Federation of American Hospitals®

Charles N. Kahn III
President and CEO

March 27, 2023

The Honorable Brett Guthrie
Chair
House Energy and Commerce Health Subcommittee
2434 Rayburn House Office Building
Washington, DC 20215

The Honorable Anna Eshoo
Ranking Member
House Energy and Commerce Health Subcommittee
272 Cannon House Office Building
Washington, DC 20215

Dear Chairman Guthrie and Ranking Member Eshoo,

The Federation of American Hospitals (FAH) is pleased to provide this Statement for the Record regarding the House Energy and Commerce Health Subcommittee's hearing on "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care."

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH and our member hospitals share the Subcommittee's goal of promoting a market-driven health care system that empowers patients with more choice and control over their health care decisions. We believe a more informed and engaged consumer will drive competition that accelerates progress towards higher quality and more affordable health care.

We look forward to working with the Energy and Commerce Health Subcommittee and appreciate the opportunity to provide input on several key policy platforms.

To help further the Subcommittee's goal of examining health care costs, this Statement for the Record addresses: hospital price transparency compliance; understanding the positive

outcomes of hospital integration; the importance of maintaining the current ban on self-referral to physician-owned hospitals (POHs); opposing site-neutral payment cuts; and raising awareness of insurer and Medicare Advantage abuses.

Hospital Price Transparency Compliance

The FAH believes that all individuals deserve transparent, meaningful and easy to understand information, especially about their cost sharing responsibility, so they can make more informed decisions regarding their health care.

Our hospitals are committed to being compliant with the Centers for Medicare and Medicaid Services (CMS) Hospital Price Transparency Rule and are supportive of the Subcommittee's efforts to highlight the importance of patients knowing how much their care will cost before they receive it. It has been falsely reported that hospitals are intentionally avoiding complying with CMS's Hospital Price Transparency Rule. Just last month, CMS released a report that found that **70%** of hospitals complied with both components of the regulation, including the consumer-friendly display of shoppable services information, as well as the machine-readable file requirements in 2022.[1] This is an increase from 27% in 2021. Moreover, when looking at each individual component of the rule, 82% of hospitals met the consumer-friendly display of shoppable services information requirement in 2022 (up from 66% in 2021) and 82% met the machine-readable file requirement (up from 30% in 2021). With this significant increase in compliance in just one year, significant progress has been, and will continue to be made, in complying with the important but cumbersome requirements. Thus, hospitals and health systems remain committed to working with CMS to implement these policies and deliver reliable and usable pricing information to patients.

Understand Positive Effects of Hospital Integration

The nation's health care landscape is, by necessity, shifting towards integrated systems and coordinated care, and mergers do create sustainable market conditions for hospital care and services. This shift has naturally occurred within the health care industry and has been further fueled by health care policies that promote a more patient-centered, value-based health care delivery and payment system. Additionally, increasingly complex health care regulatory and administrative requirements such as those regarding electronic health records, cybersecurity, quality programs, and, increasingly, payer administrative hurdles, are extremely resource-intensive and difficult for an individual hospital or an individual physician or small group practice to navigate.

Hospital integration also is a response to inadequate, below the cost-of-care, public sector funding for hospitals, forcing hospitals to adapt to real-world economic and financial factors. The priority of any integration is to keep hospitals open, preserve or expand patients' access to care and continue to provide consistent, quality care around the clock to every patient treated in a hospital. By pursuing mergers and other integration efforts, hospitals are able to maintain their

[1] "Hospital Price Transparency: Progress And Commitment To Achieving Its Potential", Health Affairs Forefront, February 14, 2023.

presence in the community, share and scale up best practices, and protect patients' access to essential and affordable quality care, especially in rural communities.

There have been multiple studies that point to the positive effect on quality as well as reduction in mortality associated with hospital mergers. For example, a study recently published in JAMA Network Open concluded that hospital mergers improve health outcomes in rural hospitals.[2] The researchers, who are affiliated with IBM Watson Health and the Agency for Healthcare Research and Quality, compared data from 172 merged rural hospitals and 266 comparison hospitals and found that in-hospital mortality rates were lower after the rural hospitals completed mergers. Researchers noted that "Mergers may enable rural hospitals to improve quality of care through access to needed financial, clinical, and technological resources, which is important to enhancing rural health and reducing urban-rural disparities in quality."

In addition, the American Hospital Association (AHA) has released numerous studies indicating that hospital integration benefits patients by providing higher quality care at a lower cost. A 2021 study reinforced the conclusions of previous reports: hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost.[3] Specifically, a previous 2018 study found that mergers of hospitals within 30 miles of each other generated savings of more than $6.6 million in annual operating expenses at acquired hospitals.[4] The studies also determined that hospital acquisitions lead to improvements on key indicators of quality. Empirical analysis continues to show a statistically significant reduction in inpatient readmission rates and a composite readmission/mortality outcome measure.[5]

Further, in 2013, the Center for Healthcare Economics and Policy released a comprehensive analysis of hospital integration studies, including 75 studies spanning the years 1996-2013, as well as 36 primary sources. The Center's analysis outlines improvements in health care for communities that result from mergers, including:

- Significant benefits to communities and patients in markets where hospitals remain open
- Preserved and expanded access to essential medical care.
- Improved service offerings and quality of care
- Sustained and necessary investment in technology, facilities and health IT
- Sensible reduction in excess capacity
- More competitive health care markets

As the health care landscape continues to evolve and providers accelerate efforts to improve patient outcomes and lower costs through coordinated care, the FAH will continue its

[2] Jiang HJ, Fingar KR, Liang L, Henke RM, Gibson TP. Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals. JAMA Netw Open. 2021;4(9):e2124662. doi:10.1001/jamanetworkopen.2021.24662
[3] Hospital Merger Benefits: An Econometric Analysis Revisited, conducted by economists at Charles River Associates, Sean May, Monica Noether and Ben Stearns, August 2021, and sponsored by the American Hospital Association.
[4] In Hospital Mergers: Foundation for a Modern, Efficient and High-Performing Health Care System of the Future, conducted by Charles River Associates, 2018, and sponsored by the American Hospital Association.
[5] See Footnote 3

efforts to inform the Subcommittee about health care competition and hospital integration. It is imperative that this issue is put in proper context, and focus is placed more holistically on the total landscape. The FAH is happy to discuss in further detail the positive effects of integration.

Maintain Current Ban on Self-Referral to Physician-Owned Hospitals (POH)

To help achieve the important goal of lowering health care costs, it is important that Congress continue to reject efforts by those who would seek to weaken the Stark Law ban on self-referral to POHs. Such arrangements are mired in conflicts of interest, and years of independent data show such arrangements result in over-utilization of Medicare services at significant cost to patients and the Medicare program. There is a substantial history of Congressional policy development and underlying research on the impact of self-referral to POHs. The empirical record is clear that these conflicts of interest arrangements of hospital ownership and self-referral by owner physicians promote unfair competition and result in cherry-picking of the healthiest and wealthiest patients, excessive utilization of care, and patient safety concerns. Today's policy includes 15 years of work by Congress, involving numerous hearings, as well as analyses by the HHS Office of inspector General (OIG), the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC).

In 2010, Congress acted to protect the Medicare and Medicaid programs and the taxpayers that fund them by imposing a prospective ban on self-referral to new POHs. The FAH strongly believes that the foundation for the current law must not be weakened. It is noteworthy that Congressional Budget Office scoring of proposals to modify existing law consistently demonstrates that self-referral to POHs increases utilization, which increases Medicare costs and health care costs generally. The law helps ensure that full-service community hospitals can continue to meet their mission to provide quality care to all the patients in their communities.

Data from the health care consulting firm Dobson | Davanzo, released today by the FAH and AHA, shows that POHs, when compared to other hospitals, treat less medically complex and more financially lucrative patients, provide fewer emergency services, and treat fewer COVID-19 cases.

Further, these arrangements have patient care margins more than 15 times those of non-POHs, they render less uncompensated care, and they treat fewer of dual-eligible (Medicaid and Medicare) patients. Even though POHs provide care to fewer patients with complex conditions, they are five times more likely to receive CMS's maximum penalty for readmissions. The new data reinforces many of the findings of earlier studies by the HHS OIG, GAO, and MedPAC, among others, documenting the conflicts of interest inherent with POHs that led to the Congressional ban in 2010. Those reports concluded that POHs:

- Cherry-pick patients by avoiding the less profitable Medicaid and uninsured patients;
- Treat fewer medically complex patients; and
- Provide fewer emergency services and often rely on publicly funded 911 services and acute care, community hospitals for these services for their own patients.

Thus, current law is key to ensuring that full-service community hospitals can continue to meet their mission to provide quality care to all patients in their communities. Weakening or unwinding the current ban opens the door to the very behaviors that Congress sought to prevent.

Oppose Site-Neutral Payment Cuts to Ensure Access to Care

The FAH strongly opposes site-neutral payment policies, as these types of policies would be detrimental for patient access to medically necessary care. Under a site-neutral payment policy, the payment for a service provided to a patient is similar regardless of the setting where the service is provided. The FAH agrees with the goal of ensuring patients receive the right care, at the right time, in the right setting. However, one-size-fits-all site-neutral payment policies ignore fundamental functional and cost structure differences between hospitals and physician offices, among other settings, and the unique, mission-critical services communities rely on hospitals to provide.

Site-neutral payments do not take into account one simple fact: hospitals and doctors' offices are not the same. Hospitals provide critical services to entire communities, including 24/7 access to emergency care and disaster relief. They need to maintain the ability to treat complex patients who require more intense care, and therefore require a different payment structure. Hospital-affiliated sites offer patients more integrated care across health care settings, services for which hospitals need to be properly reimbursed to maintain coordinated, high-quality care for patients.

Increasingly, care is shifting from the inpatient to outpatient settings, meaning that patients now seen in hospital outpatient departments may require a higher level of care than traditionally offered in a physician's office. Reimbursement for outpatient services provided in a hospital outpatient department should reflect the higher overhead costs associated with providing care in that setting. Additionally, regulatory requirements such as the Emergency Medical Treatment and Labor Act (EMTALA), hospital Conditions of Participation, hospital state licensure, and complex cost reports impose substantial resource and cost burdens that physician offices and ambulatory surgical centers do not have and therefore are not reflected in their payments.

On March 27, 2023, the AHA released a study that found that hospital outpatient departments treat underserved populations and sicker, more complex patients than other ambulatory care sites.[6] The study indicates that relative to patients seen in independent physician offices and ambulatory surgical centers, Medicare patients seen in hospital outpatient departments tend to be:

- Lower-income;
- Non-white;
- Eligible for Medicare based on disability and/or end-stage renal disease
- More severe comorbidities or complications;

[6] "Comparison of Medicare Beneficiary Characteristics Between Hospital Outpatient Departments and Other Ambulatory Care Settings"; prepared for the American Hospital Association, located at: https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristics-report

- Dually-eligible for Medicare and Medicaid; and
- Previously seen in an emergency department or hospital setting.[7]

As seen in this recent study, site-neutral payment policies fail to distinguish between types of patients hospitals serve when compared to other providers as well as the difference in level of care. Therefore, the one-size-fits-all site-neutral policies put the most vulnerable patients' access to care at risk.

Stop Insurer and Medicare Advantage Unfair Practices

The FAH is increasingly concerned by the alarming practices of Medicare Advantage (MA) and other insurance plans that harm patients by eroding access to and affordability of medically necessary care, and also require hospitals and caregivers to divert precious resources and time to respond to these tactics. These actions include excessive use of prior authorization, inadequate provider networks, extended observation care, retroactive reclassification of patient status (i.e., inpatient versus observation), and aggressive and arbitrary pre- and post-payment denial policies.

Some of these concerns were included in a recent HHS OIG Report[8] showing that MA organizations (MAOs) systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees. The OIG Report also identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from MA enrollees, as previously discussed. Specifically:

- *Improper prior authorization denials*. The OIG found that thirteen percent (13%) of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation*. The OIG found that in many cases beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials*. The OIG found that eighteen percent (18%) of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (*i.e.*, inpatient versus observation), improperly down code claims, and deploy

[7] See study results - https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristics-report

[8] Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General ("OIG"), OEI-09-18-00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

inappropriate pre- and post-payment denial policies, and even deny claims for previously authorized services.

CMS recently acknowledged many of these concerns in two recently proposed regulations[9] that would constrain some of the bad behaviors MA plans employ related to prior authorization and non-coverage of items and services that would be covered for beneficiaries covered under the traditional Medicare fee-for-service program.

As the Subcommittee explores ways to improve health care costs and delivery, we urge you to investigate these practices and, at a minimum, exercise oversight authority to help ensure MA behaviors that protect patients through, for example, prior authorization reforms, comprehensive provider networks, and requiring MA plans to follow traditional Medicare's two-midnight rule for patient admissions.

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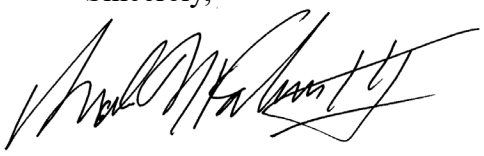
The FAH appreciates the opportunity to offer these insights. We are committed to working with Congress and the Subcommittee to ensure the availability of affordable, accessible care to all Americans. Our goal is to build on what's working in America – starting with the strength of the employer-provided health coverage that millions of Americans rely on today, rather than government-run plans such as a public option or dismantling our current pluralistic system and replacing it with a one-size-fits-all government-controlled single payer system. We look forward to working with the Subcommittee to meet the significant challenges that hospitals face in treating patients and will be a resource as the Subcommittee examines access-promoting solutions. Our focus is providing access to quality care and we look forward to working with you to ensure this outcome.

If you have any questions or would like to discuss them further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,



[9] *See* https://www.cms.gov/newsroom/press-releases/cms-proposes-rule-expand-access-health-information-and-improve-prior-authorization-process.