CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

November 4, 2024

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109
Via Electronic Submission HPC-Testimony@mass.gov

Re: 2024 Annual Health Care Cost Trends Testimony

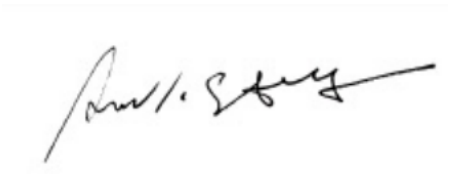
Dear Mr. Seltz:

This letter transmits Cambridge Health Alliance's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General in a communication requesting our written testimony for the 2024 Annual Health Care Cost Trends Hearing.

I am legally authorized and empowered to represent Cambridge Health Alliance for the purposes of this testimony. I attest, to the best of knowledge, that the attached testimony is accurate and true, and sign this testimony under the pains and penalties of perjury.

Please feel free to contact me should any questions arise.

Sincerely,



Assaad Sayah, M.D.
Chief Executive Officer
Cambridge Health Alliance

Enclosure

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?

The disruptions in the health care market continue to be dynamic. We appreciate that new operators are in place for 6 Steward hospital facilities. Cambridge Health Alliance's (CHA) primary service area is most proximate to the St. Elizabeth's Hospital campus. CHA serves as a regional behavioral health referral source for inpatient care, and these services were impacted by the Steward closures. CHA has been acknowledged by state agencies for accepting behavioral health inpatients on statewide waiting lists.

The pressures affecting care delivery and sustainability in today's healthcare landscape extend beyond the Steward Health Care matter. It serves as a further warning sign that there are additional vulnerable delivery systems and communities.

Like many hospitals and health systems, CHA is actively addressing serious financial and workforce challenges, which are compounded by unsustainably low commercial insurance rates and our high Medicaid and low-income payer mix. Externally-driven increases in health care expenses and cost pressures for staffing, supplies, and services outpace corresponding net patient service revenue, adjusted for volume.

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.

We look forward to working closely with the HPC, AGO, Healey Administration, and state policymakers on policies that will ensure our health system is stable, including for safety net systems and underserved communities they serve.

The recent disruption in the Massachusetts delivery system is another warning sign of vulnerabilities in our health care delivery system and for communities.

Immediate actions should start in addressing these needs first to lift up hospitals and provider organizations, particularly reforms to require equitable commercial payment rates for low-paid high Medicaid safety net hospitals and providers.

Sustainable Medicaid payment rates, while essential and among our leading priorities in partnership with EOHHS, cannot make up for shortfalls from commercial insurers for the care of patients delivered by safety net hospitals and providers. This disinvestment by commercial insurers undermines local access to health care services, particularly in lower income communities. Recommendations are described in the responses to questions 3 and 4 below.

To monitor the health of the delivery system, strengthening compliance with the existing financial oversight reporting to CHIA is necessary.

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?

CHA is pursuing organizational and state policy strategies to advance health equity and high-value health care. Safety net health systems, like CHA, serve Gateway communities and vulnerable populations facing the greatest health inequities. Equitable funding and resources are essential for us to provide and sustain equitable care in our local communities. The Commonwealth is at a major crossroads that could impede accessible care if state policy actions are not taken to address equitable payment and resources.

a. Resources for Safety Net Health Systems are Integral to Accessible Care and Advancing Health Equity. Commercial Health Insurers Must be Required to Reimburse Safety Net Hospitals and Health Systems Equitably at No Less than the Average Rate.

The Commonwealth is at a breaking point regarding equitable and sustainable reimbursement by commercial health insurers to vastly underpaid safety net hospitals - like CHA. Persistent underfunding of commercial patient care by commercial insurers for the care

of their members in low-income, diverse communities continues to deprive local safety net hospitals of resources and contributes to the destabilization of local health care.

State steps to address this documented commercial reimbursement gap will not only promote accessible care and the viability of critical safety net hospitals and providers, but also promote health equity of the vulnerable "populations facing the greatest health inequities"[1] served by these providers.

This chronic underpayment of safety net hospitals by commercial insurers is referenced in the Health Policy Commission's (HPC) report and is jeopardizing local health care access due to payment rates that inadequately reimburse for services. While the HPC recommendation 4.a. identifies this need to "address long-standing inequities in provider prices" and "allow price increases to accrue appropropriately to lower-priced providers,"[2] it must go further to recommend that the state oversight agencies/ legislature take immediate action to require a near-term pathway for commercial insurers to pay no less than the average rate for the essential care delivered by low-paid safety net hospitals. This cannot be left to the market to determine. Furthermore, the timeframe to achieve equitable rates is urgent and not something that can be spread over a decade or more.

b. Retaining a Greater Share of Care in Our Community Safety Net Hospital Level of Care

We seek to provide a greater share of the health care for our patient populations for services we deliver within our community, safety net hospital system's level of care, including primary care, behavioral health care, and community-based care. This promotes equity for our patients and community; affordable, well-coordinated care for our patients; and sustainability.

c. Strengthen and Invest in Primary Care and Behavioral Health

Primary care and behavioral health enhanced reimbursement and investments are integral to high value care that is affordable, equitable, and accessible. Incremental new reimbursement and investment are needed in these services to correlate to the important role they serve in promoting population health and wellness.

[1] 2024 Annual Health Care Cost Trends Report Policy Recommendations, See page 3, Massachusetts Health Policy Commission, October 2024.

[2] 2024 Annual Health Care Cost Trends Report Policy Recommendations, See page 3, Massachusetts Health Policy Commission, October 2024.

To respond to urgent needs in the state, CHA expanded its inpatient psychiatric services for youth (42 new beds) and adults (25 new adult beds) and is operating a Community Behavioral health Center, which complements the Commonwealth's Behavioral Health Roadmap.

Adding to its longstanding behavioral health services, CHA has a total of 156 inpatient psychiatry beds. CHA's proportion of behavioral health inpatient days to total inpatient days is greater than 50%, unique among acute hospitals. **Behavioral health is a lower reimbursed service by all public and private payers, which adversely impacts access, sustainability, and recruitment of health care professionals into these fields. As such, incremental new reimbursement rate investments are critically needed by all payers.**

CHA is also prioritizing access and improvements in its primary care and ambulatory care system. CHA operates 15 hospital-licensed health centers. This includes patient engagement, ambulatory service redesign and operational standardization to make it easier to deliver and access care. Advancing population health and health equity are strategic priorities for our organization.

We ask that focused incremental new reimbursement occur for all payers in primary care reimbursement, particularly in models that incorporate funding for primary care integration with behavioral health, care management, and coordination to respond to health-related social needs.

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.

1. Resources for Safety Net Health Systems are Integral to Accessible Care and Advancing Health Equity. Commercial Health Insurers Must be Required to Reimburse Safety Net Hospitals and Health Systems Equitably at No Less than the Average Rate in the near-term. Please see the response to question 3.a. above.

2. Medicaid Reimbursement

Among our leading priorities is sustainable Medicaid reimbursement including preservation of the 340B program. We are grateful for the ongoing partnership with MassHealth.

We are concerned about the RY25 reduction of base Medicaid rates in inpatient and outpatient services estimated to be more than $90 million. This is on top of RY24 rate reductions that stemmed from the new grouper update, which resulted in significant rate reductions for core inpatient services for the Medicaid population, including for maternal

health (labor and delivery services), newborn and neonatal care, and medical and surgical services.

In addition, we are concerned about any future Medicaid restrictions or policies to interfere with safety net hospitals' participation in the 340B drug discount program in Medicaid and Medicaid managed care. The federal 340B drug pricing program is an essential component of our safety net system, providing low-cost prescription drugs to patients and allowing hospitals to reinvest directly into their communities.

Preserving the 340B program for all eligible providers protects patient access, overall healthcare costs, and the stability of Massachusetts hospitals. CHA relies on the 340B program to support its core mission of patient care for all.

3. Incremental New investment in Primary Care and Behavioral Health. Please see the response to question 3.c. above..

We **oppose site neutral policies**, as they would potentially reduce resources for hospital-licensed health centers, ambulatory and primary care. Safety net health systems with hospital-licensed outpatient care already tend to be lower paid by commercial insurance, and site neutral policies risk reducing payer payments for services.

4. Comprehensive Health Equity Legislation *An Act to Advance Health Equity* (H.1250, S.799)

We recommend the state legislature's adoption of comprehensive health equity legislation, which embodies many recommendations of the legislature's Health Equity Task Force (chaired by CHA's CEO Dr. Assaad Sayah and Massachusetts League of Community Health Center's President & CEO Michael Curry). It will advance health equity in the Commonwealth through prioritizing equity in state government, standardizing and statewide reporting on health equity data, and improving access to and quality of care. Among other provisions, the bill will:

- Create first-ever Massachusetts Cabinet-level Secretary of Equity to lead equity efforts across state government/with state agencies
- Make medications for chronic conditions more affordable
- Ensure *all* community members, regardless of immigration status, can obtain MassHealth coverage, if otherwise eligible
- Create health care career opportunities toward a diverse workforce
- Revise licensing requirements for foreign-trained health professionals to increase access

- Provide funding to safety net hospitals and community-based providers that will enable local health care access and downstream improvements in health equity in Gateway Communities
- Invest in and empower local community health efforts called Health Equity Zones
- Preserve payment parity for telehealth services for primary care and chronic disease care.

5. Telehealth and Virtual Care We also support comprehensive telehealth legislation ***An Act relative to telehealth and digital equity for patients*** **(H.986/S.655)**, which will enable reimbursement parity for all services provided via telehealth by removing the sunset dates in Chapter 260 of the Acts of 2020; address the digital divide; and require insurers to cover interpreter services for patients with limited English proficiency and for those who are deaf or hard of hearing, among other provisions.

6. Health care Workforce/Career Pathways, especially to reflect the diversity of the community.

There are critical shortages of health care professions, causing a reliance on agency staffing/travelers and premium pay.

We encourage the continued state policy focus and investment in developing the health care workforce and career pipelines/financial incentives to encourage more people including diverse people to enter these fields in exchange for commitments to work in Massachusetts, particularly for organizations with high Medicaid and public payers.

7. Post-acute care capacity (medical and behavioral health) is needed to address emergency department boarding and patients "stuck" in an acute level of care awaiting the availability of post-acute care. Statewide, nearly 2000 inpatients are stuck in hospital beds because they cannot access the next level of care needed and more than 300 patients continue to board in hospital emergency departments and units as they await psychiatric inpatient placement.

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	144	Phone
	Q2	124	Phone
	Q3	139	Phone/MyChart
	Q4	137	Phone/MyChart
CY2023	Q1	22	Phone/MyChart
	Q2	29	Phone/MyChart
	Q3	35	Phone/MyChart
	Q4	31	Phone/MyChart
CY2024	Q1	33	Phone/MyChart

	Q2	25	Phone/MyChart
	TOTAL:	719	

- In CY 2023 forward, in accordance with the No Surprises Act effective in January 2023, we are automatically sending price estimates to self pay patients for a wide variety of visits in accordance with the regulations. Automated estimates are automatically sent to self pay patients and are not reflected in the patient-initiated requests in the table above.

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

CHA provides several options for insured and uninsured patients who cannot pay their patient balance in full.

For uninsured patients, CHA provides the contact information to the CHA Financial Assistance Team to help patients obtain Health Insurance. In the event the patient remains uninsured, CHA offers a 25% discount on the total outstanding balance when paid in full within thirty days of the service date. For the uninsured patients unable to pay the balance in full within thirty days, CHA offers interest free payment plan options to remit a monthly amount until the balance is paid in full.

For insured patients, CHA provides the contact information to the CHA Customer Service Team to establish a payment arrangement to resolve the balance over time. For insured patients, CHA offers interest free payment plan options to remit a monthly amount until the balance is paid in full.

Please note that all patient statements contain information and contact information to our Financial Assistance team to assist the patient in obtaining health insurance, as well as our Customer Service team where the patient can make a payment arrangement. This information is found on the CHA website and is shared by our Customer Service team during all patient inquiries.

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.

None of the organization's commercial global risk arrangements adjust the final settlement for bad debt.

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.

CHA is unable to complete this table because it does not have a validated cost accounting system in place at this time. While it may be possible to make estimates of the contribution margin by payer utilizing ratios from sources such as the Medicare cost report, these estimates would not be an accurate assessment of costs at the individual patient, and therefore aggregated payer, level. Given the level of assumptions necessary to develop this type of analysis, CHA has concerns that, even if it were able to submit information, the results would not be comparable across providers. We have provided the margin data at the total provider level.

Please find a table below that includes margin data that aligns with that reported in the Center for Health Information and Analysis 2022 Hospital Profile and the CHIA HFY Hospital Financial Performance Annual Report.

Entity Name	FYE	Operating Margin	NonOperating Margin	Total Margin	Excess (Deficit) of Revenue over Expenses
Cambridge Health Alliance	06/30/23	-4.80%	1.50%	-3.30%	($30.00)
Cambridge Health Alliance	06/30/22	-4.70%	6.50%	1.80%	$15.50
Notes:					
FY22 Updates: FY22 financials were restated for the change in Accounting guidance related to Subscription-based IT agreements.					

Please find below a table that includes revenue (NPSR and GPSR) by requested category: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business, which is sourced from CHIA reports.

	(a) Commercial GPSR	(a) Commercial NPSR	(b) Medicare GPSR	(b) Medicare NPSR	(c) Medicaid GPSR	(c) Medicaid NPSR	(d) All Other GPSR	(d) All Other NPSR
FY23	$36,269,731	$22,127,766	$223,198,841	$110,328,587	$532,590,305	$214,958,491	$272,284,214	$36,493,917
FY22	$26,297,997	$14,768,595	$204,900,078	$121,180,689	$410,411,937	$165,072,622	$272,924,627	$66,485,838
Source: FY22 & FY23 Cambridge Health Alliance as-filed cost reports filed with CHIA.								

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.