

October 22, 2026

Lois H. Johnson, JD
General Counsel
Massachusetts Health Policy Commission
50 Milk Street
Boston, MA 02109

Dear Ms. Johnson:

We are transmitting Baystate Health's written testimony via electronic submission (HPC-testimony@mass.gov) as required under M.G.L. c. 6D, § 8 to submit written questions from the Health Policy Commission and the Office of the Attorney General for the 2026 Annual Health Care Cost Trends Hearing.

Attached are Baystate Health's responses to the questions in the 2026 Pre-Filed Testimony for Providers. Our responses are intended to contribute to a deeper understanding of Massachusetts' evolving health care environment and to our shared work of advancing thoughtful, durable solutions that strengthen affordability, access, equity, and long-term sustainability across the Commonwealth.

I certify that I am legally authorized and empowered to represent Baystate Health for the purposes of this testimony and acknowledge it is signed under the pains and penalties of perjury.

Thank you for your anticipated understanding! If you should have any questions in this matter, please do not hesitate to reach out to AnnMarie Martinez, Baystate's Vice President of Managed Care Contracting, at Annmarie.Martinez@baystatehealth.org or 413-459-9024.

Respectfully,



Peter D. Banko
President & CEO



MASSACHUSETTS
HEALTH POLICY COMMISSION

2026 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 [2026 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on **Wednesday, October 28, 2026**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the template provided below. 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.

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
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AGO CONTACT INFORMATION

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THE 2026 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 care and affordability across the Commonwealth's health care system.

The Annual Health Care Cost Trends Hearing offers an important opportunity to examine current trends and challenges facing the health care system and residents in Massachusetts. This year's hearing will focus on the critical importance of advancing health care affordability in the Commonwealth in the face of rising health care costs and threats to access and coverage, as well as the need for collective action to ensure that Massachusetts remains a national leader in safeguarding health care affordability for its residents.

Recent polls have found that Americans rank health care costs as their number one affordability challenge, outranking housing, food, utilities, and gasoline. Health care spending has grown even faster in Massachusetts than in the rest of the country, and in 2024, the Commonwealth had the highest family health insurance premiums in the country. That same year, the average annual cost of health care for a family exceeded \$32,000 (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 utilizing needed care.

Workforce constraints, financial volatility, high prescription drug costs, and health disparities amplify the Commonwealth's health care affordability challenges, compounded by recent federal policy changes that have created uncertainties and threaten access and coverage for many Massachusetts residents.

The 2026 Health Care Cost Trends Hearing, *The Affordability Imperative: Securing a Sustainable Health Care Future*, will bring together industry leaders, policymakers, clinicians, and community members to reflect on the policy reforms necessary to advance the Commonwealth's health care affordability, access, and equity goals, including the recommendations put forth by the [Healey-Driscoll Administration's Health Care Affordability Working Group \(HCAWG\)](#).

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.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. In January 2026, the Healey-Driscoll Administration convened health care industry leaders and policymakers to establish the Health Care Affordability Working Group (HCAWG). The group was charged with developing concrete proposals to reduce health system costs with the goal to make health care more affordable for patients, families, employers, and the state. In August, HCAWG announced its first set of [twelve policy recommendations](#) that provide a roadmap to target some of the biggest drivers of health care costs in the Commonwealth.

Of the HCAWG policy recommendations please identify and describe your organization's top priorities for action. Additionally, briefly describe how your organization is working to advance these priorities, what barriers or challenges does your organization foresee to implementation of these priority areas, and what further policies or reforms would be necessary to make meaningful progress?

Overview: Affordability Requires Structural Solutions

Baystate Health appreciates the opportunity to submit pre-filed testimony for the 2026 Annual Health Care Cost Trends Hearing. As the principal academic medical center, safety-net provider, and integrated health system for Western Massachusetts, Baystate sees the affordability challenge from several vantage points: as a provider of care, as the owner of a health plan, Health New England, and as a major regional employer.

We also see it from the perspective of the residents we serve. Massachusetts families are paying more for insurance, paying more when they use care, paying more for medications, and often struggling to know what care will cost before they receive it. One recent national comparison of consumer health care costs ranked Massachusetts as the most expensive state in the country, at nearly 32 percent above the U.S. average.¹

We commend the Healey-Driscoll Administration and the Health Care Affordability Working Group (HCAWG) for their work to reduce the underlying cost of health care while preserving and improving access and quality. The recommendations seek to help individuals and small businesses, deliver the right care at the right time in the right place, invest in the health care workforce, use the Commonwealth's purchasing leverage, and make better use of technology. We particularly welcome the recommendations that look beyond price to workforce shortages, discharge delays, and avoidable hospital use, and that invest in building capacity rather than relying only on cuts.

This is important and valuable work. At the same time, our experience is that the Commonwealth's affordability challenges are structural. Measures that address the effects of structural problems at the margins can provide relief and buy time, but they do not by themselves resolve the conditions that drive costs. We encourage the Commission to view affordability through that broader lens.

Cost Is a Function of Both Price and Utilization

Many affordability proposals focus primarily on price and annual price growth. Price matters, but Massachusetts is not uniformly a high-price state for hospital care. In RAND's most recent national study of prices paid to hospitals by private health plans, Massachusetts was one of only five states, along with Arkansas, Michigan, Mississippi, and Rhode Island, where commercial hospital prices were below 200 percent of Medicare in 2022. RAND also found that hospital market power explained a larger portion of price variation, while a hospital's share of Medicare and Medicaid patients explained very little.² Within Massachusetts, prices also vary considerably by region. Baystate Medical Center's commercial prices are below the

¹ Visual Capitalist, "Mapped: The Most Expensive States for Healthcare in 2026," using the Missouri Economic Research and Information Center (MERIC) Healthcare Cost Index (U.S. = 100); Massachusetts index 131.8. <https://www.visualcapitalist.com/mapped-the-most-expensive-states-for-healthcare-in-2026/>

² Whaley, C.M., et al., Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative, RAND Corporation, 2024 (2022 data). https://www.rand.org/pubs/research_reports/RR1144-2.html

statewide average, with a relative price of 0.93 in the most recent CHIA hospital profile.³ Policies that target actual price variation, rather than applying uniform limits to all providers, will be more effective and will avoid penalizing lower-cost regional systems.

Utilization is the other half of the cost equation, and it is where Massachusetts stands out. In 2024, Massachusetts recorded 105 hospital admissions per 1,000 residents compared with 99 nationally, about 6 percent higher, and 500 emergency department visits per 1,000 residents compared with 422 nationally, about 18 percent higher.⁴ The HPC has reported that admissions originating in the emergency department were 28 percent higher in Massachusetts than in the nation.⁵ Much of this utilization reflects gaps elsewhere in the system: in primary care, behavioral health, post-acute capacity, and the workforce needed to staff them. For that reason, the three priorities we have selected focus on moving patients to the right setting and building the workforce to care for them there.

Western Massachusetts Faces Distinct Structural Pressures

- **Demographics.** Our region has experienced slow population and economic growth alongside an aging population. Western Massachusetts has real assets, including strong anchor institutions, higher education, health care, advanced manufacturing, and an attractive quality of life. Converting those assets into broader economic growth will require investment in the workforce, housing, infrastructure, and pathways to opportunity that allow more residents to participate in the regional economy.
- **Geography.** Baystate carries a regional responsibility that is unusual in Massachusetts. We serve as the principal academic, safety-net, and integrated health system for an expansive and geographically diverse region. Meeting that responsibility requires a large system with high fixed costs.
- **Payer mix.** Government payers account for approximately 70 percent of Baystate's payer mix, and that share is growing. Baystate's margin on Medicare patients is negative 7.3 percent. Medicare and MassHealth payments do not cover the full cost of care, and recent federal changes affecting Medicaid, Medicare, and Affordable Care Act coverage will place additional financial pressure on providers that serve a high share of publicly insured patients.

³ Center for Health Information and Analysis (CHIA), Massachusetts Hospital Profiles: Baystate Medical Center, Hospital Fiscal Year 2024 (commercial statewide relative price, CY 2023). <https://www.chiamass.gov/assets/docs/r/hospital-profiles/2024/baystate.pdf>

⁴ KFF State Health Facts, "Hospital Admissions per 1,000 Population by Ownership Type" and "Hospital Emergency Room Visits per 1,000 Population by Ownership Type," 2024. <https://www.kff.org/other/state-indicator/admissions-by-ownership/>; <https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/>

⁵ Massachusetts Health Policy Commission, "Admissions from the Emergency Department" (2019 data). https://masshpc.gov/sites/default/files/2023-ARM_Admissions-from-ED.pdf

- **Inflation.** Labor, drug, supply, and regulatory costs are rising faster than health systems, clinicians, health plans, and purchasers can comfortably absorb, and faster than our revenue.
- **Capital and infrastructure.** Together, these pressures have produced years of operating losses. As a locally governed, nonprofit health system, Baystate reinvests its resources in the community it serves. Without adequate margins, the region's ability to invest in facilities, technology, and access is constrained.

These pressures are visible across the region. Mercy Medical Center in Springfield has faced significant financial pressures in recent years, and Baystate stepped forward to preserve its essential services for the community. Mercy's integration into Baystate Health is expected to take effect on November 1, 2026, pending regulatory approval.⁶ We remain committed to preserving essential services and strengthening access across Western Massachusetts as the integration proceeds.

The sections that follow describe our three HCAWG priorities, how Baystate is working to advance them, and the barriers we see. We close with three structural reforms that we believe are necessary to make affordability durable.

⁶ WWLP, "Mercy Medical Center to be acquired by Baystate Health by November 2026." <https://www.wwlp.com/news/local-news/hampden-county/mercy-medical-center-to-be-acquired-by-baystate-health-by-november-2026/>

First HCAWG Policy Priority:

Transitions of Care

Why This Is a Priority

Delays in discharging patients who no longer need hospital care are among the clearest examples of avoidable cost in the health care system. According to the HPC, approximately 2,000 patients statewide remain hospitalized on an average day despite being medically ready for discharge, and hospitalizations exceeding 30 days account for approximately half of the growth in inpatient bed days since 2016.⁷ These delays lengthen hospital stays, reduce available inpatient capacity, and contribute to emergency department boarding, a significant and rising share of which involves patients who need behavioral health services.⁸

The effect is especially significant at Baystate Medical Center, the region's tertiary and trauma referral center. Every bed occupied by a patient awaiting placement is a bed unavailable for a trauma patient, a patient who needs tertiary care, or a transfer from a community hospital elsewhere in Western Massachusetts. Post-acute capacity in our region, including skilled nursing beds, home health services, and behavioral health placements, is thinner than in eastern Massachusetts, which compounds the problem.

In FY2026, Baystate Medical Center recorded 11,401 patient delay days across 1,603 patients in its five highest-volume categories of discharge barriers (Table 1). Insurance-related barriers accounted for the largest number of delay days (3,671 days involving 569 patients), followed by the lack of an available post-acute placement (3,162 days involving 634 patients). Together, these two categories represented 6,833 delay days, or approximately 60 percent of the total. Guardianship and legal delays affected only 78 patients but accounted for 2,144 delay days, an average of more than 27 days per patient. This shows how a small number of complex cases can consume substantial hospital capacity.

Table 1: Discharge Delays, Baystate Medical Center, FY2026

Discharge Barrier Category	Delay Days	Distinct Patients
Insurance barriers	3,671	569
No post-acute care placement available	3,162	634
Guardianship and legal delays	2,144	78
Social and safety issues	1,547	232
Behaviors preventing placement (non-psychiatric)	877	90

⁷ Massachusetts Health Policy Commission, "New HPC Investment Program Aims to Ease Patient Discharges from Hospital to Home." <https://masshpc.gov/news/press-release/new-hpc-investment-program-aims-ease-patient-discharges-hospital-home>

⁸ Massachusetts Health Policy Commission, "More than 1 in 3 Behavioral Health Emergency Department Patients Continued to Board in 2024." <https://masshpc.gov/news/press-release/more-1-3-behavioral-health-emergency-department-patients-continued-board-2024>

Discharge Barrier Category	Delay Days	Distinct Patients
Total	11,401	1,603

The 11,401 delay days are the equivalent of approximately 31 inpatient beds occupied every day of the year. Approximately 19 of those beds are attributable to insurance barriers and the lack of post-acute placement alone. Although these figures reflect reported delay days rather than a validated measure of avoidable inpatient days, they illustrate the scale of capacity constrained by factors largely outside the hospital's direct control. The downstream consequences include reduced bed availability, prolonged emergency department boarding, and limits on our ability to accept new admissions and transfers.

These delays also carry a financial cost. Baystate is paid for most inpatient stays through the Diagnosis Related Group (DRG) methodology, which pays a fixed amount based on the patient's diagnosis regardless of length of stay. As a result, much of the cost of these additional days goes unreimbursed. The Massachusetts Health & Hospital Association estimates that Massachusetts hospitals devote more than \$400 million annually to caring for patients who are awaiting placement at the next level of care.⁹ For payers, prolonged stays raise total medical expense without improving outcomes. Through Health New England, Baystate sees this effect directly: reducing unnecessary inpatient days benefits members, employers, and the Commonwealth, not only hospitals.

How Baystate Health Is Advancing This Priority

- **Strengthening internal throughput.** We continue to focus on care progression, discharge planning, and inpatient efficiency so that patients are ready to move as soon as it is clinically appropriate.
- **Working across the continuum.** We are strengthening partnerships with regional post-acute providers, payers, and community organizations to improve care coordination and placement for patients with complex needs.
- **Aligning provider and plan incentives.** We are aligning hospital operations with Health New England and our value-based care arrangements, so that reducing avoidable inpatient days supports both better care and lower total cost.
- **Planning for an expanded system.** Mercy Medical Center's integration will bring additional emergency department volume into Baystate Health, making throughput improvement even more important as we work to optimize inpatient capacity and patient flow across a larger regional network.

⁹ Massachusetts Health & Hospital Association, presentation to the Technical Advisory Committee on Post-Acute Care. <https://www.mass.gov/doc/tacpac-mha-presentation-252025-0/download>

Barriers and Challenges

- **Insurance barriers.** Authorization and coverage requirements are the single largest source of delay days at Baystate Medical Center.
- **Limited post-acute capacity.** Skilled nursing, home health, and behavioral health placements are scarce in Western Massachusetts, and workforce shortages in long-term care and home care limit how many patients those providers can accept.
- **Guardianship and surrogate decision-making.** When a patient lacks capacity and has no valid health care proxy, the legal process to appoint a decision-maker can take weeks or months while the patient remains in an acute care bed. We support the HCAWG's commitment to explore modernizing surrogate decision-making and health care proxy laws, together with related guardianship reform, which would address one of the longest causes of extended hospital stays at minimal cost to the Commonwealth.¹⁰
- **Patients with complex needs.** Social and safety concerns and behaviors that prevent placement together accounted for more than 2,400 delay days in FY2026.
- **Payment methodology.** Because inpatient payment is largely fixed per stay, hospitals absorb most of the cost of extended stays that result from barriers outside their control.

¹⁰ Office of the Governor, "Governor Healey Announces Health Care Affordability Working Group Recommendations to Lower Health Care Costs," August 2026. <https://www.mass.gov/news/governor-healey-announces-health-care-affordability-working-group-recommendations-to-lower-health-care-costs>

Second HCAWG Policy Priority:

Targeted Nursing & Workforce Investments

Why This Is a Priority

The HCAWG recommendation identifies the central problem: nursing programs in Massachusetts turn away qualified applicants because they lack enough faculty and classroom capacity.¹¹ The bottleneck is faculty and clinical education capacity, not a shortage of people who want to enter the profession. A July 2026 report from the MassINC Policy Center, the Massachusetts Health & Hospital Association, and their partners found that qualified applicants to community college programs in six nursing and allied health occupations outnumber available seats by at least two to one, with roughly 4,500 applicants for about 2,200 seats. The report identified shortages of faculty and clinical placements among the main barriers to expanding enrollment.¹²

Baystate feels this shortage directly, and the gap is more acute in Western Massachusetts. Through 2026, our nursing vacancy rate has averaged approximately 16 percent, overall staff turnover has been 22 percent, and turnover among first-year registered nurses has been 35 percent. To maintain safe staffing, we rely on contract and agency personnel, who currently represent approximately 14 percent of our acute care nursing workforce at an annual cost of approximately \$28 million. These resources provide necessary short-term support, but their cost is not sustainable.

Investing in nursing faculty is a long-term structural solution rather than a one-time subsidy. A larger local pipeline reduces reliance on expensive traveler and agency staff, and nurses who train in Western Massachusetts often build their careers in the communities where they trained. Baystate's community college and university nursing partners would benefit directly.

How Baystate Health Is Advancing This Priority

- **Serving as a regional clinical education site.** In 2026, 1,091 undergraduate nursing students from more than a dozen academic programs completed clinical learning experiences at Baystate. We also hosted 16 graduate nursing students pursuing MSN and DNP degrees and 6 RN-to-BSN students.
- **Expanding academic partnerships.** Baystate has strong workforce partnerships with the University of Massachusetts Amherst, Westfield State University, Springfield Technical Community College, Greenfield Community College, and Holyoke

¹¹ See note 10.

¹² MassINC Policy Center, Massachusetts Health & Hospital Association, Massachusetts Association of Community Colleges, and Richard and Susan Smith Family Foundation, Critical Shortages Ahead: Aligning the Nursing and Allied Health Education Pipeline with Growing Employer Demand, July 2026. <https://massinc.org/research/critical-shortages-ahead-aligning-the-nursing-and-allied-health-education-pipeline-with-growing-demand/>

Community College. In 2026, we established new undergraduate nursing partnerships, including with Bay Path University and the University of Connecticut.

- **Supporting new nurses in their first year.** Our Nurse Residency Program supports newly licensed nurses through the transition from school to practice, with retention rates consistently ranging from 89 to 95 percent.
- **Creating pathways into licensed roles.** The Apprentice Nurse Program (levels I through III) provides structured, progressive pathways for students and employees to advance into licensed clinical roles. We also provide stipends to ICU nurses pursuing education as nurse anesthetists, building an internal pipeline of certified registered nurse anesthetists (CRNAs).
- **Regional collaboration.** Baystate nursing leaders participate in the Western Massachusetts Nursing Collaborative, a partnership of health care organizations, academic institutions, and nursing leaders working to advance the supply, diversity, and quality of the region's nursing workforce through coordinated clinical education, workforce planning, and faculty development.
- **Sustaining nursing excellence.** In May 2025, Baystate Medical Center earned its fifth consecutive Magnet Recognition from the American Nurses Credentialing Center, marking 20 years of sustained nursing excellence. Five consecutive designations is a distinction achieved by fewer than 1 percent of the nation's hospitals.

Barriers and Challenges

- **Faculty capacity.** Schools cannot expand enrollment without additional faculty and clinical educators, and the July 2026 report identifies faculty compensation as an issue to address.
- **Clinical placement capacity.** Clinical placements depend on experienced staff serving as preceptors, which competes with patient care demands during a period of high vacancy.
- **Labor costs that outpace reimbursement.** Baystate recently reached a new agreement with nurses at Baystate Franklin Medical Center that includes a 6.2 percent first-year wage increase and 13 percent over the life of the contract. These increases support appropriate staffing and quality of care, but they are not matched by increases in government reimbursement, which accounts for the majority of our revenue.

Additional HCAWG Policy Priority:

Education Investments

Why This Is a Priority

The HCAWG recommendation identifies primary care providers, nurses, behavioral health workers, long-term care staff, and community health workers as high-value roles that address workforce shortages.¹³ We agree. Shortages in these roles drive the avoidable emergency department visits and long hospital stays described above, and investment in them reinforces our other priorities:

- **Long-term care and home care staff** expand post-acute capacity and support timely transitions of care.
- **Behavioral health workers** reduce emergency department boarding and help patients receive care in the most appropriate setting.
- **Community health workers** strengthen the value-based and MassHealth population health efforts of both Baystate and Health New England.

These investments also align with Baystate's academic and teaching mission. Shortages extend to the allied health professions. The July 2026 report found more qualified students seeking to enter associate degree nursing, medical laboratory technology, respiratory therapy, radiologic technology, and surgical technology than the state's community colleges can accommodate, with five qualified applicants for every available seat in radiologic technology.¹⁴ Baystate is also experiencing severe shortages of radiation therapists at a time when we are working to expand oncology services.

How Baystate Health Is Advancing This Priority

- **"Outside-in" earn-while-you-learn programs.** Baystate invests in individuals who want to enter health care through paid training programs, such as our Certified Medical Assistant program, supported by a Workforce Competitiveness Trust Fund grant from Commonwealth Corporation to Holyoke Community College. Many of these programs are registered apprenticeships aligned with the Division of Apprenticeship Standards that lead to nationally recognized credentials. Others include MRI Technologist, Polysomnography Technician, Patient Care Technician, and Cardiac Monitor Technician apprenticeships, as well as a paid respiratory therapy internship that leads to employment upon graduation.
- **"Inside-up" career ladders.** Our Patient Care Technician and Medical Assistant to Licensed Practical Nurse bridge program, supported by a Commonwealth Corporation

¹³ See note 10.

¹⁴ See note 12.

Senator Kenneth J. Donnelly Workforce Success Grant through Holyoke Community College, graduated its first class of 13 in August. A second cohort of 13 began the Practical Nurse program on August 31.

- **Addressing the benefits cliff.** Many entry-level employees lose public assistance, including childcare vouchers, Section 8 housing subsidies, and heating and transportation assistance, as their earnings rise above approximately \$22.00 per hour. This creates a financial disincentive to advance. Baystate is an employer partner in Bridge to Prosperity, a statewide pilot in Springfield, Worcester, and Boston that uses guaranteed income to bridge employees from one stage of career growth to the next. The pilot is now recruiting its second cohort.
- **Retaining clinicians we train.** Baystate offers career development for its own residents and for advanced practice provider students at local colleges, strengthening our ability to retain physicians and advanced practice providers who train in Western Massachusetts.

Barriers and Challenges

- **Education capacity.** Community colleges and public universities face shortages of clinical educators, limited clinical placements, and regulatory constraints on expanding programs.
- **The benefits cliff.** The loss of public benefits as wages rise discourages entry-level workers from pursuing advancement into higher-skilled roles.
- **Employer capacity to invest.** Training programs depend on employers to fund wages, preceptors, and support services, which is increasingly difficult for systems with negative operating margins.

Structural Reforms Necessary for Meaningful Progress

The priorities above will make a meaningful difference for patients and for the cost of care. Lasting affordability, however, requires structural reform rather than changes at the margins. We respectfully offer three structural reforms for the Commission's consideration, along with considerations for how the HCAWG recommendations are implemented.

1. Payment Adequacy

Affordability and payment adequacy are not opposing objectives. Payment must cover the cost of care and produce overall economics that sustain essential health systems and providers. It should recognize organizations with regional, academic, and safety-net roles, and commercial rates must be sufficient to sustain those organizations. Adequate payment supports reinvestment in access, workforce, facilities, and technology. As the Commonwealth implements the HCAWG recommendations, we urge attention to the following:

- **Address underlying cost drivers.** Default out-of-network rates, GIC price standards, or premium limits that do not account for rising labor, drug, supply, and regulatory costs could leave providers and insurers underfunded.
- **Target actual price variation.** Uniform caps or benchmarks would treat lower-cost regional and safety-net systems the same as high-priced outliers. Policy should focus on actual price variation.
- **Account for payer mix and safety-net status.** Systems with high MassHealth and Medicare volume rely on commercial payment to offset public-payer shortfalls, and rate benchmarks should reflect this.
- **Avoid Medicare-based benchmarks.** Tying commercial or out-of-network rates to a multiple of Medicare would import federal underpayment into the commercial market.
- **Keep GIC policy within its scope.** Price standards for the state employee health plan should not become de facto statewide rate-setting without a separate public process.
- **Protect 340B.** State drug purchasing strategies should not erode the 340B savings that fund safety-net care.

2. Aligned Incentives

With adequate reimbursement, a provider's financial results depend less on volume growth, and the focus can shift to access and appropriate utilization. As an integrated system that includes a health plan, Baystate sees how better utilization translates into lower premiums for employers and lower costs for MassHealth. Aligned incentives allow providers to invest in access, shift care to more appropriate settings, and provide supportive services such as care management and patient navigation. To support this alignment:

- **Fund new requirements.** New requirements for data exchange, low-value care reporting, or artificial intelligence transparency should come with implementation funding and realistic timelines.
- **Keep processes clinician-led and transparent.** Definitions of low-value care and rules governing artificial intelligence should be clinically grounded, with provider and regional representation on the committees that develop them.

3. A Regionally Rational Health Care System

Baystate's integration of Mercy Medical Center is grounded in this premise: a region's health care resources should be organized to meet the needs of its population sustainably. We encourage the Commonwealth to:

- Define health care markets regionally and determine the capacity each region requires.
- Protect essential regional infrastructure, including academic medical centers, safety-net and rural providers, and services where a system is the only regional option, such as trauma, neonatal and pediatric intensive care, and behavioral health.
- Enable providers to move appropriate care out of expensive inpatient settings.
- Rebuild primary care before removing capacity from other parts of the system, and fund primary care growth with new investment rather than budget-neutral reductions in hospital and specialty payments that shift the funding gap rather than close it.
- Rationalize the whole health care ecosystem, not only hospitals.
- Make affordability an outcome to be achieved, not only a spending target or cap.

Hospitals, physicians, other providers, and health plans are prepared to make the difficult decisions necessary to help redesign the delivery system and lower total costs. In doing so, the Commonwealth must ensure that Western Massachusetts retains the infrastructure and financial sustainability to care for its population. Baystate Health looks forward to continuing to work with the Health Policy Commission, the Office of the Attorney General, the Administration, and the Legislature toward that goal.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

- Chapter 224 of the Acts of 2012 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) 2024-2026

		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2024	Q1	4	97
	Q2	2	100
	Q3	1	87
	Q4	2	78
CY2025	Q1	6	74
	Q2	3	83
	Q3	3	89
	Q4	2	78
CY2026	Q1	3	77
	Q2	2	67
Total:		29	835