Acton Medical Associates, P.C.
321 Main Street
Acton, Massachusetts 01720

November 2, 2024

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, Massachusetts 02109

To Whom it May Concern:

Please accept the attached documentation from Acton Medical Associates, PC for the 2024 Annual Cost Trends Hearing of the Health Policy Commission.

This document is signed under the pains and penalty of perjury.

Sincerely,

Deborah Kovacs, MD, MBA
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MASSACHUSETTS
HEALTH POLICY COMMISSION

2024 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 2024 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, November 4, 2024**, 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 2023, 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.

You are receiving 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 either HPC or AGO 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 2024 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with 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 2024 Health Care Cost Trends Hearing will take place in a period of significant upheaval and reflection for the Commonwealth's health care system. The bankruptcy and dissolution of Steward Health Care, previously the third largest hospital system in Massachusetts, led to substantial disruptions to the state's health care market and has taken a significant toll on communities, patients, provider organizations, and health care workers across the region. This market instability is occurring while many providers across the health care continuum are still struggling to adapt to a post-pandemic "new normal" state, wrestling with capacity constraints, financial volatility, administrative burdens, and workforce recruitment and retention challenges.

At the same time, an increasing number of Massachusetts residents are struggling with health care affordability and medical debt. Massachusetts has the second highest family health insurance premiums in the country. The average annual cost of health care for a family exceeds $29,000 (including out of pocket spending). Recently, more than half of residents surveyed cited the cost of health care as the most important health care issue, far surpassing those that identified access or quality. Due to high costs, 40 percent of survey respondents said they are putting off seeing a doctor or going to a hospital. These affordability challenges are disproportionally borne by populations of color, and those in Massachusetts with less resources, contributing to widening disparities in access to care and health outcomes. The annual cost of inequities experienced by populations of color in Massachusetts is estimated to exceed $5.9 billion and is growing every year. These challenges require bold action to move the health care system from the status quo to a new trajectory.

This year, in the wake of the considerable harm caused by the bankruptcy of Steward Health Care and other recent market disruptions, the HPC is focusing the 2024 Cost Trends Hearing on moving forward, from crisis to stability, and building a health care system that is more affordable, accessible, and equitable for all residents of Massachusetts.

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 annual 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.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Reflecting on the health care market disruptions in Massachusetts in recent years, including the bankruptcy of Steward Health Care and related closures, what have been the most significant impacts of these disruptions on the patients and communities your organization serves, particularly with regard to equitable and affordable access to care? What have been the most significant implications for your organization and workforce?

Acton Medical Associates, PC is a forty-provider primary care organization that provides vital primary care services to patients in the MetroWest area of Massachusetts. We believe that team-based care is essential for managing the complexities of services needed to care for patients. For example, a high-functioning medical practice needs nurses, medical assistants, population health coordinators, and administrative support to respond to patients' needs for care. This includes providing phone advice, scheduling appointments, refilling medications, answering portal questions, and providing behavioral health assistance. Our organization has encountered many barriers to providing primary care to our patients since the pandemic. These barriers include: --Workforce shortages: Hiring trained staff to provide for all of our patients' needs is extraordinarily difficult. Typical wages for nurses, medical assistants, phlebotomists, radiology technicians, and other entry-level positions have increased from 10% to 40%, depending on the position and its scarcity. --Workforce training: Retirements and departures from the healthcare field led to acute worker shortages. Exacerbating the workforce shortages, many providers and clinical staff were trained remotely during the pandemic. These new graduates filled positions that previously were held by experienced workers in the field. New graduates, especially those trained remotely and with minimal hands-on experience, need extensive mentorship, supervision, and training to safely perform their duties. This slow ramp-up puts additional pressure on existing staff to fill gaps and train new staff. --Inflationary costs: In addition to drastic increases in salaries, costs of supplies have increased since the pandemic. An additional focus on value-based care requires new, expensive software applications and staff to manage population health programs, increasing the expense and burden on our organization. Providers need training on topics unrelated to taking good care of patients, such as coding for complex diagnoses, assessing multiple conditions each year, and documenting all health conditions to capture appropriate reimbursement for patient encounters. Since many payors "network-adjust" coding patterns, each organization competes to train their providers and staff to scrutinize charts for more diagnoses to capture revenue. In primary care, this revenue is still not enough to cover

all the inflationary costs related to providing care. --Diminishing reimbursement from some payors: As mentioned above, network-adjusted payments disadvantage smaller organizations who are unable to hire large numbers of staff to support these coding programs, or hire consultants to train providers on coding for complex diagnoses. Even those payors who pay slightly more for our services each year do not pay enough to cover our vastly higher expenses. Despite working harder to provide evidence-based, compassionate care for patients, we find our reimbursement dropping due to unachievable benchmarks for coding and quality metrics. --Prior authorizations: Prior authorizations have blossomed, as payors try to limit their expenses by placing barriers in front of patients for receiving certain medications or tests. For example, the popularity of weight loss medications has led to us needing to hire more nurses to process complex prior authorization forms required by insurers to cover these medications. Physicians and staff spend inordinate amounts of time processing authorization requests for imaging studies for patients, leading to demoralized providers feeling second-guessed by insurance company employees denying tests or medications for their patients. --Burnout: Primary care physicians are being pushed to do more work for the same salary, in a climate of fewer support staff members and less experienced new providers. The lack of new graduates entering primary care, as well as the pandemic-fueled retirements of primary care physicians, has caused the remaining primary care physicians to absorb even more patients on their already bursting panels. Without the support staff to manage these patients, physicians feel demoralized and disconnected from the practice of medicine. In addition, primary care physicians worry about liability of being responsible for a large panel of patients they barely know, relying on a team of inexperienced staff to provide appropriate care for those patients. --Consolidation: Finally, the closure of Nashoba Valley Medical Center has led to even more patients in our community seeking both routine and urgent care in our area. We are unable to hire enough primary care physicians to absorb the need in our area. Our local community hospital is overburdened, leading to extraordinary delays in patients being able to see specialists. These many months-long delays force primary care physicians to manage their patients' complex conditions without the help of a specialist, leading to increasing burdens on our primary care practice.

2. Please identify and briefly describe any policy, payment, or health care market reforms your organization would recommend to better protect the Massachusetts health care system from predatory actors, strengthen market oversight and transparency, and ensure greater stability moving forward.

Building support for primary care in Massachusetts is key to relieving the pressure on the market and reducing overall spending by improving access to preventive care. Massachusetts can do the following to help: --Incentivize physicians to enter primary care out of residency with substantial, immediate loan relief for physicians committed to providing primary care in the commonwealth. --Support primary care practices with grants to implement technology and software applications for population health programs, supporting team-based care to optimize preventive programs for patients. --Require payors to provide upside-only, generous reimbursement for primary care and preventive services. --Provide incentives for individuals to enter healthcare professions such as nursing and allied fields, and support their income with tax breaks or other incentives. --Restrain spending on higher cost services such as specialty care and surgeries while investing in basic primary care and behavioral health programs for residents of the Commonwealth.

3. Reflecting on consistent HPC findings showing increasing health care affordability challenges, growing difficulties accessing needed care, and widening health disparities based on race, ethnicity, and income among Massachusetts residents, what are your organization's top two to three strategies for addressing these trends? What are the most significant challenges to implementing these strategies?

Our organization partnered with the Institute for Healthcare Improvement and Blue Cross Blue Shield of Massachusetts to address health disparities in our area. Through this program, we successfully implemented several interventions to reduce disparities based on race, ethnicity, and income and improve access to primary care services. These included improving and broadening our translation services, reforming our website to provide accessible and translatable information to patients, building educational information for patients in multiple languages, expanding our behavioral health program, and increasing capture of race and ethnicity patient data. We are aware that there are more patients that need primary care providers and would like to meet their needs. However, we are restrained by our closed panels and lack of availability of primary care physicians to accept new patients.

4. Please identify and briefly describe any policy, payment, or health care system reforms your organization would recommend to achieve a health care system that is more affordable, accessible, and equitable in Massachusetts.

Many individuals have substantial health disparities and access challenges related to transportation, finances, childcare, or employment. They are most in need of robust primary care services. A team-based approach to care allows health care providers to provide affordable access to medications, community-based behavioral health services, and culturally appropriate treatment for health conditions. However, the time, staff, and financial resources needed to provide this comprehensive care are not covered by current insurance payments, which are often 50% or more below higher paying insurers. Improving care for patients who are covered by Medicaid or Medicare insurance requires supporting all primary care practices, not just community health centers, with financial support to augment the limited reimbursement provided by these payors.

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) 2022-2024			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2022	**Q1**	0	1
	Q2	0	1
	Q3	0	1
	Q4	1	2
CY2023	**Q1**	1	5
	Q2	0	5
	Q3	1	8
	Q4	1	10
CY2024	**Q1**	2	15

	Q2	2	10
	TOTAL:	8	58

2. Please describe any steps your organization takes to assist patients who are unable to pay the patient portion of their bill in full.

Our organization offers long-term, interest-free payment plans for our patients who are unable to pay their bill in full. In addition, we write off some of our nutritional and behavioral services for patients who do not have this as a covered benefit.

3. Do any of your commercial global risk arrangements adjust your final settlement for bad debt? Please provide details on any commercial arrangements that make accommodations for uncollectable patient payments.

No, this is not a factor in any of our commercial arrangements.

4. For each year **2022 to present**,
    a. For **HOSPITALS**: please submit a summary table for your hospital showing the hospital's operating margin for each of the following four categories, as well as revenue in each category expressed as both NPSR and GPSR): (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

Not applicable.

b. For **HOSPITAL SYSTEMS**: please submit a summary table for each hospital corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, as well as revenue in each category expressed as both NPSR and GPSR): (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

Not applicable.