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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

July 26, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislative proposals that are to be considered before the Committee on Ways and Means on July 26. We would like to provide feedback on sections of H.R. 4822, the "Health Care Price Transparency Act of 2023," as well as H.R. 3284, the "Providers and Payers COMPETE Act."

Health Care Price Transparency Act of 2023

Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-campus

The AHA opposes Section 203, which would create harmful site-neutral payment cuts for drug administration services furnished in off-campus HOPDs. This policy would result in a major cut to HOPDs that provide essential drug administration services to patients, including for vulnerable cancer patients, who may require a higher level of care than is available at other care settings.

Site-neutral payment policies fail to account for the fundamental differences between HOPDs and other sites of care. Hospitals and health systems are held to higher

regulatory and safety standards than other settings, including for drug administration services. Current payment rates support this higher standard of care to ensure that drugs are safely prepared and administered. For example, unlike independent physicians' offices, hospitals must take steps to ensure the drug preparation is supervised by a licensed pharmacist, employees are protected from exposure to hazardous drugs, rooms are sterilized to prevent contamination, and that they are compliant with other such Food and Drug Administration, U.S. Pharmacopeia and Joint Commission safety standards.

The cost of care delivered in hospitals and health systems considers the unique benefits that they provide to their communities that are not provided by other sites of care. This includes investments made to maintain standby capacity for natural and manmade disasters, public health emergencies and unexpected traumatic events, as well as delivering 24/7 emergency care to all who come to the hospital, regardless of ability to pay or insurance status. In addition, hospital facilities also must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care. These costs can amount to over $200 per patient, resulting in hospitals losing money when providing certain services.

Existing site-neutral payment cuts have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries. Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. Medicare outpatient margins were an average of -17.5% in 2021 and overall median hospital operating margins were negative throughout 2022 and into the beginning of 2023. The impact is perhaps even more acute for rural hospitals whose total Medicare margins were -17.8% in 2021. This is particularly alarming given the fact that 152 rural hospitals have closed or converted to another type of provider since 2010, with 11 occurring so far in 2023. This proposal would expand upon these cuts resulting in a cut of nearly $4 billion over 10 years to hospitals and health systems. This would further exacerbate the financial challenges facing many hospitals and threaten patients' access to quality care.

Some policymakers have inaccurately suggested that site-neutral payments are needed to disincentivize hospitals and health systems from acquiring physician practices. However, the reality is that over the past five years, entities like private equity firms and companies linked to commercial insurers, including UnitedHealth Group's Optum Care and Humana, are responsible for over 75% of physician acquisitions, while hospitals and health systems only account for 6%.[1] Instead of allowing these services to be lost into the community or creating new health care deserts, hospitals acquire these practices to ensure that the health care services continue to exist and that patients can continue to receive their care from their existing doctors.

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[1] https://www.aha.org/infographics/2023-06-26-setting-record-straight-private-equity-and-health-insurers-acquire-more-physicians-hospitals

Requiring a Separate Identification Number and an Attestation for Each Off-campus Outpatient Department of a Provider

The AHA opposes Section 202, which would require that each off-campus hospital outpatient department (HOPD) of a provider be assigned a separate unique health identifier from its provider. This provision is unnecessary since hospitals are already transparent about the location of care delivery on their bills. Hospitals and other providers bill according to federal regulations, which require them to bill all payers — Medicare, Medicaid and private payers — using codes that indicate the location of where a service is provided. As a result, this provision would impose an unnecessary and onerous administrative burden on providers and needlessly increase Medicare program administrative costs.

Section 202 also would require that as a condition of payment, hospitals submit an attestation of compliance with the Medicare provider-based regulations for each of their off-campus HOPDs within two years of enactment. Given hospitals' experience with review and approval of similar attestations in the past, we are concerned that this requirement would be extremely burdensome for hospitals and Medicare contractors.

Price Transparency Requirements

Section 101 would require hospitals and ambulatory surgical centers to disclose certain information relating to charges and prices. For hospitals, this would consist of current requirements under the Hospital Price Transparency Rule, including a machine-readable file of the hospital's standard charges, as well as to provide a list of at least 300 shoppable services. The legislation would allow hospitals to be deemed compliant with the shoppable service requirement if they have a price estimator tool until the No Surprises Act price transparency policies are fully implemented. The information posted would include the gross charges, the discounted cash price and allows the Department of Health and Human Services' (HHS) Secretary the discretion to require hospitals to disclose negotiated rates. The secretary would establish, as of Jan. 1, 2026, a standard format for facilities to use in compiling and making public these standard charges and prices. The Centers for Medicare & Medicaid Services (CMS) would publish on their website information regarding the number of reviews conducted for hospital compliance, the number of notifications issued, the identity of hospitals that received notices, whether civil monetary penalties were imposed and whether a hospital subsequently came into compliance. Penalties are capped at $2 million per year per facility, which is similar to current CMS enforcement standards, but the Secretary is allowed to increase that amount for persistent noncompliance and could decrease that amount or waive it entirely for hospitals when the fine would pose a hardship.

The AHA opposes the provision to eliminate the use of price estimator tools once the No Surprises Act price transparency Advanced Explanation of Benefit (AEOB) policies are in place. Requiring hospitals with price estimator tools to invest time and resources in creating a shoppable service list, in addition to complying with the AEOB, is a move in the wrong direction. This will create undue cost and burden in the health care system

and could result in public confusion around which estimates patients should use in preparing for care. Also, given that CMS is contemplating changes to the existing Hospital Price Transparency regulations in the OPPS proposed rule, we are concerned that the legislative approach to price transparency outlined in Section 101 may conflict with new guidelines. Each time CMS makes changes to the underlying transparency program, hospitals must invest additional time and resources to come into compliance. It is essential that any legislative changes are made in accordance with the most current regulatory parameters to avoid confusion and burden for hospitals as they seek to adhere to both the regulations and any statutory changes.

Streamlining Prior Authorization in Medicare Advantage

The AHA is appreciative of efforts in Section 301 that would help ensure access to high quality care in a timely manner by streamlining prior authorization requirements under Medicare Advantage (MA) plans. This section would establish an electronic prior authorization process to increase transparency around which services require prior authorization, streamline approvals, reduce the amount of time a health plan is allowed to consider a prior authorization request, create a process of "real-time decisions" for services that are routinely approved, require MA plans to report on their use of prior authorization and the rate of approvals and denials, and encourage MA plans to adopt policies that adhere to evidence-based guidelines.

However, hospitals should not have to endure site-neutral payment cuts to pay for insurer abuses. Inappropriate denials for prior authorization and coverage of medically necessary services are a pervasive problem among certain plans in the MA program. According to a 2022 American Medical Association survey, 94% of physicians reported patient care delays associated with prior authorizations, while 80% indicated that prior authorization hassles led to patient abandonment of treatment.[2] These practices add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with MA plan requirements. They are also a major burden to the health care workforce and contribute to provider burnout.

In addition to the provisions included in this section, we encourage the committee to broaden the scope of this bill to apply to state Medicaid and Children's Health Insurance Program agencies and Qualified Health Plan issuers on the Federally-facilitated Exchanges to reflect the recently proposed rules released by CMS to improve the prior authorization process.

MEDICARE SEQUESTRATION

The AHA opposes Section 302, which would implement further additional Medicare sequester cuts to hospitals. Additional cuts to hospitals will only impede our ability to maintain access to care for the patients and communities we serve.

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[2] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

After years of a once-in-a-lifetime global pandemic where hospitals and health systems treated more than six million COVID-19 patients while simultaneously dealing with near historic inflation, rising expenses for drugs, supplies and labor, and incredible workforce pressures, now is not the time to cut Medicare funding. According to the government's own data, Medicare already chronically underpays providers for caring for patients, and it's time for policymakers to acknowledge the enormous challenges facing hospitals and health systems today.

PROVIDERS AND PAYERS COMPETE ACT

The AHA opposes the Providers and Payers COMPETE Act (H.R. 3284), which would impose new regulatory responsibilities on HHS regarding consolidation. HHS is not charged with protecting competition and it lacks the necessary expertise in this area. These new responsibilities are unnecessary since two other federal agencies — the Department of Justice's Antitrust Division and the Federal Trade Commission — already have jurisdiction over federal antitrust enforcement. These agencies routinely study, report on and take action to protect competition in the healthcare sector for the benefit of consumers.

We urge Congress to reconsider this attempt to expand HHS's mission and expend resources outside its core competency. Instead, the public will be best served if HHS focuses its efforts elsewhere, where its expertise and resources can benefit the consumers that rely on the programs it oversees.

CONCLUSION

Thank you for the opportunity to share the hospital and health system field's perspective on health care price transparency with the committee. We look forward to continuing to work with you to address these important issues.