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.

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THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

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

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

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

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

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

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

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

Impacts of Current Landscape on UMass Memorial Health:

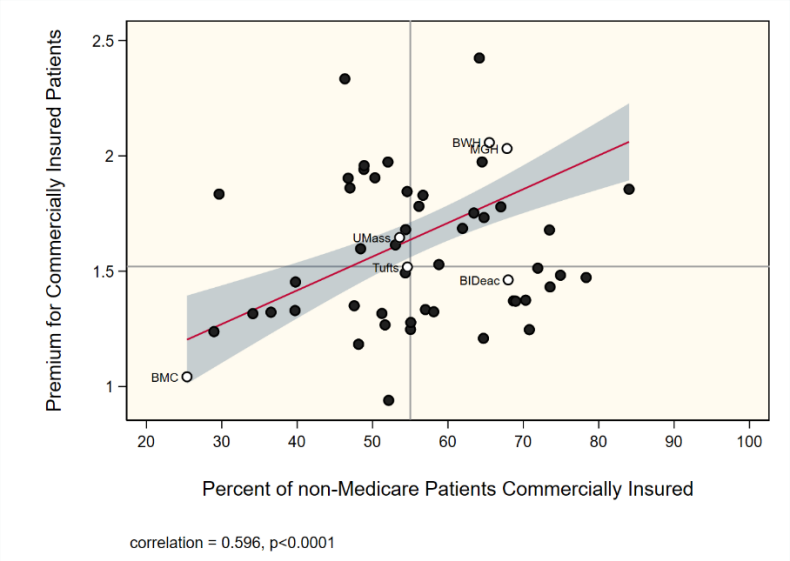
UMass Memorial Health (UMMH) is committed to providing high quality healthcare to the diverse residents of central Massachusetts including the indigent population. This commitment is enabled by the legislation that created UMMH almost 30 years ago and is reflected in the care we provide to more than 140,000 MassHealth and uninsured patients each year.

UMMH, like other safety-net providers, operates at a loss when serving Medicaid patients. Due to H.R. 1 (also known as the One Big Beautiful Bill), our health system anticipates significant reductions in federal Medicaid support in the coming years. With approximately 300,000 Massachusetts residents anticipated to lose their MassHealth eligibility, we expect large increases in the uncompensated care we provide. This will exacerbate the Health Safety Net Trust Fund shortfall and reduce our reimbursements for providing care to these patients.

Financial pressures resulting from changes to Medicaid and the Massachusetts Health Safety Net will disproportionately impact UMMH and other Disproportionate Share Hospitals (DSH) in the Commonwealth. With a smaller proportion of commercial patients to make up for increasing losses in our Medicaid and uncompensated care patient populations, DSH hospitals have few options to remain financially solvent. Unfortunately, the Massachusetts health care market operates in a way that is exactly opposite of what is needed to ensure the financial health of DSH hospitals. As illustrated in the graph below, hospitals with a higher proportion of government payor patients have lower

commercial reimbursement rates than hospitals with a larger percentage of commercial patients.

Figure 1: Graph of commercial prices (standardized to Medicare PAF) vs Payor Mix



The direct impacts of H.R. 1 will be compounded by other potential actions, such as significant changes to the 340B program, which removes an opportunity for safety net providers like UMMH to recoup losses in serving MassHealth patients and further increases administrative burden on 340B eligible hospitals for implementing the program. The financial challenges facing long-term care providers and social service providers will translate into sicker patients with fewer options for effective discharge planning and community referrals.

Additionally, embedded in the legislation that created UMMH more than 25 years ago is a statutory obligation for UMMH to financially and operationally support the UMass Chan Medical School, the state's only public medical school. The cuts to research and academic funding at the federal level directly affect UMass Chan Medical School. Not only will these cuts negatively affect state-wide healthcare cost management and stabilization efforts by reducing investments in clinical innovations and the healthcare workforce, but they will further strain UMMH's financial stability because of our relationship with UMass Chan. Many UMMH providers and clinical leaders play dual roles in both institutions; therefore, cuts to staff or salary time at the UMass Chan Medical School significantly impact UMMH budgets and costs.

In recent years, the costs of providing care to MassHealth and Health Safety Net patients combined with our financial support to the UMass Chan Medical School has surpassed State reimbursements by more than $250M annually. As a result of the current

landscape, we anticipate the costs of these obligations to increase while government payments decline, with limited opportunities to make up any differences in our commercial rates.

Without innovation and meaningful changes to the architecture of the healthcare infrastructure in Massachusetts, health systems like ours and other DSH providers will be forced to close critical programs, and potentially their doors. Health systems with a majority of commercially insured patients and single digit percentages of Medicaid patients will be able to weather this storm more easily. The results will be a bifurcated healthcare system that works for the affluent and doesn't work for the poor and those without commercial insurance.

UMMH's Role and Contributions to Mitigating Negative Impacts:

With significant operating losses in FY 2024 and FY 2025, UMMH is taking a close and thoughtful look at all spending with a goal of maintaining the vital healthcare services we provide to the region. Among other initiatives, UMMH has put a pause on all non-essential travel, implemented a review/freeze on non-patient facing staff, implemented plans to reduce traveler staff, deferred some capital projects, limited premium pay and bonuses, closed under-performing programs at Community HealthLink (UMMH's behavioral health provider), and implemented our 'finding the 4%' effort to collect and implement innovative ideas from our frontline employees for closing our budget gap.

Additionally, we continue to negotiate with commercial payers in good faith to reach fair and equitable agreements that enable us to provide the exceptional care that our patients across central Massachusetts expect and deserve. We will continue to ask our payor partners to engage in negotiations that reflect the financial realities of today's health care ecosystem, the disproportionate impact federal Medicaid cuts will have on our safety net system and needed investments in services that allow their members and our patients to live fulfilling, healthy lives.

Finally, we continue to promote innovative approaches to care delivery, leveraging our team of thoughtful, engaged staff and our unique partnership with the UMass Chan Medical School. This includes using our health system's purchasing power, community benefits infrastructure, and other assets to expand partnerships with community-based organizations to address upstream social drivers of health like food insecurity. While times of austerity can reduce innovation, we hope to continue leaning in to test and develop new approaches to healthcare that promote access, affordability, and equity for our patients.

Recommendations to Stabilize Massachusetts Healthcare:

Healthcare is at a tipping point. The current models for reimbursement and cost containment are not working. UMMH believes that the time is right for new, innovative, disruptive approaches to healthcare. At the same time, there are immediate steps that can and should be taken to stabilize health care in the near term for the Commonwealth's residents:

- Stabilize the Health Safety Net (HSN): We are grateful for the attention of the legislature, the Governor, and EOHHS to address short-term stabilization of the Health Safety Net funding. All stakeholders need to continue to work together to further strengthen the HSN particularly considering expected increases in the number of residents who will be HSN eligible. HSN solutions need to prioritize equitable sharing of financial responsibility for the care of residents without coverage.

- Update the HPC's cost growth benchmark and cost-containment strategy: The HPC's current one-size-fits-all approach does not take into account the critical differences between Massachusetts DSH and non-DSH providers, including base price, payor mix, market share, and patient population, and effectively reenforces the existing revenue disparities between providers. For example, Mass General Brigham's physician prices and hospital fees are 19% and 20% higher, respectively, than UMass Memorial Health's pricing, and Mass General Brigham also has the highest proportion of commercially insured patients in the state, with a market share of 26.7%.

  While there could continue to be a statewide growth target for tracking state-wide progress in cost containment, the legislature should create a new, variable benchmark for entity-level accountability that factors in commercial volumes, all-payor relative pricing, and a provider's overall impact on health care spending in the Commonwealth.

  Even without enacted changes to the benchmark, the HPC should be clear on the purposes and utility of the statewide cost growth benchmark, particularly given the current trend of payors using the benchmark as an immovable target in pricing negotiations with provider organizations.

- Reduce Administrative Burden: The legislature should impose further restrictions on unnecessary prior authorizations and establish reasonable timeframes for payor approvals to avoid delays in care, reduce costly overhead and reduce the administrative burden on providers. Alleviating the administrative burden on all providers, but particularly primary care providers, will reduce costs and increase access to medically necessary primary care services.

- **Ensure 340B Continuation and Flow to Safety Net Providers:** With new and threatened changes at both the state and federal level to the 340B program and efforts by pharmaceutical companies to weaken the program, the state must work to ensure that 340 pricing continues for all eligible DSH providers like UMMH who rely on the program to finance services for the Commonwealth's most vulnerable residents.

- **Strengthen Primary Care:** The legislature should pass meaningful legislation that increases access to primary care services, reduces administrative burden, and sets targeted reimbursement for low paid primary-care services. These reforms and investments will reduce the overall cost of care, allow struggling healthcare systems to grow, help keep patients out of the emergency room and allow primary-care physicians to spend more time with patients and less time on burdensome paperwork. Alternatively, the state could set a floor on commercial insurance rates paid to primary care providers at the national average, i.e., 250% of Medicare.

Support adoption of and payor coverage for innovative models that reduce total medical expenses: Innovative approaches are required to address barriers to access, affordability, quality and equity while facing existential financial challenges. The state can act more proactively to support investments in innovative approaches to health care delivery, including requiring coverage for proven approaches such as hospital at home and mobile integrated health programs.

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?

As noted above, UMMH currently has a negative operating margin and is facing significant financial challenges. As a result, we've been forced to make difficult decisions that impact our workforce, including a freeze on non-clinical hires and elimination of coverage under our self-insured health plan for GLP-1s for weight loss. Even still, we continue to invest in our workforce to ensure the long-term strength and viability of our organization.

- In the last 3 years, we've established and grown a workforce development team within our HR department with a specific focus on sustaining, strengthening and diversifying the UMMH workforce through "earn and learn" programs for priority jobs, including through our Medical Assistant Registered Apprentice Program,

Patient Care Associate (PCA) Pathway Program, CT Technologist Pathway Program, and Surgical Technologist Frontline Scholars Program.

- Implementing specific occupation strategies like the new nurse residency program, the NextGen Workforce Program, and an international agency contract for recruiting and supporting medical lab technologists.
- Expanding community access to UMMH jobs through increased access to Talent Acquisition recruiters/jobs through Walk-in Wednesdays, Virtual Tuesdays, and extensive presence at community events. Additionally, we've moved toward skill-based hiring and integrated interpreters into the interview and onboarding processes for new hires.
- Improving the process for internationally trained individuals to get the needed credentials to work within our system. Our Talent Acquisition team has worked to more clearly state conditions of employment, including guidance on international credential evaluation as well as implementing an immigrant and refugee pilot program to identify and address barriers to employment.
- Supporting career advancement by listening to our lowest wage-earning staff, we've implemented several new projects including offering multiple workplace English classes to staff, offering a citizenship interview prep course, and providing career coaching and introductions to 'hot jobs' for any existing staff who want information on how to further progress their careers.

Additionally, our Office of People Development has focused on implementing multiple staff retention strategies, including:

- Thoughtful onboarding approaches to set new staff up for success and to ensure new hires feel informed, supported, and emotionally connected to the mission from day one, with multiple touchpoints throughout the first year.
- Leadership development and engagement efforts that include multi-month cohort-based programs, personalized coaching, individual and team-based workshops, and multiple touchpoints for managers to get connected to senior leadership (leader town halls, manager CEO sessions, etc.)
- Team-based action plans responding to findings in our recent employee engagement survey. All managers were required to work with their teams to develop a plan to address any opportunities identified in the 2025 employee engagement.
- Innovation and recognition programs continue to engage and reward our workforce. For over a decade, UMMH has invested in a system-wide Lean Management System which prioritizes empowering all employees as an "army of problem solvers" engaged in continuous improvement. More than 200,000 employee ideas have been implemented across the health system. We also

launched an online recognition program to acknowledge caregivers for their work in a social-media-like environment that includes a point system for rewards.
- Unique labor relations efforts through Unit Based Teams have been central to our partnership with our SHARE union. We've established more than 75 Unit-Based Teams, frontline-led, department-level improvement systems with a primary goal of changing the way staff feel about coming to work every day by engaging them at a deep level in measurably improving the work itself.

UMMH recommends the following policy and practice improvements at the state level that would support a more diverse and stable healthcare workforce. These include:

- Require all payors to reimburse for services provided by Advanced Practice Providers like Nurse Practitioners and Physician Assistants at no less than 85% of the physician fee schedule.
- Fully implement the Physician Pathway Act (also known as the internationally trained physician bill) that was signed into law last year and allows for the medical licensure of qualified internal physicians who practice for at least three years in areas in the state with a physician shortage.
- Support innovative collaborations between employers and community colleges to expand capacity to train technologists to address current workforce shortages.
- Use Medicaid funding (or another source of state funding) to add new residency positions for primary care, which would increase the availability of these roles in areas with the highest need. Currently, Massachusetts is one of only seven states that does not use Medicaid funding to support residency programs in its teaching hospitals.
- Renew the focus on the Commonwealth's behavioral health workforce, including creating incentives to retain clinicians and developing supports for mental health associates to pursue advanced degrees.=

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?

As stated in past cost trend testimony, UMMH strongly recommends that the State take action to align administrative requirements and systems across payers to decrease the burden placed on providers. Whether this burden comes from obtaining pre-authorizations, managing denials for payments, excessive documentation to get reimbursed by payers, or more recently tracking dozens of payer-specific quality metrics (many of which differ slightly by payer and few of which result in actual higher quality care).

One of the biggest drivers of burnout of primary care providers—and therefore the shortage of primary care providers in the Commonwealth—is the excessive administrative requirements imposed by payers, including unnecessary prior authorizations, time-consuming concurrent reviews and audits, and baseless denials. Reducing the onerous administrative burden on our primary care providers will allow them to use their limited time to focus on delivering care to patients.

Specifically, we recommend these key legislative and regulatory reforms related to administrative simplification:

- Require insurers to reduce the administrative burden on providers by making payers pay for services subject to prior authorizations and denials that are later overturned. Alternatively, ban prior authorizations altogether to allow primary care providers to manage their patients' care.
- Limit the amount of insurer spending that can be used for administrative costs to 5% of total expenses. The federal government runs Medicaid with an administrative cost of just 3%. There is no reason the private sector should need to allocate 15% of premium dollars to fund administrative functions.
- Reduce the number of quality metrics that a primary care practice must track and report on to a single set of no more than 10 measures aligned across all payers.
- Require payers to reimburse new, innovative approaches and services—like mobile integrated health, Hospital at Home, Sub-Acute Rehab at Home, and eICU that have been demonstrated to improve outcomes while reducing overall total medical expenditures (TME). This will strengthen our ability to expand the implementation of programs that can reduce TME and improve outcomes, access, and equity, particularly for the most vulnerable residents of the Commonwealth.

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?

UMMH's Current Strategy to Promote Access to Primary Care: UMMH is committed to ensuring that patients can access high quality primary care and other important services for managing complex chronic diseases within their local communities, especially our lowest income patients and patients facing social needs. To support this effort, we've launched several specific interventions:

- **Patient Access Center:** In the last two years we've implemented our Patient Access Center (PAC), a centralized infrastructure for scheduling and financial clearance-- to support our hospital-based clinics and medical group's practices. The PAC helps patients manage the challenge of finding available appointments and the administrative challenge of processing prior authorizations, while also reducing the burden on individual clinics and practices, improving patient experience, and reducing overhead administrative costs. This approach allows us to leverage the assets we have available as a regional health system to ensure that care remains accessible in residents' local communities without having to travel far from home.

- **Medical Assistant Staffing and Training:** Due to the changing labor market and the growth in wages outside of healthcare in the years since COVID, our primary care practices have faced significant challenges recruiting and retaining medical assistants and office-based support staff. In response, UMMH has heavily invested in market adjustments and annual cost of living adjustments to help make these positions competitive with other industries. Additionally, we've expanded opportunities for interested medical assistants and office-based employees to move through a professional ladder by developing more tiered positions and steps for advancement. We've also leveraged the use of float pools to support practices with vacancies or staff out on medical and family leave.

- **Bridge Clinic:** Given severe shortages in the availability of primary care providers (PCPs) in the Commonwealth, patients can sometimes wait for many months to see a new PCP. To meet this challenge in its service area, UMMH established a new virtual clinic in March 2024 to provide patients awaiting a new PCP visit with a virtual bridging provider who can provide medication refills, referrals, and acute medical condition assessments. Since its launch in 2024, the Bridge Clinic has held more than 1500 visits with nearly 900 unique patients. With an average lag time of 17 days between scheduling to an appointment (vs 140 days for a new PCP visit at UMMH), patients save an average of 123 days to see a UMMH provider when utilizing the Bridge Clinic.

- **Multi-Disciplinary Clinics:** UMMH has invested in multi-disciplinary clinics located in Leominster at HealthAlliance-Clinton Hospital and in Sturbridge at Harrington Hospital, which allows patients to access specialty care they need, closer to home, and in greater collaboration with primary care providers.

- **Digital Health Solutions:** UMass Memorial Health has continued to invest in and expand digital health solutions that improve patient experience, improve quality of care, and ease the burden on providers. For example, through our remote patient monitoring (RPM) program, UMMH leverages wearables and a virtual platform to allow providers to more closely manage and improve chronic conditions such as hypertension, diabetes, COPD and heart failure. RPM can support providers' efforts to make medication dose adjustment and implement lifestyle interventions. We've integrated our RPM program with Mobile Integrated Health which leverages community paramedics and a virtual provider to care for patients in their homes. The MIH team coordinates care with PCPs to support the patient — all with a goal of decreasing unnecessary hospitalizations and ED visits, which will both improve overall health status and reduce total medical expenses. Our early results on patients with CHF receiving RPM show a 25 percent reduction in both ED visits and hospitalizations compared to similar patients not receiving RPM.

Proposed New Approach to Primary Care—the Patient-Centered Medical Home 2.0: .
UMMH believes that while piecemeal, incremental improvements can help address some of the challenges facing primary care in the Commonwealth, new innovative models are needed to create a stable, long term primary care solution for Massachusetts' residents. One potential approach is the implementation of Patient-Centered Medical Home 2.0 (PCMH 2.0).

First introduced in the late 1960s, the patient-centered medical home (PCMH) is a care model designed to create a comprehensive approach to understanding and treating the complete needs of a patient, prioritizing the coordination of care and proactive chronic disease management to improve health outcomes and decrease overall costs. Historically, this approach failed to consistently meet clinical and financial goals because it was built on a traditional model of care being only available in the office 9-5 Monday to Friday in the clinical setting. We believe that by leveraging technical integration and other investments into whole-person care, a new version of PCMH has the potential to positively disrupt and redefine the delivery of primary care in the commonwealth.

PCMH 2.0 transforms primary care into a continuous service by leveraging and combining already proven technology like Remote Patient Monitoring (RPM) to continuously track

vital signs and other patient data in real time; Remote Therapeutic Monitoring (RTM) to track adherence to medication plans; Mobile Integrated Health (MIH) which brings specially trained community paramedics to patients' homes and Hospital at Home (HaH) which delivers hospital level care to patients in their own homes when needed. The model also leverages an intentional focus on care navigation and connection to community resources provided by a team of community health workers, social workers, and nurse navigators. Based on available data, UMMH anticipates that this coordinated approach can be most advantageous for patients covered by Medicaid or Medicare or who face significant social needs.

One significant challenge to further testing and expanding PCMH 2.0 is the fragmented payment system that currently does not support the necessary investments to build a comprehensive 24/7 infrastructure that would make PCMH 2.0 possible, particularly given the large upfront investments and time-lagged, downstream savings on total medical expense. A solution to this challenge would be the establishment of a regional primary care infrastructure that would require any insurer providing coverage in the service area to accept an agreed-upon per patient, capitated fee for all primary care services, with only specialized tertiary and specialty services being reimbursed under a fee-for-service arrangement.

While such an approach would require agreement and aligned strategy among many stakeholders, UMMH invites the Commonwealth to take the initiative to support such an innovative pilot to try to develop a comprehensive long-term solution to the primary care crisis. As with health reform and countless other innovations, Massachusetts is uniquely positioned to lead the nation-wide charge to find an effective solution to the pressing problem of primary care access.

Additional Policy and Payment Reforms: Since a comprehensive solution is not imminent, we urge EOHHS and the legislature to make additional incremental policy and payment reforms to deal with the capacity issues in primary care today. Our top recommendations were all covered in our response to questions 1 and 2 above.

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?

UMMH welcomes the opportunity to work in close collaboration with the HPC, state government, payers, and other stakeholders to find real solutions to the healthcare affordability crisis facing Massachusetts residents.

One of the ways UMMH contributes to the effort to reduce the overall health care costs for the residents of Massachusetts is by leveraging our 'innovation engine' to test and develop models of care that can provide higher quality care at lower cost. We outlined several of these efforts related to primary care in question 4; here are some additional new approaches to care delivery to reduce costs and promote high-quality and equitable care:

- Leveraging the power of AI to gain efficiency in care delivery
- Expanding Hospital at Home to cover even more patients with in-home hospital level care that improves outcomes and reduces TME particularly for patients covered by Medicare and MassHealth coverage.
- Expanding and building quality improvement projects that reduce length of stay, readmissions and unnecessary ED visits. These include programs like UMove2Improve that improves recovery times by encouraging and supporting mobility for hospitalized patients, Advanced Therapeutics that improves outcomes and adherence by supporting patients taking high cost medications, and our Multi-Visit Patient (MVP) initiative to provide wraparound care coordination addressing non-clinical drivers of return ED visits and hospitalizations.
- Continuing to implement eICU to keep patients in lower cost community hospital settings.

We are committed to listening to the ideas from our frontline staff and patients to identify opportunities for continuous improvement and new models that we can develop and test. And as our learnings and insights grow, we are committed to disseminating and sharing what we learn with HPC and other stakeholders.

Finally, we remain committed to consistently coming to the table for meaningful dialogue to find solutions to the affordability challenge in healthcare. As underscored throughout this testimony, we believe that we are at a critical tipping point for the equitable and accessible delivery of healthcare in the Commonwealth of Massachusetts. Only when the state, providers, payers and other stakeholders come together to support and expand innovation that comprehensively combats the root causes of rising costs in healthcare can we hope to weather the storm we are facing today. We are committed to using our voice, power, data, and ideas to contribute to this collective cause.

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	19	142
	Q2	16	129
	Q3	09	151
	Q4	18	156
CY2024	Q1	47	177
	Q2	18	160
	Q3	26	140
	Q4	101	97
CY2025	Q1	128	134
	Q2	112	126
	TOTAL:	**494**	**1,412**