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COMMUNITY CARE
COOPERATIVE

Statement of Authorization and Verification

I, Christina Severin, am the President and Chief Executive Officer and am legally authorized and empowered to represent C3 for the purposes of this testimony.

I affirm that the attached testimony has been prepared and submitted on behalf of Community Care Cooperative. I further declare under the pains and penalties of perjury that the statements contained therein are true and accurate to the best of my knowledge and belief.

Christina Severin
President & Chief Executive Officer
Community Care Cooperative (C3)
Dated: 11/3/2025

MASSACHUSETTS
HEALTH POLICY COMMISSION

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 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.

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?

Community Care Cooperative (C3) is a Federally Qualified Health Center (FQHC)-led Accountable Care and Management Services Organization representing 24 FQHCs and additional affiliated provider practices across Massachusetts. Our network delivers vital, community-based primary care, retail pharmacy, and co-located behavioral health, vision, dental, and other services. Our network serves patients covered by Medicaid, Medicare, and commercial insurance, as well as individuals without insurance.

We are the largest Medicaid ACO in Massachusetts, and service every geography in the state including the Cape and Islands. We have out-performed the market average on Total Cost of Care (TCOC) every year of the MassHealth ACO program and similarly generated a surplus in our rapidly growing Medicare ACO portfolio every year. Our clinical quality, care management performance, and member satisfaction scores are similarly strong. We have proven that independent, non-profit, primary care-owned networks can excel at managing substantial risk contracts with much lower administrative overhead than traditional health insurance companies or managed care plans. Our model is proven to outperform our competitors, saving MassHealth and CMS tens of millions a year on average.

Federal policy actions now underway will have significant implications for FQHCs and the patients they serve, with challenges emerging on several fronts.

1. Patient Impacts:

Changes to Medicaid eligibility, such as new work requirements, frequent re-determinations, and increased administrative paperwork, are expected to result in both real coverage losses

and procedural churn among individuals who remain eligible but lose coverage due to the complexity of maintaining enrollment. The Blue Cross Blue Shield Foundation of Massachusetts and Urban Institute estimate that 141,000 to 203,000 MassHealth members could lose coverage under these changes. Additionally, expiration of enhanced premium tax credits would place coverage out of reach for many who currently rely on those credits for affordability of plans purchased through the Health Connector. As a result, FQHCs and emergency departments will see more uninsured patients seeking care, straining the safety-net system and threatening access to preventive and chronic care management.

2. **Limits on FQHC Provision of Care**:
Recent federal executive actions related to immigration status and gender-affirming care have introduced uncertainty for health centers. The Health Resources and Services Administration (HRSA)'s newly stated strategic priorities conflict with the Community Health Center Program's long-standing federal mandate to provide care to all patients, regardless of ability to pay. FQHCs could risk loss of federal Section 330 Community Health Center program funding if they serve certain non-qualified alien populations, provide gender-affirming care, or participate in "housing first" initiatives. HRSA has also indicated that future grant funding will be prioritized for FQHCs in states and municipalities that align with Administration priorities, including those related to vaccination policies. These new requirements are at odds with the mission and purpose of community health centers as directed by federal law (42 U.S.C. § 254b), and make navigating the service they provide to their communities significantly more complicated.
3. **Secondary impacts of Medicaid funding cuts:**
One cumulative effect of federal changes, including cascading impacts in the state's tax code and revenue forecast, is a substantial worsening of MassHealth's financial picture. This worsening will inevitably prompt difficult decisions about funding cuts or other policy changes, intended to keep the program solvent. We are already seeing early examples of this (e.g., MassHealth is making changes to the 340b program and pharmacy reimbursement, intended to increase their access to manufacturer rebates. These changes will have unintended, negative financial consequences for safety net pharmacies). We expect more to come, including potential cuts to services, provider rates, and/or ACO administrative payments.

Actions we are taking

We are pursuing four main strategies to try to mitigate the devastation these policy changes will otherwise cause in the safety net:

1. **Build shared infrastructure.** C3 already centralizes or offers as an optional shared service several key FQHC functions. We are aggressively diversifying and expanding this set of services, with the goal of allowing FQHCs to offload their more burdensome, inefficient/ sub-scale, or otherwise challenging functions, so that they can focus more solely on the provision of care. Our FQHCs have asked us to step into this role, driven by the increasing adversity they face and also their confidence in C3's track record of launching and running these services. At present, our services include: our own instance of the Epic EHR optimized for FQHCs, which we license, install, maintain, and support at most of our FQHCs; on-site retail pharmacies which we build, staff, and run at several FQHCs; additional pharmacy support services including 340b optimization; an employer-sponsored insurance captive; a billing and credentialing service; a risk adjustment coding service; IT; payor contracting; and enterprise contracts for legal services, cybersecurity assessments, and other key vendors.
2. **Maximize TCOC performance and value-based care revenue.** We are already a high-performing ACO, which has allowed us to generate tens of millions of dollars of new value-based incentive payments and provide that revenue directly to FQHCs. We are doubling down on this strategy – we have aggressively expanded our value-based contracts in Medicare and are pursuing additional commercial value-based contracts as well; and we are also investing in ways to further optimize our performance under these contracts to generate as much value for FQHCs as possible.
3. **Directly support efforts to maintain eligibility and enrollment.** We already support our FQHCs with monitoring upcoming MassHealth redeterminations and assisting members with the application process, and we intend to expand on these efforts to address the coming crisis, in coordination with EOHHS, the Mass League, Healthcare for All, and other key organizations.
4. **Grant funding.** Lastly, we have been fortunate enough build a balance sheet through our years of successful ACO operations, and our Board has authorized us to use a large portion of these funds to provide grants directly to FQHCs to support infrastructure investments and other sustainability initiatives. These grants are aligned with our mission and non-profit status.

Recommended State Actions

To mitigate the impact of federal policy shifts, Massachusetts should:

- **Ensure that the Health Safety Net holds FQHCs effectively harmless** from the expected decrease in Medicaid/ Connector volume and increase in uninsured volume that they will see over the coming years. FQHCs have very limited funding reserves to

deficit-fund this work, and will inevitably need to consider laying off staff, reducing hours and access, and eliminating programs or sites of care. This is an unacceptable outcome at a time when we have a primary care crisis and other entities in Massachusetts healthcare are so much better capitalized, because it is 100% avoidable if the state has leaders willing to take action. **The state needs to pursue aggressive redistribution via raising new revenue and funneling it into HSN or be complicit in the decimation of safety net primary care.** Doing so will require:

  - **Increasing investment in the Health Safety Net.** The state should size the expected deficit; comprehensively evaluate potential sources of revenue, including the Rainy Day Fund, high earners taxes, increased assessments on less vulnerable parts of the healthcare system (e.g., for-profit entities, commercial health plans, pharmaceutical manufacturers); and then pursue a plan that demonstrably closes the deficit through raising revenue from a combination of these sources
  - **Reaffirming and improving the Health Safety Net's commitments around FQHC reimbursement.** MassHealth currently reimburses FQHCs through a primary care capitation model; this capitation is based on the FQHC Prospective Payment System (PPS) rate and also includes an add-on payment to fund key aspects of high-performing primary care (team-based care, extended hours, integrated behavioral health, supports for children and families, etc.). HSN currently does not reimburse FQHCs using this methodology; therefore, when FQHCs see significant MassHealth volume decline, replaced with increased uninsured/ HSN care, they will experience a significant reduction in funding for their model of primary care. HSN should commit to reimbursing FQHCs using the MassHealth capitation rates

- **Cut underperforming parts of the Medicaid system** before reducing funding for primary care or Primary Care ACOs (which have proven extremely effective in saving the Medicaid program money while delivering on its policy goals at a fraction the cost of traditional managed care). MassHealth will have difficult choices to make in order to meet its budget targets, and may consider "spreading the pain" as a way to manage challenging politics. However, some parts of the MassHealth delivery system are higher performing than others. Specifically:
  - **Managed Medicaid is a failed experiment that demonstrably costs the state hundreds of millions of dollars a year.** Before cutting anything else, MassHealth should eliminate MCOs and the Model A ACO program

(Partnership Plans) and use its procurement vehicles to drive providers into the cheaper, higher-performing Model B ACO program (Primary Care ACOs). MassHealth would save hundreds of millions in reduced administrative payments (Primary Care ACOs are cheaper), along with a host of other efficiency and policy benefits, such as: reduced administrative waste for providers; larger provider networks for beneficiaries (Primary Care ACOs do not limit the network unlike Partnership Plans and MCOs; enrollees can see any MassHealth participating provider); full control over the pharmacy benefit, allowing the state to maximize pursuit of manufacturer rebates (which it currently cannot do for a significant portion of managed care volume); and greater state control over spending in general

- At minimum, **MassHealth should end its longstanding discriminatory treatment of the 340B pharmacy program**, which leaves potentially tens of millions of dollars a year in manufacturer rebates on the table in order to artificially subsidize hospitals (but not FQHCs).
    - Currently, FQHCs are prohibited from making any margin on drugs from the 340B discount (if they dispense to a Model A/ MCO member, they are disallowed from using 340B stock entirely; if they dispense to a Model B/ PCC Plan member, they are required to use 340B stock, but their reimbursement is reduced by the state so there is no margin)
    - However, hospitals were exempted from this restriction; they are allowed to use 340B stock when dispensing to a Model A/ MCO member and get reimbursed at NADAC or WAC prices, making significant margin
    - MassHealth has recently proposed to further change the rules for FQHCs only, disallowing the use of 340B stock for Model B/PCC Plan patients as well, citing the need for the state to pursue manufacturer rebates on this volume of drugs as a revenue source for the MassHealth program
    - While we respect the state's intention, their inconsistency is glaring, as they are continuing to not touch the (likely much larger) volume of 340B drugs dispensed by hospitals to Model A/ MCO patients. Nationally, hospital 340B volume is over 90% of the 340B program (FQHCs are <10%). Most managed care-eligible MassHealth

beneficiaries are enrolled in Model A/ MCO products vs. Model B/ PCC Plan. **If the state is serious about maximizing pharmacy rebates, they should level the playing field for all 340B eligible entities so that no health care organization is advantaged or disadvantaged.**

    - If the state is concerned that doing so would destabilize hospitals dependent on 340B margin, we would respectfully argue that FQHCs are even more dependent on 340B margin, but already had this margin taken away by the state. With desperate times coming for the safety net, and the state showing willingness to change their 340B approach (although, again, just for FQHCs), now is the time to step back and re-evaluate this disastrous and inequitable policy more fully. The state has an opportunity to maximize pharmaceutical rebates, but do so equitably and share those rebates with both hospitals and FQHCs.

- **Make targeted investments in high-performing safety net providers.** Every crisis is an opportunity, and in addition to the incipient crisis of safety net funding, Massachusetts already faces a crisis of healthcare affordability and another of primary care access. The solution to our problems already exists – the state's FQHCs represent a home-grown, highly efficient primary care network that can manage costs more effectively and cheaply than others. This network already serves 1 in 10 residents of the Commonwealth. With the right infrastructure investment and policy supports, this network could serve 1 in 5 or even 1 in 3, providing a way to actually meet residents' need for primary care access and serving as a powerful mechanism for controlling runaway costs.
  - C3 represents one of the largest, statewide networks for primary care in the Commonwealth, and the only one that is non-profit and fully owned by its primary care providers. **C3 is also perhaps the most cost-effective network in the Commonwealth**, consistently out-performing hospital-based networks and for-profit competitors in both the MassHealth and Medicare ACO programs. Our own track record as well as multiple studies in the national published literature demonstrate that risk-adjusted TCOC is lower for individuals whose primary care is managed at an FQHC than those who get care in other systems. FQHCs are independent and do not have the same incentives to generate hospital referral volume that other providers do, leading to a lower cost pattern of care with fewer avoidable specialist visits,

labs, and images. Instead, FQHCs have a decades-long culture of integrated services on-site and in the community (pharmacy, behavioral health, vision, dental, etc.), and providing a maximalist whole-person care experience, in the patient's community and often in their preferred language

  - C3 could collaborate with the state to develop an **ambitious program of capacity expansion**, including implementing innovations like virtual-first triaging and urgent care, expanded use of Nurse Practitioners and Physician Assistants and unlicensed staff where appropriate, and geography- and site-agnostic care. Such an expansion could serve as a solution to the state's primary care and pharmacy desert crisis, a revenue generator to make the safety net more financially sustainable and less sub-scale, and a TCOC and cost trend control measure (given FQHCs' proven track record at managing costs better than other providers)

  - **C3 is already well positioned to be a "force multiplier" for state infrastructure investments.** We received seed money from the legislature on two prior occasions; in both cases we augmented these with funds from our own balance sheet and then deployed our management team and expertise to achieve massive expansions in safety net infrastructure that were well beyond the scope of the initial investments. In one case, we built the state's only FQHC-controlled instance of the Epic EHR, which has now been deployed at 13 FQHCs and is financially self-sustaining. In the other, we built our FQHC-controlled, non-profit pharmacy cooperative, which is directly addressing the state's pharmacy desert crisis by building and operating FQHC pharmacies in places like Brockton and Lynn.

- **Make commercial payors do their fair share**. Currently, commercial payors in the Commonwealth do not follow MassHealth's payment methods or rates for FQHCs. In many cases, that results in payments lower than what MassHealth is paying. The fact that commercial insurance companies are effectively free-riding off of the taxpayer-funded Medicaid program, by counting on MassHealth to keep FQHCs afloat while themselves paying FQHCs as little as they can get away with, is unconscionable. C3 and Mass League have supported legislation in prior sessions that would mandate commercial payors at least pay the same "floor" rate that Medicaid is required to (the PPS).

- **Take action, as over a dozen other states already have, to protect FQHCs from pharmaceutical manufacturers making the funding situation worse.** Outside of the

MassHealth 340B issue described above, 340B margin for commercial patients is as important source of revenue for FQHCs (in the millions of dollars per year for a single site). However, this revenue (which comes at no cost to the state or taxpayer, and is financed instead by the pharmaceutical manufacturers themselves) is under significant threat from a host of unilateral rule changes the manufacturers (as well as for-profit contract pharmacies like CVS) have implemented. Many of these are being challenged in the courts, but in the meantime a number of states have passed legislation banning these activities, which are intended to reduce the margin that the 340B program intentionally transfers from pharmaceutical manufacturers to FQHCs. C3 and Mass League have supported legislation in prior sessions, based on that successful legislation in other parts of the country, which would provide similar protections to Massachusetts FQHCs. **At a time of massive funding contraction for the safety net, allowing the already rich to get richer off of this program intended to help sustain safety net primary care is beyond perverse.** Massachusetts is already far behind the curve on this issue and the state must take action.

- Additionally, the state should **ensure timely and transparent communication** from state agencies regarding changes in federal payment methodologies to enable FQHCs and ACOs to plan responsibly, and **strengthen state public-health data infrastructure** to fill the information gaps created by federal cuts to the CDC and other agencies, and continue to position Massachusetts as a leader in data-driven health policy and preparedness.

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?

C3 and our network of FQHCs continue to invest in strategies to recruit, retain, and develop both clinical and non-clinical staff. Current initiatives include leadership training programs for emerging non-clinical and clinical leaders, targeted upskilling opportunities for key care team roles, float pool staffing to provide relief during vacancies, and development of new residency and fellowship programs for primary care providers. In the past year, C3 invested nearly $3M in direct workforce grants to FQHCs, supporting initiatives that have helped improve recruitment, reduce turnover, and expand training pipelines for future health

center professionals. One FQHC noted that as a result of workforce investments their 2025 retention improved more than 10% from the previous three years.

However, workforce investments like these cannot offset the impact of inadequate reimbursement for primary care services. The single most important policy reform to sustain and grow the workforce - particularly within FQHCs - is payment parity across payors. Today, commercial payers are not required to reimburse FQHCs at least at the federally mandated Prospective Payment System (PPS) rate. As a result, health centers are routinely paid less by commercial insurers than by MassHealth for the same primary care services, putting them at a severe financial disadvantage.

These inequities undermine FQHCs' ability to offer competitive compensation and benefits to providers, nurses, and care team members - exacerbating recruitment and retention challenges. Policies that require all payors to reimburse FQHCs at no less than the PPS rate, and that align payment for equivalent services across health care provider settings, would directly strengthen the primary care workforce. Ensuring FQHCs are fully staffed will, in turn, expand timely access to comprehensive primary care across Massachusetts.

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?

Pursue a statewide single-payor system. Or, at minimum, re-implement a central all-payor rate-setting authority (which Massachusetts used to have). The massive administrative savings of these approaches, over our current environment in which every payor and every provider independently negotiate rates, are obvious and well studied. Beyond just administrative savings, a central authority that sets provider rates through regulation can reduce the enormous inequities that pervade our current healthcare system in the form of price index variation, and is also the only serious way to get control of runaway healthcare price inflation. This central authority could also unify provider credentialing and enrollment – currently an administratively burdensome, patchwork process that each clinician must do with each payor (and often re-do when their provider affiliations change), resulting in months-long delays in their ability to see patients.

While these solutions may not seem immediately feasible, they are the only serious way to address the enormous amount of waste and cost inflation in our current system, and a multi-year strategy to achieve them must be a core component of any credible strategy to address these problems. Multiple states (including Massachusetts) have active single-payor legislation; federal legislation has been filed in both the House and Senate that would support state waivers along these lines.

The current system has failed. Massachusetts has been a national leader in health policy thinking before – we can (and must) do it again.

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?

C3 and our network of FQHCs are committed to advancing high-quality, affordable, and equitable primary care. FQHCs are the backbone of the primary care system for many of the Commonwealth's most medically and socially complex residents, delivering integrated, team-based care that addresses the full spectrum of physical, behavioral, and social needs.

FQHCs employ interdisciplinary care teams, including primary care providers, behavioral health clinicians, nurses, care coordinators, community health workers, and pharmacists to ensure that care is patient-centered, and culturally responsive. This model allows patients to access medical, behavioral, and preventive services in one setting, often including on-site pharmacy and dental care. All but one of the FQHCs in our ACO are Tier 3 providers, reflecting the highest standards of care coordination, quality improvement, and patient engagement. Behavioral health services are integrated directly into primary care, enabling coordinated access to therapy, psychiatry, and substance use treatment.

C3 supports our health centers in testing and scaling innovative approaches to primary care. This includes expanding telehealth and digital navigation support to help patients leverage technology to access care, limiting barriers of transportation, work, or childcare. We are piloting artificial intelligence (AI) tools to reduce documentation burden and enhance care team efficiency; and strengthening care coordination for high-risk patients, including best-in-class support for social needs interventions through our community care hub model.

Recommendations

To sustain and expand access to high-quality primary care, we recommend the policies already highlighted in this response:

- ambitious investment in the capacity of high-performing and low-cost safety net primary care;
- properly funding HSN including through raising revenues from other parts of the system;
- bold streamlining of the Medicaid agency's delivery system by eliminating managed care and directing more resources towards primary care and Primary Care ACOs (which ultimately save money);
- a multi-year strategy to seriously pursue statewide single payor and/or all-payor rate setting; and
- a more short-term set of common-sense protections for FQHCs on 340B revenue and commercial rates of payment.

Aside from these policies (and as a potential alternative or stepping stone to single-payor or all-payor models), we support the creation of a single payment authority and mechanism for

primary care (even if the rest of the system remains temporarily fragmented). Proposals along these lines exist in legislation, in which a capitated primary care model could be administered by the state through a Primary Care Trust fund, financed through payor contributions and targeted assessments. This approach would simplify access to primary care, reduce disparities for populations facing uncertainty stemming from federal changes, and strengthen the financial foundation of Massachusetts' safety-net and primary care system.

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?

C3 and our network of FQHCs stand ready to be part of solutions that make health care more affordable and sustainable for Massachusetts families. Every day, FQHCs deliver primary care that prevents costly hospitalizations and emergency department use, helps manage chronic disease, and addresses the social needs that drive poor health outcomes. However, reversing the trend of rising costs and medical debt will require more than efficiency at the margins. It requires the political will to reorient investments from high-cost tertiary care toward robust community-based primary care.

Despite broad consensus that strong primary care improves outcomes and lowers spending, current payment structures continue to undervalue it. A rebalanced system - one that prioritizes prevention, early intervention, and continuity of care -would not only bend the cost curve but also improve health equity across the Commonwealth. C3 and our health centers are prepared to partner with state leaders, payors, and community organizations to make this vision real, but sustained commitment and policy alignment are essential to achieve the scale of transformation Massachusetts needs.

We believe Massachusetts has the opportunity to lead the nation in equitable primary care access by establishing a state-wide single-payer primary care infrastructure. To sustain and expand access to high-quality primary care, we recommend the policies already highlighted in this response.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. 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.

As an ACO, our member advocates answered a variety of calls from members regarding benefits details and coverage. However, we do not track specifics of pricing questions as all claims are processed by MassHealth or Medicare.

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:		