TO: **Health Policy Commission**

FROM: **Donna Kelly-Williams, RN President, Massachusetts Nurses Association**

DATE: **March 22, 2019**

RE: **Testimony on the Health Care Cost Growth Benchmark**

As the president of the Massachusetts Nurses Association (MNA), I offer this testimony on behalf of the 23,000 members we represent in 85 health care facilities, including 51 acute care hospitals, across Massachusetts. The MNA supports the maintenance of the health care cost benchmark at 3.1% for 2020 and believes the Health Policy Commission (HPC), together with other state policy makers, should continue to pursue bold policy initiatives that control health care costs while improving quality and access.

Since the landmark Massachusetts health care reform law was passed in 2006, the Commonwealth has attempted to balance quality, cost and accessibility. Subsequent laws, including Chapter 224 of the Acts of 2012 which established the health care cost growth benchmark, have offered additional tools to achieve these goals. As frontline caregivers, we see up close how these health care policy decisions affect our patients and the care they receive. This is the perspective from which we will address two specific opportunities for savings put forth by the HPC at the March 13th hearing on the cost growth benchmark.

Preventable Readmissions

As noted by the Health Policy Commission (HPC) at the March 13th hearing, preventable readmission rates in Massachusetts hospitals have continued to increase, despite the national downward trend. As Massachusetts is currently the second worst performing state in the nation when it comes to preventable readmissions, up from fifth place in 2016, this trend is troubling from both a cost and quality of care perspective. Massachusetts hospitals are also consistently among those penalized for high readmission rates by the federal Hospital Readmissions Reduction Program. For the second year in a row, the HPC has identified reducing preventable hospital readmissions as a fundamental way to reduce health care spending. In its May 2018 report, *Opportunities for Savings in Health Care*, the HPC estimated that as much as $1.04 billion could be saved by reducing readmissions by 20% over five years. The MNA has previously submitted detailed testimony on reducing preventable readmission by ensuring patients receive appropriate care while in the hospital and that they and their families are properly prepared for discharge. The HPC cited a 2011 report from The Commonwealth Fund which pointed to the importance of ensuring "smooth care transitions as their patients are discharged to avoid the deterioration in health status" that often leads to readmissions.[1] In order to ensure this smooth

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[1] Silow-Carroll S, Edwards JN, Lashbrook A. *Reducing Hospital Readmissions: Lessons from Top-Performing Hospitals*. The Commonwealth Fund. April 2011.

transition, hospitals need to ensure nurses have enough time to spend with patients and the patients' families to review the reasons for the hospitalization and the treatment received while inpatient as well as the care plan post-discharge. This allows patients to go home with the right instructions, the right equipment and supplies, and the right medications. When patients receive appropriate discharge information, once home, they will have the knowledge necessary to take their medications safely and as prescribed, to do wound care appropriately and safely, to begin to rebuild their strength and prevent falls, and know what potential complications to watch for and report to their caregivers. All these things are crucial to preventing complications that could necessitate a preventable return admission. And all of these require appropriate nurse staffing. As nurses, we see every day how inadequate nurse staffing leads to less time spent on educating patients and families- and how this in turn can lead to these preventable readmissions. Studies have supported these observations. In a 2014 study on heart failure published in the *Journal of Nursing Care Quality,* the authors cite previously published research stating, "evidence suggests that education provided by nurses prior to discharge improves outcomes such as increased patient satisfaction and decreased hospital readmissions for individuals with chronic illnesses".[2] Discharge is a crucial time for nursing care. Ensuring a smooth transition of care to the home setting can make a significant difference as to whether or not the patient returns to the hospital. Nurses must be afforded the time to clearly communicate post-discharge instructions- and this means that hospital units must be adequately staffed at all times. Unfortunately, I can report again this year that this is most often not the case.

In addition to ensuring a smooth transition of care at the time of discharge, we must ensure that patients receive appropriate care while in the hospital. According to a 2013 *Health Affairs* article, hospitals with higher nurse staffing had 25% lower odds of preventable readmissions compared to otherwise similar hospitals with lower staffing and 41% lower odds of receiving the maximum penalty under the Hospital Readmissions Reduction Program than their lower-staffed counterparts. The article states, "Investment in nursing is a potential system-level intervention to reduce readmissions that policy makers and hospital administrators should consider in the new regulatory environment as they examine the quality of care delivered to US hospital patients."[3] In looking at two of the most common conditions associated with preventable readmissions, heart failure[4] and pneumonia[5], recent studies have shown that higher nurse-to-patient staffing levels are factors in lowering preventable readmissions, while poor nurse-to-patient staffing levels are associated with higher rates of readmissions. And the association between appropriate nurse staffing and better outcomes is not limited to one particular population. Though many studies focus on preventable readmissions in the Medicare population, research also demonstrates a relationship between higher nurse-to-patient staffing levels and outcomes in children. A 2013 study found that for children with medical conditions, nurse staffing levels were significantly associated with hospital readmission rates, with every patient assigned to a nurse above four resulting in an 11% increased risk for a readmission.[6]

The MNA again encourages hospitals and the HPC to look to appropriate nurses staffing to help combat increasing readmission rates.

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https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_case_study_2011_apr_1473_silowcarroll_readmissions_synthesis_web_version.pdf

[2] Stamp, Kelly D., Flanagan, Jane, et al, *Predictors of Excess Heart Failure Readmissions: Implications for Nursing Practice,* Journal of Nursing Care Quality. April-June 2014.

[3] McHugh, Matthew D., Berez, Julie, et al, *Hospitals with Higher Nurse Staffing Had Lower Odds of Readmissions Penalties Than Hospitals With Lower Staffing,* Health Affairs. October 2013.

[4] Stamp, Kelly D., Flanagan, Jane, et al, *Predictors of Excess Heart Failure Readmissions: Implications for Nursing Practice,* Journal of Nursing Care Quality. April-June 2014.

[5] Flanagan, Jane, Stamp, Kelly D., et al, *Predictors of 30-Day Readmission for Pneumonia,* Journal of Nursing Administrators. February 2016.

[6] Tubbs-Cooley, Heather L., Cimiotti, Jeannie P., et al, *An Observational Study of Nurse Staffing Ratios and Hospital Readmissions Among Children Admitted for Common Conditions,* BMJ Quality & Safety. September 2013.

Shift Community Appropriate Inpatient Care

The HPC has estimated that shifting 25% of commercial and Medicare community appropriate care from teaching hospitals to community hospitals could save $211.4 million over five years. The MNA supports this goal, but asks that in the service of this goal, the HPC take an interest in the essential health services, as defined in CMR that community hospitals have been eliminating over the past decade. As the HPC noted in its March 13th presentation, Massachusetts patients tend to seek care at more expensive teaching hospitals and academic medical centers (42% vs the national average of 18%) when there is appropriate, comparable care available at lower-cost community hospitals. This has long been an issue identified as a cost-driver in the Massachusetts health care market. Following a five-year period of increasing use of academic medical centers over community hospitals, in 2017 there was a slight downtick, however it is too soon to determine whether this is indicative of a pattern. If we wish for this to continue, we must take steps to ensure that the appropriate care continues to be available at community hospitals. Unfortunately, over the past six years we have lost two full-service community hospitals- North Adams Regional Hospital which closed in 2013 and Quincy Medical Center which closed in 2014. In each instance, these hospitals closed in violation of the regulations that govern the elimination of essential health services and left thousands of patients without a local community hospital. This led to both cost and access issues. Patients who had received community appropriate care at North Adams Regional Hospital were now forced to travel at least 40 minutes to receive care at Berkshire Medical Center (a community teaching hospital) or Baystate Medical Center (a teaching hospital). When Quincy Medical Center closed its doors, some patients sought care at South Shore Hospital in Weymouth, but others migrated towards Boston area-teaching hospitals.

In addition to the loss of these two long-standing community hospitals, other community hospitals are eliminating essential health services. In the past decade, community hospitals have closed mental health beds, shuttered maternity and pediatric services, urgent care centers and emergency departments. This presents access problems and diverts patient near larger urban areas to expensive teaching hospitals and academic medical centers. In order to increase the volume of patients seeking community-appropriate care at community hospitals, we must ensure that these community hospitals are providing the necessary services. In most cases when a closure or reduction in services is proposed, the Department of Public Health investigates and issues a recommendation as to whether the facility or service is essential and should not close. However, despite issuing this opinion, there is nothing the DPH can do to protect the essential health service. The MNA encourages the HPC to look to ways to ensure that these essential health services are available at community hospitals, such as incorporating this into the criteria used to award Community Hospital Acceleration, Revitalization, and Transformation (CHART) grants.

Market Consolidation

While not addressed directly in the HPC's recommendations, market consolidation and market power continue to play a large role with regards to health care costs. Research has shown that consolidation- particularly in concentrated markets- can lead to substantial price increases. Though consolidations are often presented as benefitting from "economies of scale", the result can be price increases anywhere from 8% to 50%, though 20%-30% is more common.[7] Following reviews by the Public Health Council, the HPC and the Massachusetts Attorney General's Office, a merger between Beth Israel Deaconess Medical Center and Lahey Health became effective earlier this month. This creates a new provider system in the already concentrated Massachusetts market

[7] Gaynor, Martin. *Examining the Impact of Health Care Consolidation*. Statement to the Committee on Energy and Commerce Oversight and Investigations Subcommittee

that will be second only to Partners Health Care. This newly created provider system will include 13 hospitals, over 1,000 primary care physicians and 3,600 specialists. In its own assessment of the merger, the HPC stated, "the parties have also proposed care delivery programs that may result in savings, but the scope of these savings is uncertain, and even the parties' highest estimate of $52 million to $87 million would not be sufficient to offset projected price increases" which the HPC estimated could be between $158.2 million and $230 million annually.[8] Though subsequent conditions imposed on the merger from the Attorney General's Office would set price caps for seven years, there is no guarantee beyond that. And Massachusetts knows from experience that the other large health systems- Partners- has leveraged its market power for years to drive prices up. While the HPC has fulfilled its charge by conducting several Cost and Market Impact Reviews, we encourage the HPC to remain vigilant as to how future consolidations could negatively impact the health care market from a cost perspective. It is also important to note that several studies have also found substantially worse patient health outcomes in highly concentrated markets.[9]

While the HPC has reviewed hospital mergers and consolidations, there has not been the same level of scrutiny or oversight with regards to the mergers and consolidations of physician groups. Though not as widely studied as hospital mergers, this type of market consolidation can also increase costs by driving out competition and has not been shown to demonstrate improved health outcomes for patients.[10] This is something the HPC should examine more closely. The 2015 Atrius Health merger, as well as various acquisitions of provider groups by hospital systems, fits with the national trend whereby the same year, 1 in 4 physician groups was hospital-owned. This type of vertical integration is also associated with higher costs and higher prices. One study showed that prices for services rendered by hospital-acquired physicians increased by an average of 14% following an acquisition[11]. And not surprisingly, physicians who have been acquired by hospitals are much more likely to refer patients to that hospital- regardless of cost or quality concerns.

Another area of consolidation that should be examined for affect on cost and quality is vertical integration of hospital systems and insurance providers. In Massachusetts, hospitals and insurance carriers are increasingly becoming one in the same. At one time, this was mostly confined to the Medicaid and subsidized insurance space, with Boston Medical Center owning and operating BMC HealthNet a Medicaid Managed Care Organization (MMCO), and Cambridge Health Alliance which had at one time owned and operated Network Health, but in 2011 Partners Health Care acquired Neighborhood Health Plan, which at the time had a small book of commercial business but was largely covering individuals in the Medicaid and subsidized markets. But by 2017, Partners was moving to reduce the percentage of subsidized enrollees and instead grow the commercial book of business. The HPC should also look to examine these types of arrangements to understand their impact on health care cost growth.

Thank you for the opportunity to provide this feedback on efforts to contain health care costs while improving quality and access.

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[8] Health Policy Commission Review of The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; AND The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; AND The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association (HPC-CMIR-2017-2) Final Report. September 27, 2018. https://www.mass.gov/files/documents/2018/09/27/Final%20CMIR%20Report%20-%20Beth%20Israel%20Lahey%20Health.pdf

[9] Gaynor. p.10

[10] Gee, Emily and Gurwitz, Ethan. *Provider Consolidation Drives Up Health Care Costs.* Center for American Progress.

[11] Ibid.