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 health care market has been greatly impacted by a number of things including the larger disruptions like the Steward Health Care bankruptcy, but also by a number of other culture shifts that have challenged every healthcare organization. The rising cost of securing competent and trained healthcare staff along with the shortage of healthcare providers has created a system of competition that has been devastating for all, but most prominently the community health systems resulting in longer waits for patients, inability to provide sufficient primary care to meet the demand and extensive waits for that care. These reverberations have been most significantly felt by the most vulnerable populations in the commonwealth. The Federally Qualified Health Centers and mental health centers have labored at always stepping forward to maintain and grow services but are consistently challenged to compete in a labor market where it is almost impossible to compete with for profit systems and newly entering entities backed by venture capital and expanding virtual services.

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.

Promoting public policy that further supports a payment structure that is consistent with funding that addresses acuity including full assessment and management of medical, mental health, and substance use disorder treatment with the ability to address all areas of health-related social needs would preserve those organizations providing integrated care services with a focus on total care and actually promote better outcomes. Predatory actors identify opportunity to profit and to extract. Incentivizing models that address integrated care through community partnerships requiring subcontracting with the robust systems of care in Massachusetts to maintain system dollars in the community health care system and reduce the trend of building services that are best done in the neighborhoods where they can be provided. Providing equitable payment models to the community health system consistent with hospital reimbursement would increase access promoting health equity.

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?

SSTAR has implemented a number of strategies to address growing health disparities in the Commonwealth including increased attention to DEI initiatives to address the need to recruit and retain more diverse staff at every level creating an atmosphere that promotes access and trust. SSTAR has also expanded efforts in the community to deliver services in sites where the most vulnerable populations can be reached to promote access to health care. Our mobile van has been serving Fall River and the surrounding community for years. By expanding hours and services including primary care, HIV, Hepatitis and AIDS prevention and treatment, same day induction of methadone and buprenorphine evaluations within community settings including un-homed shelters, migrant shelters, and encampments, SSTAR can provide services to those who have historically had more restricted access to care. This fall SSTAR is launching services to adolescents who have had poor access to care by providing primary care, emergent care, vaccines, and sports physical services from the van adjacent to the local high school promoting access for all, not just for health care, but to extra curricula programs requiring health screenings. Our rapid access model that provides same day access to substance use disorder and mental health treatment is another model that promotes health access.

The most significant challenge to implementing and maintaining these strategies is the increased cost of the services and the productivity lost during outreach. Outreach efforts do not fund themselves through the conventional means. They cost more to provide including lost productivity during transport and transition, the level of support staff needed to address social determinant of health and the added capital and operational expenditures such as insuring mobile vehicles, the price of fuel, maintenance, and supplies. Conventional funding does not support these efforts, and one time funding simply creates a mechanism to create services that already burdened organizations must face supporting when the funding ends or in the worst-case scenario the loss of these vital services in the community. The rapid access model for substance use disorder and mental health care is a model that requires high staffing levels of mental health professionals including psychiatric nurse practitioners. Because this model requires access for anyone who walks through the door it does not and cannot support itself through conventional third-party billing alone. These, "firehouse" models, where clinicians stand at the ready require a more creative funding stream. Despite the most creative approaches in scheduling, it is not self-sustaining, leaving us with the dilemma that we face in multiple programs: How do we maintain mission critical programs without sufficient reimbursement? I would urge that the health policy commission find a way to advocate for

a reimbursement structure that promotes the use of community based mobile care and creative models that brings our healthcare system to the patient that funds the total price of the services. Promoting health equity as a mission has been the role of community health providers, but the reimbursement structures must support the cost of that care. We are thankful for the support that our legislators have shown in their attention to the rates and to the FQHCs, however, despite these efforts and acknowledgements many of us are losing ground with the increasing costs of staffing and service delivery.

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.

As noted in question number 3 above, I would urge more creative and inclusive funding of mobile health and rapid access models. Providing increased funding of urgent care to health centers to increase capacity to serve patients would promote greater access in our communities in sites where attention to integrated care addressing social needs can provide the best outcomes. Most private practices and urgent care settings are not equipped to address the total needs of the most vulnerable populations that need to be served to promote health equity. SSTAR has been an active health care provider for the migrant population in our area. Our doctor has mobilized to go to the migrant shelter in instances of suspected varicella and to provide care. We have created access to care for all of those who need it when requested. Providing care to the migrant population brings with it increased expense for services including increased need for interpreters, decreased productivity of our providers secondary to increased complexities in securing histories, lengthier visits due to work through interpreters and through addressing every need for a population who may not have had access to care prior. These services require funding for the health centers who are the safety net providers of care in the Commonwealth.

Creating systems of reimbursement that mirror the level of, and scope of services being delivered by the community providers who serve the most acute and disenfranchised population with equitable reimbursement rates will provide opportunities for even more outreach and engagement to achieve the mission of health equity that has been the cornerstone of the Community Health Centers since inception. We have always known that prevention is a better model than emergency care. There is no easy answer but beginning to shift the long-term funding structure to the models that promote community-based medicine in a way that is significant to our capacity to sustain the care that is needed is the first step in creating that system.

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**		
	Q2		
	Q3		
	Q4		
CY2023	**Q1**	0	
	Q2	0	
	Q3	0	20
	Q4	0	23
CY2024	**Q1**	0	40
	Q2	0	13
	TOTAL:	0	96

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

When a patient presents at the Health Center with no insurance or a lapse in coverage a front office staff member calls a Health Access team member to assist the patient. Health Access offers the patient a sliding fee application to complete. With this application, the patient is required to submit a copy of a valid driver's license/state ID, proof of income (pay stub for each job or unemployment letter, if self-employed most

recent tax forms including schedule C, proof of rental income, proof of child support or alimony or proof of Social Security income).
Once information and required documents are submitted a member of the Health Access team determines if the patient is eligible for one of the Health Center's sliding fee categories by comparing their weekly income to the SSTAR Family HealthCare Center Sliding Fee Scale chart.
If a patient is eligible for a sliding fee plan that has a copayment ($10, $13, $15, $20, or full charge), the patient is expected to pay that copayment at time of visit and the remaining charge is adjusted off at time of charge entry.
It is the patient's responsibility to renew their application every 6 months.

If a patient arrives at SSTAR seeking treatment for substance use disorder and meeting the criteria for that level of care, the following procedures are followed:

1. Upon presentation to either the Opioid Treatment Center or to the inpatient intake department a full screening for insurance information is secured.
2. If a patient has no insurance, a health access employee will screen the patient and assist in filing a Mass Health Application if the patient accepts the referral.
3. Those patients who are not eligible for Mass Health and who have no present insurance and refuse a referral can access methadone treatment or inpatient treatment with BSAS as the payer of last resort with no expense to the patient. Every effort is made while in treatment to assist patients to apply for and access Mass Health options
4. Those patients who are covered by a health insurance plan with a deductible, co-insurance or copay are advised of the financial obligation of their insurer.
5. If a patient indicates an inability to pay for their obligation and requires inpatient level of care the OTC front desk or intake staff initiate a conversation about capacity to pay and work toward a payment plan agreement.
6. The CEO or COO approves all payment plan agreements prior to admission with the emphasis of admission as the priority.
7. If there is a financial obligation by the patient, a copy of the payment plan is put into the patient record.
8. SSTAR accepts cash, checks and credit cards and provides an easy online payment option for patients to submit payments once discharged.
9. Patients receive statements post discharge until their balance has been settled.

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.

Not applicable – no commercial arrangements with accommodations

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.

NA

    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.

NA