MASSACHUSETTS
Health & Hospital
ASSOCIATION

TESTIMONY

500 District Ave.
Burlington, MA 01803
11 Beacon St., Suite 11
Boston, MA 02108
(781) 262 - 6000
mhalink.org

Testimony Regarding the Potential Modification of the 2024 Healthcare Cost Growth Benchmark

Health Policy Commission & Joint Committee on Health Care Financing

March 15, 2023

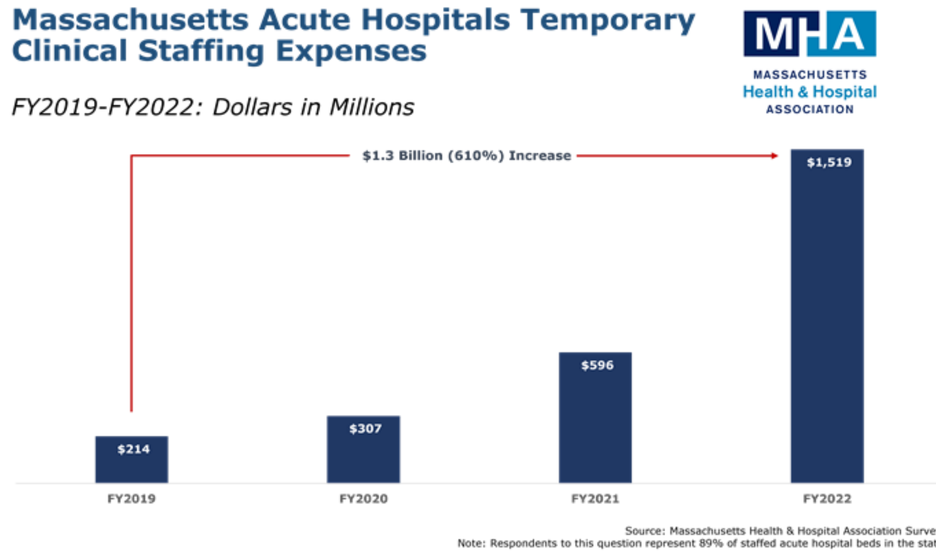
On behalf of our member hospitals and health systems, affiliated physician practices, and other healthcare interests, the Massachusetts Health & Hospital Association (MHA) appreciates this opportunity to offer comments on the state's 2024 healthcare cost growth benchmark to the Health Policy Commission (HPC) and the Joint Committee on Health Care Financing as they deliberate a potential modification to the benchmark. Pursuant to Chapter 224, from 2023 through 2032, the healthcare cost growth benchmark will be set equal to potential gross state product, or 3.6%, unless the HPC determines that an adjustment to the benchmark is reasonably warranted. While hospitals remain strongly committed to the healthcare delivery reforms and goals of Chapter 224, MHA continues to have concerns about the benchmark process and its application at a time when the system is still struggling to regain stability.

MHA's members are dedicated to creating a delivery system that is affordable, accessible, equitable, and of high quality. To achieve and sustain those goals, any state total healthcare expenditure growth benchmark must be applied in a fair and reasonable manner that reflects current circumstances and economic realities. As we stated in our 2022 comments, the effects of the COVID-19 pandemic and economic conditions the healthcare system faces going forward warrant a re-examination of the benchmark and the way it is applied. The 2012 law that established the benchmark never contemplated the volatility now affecting patient care expenses, clinical and non-clinical staffing, behavioral healthcare, and healthcare provider financing. It is imperative that the timing and circumstances between when the growth standard is set and when it is measured 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.

As the commission and legislature knows, hospital labor expenses represent the largest share of hospital costs. Those costs have been tremendously disruptive during the public health emergency. Prior to the pandemic, hospitals were already facing significant challenges in recruiting and retaining the healthcare workforce. The pandemic only accelerated these challenges, creating an historic workforce crisis throughout the country. Relative to early 2020, labor expense growth, including wage increases and other compensation, remains considerable. A recent MHA workforce survey found that the median increase in average hourly

wages (AHW) for the 47 positions surveyed exceeded 13% compared to the pre-pandemic period, with some increases more than 20%. Hospitals are also offering extensive signing bonuses and retention packages to keep employees, especially for those that work at the bedside. The Peterson-KFF Health System Tracker reported an increase of 17% for the healthcare sector as of November 2022, compared with 14.5% for the economy. The increase for hospitals was 16.9% and had steadily risen in each successive month except for slight dips in March and September 2022.

In addition to compensation-related spending for recruitment and retention, hospitals have had to rely on high-cost temporary staffing through "traveler agencies" to fill critical positions that allow them to maintain care for patients.



The average hourly wage rates for travel nurses far exceed the rates paid pre-pandemic, with an average increase of 90% since 2019. A recent MHA survey found that temporary staffing costs increased 610% in FY2022 compared to the pre-pandemic levels in FY2019 – a $1.22 billion increase. Hospitals have been forced to absorb these skyrocketing costs to continue treating patients amid a severe workforce shortage, a global pandemic, and a systemic behavioral health crisis.

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. A January 2023 news release by the Bureau of Labor Statistics stated that the Boston-Cambridge-Newton Metropolitan Statistical Area Consumer Price Index increased by 6.4% in the past 12 months. Energy prices have increased by 22.8%, driven by a 46.7% increase in the price of electricity.[1]

According to a report by McKinsey & Company, "The impact of inflation on the broader economy has driven up input costs in healthcare significantly. Moreover, the likelihood of

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

continued labor shortages in healthcare—even as demand for services continues to rise—means that higher inflation could persist. Our latest analysis estimates that the annual U.S.

national health expenditure is likely to be $370 billion higher by 2027 due to the impact of inflation compared with pre-pandemic projections."[2]

It is clear that the current healthcare cost growth benchmark has lost relevancy. It is now time for the commonwealth to adopt a more meaningful, modernized approach that can effectively incorporate 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.

We also respectfully request the HPC and legislature take more direct action to **prohibit the inappropriate use of the benchmark in health insurance contracts with providers**. As the HPC has noted in its public meetings, the application of the benchmark as a cap to healthcare provider reimbursement was never the intent of Chapter 224 of the Acts of 2012, which established the benchmark to help control the growth of total healthcare expenditures across all payers (public and private). At last year's health cost growth benchmark hearings, the HPC reinforced this point, stating "the healthcare cost growth benchmark is not a cap on spending or provider-specific prices but is a measurable goal for moderating excessive healthcare spending growth and advancing healthcare affordability."[3] Unfortunately, health insurance carriers routinely use this benchmark as a *de facto* cap on reimbursement for healthcare providers.

MHA and the hospital community support a state total healthcare expenditure growth benchmark that is established and applied in a fair and reasonable manner that reflects current circumstances and economic realities. To this end, we urge your careful consideration of the following concerns related to the application of the current benchmark.

Workforce Shortages and Labor Costs

According to the Bureau of Labor Statistics, U.S. healthcare organizations will have to fill more than 203,000 open nursing positions every year until 2031. There are also significant projected shortages of physicians and allied health and behavioral healthcare providers, with these shortages even more acute in marginalized communities. The AHA reports that "The use of contract labor continues to remain much higher than pre-pandemic levels, which has led to increased labor expenses overall for hospitals and health systems. Data from a forthcoming Syntellis Performance Solutions/AHA report will show that travel nurse full time equivalents (FTEs) per patient day rose over 183.4% from 2019 to 2022. Though travel nurses are often the bulk of contract labor, similar trends have affected specialties and departments across

[2] (https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector)

[3] https://www.mass.gov/doc/presentation-benchmark-hearing-march-16-2022/download, Slide 7

hospitals. For example, emergency service contract FTEs per ED visit rose 187.2% over the same time period. As a result, contract labor as a share of total labor expenses rose 178.6% from 2019 to 2022."

In February 2023, the U.S. Senate Committee on Health, Education, Labor, and Pensions held a hearing entitled "Examining Healthcare Workforce Shortages: Where Do We Go from Here?" **In announcing the hearing, the committee noted that the U.S. will face a shortage of up to 124,000 physicians by 2034, according to the Association of American Medical Colleges. During the hearing, committee members and a panel of witnesses discussed the fact that workforce shortages have led to rising costs and increased competition for qualified health professionals, and that the pandemic has exacerbated the challenges facing the healthcare system and contributed to provider burnout.**

Massachusetts' experience mirrors what is happening throughout the country. **Labor accounts for close to 70% of a hospital's operating costs, yet salary and wage growth pressures are not fully accounted for in the cost growth benchmark.** To quantify the severity of workforce shortages, MHA conducted a survey in the summer of 2022. The results show that respondent hospitals – representing 70% of total acute care hospital employment in the state – currently have 6,650 vacancies among 47 key positions that are critical to clinical care and hospital operations. These positions range from direct care nurses to laboratory personnel, clinical support staff, and beyond. The median vacancy rate for these positions is 17.2%, and for several positions, the vacancy rate is much higher. Forty-two of these positions have double-digit vacancy rates and 18 have a vacancy rate that is greater than 20%. These 47 positions account for less than half of all positions within hospitals. **Extrapolating the vacancy data to all positions in all Massachusetts acute care hospitals shows that an estimated 19,000 positions are unfilled.**

The report further shows that in addition to compensation-related spending for recruitment and retention, hospitals have had to rely on high-cost temporary staffing through "traveler agencies" to fill critical positions that allow them to maintain care for patients. **The average hourly wage rates for travel nurses far exceed the rates paid pre-pandemic, with an average increase of 90% since 2019.** To fulfill their mission of treating patients amid a severe workforce shortage, a global pandemic, and a behavioral health crisis, hospitals have painfully absorbed these skyrocketing costs.

Similar to the national experience, to fill these vacancies over the past year and more, Massachusetts hospitals reported, as noted above, that during FY2022 they had spent **$1.52 billion on temporary staffing, a 610% increase from FY2019.**

The MHA workforce report also highlights the capacity constraints that have emerged because of the behavioral health crisis, the need to create surge capacity earlier this year when both influenza and RSV levels were extraordinarily high, and the obstacles related to discharging patients to post-acute care settings. As **MHA's weekly behavioral health report** shows, between 500-700 patients are boarding each week in hospital emergency departments and on

medical surgical floors as they await placement in an appropriate setting. Likewise, **MHA's monthly Throughput Survey Report** has repeatedly shown that as many as 1,000 patients per day are medically able to be discharged but linger in hospital beds, due to staffing vacancies at post-acute care facilities, insurance and transportation obstacles, guardianship issues, and a host of other barriers. When patients cannot be discharged to the appropriate level of care, needed beds cannot be freed up for new patients, resulting in a backlog that resonates throughout the healthcare system. When taken together, these factors have resulted in significant challenges to hospital capacity and workforce and have contributed to higher staffing and resource costs across the entire continuum of care.

While there are no quick solutions to the workforce crisis, there are several steps that healthcare organizations, the state, and federal agencies are considering to address the problem. These include advancing new models of care such as telehealth and Hospital at Home, investing in training, expanding the workforce pipeline, protecting the safety and wellbeing of healthcare workers, and providing financial support. Each of these will require resources and time to be effective. **Enforcing a benchmark that penalizes providers and that fails to account for this tremendous ongoing upward pressure on the largest component of hospital costs would be, at best, unrealistic and, at worst, seriously damaging to the healthcare system.**

Effects of COVID-19 and Inflation on Hospital Finances

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 the COVID-19 public health crisis. 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.

Hospitals, which remained open 24/7 throughout the pandemic, are losing money on a daily basis. The Center for Health Information and Analysis' most recent quarterly report through June 30, 2022, shows:

- The statewide median operating margin for hospitals was negative 1.4%, 3 percentage points worse compared to the same period last year.
- The statewide total margin was negative 4.4%, 9.7 percentage points worse compared to the same period in the prior year.
- Of the 59 hospitals reporting, 78% reported negative total margins during this time period. 39 of 41 hospital affiliated physician organizations reported a net loss for the period.
- Through June 2022, aggregate expenses exceeded aggregate total operating revenue by $278 million, a figure that includes government relief.

Inflation is also a major compounding factor. Like the rest of the economy, the healthcare provider sector is grappling with historic inflationary cost pressures within all essential areas of

operations, including labor, fuel, supplies, pharmaceuticals, and cybersecurity. According to an April 2022 AHA report, drug expenses increased dramatically – 36.9% on a per patient basis, compared to pre-pandemic levels.[4] As a share of non-labor expenses, drug expenses grew from approximately 8.2% in January 2019 to 10.6% in January 2022. Medical supply expenses grew 20.6% through the end of 2021, compared to pre-pandemic levels. When focusing on hospital departments most directly involved in care for COVID-19 patients − ICUs and respiratory care departments − medical supply expenses increased 31.5% and 22.3%, respectively, from pre-pandemic levels. Faced with such unexpected increases in costs and thin margins, hospitals will be forced to make difficult decisions, including potential reduction of services.

Although inflation has moderated slightly in the past few months, according to the Bureau of Labor Statistics' January 2023 report, over the last 12 months, the Boston-Cambridge-Newton, MA-NH Consumer Price Index increased 6.4%. Energy prices increased 22.8% over the year, led by a 36.5% advance in household energy. Higher prices for electricity (46.7%), natural gas (24.8%), and fuel oil contributed to the rise. **But unlike other sectors, providers cannot simply pass along increases to their customers (patients), meaning they must absorb those increases on their own.** Payments for healthcare services are set a year or more in advance through negotiated contracts between payers and providers, or resulting from government regulation, and thus 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. When health plans use the benchmark as a rate cap, it further erodes the ability of hospitals to recoup these substantial losses that are largely out of their control.

1115 Medicaid Waiver

Of note, FY2023 marks a year of significant new funding to the MassHealth program. The FY2023 state budget incorporates a substantially revised hospital assessment and related Medicaid spending plan that was developed in strong collaboration with the hospital community. The financing plan will yield more than $1.6 billion in new spending per year across hospitals, physician groups, ACOs, and Community Partners. This spending will 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 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 the Executive Office of Health and Human Services are working to implement this historic initiative to enhance the viability of Massachusetts hospitals and the MassHealth program.

[4] https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-One-Pager.pdf

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

Deferred Care

Healthcare spending in 2020 was lower than expected, in large part due to the deferral of care during the pandemic. Much of this care has rebounded 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. Reports by KaufmanHall and others show that delayed care for non-COVID patients during the pandemic has contributed to increasing patient acuity in hospitals, which in turn has been a driver of increases in labor, drug, and supply costs for hospitals, creating unsustainable financial challenges. This is unlikely to abate for some time. In addition, population health worsened during the pandemic; poor pandemic-era health behaviors such as lack of exercise, poor nutrition, increased substance use, obesity, and smoking may lead to further deterioration in U.S. population health and increase healthcare spending in coming years.

Infrastructure

Notably, the pandemic has revealed that our healthcare infrastructure was under-resourced for a pandemic. At the same time, cybercriminals started to target hospitals' networks at a time when they were least able to respond. In addition, there is a growing awareness that **hospitals are vulnerable to environmental challenges, including the increasing severity and frequency of extreme weather events.** Hurricanes, blizzards, floods, and tornadoes compromise not only the physical integrity of hospitals, but also that of the broader infrastructure on which they depend, such as the power grid. In February of this year, several hospitals had to divert patients due to burst pipes during an extreme cold spell, while a fire at Brockton Hospital has shuttered inpatient units for several months. Yesterday's blizzard in Central and Western Massachusetts resulted in one hospital declaring "Code Black" – that is, shutting its emergency department. As previously reported by the *Boston Globe*, according to Dr. Margaret E. Kruk, professor of health systems at the Harvard T.H. Chan School of Public Health, "all infrastructure has a built-in failure rate that is to be expected. But **continued investment to deal with climate change will be essential for hospitals as they confront growing numbers of weather emergencies**…"[5]

In that same *Boston Globe* article, Dr. Gaurab Basu, co-director of the Center for Health Equity Education & Advocacy at Cambridge Health Alliance, said that **climate-related demands and the planning to manage them come at a time when the effects of the COVID-19 pandemic, including worker shortages and sicker patients, continue to overwhelm health systems. "The health system is under tremendous strain, and add on these additional strains, it's a recipe for great challenge," Basu said.**

[5] https://www.bostonglobe.com/2023/02/19/metro/one-frigid-weekend-four-emergency-rooms-closed-are-hospitals-ready-changing-climate/?p1=BGSearch_Overlay_Results

Hospitals are taking steps to address climate change and to become more energy efficient, including bolstering IT systems, renovating electrical systems, retrofitting more energy efficient technology, installing solar panels, or procuring from more sustainable sources. Many hospitals also continue to innovate in managing the waste they produce. These steps often come with significant cost, at a time when hospitals are still experiencing financial pressure resulting from the COVID-19 pandemic. Along with severe workforce shortages and the COVID-19 pandemic, investing in infrastructure to protect hospitals from climate change and cyber-attacks, in addition to replacing aging capital, was not contemplated when the benchmark was established in 2012.

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 a recent presentation to the Market Oversight and Transparency Committee, the HPC noted that "The commonwealth should take action to constrain excessive price levels, variation, and growth for healthcare services and pharmaceuticals, by expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value." It was further noted that annual growth in retail drug spending in Massachusetts, net of rebates, has been above the benchmark in most years since 2014. The HPC's 2022 Cost Trends Report specified that pharmacy spending represented one of the only areas of commercial spending that grew significantly in 2020, much of it driven by branded drugs that had both high launch prices of new drugs and price increases for existing drugs.

MHA recognizes that the HPC has made pharmaceutical spending a continuing focus by recommending that the commonwealth 1) pursue price transparency and enhanced oversight for pharmacy benefit managers; 2) build on MassHealth's successful process by expanding the HPC's drug pricing review authority; and 3) continue to include pharmaceutical industry representatives as witnesses for the cost trends hearing. Each of these are a welcome step in shining a light on drug pricing, but 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 the 3.6% benchmark.

Use of the Benchmark as a Rate Cap

MHA also notes the continuing concern our members express regarding commercial insurers' use of the benchmark as a cap on any rate increases; this is particularly problematic both as a result of the catastrophic losses during the pandemic and the challenges outlined above, as well as when this payer strategy is used against lower-paid community hospitals. The benchmark was never intended to be used in his manner. This 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***. MHA has filed legislation that would 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. We urge the legislature to swiftly approve this important proposal.

In summary, MHA and our members support 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 a thorough redesign of the benchmark-setting and cost-growth-evaluation process and establishment of a more meaningful and relevant measure. We also urge the enactment of 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 effect 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.