CODMAN SQUARE HEALTH CENTER
2024 SLIDING FEE DISCOUNT SCALE
EFFECTIVE 3-1-2024

Federal Register published 01-17-2024: Annual Update of the HHS Poverty guidelines on or after January 11, 2024

	Coverable by Federal Grant Resources					*Coverable by Massachusetts Health Safety Net*
	POVERTY	*over 100% through 150% FPL*		*over 150% through 200% FPL*		*over 200% and under 300%*
		Low Income				
Family Size	**up to and equal to 100% FPL**	**over 100% to 133% FPL**	**over 133% to 150% FPL**	**over 150% to 185% FPL**	**over 185% to 200% FPL**	**over 200% to 300% FPL**
1	$ 15,060	$ 20,029.80	$ 22,590	$ 27,861	$ 30,120	$ 45,180
2	$ 20,440	$ 27,185.20	$ 30,660	$ 37,814	$ 40,880	$ 61,320
3	$ 25,820	$ 34,340.60	$ 38,730	$ 47,767	$ 51,640	$ 77,460
4	$ 31,200	$ 41,496.00	$ 46,800	$ 57,720	$ 62,400	$ 93,600
5	$ 36,580	$ 48,651.40	$ 54,870	$ 67,673	$ 73,160	$ 109,740
6	$ 41,960	$ 55,806.80	$ 62,940	$ 77,626	$ 83,920	$ 125,880
7	$ 47,340	$ 62,962.20	$ 71,010	$ 87,579	$ 94,680	$ 142,020
8	$ 52,720	$ 70,117.60	$ 79,080	$ 97,532	$ 105,440	$ 158,160
Each Additional Family Member (See Below)	$ 5,380	$ 7,155.40	$ 8,070	$ 9,953	$ 10,760	$ 16,140

Computation of Family-Sized Threshold when greater than a Family Size of 8:

A	Threshold Base for Family Size of 8	$ 52,720	$ 70,117.60	$ 79,080	$ 97,532	$ 105,440	$ 158,160
B	Per Incremental Family Member Allowance:	$ 5,380	$ 7,155.40	$ 8,070	$ 9,953	$ 10,760	$ 16,140
C	Count of Addtn'l Family Members: (*Subtract 8 from Total Family Size*)						
D	Incremental Allowance: (*Multiply B times C*)	-	-	-	-	-	-
E	**Family-Size Adjusted Thresholds:** (***Add A and B***)	**$ 52,720**	**$ 70,117.60**	**$ 79,080**	**$ 97,532**	**$ 105,440**	**$ 158,160**

Application of Sliding Fee Discount for each FPL Level, if HSNO Eligible:

Published Charge for Visit *(fill in the Gross Charge)*						
Patient Charge per Visit	NONE	NONE	NONE	NONE	NONE	20%
Minimum Fee Charged	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 20.01 **
	No Fee Allowed to be Charged by HSNO Regulations.					

Application of Sliding Fee Discount for each FPL Level, if NOT HSNO eligible:

Published Charge for Visit *(fill in the Gross Charge)*						
Patient Charge per Visit	**NOMINAL FEE**	20%	40%	60%	80%	100%
MINIMUM Fee Charged	**$ 20.00**	$ 20.01 **	$ 20.01 **	$ 20.01 **	$ 20.01 **	$ 20.01 **

*** NOTE: Actual Fee Charged to patients with incomes over 100% FPL must be greater than the Nominal Fee.*

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?

Click or tap here to enter text.

Market disruptions have laid bare the fallacy that we have a "health care system"; we do not. The term "system" connotes degrees of design, organization, planning, and intentional connections, with excellent systems exhibiting learning and anticipating the need for redundancy. What we do have is a health and medical industry, characterized by independent actors seeking to maximize self-interest. Whether the disruptions were by disaster (fire, flooding) or avarice, there was no "system" redundancy to invoke in this industry of independent actors.

Our patients and community experience this as the abrupt disappearance of bedrock institutions which were relied upon for far more than the most obvious medical services delivered. I cite three reliances: Local Economies, Societal Trust, Health Equity

Local economies: Case studies have been written about industry closures in small communities (see Winchester Arms closure in New Haven post WWI) and the hollowing out of an entire town due to direct loss of employment, and secondary economies affected (*e.g.*, local lunch vendors patronized by employees of shuttered companies having an acute decline in business.) In that regard, the impact of these closures often take many months to years to play out in work dislocations, unemployment claims, reduced family income, reduced local patronage, shuttered stores, more work dislocations, *etc*. Eventually, these stressors present as patients with loss of health coverage, loss of primary care access, and worsened health conditions and outcomes. At Codman, we are seeing the earliest signs of this with our volume in our urgent care clinic up 12% overall comparing the weeks before *versus* after Carney closure. It is likely too early to see the full impact on secondary economies.
And while 12% seems a small percentage for a weekly increase, on a daily basis, we have routinely recorded 30 to 50% increases in demand. This "spikey" demand is very difficult for a thin margin operation to actively staff on the supply side. We risk, on one hand, understaffing leading to staff burnout and an unusually high number of patients who registered "cancelling" (walking out without being seen, up to 15 -20 on some days), to on the other hand, overstaffing beyond our FY2025 budget and then running deficits. The choice is poorer care delivered, or organizational sustainability problems.

Societal trust: When fundamental human needs are being met, there is confidence that society - embodied by local and state governments – has the interests of citizens in mind. The closure of the Carney hospital at all, and even worse in an accelerated manner without any community engagement, resulted in patients and community members' perception that society does not understand their needs, value their lives, or see them as having a right to health equity. One Codman patient who had used Carney for specialty care for 25 years told us she is "now very disappointed in the Mayor and the city for this closure." Another said, "The timeline given to the patients of Carney

was unacceptable, but to learn the owners never cared is really hard to hear. [I am] very hurt because this is an area of high minorities, and I feel the effort was not made to keep these hospital doors open for care." The cost of diminished societal trust goes well beyond my remit for commentary, but it can negatively impact patient engagement with other services to which we may refer them.

Health Equity: Regardless of who you are, it is obvious that when your transit time for stroke care deteriorates from 6 minutes in most communities to 11 minutes because your local hospital is closed, there is heightened risk of poorer outcomes. Even in the non-emergency setting, at CSHC we have an early perception of increased level of illness for many who present to us recently, which we fear results in poorer outcomes. That is not health equity. One of the above patients tell us access is a major issue for her as a Dorchester resident with some difficulties walking and now finding herself in a place where she has to go to Brighton for her medications and her specialty service due to her coverage. Recently she was told she has beginning stages of Parkinson's, and is now worried about how often she will need to make her way out to Brighton for care in the near future.

Many of our providers are frankly fatiguing with the weight of these combined insults etched on the faces and lives of our patients.

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.

Click or tap here to enter text.

If we want to fight the last war, as military generals advise not to do, then we look backwards and focus on guarding against bad actors. The truth is predatory actors sensed a market opportunity we created and they took advantage. Instead of building a wall against invaders, we might want to change the conditions and strengthen those players already present so that the market is so well served, there is no opportunity for predation. At present, one in six MA residents receive care in a community health center. These centers are proven to be the most effective and efficient care delivery systems nationwide, with 52 here in MA. That efficiency is hard won from decades of being resourced starved, engendering creativity in meeting the needs of individual patients and communities, often by partnering with other Community Based Organizations. Imagine what could happen if they were not resource starved?

There has been talk about beefing up the DON process, perhaps in conjunction with resource mapping and a planning council. I am sure we can all recall the implementation issues with both. The USA, and other societies (Eastern Block circa 1960's), have run that experiment with little to show other than how difficult it is to bureaucratically control markets. If there is a lesson from last century, it is that correctly incentivized and sometimes protected markets can work very well. In contrast, the experiment that has performed well is the provisioning of primary care through community health centers. Imagine a more organic beefing up of the delivery ecosystem with investments into a cost-effective CHC care model that is predation resistant? Satisfying demand with high quality services in already established delivery systems is far less difficult than building and sustaining regulatory walls.

The trick is to be sure that the services match the needs of the community. Here, there is a role for the HPC to perform its data gathering and analysis expertise to help CHCs direct the right services to the right populations, and to evaluate the impact.

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?

Click or tap here to enter text.

Put succinctly, the cost of access kills access to care. And ironically, when access to care deteriorates, (barring death) the cost of the **eventually-needed care** goes up. The statistic that Massachusetts has the second most expensive premiums in the nation is dumbfounding. But it begs the question: for what? One possible answer is that at $29,000 for a family, you are purchasing access to "**eventually-needed care**" – which, by definition, is expensive.

But what if we reject the notion that what we want is coverage for expensive eventually-needed care? What if we recognize that 80% of health is not medical care, but the interplay of societal drivers like nutrition, housing, transportation? What if we look at the most recent literature that is beginning to show that intensive social interventions and focus on specific subpopulations is cost effective? And what if we examine evolving methodologies for pricing the values of those interventions among industry participants, avoiding the "wrong pocket" or the "free rider" problems?

If that is true, then we can follow the health needs assessments of communities and establish cross-sector partnerships to NOT reinvent Carney Hospital (1880's model of health delivery focused on specialization), but rather address the needs of the community with new models, and avoid eventually-needed care. CSHC is engaged in the work of partnering with local organizations to address total cost of care under capitation. We are in early innings.
Our biggest challenges underfunding where it is currently estimated that only $0.05 of every health care dollar spent is spent on primary care. Useful policies include:

- convincing Mass Health to stay the course without changes to the rules of the Section 1115 waiver,
- achieving commercial payer parity on rates
- simultaneously engendering the support of state legislators to fully fund an already working model[1]

[1] In a Commonwealth where $200M invested into any one of the dominant hospital systems would make a small impact; the same investment in 52 CHCs would unlock programming with major returns in health equity and overall cost.

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.

Click or tap here to enter text.

At the recent MASSter List Event, John Fernandez of Brown University Health said, "follow the money" to obtain a better health industry. Building on that, I would suggest actively directing the money.

Useful policies include:

- Create programs and funding opportunities to scale working, existing models of care to create a predation-resistant health care ecosystem.
    - Primary Care is being redefined by the community health center movement that now serves 32Million Americans across the USA, and we are just getting started.
    - With support, these innovative and scrappy centers can and are embracing AI, telehealth, hospital-at-home, PACE and other programs so we can reduce our reliance on and need for "eventually-needed (expensive) care".
- Funding CHCs in cross-sector partnerships (with public health, community based organizations and private insurance), we can leapfrog well beyond the 1880's brick-and-mortar concept of care delivery (hospitals and specialized medical care) and provide these underserved communities the health care of tomorrow. Done well, we shouldn't need $29,000 premiums for a family.
- Reducing the glut of specialization with
    - medical school tuition reimbursement free for students entering primary care
    - reduced GME payments to hospitals for specialty resident slots
    - enhanced GME payments to hospitals for each primary care residency slot

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**	N/A	N/ A
	Q2		
	Q3		
	Q4		
CY2023	**Q1**		
	Q2		
	Q3		
	Q4		
CY2024	**Q1**		
	Q2		
	TOTAL:	N/ A	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.

We follow Health Resources Services Administration (HRSA) sliding scale policy. Depending on income level we apply a discount based on FPL and family size (See attached sliding discount scale)

- Up to including 100% FPL pays nominal fee.
- From 100% to 133% FPL pays 20% of Charges
- From 133% to 150% FPL pays 40% of charges
- From 150% to 185% FPL pays 60% of charges
- From 185% to 200% FPL pays 80% of charges

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.

N/A

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.

N/A

    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.

N/A