MASSACHUSETTS Health & Hospital ASSOCIATION

Testimony Regarding the Potential Modification of the 2022 Healthcare Cost Growth Benchmark

Health Policy Commission Public Hearing

March 25, 2021

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 2022. 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. Unlike past years, since March 2020, the healthcare delivery system has been faced with unprecedented challenges as a result of COVID-19. The devastating economic and clinical effect on hospitals and physician practices has been significant and must be taken into account as the state considers how it will use the benchmark to evaluate performance of healthcare entities, both now and in subsequent years as organizations begin to recover from the pandemic.

From 2013 through 2017, the benchmark for healthcare spending growth was set at 3.6% annually. It was reduced to 3.1% for years 2018-2022. In its 2019 Annual Report, the Center for Health Information and Analysis (CHIA) reported that the per capita spending growth in Massachusetts was 3.1%, matching the cost growth benchmark. This continues a consecutive multi-year trend of per capita spending growth below the national per capita rate. 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 2022, but also recognizes that there are several critically important caveats that must be considered for this benchmark – or any alternative threshold – to function effectively.

MHA's member hospitals and health systems are fully committed to creating a delivery system that is affordable, accessible, and of high quality. 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:

- Historical and continuing effects of the pandemic in terms of clinical care needs, caregiver workforce issues, emergency preparedness, personal protective equipment, temporary staffing and capacity planning and implementation costs, healthcare supply chain disruptions, shortages, delayed/canceled elective procedures, vaccine supply and demand;
- Key cost drivers, such as pharmaceutical and labor costs, an aging workforce, physician recruitment, and new technology;
- Continued efforts to address the opioid epidemic;
- Continuing changes to the federal landscape; and
- The effect of demographics and population health on the benchmark.

COVID-19

The financial effect on hospitals and health systems did not discriminate by population or geography. Hospitals across the state had to suspend all elective procedures, convert beds, open and staff field hospitals, and retrain and redeploy staff in order to care for the influx of COVID-19 patients. From FY19 to FY20, emergency department utilization fell by 16.8% as patients feared even entering a hospital. During that same period, discharges fell by 7.4%, operating room visits dropped by 17.9%, and inpatient days fell 3.8%. Emergency Department (ED) boarding for behavioral health patients rose to record numbers as the pandemic's effects on mental health resulted in a substantial increase in behavioral health diagnoses and an increase in acuity. Hospitals were also unable to transfer behavioral health patients due to volume, infection control, and staffing needs and had to care for them for multiple days. Physician practices cut salaries, and services and staff were furloughed throughout the healthcare system. With utilization reduced significantly, revenues followed the same trend with devasting results that has required substantial government financial relief in the form of grants and supplemental payments. Both federal and state government also provided loans that will be repaid in 2021.

In addition to the necessity of reducing services, the cost of personal protective equipment (PPE) for staff and patients increased exponentially from pre-pandemic times. Whereas prior to the pandemic, only some clinicians needed to use PPE for certain patients or procedures, the pandemic necessitated hospitals to provide PPE to all clinicians and staff, as well as to all patients and visitors. MHA conducted a hospital survey over the summer of 2020 where hospitals reported increases in PPE costs from 20%-1,200% on units of PPE and 60%-1,600% on the total monthly PPE budget relative to the same time period the previous year. World-wide supply chains were drastically reduced as factories closed or decreased production while the demand simultaneously increased, thus raising prices drastically amid the global competition.

Hospital finances have therefore been severely challenged and unstable during calendar year 2020. In its June 30, 2020, report (the most current financial report reflecting all hospitals during FY2020), CHIA found acute hospital "aggregate net patient service revenue, the most significant component of operating revenue, decreased by $1.5 billion (-7.7%), while aggregate expenses increased $1.1 billion (5.1%) for the fiscal-year-to-date period through June 30, 2020, as compared to the same period in 2019."[1] These expense and revenue changes do not follow typical trends reflective in a steady-state environment suitable for measuring against a benchmark. As the HPC evaluates healthcare provider spending in relation to the benchmark, these abnormalities experienced as a result of COVID-19 emergency will need to be taken into account.

This instability continues in calendar year 2021. A resurgence in December 2020 and January 2021 required hospitals to once again suspend elective procedures and re-open field hospitals. Now, as vaccines have become available, hospitals are using their resources to set up and staff vaccine clinics in underserved communities, develop processes to determine eligibility, and reach out to their own patients to get them vaccinated. While the future looks promising, there are still uncertainties regarding variants and how long immunity lasts, so the healthcare delivery system must continue to be vigilant. The toll that COVID has taken on health systems must be considered as organizations struggle to recover.

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, with

[1] https://www.chiamass.gov/assets/Uploads/mass-hospital-financials/data-through-6-30-2020/Data-Through-June-30-2020-Report.pdf

pharmacy spending totaling $9.9 billion in 2018, a 5.8% increase from 2017. MHA appreciates that the HPC has made pharmaceutical spending a continuing key focus by recommending that the commonwealth pursue price transparency and enhanced oversight for pharmacy benefit managers, encourage the use of risk-based contracting with manufacturers, 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. 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 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. The commonwealth has one of the oldest RN populations in the country, with 51% of RNs over age 50 and 25% over age 60. Nationally, the Health Resources and Services Administration projects that more than 1 million registered nurses will reach retirement age within the next 10 to 15 years. In Massachusetts, 4,500 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 mental health and substance use treatment services has never been higher, the current shortage of providers that specialize in behavioral health patients, from psychiatrists and nurses to mental health counselors, prevents many existing facilities from operating at full capacity. The pandemic only exacerbated this situation. The state's behavioral health roadmap proposes sensible reforms, but expanding access and workforce, including broadening the pipeline of this workforce, will also come with a cost.

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, challenging the ability to meet the state benchmark.

There is also uncertainty regarding insurance coverage. There are continuing legal challenges to the Affordable Care Act that could render it unenforceable and potentially unconstitutional. Even with the new Administration in place at the federal level, MHA would recommend that the HPC consider these factors 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 (EOHHS) 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.[2] 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 continuing to promote the importance of collaboration among payers, providers, government agencies, and community-based organizations to address social determinants of health in its 2019 Cost Trends Report. Failure to address social determinants can result in healthcare disparities that affect patient outcomes, productivity, and, ultimately, add costs across the healthcare continuum. This has been particularly evident throughout the pandemic. For all these reasons, it is particularly important to consider the health care cost benchmark through a health equity lens.

[2] "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

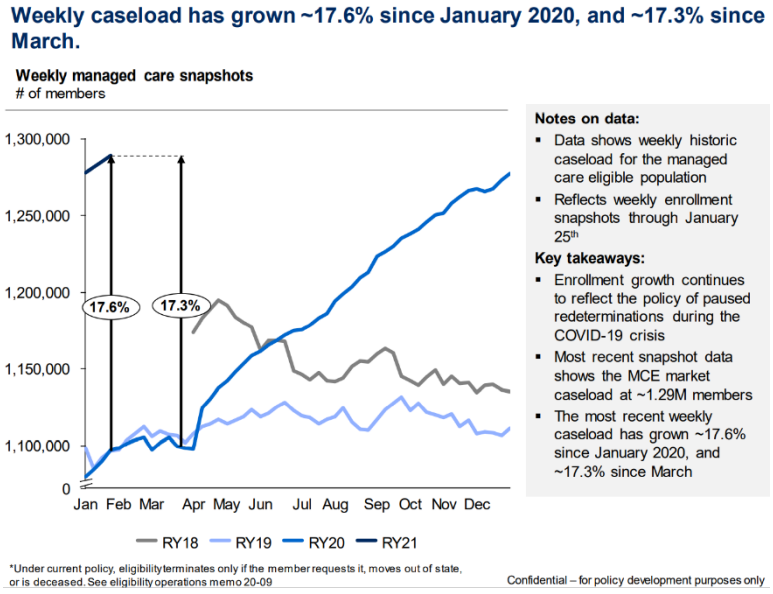
Hospitals care for patients 24 hours per day/7 days per week and, along with physician and community partners, are making significant investments in services to address the social determinants that affect health. Investing in these interventions that address social as well as clinical needs is the right 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. In 2020, the MassHealth ACO program began its Flexible Services program which provides added funding for certain ACO members with housing and nutritional needs. The program is expected to introduce $150 million over the next three years for these services. MHA recommends the HPC use caution when setting the appropriate benchmark, given the uncertain timeframes related to the realization of these cost-saving measures and the added funding to support these efforts.

Opioid Crisis

Regarding the opioid crisis, Massachusetts continues to be one of the hardest hit states, and more recently has seen the opioid crisis expand to other substances of concern, particularly the use of stimulants. 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. As with other chronic diseases, the pandemic has only exacerbated this crisis.

State Reform and the MassHealth ACO Program

The single largest factor driving MassHealth spending today is enrollment. Since March 2020, MassHealth has protected all enrollees and not initiated any eligibility redeterminations. As a result, enrollment is up 17% since the state public health emergency took effect as indicated by this recent chart from EOHHS. This increase has been supported by approximately $1 billion in enhanced federal revenues during calendar year 2020. This unprecedented enrollment growth will need to be considered when evaluating spending in relation to the state cost benchmark.



At the same time, MassHealth utilization and spending has been greatly affected by the pandemic. Similar to the general trend in hospitals, MassHealth outpatient utilization and spending saw a significant decrease in calendar year 2020. Inpatient utilization was also negatively affected but not by the same degree, largely due to COVID-19 patients as well as the continuation of labor and delivery – the largest category of inpatient services for MassHealth enrollees. MassHealth also took significant steps to stabilize provider finances, providing a 7.5% rate enhancement between April 1 and July 30. Further, MassHealth provided a 20% rate enhancement on select inpatient hospital DRGs related to COVID-19 patients that continues today. MassHealth also issued more than $360 million in special COVID-19 supplemental payments to safety net and pediatric hospitals to support lost revenues. The agency also provided loans to address the early cash needs of many providers.

To help address the effect of the COVID-19 emergency on inpatient behavioral health providers, MassHealth introduced a variety of new payment adjustments and investments. These include funding of more than $40 million beginning in spring 2021 to support hospitals that create new inpatient beds, additional incentive payments to increase inpatient volume, and enhanced rates for care provided to COVID-19 positive patients.

In its ACO program, MassHealth continues to adjust its capitation payments and benchmark targets in a way that will exceed the state cost benchmark. As a reminder, MassHealth increased capitation rates and benchmark targets on average by 10% in calendar year 2020. This was done in recognition of the 2018 and 2019 rates being markedly off from the target, creating significant financial losses for many MassHealth ACOs. In 2021, MassHealth increased its rates by 4.0% to account for a general rate increase and effects of COVID-19. MassHealth also introduced numerous other changes to its rating structure that affect ACO financial accountability, including new risk corridors and risk adjustments.

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 HPC noted in its recent report, "Health care affordability is a continued concern for Massachusetts residents. Health insurance premiums rise year after year even as the percentage of commercially insured residents enrolled in high deductible plans increases (from 28.5% in 2017 to 35.1% in 2019) and as out-of-pocket (OOP) spending continues to rise (5.6% in 2018) faster than residents' incomes." As the prevalence of high-deductible plans grows, the resources needed to collect patient liability after insurance and the amount of resulting bad debt has grown as well.

An increase in benefit designs that mandate that patients obtain certain services outside of hospitals (site of service plans) may not only adversely affect patient care but, because these changes are done unilaterally by carriers, may result in significant and unanticipated reduction in revenue. Hospitals must maintain these services 24/7, unlike freestanding facilities that often are only open during business hours and do not accept Medicaid patients. 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 both as a result of the catastrophic losses during the pandemic as well as when used against lower-paid community hospitals – a practice that 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 and General Counsel, at (781) 262-6055 or msroczynski@mhalink.org.