MASSACHUSETTS Health & Hospital ASSOCIATION

Testimony Regarding the Potential Modification of the 2020 Health Care Cost Growth Benchmark

Health Policy Commission Public Hearing

March 13, 2019

On behalf of our member hospitals and health systems, the Massachusetts Health & Hospital Association (MHA) appreciates this opportunity to offer comments on the state's healthcare cost growth benchmark for 2020. We value the careful consideration the Health Policy Commission (HPC) offers in evaluating the progress and goals of the state's healthcare cost growth goals set forth in Chapter 224 of the Acts of 2012.

In its 2018 Annual Report, the Center for Health Information and Analysis (CHIA) reported that total healthcare expenditures increased 1.6% from 2016 to 2017, well within the 3.6% benchmark standard set for that period and, as the HPC noted, significantly below the national growth rate. This continues a consecutive eight-year trend of spending growth below the U.S. rate. The fact that the state came in significantly below the benchmark validates all of the hard work that hospitals, physicians, and health plans have directed towards addressing costs. Because of the success of these concerted efforts, MHA has, since 2017, offered its support for the benchmark target at potential gross state product minus 0.5% – or 3.1%. MHA continues to support this target for 2020, but also recognizes that there are several critically important caveats that must be considered in order for this benchmark – or any alternative threshold – to function effectively.

MHA's member hospitals and health systems are absolutely committed to creating a delivery system with affordable, accessible and high-quality care. Still, the healthcare sector continues to face unprecedented challenges that must be considered to help ensure that providers are not penalized unfairly for circumstances beyond their control. Among these challenges are:

- Key cost drivers, such as pharmaceutical and labor costs, an aging workforce, physician recruitment, and new technology;
- Continuing changes to the federal landscape;
- Administration proposals to allow insurance to be sold across state line, association health plans, and legal challenges to the Affordable Care Act;
- The effect of demographics and population health on the benchmark;
- Behavioral health issues such as expansion of services and addressing the opioid epidemic;
- Implementation of MassHealth reforms; and
- Administrative complexity.

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, increasing by 5.0% between 2016 and 2017 and accounting for 36.5% of Total Health Care Expenditures (THCE). MHA appreciates that the HPC has made pharmaceutical spending a continuing key focus

by recommending that the commonwealth pursue price transparency and accountability for pharmacy benefit managers, develop a process for reviewing high-cost drugs, enhance the ability of MassHealth to negotiate directly with drug manufacturers, and continue to include pharmaceutical industry representatives as witnesses for the cost trends hearing.

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 brown/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 the 3.1% benchmark.

Labor Costs, Labor Shortages, New Technology

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. 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.

It is also important to note that Massachusetts has an aging workforce. There are currently 1,200 unfilled Registered Nurse (RN) vacancies across Massachusetts hospitals for which hospitals are actively recruiting. The commonwealth has one of the oldest RN populations in the country, with 51% of RNs over age 50 and 25% over age 60. In fact, 4,500 Massachusetts RNs are expected to retire annually for the foreseeable future, perpetuating a fiercely competitive market for RNs. Currently, Massachusetts' average RN annual salaries are the third highest in the nation, trailing only California and Hawaii.

The most pressing concern however is the statewide shortage of behavioral health providers. While the need for behavioral and addiction treatment services has never been higher, the current shortage of providers that specialize in behavioral health patients, particularly psychiatrists and nurses, prevents many existing facilities from operating at full capacity.

Competing for physician talent in certain areas of the state is also a challenge and often results in hospitals having to directly employ or subsidize physician practices in order to retain physician access in the communities they serve. Such partnerships have become particularly important as the system continues to evolve to value-based payment strategies.

Finally, while the pricing of new technology is variable, it can represent substantial costs that are not built into the baseline. Maintaining the ability to provide leading edge technology often requires significant space renovation, new equipment, and training.

Changes to the Federal Landscape

The threat of significant and potentially disruptive changes to healthcare coverage and funding at the federal level remains very real. Under CMS, shifting payment policies and changes to the Medicare 340B drug pricing program increase the financial uncertainty for hospitals and can make it difficult to meet the state benchmark.

There is also great uncertainty regarding insurance coverage. There are continuing legal and regulatory challenges to the Affordable Care Act that could render it unenforceable. In addition, the Trump administration has introduced new rules allowing association health plans and short-term health insurance policies. Now, the administration is seeking comments on allowing insurers to sell products across state lines. All of these coverage options have the ability to significantly destabilize the market and affect provider reimbursement. Given these potential challenges, MHA would recommend that the HPC use caution as it sets the appropriate benchmark, given the uncertainty of these factors that are outside the control of providers.

Impact of Demographics and Population Health

Aging Population

According to the Kaiser Family Foundation, 29% of the Massachusetts population is 55 or older and this number is expected to grow. In Boston alone, according to the 2010 census, 88,000 older adults resided in the city and projections show that by 2030, the number of older adults in Boston will grow considerably, comprising about one fifth of the city's population. Data presented by the HPC shows that the percent of residents aged 65 and older is projected to grow from 13.9% to 17%, contributing 0.6% to the growth in total healthcare expenditures between 2016 and 2019. Demographic trends in Massachusetts mean more and more residents are facing choices about their care, or the care of loved ones, as they age. Recently, acting Executive Office of Elder Affairs Secretary Robin Lipson told state lawmakers that people are outliving their ability to drive by seven to 10 years, creating mobility challenges and concerns about isolation. Executive Office of Health and Human Services Secretary Marylou Sudders stated that the average life expectancy in Massachusetts rose to 80 years and eight months in 2016, bucking national trends.

Healthcare per capita costs rise exponentially with age and this factor should be accounted for in the measurement of the state's healthcare cost benchmark.[1] Unfortunately, an adjustment has not yet been incorporated into this calculation. MHA recommends the HPC consider an adjustment to appropriately reflect the higher costs of a growing older population.

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 reduced costs as well. As the HPC and others have recognized, there is a clear need to address how social determinants of health affect healthcare costs. We applaud the HPC for noting in its 2018 Cost Trends Report that commercial payers should replicate and expand payment innovations to provide flexible funding to medical providers to address health related social needs for patients. Failure to address social determinants can result in healthcare disparities that affect patient outcomes, productivity, and, ultimately, add costs across the healthcare continuum.

Hospitals care for patients 24 hours per day/7 days per week 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 often take years to realize the benefits. Similarly, as providers embark on forming ACOs and take on greater amounts of risk, there must be recognition that addressing unmet social needs invariably will cost money. MHA recommends the HPC use caution when setting the appropriate benchmark, given the uncertain

[1] "U.S. HEALTH CARE: Facts About Cost, Access, and Quality" (Rand Corporation, 2005). https://www.rand.org/content/dam/rand/pubs/corporate_pubs/2005/RAND_CP484.1.pdf

timeframes related to the realization of these cost-saving measures and the commitment of resources for these efforts.

Behavioral Health

The commonwealth recognizes the importance of improving behavioral healthcare, including care provided to those with substance use disorders and opioid addiction. Currently, providers cross-subsidize underpaid behavioral health services by relying on revenue from those services that are reimbursed at a higher level. 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, and could potentially result in unintended consequences for expanding behavioral healthcare. MHA encourages the HPC to recognize the methods by which providers support underfunded services when determining the appropriate benchmark.

Regarding the opioid crisis, Massachusetts continues to be one of the hardest hit states. The effects of this crisis on patient care and healthcare costs going forward remains of grave concern, particularly the increasing burden placed on emergency services to care for overdose victims, which puts a strain on already limited resources.

State Reform and the MassHealth ACO Program

In March 2018, the state's MassHealth program launched an ACO program available to 1.2 million people. Seventeen ACOs are now participating in three types of ACO models and are accountable for medical, behavioral health, and prescription drug utilization. As part of this initiative, healthcare providers are making major investments in their organizations to advance the way they deliver and manage care for MassHealth patients. This is supported by substantial new ACO investments and funding, including Delivery System Reform Incentive Payments (DSRIP). Over the course of five years, $1.8 billion in DSRIP funding is expected to enter the healthcare system to support investments in MassHealth ACOs and Community Partners, statewide initiatives, EOHHS administrative expenses, and supplemental payments to hospitals. The Medicaid waiver and state budget also includes new funding called Safety Net Provider Payments (SNPP) that support hospitals with high Medicaid and low commercial insurance volume.

This funding is critical to the success of the MassHealth program and the providers who will be working to make the program's payment and delivery reform goals a reality, including improving care coordination and quality, reducing unnecessary utilization, and bending the MassHealth cost trend. How this funding is accounted for in the measurement of the state cost benchmark and an individual healthcare provider's total medical expenditures (TME) must be done in a manner that does not penalize these providers. The funding is authorized by the federal and state governments to support these ACOs and healthcare providers, and to allow them the opportunity to succeed in this challenging endeavor that holds promise to moderate spending in the MassHealth program over the long term.

A significant source of the DSRIP funding and new MassHealth disability access supplemental payments to hospitals paid out of the MassHealth Delivery System Reform Trust Fund created under Chapter 115 of the Acts of 2016, comes from acute care hospitals through an increased provider assessment totaling $257.5 million. Acute care hospitals now receive $265 million in supplemental payments for a new state program aimed at measuring and improving access for disabled patients. However, it is very important to note the funding source of this supplemental payment is the $257.5 million assessment, therefore the hospital net gain statewide is only $7.5 million. If fact, many hospitals are *net payers* to the trust fund. This accounting could be absent from the traditional measurement of provider payments and must be accounted for so hospitals are not penalized for their participation in this important program or their financial contribution to it and the DSRIP program generally.

Other funding that should also be considered includes the new Community Hospital Reinvestment Trust Fund (CHRTF), which per Chapter 115 of the Acts of 2016 allocates $10 million to hospitals in FY2018 through FY2021. In 2018, chronic, rehabilitation, and psychiatric hospitals were subject to a provider tax that dedicates that funding along with federal revenue to new MassHealth expenditures. The provider assessment must be acknowledged in any measurement of increased funding to these hospitals.

Commercial Insurance Market

When considering the ability to meet the cost growth benchmark, it is important to recognize that insurer benefit design can significantly affect providers. As the prevalence of high-deductible plans grows (currently representing 28% of the private commercial market according to CHIA) the resources needed to collect patient liability after insurance and the amount of resulting bad debt has grown as well. Additional costs are also generated by administrative complexities such as prior authorization requirements that differ for every carrier, increasing volumes of audits and denials, redundancies in utilization management (particularly in ACO arrangements), and other administrative burdens. Lastly, MHA notes the continuing concern expressed by our members regarding commercial insurers using the 3.1% benchmark as a cap on any rate increases; this is particularly problematic when used against lower-paid community hospitals and was never intended to be used in this manner.

In summary, MHA supports the collective goal to continue to provide high-quality care and universal access, while at the same time ensuring affordability. While we support the aggressive 3.1% benchmark, it is critical to recognize that there are factors – many of which are outside of the direct control of providers – that could make meeting this target difficult to attain.

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 at (781) 262-6055 or msroczynski@mhalink.org.