TO: **Health Policy Commission**

FROM: **Donna Kelly-Williams, RN President, Massachusetts Nurses Association**

DATE: **March 10, 2017**

RE: **Testimony on the Health Care Cost Growth Benchmark**

On behalf of the more than 23,000 registered nurses and health care professionals we represent, the Massachusetts Nurses Association (MNA) offers the following testimony regarding steps we believe the Health Policy Commission and the state legislature can take to address increasing health care costs regardless of adjustments to the benchmark. As frontline caregivers, we have front row seats to the state of health care in this the Commonwealth. And as the president of the Massachusetts Nurses Association, I can offer the perspective of both a bedside nurse and someone who has attended numerous hearings, taskforces and workgroups on rising health care costs over the past few decades.

As we know, health care costs continue to rise here in the Commonwealth, and though this is not a problem unique to Massachusetts, we have been unique in our attempts to address the problem for quite some time. And yet, here we are today, the second year in a row where health care cost growth has exceeded the benchmark set by this Commission. And not only have these costs outpaced the established benchmark of 3.6%, they have also exceeded both inflation and overall state economic growth. Furthermore, we not only know how much and how fast costs are increasing- we know the reasons why because they are also well documented. And if we do not address these issues, it does not matter if the Health Policy Commission adjusts the health care cost benchmark a half of a percentage point or leaves it at the number prescribed by Chapter 224 for 2018, because the only thing that will change is that we will miss it by that much more or less next year. Instead, we must address the roots of health care cost increases in the Commonwealth. Until we do that, we will not make real progress in reducing the cost growth in any meaningful way.

In many ways, health care stakeholders have been having this same conversation for decades. What steps can we take to get health care costs under control? And we have tried many, many things, including but not limited to: managed care and capitation- in several different iterations, deregulating the hospital industry, merging hospital systems to "create efficiencies", new care delivery models, alternative payment methodologies, high deductible health plans, tiered health plans, limited network plans, etc. Many in the health care stakeholder community have worked hard on these endeavors and yet in 2017, we are still having another version of that same conversation about reducing health care cost growth. So regardless of what is decided about setting the 2018 benchmark, the MNA asks the Health Policy Commission to act in its capacity as the state's independent agency charged with developing policy to reduce health care cost growth and improve the quality of care by proposing policies to address cost increases based on the information that has been gathered since the passage of Chapter 224.

The good news is that because of Chapter 224 and other laws aimed at curbing cost increases, we have dozens of reports and hundreds of data points to direct us as to what policy initiatives we should be looking to. Over the past several years, a core group of issues have been identified as the primary cost drivers in the Commonwealth- significant variations in the prices charged by providers that are not based on quality differentials, increased utilization of high cost providers, increased consolidation in the health care marketplace, preventable hospital readmissions and increased pharmaceutical costs. These pressure points have been consistently identified by the Attorney General's Office the Center for Health and Information Analysis, the Health Policy Commission and various others as the primary forces behind health care cost increases in the Commonwealth. The Health Policy Commission should therefore look to recommend policy to begin to address these specific issues.

Provider Price Variation

Provider price variation has been consistently identified as a barrier to reining in health care cost growth. The problem is well documented and must be addressed. And this is not something that is going to go away without some sort of intervention. In its 2016 Provider Price Variation report, the Health Policy Commission noted this, stating, "unwarranted price variation is unlikely to diminish over time absent direct policy action to address the issue[1]." It is time to take that direct policy action. **The MNA joins the Attorney General and the Governor in calling for some intervention to directly regulate the variation in provider prices in the Massachusetts health care marketplace.**

When Massachusetts abandoned hospital rate setting in 1991, it was billed as a way to lower costs through competition. Twenty-five years later we can see that this was not the case. The deregulation of the Massachusetts hospital industry restructured the health care system, but it has not produced the desired effects. From the bedside nurses' perspective, deregulation and unbridled competition have not brought about cost savings nor improved quality of care. Instead, deregulation closed 30 hospitals across the state and widened the gap between the "have" and "have not" hospitals. And it is not a coincidence that as this was happening, more and more individuals were seeking care at higher cost hospitals. In the deregulated environment, a disproportionate share of health care is being provided by higher cost providers- when a community hospital would be a high quality/lower priced option. This is why we must revisit some form of regulation over the prices charged by providers- especially when those price variations are not based on a variation in quality of care. It is time to accept the fact that the market is not going to correct itself. As the Health Policy Commission noted in its 2016 report on provider price variations, "direct limits have the potential to address price variation more directly and quickly than demand or supply-side approaches and they may be more specifically targeted to reducing variation"[2]. So while hospital rate setting fell out of favor in the 1980s, we believe it is time to take a second look at what the Health Policy Commission termed, "policy options that can be categorized as direct limits on price variation".

In his FY2018 budget, Governor Baker proposed a modest, three-year plan to rein in costs by capping increases to certain providers. **The MNA is supportive of exploring this option and any similar proposals. The MNA is also in favor of exploring any rate setting plans that would help to narrow price disparities, lower overall costs and improve quality of care.**

[1] Health Policy Commission. "Provider Price Variation: Stakeholder Discussion Series Summary Report". July 2016.
[2] Ibid.

Market Consolidation

A by-product of the deregulated hospital environment was rapid consolidation, as noted previously. In addition to the increased variation in prices charged by providers, there are many questions as to whether the consolidation in today's marketplace actually produces efficiencies and cost savings. In fact, history would seem to indicate that rapid provider consolidation over the past twenty years has actually increased costs, as larger, consolidated health care entities exert undue upward pressure on costs due to their market share power. Further market consolidation would seem to only exacerbate this problem**. The MNA encourages the Health Policy Commission to continue to use its market oversight authority to prevent mergers, acquisitions and affiliations that will increase health care costs and cause further variations in provider prices.**

Preventable Readmissions

Preventable hospital readmissions have been consistently identified as a health care cost driver- at both the state and federal level. As noted by the Health Policy Commission at its March 8th hearing on the cost growth benchmark, lowering Massachusetts hospital readmission rates could lower costs by between $61 million and $245 million annually. One way to combat increasing readmission rates is to ensure that patients get appropriate care while in the hospital. And in tandem with this, patients and their families must receive the necessary discharge instructions related to the reasons for their hospitalization and the treatment they received while inpatient. This allows patients to go home with the right instructions, the right equipment and supplies, and the right medications. When they receive appropriate discharge information, once home, patients will have the knowledge of how to take their medications safely and as prescribed, how to do wound care appropriately and safely, how to begin to rebuild their strength and prevent falls, and know what potential complications to watch for and report to their caregivers. All of these things are crucial to preventing complications which could necessitate a preventable return admission. As nurses, we see everyday how inadequate nurse staffing leads to less time spent on teaching patients and families- and how this in turn can lead to these preventable readmissions. According to a 2013 *Health Affairs* article, hospitals with higher nurse staffing had 25% lower odds of preventable readmissions compared to otherwise similar hospitals with lower staffing. The article states, "Investment in nursing is a potential system-level intervention to reduce readmissions that policy makers and hospital administrators should consider in the new regulatory environment as they examine the quality of care delivered to US hospital patients.[3]" Effective and proper nurse staffing leads to improved patient care. Discharge is a crucial time for nursing care. Ensuring a smooth transition of care to the home setting can make a significant difference as to whether or not the patient returns to the hospital. Nurses must be afforded the time to clearly communicate post-discharge instructions- and this means that hospital units must be adequately staffed at all times. Unfortunately, my colleagues and I can report that this is most often not the case. The investment in resources such as nurses is an important one if we are looking to reduce unnecessary readmissions- and it is an investment that pays for itself. **The MNA encourages the Health Policy Commission to support policy recommendations for appropriate nurse staffing levels.**

Pharmaceutical Costs

[3] McHugh, Matthew D., Berez, Julie, et al, *Hospitals With Higher Nurse Staffing Had Lower Odds of Readmissions Penalties Than Hospitals With Lower Staffing,* Health Affairs. October 2013

Another area consistently identified as a cost driver is pharmaceutical costs. According a September 2016 report from the Center for Health Information and Analysis[4], spending on prescription drugs accounted for roughly a third of per capita spending growth for the second year in a row and 15% of total health care expenditures in 2015. This mirrors the national trend of sharp prescription drug spending increases over the past two years. And at the bedside, nurses are seeing more and more patients who are having difficulty affording their cost sharing for prescription drugs. And as we all know, if an individual is not properly taking his or her medications, those costs will pop up elsewhere in the health care system- in our emergency departments, repeated readmissions to the hospital and further, often expensive, complications. So, how do we get a handle on prescription costs while maintain access to necessary medications? As noted this past fall during the Health Policy Commission's Annual Health Care Cost Trends Hearing, the Health Policy Commission could take a leadership role in drug price transparency and cost containment efforts. **The MNA encourages the Health Policy Commission to explore any and all options available to them to reduce the increase in prescription drug costs including but not limited to, increased transparency in drug pricing, requiring justification for price increases, and exploring price control options specifically aimed at prescription drugs.**

Medicare for All

I would be remiss to not mention one policy solution that would address the majority of these ongoing concerns - the adoption of a Medicare for All system. If Massachusetts were to move to a system of truly universal coverage with the government acting as a single payer pool. This would help rein in provider price disparities, curb prescription drug increases, allow adoption of a standardized electronic patient data platforms, improve the quality of care and lower overall costs across the system. The MNA encourages the Health Policy Commission to seriously evaluate the benefits of moving Massachusetts to a Medicare for All system.

Finally, at the March 8th hearing, there was testimony presented that identified costs associated with collective bargaining as a cost driver. Nursing as a percentage of budget has been flat for over two decades – this is clearly not the driving force for health care inflation. Additionally, the MNA would like to note for the record that staffing expenses associated with direct care workers provide a net positive return on investment for hospitals. Here is just a sample of studies substantiating this:

- **Nurse staffing levels have a positive association with financial performance** in competitive hospital markets. Hospitals should reconsider reducing nursing staff, as this is inefficient and can negatively affect financial performance. (Everhart D, Neff D, Al-Amin M, et al, *The Effects of Nurse Staffing on Hospital Financial Performance: Competitive Versus Less Competitive Markets,* Health Care Manage Rev. April-June 2013)

- **Higher nurse staffing protects patients against poor outcomes**, including congestive heart failure mortality, infections and prolonged length of stay. (Blegen, Mary A., Goode, Colleen J., et al, *Nurse Staffing Effects on Patient Outcomes: Safety Net and Non-Safety Net Hospitals,* Medical Care. April 2011)

[4] Center for Health Information and Analysis. "Performance of the Massachusetts Health Care System: Annual Report". September 2016.

- "Because **all hospitalized patients are likely to benefit from improved nurse staffing**, not just general surgery patients, the potential number of lives that could be saved by improving nurse staffing in hospitals nationally is likely to be many thousands a year".
  (Aiken, Linda H, Sloane, D.M., et al, *Implications of the California Nurse Staffing Mandate for Other States*, Health Services Research. August 2010)

- "The Evidence clearly shows that **adequate staffing and balanced workloads are central to achieving good patient, nurse and financial outcomes**. Efforts to improve care, recruit and retain nurses, and enhance financial performance must address nurse staffing and workload."
  (Unruh, Lynn, *Nurse Staffing and Patient, Nurse and Financial Outcomes*, The American Journal of Nursing. January 2008)

- "…**a 0.1% increase in the patient-to-nurse ratio led to a 28% increase in the Adverse Events rate**."
  (Weisman, Joel S, Rothschild, Jeffery M., et al, *Hospital Workload and Adverse Events*, Medical Care, May 2007)

- **Increasing the proportion of nurses** without increasing the total nursing hours per day **could reduce costs and improve patient care by reducing unnecessary deaths** and shortening hospital stays. "Whether or not staffing should be increased depends on the value patients and payers assign to avoided deaths and complications."
  (Needleman J, Buerhaus PI, Stewart M, et al, *Nurse Staffing in Hospitals: Is There a Case for Quality*, Health Affairs. January-February 2006)

We are at an important point for making decisions about health care and health care cost control. We face somewhat of an uncertain future on the federal level, as changes big and small are considered around the Affordable Care Act. But there are some things we know for sure- like the issues driving costs here in the Commonwealth. The Governor has recently pledged to find a way to cover any individuals who might lose coverage under any of the changes made at the federal level. But getting a handle on cost increases will be necessary to fulfill that promise over the long term. We have identified the cost drivers- we must now take the next steps to address them head on. If we spend another year just tinkering around the edges- adjusting the benchmark up or down a smidge- we will just be back here again next year having the same conversation all over again.

Thank you for the opportunity to share our thoughts on these important issues.