March 10, 2017

Potential Modification of the Health Care Cost Growth Benchmark

For the first time since the inception of Chapter 224, the statewide spending target for calendar year 2018 will be set at a benchmark equal to potential gross state product *minus 0.5 percent, or 3.1%,* unless the HPC determines that an adjustment to the benchmark is "reasonably warranted". Hospitals have consistently performed well under the benchmark (according to the Center for Health Information and Analysis (CHIA) 2016 Annual Report, the rates of growth for commercially insured members on a per member per month basis for hospital inpatient (2.2%) hospital outpatient (2.9%) and physician services (1.9%) are well below the 3.6% benchmark) and are continuing to implement innovative approaches to managing costs and improving care.

All hospitals, health systems and the physicians that work with them are absolutely committed to the goals of more affordable, accessible and high quality care. However, the health care industry is also facing unprecedented challenges. **Accordingly, the Massachusetts Health and Hospital Association (MHA) believes that the 3.1% benchmark can be appropriate, but with a few critically important caveats that must be considered for any benchmark to function effectively Each of these caveats are highlighted below and explained in greater detail in our comments.**

- There must be a greater focus by the commonwealth on input costs such as pharmaceuticals and labor
- Significant uncertainty around the future of the Affordable Care Act must be recognized
- Delivery system reform at the state level contributes to the uncertainty
- Growth in Mass Health enrollment and its impact on the benchmark
- Elimination of CHIA's proposed methodology to refer entities to the HPC that are within 15% of the benchmark
- Consideration of socio-demographic factors and an aging population and their influence on cost
- Expansion of services for behavioral health

In its February 8, 2017 presentation to the Board, the HPC recognized that there are many factors to take into account when considering whether any modifications to the 2018 cost growth benchmark are appropriate. MHA appreciates the opportunity to offer our observations to the HPC board as it examines these various factors and considers whether an adjustment to the cost growth benchmark is warranted and if so, how significant an adjustment should be adopted.

Key Cost Driver Challenges – Input Costs

More attention must be paid and action taken on input costs which are causing the state to miss the benchmark. What often gets overlooked is that these factors, which are largely outside the control of providers, continue to make it extremely difficult to meet the current health care cost growth benchmark and must be considered when deciding whether or not to modify the benchmark.

Pharmaceutical Costs

Among the factors largely outside provider control are pharmaceutical costs. We do not accept the argument that this is solely a federal issue which the state cannot influence. There must be more of a commitment from the HPC and the state to study and address this issue.

1. As noted in CHIA's 2016 Annual Report on the Performance of the Massachusetts Health Care System, pharmacy spending continued to grow at a substantial rate (10.2% in 2015) accounting for one third of the overall growth in total health care expenditures. This was amplified in the Health Policy Commission's (HPC's) 2016 Cost Trends Report which stated that: "Prescription drug spending continues to grow more rapidly than any other commercial category of service; continued growth is projected. Drug spending has grown faster than overall commercial trends in the past three years and now accounts for more than 20% of commercial spending in Massachusetts."
2. In pre-filed testimony for the 2016 cost trend hearings, one hospital reported that even with cost control mechanisms in place, it was experiencing a pharmaceutical inflation rate of almost 8%. Another hospital stated that it had been experiencing increases in excess of 15% for many years. A large medical group practice experienced increases averaging 10-12% per patient. A large hospital system reported that in one specific commercial risk contract, pharmacy expenses increased by 34%. When pharmacy expenses were excluded, the TME actually decreased by 1.1% across all other expense categories.
3. Rising prescription drug costs are a significant factor in the ability of both payers and providers to meet the 3.6% cost growth benchmark. In efforts to control costs, payers have introduced additional utilization management strategies and shifted more costs to patients. Providers have targeted additional education on treatment alternatives, monitoring prescribing practices, implementing medication adherence strategies and adopting alternative payment contracts that include pharmacy spending. However, the reality is that absent meaningful price reform and greater accountability in the pharmaceutical industry, further reducing the benchmark to 3.1% will make it difficult if not impossible for providers to be successful in meeting the lower benchmark.

Labor Costs:

Labor accounts for 70% of a hospital's operating costs, yet salary and wage growth pressures are not accounted for in the cost growth benchmark. Collective bargaining pressures and keeping pace with a competitive labor market for both clinical and administrative talent can significantly affect a hospital's ability to meet the cost growth benchmark and must be considered.

Changes to the federal landscape

Some of the most critical factors that could impact the ability to meet the cost growth benchmark involve significant and potentially disruptive changes to the federal landscape. The uncertainty within the federal government regarding the future of the Affordable Care Act, including what provisions will be in place for subsidized insurance coverage through the exchange and how Medicaid will be funded are of great concern. Under the current proposal, hospitals could face huge financial hits from a Medicaid overhaul as well as be exposed to greater financial risk from loss of coverage and higher levels of uncompensated care. Should there be a straight repeal of the ACA , it could result in a decrease in Medicare reimbursement to Massachusetts hospitals of over $100 million in 2018 due to wage index reductions. In addition, the impact of other Medicare programs that are in the process of being implemented, such as MACRA, are likely to result in unprecedented disruption to the health care system.

Changes to the state landscape

At the state level, numerous changes are being discussed to lower health care costs and incentivize patients to use high value, lower cost providers. Hospitals and other healthcare providers are working earnestly to be part of the new MassHealth Accountable Care Organization (ACO) program that will go live in December 2017. Implementing this new payment system and risk-based payment methodologies will be a major undertaking for MassHealth and healthcare providers given it is probably the most complex patient population and program in our healthcare system. The new ACO program requires the acceptance of upside and downside risk on finances that are already strained. The program also includes new spending from funding called Delivery System Reform Incentive Payments (DSRIP) that assumes major upfront spending by ACOs in FY2018 and FY2019. The Medicaid Waiver assumes up $425 million in funding for each of these years to support start-up costs for ACOs, safety net hospitals, and new spending on flexible services to address patient needs through other methods besides medical services.

In addition, hospitals have already accepted repeated cutbacks in state Medicaid payment, including Medicaid Managed Care Organization reimbursements, Disproportionate Share

Hospital (DSH) supplemental payments, and pay-for-performance payments. Hospitals are also now paying a new $257 million annual assessment to support Medicaid and help close budget shortfalls, which also assume Medicaid hospitals payments in return of new Medicaid reporting. Every hospital fares differently in that new process and these required payments and expenses will need to be appropriately considered in the context of the benchmark.

Growth in MassHealth Enrollment

As noted by the Baker Administration, MassHealth enrollment continues to grow despite the commonwealth's near universal health insurance coverage. Notably 85% of the growth has been driven by enrollment which will account for $600M of growth in FY18. According to EOHHS, some of this growth is due to a shift in commercial insurance to the MassHealth program. This enrollment growth has contributed to the state exceeding the benchmark even though MassHealth reimbursement rates underpay hospitals relative to the cost of care. The Baker Administration is seeking to reverse this trend through new eligibility processes in the MassHealth program as well in the commercial insurance market through a proposed employer shared responsibility contribution. Both the continued growth in MassHealth enrollment (expected to be 4% in FY2018) and policy changes that seek to offset some enrollment to commercial insurance may impact the benchmark.

CHIA Revised Methodology, Effect on Benchmark and Performance Improvement Plans

Hospitals must have the flexibility to manage any revenue loss resulting from the types of significant changes outlined above. This could mean shifting some of the decline in reimbursement to the commercial sector. Without that ability, the alternative could be the difficult choices of terminating programs, job losses and disrupting patient access to care. The changes described in Chapter 224 did not envision that the benchmark for healthcare providers be payer specific but rather be considered in total, therefore such a cost-shift is not unwarranted if hospitals operate within the growth benchmark across all payers. CHIA's proposed methodology, if adopted, will result in additional and unnecessary disruption.

- In December 2016, CHIA proposed expanding the criteria for a health care entity to be referred to the HPC beyond those entities whose HSA TME growth ***exceeds*** the cost growth benchmark to also include those that have HSA-TME growth ***within 15% below the benchmark***; along with other criteria. CHIA is expected to issue a final methodology or revised proposal shortly. MHA did not support this change and shared our written concerns with CHIA last December.
- If HPC lowers the cost growth benchmark to 3.1%, and CHIA finalizes its proposal to include entities within 15% of the benchmark, it could increase the number of providers that could be subject to PIPs since entities with HSA-TME growth rates above 2.6% could be subject to PIPs.

- MHA members have indicated that during negotiations payers use the benchmark as a de-facto upper limit to rate increases, arguing that they are themselves subject to PIPs. This poses significant challenges, especially for lower paid providers. The HPC should condemn this practice and clarify that the benchmark for payers is not meant to be applied on a provider-by-provider basis.

Impact of Demographics and Population Health on Benchmark

- **Aging population**
  According to the Kaiser Family Foundation, 29% of the population in Massachusetts is 55 and older and this number is expected to grow. In Boston alone, the population over age 60 is projected to rise 65% by 2030, from 88,000 to around 130,000 people. Data presented by the HPC showed that the percent of residents age 65 and older is projected to grow from 13.9% to 17%, contributing 0.6% to the growth in total health care expenditures between 2016 and 2019.

- **Social determinants of health**
  Social determinants of health include social, behavioral and environmental influences on the health of an individual or population. Research indicates that focusing on social determinants can result in improved health outcomes and reduce costs as well. As the HPC and others have recognized, there is a clear need to address how social determinants of health impact health care costs. Failure to address social determinants result in health care disparities that affect patient outcomes, productivity, and ultimately add costs across the health care continuum. Hospitals care for patients 24/7 and along with physician and community partners are making significant investments in services to address the social determinants that affect health. Investing in these interventions that address social as well as clinical needs is the right thing to do, but it is not free. Providers are prepared to commit operating dollars to fund interventions connecting individuals to social supports, but it can take years to realize the benefits. Similarly, as providers embark on forming ACOs and take on greater amounts of risk, there has to be a recognition that addressing unmet social needs will invariably cost money.

Behavioral Health

The Commonwealth recognizes the importance of improving care for behavioral health, including substance abuse and opioid addiction. Currently, however, providers cross subsidize underpaid behavioral health services by relying on revenue from higher paid services. Targeting cuts for higher margin services in an effort to reduce the cost growth benchmark has the potential to result in fewer resources to support underfunded services such as behavioral health and could potentially result in unintended consequences for expanding behavioral health services.

In summary, on behalf of our member hospitals and health systems, MHA supports the goals we all have to address rising costs and to insure that affordable access to healthcare in the commonwealth is sustainable. Moving to a 3.1% benchmark is aspirational and potentially achievable. But we must all recognize the significant challenges that we face in getting there and we certainly do not want to unduly penalize the very providers that are the backbone of the state's excellent health care system and much of its economy as we work together to reach that goal. Thank you again for the opportunity to provide critical feedback on this important process.