PREMIER TRANSFORMING HEALTHCARE TOGETHER®

March 17, 2023

The Honorable Bernie Sanders
Chairman
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

Submitted electronically to HealthWorkforceComments@help.senate.gov

Re: Senate Committee on Health, Education, Labor and Pensions Request for Information on Potential Solutions to Address Healthcare Workforce Shortages

Dear Chairman Sanders and Ranking Member Cassidy:

Premier Inc. appreciates the opportunity to provide feedback to the Senate Health, Education, Labor and Pensions (HELP) Committee around pressing healthcare workforce issues and potential legislative solutions. Premier further appreciates the thoughtful and bipartisan approach outlined under your leadership to seek stakeholder input in the development of consensus policy proposals to remedy our nation's healthcare workforce shortages.

The U.S. continues to face a shortage of healthcare workers across the care continuum, a reality that rages on even as the COVID-19 pandemic subsides. According to a 2022 Premier member survey of hospital CEOs, 78 percent of respondents cited workforce resources as their top concern. During the pandemic, one-third of all clinical employees quit their jobs, nearly double the rate from 2019. At the same time, the U.S. Bureau of Labor and Statistics' December 2022 report indicated 2.7 open positions for every 1.0 position filled.[1]

To retain valued employees, providers have been increasing pay for qualified staff. Premier data[2] shows increased labor costs for hospitals of more than 16 percent since 2020, leading to $24 billion in added salary expense[3]. Exacerbating the economics, experts estimate a shortage of as many as 124,000 physicians by 2034[4] and the need to hire 200,000 or more nurses per year[5] to meet the needs of an aging population and to fill the gap left by retiring nurses.

As the Committee considers solutions to this pressing problem, Premier recommends keeping two key themes front and center. First, it is critical that any potential solutions are developed with the understanding that the delivery of healthcare will continue to evolve and therefore it is critical for solutions to be flexible and adaptable to future models of care delivery. Secondly, solutions should be sustainable and not result in a boomerang effect – for example, pharmacists had a shortage in the early 2000s, then a boom and pharmacist surplus in the 2010s, followed by another shortage now – solutions must have longevity and not be a temporary Band-Aid to the problem.

Premier believes addressing these challenges will require a multi-pronged approach, and a mix of both near term and longer-term solutions. Our recommendations include:

[1] JOLTS Home : U.S. Bureau of Labor Statistics (bls.gov)
[2] PINC AI™ Data: CMS Data Underestimates Hospital Labor Spending | Premier (premierinc.com)
[3] PINC AI Data Shows Hospitals Paying $24B More for Labor Amid COVID-19… | Premier (premierinc.com)
[4] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)
[5] Registered Nurses : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov)

- To address the new economic status quo of higher pay for clinical professions, the Centers for Medicare & Medicaid Services (CMS) needs better and more real-time data to calculate labor costs, including actual wages paid directly from hospitals for employed and contracted labor. With more accurate reimbursement, health systems will have funds to pay the market rates necessary to attract and retain talent.
- The nation needs to strengthen the physician training pipeline by providing additional support to existing federal programs that support graduate medical education. Additionally, we must create and support new educational opportunities for non-physician healthcare workers, both in clinical and technical roles.
- Addressing the rise in acts of violence and intimidation directed towards healthcare workers. Specifically, Premier encourages Congress to enact bipartisan legislation providing federal protections for healthcare workers who experience violence and intimidation in their workplace settings and grants to reduce incidences of violence.

I. BACKGROUND ON PREMIER INC.

Premier Inc. is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

Premier, in partnership with CommonSpirit Health and Providence, recently invested in Dignity Health Global Education (DHGE), a healthcare workforce development company. DHGE's learning solutions support healthcare organizations in retaining, upskilling and reskilling their workforce. DHGE develops degree and certificate programs specifically for healthcare professionals, alongside fully customized education solutions for healthcare groups. Most recently, DHGE launched the country's largest and most comprehensive nursing residency program across 21 states with CommonSpirit Health to address national high attrition rates among first-year nurses.

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. PREMIER'S RECOMMENDATIONS TO ADDRESS CHALLENGES IN THE HEALTHCARE WORKFORCE

More accurately accounting for labor costs – Hospitals and health systems continue to operate under enormous financial challenges, due in significant part to skyrocketing labor costs. A 2022 PINC AI™

analysis found that labor costs increased by more than 16 percent since the start of FY 2021 and increased by more than 10 percent in FY 2022 alone. As talent shortages become more severe, providers are paying more to attract and retain scarce staff, a reality that is not expected to significantly subside as we move out of the pandemic.

Annually, CMS updates hospital rates based on a number of factors including an inflation index specific to hospitals. Labor costs represent approximately 68 percent of the index. In comments submitted to CMS as part of the annual comment and notice process, Premier has shared analysis which shows how CMS' data and analysis have understated actual labor costs, and correspondingly provided for annual updates in FYs 2021, 2022 and 2023 below the level warranted.

Furthermore, Premier has ongoing concerns that without methodological changes, CMS payment updates will continue to not reflect the actual cost increases hospitals are experiencing now and into the future. For example, CMS updates labor costs using data from the U.S. Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI). However, the BLS' ECI does not appear to accurately reflect the increased labor costs resulting from these projected ongoing shortages. Specifically, CMS uses a four-quarter rolling average of change in compensation and benefits as measured through the ECI survey of hospital workers. This compares to Premier data that comes directly from hospital payroll. One critical difference between Premier's analysis and the ECI data, is that the ECI survey of hospital employment costs only includes employed hospital workers, not contracted ones. Driving the growth in labor expenses has been an increased reliance on contract staff, especially contract nurses, who are integral members of the clinical care team. This data gap in CMS' analysis represents a significant reason why the hospital market basket updates for FYs 2021, 2022 and 2023 understated hospital increases in costs.

The Medicare Payment Advisory Commission (MedPAC)'s most recent report examining the adequacy of payments to healthcare providers supports Premier's analysis. In its March 2023 Report to the Congress[6], MedPAC states that Medicare payments continued to fall below hospitals' costs in aggregate in 2021. MedPAC projects that hospitals' Medicare margins in 2023 will be even lower than in 2021, "driven in part by growth in hospitals' input costs, which exceeded the forecasts CMS used to set Medicare payment rate updates."

Premier has recommended to the agency that CMS use existing "exceptions and adjustments authority" to provide more accurate updates. Additionally, Premier has recommended that CMS' Office of the Chief Actuary (OACT) reevaluate the data sources that it uses for calculating labor costs and consider adopting new or supplemental data sources in future rulemaking, such as more real time data from the hospital community. ***Premier urges Congress to also work with CMS to expand the type of data used in its annual hospital payment update process to more accurately account for the true level of labor expenses.***

Growing the physician workforce – Projections by the Association of American Medical Colleges (AAMC) show that physician demand will grow faster than supply leading to a projected total physician shortage of up to 124,000 physicians by 2034[7]. These shortages will have real impact on patients, particularly those living in rural and underserved communities. To help grow a sustainable physician workforce to meet patient needs, increased Medicare support for graduate medical education (GME, or residency training) is needed.

Dating back to 1997, Medicare caps the number of GME positions it supports at each teaching hospital. However, in response to workforce needs, many teaching hospitals train "above their cap." The costs of supporting these additional residency positions are typically supported from clinical revenues. The financial

[6] March 2023 Report to the Congress: Medicare Payment Policy
[7] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)

pressures facing many hospitals threaten the ability of teaching hospitals to continue to invest their own resources to train physicians over the cap.

Adding new Medicare-supported GME slots will alleviate some of the pressure and allow hospitals to increase training. Congress in recent years has made investments in physician training by adding 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act of 2021 and an additional 200 slots dedicated to behavioral health in 2022. These slots are critical to helping ensure a workforce to care for patients and communities.

Premier urges Congress to take additional action to increase Medicare-supported GME slots. In the 117th Congress, Senators Robert Menendez (D-NJ), John Boozman (R-AR) and Majority Leader Charles Schumer (D-NY) introduced the bipartisan Resident Physician Shortage Reduction Act of 2021 (S. 834). This legislation, which had broad stakeholder support, would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied needs, including hospitals in rural areas and hospitals serving patients from federally-designated health professional shortage areas (HPSAs). Premier also urge Congress to continue to support the Teaching Health Center (THC) GME program, which supports the training of medical and dental residents in alternate sites such as Federally Qualified Health Centers (FQHCs) and increases access to primary care physicians in underserved areas.

Strengthening the pediatric physician workforce – In addition to supporting Medicare GME, Premier believes it is also vitally important to provide strong support for the Children's Hospitals Graduate Medical Education (CHGME) program. CHGME is the most important federal investment supporting the pediatric physician workforce. Since its creation in 1999, the CHGME program has enabled children's hospitals to dramatically increase pediatric physician training and significantly increase the number of pediatricians and pediatric specialists. Continued support for CHGME is vital to maintaining and strengthening the pediatric physician pipeline.

Premier urges Congress to pass reauthorization of the CHGME program, which is up for reauthorization in 2023, without delay. Further, Premier encourages Congressional appropriators to provide increased program funding that creates parity between CHGME and other federal residency programs on a per-resident basis. CHGME per-resident funding is currently about one-half of that provided through programs such as Medicare GME on a per-resident basis. We cannot continue to fall behind - we must protect children's access to care.

Boosting the non-physician pipeline - In addition to addressing physician workforce needs, it is equally important that we take steps to bolster the ranks of non-physician clinical roles, including nursing, but also other vital roles such as pharmacists, occupational therapists, respiratory therapists and more. An issue we frequently hear with respect to nursing shortages is that the pool of willing candidates exceeds the number of available training slots in schools of nursing, at least partly due to limited number of available training faculty. ***Premier encourages Congress to consider ways to increase capacity, including examining whether all educators in such programs should require an advance degree or if there are opportunities for flexible standards that might create additional training capacity if some educators are permitted to have a bachelor's degree only for example.***

In addition, loan forgiveness programs should be considered to incent new talent to join the field. However, in many cases healthcare workers opt to not accept loan forgiveness funds because they are accounted for as income and can have a detrimental impact on an individual's finances if pushed into a higher tax bracket. Similarly, healthcare workers are often hesitant to accept employer assistance funds as they can also be counted as income and force the worker into a "benefit cliff." Therefore, ***Premier urges Congress***

to ensure that the tax implications of loan forgiveness programs do not act as inadvertent disincentives to individuals participating.

Premier also recommends that Congress seek opportunities to provide support to grant programs that expand vocational programs to help train for clinical roles that do not require four-year degrees, such as home health aides; nursing assistants; or technicians for pharmacy, radiology, and laboratory. For example, most states permit training opportunities for emergency medical technicians (EMTs) to begin in high school and similar programs should be considered for other non-four-year degree programs in the healthcare space. Premier additionally encourages Congress to support approaches and programs that connect high school students to health careers by enhancing recruitment, education, training and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in healthcare, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from those communities.

Finally, Premier recommends that Congress provide continued strong funding for existing health workforce training programs under the Health Resources and Services Administration (HRSA) intended to target allied health professionals. Congress should continue to support the National Health Service Corps (NHSC), which provides scholarships and loan repayment funds for medical providers who agree to practice in medically underserved areas. Congress should also consider support for "earn while you learn" programs that support the growth and development of healthcare workers while employed in a healthcare facility.

Protecting the safety of the healthcare workforce – In a 2018 study, nearly 89 percent of nurses reported incidents of workplace violence - ranging from verbal abuse at the low end of the spectrum, to physical assaults and even deaths at the other - and there are indications that workplace violence against nurses increased during the pandemic. This trend, coupled with the aging of the clinical workforce and pandemic burnout, explains why nearly five million nurses are expected to leave the profession by 2030.

Premier encourages Congress to enact legislation similar to the bipartisan Safety from Violence for Healthcare Employees (SAVE) Act from the 117th Congress (H.R. 7961) that would provide federal protections for healthcare workers who experience violence and intimidation in their workplace settings similar to those in the federal statute that criminalizes the assault and intimidation of aircraft and airport workers. While hospitals have for many years had protocols in place attempting to protect their employees, the number of violent attacks against healthcare workers has increased steadily in recent years, with a sharp uptick during the COVID-19 pandemic. These experiences impact the individual caregiver, who may suffer from both physical and psychological trauma, and they can also disrupt care when providers fear for their personal safety, are distracted by disruptive patients or family members, or are traumatized from prior violent interactions. These types of incidents also consume hospital and health system resources that may impact care available for other patients.

Premier believes that these legal protections would help provide healthcare workers with a safer environment in which to deliver patient care. The SAVE Act additionally would have provided grants to hospitals for programs to help reduce the incidence of violence in our care settings. These grants could be used for training hospital personnel, coordinating with state and local law enforcement and purchasing of equipment or technology that will assist in creating a safer environment.

Moreover, in keeping with our proven dedication to safety, Premier has committed to working with the Agency for Healthcare Quality and Research (AHRQ) to gather data on violence in the healthcare workplace and develop evidence-based practices to prevent these occurrences from occurring. To better inform prevention and mitigation strategies, Premier, with input from AHRQ, created a survey to capture

insights that can provide actionable data around workplace violence. The survey intends to gather additional information in this space such as the characteristics and demographics of those involved in workplace violence to help develop best practices to identify and thwart potential violence in the future. In addition, the survey will capture the response of law enforcement to workplace violence reports to better understand how hospitals should be partnering with law enforcement. Premier launched this survey in February and looks forward to sharing the results with the HELP Committee in the near future to help inform legislative efforts moving forward.

Support use of technology and workflow solutions to address burnout - Clinical burnout is a symptom of a system in distress. If not addressed, the healthcare worker burnout crisis will hinder access to care, increase healthcare costs cause and worsen health disparities. However, technology can play a critical role in decreasing burnout in clinical setting. Therefore, ***Premier encourages Congress to support the adoption of technology in healthcare settings to optimize workflows, reduce administrative burden and stress on workers and permit healthcare workers to focus their time and energy on direct patient care.***

For example, Premier supports requiring greater payer adoption of electronic prior authorization procedures. The prior authorization process is burdensome to providers and patients and remains a manually-intensive process that requires healthcare professionals to take time away from caring for their patients to engage with payers. Additionally, it can delay access to care. Because of prior authorization time lags, 93 percent of providers responding to a survey by the American Medical Association (AMA) reported treatment delays, 82 percent reported that prior authorization can sometimes lead to treatment abandonment, 24 percent said these delays resulted in hospitalization and 18 percent said delays led to a life-threatening event or required intervention to prevent permanent impairment or damage.[8]

Additionally, Premier encourages Congress to support wider adoption of interoperable health information technologies across the spectrum of care that can further ease provider burden and streamline data collection and reporting, particularly in long-term care and post-acute care (LTPAC) settings. Inequitable access to and use of interoperable health IT persists across the continuum. As a result of technology gaps, it is more difficult to broaden data exchange between stakeholders, especially during instances of shared care and transitions of care between hospitals and the LTPAC sector. Moreover, these providers face the same labor challenges, including shortages and burnout, as acute-care settings. For example, the role of infection preventionists (IPs) has been front and center more than ever during the pandemic. However, many infection prevention departments are understaffed as IPs near retirement age or leave due to pandemic burnout. Greater use of interoperable technology, such as, interoperable electronic infection control and remote surveillance technologies, would enable more seamless patient care and also help alleviate some of the administrative burden that providers struggle with. While surveillance is intended to be a small amount of an IP's job, most IPs today spend much more of their time on surveillance activities. Remote surveillance technology can aid infection prevention departments with daily infection surveillance and healthcare associated infection (HAI) review, investigation and documentation, reducing the daily surveillance load for department staff and increasing their ability to perform prevention activities.

Leveraging qualified international resources – During the pandemic, a backlog of 10,000 international nursing visas built up because of an inability by the U.S. State Department to process visa applications, delaying the deployment of critical resources to reduce labor pressure across the nation. In recent months, progress has been made in working through this backlog, providing some short-term relief. However, more can be done to leverage qualified international healthcare workers domestically in ways that will ensure appropriate standards of care are met and labor shortages are addressed. Specifically, international nurses

[8] AMA prior authorization (PA) physician survey | AMA (ama-assn.org)

play a critical role in filling shortages of lower acuity nursing positions. In addition, there are almost 280,000 unused nursing visas from FYs 1992-2020 that can be recaptured and utilized to help address the current workforce challenges, as highlighted in the Healthcare Workforce Resilience Act (S.1024) from last Congress. Therefore, ***Premier urges Congress to work with the State Department to address the backlog of nursing visas and identify opportunities to recapture the unused visas from the past three decades.*** Critical to this will be ensuring that the State Department continues to prioritize visa applications and interviews for nurses and other healthcare workers, as well as ensuring proper staffing at U.S. embassies to carry out this work.

Premier also recognizes that several U.S. health systems have an international footprint and believes this may serve as an opportunity for these international outposts to recruit and train healthcare workers to U.S. standards. By working collaboratively with the State Department and HRSA, international training programs could help match workers with shortage areas in U.S. communities. Therefore, ***Premier urges Congress to consider a grant program or pilot program to test leveraging U.S. healthcare facilities overseas to recruit and train healthcare workers for placement in shortage areas in the U.S.***

Premier also encourages Congress to pass bipartisan legislation introduced by Senators Klobuchar (D-MN), Collins (R-ME), Rosen (D-NV) and Tillis (R-NC) that would expand the healthcare workforce in rural and medically underserved areas. The Conrad State 30 and Physician Access Reauthorization Act would allow international doctors to remain in the U.S. upon completing their residency under the condition that they practice in areas experiencing doctor shortages.

III. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments to the Senate HELP Committee as it weighs bipartisan approaches to addressing workforce shortages and related issues. If you have any questions regarding our comments, or if Premier can serve as a resource on these issues to the Committee, please contact John Knapp, VP of Advocacy, at John_Knapp@premierinc.com or 240.839.0739.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.