Written testimony of Arlene Ash in Support of S.750
September 19, 2023, Massachusetts State House

Honorable legislators. My name is Arlene Ash. I am a mathematician. Since 1984 – with others – I have built models to *measure medical complexity*, enabling higher payments to health plans when they enroll sicker people.

On September 12, you heard much eloquent testimony concerning the primary care crisis in our State. Each of us knows someone who has struggled to find a primary care doctor or schedule a visit. Why is this? Partly, of course, because primary care salaries are lower, often much lower, than those of specialty providers. But maybe even more so, because their practices are *under-resourced* and *micromanaged*. I support this legislation because it addresses these root causes of the current crisis.

The answer to "How big is your practice?" should *not* be of the form "Our clinic provides 10,000 visits per year," but rather "We care for 8,000 people." You and I need so much more than *visits* from primary care teams: coordinating our care; fielding our phone calls and emails; linking folks to social services; reaching out when people with chronic conditions have been out of touch for too long; … gaining the trust of historically marginalized communities.

When we don't pay for "virtual" interactions, doctors get paid only when they make you come in for a visit – even when this is not the best use of either your time or theirs. However, paying for primary care by reimbursing for each activity that we want done, as we do for major surgical procedures, is not the solution. For example, imagine the flood of minimally useful, AI-generated e-mails from some "sharp actors" if practices are paid for each message. Arguably, the most important things that we need from primary care doctors cannot be readily

squeezed into the “square hole” of fee-for-service procedure-based reimbursement.

Indeed, it is *not normal* to pay professionals via “piecework,” aka fee-for-service. Professional workers receive salaries. They are rewarded by their organization for exceptional contributions and can be let go for underperforming.

What are you afraid of when giving up fee-for-service? Adequate, predictable payment to their practices lets “good doctors be good doctors.”

Since 2014, our team at UMass Chan Medical School has worked with MassHealth to improve equity … by also accounting for social determinants of health when allocating dollars and judging outcomes… One example is using an area-based measure that summarizes the relative abundance (or lack) of resources where people live. It is easy to map “place of residence” to a census block group or tract (typically between 600 and 2000 people), or “neighborhood.” This is much better than using 5-digit ZIP codes that often include over 10,000 residents, and span a wide range of socioeconomic conditions. Area-based measures can be used to provide more resources to practices whose patients live in under-resourced neighborhoods.

As of this year, MassHealth requires Medicaid ACOs to put more money into primary care, pay practices through monthly payments, and pay more for practices that can provide more comprehensive care. … It currently suggests, but will soon require, payments that also account for differences in medical and social risk.

I share the concern that judging medical risk from diagnoses coded on claims can lead to well-resourced plans getting more than their fair share of health care dollars through aggressive “upcoding.” In MassHealth, we address this concern in several ways, including: 1)

accounting for non-medical “social determinants of health” (such as, being homeless or unstably housed (3 or more addresses in 12 months), 2) not just using a medical morbidity score that relies on diagnoses alone, but also using a pharmacy-based score (that can identify, for example, diabetes that is managed with insulin) to more fully characterize medical risk, and 3) by boosting payments to systems whose patients live in “tough neighborhoods.” Our models and methods address most concerns reasonably well. Furthermore, we are “learners:” MassHealth uses an open and transparent process for implementing (and improving) its primary care transformation model.

All ways of paying for health care can be misused by bad actors. It is better to adopt a reasonable, imperfect payment model than to cling to conceptually wrong methods that have failed us.

Decades of ineffectual hand wringing over the primary care crisis underscores that state action is needed. Even those who have not yet “come on board” know that this bill is a good blueprint for necessary reform. Just as it took government regulation to require manufacturers to install seat belts, this bill will provide “cover” for those who want to do the right thing but cannot do it alone.

If asked, I will be happy to help.

Senate Bill 750 proposes alignment with MassHealth’s nation-leading initiative to reform primary care. Pass this, and our State will also be a national leader.