Sturdy Health

October 31, 2025

Via Email Submission

Mr. David Seltz, Executive Director
Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

RE: Statement of Authority – 2025 HPC Written Testimony of Sturdy Health

Dear Mr. Seltz:

Thank you for the opportunity of providing the attached written testimony for the 2025 Annual Health Care Cost Trends Hearings. As requested, this pre-filled testimony is being submitted to you via email HPC-Testimony@mass.gov, along with this statement of authority.

As President and Chief Executive Officer, I am legally authorized and empowered to represent Sturdy Health for the purposes of this testimony. This testimony is being provided under the pains and penalties of perjury, and I acknowledge this statement through my signature below.

Please feel free to contact me with any questions regarding this submission via email ABrewer@sturdyhealth.org or dialing (508) 236-8000.

Sincerely,

Aimee Brewer

Aimee Brewer, MPH
President and Chief Executive Officer

Attachment

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?

With decreased insurance subsidies and Medicaid eligibility, we anticipate decreased payment for services provided and an increase in bad debt and unfunded (by the Health Safety Net) charity care. If this occurs, we may be forced to evaluate programs and focus available resources on core services (ED, med/surg) and other essential service lines. We continually focus on improved efficiency of resource utilization. Decreasing administrative hurdles imposed by insurers – which often delay or prevent payment for necessary care – would allow more of our constrained resources to be directed toward clinical staff and patient care.

A failure to renew telehealth waivers in the Medicare program presents a serious concern for patient access. Telehealth has proven essential for patients facing transportation or financial barriers to in-person care, while also increasing provider capacity and availability. Not renewing this waiver could limit access for vulnerable patients and prompt other insurers to discontinue coverage of telehealth services. Massachusetts can protect against this by working with insurers and MassHealth to ensure coverage persists.

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?

Workforce shortages remain a significant challenge for Sturdy Health, particularly in nursing, imaging, and laboratory services. Heightened competition and post-pandemic labor shifts are straining care access, employee well-being, and system performance.

Key Challenges

- Nursing: Persistent inpatient, LDRP, and critical care vacancies; salary competition hinders retention.
- Imaging & Technical Roles: National shortages, prolong hiring, strains all parts of the system.
- Support Roles: Difficult to fill entry and mid-level positions due to wage competition and high turnover.

Sturdy's Strategic Response

- Pipeline Development: Expanding relationship with local colleges (Wheaton College, Community College of Rhode Island, Lincoln Tech, Curry College, and Bristol Community College) for recruitment.
- Career development programs starting at the high school level with career exploration day, partnership with local high school and the technical program for Medical Assistants and Laboratory Assistants.
- Developed internal residency program for Emergency Department nurses
- Targeted Outreach: Using digital campaigns and community partnerships to attract diverse, local candidates.
- Process Optimization: Streamlining recruitment through technology and turnaround time improvements.
- Workforce Development: Evolve nursing governance to empower clinical staff and elevate their roles in decision-making.

There are several priorities Massachusetts can address, including passing workplace violence protections for healthcare workers, expand and market free community college programs with a directed focus on nursing, radiology tech and laboratory tech, finalize nurse licensure compact.

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?

We favor administrative simplification through standardized processes, interoperable systems, and shared data and communication platforms. Work with payors must continue

to reduce the need for prior authorizations before delivering care that should not require prior authorization, improving the efficiency of the authorization process, and decreasing the time from request to approval. The need for authorization for placement in post-acute facilities needs to be eliminated because it is not productive and delays discharges, thereby adding cost. If it can't be fully eliminated, the process needs to be made more efficient with a turnaround time of less than 24 hours, 7 days a week, including holidays. Insurers who impose additional administrative hurdles to delivering care and moving patients to the appropriate level of care should be required to share transparent data on the impact of these administrative policies.

The cost to collect (payer reimbursement) has increased dramatically over the past few years. The ongoing battle, to be compensated for services provided, not only drives up health care costs by forcing providers to hire additional staff and purchase services to help with timely reimbursement and recovery of lost revenue, but can delay patient care unnecessarily. These payment delay tactics by third party payers are not in the best interest of providers trying to care for patients and certainly not in the best interest of the patient. Now, we add in the layer of AI and it is almost a competition of who has better/more AI, which drives up costs.

The following administrative burdens and complexities contribute to these issues providers are facing:

Issue #1: Payer policies change constantly, usually monthly. It's very difficult to track changes when payers update policies frequently and at different intervals. Providers need additional time/staff just to keep on top of the changes, let alone be able to decipher and distribute across the health care system to the affected areas in a timely fashion. The work does not stop there as systems often require updates, both clinically and financially to accommodate many of the changes. This puts stress and strain on the entire system from clinicians, to IT, to back-office staff and beyond.

Resolution:

1) Mandate policy changes be quarterly with a three-month notice to give providers enough time to plan and make the necessary changes to prevent delays in patient care and reduce cost to the system.
2) Create a governing body or fold within an existing state agency to categorize policy changes that would be statewide for all payers. This would streamline and level the playing field for patient care requirements for providers and decrease confusion and ultimately cost.

Issue #2: Claim edits are extremely time-consuming, costly, and delay reimbursement to providers. Providers are being forced to create too many payer-specific custom claim rules, often for the same service. These are hard to manage and require significant administrative time.

Resolution:

1) Reduce the amount of edits payers can utilize for a given service and simplify claim requirements for routine services.
2) Standardize edits across payers for similar services. Having different edits by payer for the same service is unnecessary and costly.

Issue #3: Prior authorization requirements are extremely burdensome, confusing, and delay patient care. While providers appreciate the move to standardizing the prior authorization form, more needs to be done. Payer customer service staff are often unaware of their own company's policies and/or give out wrong information, which leads to the need to appeal in many cases (which again increases costs).

Resolution:

1) In addition to standardizing the prior authorization form, there is a need to standardize what services should require prior authorization and even remove the requirement altogether for common/routine services. This can also be under the charge of the governing body mentioned in Issue #1 above.
2) Mandate that providers should be allowed to obtain retro-authorization (for at least 72 hours after the date of service) in cases where delaying care is detrimental to the patient and in situations where the procedure delivered needed to be different than the intended procedure. An example is an open vs. closed procedure as the resulting CPT code would be different than what was authorized. Providers should not have to appeal these but instead simply get an updated/retro authorization. This would reduce cost for the provider and payer.

Issue #4: This is more of a national issue that needs consideration, but Massachusetts could help lead the way for change. The administrative burden and complexity around level of care (both clinically and financially) for inpatient and observation patients are completely unnecessary.

Resolution:

1) Eliminating observation status altogether is a more logical and streamlined approach. Patients "admitted" to a nursing unit is exactly what it is – a patient in a bed. The level of acuity and severity is what ultimately drives how long the

patient is in the bed. In a majority of the cases, patient care and resources to treat patients in observation or inpatient statuses are relatively similar, yet the payment disparity between the two statuses is dramatic. In addition, the status directly dictates rules around what type of post-care a patient can receive and how much the patient will ultimately owe.

2) Create one status (Inpatient) and develop a reimbursement model tied to expected length-of-stay and severity of illness. This will eliminate the need for clinicians to teeter on making difficult and often confusing decisions on "patient status" and instead let them focus on patient care and getting the patient safely discharged. It will also eliminate the need (and cost) for payers to review (both concurrently and post-discharge) the appropriate level of care and allow them to reimburse based on the care given. It will eliminate the costly need of appeals by providers and appeal adjudication by payers.

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?

Recruitment and retention of Primary Care Providers has been a top priority for our health system for many years. We have focused on creating an environment where primary care providers have a team of people to support patient care such as adding a clinical pharmacist, care navigators, and partnership with mental health providers. On the provider side, our focus has been on reducing administrative burden, rightsizing patient panels, enhancing at-the-elbow support, and a competitive compensation structure. These investments are the right thing to do for the communities we serve, but come as a major investment/subsidy for our health system.

Over the past year, Sturdy Health has advanced its population health and primary care transformation strategy through targeted investments in integrated behavioral health, pharmacist-led chronic disease management, remote patient monitoring, and enhanced care continuity. We also have embedded a maternal care navigator within our OB/GYN practices to focus on resource exploration for pregnant and postpartum patients, linking them to community support, behavioral health referrals, and

eliminating health-related social need barriers such as transportation, food insecurity, housing instability or childcare needs.

Through our partnership with Concert Health, behavioral health services have been embedded within primary care practices using a collaborative care model that provides a virtual option for patients who prefer or require remote access. This model has been further strengthened through partnerships with Thriveworks and the continued integration of a licensed independent clinical social worker (LICSW) who delivers in-person and virtual talk therapy and behavioral health support across our medical group. Collectively, these partnerships ensure timely, coordinated, and flexible social and behavioral health access within our ambulatory care settings. Sturdy Health monitors the impact of these efforts through performance analytics that track Patient Health Questionnaire-9 improvement rates, time to initial contact, and numbers served and sustained engagement, with outcomes reviewed quarterly using data from Concert Health, Thriveworks, and our electronic health record (EHR).

The integration of a Clinical Pharmacist (PharmD, CDCES) has allowed for expansion of chronic disease management under a collaborative drug therapy management agreement, caring for patients with diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), and congestive heart failure. This pharmacist-led model supports evidence-based medication optimization, patient education, and consistent follow-up to improve outcomes and reduce complications. Using internal data analytics, we evaluate pre- and post-intervention trends in A1c, blood pressure, medication adherence, emergency department utilization, and hospital readmission. Early findings demonstrate improvements in both glycemic and blood pressure control among engaged patients, along with greater medication adherence and continuity of care.

Sturdy Health has also broadened its use of remote patient monitoring (RPM) through Brook Health to enhance care continuity and patient engagement after patients leave the provider's office. The program bridges the gap between visits by monitoring blood pressure, weight, blood glucose, and oxygen saturation (SpO_2) levels in real time, allowing care teams to identify early deterioration and intervene proactively, as well as timely titration of medications as needed in-between PCP visits. Patient data are continuously analyzed to evaluate engagement and mean clinical trends, reinforcing Sturdy's commitment to proactive, technology-enabled care coordination.

From a policy perspective, Sturdy Health recommends several system-level reforms to sustain and enhance equitable access to care. These include extending

telehealth flexibilities that recently expired to preserve virtual access for patients; advancing provider status for clinical pharmacists to allow reimbursement for direct patient care; and enhancing reimbursement rates to support team-based, data-driven care infrastructure. Additionally, the recent impacts of the OBBB are expected to significantly affect health care insurance coverage for many patients who are already financially challenged. This will likely strain health care systems across the state and the nation, creating further barriers to access and driving rising health care costs. Together, these policy and payment reforms are critical to maintaining accessible, coordinated, and financially sustainable ambulatory care delivery for the communities we serve.

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?

Our priority and goal have been to expand access to primary care to allow for more preventive services, identifying health issues before they are more advanced and costly to treat. This also decreases use of expensive and unnecessary emergency department visits, which are often used as "primary care" when true primary care services are not available. We are also trying to offer as much care as we can locally and investing in our health system such as expanding our emergency department and adding a 12-bed behavior health space to keep as much care local as possible.

In addition to the policies we discuss throughout this document, including administrative burden reduction, comprehensive workplace violence reform and streamlining the prior authorization process, from a state policy perspective, we would also recommend the following:

- Participating in efforts to improve transparency of care between health systems to reduce duplication of services. Regional health care planning to reduce duplication of services and ensure communities have access to care (e.g., Labor, Delivery, Recovery, and Postpartum services).

- Implementing increased restrictions/tort reform to reduce medical malpractice liability can help reduce excessive testing or increased health care costs that result due to fear of litigation.

- Recognize the complex challenges faced when caring for boarding patients for extended periods (we currently have a 19-year-old who has been boarding for 40 days with no end in sight). This type of boarding results in a financial, clinical and space strain on the health system, and a patient that is not getting the right level of care for an extended period.

- Develop a method to prioritize and incentivize patients to get preventive care and recommended health screenings.

Community hospitals in Massachusetts face financial instability, workforce shortages, and unequal reimbursement rates compared to larger academic centers. These challenges threaten our ability to deliver accessible, cost-effective care. Despite these struggles, community hospitals are vital to the state's healthcare system, offering essential services close to home. To preserve their role and expand access, further state support is needed to stabilize funding, invest in staffing, and ensure equitable healthcare delivery

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.

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**	6	8
	Q2	13	4
	Q3	0	3
	Q4	0	0
CY2024	**Q1**	0	3
	Q2	1	15
	Q3	0	16
	Q4	0	15
CY2025	**Q1**	0	17
	Q2	0	19
	TOTAL:	20	100