Testimony for the Record

Submitted to:

Joint Committee on Healthcare Financing
and
Health Policy Commission

For the hearing:

Public Hearing on a Potential Modification of the CY 2026 Health Care Cost Growth Benchmark

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As the CEO of UMass Memorial Health (UMMH), a vital part of the commonwealth's health care infrastructure, I share the Health Policy Commission's (HPC) and Joint Committee on Healthcare Financing's (Committee) concerns about healthcare affordability and access challenges facing the residents of Massachusetts.

UMMH serves a critical role in providing integrated healthcare to the residents of central Massachusetts through our flagship Academic Medical Center (AMC), our four community hospitals, our substance use disorder and behavioral health service provider, and our more than 70 clinics. Created by an act of the Massachusetts legislature, UMMH serves as the training ground for the only public medical school in the state, helping to build a sustained workforce of physicians who work in health systems, hospitals, and clinics throughout the state and region.

Access and care for the diverse and marginalized patients in central Massachusetts is woven deeply into the mission of our organization. Four of our hospitals are disproportionate share hospitals, with more than 70 percent of our patients covered by MassHealth or Medicare. These aspects of our organization give us both real insights and the ability to implement meaningful solutions to the challenges contributing to the affordability and access crisis in the state.

Fragility and instability of healthcare in Massachusetts

The HPC and Committee are already aware of the incredible fragility of healthcare infrastructure in the commonwealth. Over the last five years the average health system's operating margin was -1.7 percent. This is not a sustainable trend if our goal is to improve, or even maintain, access to vital health services for all residents of Massachusetts.

Without innovative solutions and direction, the downward trend of hospital finances will likely continue to worsen rather than improve. The state's Health Safety Net Program currently faces a historic budget shortfall, expected to exceed $230M in FY 2025. The recent U.S. House of Representatives budget resolution recommended $880 billion in cuts to Medicaid over the next 10 years. That's 11 percent of the Medicaid budget.

If these cuts are passed along to providers like UMass Memorial Health, we would have to make difficult decisions. This would likely include re-examining our financial capacity to offer essential but typically loss-generating programs like behavioral health, psychiatry, primary care, and our innovative digital and telehealth health programs. These services, vital to the health and wellbeing of our patients and the communities we serve, also lower total medical expense in the long run.

Current benchmark approach not working for Safety Net Hospitals

UMass Memorial Health has consistently called for adaptation of the cost growth benchmark to more precisely and meaningfully monitor and contain healthcare spending. As described in a recent analysis by Massachusetts Health and Hospital Association (MHA), the data used to set the benchmark is two years old and does not accurately reflect current economic conditions, including existing inflationary pressures, workforce shortages and labor costs, as well as prospective new challenges, such as the impact of recently implemented tariffs on supply chain costs and proposed cuts to Medicaid.

Further, individual hospitals are measured against this benchmark by only examining commercial reimbursements relative to a percentage-based, year-over-year benchmark that does not adequately take into account governmental payor mix or baseline rates. This cost containment strategy favors systems with higher commercial rates and higher percentages of commercial payer patients, while disadvantaging those that serve low-income and underinsured residents.

Holding lower cost safety net hospital systems to the same rates of increase as the higher cost systems with more commercially insured patients only freezes the existing commercial rate inequities in place, leaving high public payer, lower cost hospital systems without the resources necessary to subsidize their public payor losses and to invest in services to meet community needs and remain competitive in the market. It is difficult to justify holding safety net hospitals to the same cost trend benchmark as hospitals without similar obligations to treat indigent and underinsured patients. A more meaningful analysis would include a weighted average of all governmental and commercial payor rates and a consideration of not only year-over-year increases but absolute prices and payer mix as well.

The HPC's 2024 Cost Trend Report and CHIA's 2025 Annual Report detailed many of the drivers of the affordability and access challenges facing our state, including capacity constraints causing overwhelmed emergency departments and longer hospital stays, excessive administrative burden on providers, and trends toward fewer primary care providers across the state due to burnout and retirement.

None of these drivers of total medical expenditures can be addressed by hospitals working independently to reduce costs. In fact, most of the drivers are outside the direct control of hospitals and healthcare systems. Further, the current cost containment strategy of measuring providers commercial price growth will do little to address these drivers and contain future growth of total medical expense (TME) across the commonwealth.

Using a benchmark to bring about solutions

While the 2024 Healthcare Market Review Bill granted additional and necessary authority to the HPC, it did not improve the preciseness or impact of the benchmark. Despite this, we believe that the HPC can more thoughtfully use the benchmark as a tool for overall monitoring of trends in the commonwealth, without holding health systems and hospitals accountable for growth in costs outside of their control, for growth in costs that are needed to offset reimbursement large cuts from government payers, or for starting at a lower absolute cost than other hospital peers.

As one example, hospitals should not be held responsible for cost growth resulting from increases in pharmaceutical prices. Instead, the HPC should leverage its new authority over pharmaceutical prices to target this primary driver of year-over-year cost growth in the commonwealth and interpret hospital cost growth with a consideration for pharmaceutical price growth.

The committee should develop future legislative action to update the tool used by HPC to hold hospitals accountable for cost growths to make it more appropriate for addressing the drivers of cost growth. However, if individual health systems are to be examined in light of the current benchmark, we strongly suggest that the HPC interpret the benchmark alongside health status acuity, relative absolute prices and TME, payor mix, pharmaceutical cost growth, and overall economic trends.

Perhaps more importantly, the HPC should expand ongoing efforts to engage stakeholders in identifying, testing, and bringing to scale critical solutions to lower total medical expense in the commonwealth, particularly solutions that address the largest drivers of cost growth. UMass Memorial Health is eager and willing to come to the table as an active partner to achieve more accessible and affordable healthcare across Massachusetts.