Federation of American Hospitals®

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The Honorable Jodey Arrington
1107 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

The Honorable Michael C. Burgess, M.D.
2161 Rayburn House Office Building
United States House of Representatives
Washington, D.C. 20515

Submitted Via Email to: hbcr.health@mail.house.gov

Dear Chairman Arrington and Representative Burgess,

On behalf of the Federation of American Hospitals (FAH), we appreciate the Committee's focus on examining key drivers of our nations' health care spending and commitment to finding solutions to improve health outcomes while lowering health care costs. We are pleased to provide the following comments in response to the Task Force's request for information and look forward to working with the Committee on solutions to improve our nation's health care system.

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.

To help further the Committee's goal of improving health outcomes while lowering health care costs, the Federation of American Hospitals offers the following recommendations.

Regulatory, Statutory, or Implementation Barriers That Could Be Addressed to Reduce Health Care Spending

The FAH urges policymakers to pass legislation that reduces barriers to telehealth, addresses workforce shortages, maintains the existing ban on physician-owned hospitals, and encourages responsible use of artificial intelligence. We believe important changes in these critical areas will increase access to care and reduce health care spending.

Increase Access to Telehealth

One of the silver linings to emerge from the COVID-19 pandemic is the increase in health care services provided via telehealth. Telehealth allows timely access to patient-centered care, enhances patient choice. Particularly in rural and underserved communities 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 drastically lowers the bar for accessing quality care.

Telehealth enables hospitals to meet patients literally where they are, allowing for more tailored treatment. In many cases, particularly in rural areas where it is difficult to recruit physicians and other highly trained staff, telehealth and other remote technologies can help make up for any staffing shortfalls or staff burnout. We thank Congress for extending the pandemic era telehealth provisions through 2024 in the *Consolidated Appropriations Act, 2023*. We urge lawmakers to build on this progress and make permanent pandemic-era Medicare telehealth provisions to improve health outcomes by giving patients better access to the care they need. Unfortunately, we understand that commercial health insurance companies have begun to eliminate access to lifesaving virtual care including behavioral care, alcohol and drug treatment services, and audio-only care for services for psychotherapy and counseling, as reported widely in the press. We urge Congress to exercise oversight over these and other insurer practices that limit patient access to care and to take appropriate action to help curb behaviors that limit, delay, or deny medically necessary care.

Invest in the Health Care Workforce

Perhaps the greatest challenge facing hospitals today is maintaining an adequate workforce. Hospitals in rural and underserved communities are experiencing a combination of provider burnout, physician and staffing shortages, and difficulty attracting workers to these areas – all factors causing significant strain on hospital operations.

Hospitals are investing in the recruitment, training, and upskilling of employees. Investments in schools of nursing are contributing to private sector solutions by making high quality programs available to those seeking to enter the profession. However, ensuring that barriers to learning are addressed, creating incentives to attract nursing students, encourage nurses to remain in the workforce or return from retirement, could be significant for the nursing workforce of tomorrow. Unfortunately, many federal investments focused on the nursing

workforce are limited to community colleges and non-profit institutions. We urge lawmakers to extend these investments to all accredited nursing programs.

Hospitals are also investing heavily in both training and patient care management innovation to improve the bandwidth of registered nurses and reduce nurse workload burden. Allowing nurses to reduce paperwork and non-clinical responsibilities through technology and process enhancements would have the added benefit of reducing burnout. Medicare Advantage (MA) prior authorization processes, for example, cause increased administrative burden for clinicians. Recent polling found that nearly nine in ten nurses reported insurer-required administrative burdens have negatively impacted patient clinical outcomes, and nearly three-fourths reported an increase in administrative tasks over the last five years.[1]

Another pathway for new workers in the health care sector is legal immigration from foreign countries. The downstream impact of reduced net legal immigration in recent years due to both policy and pandemic factors has created enormous gaps in "unskilled" employment areas, increasing labor costs for struggling hospitals. There are an estimated two million fewer working-age legal immigrants in the US than there would have been if pre-pandemic levels were maintained.[2]

Federal legislative action is essential to help hospitals maintain a strong workforce, including:

- *The Conrad State 30 and Physician Access Reauthorization Act* (H.R. 4942) to improve and extend the existing program that allows international physicians trained in America to remain in the country if they practice in underserved areas.
- *The Healthcare Workforce Resilience Act* to recapture 25,000 unused immigrant visas for nurses and 15,000 unused immigrant visas for physicians that Congress has previously authorized and allocate those visas to international physicians and nurses.

We urge lawmakers to work with the Administration to address visa backlogs and "visa retrogression." There are currently thousands of fully qualified foreign trained doctors and nurses who have been approved for US green cards but who are not in the US because of "visa retrogression," causing applicants to wait for a visa to become available due to the EB-3 visa category being oversubscribed. In addition to immigration reform solutions, other actions include eliminating State Department bureaucratic delays and inefficiencies in immigration to allow foreign-trained qualified physicians and nurses to come to the US to fill vacancies unfilled by US workers.

[1] *Costs of Caring - The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise.* (2023, April). American Hospital Association. https://www.aha.org/costsofcaring

[2] Sasso, M. & Bloomberg News. (2023, February 24). Where are the Workers: Labor Market Millions Short Post-Pandemic. *Governing*. https://www.governing.com/work/where-are-the-workers-labor-market-millions-short-post-pandemic

Lastly, we urge lawmakers to enhance investments in provider loan repayment programs, including the Nurse Corps, to incentivize providing care in rural and underserved communities without limits to the clinician's choice to serve in a tax-paying health facility.

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

To help achieve the important goal of preserving health care access, it is important that Congress continue to reject efforts to weaken the existing 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. It is for this reason the FAH strongly opposes *The Patient Access to Higher Quality Health Care Act of 2023* (H.R. 977).

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 the conflicts of interest inherent in these hospital ownership arrangements 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), Government Accountability Office (GAO), and Medicare Payment Advisory Commission (MedPAC).

In 2010, Congress acted to protect the Medicare and Medicaid programs and taxpayers that fund them by imposing a prospective ban on self-referral to new POHs. The FAH strongly believes that the foundation for current POH law must not be weakened. The law helps ensure that full-service community hospitals, especially those in rural communities, can continue to meet their mission to provide quality care to patients. Recently released data from the health care consulting firm Dobson | DaVanzo 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;
- Treat fewer medically complex cases;
- Enjoy patient care margins 15 times those of community hospitals;
- Provide fewer emergency services—an essential community benefit; and,
- Despite POH claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.[3]

The new data reinforces many of the findings of earlier studies by 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 reimposed "program integrity restrictions" on POH expansion criteria to guard against "a significant risk of program or patient abuse," and to

[3] Dobson | DaVanzo Study. (2023). https://www.fah.org/wp-content/uploads/2023/03/2023 FactSheetwAppendixandCharts_POH-vs.-NonPOH-Only.pdf.

"protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking."[4]

While POHs create unfair competition across all communities in which they operate, opening the door to POHs in rural communities specifically would undermine the delicate health care infrastructure, patient mix, and patient volume that rural hospitals rely on to keep their doors open. Thus, maintaining current law is key to ensuring that hospitals can continue 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 has successfully deterred for more than a decade.[5]

Encourage Responsible Use of Artificial Intelligence (AI) Tools to Improve Health Care

While it is critical for developers and end users of AI to take steps that safeguard patients and promote privacy of health data, the responsible use of this technology can improve health care and address long-standing systemic issues. For example, the administrative burden on health care providers and clinicians has been a significant impediment to improving efficiency in health care delivery. Physicians and nurses often spend between 30-50 percent of their time on documentation, payer authorization processes, and other administrative processes. Generative AI, in particular, is capable of becoming a tool to assist in documentation, searching for and summarizing patient information, generating communication (e.g., with payers) and supporting communication with patients and families. These use cases are lower risk (i.e., they do not rely on the AI to directly answer clinical questions or support diagnosis or treatment) but high value in the form of returning time to the care teams so they can focus on patients, critical decision making, and improving the quality of care delivered.

As Congress considers approaches for regulating AI, we urge you and your colleagues to recognize that the health care sector has an existing set of risk management frameworks. To be most successful at realizing the promise of AI and protecting against negative outcomes, the health care sector will need tools, standards, and guidance to incorporate the use of AI-enabled tools into existing risk management structures. Any AI regulatory requirements that conflict with existing risk management processes will slow down progress in realizing the benefits of technology and could inadvertently result in less effective risk management of complex health care systems and organizations.

Congress should consider an AI framework that is risk-based and focuses on processes to ensure algorithms are transparent, auditable, ethical, fair, non-biased, and safe – as this would provide health care stakeholders with the necessary information for responsible use similar to the *Health Insurance Portability and Accountability Act* (HIPAA).

[4] Centers for Medicare and Medicaid Services. (2023). Proposed Inpatient Prospective Payment System and Policy Changes. Retrieved from https://www.govinfo.gov/content/pkg/FR-2023-05-01/pdf/2023-07389.pdf

[5] FAH Blog on POH. (2023). https://www.fah.org/blog/new-analysis-reaffirms-need-to-maintain-currentlaw-banning-self-referral-to-physician-owned-hospitals/?swcfpc=1.

Recommendations to Reduce Improper Payments in Federal Health Care Programs

The FAH is increasingly concerned by the alarming practices of 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 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 13 percent 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 18 percent of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.[6]

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 MAO abuses including:

- Abuse of prior authorization requirements.
- Failure to maintain inadequate provider networks.
- Improper use of extended observation care.
- Retroactive reclassification of patient status (i.e., inpatient versus observation).
- Improper downcoding of claims.
- Inappropriate use of pre- and post-payment denial policies.
- Denial of previously authorized services.

CMS recently acknowledged many of these concerns in two proposed regulations 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.

[6] HHS-OIG. (2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. In *HHS-OIG* (OEI-09-18-00260). https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

As the health care task force explores ways to reduce improper payments in federal health care programs, we urge you to investigate these practices and exercise oversight authority to protect MA beneficiaries and reduce waste and abuse of taxpayer dollars. We also urge the task force to consider reforms to ensure comprehensive provider networks and to require MA plans to follow traditional Medicare's "two midnights" rule for patient admissions. Finally, the FAH strongly urges lawmakers to pass the *Improving Seniors Timely Access to Care Act* (H.R. 3173).

Thank you for taking our comments under consideration as you consider solutions to improve access to health care and reduce health care spending. 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,