



Massachusetts Council of Community Hospitals

July 15, 2011

Ms. Seena Perumal Carrington
Acting Commissioner
Division of Health Care Finance and Policy
China Trade Center
Two Boylston Street
Boston, MA 02116-4704

Dear Acting Commissioner Carrington:

The Massachusetts Council of Community Hospitals (MCCH) member hospitals provide care to approximately 25% of the Commonwealth's acute care patients. We advocate for community hospitals with the belief that the community hospital, as the centerpiece of coordinated care, will produce a higher quality service at an affordable cost to their respective communities than niche or more fragmented providers or the high cost teaching model that also provides secondary care. Dr. Edward Moscovitch, in his April 2010 Report, provides the clearest global view as to what has ailed the community hospital sector over time and prevented this sector from assuming an even larger role in the delivery system. His work established the following:

- Private payers have always paid our community hospital sector significantly less than the sector's national counterparts.
- In more recent years, private payer payments to the sector have increased but still below national averages. (about 13% less)
- Private payer increases in payments have not been high enough to offset the significant reductions in the Medicare program payments that have occurred.
- The use of teaching hospitals for acute care is over two times the national average (45% of admissions vs. 20% in 2008) with the implication that inpatient secondary care provided in a teaching model of care exceeds the national average by approximately \$1B annually. Another \$1B is associated with the use of ambulatory services.
- As a result of historically low payments as compared to our national community hospital counterparts, our community hospital's employment of plant and equipment in patient care delivery is 34% lower than the national average.

The important point to be taken from Dr. Moscovitch's analysis, beyond the very favorable cost performance of our commonwealth's community hospitals, is the continued and extreme underfunding by federal and state programs not only compromises the ability of community hospitals to fulfill their mission but greatly contributes to accelerating the loss of well paid, local jobs. This underpayment works against maintaining and improving access and managing private insurance premium growth.

The report goes on to point to other disparities in cost performance among teaching and community hospitals that were reinforced by the recent Attorney General's investigation of cost and price disparities in the commercial market. For us they reinforced a long held belief that our community hospitals have been incurring collateral damage in the delivery and financing system that has been simply broken and inequitable to our communities, employers and most importantly our patients who for whatever reason could not or would not avail themselves of our services.

The Attorney General's recommendation of transitory price controls preceding ACO development and implementation greatly concerns us for the following reasons;

- The fixing of a "price" for services can result in an arbitrary outcome for any one provider that has been historically disadvantaged in the past. In their effort to seek economic parity in the market they could be defeated depending on the rate(s) selected, thus depriving their community of needed services.
- A rate selection process that focuses on mathematical measures of central tendency (mean, mode etc.) looks equitable but again fails to consider the individual circumstances that has led so many providers to seek shelter in the for profit sector or consolidate into the well heeled teaching sector.
- The concept of "rate freeze" often looks like a good compromise in the public eye, but in fact would greatly continue the damage to the community hospital sector since the basis of competition is affected by the relative relationship between competing parties. "Baking-in" price advantage or cost inefficiencies should not occur.

Dr. Moscovitch warns our membership that since the not for profit community hospital sector has had very restricted operating margins, and so little capital as compared to the teaching sector (and now the for profit sector), any effort to restrict community hospital revenues will likely accelerate the use of the high cost teaching sector as community hospitals close or reduce services. The historical record going all the way back to Nixon-era price controls and our own state rate control programs reinforce the belief that rate controls only damaged the community hospital system and the objectives it was trying to achieve.

We hope that your office, the Administration and Attorney General give consideration to the following questions before provider controls are proposed to be introduced as a short term solution;

- Where do you want future growth in acute care delivery to occur? (It is now likely that current use of the teaching model of care now exceeds 50%).
- What services do you expect community hospitals to provide? (studies show that more than 90% of all acute care can be provided in the community hospital setting)
- What is the appropriate allocation of insurance premium and level of payment that allows community hospitals to fulfill their mission and the opportunity that community based medicine offers to society to mitigate the cost of health care?
- Where do you want job loss to occur? Simplistically stated, hospitals must maintain a certain financial profile to avoid default on its debt.

An additional observation we would like to make is that the recent public debate appears to center around provider rates and gives the impression to the public that this is the central issue in cost control. We would remind the Administration that the collective agreement reached, as documented in the Roadmap to Cost Containment (2009), highlighted other strategies requiring implementation of far greater importance than the focus on rates of payment. Public policy and importantly action must shift to provide equal attention to the real underlying cost drivers that lie in increasing personal responsibility for personal health, supporting their ability to have access and information to make more informed decisions, providing incentive in plan designs to help consumers and employers to make more rational decisions in having their care at the right time, in the right place and at an affordable cost.

Thank you for the opportunity to comment on the work you have done to date, which we believe contributes to the transparency needed for the Commonwealth to make the best decisions for all. The Moscovitch Report can be accessed at mcchweb.org. If you have any questions, please contact me at 781-424-0930.

Sincerely,



Donald J. Thieme
Executive Director

cc: JudyAnn Bigby, Secretary of Health and Human Services
Martha Coakley, Attorney General