Mass General Brigham

Anne Klibanski, M.D.
President & Chief Executive Officer

November 4, 2024

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

Submitted via HPC-Testimony@state.ma.us

Dear Mr. Seltz:

Enclosed you will find the pre-filed testimony for Mass General Brigham as requested for the upcoming Health Policy Commission Cost Trends Hearings.

By my signature below, I certify that I am legally authorized and empowered to represent Mass General Brigham for the purposes of this testimony, and acknowledge it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Chris Philbin, Vice President of Government Affairs for Mass General Brigham (cphilbin@mgb.org; 857-282-5151).

Sincerely,

Anne Klibanski, M.D.
President & Chief Executive Officer

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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 Steward situation has brought to light the vulnerability in the hospital infrastructure in Massachusetts. Hospitals are operating in an extreme resource constrained environment caused by pandemic recovery, supplier issues, commercial and public payer rates failing to keep pace with inflation, growing labor costs, increased volume and acuity of patients, new and increasing demands on hospitals to address a broad range of societal issues, and the constant demand to reduce costs without a recognition of underlying expenses. According to the most recent financial data from the Center for Health Information and Analysis data (June 30, 2024) the statewide median operating margin for hospitals was *negative* 0.9%. Over half of hospitals reported negative operating margins, and two-thirds of health systems – which include affiliated physician practices – experienced negative operating margins.

Despite the challenging financial situation, hospitals are busier than and facing ever greater capacity challenges. The statewide hospital system has little to no standby capacity available to address the next crisis. According to the last available data from the U.S. Department of Health and Human Services (April 2024), 27 hospitals in Massachusetts were at or above 90% capacity and another 10 hospitals were at or above 85% capacity. A hospital is considered functionally full at 85% capacity, anything higher creates significant challenges. The capacity challenge is exacerbated by the inability to move patients out of the inpatient environment to a more appropriate setting. According to the most recent data from the Massachusetts Hospital Association, 2,149 patients are awaiting discharge to a post-acute facility. This is the highest this number has been in the last two years.

Data from Mass General Brigham is consistent with statewide trends. In FY2024, Mass General Brigham declined more than 1,836 inpatient transfers from the community due to capacity constraints. Our two academic medical centers (AMCs) were at capacity disaster 95% of the time, up 7% from last year. On average our AMCs had 102 boarders in their emergency department each day, an increase of 20% compared to last year, and the average waiting time was 19 hours for a medical/surgical inpatient bed, and 31 hours for a behavioral health inpatient bed.

The Steward bankruptcy illustrates the fragile infrastructure that the state relies upon to care for its citizens. Steward hospitals have strong ties to their communities and serve a critical patient population. These hospitals are critical to ensuring patient access remains within their local communities and preserving continuity of care. We are grateful for the Administration's extraordinary efforts, including investments, in supporting the transition of Steward's hospitals to new owners to minimize patient disruption and preserve access to care locally. However, the Steward's situation should be a warning to policy makers that all hospitals in Massachusetts are at a breaking point.

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 believe that it is critical that there is a robust group of healthcare systems across the Commonwealth that serve every community's needs and preserve and protect patients' continuity of care. We, along with the Massachusetts Hospital Association and other health systems across Massachusetts, are continuing to work together with the Attorney General, Governor, Secretary and Department of Public Health Commissioner in order to make sure patients have access to care in their communities. Throughout, we have kept the patient at the center and have worked collaboratively with important stakeholders to help mitigate the disastrous disruption to care caused by Steward's leadership failures and malfeasance.

Going forward, the state should play an important role in monitoring the financial stability of all essential health care facilities. The goal should be to identify problems early and mitigate any potential impacts on patient care and access. Therefore, we support identifying additional enforcement mechanisms for the state to ensure that all essential health care facilities comply with existing financial solvency reporting requirements regardless of ownership status (non profit vs. for profit). In the situation where an essential health care facility is owned by a third party who is not the operator, the state may consider additional oversight tools, including monitoring of the quality and care provided. For approved market transactions the state should consider conducting more frequent post transaction assessments to ensure the transaction complies with any required terms set by the state and the impact on patient access, quality of care, workforce, and costs.

Finally, the state should examine the overall trend of for profit health care in Massachusetts, including growth over time, types of services (low vs. high margin; hospital vs physician, etc.), location and demographics of the communities they serve, and overall financial stability. The report should examine both risks and opportunities these entities provide to the sector.

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?*

We understand that many patients report challenges with access to care due to affordability and we share the common goal of improving access to high quality affordable care. However, it is important that policy makers consider all the relevant data before crafting meaningful policy solutions. In fact, Massachusetts is doing better than most states when it comes to addressing affordability.

- Massachusetts is ranked the 4th lowest state for the number of people in debt collections due to medical debt. (Commonwealth Fund)

- Massachusetts is ranked the 5th lowest state for the cost of employer sponsored premiums as a share of state median income. (Commonwealth Fund)
- Massachusetts is ranked the 10th lowest state for the number of individuals with high out-of-pocket expenses as a percent of income at 6.2%. (Commonwealth Fund)
- Total health care spending in Massachusetts is in line with the national average and lower than 37 other states as a percent of GSP, at 15.5%. (Mass General Brigham analysis of National Health Care Expenditure Date, Centers for Medicare and Medicaid)

Mass General Brigham is committed to helping its patients access affordable care through its participation in the MassHealth ACO program and the Connector Care products; providing a robust financial assistance policy; employing a team of financial counselors to ensure patients are enrolled in eligible coverage options; and continuing our efforts to reduce costs and maximize efficiencies where possible.

Healthcare is evolving at an incredible pace. At Mass General Brigham, we have a unique opportunity to lead the future of academic medicine. Our integration strategy breaks down barriers, making it easier for patients to navigate between departments and reducing administrative burden on clinicians. We are bringing our clinical departments together and creating disease-focused institutes to ensure that our patients receive the high-quality care they deserve. This also means our clinicians will have the support they need to focus on what they do best: provide outstanding care.

Announced in March of this year, we launched a new, two-pronged initiative aimed at transforming the way we deliver care with the goal of improving patient access, outcomes, and equitable care. First, we are integrating our clinical departments and academic programs across our two academic medical centers into single departments. To date we have selected 8 of the 18 new clinical department leaders. The new leaders will allow us to be more nimble in our decision-making and help to achieve our goals moving forward.

Second, we are also creating interdepartmental disease-focused institutes that will multiply our ability to provide seamless, integrated care for our patients. To date we have announced three institutes: the Cancer Institute, the Heart and Vascular Institute, and most recently the Neuroscience Institute. These efforts are a critical step toward transforming patient experience, measuring and improving clinical outcomes, clinical operations and better supporting our exceptional clinicians and researchers.

Mass General Brigham's health equity goals are focused on reducing inequities in clinical outcomes and targeting those conditions that are the key drivers of health inequities among our patients and in the communities we serve—hypertension, substance use disorder, cancer, and maternal health. We are also responding to the social risk factors that contribute disproportionately to health disparities—such as food insecurity, housing instability and lack of digital access. We have dedicated, passionate frontline workers who spend their days connecting patients directly with needed services. These societal inequities are felt acutely in our hospitals each and every day and all too often our hospitals serve as a safety net. Below we highlight a few of our programs aimed at addressing health disparities:

- Collaboration with La Colaborativa to tackle key health issues, address social determinants of health, and improve access to vital services for the community. Designed by La Colaborativa and Mass General Brigham, this novel approach is guided by the principles of accessibility and trust, focusing on residents historically underserved by the health system. The first phase, launching this month, will prioritize services that promote community well-being while specifically addressing cardiometabolic disease—a major contributor to health disparities and a leading cause of premature mortality in historically underserved communities like Chelsea.

- Mass General Brigham's Community Care Vans provide mobile health services communities across Massachusetts, focusing on improving access to care and reducing health inequities. Operating in more than 20 communities, the Care Vans provide a broad menu of medical services, including screenings and interventions for chronic health issues like hypertension, diabetes and substance use disorders. Originally deployed during the height of the COVID-19 pandemic, the vans are staffed with multilingual and multicultural clinicians to help better connect with the communities we serve.

- To decrease disparities in Substance Use Disorder (SUD) treatment we have expanded the number of Bridge Clinics to four located at Mass General Hospital, Brigham and Women's Hospital, Salem Hospital, and Pentucket Medical in Haverhill. Our Bridge Clinics offer immediate access, low threshold, person-centered care and are open to anyone in the community. Through our Bridge Clinics, we have increased access to SUD care for patients, and importantly have increased the number of visits for patients who identify as Black, Hispanic/Latine, or as having limited English proficiency.

- Maternal mortality has been on the rise across all ethnic and racial groups for decades, with the rates for Black women the highest of any group regardless of education or income. To address maternal mortality rates, we have launched the Birth Partners Doula project to help close the racial gaps that exist. This program matches eligible pregnant patients who are most at risk of negative outcomes during pregnancy and birth with doulas. The aim is to connect a patient with a doula who speaks their language and understands the patient's cultural values and beliefs. The doula meets with the patient twice before birth, is present for labor and birth, and visits the new parent and baby twice after they transition home.

One of the unique aspects of Mass General Brigham is that we have integrated the delivery side and payer side into a single system, working toward a common goal. Our health plan manages ~145,000 MassHealth patients enrolled in the MassHealth Accountable Care Organization (ACO). The collaboration between clinicians and payer teams has led to innovation and better integrated models of care to improve health outcomes and deliver better patient experiences for our MassHealth population. We are excited to expand our offerings to include patients that are dually eligible for both Medicare and Medicaid through the Massachusetts One Care and Senior Care Options (SCO) programs. Through our participation in One Care and SCO, we will continue to deliver on our mission by providing high quality equitable care to a new cohort of patients.

We are equally focused on high quality, high reliability care delivered equitably through our For Every Patient initiative. Now, more than ever, we must deliver the best possible outcomes for every patient who needs us. Our hospitals and clinical care sites work together as one system, with a single approach to quality that focuses on the essential elements of care. For Every Patient is Mass General Brigham's unified quality strategy that seeks to achieve the best possible for every patient who needs us, every time they need us, from the common to the complex, from the hospital to the home. We are able to do this through our integration as one system with aligned goals for care no matter which location our patients seek their care from.

We are also focused on combating the capacity crisis impacting healthcare throughout the Commonwealth. One year ago, Mass General Brigham launched its integrated hub for coordinating patient transfers and ensuring access, the Patient Transfer and Access Center (PTAC). Through systemwide, daily capacity huddles and real-time coordination, the PTAC collaborates with hospitals across our system to understand the challenges that each face and helps support the flow of patients between our academic medical centers (AMCs) and community sites, ensuring that patients are matched with the site of care that fits their needs. This center addresses capacity challenges by improving access throughout the system by coordinating patient admissions and transfers.

- Average 52 transfers per week from AMC Emergency Departments (EDs) to our community hospitals
- Average 15 transfers per week that the PTAC redirects to our community hospitals for appropriate level of care, preserving AMC access for most critical/complex patients
- 56% growth in repatriation – the returning of patients who were transferred into our AMCs back to their original hospital, when medically appropriate, to recover
- 27% reduction in ED-to-ED transfers

Another important strategy of Mass General Brigham's to address the capacity challenge is Home Hospital. Mass General Brigham's Home Hospital brings expert hospital-level care right to the patient. There, patients are close to established support systems, including family members, caregivers that play a role in healing and wellbeing. In FY2024, 2,400 patients were admitted to Home Hospital, saving over 12,000 inpatient days in a traditional hospital. The program has demonstrated a high level of quality of care, in particular lower readmission rates, as well as high patient and provider satisfaction. The program is launched at five of our hospitals -- Mass General Hospital, Brigham and Women's Hospital, Brigham and Women's Faulkner Hospital, Newton-Wellesley Hospital, and Salem Hospital. Home Hospital offers daily visits from healthcare providers (physicians, nurses, therapists, home health aides and more) and provides services such as intravenous fluids, medications, lab draws, oxygen therapy, X-rays, electrocardiograms and ultrasounds directly in the home. All of this is supported by a 24/7 continuous remote patient monitoring platform that transmits a patient's vital sign readings to their clinicians as well as a two-way text and video communication pathway to ensure continual access to a patient's clinical team.

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.*

The most important policy lever that state has to address access and equity is the MassHealth program. It should not be considered an accident that all of Steward hospitals are high public

payer hospitals and care for a disproportionate share of MassHealth patients. And yet, MassHealth provider rates continue to lag substantially behind Medicare and commercial payers and, most importantly, behind the actual cost of care. The Center for Health Information and Analysis and the Health Policy Commission should provide the same level of transparency for Medicaid prices as they do for commercial prices. They should annually report for Medicaid the average price for services, per member per month (pmpm), both for hospitals and physician groups. Medicaid prices and pmpm should be compared to both commercial payers and Medicare. They should assess the impact of Medicaid rates on patient access and provider financial stability both in the fee-for-service program and the Accountable Care Organization (ACO) program. Most importantly, we urge the state to continue to make needed investments in total MassHealth funding both in the fee-for-service program and in the ACO program to ensure all MassHealth members continue to have equitable access to care throughout the Commonwealth.

We support the need to expand access to primary care and behavioral health services. Toward that goal, we recommend the state fast track all regulatory review processes for increasing primary and behavioral health services even if there is likely to be an associated increase in spending. Such transactions should be exempt from a Health Policy Analysis Cost Market Independent Review and a Dept. of Health Independent Cost Analysis.

To address the ongoing workforce challenge, Massachusetts should continue to fund and build on the many successful program in place, such as free community college, the Massachusetts Loan Repayment Program for Health Professions, and the Expanded Behavioral Health Student Loan Repayment program to help encourage new entrants into the field. Additionally, the state should also consider ways to highlight and provide entry to other health care careers that do not require a 4-year degree and yet are critical members of the care team, such as lab technicians, radiology technicians, emergency medical technicians, medical assistants, and community health workers. Funding for high school internships or dual enrollment programs could assist with filling these critical roles.

Finally, we continue to encourage policymakers to streamline the determination of need process for lower cost, alternative sites of care such as ambulatory care centers (ASCs). As the prior Cost Trends Report also pointed out, Massachusetts is ranked 47th out of 50 states in ASC capacity. Therefore, it should not be surprising that almost all surgical care in Massachusetts is delivered in more expensive hospital outpatient departments instead of lower cost ASCs. Moving care out of the hospital to lower-cost settings such as ASCs, physician offices, post-acute facilities, and the home, when possible, is the most promising approach to achieving sustainable cost savings. Removing unnecessary regulatory barriers to shifting site of care would help to reduce costs as well as bring care close to home for patients.

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	12,616
	Q2	N/A	16,586
	Q3	N/A	27,137
	Q4	N/A	25,838
CY2023	Q1	N/A	37,034
	Q2	N/A	19,143
	Q3	N/A	8,927
	Q4	N/A	8,271
CY2024	Q1	N/A	8,584
	Q2	N/A	8,564
	TOTAL:	N/A	172,700

Starting in FY2023 quarter 3 Mass General Brigham adjusted system estimate auto finalization logic, which dramatically reduced the number of finalized estimates being provided to patients. Rationale for this adjustment was due to inaccuracy of the estimates and pre-payments being made increased credits on patient's accounts. Corrections have been made and we expect to see an increase in finalized estimates in FY2025.

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

All patients who incur a balance for services will be informed of the availability of our Patient Financial Counseling services to assist them in fulfilling their financial responsibility. Our Mass

General Brigham's financial counselors will work with patients to see if they qualify for a state program that meets their needs. They can help Massachusetts residents sign up for MassHealth, Health Safety Net, or the Massachusetts Health Connector. Mass General Brigham will make its best efforts to advise all patients of any significant financial responsibility prior to service delivery to the extent that this information is available.

Patients with demonstrated financial need, either due to limited income or because their medical bills are an excessive portion of their income, will be considered for discounts. Discounts based solely on income are generally limited to patients with family incomes less than or equal to 300% of the Federal Poverty Level. Patients with insurance may receive a discount on medically necessary services not covered by their insurance. Uninsured patients can receive a discount on most balances for medically necessary services. Payment plans at 0% interest for most bills, including a bill for a health insurance co-payment, co-insurance, or deductible are available for most patients.

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.

Mass General Brigham does not have any bad debt adjustments in its final settlements for risk 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.

   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.

FY23 Acute Hospitals
Payer P&L

$M		GPSR	NPSR	Cost	Clinical Net Margin $	Clinical Net Margin %	Payer Mix % of GPSR	Payer Mix % of NPSR
Commercial	Local	$8,689.9	$3,320.1	$2,469.9	$850.3	26%	31%	40%
	National	$1,688.9	$972.5	$478.2	$494.3	51%	6%	12%
	Other	$1,219.1	$391.3	$311.4	$79.9	20%	4%	5%
	Total	**$11,598.0**	**$4,684.0**	**$3,259.5**	**$1,424.5**	**30%**	**42%**	**56%**
Government	Medicare	$11,501.3	$2,571.9	$3,467.4	$(895.5)	-35%	41%	31%
	Medicaid	$3,795.8	$847.9	$1,201.8	$(353.9)	-42%	14%	10%
	Other Government	$542.2	$126.4	$158.2	$(31.7)	-25%	2%	2%
	Total	**$15,839.3**	**$3,546.2**	**$4,827.3**	**$(1,281.2)**	**-36%**	**57%**	**42%**
Other	**Total**	**$400.5**	**$130.2**	**$115.5**	**$14.7**	**11%**	**1%**	**2%**
	Total	**$27,837.8**	**$8,360.4**	**$8,202.4**	**$158.0**	**2%**	**100%**	**100%**

FY22 Acute Hospitals
Payer P&L
$M

		GPSR	NPSR	Cost	Clinical Net Margin $	Clinical Net Margin %	Payer Mix % of GPSR	Payer Mix % of NPSR
Commercial	Local	$8,087.9	$3,155.9	$2,328.2	$827.7	26%	32%	41%
	National	$1,443.6	$852.7	$413.1	$439.6	52%	6%	11%
	Other	$1,124.4	$388.7	$298.9	$89.8	23%	4%	5%
	Total	**$10,655.9**	**$4,397.2**	**$3,040.2**	**$1,357.1**	**31%**	**42%**	**57%**
Government	Medicare	$10,434.3	$2,381.3	$3,173.4	$(792.1)	-33%	41%	31%
	Medicaid	$3,550.1	$705.4	$1,147.9	$(442.6)	-63%	14%	9%
	Other Government	$508.0	$117.0	$149.7	$(32.7)	-28%	2%	2%
	Total	**$14,492.4**	**$3,203.7**	**$4,471.0**	**$(1,267.3)**	**-40%**	**57%**	**42%**
Other	**Total**	**$350.1**	**$116.6**	**$103.2**	**$13.5**	**12%**	**1%**	**2%**
	Total	**$25,498.4**	**$7,717.6**	**$7,614.3**	**$103.2**	**1%**	**100%**	**100%**

Notes for Both Tables

- The margin represented above is clinical margin, excluding factors like research loss, fundraising, investments.

Acute Hospitals:
- AMCs: Mass General Hospital and Brigham and Women's Hospital
- Community Hospitals: Brigham and Women's Faulkner Hospital, Salem Hospital, Newton-Wellesley Hospital

Service Areas:
- Includes: Inpatient (Facility and Hospital at Home) and Outpatient (Main Campus, Ambulatory Care Center)
- Excludes: BWH DFCI Inpatient beds

Payer Category Definitions:

Commercial:
- Local: Blue Cross Blue Shield MA & Out of Area, Point32Health, Mass General Brigham Health Plan
- National: Aetna, Cigna, United, and other smaller national plans
- Other: Smaller commercial plans (e.g., Wellpoint formerly UniCare GIC)

Government:
- Medicare Fee for Service and Medicare Advantage Plans
- Medicaid Fee for Service and Managed Plans (e.g., ACOs)
- Other Government includes Worker's Comp, TRICARE, other smaller plans

Other:
- Free Care / Health Safety Net
- Self Pay (Domestic)
- Self Pay (International)