MASSACHUSETTS Health & Hospital ASSOCIATION

Testimony Regarding the Potential Modification of the 2023 Health Care Cost Growth Benchmark

Health Policy Commission & Joint Committee on Health Care Financing

March 16, 2022

On behalf of our member hospitals and health systems, affiliated physician practices, and other healthcare interests, the Massachusetts Health & Hospital Association (MHA) appreciates this opportunity to offer comments to the Health Policy Commission (HPC) and the Joint Committee on Health Care Financing as they deliberate a potential modification of the state's 2023 Health Care Cost Growth Benchmark. Pursuant to Chapter 224, from 2023 through 2032, the Health Care Cost Growth Benchmark will be set equal to potential gross state product, or 3.6%, unless the HPC determines that an adjustment to the growth standard is reasonably warranted. While we appreciate the HPC's work in determining and applying the benchmark, and while hospitals remain strongly committed to the healthcare delivery reforms and goals of Chapter 224, MHA has concerns about the benchmark process and its application during these extraordinary times.

MHA's members are dedicated to creating a delivery system that is affordable, accessible, equitable, and of high quality. To that end, **we strongly support a state total healthcare expenditure growth benchmark – but it must be established and applied in a fair and reasonable manner that reflects current circumstances and economic realities.** The events of the past two-plus years, and the uncertainties that the healthcare system faces going forward, warrant a re-examination of the benchmark and the way it is applied. The volatility now affecting patient care expenses and healthcare provider financing was never contemplated in the benchmark process defined in 2012, which effectively relies on a steady state of economic and cost growth. The timing and circumstances between when the growth standard is set and when it is measured must now be reconsidered in light of this instability. Without acknowledging this gap, the HPC benchmark and measurement process will forever be caught both in the past and future, but never with a fair or accurate eye on the present.

Since the benchmark is set for a future period but actually is applied to a past period, insufficient weight is given to current events in the healthcare system. Because there is a two-year lag before the Center for Health Information and Analysis (CHIA) publishes its annual report on cost growth during the time period in question (e.g., preliminary data on 2022-2023 cost growth will not be reported by CHIA until 2025), any healthcare entities that the HPC requires to file Performance Improvement Plans (PIPs) in 2025 would be doing so based on past circumstances from three years prior (2022) and would be afforded little opportunity during the PIP process to highlight their current circumstances (2025).

Under normal times and when financial performance was more consistent, these lags between benchmark setting, measurement of cost growth, and filing of performance improvement plans may have been reasonable. However, given the pandemic and its continuing effects on healthcare providers and the current state of the Massachusetts economy – which includes substantial inflation, labor cost increases, and numerous examples of new spending – the existing timelines result in a cost benchmarking mechanism that is neither a fair nor an appropriate way of evaluating year-to-year changes in healthcare spending.

Since the pandemic began in March 2020, the healthcare delivery system has faced unprecedented challenges and remains in a state of significant financial instability. Providers have lost billions in revenue and experienced new expenses associated with COVID-19; these extraordinary financial losses will require further government relief. Healthcare providers face continued cost pressures related to the pandemic, including expenses related to emergency preparedness, personal protective equipment, temporary staffing, capacity planning and implementation, healthcare supply chain disruptions and shortages, delayed/canceled elective procedures, COVID-19 therapeutics, testing, vaccine administration, and challenging clinical care delivery dynamics. A return to "normal" pre-COVID patient utilization has yet to be experienced; patient demand is down for some services while cost pressures continue for long-term COVID-19 patients, and for sicker patients who deferred care.

Like the rest of the economy, the healthcare sector is now facing substantial inflationary cost pressures in all areas of operations that greatly exceed historic economic growth rates. As the HPC and legislature know, hospital labor expenses represent the largest share of hospital costs and have grown significantly during the public emergency. Hospitals are feeling the effects of the "great resignation" due in large part to fatigue, stress, and burnout. Meanwhile, patient demand remains high particularly with the recent COVID-19 surge subsiding. Behavioral health boarding, where patients – especially pediatric and geriatric patients with mental health needs – cannot be admitted to an inpatient bed due to staffing shortages, has only been exacerbated by the stresses of the pandemic. The ability to discharge patients to needed post-acute levels of care, such as skilled nursing facilities, is similarly strained. The healthcare workforce is at a crisis point. These staffing level dynamics combined with other market forces has created a new, unaccounted for, and unsustainable cost to hospitals. To help address these workforce shortages, hospitals must pay exorbitant costs to traveling nurses and staffing agencies, which can be double, triple, and, in some cases, quadruple normal salaries.

For these reasons and as explained in further detail below, **MHA respectfully requests that the HPC and legislature suspend the application of the statutory Health Care Cost Growth Benchmark in FY2023 until the legislature can determine a meaningful, modernized approach that incorporates real-time circumstances and pressures on the healthcare system.** We urge an immediate thorough review of the benchmark setting and cost growth evaluation process, including the incorporation of current realities when evaluating healthcare entity cost growth. Further, we ask the legislature to take action to ensure that the payers do not use the benchmark as an arbitrary and inappropriate cap on provider rate increases, as it was never intended for that purpose.

In addition, we ask that the HPC and legislature consider these circumstances in measuring performance against the Health Care Cost Growth Benchmark already in effect for FY2021 and FY2022 to ensure healthcare providers are not penalized unfairly for these unforeseen conditions beyond their control. The application of a rate that was determined a decade ago to this new financial reality would be grossly unfair and inaccurate. CHIA's recently released Annual Report shows that between 2019 and 2020, statewide total healthcare expenditures (THCE) *declined* by 2.4%, underscoring the anomalous nature of the pandemic years in terms of healthcare cost and utilization. Given this unusually low baseline in 2020, THCE growth rates in the next two pandemic years (2020-2021 and 2021-2022) are likely to be/appear abnormally high. Given these aberrant and unprecedented changes affecting healthcare utilization and spending, it is evident the Health Care Cost Growth Benchmark already in effect for FY2021 and FY2022 is out of alignment with financial realities of healthcare providers.

COVID-19 Financial Effects

The COVID-19 pandemic has resulted in upward pressure on hospital expenses and a downward effect on revenues, which has caused a significant financial strain on providers. As evidenced in reporting to both federal and state governments, providers have recorded devastating lost revenues and increased expenses associated with COVID-19. While substantial government relief has been afforded for some of

these expenses, there is still significant lost revenue that has not been, and may never be, fully recouped.

Of note, the commonwealth made available $250 million to hospitals and affiliated providers through the newly created COVID-19 Public Health Emergency Hospital Relief Trust Fund that is financed by funding Massachusetts received from the American Rescue Plan Act. Through the Executive Office of Health and Human Services (EOHHS) application process for the first round of these grant dollars, 84 hospital and health system applicants displayed a total of $2.8 billion in financial need above and beyond government relief already provided throughout the COVID-19 public health emergency.

The bottom-line finances of hospitals have also been affected negatively. According to the most recently available CHIA data for the October 2020 through June 2021 period, the statewide median operating acute hospital margin as of June 30, 2021, was only 1.6% – half of what it was in 2019. This is far below industry performance expectations of 3% and recent historical averages. Twenty-two hospitals had a negative operating margin, even including COVID-19 relief funds; without COVID relief funds, that figure grows to 25.

This instability continues in calendar year 2022. The arrival of the Omicron variant resulted in increasing rates of infection and hospitalization. Once again, hospitals were required to pause 50% of elective surgeries, with many suspending elective procedures entirely, which in turn harmed revenues. Expenses remain high for costs associated with the pandemic. While the future of the COVID response looks promising, there are still uncertainties regarding variants and how long immunity lasts, so the healthcare delivery system must continue to be vigilant beyond the continuing crises the pandemic has created. This ongoing toll that COVID-19 has taken on health systems must be considered as organizations struggle to recover.

Care Deferred During the Pandemic

Healthcare spending in 2020 was lower than expected, in large part due to the deferral of care as a result of the pandemic. As previously noted, CHIA's newly released 2022 Annual Report reflects both the financial effects on providers and the volatility that has resulted from the pandemic, as total healthcare expenditures declined 2.4% between 2019 and 2020, including an 11% drop in hospital outpatient spending, 1.8% drop in hospital inpatient spending, and a 12% decrease in physician services.

Some of this care is expected to rebound in 2022, and while this is a good thing for patients, it must be recognized that it will increase healthcare spending above the level of the prior two years. In addition, population health worsened during the pandemic. Pandemic-era health behaviors such as deferred screenings, lack of exercise, poor nutrition, increased substance use and smoking, in addition to the long-term mental health effects due to stressors the pandemic created, may lead to the deterioration of the population's health and increased healthcare expenses. Hospitals are now treating patients with advanced disease resulting from postponed care, which leads to higher costs. Recent data[1] hints at "potentially dire consequences of the deferral of 'elective surgeries' as a result of COVID-19", although the full impact "has yet to be measured."

Workforce Shortages and Labor Costs

Labor costs are increasing across the country, and hospitals are not immune to this. According to a study released in October, U.S. hospitals and health systems are paying $24 billion more for qualified clinical

[1] https://www.hfma.org/topics/cost-effectiveness-of-health/article/consequences-of-pandemic-drive-care-deferrals-remain-an-impendin.html

labor than they did pre-pandemic.[2] Additionally, overtime hours are up 52% when compared to pre-pandemic level, and the use of agency temporary labor is up 132%.[3]

Labor accounts for close to 70% of a hospital's operating costs, yet salary and wage growth pressures are not accounted for fully 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 acknowledged. While these labor factors have always affected healthcare costs, the current nursing shortage and the necessary use of travel nurses has exacerbated the labor spending to a level where these costs cannot simply be wished away in setting the benchmark.

According to a January 2022 report from the Organization of Nurse Leaders[4], as a result of *"an uptick in retirements, resignations, requests to reduce hours, and competitive labor markets, healthcare organizations across the Northeast are struggling to maintain a nursing workforce."* The report goes on to note the high cost of nurse turnover rates, especially in the Northeast: "*National data suggests the average cost of turnover for a clinical nurse is $40,038, ranging between $28,400 and $51,700 … [N]urse leaders in the Northeast report significantly higher turnover costs for nurses. One nurse leader estimated it costs $75,000 - $110,000 to replace a nurse once base pay, benefits, and temporary staff costs are tallied. This estimate is at least double the national average."*

The increasing demand and rising cost of travel nurses is driving up hospital costs, a trend projected to continue even after the pandemic wanes. Travel nurse rates have sky-rocketed, and while the use of travel nurses is a necessary short-term staffing strategy, the cost to organizations is prohibitive. As the ONL report notes, rates *"jumped over 200%, with premiums still elevated. Currently, hospitals are spending approximately 62.5% more for travel RNs than they did at the start of 2020…. When comparing the cost difference between employed RNs and travel RNs, the amount is staggering."* The ONL report includes worrisome statistics, including "*a 558% increase in Medical/Surgical travel nurse costs compared to the same month pre-pandemic, and ICU travel nurse costs increased by 750%.".* Many reports indicate that hospitals have been forced to expend more than $250/hour for travel nurses.

Another pressing concern is the statewide shortage of behavioral health providers. While the need for mental health and substance use disorder services has never been higher, the current shortage of providers that specialize in behavioral health, from psychiatrists and nurses to mental health counselors, prevents many existing facilities from operating at full capacity. An October 2021 survey by MHA and Massachusetts Association of Behavioral Health Systems (MABHS) of psychiatric units and psychiatric facilities found that 362 inpatient psychiatric beds, or 14% of the licensed beds of reporting facilities, were offline due *solely* to staffing needs. MHA's weekly behavioral health boarding metrics show that at any given time, more than 600 patients are in hospitals awaiting a psychiatric facility bed, with some boarding for weeks. Hospitals are generally not reimbursed for the services they provide to patients while they board and must absorb the costs of the care delivered. Given the current, sustained boarding crisis and the length of time patients are now boarding, many hospitals have devoted significant resources over the last two years toward additional personnel, infrastructure, and services to care for these patients without any additional reimbursement. The state has dedicated substantial investments toward expanding inpatient psychiatric capacity and addressing behavioral health workforce needs, and

[2] https://www.aha.org/news/headline/2021-10-07-study-hospitals-paying-24b-more-year-clinical-labor-amid-pandemic
[3] https://www.premierinc.com/newsroom/blog/pinc-ai-data-shows-hospitals-paying-24b-more-for-labor-amid-covid-19-pandemic

[4] https://onl.memberclicks.net/assets/docs/ONLWorkforceReportJan2022/ONL_Workforce_Report_Jan2022.pdf

the *Roadmap for Behavioral Health Reform* proposes sensible reforms to the community behavioral health system. But, expanding access and the behavioral health workforce, including broadening the pipeline for these caregivers, will take time and will come with a cost.

Setting a benchmark that fails to account for all of these tremendous ongoing upward pressures on the largest component of hospital costs would be, at best, unrealistic and, at worst, seriously damaging to the healthcare system.

Inflation

According to Altarum, inflation-driving trends, such as rising workforce costs, have only accelerated throughout 2021. For the last decade, healthcare prices have consistently grown at a roughly 1-to-2% rate. Already, in the last 18 months, prices for hospital and physician prices have exceeded a 3% inflation rate. Altarum's experts say they are watching whether healthcare prices eventually increase at the same 5-to-7% rate the rest of the economy is currently experiencing, which would be the fastest rate since 1993. The problems affecting prices in the rest of the economy — including supply chain shortages – are also affecting the healthcare sector.

Also increasing are components of costs that go into operating a hospital, such as labor, fuel, material, pharmaceuticals, and cyber security, among others. A February 2022 Bureau of Labor Statistics release stated that the Boston-Cambridge-Newton Metropolitan Statistical Area Consumer Price Index increased by 6.3% in January 2022, as compared to January 2021.[5] This is the largest increase in the Consumer Price Index since July 2008. Energy prices have increased by 29.5%, driven by a 46.8% increase in the price for gasoline, and a 16% increase in the price of electricity.

It is also important to note that since payments for healthcare services are set a year or more in advance through negotiated contracts between payers and providers, or resulting from government regulation, they cannot be adjusted quickly to account for inflation. Instead, as providers negotiate new contracts with health plans, it is possible that current inflation will be reflected in those negotiations and ultimately reflected in higher costs.

MassHealth

The single largest factor driving MassHealth spending today is enrollment. Since March 2020, MassHealth has protected all enrollees and has not initiated any eligibility redeterminations. As a result, enrollment is up 24% since the state public health emergency took effect and spending has increased at a commensurate amount. This increase has been supported by billions of enhanced federal Medicaid revenues in 2020, 2021, and 2022. The unprecedented enrollment and spending growth will need to be considered when evaluating spending in relation to the state cost growth benchmark.

Of note, FY2023 will mark a year of significant new funding to the MassHealth program. Governor Baker's FY2023 budget proposal incorporates the hospital assessment and related Medicaid spending plan that MHA put forth to the Executive Office of Health and Human Services. MHA and the hospital community undertook an extensive effort to dramatically improve hospital Medicaid financing through a revamped hospital assessment. EOHHS endorsed the proposal and many key aspects of it were incorporated into the commonwealth's recent 1115 Medicaid waiver extension request to the Centers for Medicare and Medicaid Services (CMS).

If enacted by the legislature and approved by CMS, the plan will yield more than $1.6 billion in new spending per year across hospitals, physician groups, ACOs, and Community Partners. This spending will

[5] https://www.bls.gov/regions/new-england/news-release/consumerpriceindex_boston.htm

be financed by a $710 million annual assessment on acute hospitals and has the potential to introduce more than $900 million in new federal revenues to the commonwealth.

The hospital assessment and related spending provisions now before the legislature and CMS will advance the priorities of the commonwealth on several important fronts, including health equity, improving clinical outcomes, supporting safety net providers, funding delivery system reforms, and reimbursing hospitals for the care they provide to MassHealth patients. It includes significant support for non-hospital uses, including health-related housing needs, nutrition, and care coordination in the community. MHA, hospitals, and EOHHS are working to implement this historic opportunity to enhance the viability of Massachusetts hospitals and the MassHealth program.

As it relates to the healthcare cost benchmark, it is difficult to understand how the HPC in setting the cost growth benchmark can fairly account for this spending and the assessment. These needed investments in health equity, clinical quality, and safety net providers must be welcomed and not result in penalizing healthcare providers.

Pharmaceutical Costs

Pharmaceutical pricing is largely outside of healthcare provider control. Pharmaceutical costs continue to be one of the most significant drivers of total healthcare expenditure growth. In its March 2021 report, CHIA found that gross pharmacy spending totaled $10.7 billion in 2019, an increase of 7.2% from 2018. Net of prescription drug rebates, pharmacy spending was $8.3 billion, an increase of 3% from the prior year.

MHA appreciates that the HPC has made pharmaceutical spending a continuing focus by recommending that the commonwealth pursue price transparency and enhanced oversight for pharmacy benefit managers, encouraging the use of risk-based contracting with manufacturers, developing a process for reviewing high-cost drugs, enhancing the ability of MassHealth to negotiate directly with drug manufacturers, and continuing to include pharmaceutical industry representatives as witnesses for the cost trends hearing. The HPC's drug pricing review process for MassHealth brings pharmaceuticals into the HPC's market oversight purview and is a welcome step in shining a light on drug pricing.

Despite this needed attention, rising prescription drug costs continue to be a significant factor in the ability of both providers and payers to meet the statutory obligations of Chapter 224. In their efforts to control expenses, providers have targeted strategies such as treatment alternatives, monitoring prescribing practices, implementing medication adherence strategies, and adopting alternative payment contracts that include pharmacy spending. Payers have introduced additional utilization management strategies and shifted more costs to patients. Yet some of these pursuits, such as the forced white bagging of prescription drugs administered at healthcare facilities, have proven problematic from a patient care perspective. The reality is that absent meaningful price reform and greater accountability in the pharmaceutical industry, the increasing price of pharmaceuticals will continue to affect the ability of providers to successfully meet a 3.6% benchmark.

MHA also notes the continuing concern our members have expressed regarding commercial insurers using the benchmark as a cap on any rate increases. This was never the intention of Chapter 224 and is particularly problematic when used as a negotiating tool against lower-reimbursed community hospitals. If this practice is carried forward, many providers may never recover from the catastrophic losses the pandemic caused. This insurer strategy is especially concerning, since as noted in CHIA's 2022 Annual Report, *the net cost of private health insurance increased 31% and health plan gains increased 413%, highlighting a startling disparity between health plan profits and provider losses.*

In summary, MHA supports the collective goal of continuing to provide high-quality care and ensuring universal access for patients, while at the same time ensuring affordability and system efficacy. For the many reasons cited here, MHA respectfully requests that the HPC and legislature suspend the application of the statutory Health Care Cost Benchmark in FY2023. At the same time, we urge the legislature to conduct a thorough revision of the benchmark setting and cost growth evaluation process and establish a more appropriate measure for FY2023. We also urge explicit protections to ensure that payers do not use the benchmark as an arbitrary and inappropriate cap on provider rate increases. Further, we ask that HPC consider the impact of the pandemic and current economic realities in measuring performance against the FY2021 and FY2022 Health Care Cost Growth Benchmark to ensure healthcare providers are not penalized unfairly for circumstances beyond their control.

Thank you for the opportunity to offer testimony on this matter. If you have any questions or require further information, please do not hesitate to contact Michael Sroczynski, MHA's Senior Vice President, Government Advocacy and General Counsel, at (781) 262-6055 or msroczynski@mhalink.org.