CONNECTICUT HOSPITAL ASSOCIATION

June 27, 2025

Amy Porter
Acting Commissioner
Office of Health Strategy
PO Box 340308, 450 Capitol Ave MS510OHS
Hartford, CT 06106

RE: CHA Comments – Healthcare Benchmark Initiative, Proposed Benchmarks for Years 2026 - 2030

Dear Acting Commissioner Porter:

The Connecticut Hospital Association (CHA) appreciates the opportunity to comment on the proposed 2026–2030 Cost Growth Benchmark recommendations.

Since the launch of the Healthcare Benchmark Initiative in early 2020, Connecticut hospitals and health systems have served as committed partners in advancing its goals. Hospital representatives have actively participated in the Stakeholder Advisory Board, the Healthcare Benchmark Initiative Steering Committee, the Data Analytics Work Group, and various public forums and hearings. Throughout, we have advocated consistently for a more cohesive and transparent data process and a benchmark methodology that better accounts for the real operational costs of healthcare providers and supports the ongoing development of the state's healthcare delivery system.

As the Office of Health Strategy (OHS) and the technical team consider updates to the Healthcare Cost Growth Benchmark, Quality Benchmarks, and Primary Care Spending Targets for the next five-year period, we urge thoughtful revisions that more accurately reflect the dynamic nature of the healthcare market. Specifically, we strongly encourage OHS to set targets that realistically reflect the cost for hospitals and other providers to deliver care to patients, address the persistent data inconsistencies that compromise stakeholder trust in the process and undermine the program's stated goal of accountability and improvement, and advance the benchmark program in a way that takes into consideration the suggestions and views of stakeholders that actually provide care to patients and are responsible for the healthcare infrastructure on which the state's residents depend.

Flawed Benchmark Methodology

We believe OHS's newly proposed 2.8% benchmark for 2026–2030 continues to overlook several critical factors that directly impact hospitals' ability to deliver affordable high-quality care in Connecticut. Though a clear goal of the benchmark, as outlined in OHS's June 9 Healthcare Benchmark Initiative report, is to provide a stable, predictable target grounded in transparent calculations, the benchmark and its proposed associated

recommendations fall short of reflecting the operational and financial realities hospitals and health systems face. The continued exclusion of key cost drivers from the methodology — specifically, the impact of inflation, tariffs, workforce shortages, supply chain disruptions, and chronic government underpayment — present a fundamental obstacle to setting a realistic and achievable benchmark over the next five years and highlight a growing disconnect between the stated goals of the cost growth benchmark and the current approach OHS is taking to calculate and report on benchmark performance.

We are concerned that the lack of attention to underlying structural issues hinders progress toward the program's intended outcomes and risks undermining broader efforts to address healthcare affordability and access across the state. As OHS finalizes its recommendations, we urge consideration of a more comprehensive and pragmatic recalibration of the benchmark methodology to better reflect the true cost of care delivery.

OHS's proposed recommendations do not adequately address the impact of increased economic pressures and government underpayment for hospitals. Like any other industry, hospitals are significantly affected by external economic pressures beyond their control. In just one year in Connecticut, from FY 2022 to FY 2023, hospitals faced operating expenses that grew by $1 billion, including workforce expenses that grew by $169 million, drug expenses that grew by $249 million, and the cost of medical supplies that grew by $92 million. Rising expenses, combined with other factors, have resulted in Connecticut hospitals losing more than $76 million in FY 2023 (Kaufman Hall). Moreover, the chronic underpayment of Medicaid and Medicare continues to strain access to essential health services. After accounting for the taxes that hospitals pay to fund the state share of Medicaid services, reimbursement for care provided to beneficiaries sits at less than 60 cents on the dollar. Low reimbursement rates not only result in a cost shift to the private market but also force hospitals and health systems to consider scaling back on essential services, jeopardizing patient access. OHS notes that both healthcare access and cost shift to the commercial market are priorities of interest in its report, yet the recommendations do not address their connection with government underpayment.

OHS's proposed recommendations lack the flexibility needed to account for the wide range of factors that routinely impact the cost of care. In addition to economic pressures, hospitals must remain nimble and responsive to any number of situational, clinical, demographic changes. This includes adapting to pandemic-related pressures, increased complexity of care for patients, environmental disasters, or changes to state and federal legislation that impact how care is delivered. Neglecting to appropriately apply risk - adjustment for patient acuity and other demographic factors is a fundamental flaw in the benchmark methodology that further endangers the validity of reported results. This error should not be perpetuated for another 5 years.

CHA objects to the sole reliance on the forecasted median household income as the basis for the benchmark. This proposed approach oversimplifies the complexities of healthcare costs and creates a disconnect between benchmark projections and the realities of hospitals' financial status. We note that the current benchmark methodology applies an 80/20 weighting of Connecticut Median Income (MI) and Connecticut Potential Gross State Product (PGSP). Though this methodology is not without its limitations, we believe applying a heavier weight on PGSP would at least be helpful in capturing some of the costs associated with care delivery. The recommendation to scale back from the use of PGSP presents an even more constrained approach—one that makes it harder to align the benchmark with the real-world financial and operational challenges hospitals are forced to grapple with daily.

Deficiencies in the Data Reporting Process

We are concerned that the proposed recommendations do not include steps to improve the data collection and reporting process, despite longstanding issues of data discrepancies.

Since the outset of the benchmark program, there have been persistent concerns about misalignment between the data submitted by insurers about the Advanced Networks and the data validated by the Advanced Networks themselves. Often, the submitted data has not been thoroughly validated, and even when discrepancies are identified, they frequently go unresolved before publication.

While we acknowledge that OHS has routinely referred Advanced Networks to the Cost Growth Benchmark Implementation Manual for reporting requirements, it is clear that payers may interpret instructions differently, leading to variation in payer reported data.

We strongly urge OHS to make a concerted effort to ensure there is mutual agreement between payers and Advanced Networks on both the content and application of submitted data. Without full access to standardized payer data submissions, Advanced Networks are left with limited insight into the trends and performance metrics that they are later expected to explain during public hearings, or more importantly act on to help slow the rate of healthcare cost growth. If one of the core goals of the benchmark is indeed increased transparency, we believe OHS should use its full authority to facilitate better communication and data sharing among all stakeholders.

Premature Implementation of Enforcement Mechanisms

We find the recommendation for increased enforcement measures for non-attainment of the benchmark to be premature and unnecessary. Hospitals and health systems have been active and engaged participants from the beginning of the process. Despite ongoing challenges—including flaws in the current implementation process and accounting for the broader economic pressures facing healthcare—the proposed recommendations continue to emphasize penalties for non-attainment of the annual benchmark. With so many areas of misalignment still unresolved, pursuing enforcement at this stage is counterproductive and unlikely to lead to meaningful progress.

Improving affordability, sustaining exceptional patient care and improving access to healthcare services are at the center of our collective goals, yet we believe strongly there is a better way to achieve them. We urge OHS to consider more meaningful revisions to the program and avoid setting the same rigid conditions for the next 5 years. CHA remains optimistic that with appropriate and significant changes, the benchmark program could be a meaningful tool for the state.

Thank you for your attention and consideration of our comments.

Paul Kidwell
Senior Vice President, Policy

cc: Alex Reger, Director, Healthcare Benchmark Initiatives, Office of Health Strategy