November 4, 2024

David Seltz
Executive Director
Health Policy Commission
The Commonwealth of Massachusetts
50 Milk Street, 8th Floor
Boston, MA 02109

RE: 2024 Written Testimony for Cost Trend Hearings

Dear Director Seltz:

On behalf of Boston Medical Cener Health System (BMCHS), attached please find the required pre-filed testimony in advance of the Health Care Cost Trends Hearing.

I am legally authorized and empowered to represent BMCHS for the purposes of this testimony. This testimony is signed under the pains and penalties of perjury.

Should you have questions about this testimony, please reach out to Andrea Pessolano at Andrea.Pessolano@bmc.org.

Sincerely,

Alastair Bell

Alastair Bell, MD, MBA
President & CEO

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?

Today's healthcare landscape in the Commonwealth has a set of challenges that provider systems like BMC Health System are working hard to navigate—addressing the fallout of Steward's bankruptcy, while also continuing to recover from COVID and grapple with significant cost escalation that have not been matched with increases in reimbursement. BMC Health System played a direct role in responding to Steward's bankruptcy. We evaluated our potential role in helping to solve for the pending public health crisis caused by the bankruptcy and determined that we could make the biggest impact on the region by assuming responsibility for Good Samaritan Medical Center and St. Elizabeth's Medical Center. The integration of the two hospitals into BMC Health System builds on our existing clinical relationship with St. Elizabeth's and deep presence in Brockton through the Brockton Behavioral Health Center. Welcoming Good Samaritan and St. Elizabeth's to BMC Health System greatly expands the impact of our mission to provide affordable, high-quality, and culturally competent care to more patients and communities. With the introduction of these new hospitals, BMC Health System has 1,026 licensed beds and approximately 15,000 employees.

As we implement this integration, our focus in the first month has been on stabilization at these sites—ensuring safe ongoing clinical operations and welcoming our new employees. All the while, we will protect the base of BMC's core operations through thoughtful use of resources and clinical expertise. And, following the closure of Carney Hospital, we will continue to work with the Commonwealth, other health systems, and our community health center partners to meet patient needs in our region.

As we welcome Good Samaritan and St. Elizabeth's, we aim to create a transition that is stable in the short-term and sustainable in the long-term. This will be no easy task. Due to a payer mix dominated by Medicaid, Medicare, and the Health Safety Net, BMC has always operated with slim to negative margins. In our last two fiscal years we have incurred significant losses —a result of insufficient rate growth in the context of generational cost growth post-COVID. Our two new hospitals share BMC's heavy public-payer mix and face additional challenges beyond that: while they are essential community institutions providing much-needed medical care, they have experienced years of distress and problematic underinvestment in capital and operations during Steward's ownership. BMCHS appreciates the significant and necessary investment from the Commonwealth to keep these two former Steward hospitals open—in the short term, these hospitals need all that and more to keep them operating.

In the long term, we see a significant need for more sustainable funding mechanisms for high-Medicaid hospitals in the Commonwealth. While we are grateful for the supplemental payment support BMC has received for our work as a safety net hospital, the mechanism itself both keeps us in a precarious financial position and creates barriers to promoting delivery system reforms that increase the value our system delivers. New models of financing will be critical for protecting the viability of safety net institutions like ours, in turn ensuring the provision of high-quality care to all low-income populations in the Commonwealth, including often inequitably served communities of color. We see this as an important element of the next 1115 waiver amendment.

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.

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Addressing inadequate Medicaid reimbursement rates would provide further stability to the healthcare market. MassHealth rates are falling increasingly behind the costs for care delivery, as rate growth does not nearly match inflation. MassHealth needs to adjust this formula to keep high public-payer systems financially stable—without financial stability we cannot deliver equitable, essential care. Further, both fee-for-service payments and supplemental payments should reflect the social complexity of the patients served. Unfortunately, providers are facing proposed cuts to MassHealth, further threatening market stability. Safety net providers and other providers with a diverse payer mix already struggle to break even given the underinvestment in MassHealth. This challenge creates opportunities for predatory actors. To protect safety net providers and others who serve MassHealth patients, investment is needed in Medicaid rates.

Preserving the 340B drug discount program for safety net providers is crucial for the financial health of safety net providers. The 340B drug discount program is a federal law that allows safety net providers to purchase prescription drugs from pharmaceutical manufacturers at a reduced cost and use the savings to support other programs. The law was designed to reduce safety net hospitals' reliance on government funding. MassHealth is contemplating expanding the use of direct rebates from pharmaceutical manufacturers in a way that prevents hospitals from capturing the 340B discount from manufacturers. MassHealth began exploring this strategy recently but set a limit – they would carve out no more than 25 drugs, each costing more than $100,000 per person, per year, and the GLP-1 drugs. MassHealth is now considering moving beyond that limit, which will cut off a key source of revenue for safety net providers. Holding MassHealth to their own previously established limit of 25 high-cost drugs and the GLP-1s is necessary for the 340B program to continue as intended. Maintaining access to 340B pricing is essential to the short- and long-term viability of safety net providers.

To strengthen market oversight, an equity analysis should be more deeply embedded in any new state health resource mapping or planning initiatives. BMC understands the need to update current state health planning processes as recommended by the HPC and debated by the legislature this past session. In line with these efforts, BMC wants to ensure health care growth addresses gaps in care and targets those who truly need greater access to services, particularly low income and diverse populations. As such, resource mapping should not simply document the quantity of existing health resources, but truly examine access to those resources. Any new state planning process should capture access to health resources for diverse, low-income, and high Medicaid populations by noting the availability of resources that are culturally competent, preferred by these communities, or have a history of serving this population. An updated health planning process should capture how many providers readily accept MassHealth or MassHealth Limited patients. Noting the amount of health resources, without noting who they actually serve, will not provide an accurate picture of the state's healthcare inventory. Accordingly, the state should not base future health care growth decisions using a plan that does not take this into account. It is critical that an equity lens is incorporated in any new state health planning initiatives.

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?

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1. BMC is expanding access to affordable, quality care for more patients and communities.

As a response to the Steward Health Care crisis and potential service closures, BMC Health System welcomed Good Samaritan Medical Center and St. Elizabeth's Medical Center into Boston Medical Center Health System ensuring these important safety net providers remain operating. This integration allows patients in the Boston and Brockton regions to continue receiving care in their communities with their trusted providers. This acquisition also maintains important statewide capacity in critical service areas such as behavioral health, labor and delivery, and emergency care. This integration allows BMC to expand the impact of our mission – providing affordable, high-quality, and culturally competent care to more patients and communities.

BMC is improving workflows in our emergency department in order to serve more patients efficiently. One area of focus is addressing the number of patients who leave the emergency department (ED) without being seen. BMC has piloted placing a physician in triage in the waiting room on weekday overnight shifts to collaborate with existing triage nurses and care for lower acuity patients. This physician can start any labs and workups while the patients wait for space in the ED. This helps jumpstart this process, so it is completed faster and provides care more quickly. In some cases, this physician can

immediately address patient needs and discharge them directly. For example, a patient seeking a prescription or a return-to-work note can be served completely in this setting. Initial data show this innovation has promise. BMC's rate of patients leaving without being seen was reduced about 4 percentage points from FY23 to FY24.

2. Through our Health Equity Accelerator, data analysis and targeted interventions are transforming the care we provide and improving patient outcomes.

The Health Equity Accelerator at BMC is working to transform healthcare to eliminate gaps in life expectancy and quality of life among different races and ethnicities. BMC has improved baseline collection data, stratified performance to understand disparities, investigated high-priority disparities, and begun implementing interventions to address these gaps.

Through our equity in pregnancy initiatives, BMC is working to address existing racial inequities in severe maternal morbidity (SMM) and improve outcomes for our patients. BMC's work in this area is critical to the state's overall efforts to reduce inequities in SMM as 1 in 7 Black births and 1 in 13 Hispanic births in Massachusetts occur at BMC. Our innovative remote health monitoring program uses cellular-enabled blood pressure cuffs to easily track the blood pressure readings of patients at risk of pre-eclampsia or hypertension. Through this program, we can identify trends in our patients' blood pressure that indicate potential health impacts and connect those patients with timely life-saving interventions. Since May 2022, this program has served over six hundred patients during the prenatal period and over a thousand patients during the postpartum period. BMC is working on expanding its postpartum program to include patients of NeighborHealth (formerly East Boston Neighborhood Health Center).

This past year, BMC's Equity in Cancer initiative launched to help reduce cancer-related outcome disparities for patients of color. Cancer is the second leading cause of death in the United States and mortality rates across the city of Boston disproportionately affect Black residents. BMC has set out to improve adherence to screening recommendations as a first step to addressing this disparity given timely and regular screenings have shown to lower mortality rates for breast, cervical, and colon cancers through early detection. Using a population-health based approach, our patient navigators provide direct outreach to patients to assist with scheduling missed cancer screening appointments and identify any patient-reported barriers to screening. Our navigator-led intervention launched in November 2023 and since then BMC has been able to close over two thousand screening gaps for unengaged patients.

BMC believes economic security is a health equity issue. Increasing the financial stability of our patients is essential to improving their health and well-being. Every day, BMC providers and staff see the downstream health consequences of poverty in our clinics, emergency rooms, and inpatient services as economic insecurity has negative physical and mental health impacts for patients. To address this, BMC has developed initiatives to connect our patients with jobs and skills training, engage in workforce development across our communities, invest in housing where and for whom it is needed most, and

advocate for tax policy that enables those with the lowest incomes to generate income, assets, and wealth.

Many of our equity initiatives are supported through philanthropy as they are currently not reimbursable, making long-term sustainability a challenge. While there has been movement by some payers to reimburse certain interventions (for example MassHealth's recent coverage of remote patient monitoring services), BMC is not paid for much of the rest of this work. The interventions detailed above are creating better health outcomes - allowing patients to live healthier lives with less care needed in the long term. This will ultimately save costs to the overall healthcare system. In the short term however, as a safety net provider, it is challenging to invest when working in a resource constrained environment. Equity is core to our mission so despite funding challenges, BMC continues to prioritize moving this work forward.

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.

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1. Continued investment in the state's Medicaid program is necessary to address health equity and expand affordable care.

Investments in Medicaid should direct more health resources to patients of color. Systemic underpayment of safety net providers threatens health equity efforts given these providers typically care for the most diverse patient population. It is troubling that MassHealth is contemplating rate cuts, which could perpetuate or widen inequities. As a Commonwealth, if we want to improve health equity, we need to invest in providers serving patients of color. A robust MassHealth program also ensures communities have access to quality, affordable care. Further, addressing equity also helps address affordability. Tackling racial disparities produces better health outcomes for patients of color and reduces the total cost of care.

2. The statewide cost containment benchmark should be updated to allow for the consideration of additional factors that impact cost growth.

When considering statewide cost containment, a one-size-fits-all approach for limiting price growth is not appropriate, as it does not account for important factors that differentiate providers. As proposed in recent healthcare reform legislation, BMC supports allowing more flexibility in the cost growth benchmark to better address affordability and equity. The pending language would allow CHIA to develop referral standards for cost growth increases that recognize healthcare entities vary considerably in their baseline spending levels, pricing levels, and populations served. This change would allow the HPC to consider payer mix and other factors when examining cost increases. This approach acknowledges that spending growth may be more or less concerning for a given entity

based on these contextual factors. It also enables the HPC to better focus its cost containment analysis and work on entities that would have the most impact on overall healthcare spending.

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**	66	N/A
	Q2	85	N/A
	Q3	88	N/A
	Q4	159	N/A
CY2023	**Q1**	98	N/A
	Q2	115	N/A
	Q3	142	N/A
	Q4	108	N/A
CY2024	**Q1**	130	N/A
	Q2	135	N/A
	TOTAL:	1,146	N/A

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

Click or tap here to enter text.

It is the policy of BMC to provide medically necessary care to all patients, regardless of their ability to pay, and to offer financial assistance to those who are uninsured or under-insured and cannot pay. All patients who present to BMC and require emergent or urgent services, or other medically necessary care, shall be treated regardless of race, color, religion, creed, sex, national origin, age, disability, gender identity or expression, or ability to pay.

BMC offers financial assistance programs to all low-income, uninsured or under-insured, patients who demonstrate an inability to pay for all, or some portion of, charges normally due. Patients requesting assistance will be screened for eligibility and coverage under Medicaid or other state programs, Qualified Health Plans, or may be evaluated against pre-established guidelines to determine eligibility for assistance under the Hospital's Charity Care Program, (CCP). A determination of eligibility under a state or federal financial assistance program may cover some or all a patient's unpaid hospital bill. Patients found ineligible for state or federal financial assistance programs may be reevaluated for free or discounted care under the hospital's CCP. The level of discount offered under the CCP to qualifying patients is determined by household income, assets, family size, and medical needs as specified in the eligibility guidelines. For patients with private insurance plans, the Hospital is required to work through the insurance payor to determine what may be covered under the patient's policy.

All patients may request and be considered for financial assistance at any time during the billing and collection cycle.

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.

Click or tap here to enter text.

BMC does not have any commercial contracts that give accommodations or reimbursement for uncollected patient co-pays or deductibles.

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.

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Please see attached spreadsheet with financial data and list of carrier and programs included in each margin.

In general, very few of BMC's contracts have differential reimbursement by HMO/PPO products. In cases where this does exist it is minimal – under 5%. BMC has tried to minimize the differential as from our perspective we are treating patients the same.

For contracts that have a value-based component, there is usually an opportunity to earn additional revenue, but there are additional resources required to support these additional activities. Margins in these arrangements vary significantly by payer type (Medicaid vs Commercial) but are generally better than margins in standard fee-for-service contracts.

    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.

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Boston Medical Center
Summary of Financials
Requested by Health Policy Commission

FY22

	Gross Revenue	Net Revenue	Operating Margin
Medicaid	$ 1,333,528,361	$ 389,447,028	$ (231,177,004)
Medicare	$ 906,039,645	$ 352,988,485	$ (40,378,740)
Commercial	$ 515,098,150	$ 207,079,067	$ (18,668,454)
Other Payors	$ 136,274,813	$ 40,529,020	$ (19,150,771)
Total	$ 2,890,940,969	$ 990,043,600	$ (309,374,968)

Other Business	
Supplemental Payments	$ 174,556,347
Retail Pharmacy Net Margin	$ 85,750,566
Research/Other	$ (41,869,006)
Total Operating Margin	**$ (90,937,062)**

FY23

	Gross Revenue	Net Revenue	Operating Margin
Medicaid	$ 1,561,817,936	$ 455,992,448	$ (294,991,338)
Medicare	$ 1,011,162,976	$ 367,887,859	$ (94,673,658)
Commercial	$ 554,879,326	$ 217,719,437	$ (34,315,205)
Other Payors	$ 124,800,990	$ 35,437,893	$ (20,872,546)
Total	$ 3,252,661,228	$ 1,077,037,637	$ (444,852,747)

Other Business	
Supplemental Payments	$ 327,939,420
Retail Pharmacy Net Margin	$ 108,989,854

Research/Other	$	(62,562,793)
Total Operating Margin	**$**	**(70,486,267)**

Notes

Excludes Health Safety Net supplemental payment as that is included above
Applies overhead costs to normal retail pharmacy contribution margin
Includes items or services that are not related to the usual hospital services for which we are reimbursed or generate patient encounters at the hospital - such as Roundhouse Facility and Greater Roslindale Health and Dental Center

Excludes E. Newton sale $68.3M

Excludes Health Safety Net supplemental payment as that is included above
Applies overhead costs to normal retail pharmacy contribution margin

Includes items or services that are not related to the usual hospital services for which we are reimbursed or generate patient encounters at the hospital - such as launch of Brockton Behavioral Health Facility, Roundhouse Facility and Greater Roslindale Health and Dental Center