior authorization (PA) requirements among carriers, promoting electronic PA practices, reducing the number of services requiring PA, and providing greater transparency on denials.
- Addressing the unilateral contract and policy changes that add strains to provider operations, challenge patient access, and limit needed reimbursements.
- Encouraging health plans to offer discharge authorizations over the weekend.
- Minimizing new, burdensome reporting responsibilities or mandated administrative requirements for providers.
- Streamlining the administrative requirements for innovative care that can increase access and keep people out of the hospital (telehealth, hospital-at-home, mobile integrated health, etc.)

Other Recommendations:

In order to be considered for Licensure, a registered nurse applicant must fulfill the Good Moral Character requirement for the State of Massachusetts and Board of Nursing. Currently, BHS RN and LPN hires have seen a significant increase in licensure applications being denied due to this regulation. The applicant must prove to the State via written submission that they have corrected the offense noted when denied licensure. Most applicants are able to satisfactorily demonstrate the issue has been resolved (or never was an issue at all); however, they continue to experience long delays waiting for license approval. **We recommend that the state allow the applicant the ability to address these offenses well before they apply for licensure and that nursing students be made aware of this requirement upon applying to nursing school.**

We are constantly focused on reducing administrative complexity in our own organization and it is embedded in our daily thinking. Some current examples of this work include:

- Investing in ambient listening technology for our providers, which will provide editable patient visit notes reducing documentation burden allowing more time for direct patient contact while improving caregiver quality of life;

- Expanding our operational excellence and project management resources aimed at improving work processes and removing inefficiencies;
- Exploring AI for revenue cycle activities including eligibility, prior authorizations, coding, denials, etc. with the expected benefit of being able to shift resources to more meaningful work;
- The creation of an AI sub-committee tasked with creating structure to vet the wave of new applications being delivered by this technology. The sub-committee's work is aimed at protecting BMC from the risks of AI (hallucinations, patient data being exposed, algorithm bias, etc.) while allowing us to harness efficiencies.

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?

Our organization significantly invests in primary care as the foundation of healthcare delivery. We appreciate the state's focus on our commonwealth's strained primary care system. Primary care practices face similar increasing cost pressures as their larger health system partners, especially as they compete for labor in the same market for nurses, case managers, behavioral health specialists, and support staff. As HPC has documented, Massachusetts lags behind the nation when it comes to the primary care workforce. This trend, along with the longstanding financial model, is limiting providers' ability to grow primary care services.

In response, BHS is actively dedicating efforts to address:

#### Primary Care Expansion and Practice Innovations

By focusing on improving access for patients, we are able to support improved outcomes at the bedside. We are currently in the process of launching an Advanced Practice Provider (APP) residency program that is specifically designed to complement existing training and give APPs the experience and support they need to successfully transition APPs into busy primary care practice. BHS has also adopted a new provider model to assist APPs in shadowing a physician with a decreased patient load to ensure APPs from training to bedside are able to be successful and reduce turnover. Investing in these providers will have an exponential impact on access to care for patients, ultimately resulting in between 4,000 – 8,000 additional primary care visits in the county within two years of operation.

BHS has also established a remote APP practice to assist providers to keep up with administrative needs such as portal messages or urgent visits while on vacation so

that they are not overwhelmed upon their return and experience a better work-life balance thus reducing burnout and more timely patient access. The remote APP practice also serves to provide additional capacity for wellness and health organizing visits as well as daily patient overflow volumes. The creation of this practice is expected to result in capacity for an additional 10,000 to 12,000 visits per year.

BHS's flagship hospital, Berkshire Medical Center, was approved by ACGME to expand its internal medicine residency program by six slots to create a specific primary care track. Historically, BMC's residency program has been very successful generating providers who chose to begin their careers in hospital medicine as hospitalists. However, very few chose to become family practice providers. With the expansion of the BMC residency program, we are adding training opportunities more focused on primary care, as opposed to internal medicine, to ultimately expand the number of primary care providers available to meet the demand. The first cohort of primary-care-track residents will match in 2026.

Complex patients (those with a high number of emergency visits and admissions) may often require much longer primary care visits to address their care needs and require more time to establish the appropriate transition of care planning. To better serve these more complex patients, BHS is establishing a multi-visit clinic to provide additional resources for these higher acuity primary care patients who cannot easily be accommodated within the traditional visit duration. In addition to creating primary care capacity, we expect patient outcomes will be improved. We expect to open this practice in 2026.

#### Value Based Care and the Berkshire Fallon Health Collaborative ACO

Building upon our strategic efforts around primary care delivery, BMC has renewed its partnership with Fallon Health to jointly operate the Berkshire Fallon Health Collaborative (BFHC), a MassHealth Model A ACO - which will improve access and outcomes. We are excited to build upon this foundation to enable high quality outcomes while simultaneously advancing health equity and striving to reduce healthcare costs.

As background to provide context for the challenges our ACO faces when delivering care, Berkshire County is a rural community covering 946 square miles with a population of approximately 128,000 and a density of roughly 135 people per square mile. Massachusetts, with a density of 900, is almost seven times Berkshire County. The county is also older, poorer, and less educated:

- Berkshire county's average age is 47 vs. 40 for Massachusetts with 26% of residents being 65 years or older, which is almost 1.5 times the state and national rate of 18%;
- Median income is nearly \$27,000 lower than the state (\$96,505 vs. \$69,744);
- Community health needs assessment shows that poverty rates were highest for children of color;
- Only 19% of the population aged 25 or over has a bachelor's degree compared to 45% for the state.

These demographics have impacted health outcomes resulting in the county rate of premature deaths (before 75) exceeding the state average by 42% with 8,500 lost years per 100,000 population compared to 6,000 for the state.

Substance use is also more prevalent in the county with opioid-related overdose deaths per 100,000 are 78% higher than the state average (32 compared with 18).

Through the work of BHS and our ACO, we are striving to address the lower health outcomes and health inequities caused by these social determinants of health. Our model of care has been restructured to bring care closer to our patients by embedding baseline and enhanced care team members within primary care practices. This is further supported by care coordination at the ACO level to assist with referrals for the most complex patients. We have built a more robust data warehouse to capture patient activity across all members of the ACO. This will better enable care by supporting data driven decision making such as the early identification of at-risk patients through data stratification.

Our data warehouse will support the attainment of our goals for high quality outcomes, health equity and reduced costs by allowing performance to be measured at the provider level. We have set goals in the following broad categories:

- reducing cost by decreasing unnecessary utilization (avoidable admissions and emergency department visits and readmissions),
- improving quality/outcomes
- member experience (communication, integration of care)
- care coordination (transitions of care, outreach and engagement rates and assessment completion)
- health equity (improving screening rates and reducing disparities)

**To further promote primary care, we recommend that policymakers explore expanding the qualifications for loan forgiveness for healthcare professionals beyond Federally Qualified Health Centers, as many healthcare workers at crucial healthcare centers such as Sole Community Hospitals and Critical Access Hospitals are not eligible for this assistance.**

**Policy makers should also support licensed healthcare providers within our immigrant populations as currently between red tape and visa limitations, qualified healthcare providers are not able to utilize their training and are forced to pursue employment elsewhere, wasting their trained expertise at a time when our healthcare industry could benefit from their skills.**

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?

As noted above, the cost of health insurance is driven by the underlying costs across the state's healthcare landscape including complex and, at times, burdensome regulations enacted to protect patients and staff, the continuous development of expensive new technologies and drugs to improve patient outcomes, increasing malpractice, general and cyber insurance risks/costs, and the shortage of healthcare workers driving labor expenses in excess of core inflation. We are continuously focused on decreasing costs and striving to be more efficient. We previously cited some of our efforts to reduce costs including:

- Career Pathways Programs aimed at growing our local workforce and decreasing dependency on contract labor and premium pay;
- Patient throughput resulting in improved patient experience and decreased costs;
- The pursuit of Magnet status for nursing which will enable work at the top of license, improved staff engagement, patient experience and employee retention;
- Efforts to utilize AI and deliver efficiencies;
- Participation in Medicaid and Medicare ACO's aimed at providing the right care at the right time resulting in improved patient outcomes and decreased costs;
- Active collaboration with patients through Advocacy for Access, our insurance enrollment program, financial counseling and payment-plan support, and a pharmacy liaison program that works one-on-one with patients to help them find ways to reduce their out-of-pocket costs;
- Investments in primary care recognizing this service as foundational to delivering on our commitment to improved patient outcomes at lower costs.

An example of a well-intended, but very expensive and unsustainable regulation is Massachusetts Paid Family Medical Leave (PFML). The program is structured so that both extended and intermittent (time off is not continuous) leaves are permissible and can be taken with limited/no notice. The program is also structured such that a wide range of reasons for leave are permitted. Given that BHS operates around-the-clock caring for patients, the majority of these leave hours must be filled and often requires premium costs to do so.

When comparing current leave hours prior to the start of PFML to this most recent year, we have seen an annual increase in leave hours of 100,000 or the equivalent of 55 FTE's. The incremental cost of backfilling staff leaves for this new benefit after deducting employee contributions is \$4.4 million per year. Re-thinking this program could help decrease costs for providers and ultimately decrease the underlying costs of healthcare and health insurance. Though we support the concept of Paid Family Medical Leave, we recommend the state review the cost of the program to identify ways to decrease the significant financial burden to employers.

The cost of providing care has been significantly impacted by contract labor. Massachusetts has attempted to cap the hourly wage of contract staff, in particular, Registered Nurses. However, this initiative was unsuccessful due to the fact that no other State in the country joined in the effort. To be effective in reducing the cost of contract labor, a policy must be developed at a national level. The policy should place a cap on wages paid to caregivers and charged to provider organizations limited to a reasonable mark-up when compared to provider average rates of pay. The policy should also require any travelers to work a designated number of miles away from their primary residence, such that a daily commute would not be possible.

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	14	3
	Q2	15	7
	Q3	9	5
	Q4	5	4
CY2024	Q1	5	7
	Q2	24	2
	Q3	18	1
	Q4	8	2
CY2025	Q1	6	3
	Q2	7	7
<b>TOTAL:</b>		<b>111</b>	<b>41</b>