Charles N. Kahn III
President and CEO

September 18, 2023

The Honorable Bernie Sanders
332 Dirksen Senate Office Building
Washington DC 20510

The Honorable Bill Cassidy
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ed Markey
255 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Roger Marshall
479 Russell Senate Office Building
Washington, D.C. 20515

Dear Chairman Sanders, Ranking Member Cassidy, Senator Markey, and Senator Marshall:

On behalf of the Federation of American Hospitals (FAH), we appreciate your Committees' focus on addressing Community Health Center funding and health care workforce shortages. However, the FAH opposes policy proposals that threaten patient access to hospital care. We urge Committee leaders to work together to reauthorize funding for expiring health care programs, while also ensuring continued access to critical health care services provided by hospitals in our communities. We offer the following comments on the *Primary Care and Health Workforce Act*.

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.

Section 205 – Nurse Education Practice, Quality, and Retention Program

We applaud the Committee for including robust funding toward nurse education and retention programs; however, the lack of parity for nursing colleges is problematic. Congress should incentivize nurses to practice in rural and underserved communities without limiting the clinician's choice to serve in a tax-paying health facility.

Taxpaying institutions with high quality education and training programs play a critical role in addressing the acute nursing shortage. These institutions are reaching a wide array of students committed to the profession, thereby significantly increasing the number of prepared and qualified nurses entering the profession in high need areas.

Unfortunately, many federal investments focused on the nursing workforce are unnecessarily limited to community colleges and non-profit institutions. This diminishes the positive impact those investments could have on stemming the nursing workforce shortage.

To truly address the nursing workforce shortage, programs like those in sections 205, 206 and 207 of the *Primary Care and Health Workforce Act*, should be expanded to all accredited nursing programs and eliminate the unnecessary tax status-based distinction.

Section 301 - Banning Anticompetitive Terms in Facility and Insurance Contracts That Limit Access to Higher Quality, Lower Cost Care

The FAH urges the Committee to remove Section 301 as it is both unnecessary and a significant and unprecedented government intrusion into private negotiations and contracts. This provision incorrectly presupposes that certain terms in contracts are anticompetitive and detrimental to consumers.

This provision is also particularly concerning in light of the *No Surprises Act* (NSA), which the FAH supports because it protects patients from surprise out-of-network medical bills. Yet, health insurance plans have exploited key provisions under the NSA by further narrowing their networks, refusing to contract with health care providers and instead paying those providers the out-of-network rate as determined under the NSA.

The concerns that Section 301 is trying to address – predatory business practices and anticompetitive practices – are already more than adequately covered by existing law, namely antitrust laws. These laws protect consumers from contracts that favor an entity over the consumer and the Department of Justice (DOJ) and the Federal Trade Commission (FTC) already have the authorities and resources to investigate and pursue such arrangements. Insurance plan and health care provider negotiations are the basis for insurance networks and those negotiations must be permitted to continue to ensure that plans and providers can determine the scope and the pricing of the contracts, including volume-based discounts. For example, narrowing the scope of these contracts would require constant negotiations between health plans and hospitals and health systems for each provider type in each specific locale – an expensive, arduous, and unnecessary process.

The FAH is concerned about the "additional requirement for self-insured plans" contained in Section 301. This provision could enable self-insured group health plans (i.e., employers) to avoid financial responsibility for services provided to their enrollees/employees and for which the employer's third-party administrator (TPA) negotiated a contract. If a TPA is representing the interests of a self-insured group health plan, then the group health plan/employer should be bound by the terms of any contract between that TPA and a health care provider. To do otherwise would unfairly penalize health care providers who negotiated in good faith.

Given the significant concerns raised regarding Section 301, the FAH urges its removal. Instead, the Committee should permit the market to work and recognize the current and appropriate DOJ and FTC authorities to investigate and pursue arrangements in which an entity inappropriately uses its market power in a way the negatively impacts consumers.

<u>Section 302 – Requiring a Separate Identification Number and Attestation for Each Off-Campus Outpatient Department of a Provider</u>

Requiring off-campus hospital outpatient departments to bill under a separate National Provider Identifier imposes duplicative and unnecessary regulatory burden on hospital off campus outpatient departments who already report this information to CMS. **We urge Congress to utilize this information reported to CMS instead of imposing a new layer of regulatory requirements on already burdened providers.**

<u>Section 303 – Banning Facility Fees for Certain Services</u>

Section 303's approach to banning facility fees for outpatient services provided by hospitals would fundamentally alter and significantly harm the health care infrastructure for the hospital services that patients want and need.

Section 303 appears to assume that all outpatient services are the same and that there is never a need for a facility fee to cover the costs for any type of outpatient provider. However, one-size-fits-all policy such as this ignores 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.

Section 303 fails to account for 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.[1] 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:

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[1] "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

- Lower-income;
- Non-white;
- 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.

As seen in this recent study, a policy that does not allow a hospital facility fee for the evaluation and management services provided to hospital patients fails to distinguish between types of patients that hospitals serve when compared to other providers – as well as the difference in level of care.

Additionally, Section 303 would not allow for a facility fee related to telehealth services. Telehealth was one of the silver linings to emerge from the COVID-19 pandemic. Telehealth allows timely access to patient-centered care, enhances patient choice, and most importantly, improves access to care in rural areas where many patients travel over an hour for a routine doctor's appointment, and often much further to seek specialty care. Telemedicine eliminates this geographic barrier and greatly lowers the bar for accessing quality care.

Telehealth enables hospitals to meet patients literally where they are, allowing for more tailored treatment. This is especially important, given that labor often accounts for hospitals largest cost center. In many cases, particularly in rural areas where it is difficult to recruit physicians and other highly trained staff, telehealth and other technologies can help make up for any staffing shortfalls or staff burnout.

For hospitals and providers to be able to continue delivering improved patient care through telehealth and other virtual services, they need adequate reimbursement for the substantial upfront and ongoing costs of establishing and maintaining their virtual infrastructure, including secure platforms, licenses, IT support, scheduling, patient education and clinician training. Without adequate reimbursement of these costs, providers may be forced to decrease their telehealth offerings, thus returning many patients to the previous system of unequal access to care. Adequate reimbursement through a facility fee for virtual services also is key to ensuring providers have the means to invest in HIPAA-compliant technologies and to deliver these services with high quality of care. There are, in fact, significantly more actions that hospital staff and providers must take to execute a virtual visit than they do for an in-person visit. For example, before the visit takes place, the hospital must first equip providers with the hardware they need, such as laptops and webcams, and acquire professional licenses for the virtual platform they choose to use.

Section 303 would jeopardize access to telehealth and other essential health care services, particularly for patients in rural and underserved areas. Instead of creating barriers and disincentives around telehealth utilization, we urge the Committee to instead work toward policy that promotes and encourages telehealth innovation and ensures continued access to health care in our communities.

The FAH opposes Section 303 and urges the Committee to remove it from the bill.

We look forward to working with you and your colleagues in Congress to protect patients' access to affordable health care services. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

cc: Members, Senate Committee on Health, Education, Labor, and Pensions