Hartford HealthCare

COMMENTS OF HARTFORD HEALTHCARE
SUBMITTED TO THE OFFICE OF HEALTH STRATEGY

REGARDING THE PRELIMINARY RECOMMENDATIONS OF THE
COST GROWTH BENCHMARK TECHNICAL TEAM

OCTOBER 20, 2020

Hartford HealthCare (HHC) appreciates the opportunity to comment on the Cost Growth Benchmark Technical Team's Preliminary Recommendations. HHC is committed to sustaining and improving access to high quality healthcare services in the communities we serve. Affordability is central to that commitment and we believe the benchmark effort is an important opportunity to alter the trajectory of healthcare spending in our state.

Background

HHC is a fully integrated health system. With over 30,000 colleagues, HHC includes seven acute care hospitals; behavioral health, rehabilitation and homecare networks; a physician group; and an array of senior care services. The HHC acute care hospitals are The William W. Backus Hospital (Norwich), Charlotte Hungerford Hospital (Torrington), Hartford Hospital, The Hospital of Central Connecticut (New Britain/Southington), MidState Medical Center (Meriden), Windham Hospital, and St. Vincent's Medical Center (Bridgeport).

This year has been an unprecedented year for healthcare providers in Connecticut. At HHC we are proud of our efforts to support our colleagues and our communities as they continue to respond to the Covid-19 pandemic. These efforts include sourcing and purchasing millions of pieces of personal protective equipment and navigating supply chain disruptions to secure basic supplies and drugs at inflated costs; launching a Community Care Center staffed by clinicians to answer over 172,000 calls to date and provide emotional support and behavioral health referrals; standing up free drive through testing sites across the state virtually overnight; and partnering with towns and community organizations to perform additional targeted testing. As of October 16, HHC had performed more than 330,000 Covid-19 tests.

At the start of the pandemic, HHC quickly pivoted to virtual care appointments, expanding capacity to accommodate over 135,000 visits. We also partnered with the state to set up three alternate care sites to accommodate a surge of patients—thankfully these sites were not needed. And we launched a screening and testing program for staff to keep everyone who walks through our doors safe. We are so proud of our brave colleagues who have stepped up to care for the most severely ill Covid-19 patients and to staff these community initiatives.

In addition to accruing these unbudgeted expenditures, the pandemic took a well-documented toll on revenue. To ensure capacity, HHC and our counterparts around the country suspended thousands of non-urgent "elective" procedures. Concurrently, thousands of patients deferred treatment for both chronic and acute conditions across all settings. While the pandemic has resulted in a windfall for payers, as insurance claims dried up, it has quite the opposite impact on care providers.

While the federal Covid-19 provider relief funds have been a lifeline, they have not closed this gap.

Cost Growth Benchmark

This is the backdrop from which we evaluate the recommendations of the Cost Growth Benchmark Technical team. It is critical that the benchmark framework account for inherent uncertainty as the healthcare sector pivots to a "new normal." This includes shouldering unexpected expenses of the initiatives described above and the costs of adapting our delivery model to a Covid world. And there are the unknowns: the long term public health consequences of Covid-19; how long the economy will take to recover and with it employment rates and access to health insurance; and the specter of a second wave still looms large.

Given this context we would respectfully request that OHS give health systems time to recover from the pandemic before implementing the benchmark.

In making your implementation plan, we would ask that you consider the spending anomalies of the past seven months and the coming months before a vaccine is expected to be widely available when calculating the base period for the benchmark. The technical underpinnings of building the base year have not received significant attention in the stakeholder groups who have met thus far. We feel it is imperative that stakeholders weigh in on this issue to ensure we are embarking on the benchmark process from a realistic and equitable starting point. Along those same lines, we think it is paramount that if commercial payers are permitted to use their own clinical risk adjuster, that OHS take steps to ensure the underlying methodologies are transparent and consistent.

Spending Targets

The annual spending targets should appropriately reflect and promote healthcare's important role in the state's economy and accommodate the capital investments needed to address deferred facility maintenance and prepare for the next public health crisis.

In 2018, the HHC system had a direct economic impact on the community of more than $5.9 billion.[1] Expenditures for salaries, goods, services, and facility construction, ripples out into the community and drives growth in the health, medical, and research fields, as well as in many other sectors. Since late 2019, HHC has been the largest private employer in Connecticut, with over 30,000 employees and a payroll in excess of $2 billion. These payroll expenditures serve as an important economic stimulus, creating and supporting jobs throughout the local and state economies.

And nearly every hospital job produces another job outside the hospital. Salaries earned by HHC employees are spent in the community on housing, food, transportation, and other goods and services. HHC's economic activities also create a need for healthcare-related businesses, suppliers and main street and service-oriented businesses utilized by employees, patients and their families.

[1] *This analysis is based on the statewide multipliers from the Regional Input-Output Modeling System (RIMS II), developed by the Bureau of Economic Analysis of the U.S. Department of Commerce. It uses data from the hospital health system FY 2018 audited financial statements. RIMS II provides an accounting of "inputs" purchased and "outputs" sold by an industry in the state. The spending of one industry will have several rounds of ripple influence throughout the state economy – this is known as the multiplier effect. RIMS II regional multipliers measure both the direct and indirect impact on the state economy from a specific industry.*

The Technical Team's recommended benchmark ratio of 20% potential gross state product (PGSP) to 80% median income is not proportional to hospitals' impact on the state's economy.

This 20/80 ratio is in contrast to the ratios used by three of the four other states who have adopted cost growth benchmarks. Delaware, Rhode Island and Massachusetts set their initial health care cost growth targets equivalent to their states' PGSP. In fact, for the first three years, Delaware's cost growth target is based on the state's PGSP plus an additional "transitional market adjustment."

We recommend that OHS adopt initial target rates that more closely match PGSP.

We also ask that OHS be flexible about revising the benchmark values as circumstances change. Given that the volatility around healthcare finances will continue into the foreseeable future, it would be prudent to add conditions which would trigger a revisiting of the benchmark values, in addition to a sharp rise in inflation. For example, Massachusetts and Delaware allow committees (the board of the Massachusetts Health Policy Commission and the Delaware Economic Financial Advisory Council, respectively) to adjust the values. In the case of Delaware, the council reviews the target methodology annually and may make changes if the cost growth forecast has materially changed.

Implementation

Considering the context, we would also ask OHS to consider a phase-in that permits providers and payers to acclimate to the benchmark without fear of punitive treatment for the first two years, as they recover from the pandemic.

In addition, we want to commend OHS on your commitment to transparency and soliciting stakeholder input. We would encourage OHS to continue soliciting feedback as you answer outstanding questions and develop implementation guidance, particularly as it pertains to the assessment and evaluation process. For example, we would ask that as you develop a methodology for determining how patients are attributed to providers and when an entity has exceeded the benchmark, that you include providers who will be subject to this methodology in your deliberations.

Primary Care Spending Targets

It is clear that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience. Leaving mental health out of the definition of primary care would be a missed opportunity to drive investment into this area. In order to enable better outcomes and avoid unnecessary costs, primary care prevention must include behavioral health services rendered by clinicians trained in this area.

Thank you again for your commitment to a collaborative approach and for your consideration of these comments. For additional information, contact Cara Passaro at cara.passaro@hhchealth.org or 860-310-7783.