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Testimony Regarding the Potential Modification of the 2025 Healthcare Cost Growth Benchmark

Health Policy Commission & Joint Committee on Health Care Financing
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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 2025 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. While hospitals remain strongly committed to the healthcare delivery reforms and affordability goals of Chapter 224, MHA and our members across the state continue to have serious concerns about the benchmark process and its application at a time when the system is facing an unprecedented crisis.

This week, the Center for Health Information and Analysis (CHIA) reported an increase of 5.8% in total healthcare expenditures for the commonwealth between 2021 and 2022. **While this number exceeds the 3.1% benchmark the HPC established, the hospital community notes that hospital expenses (inpatient and outpatient) grew by only 1.8%, according to CHIA.**[1] Despite the immense challenges that our health system has endured in the wake of the pandemic, a rise in inflation, and a dramatically challenged workforce, this positive result clearly demonstrates that the hospital community is dedicated to addressing healthcare affordability.

Since the inception of Chapter 224 more than a decade ago, hospitals have proudly led the charge for care affordability and answered the call every time collaboration and action were needed to address the challenges facing our system. But 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 and 2023 comments, the very factors defining today's healthcare system were never considered when the benchmark was established in 2012.

Throughout this testimony, we will tie together the multitude of pressures that illustrate the current state of the Massachusetts healthcare system and the need to modernize the benchmark approach, including:

- Unprecedented capacity pressures
- Vast workforce challenges and skyrocketing labor costs
- Deep financial losses and added costs, including many that are not within hospitals' control.
- Essential infrastructure improvements
- Unanticipated events such as the pandemic or a massive cyberattack

What's more, no one expected in 2012 that a major Massachusetts system with nine hospitals could be facing financial collapse, leading to a lack of adequate staffing and supplies in some of its facilities. There are concerns that some of the system's hospitals will close, leaving communities without crucial healthcare services and placing further burdens on other hospitals.

[1] Performance of the Massachusetts Health Care System Annual Report, Center for Health Information and Analysis, March 2024, pg. 27

As we have emphasized repeatedly, 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 current ongoing instabilities. 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.

On every imaginable level, our commonwealth's healthcare system is in a different place than it was before the pandemic struck, and all aspects of it are dramatically different in comparison to 2012 when Chapter 224 was passed. Yet while every piece of the system has worked to adjust to these new realities, the benchmark remains a relic in the past.

MHA members cannot continue to support a benchmark process as written in statute. We believe current conditions and the challenges the healthcare system faces going forward warrant a re-examination and modernization of the benchmark, as well as the way in which it is applied.

The Cost of Inequities

The economic burden of health inequities that Black, Hispanic/Latino, and Asian populations in Massachusetts experience total $5.9 billion each year, according to a recent report, which goes on to note "about one-quarter of this burden, is associated with avoidable health care spending, which translates to approximately 2.2 percent of total medical spending in Massachusetts." These costs are largely associated with systemic inequities in social determinants of health (SDOH), such as economic opportunity, education, housing, and food access.

Hospitals are now undertaking significant expenses to address health equity for all their patients, including those enrolled in MassHealth. The 1115 Medicaid Waiver's ambitious and expansive goals have required intense engagement from all levels of hospital staff — from leadership, clinical departments, IT, human resources, finance, community relations, and the thousands of team members who interact with patients on a daily basis. Hospitals and health systems are investing significant funds to bring this commitment to life. **Through a new assessment that helps finance these health equity incentives, Massachusetts providers are contributing $875 million over the five-year waiver period to fund the program.** This is in addition to significant investments they will make to achieve the program's many goals. *(See more on the 1115 Waiver on page 5.)*

Capacity Challenges

Massachusetts hospitals – like those across the nation – are experiencing a capacity crisis. On any given day, there are collectively more than 1,500 patients "stuck" in hospital beds since they cannot access the behavioral health or post-acute care they need. The problem has become so severe that the Department of Public Health has declared much of the system at "high risk", with Cape Cod and the Islands, the greater Boston area, northeastern Massachusetts, and southeastern Massachusetts all designated Tier 3 on a scale of 4. **As the HPC highlighted during its February 29 Advisory Committee meeting, "delays in care and barriers to patient flow, exacerbated by workforce shortages and affordability concerns, can create access challenges throughout the healthcare system."** In that same presentation, the HPC noted that average length of stay has increased by roughly half a day since 2019. Payments to hospitals do not increase as average length of stay increases. The opposite is true. The healthcare system is a volume driven system, not one based on length of stay, meaning hospitals are continuing to devote a large volume of resources to treating hundreds of patients who no longer need acute-level care.

Capacity challenges have been well documented in MHA's monthly Throughput Survey Report, which shows how delays in patient discharges to post-acute care settings have become a growing challenge for both acute care hospitals and post-acute care providers. Contributing factors to the capacity issue include insurance administrative barriers related to treatment authorization, delays for non-emergency transportation, and the lack of guardianships and conservatorships – all issues beyond a hospital's control.

MHA also has been capturing behavioral health (BH) boarding metrics on a weekly basis, which show the number of patients waiting in an emergency department (ED) or medical surgical floor for a psychiatric evaluation or a bed in a psychiatric unit. The March 4 report showed that there were 428 BH patients of all ages boarding in hospitals across the state.

Psychiatric units and freestanding psychiatric facilities also face significant barriers discharging patients to Department of Mental Health (DMH) continuing care beds; some Massachusetts patients have been waiting more than two years for such a bed to become available. In calendar year 2023, DMH continuing care facilities admitted 1,015 patients from the forensic system and only nine patients from the inpatient psychiatric system, effectively closing off the ability of patients in inpatient psychiatric settings from gaining admission to the continuing care level of care.

More recently, well-documented emergency shelter shortages due to increased housing instability and newly arriving migrants has added pressures on emergency departments, which continue to experience increases in individuals with housing and healthcare needs. This has further stretched providers' resources.

In addition to the factors described above, deferred care resulting both from the pandemic and from patients delaying care due to cost sharing and lack of access has led to higher patient acuity, requiring more intensive resources and longer lengths of stay, increasing costs and exacerbating capacity challenges in the process.

Workforce Shortages & Labor Costs

Capacity challenges cannot be viewed in isolation and must include consideration of the workforce shortages and labor costs that persist throughout the care continuum. MHA estimates there are 19,000 full-time job openings across the commonwealth's acute care hospitals, and nearly 600 in post-acute care facilities, leading to drastic changes in the market for talented workers.

As the commission and legislature knows, **hospital labor expenses account for close to 70% of a hospital's operating costs, yet salary and wage growth pressures are not accounted for fully in the cost growth benchmark.** Those costs have been tremendously disruptive over the past three-plus years. The pandemic accelerated challenges that hospitals already were facing in recruiting and retaining healthcare workers. Relative to early 2020, labor expense growth, including wage increases and other compensation, remains high. A recent MHA workforce survey found that the median increase in average hourly wages for the 47 positions surveyed exceeded 13% compared to the pre-pandemic period, with some positions increasing more than 20%. Hospitals are also offering extensive signing bonuses and retention packages to keep employees -- especially for those that work at the bedside.

Hospitals have had to rely heavily on temporary staffing to fill the gap. The average hourly wage rates for travel nurses far exceed the rates paid pre-pandemic, with an average increase of 90% since 2019.

CHIA reported $1.54 billion in hospital temporary clinical staffing expenses for FY2022, or $1.2 billion more than pre-pandemic year of FY2019. Through June of FY2023, CHIA reports $886.5 million more in temporary clinical staffing costs for 47 acute hospitals, which annualizes to 97% of FY2022 temporary staffing expenses for the respective group of hospitals. A continuation of this trend would mean temporary labor expenses across all Massachusetts acute hospitals in FY2023 will likely approach the highwater mark of $1.5 billion set in FY2022. Hospital health system-affiliated providers

have experienced this same growth in staffing costs, incurring $194 million in temporary staffing expenses during FY2022, and $176 million through Q3 of FY2023. All told, more than $2.6 billion has been spent on temporary labor over the past two years thus far, which represents one of the largest and unsustainable cost pressures for providers throughout the commonwealth.

The problem is not abating. The Bureau of Labor Statistics projects that the country will face a shortage of 195,400 nurses by the year 2031, and that the number of openings for home health aides and personal health aides will increase 37% by 2028. The National Center for Health Workforce Analysis predicts that nationally, across all physician specialties in the United States, there is a projected shortage of 139,940 full-time equivalent physicians in 2036.

In March 2023, the HPC presented findings highlighting the following:

- Healthcare providers have experienced high rates of vacancies and turnover, including registered nursing vacancies doubling from 6.4% in 2019 to 13.6% in 2022. In long-term care, the share of hours worked by contracted registered nurses has quintupled, from 4% in 2019 to 19% in 2022.
- Shortages of workers have serious effects on patient care, such as patients remaining in hospital beds awaiting discharge, boarding in emergency departments, and lacking access to timely and appropriate care.

While there are no quick solutions to the workforce crisis, there are an array of steps that healthcare organizations, the state, and federal agencies are taking to address the problem. These include finding new and creative ways to support existing workers, advancing new models of care such as telehealth and hospital-at-home, investing in training, expanding the workforce pipeline, and providing financial supports. MHA and its members have been at the forefront of this work, including through progressive workforce legislative proposals, a statewide Find Your Place in Healthcare campaign to draw people into the caring profession, and a new HEALTHCAREers Academy to train and place people in high-need roles. Even with such proactive actions, expanding the workforce will take time and resources. **Enforcing a benchmark 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.**

Inflation & Improper Use of the Benchmark

Within the 2021-22 period analyzed by CHIA, skyrocketing inflation rates struck the healthcare sector as it did other sectors of the economy. **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.

At last year's healthcare 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."[2]

Using the benchmark as a *de facto* reimbursement cap is problematic in light of the challenges outlined above, and particularly harmful when this payer strategy is used against lower-paid community hospitals. The benchmark was never

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

intended to be used in his manner.

We respectfully request the HPC and legislature take more direct action to prohibit the inappropriate use of the benchmark in health insurance contracts with providers.

Hospital Finances

All of the factors referenced in this testimony have resulted in upward pressure on hospital expenses and a downward effect on revenues, which has caused a drastic 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 pandemic and other pressures outlined in this testimony. 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 have remained open 24/7 throughout the pandemic and beyond, are losing money on a daily basis. The Center for Health Information and Analysis' most recent Acute Hospital and Health System Financial Performance showed that:

- The statewide acute hospital median total margin in HFY 2022 was -4.2%, a decrease of 9.2 percentage points in comparison to the prior fiscal year.
- Similarly, the statewide acute hospital median operating margin (-1.3%) and non-operating margin (-0.4%) decreased from the prior year.
- All four cohorts (academic medical centers, community hospitals, teaching hospitals, and community high public payer hospitals) reported decreases in median total, operating, and non-operating margins.
- In HFY 2022, expenses increased 8.9% while operating revenues increased 5.5% as compared to the prior hospital fiscal year.

The Hospital Assessment, 1115 Medicaid Waiver, and MassHealth

Of note, FY2024 marks another year of significant new funding to the MassHealth program. The FY2024 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 above FY2022 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 health-related social needs, including housing, nutrition, and care coordination in the community. MHA, hospitals, and the Executive Office of Health and Human Services are working to implement this historic commitment to close persistent disparities and enhance the viability of Massachusetts hospitals and the MassHealth program.

As it relates to the healthcare cost benchmark, it is still 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.

It is also important to note that much of the unique funding in the MassHealth program contributes to the overall spending growth of the commonwealth. According to CHIA, MassHealth supplemental payments increased 47.0% from 2021 to 2022, with COVID-19 supplemental payments accounting for most of this increase. These payments are financed primarily by the federal government. In 2022, MassHealth reported $621.5 million in supplemental payments related to the COVID-19 pandemic, compared to just $43 million the previous year. [3]

Enrollment growth in the program also contributed to FY2022 spending with COVID-19 eligibility protections still in effect. This additional enrollment was supported by enhanced federal revenues. Looking forward into 2024, the MassHealth program is near complete with its massive effort to redetermine eligibility in the program. Through February, the MassHealth caseload has been reduced by 280,000 people. Many of these individuals will likely be covered by other insurance, including through the Health Connector, which will reimburse at rates above Medicaid. Those that become uninsured will seek care through more expensive settings such as the emergency department.

Infrastructure

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. According to the Massachusetts Department of Public Health, climate change is expected to cause more heat waves, poor air quality days, inland and coastal flooding, sea-level rise, poor water quality, and extreme storms that negatively impact human health and increase the need for healthcare services.

Hospitals are taking meaningful 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, procuring from more sustainable sources, and manage the waste they produce. **These steps often come with significant cost. Just as with severe workforce shortages, capacity constraints, and the lingering effects of the pandemic, the necessary investments to protect hospitals from climate change and replacing aging capital were not contemplated when the benchmark was established in 2012.**

Another significant concern that was not prevalent when the benchmark was created is protecting the healthcare system from cyberattacks. As this testimony is being prepared, the entire country is dealing with a cybersecurity attack on Change Healthcare, affecting the ability of hospitals and other providers to submit claims, get reimbursed, check patient eligibility, and submit prescriptions to pharmacies so that patients can obtain medications at the appropriate copayment. The full effect on patients and providers is not yet known, but a spot survey from MHA showed respondent hospitals were losing $24 million per day due to the Change Healthcare breach. This attack affects all lines of business – Medicare, Medicaid, and commercial.

Pharmaceutical Costs

According to CHIA's 2024 Annual Report, pharmacy spending net of rebates was the largest driver of the increase in THCE from 2021 to 2022. In 2022, gross pharmacy spending surpassed hospital outpatient spending to become the largest individual service category. Net of rebates, pharmacy spending increased 8.3% to $10.1 billion in 2022. Without adjusting for rebates, pharmacy spending increased 8.8%.

[3] Performance of the Massachusetts Health Care System Annual Report, Center for Health Information and Analysis, March 2024, pg. 27

Pharmaceutical costs continue to be one of the most significant drivers of total healthcare expenditure growth. Yet, pharmaceutical pricing is largely outside of healthcare providers' control. MHA recognizes that the HPC has made pharmaceutical spending a continuing focus with enhanced oversight listed as one of the nine recommendations in the 2023 Cost Trends Report. Such action is needed both within Massachusetts and by the federal government for meaningful prescription drug price reform to become a reality.

In Summary

MHA and our members strongly 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. However, due to the many reasons cited in this testimony, MHA and its members believe the benchmark as currently designed is no longer a viable mechanism to help us reach this goal.

It is clear that the current healthcare cost growth benchmark as codified in statute has lost relevancy. It is now time for the commonwealth – in close partnership with state leaders and healthcare stakeholders – to adopt a more meaningful, modernized approach that can effectively incorporate real-time circumstances and pressures on the healthcare system. We once again 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 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. The Health Care Cost Growth Benchmark process must be modified 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.