



Charles N. Kahn III
President and CEO

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

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

Dear Chairman Guthrie and Ranking Member Eshoo,

The Federation of American Hospitals (FAH) submits the following Statement for the Record in advance of the House Energy and Commerce Health Subcommittee's hearing on "*Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care.*" The FAH is deeply concerned with several legislative proposals being considered and how their enactment would ultimately amount to significant cuts to Medicare and thereby patient access to 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.

We welcome the opportunity to work with the Energy and Commerce Committee to find solutions that will reduce health care costs without compromising access to care for patients, and we appreciate the opportunity to provide input on these key issues. This statement reflects our initial reactions to the legislative proposals and discussion drafts as released. We look forward to a continued dialogue with the Committee after the hearing.

Legislative Proposals Under Consideration by the E&C Health Subcommittee:

Eliminating the Current Ban on Self-Referral to Physician-Owned Hospitals (POH): *The FAH Strongly Opposes H.R. 977, The Patient Access to Higher Quality Health Care Act of 2023*

To help achieve the important goal of lowering health care costs, it is important that Congress continue to reject efforts by those who 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. The standing policy includes more than a decade of work by Congress, involving numerous hearings, as well as analyses by the Department of Health and Human Services (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 last month¹, 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. Specifically, the new study shows that:

- POHs cherry-pick patients by avoiding Medicaid beneficiaries and uninsured patients;
- POHs treat fewer medically complex cases;
- POHs enjoy patient care margins 15 times those of community hospitals;
- POHs provide fewer emergency services—an essential community benefit; and
- POHs, despite their claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.

¹ Dobson | DaVanzo Study: https://www.fah.org/wp-content/uploads/2023/03/2023-Fact-Sheet_20230323_wAppendixandCharts_POH-vs.-NonPOH-Only.pdf

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.

CMS itself recently proposed to reimpose “program integrity restrictions” on POH expansion criteria to guard against “a significant risk of program or patient abuse,” and to “protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking.”²

Thus, maintaining 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 expanding the very behaviors that Congress successfully has deterred for more than a decade.³

Cutting Medicare Through Site-Neutral Payment Cuts: *The FAH Strongly Opposes Site-Neutral Payment Cut Legislative Proposals*

The FAH strongly opposes the three Site-Neutral Payment Policy proposals that would reduce hospital-based outpatient department (HOPD) payments in a non-budget-neutral manner.

Site-neutral payments do not consider 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 high acuity 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.⁴

Increasingly, care is shifting from the inpatient to outpatient settings, meaning that patients now seen in HOPDs may require a higher level of care than traditionally offered – or even available – in a physician’s office.

A recently released study from the American Hospital Association (AHA) backs up this fact.⁵ Researchers found that HOPDs treat more underserved populations and sicker, more complex patients than other ambulatory care sites. 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;

² FAH Blog on POH. April 24, 2023: <https://www.fah.org/blog/physician-owned-hospitals-are-bad-for-patients-and-communities/>

³ FAH Blog on POH: March 28, 2023. <https://www.fah.org/blog/new-analysis-reaffirms-need-to-maintain-current-law-banning-self-referral-to-physician-owned-hospitals/?swcfpc=1>

⁴ FAH Blog on Site Neutral: April 23, 2023. <https://www.fah.org/blog/stronguwhats-in-a-name-because-there-is-nothing-neutral-about-site-neutral-policyustrong/>

⁵ AHA Report: <https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristics-report>

- Eligible for Medicare based on disability and/or end-stage renal disease;
- More severe comorbidities or complications;
- Dually-eligible for Medicare and Medicaid; and
- Previously seen in an emergency department or hospital setting.

It is vital that reimbursement for outpatient services provided in a HOPD reflects 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.

Eliminating Medicaid DSH Cuts: *The FAH Strongly Supports H.R. 2665, The Supporting Safety Net Hospitals Act*

The FAH appreciates the inclusion of *H.R. 2665, The Supporting Safety Net Hospitals Act*, which eliminates the scheduled Medicaid DSH cuts for 2024 and 2025. Medicaid patients need to know hospitals will be there when they need care. This legislation is vital for ensuring access to quality care for our most vulnerable patients and safeguarding the essential hospitals that serve them.

Increasing Transparency of Medicare Part C and D Plans: *The FAH Supports Proposals to Increase Transparency of Health Plan Prior Authorization Practices that Delay and Deny Needed Patient Care*

The FAH appreciates the Committee's efforts to highlight the importance of transparency in Medicare Advantage (MA) plan practices that can limit and deny patient care. We have raised serious concerns about prior authorization practices of MA plans and how they systemically apply problematic operating policies, procedures and protocols that limit care to Medicare beneficiaries and prevent them from receiving the same services they would under traditional Medicare fee-for-service.

MA practices can become a health risk for patients if inefficiencies in the process cause care to be delayed, create significant burdens and costs on hospitals and providers, and can be a major source of burnout for health caregivers. In particular, our members experience difficulty determining payer-specific requirements for items and services that require prior authorization; inefficient use of provider and staff time processing prior authorization requests and information (sending and receiving) through fax, telephone, and web portals; and unpredictable wait times to receive payer decisions. In short, prior authorization is a burdensome process that diverts provider resources away from patient care, increases health care costs, and, at worst, may prompt patients to delay or forego needed care.

We believe that publicly available data reported to CMS would aid interested providers and patients to generally understand payer performance with respect to prior authorization processes for decisions, approvals, denials, and appeals. This data could be used to create

understandable quality metrics, as proposed by the FAH, and help Medicare beneficiaries select MA plans not just based on cost, but on whether MA plan practices delay or even deny needed patient care.

Hospital Price Transparency Compliance: *The FAH Appreciates the Committee's Efforts in Highlighting the Importance of Price Transparency*

The FAH appreciates the Committee's efforts in highlighting the importance of price transparency, especially focusing on all stakeholders in the health care industry. 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 CMS Hospital Price Transparency Rule and are supportive of the Committee's efforts to highlight the importance of patients knowing how much their care will cost before they receive it.

It has been falsely reported by some based on questionable reviews that hospitals are avoiding complying, sometimes intentionally, with the Hospital Price Transparency Rule. The truth is that in early 2023, 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 2022.⁶ 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 challenging requirements.

Turquoise Health – whose Co-Founder & Chief Executive Officer Chris Severn provided testimony at the Subcommittee's March 28th hearing – recently released a new state-of-the-industry report outlining major strides in price transparency in the health care sector.

Nearly 5,400 hospitals, or 84% of the roughly 6,400 applicable hospitals, have posted a machine-readable file with pricing data as of the end of Q1 2023, according to Turquoise Health.⁷ Those numbers are up from the company's fall numbers, which listed about 4,900 (76%) hospitals with a machine-readable file, nearly 4,200 (65%) with negotiated rates and almost 4,100 (63%) with cash rates.

⁶ "Hospital Price Transparency: Progress And Commitment To Achieving Its Potential", Health Affairs Forefront, February 14, 2023. <https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential>

⁷ Turquoise Health: Price Transparency Impact Report Q1 of 2023: https://s3.amazonaws.com/turquoise-app.user-uploads/impact_reports/Turquoise_Health_Impact_Report_Q1_2023.pdf?AWSAccessKeyId=AKIAQZA EKZBJGI FVBXVJ&Signature=ChpNNgBt07xjECtH%2F2YksOKg15U%3D&Expires=1682194899

Thus, hospitals and health systems remain committed to working with CMS to implement these policies and deliver reliable and usable pricing information to patients.

Phase-out of the Medicare Inpatient-Only (IPO) List: *The FAH Supports Current Approach by CMS to Evaluate Services to Include on Medicare's IPO List to Ensure Medicare Beneficiary Care is Safe and Effective*

The FAH opposes proposals to arbitrarily eliminate the IPO list or procedures on the IPO list, which designates those procedures that are not payable under the OPSS because they can only be appropriately provided on an inpatient basis. The assignment of procedures to the IPO list considers key clinical considerations that preclude the procedure from being provided to Medicare beneficiaries on an outpatient basis: (1) the invasive nature of the procedure, (2) the need for postoperative care, and (3) the underlying physical condition of the patient who would require the surgery. The IPO list serves as an important programmatic safeguard, ensuring that Medicare beneficiaries undergoing any of the 1,740 procedures on the IPO list receive inpatient care and monitoring, and its proposed elimination without any supporting clinical analysis arbitrarily removes an important patient safety mechanism. In addition, eliminating the list imposes administrative burdens on physicians and hospitals, increases beneficiaries' financial burden, and erodes the value of Part A coverage.

Instead, the FAH strongly supports the case-by-case evaluation by CMS of procedures against longstanding clinical criteria for removal.

The FAH is committed to working with Congress to ensure the availability of affordable, accessible health care for all Americans. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

