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Statement

of the

American Hospital Association

for the

Committee on Health, Education, Labor and Pensions

of the

U.S. Senate

"Reducing Health Care Costs:

Eliminating Excess Health Care Spending and Improving Quality and Value for Patients"

July 17, 2018

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and the 43,000 individuals who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on understanding the cost of health care in America, how to ensure patients receive value and high-quality care, and strategies to address those costs.

The cost – and affordability – of health care in America affects stakeholders from across the community, including patients and their families, employers, policymakers, and providers of care. Hospitals and health systems understand the importance of this issue, and of ensuring access to affordable health care.

Although the rate of growth in health expenditures has slowed in recent years, in 2016, health spending accounted for 17.9 percent of Gross Domestic Product (GDP) and is projected to reach 20 percent of GDP by 2025. Hospitals' share of total health expenditures has gradually decreased over time, however. As a percentage of total national health expenditures, hospital care declined from 42.7 percent in 1980 to 34 percent in 2016. By comparison, during the same period, retail

prescription drug spending, which does not include drugs administered in institutional settings, doubled as a share of total national health expenditures.[1]

The cost of providing hospital care is subject to a number of inputs, such as the cost of prescription drugs, new technologies, and labor expenses. For instance, a study commissioned by the AHA and the Federation of American Hospitals (FAH) found that, while retail spending on prescription drugs (what consumers pay) increased by 10.6 percent between 2013 and 2015, hospital spending on drugs in the inpatient space rose 38.7 percent per admission. Unsurprisingly, our study found that more than 90 percent of hospital administrators said that drug spending had a moderate to severe impact on their budgets. Price increases for specific products necessary for patient treatment can be even more dramatic. For example, the price that hospitals paid for Nitropress, a drug used to lower blood pressure, increased 672 percent between 2013 and 2015.[2]

Hospitals and health systems also face challenges related to the high number of regulatory requirements, which increase administrative expenses and staffing needs for compliance. Nationally, it is estimated that hospitals, health systems, and post-acute care providers spend nearly $39 billion annually on the administrative aspects of regulatory compliance. An average-sized community hospital spends $7.6 million per year, or $1,200 per admission, to support compliance with regulations from just four federal agencies.[3] Compounding the burden associated with this patchwork of federal regulatory requirements, hospitals also must contract with more than 1,300 commercial insurers nationally, each with their own reporting and administrative requirements.

Despite rising input costs, hospital price growth as measured by the Bureau of Labor Statistics Producer Price Index, has remained under 2 percent for each of the last four years. From 2008 to 2017, hospital prices had an average annual growth rate of 2 percent.[4] In comparison, the overall price of medical care had an average annual growth rate of 3 percent,[5] while drug prices had an average annual growth rate of 5.6 percent for that same time period.[6]

America's hospitals and health systems also continue to provide a significant amount of uncompensated care. In 2016 alone, hospitals provided $38.3 billion in uncompensated care – up more than $2 billion from 2015.[7] Increasingly, uncompensated care is driven not just by the uninsured but also by individuals who have insurance but cannot meet their high deductibles and other cost-sharing requirements. Moreover, this amount does not include the resources hospitals

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[1] National Health Expenditure Data, 1980-2016. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

[2] "Trends in Hospital Inpatient Drug Costs: Issues and Challenges," NORC at the University of Chicago for the AHA and the Federation of American Hospitals, October 11, 2016.

[3] "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers," Manatt for the American Hospital Association, October 2017.

[4] Bureau of Labor Statistics (BLS), Producer Price Index (PPI), Series ID PCU622622, 2008-2017

[5] BLS, Consumer Price Index, Series ID: CUUS0000SAM, 2008-2017

[6] BLS, PPI, Series ID: PCU32543254, 2008-2017

[7] AHA Uncompensated Care Fact Sheet, December 2007

spend on services and programs to meet community needs to positively impact health such as help in accessing healthy food and transportation assistance to ensure patients arrive at medical appointments safely.

SITE-NEUTRAL PAYMENT EXPERIENCE AND PROBLEMS

So-called site-neutral payment policies would pay the same amounts for services, regardless of the site of care. Site-neutral payment was implemented via Section 603 of the Bipartisan Budget Act of 2015, which requires that, with the exception of emergency department (ED) services, services furnished in off-campus provider-based departments (PBDs) that began billing under the outpatient prospective payment system (OPPS) on or after Nov. 2, 2015 (referred to as "non-excepted services") are no longer paid under the OPPS. Instead, these services are covered and paid under "another applicable Part B payment system."

For calendar year (CY) 2017, the Centers for Medicare & Medicaid Services (CMS) finalized the physician fee schedule (PFS) as the applicable Part B payment system and set payment for most non-excepted services at 50 percent of the OPPS rate. For CY 2018, CMS further reduced the site-neutral payment rates – to 40 percent of the OPPS rate. The agency estimated that this change will save Medicare Part B $12 million in 2018. CMS did not make any other changes to its site-neutral policy in CY 2018, including to its problematic policy that the relocation of an existing (referred to as "excepted") PBD would result in it losing its excepted status and being paid at the site-neutral rate, except in extraordinary circumstances.

The AHA supports the continued use of CMS's current methodology to determine site-neutral payment rates in future years. This methodology bases payment rates for non-excepted services on a comparison of outpatient and physician rates for the most frequently billed services in off-campus PBDs. However, we urge CMS to improve the accuracy of this methodology by accounting for differences in packaging between the outpatient and physician payment systems. Based on an updated AHA analysis, this improved methodology would have resulted in a payment rate of 65 percent of the OPPS payment for non-excepted services in 2018.

Further, we remain concerned that CMS's short-sighted policies on the relocation of excepted off-campus PBDs prevent communities from having access to the most current services. We continue to urge CMS to provide payments that are adequate to cover the costs of providing care so that hospitals and health systems can continue to serve as the access point for community care.

Hospitals already suffer negative margins treating Medicare patients in PBDs. According to the fiscal year 2016 Medicare cost report data, Medicare margins for outpatient services were a record low of negative 14.8 percent in 2016. Overall Medicare margins were a record low of negative 9.6 percent in 2016, with a new record low of negative 11.0 percent projected for 2018.3 Of note, even "efficient" hospitals had a negative margin in 2016, for the first time ever. Additional cuts to PBDs threaten beneficiary access to these services.

Medicare payment rates for non-excepted services should explicitly account for differences in packaging of costs between the OPPS and the PFS. There are greater packaging of costs under the OPPS compared to the PFS. Therefore, one cannot make a direct comparison of rates for similar services in PBDs and freestanding physician office settings without first accounting for the additional packaging included in OPPS payments.

Hospital-based clinics provide services that are not otherwise available in the community for vulnerable patient populations. The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and underserved populations. For example, relative to patients seen in physician offices, patients seen in PBDs are:

– 2.5 times more likely to be Medicaid, self-pay or charity patients;

– 1.8 times more likely to be dually eligible for Medicare and Medicaid;

– 1.8 times more likely to live in high-poverty areas;

– 1.7 times more likely to live in low-income areas;

– 1.7 times more likely to be Black or Hispanic; and

– 2 times more likely to receive care from a nurse in addition to a physician.

Patients who are too sick for physician offices or too medically complex for ambulatory surgery centers (ASCs) are treated in the PBD. Physicians refer more complex patients to PBDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, PBDs treat patients who are suffering from more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and EDs.

PBDs have more comprehensive licensing, accreditation and regulatory requirements than do freestanding physician offices and ASCs. These higher costs created by government regulation drive up costs significantly.

Site-neutral payment policies endanger hospitals' ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response. Hospitals have a higher cost structure than freestanding physician offices due, in part, to the costs of stand-by capability and capacity that they bear. CMS's site-neutral policy reimburses non-excepted PBDs less for services while still expecting them to continue to provide the same level of service to their patients and communities. Hospitals are the only health care provider that must maintain emergency stand-by capability 24 hours a day, 365 days a year. This stand-by role is built into the cost structure of hospitals and supported by revenue from direct patient care – a situation that does not exist for any other type of provider. Following a year in which the nation experienced record-setting natural disasters, and with projections for an increase in the severity and frequency of extreme weather events, we must do everything we can to ensure that hospitals have the resources needed to prepare for and respond to future disasters.

Payment should reflect PBDs costs, not physician or ASC payments. PBD payment rates are based on hospital cost report and claims data. In contrast, the PFS (and specifically the practice expense component) is based on physician survey data. ASCs do not report costs.

EMBRACING VALUE AND ADDRESSING AFFORDABILITY

In spite of these cost pressures and trends, America's hospitals and health systems are fully committed to and engaged in the ongoing transformation of health care from a volume-based to a value-based care system. For instance, from 2011 to 2016, the number of hospitals that reported participating in bundled payment arrangements increased by 189 percent, and those reporting participation in an accountable care organization (ACO) increased by 492 percent.[8]

At the same time, hospitals and health systems have made great strides in improving patient quality of care. For instance, preliminary estimates for 2015, the most recent available data, show a 21 percent decline in hospital-acquired conditions since 2010.[9] There also has been a significant decline in hospital-acquired infections, with the standardized infection ratio for central line-associated bloodstream infections (CLABSI) showing a more than 40 percent decrease between 2009 and 2014.[10]

As the national voice for hospitals and health systems, the AHA knows that it is vital that we do our part to support the transformation of care delivery to value-based care. Accordingly, we created The Value Initiative to provide leadership to the hospital field on the issue of affordability. Through The Value Initiative, the AHA provides hospital and health system leaders with the education, resources and tools they need to advance affordable health care and improve value within their communities. We also are gathering the data, information, and hospital experiences necessary to develop and support federal policy solutions that reduce health care costs, improve quality, and enhance the patient experience. In addition, The Value Initiative will serve as a platform for hospitals and health systems to engage in dialogue and foster change on this important issue with key stakeholders, policymakers, think tanks, and advocacy groups.

The Value Initiative specifically focuses on four areas where we believe improvements can be made without compromising access or quality. These are also areas in which many hospitals and health systems already are making progress. Hospitals and health systems are redesigning the delivery system to cut costs and improve patient and community health. They are improving quality and outcomes of care. They are delivering high-value care for patients by embracing risk and new reimbursement models. And they are implementing operational solutions to reduce costs.

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[8] AHA Annual Survey Data, 2011-2016

[9] National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data From National Efforts To Make Health Care Safer. Content last reviewed December 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html

[10] Chartbook on Patient Safety. Content last reviewed September 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/chartbooks/patientsafety/index.html

REDUCING THE COST OF CARE

In addressing this critical issue of the cost of health care, it is important to first understand the underlying drivers of cost. We encourage Congress to pursue actions that will help reduce the cost of coverage without putting access to care at risk, including:

1. Addressing the underlying drivers of high costs, such as the unsustainable growth in prescription drug prices; duplicative, unnecessary and potentially harmful regulatory and administrative burden; and high rates of chronic disease; and

2. Promoting enrollment in comprehensive health care coverage to share costs across the broadest population possible, including through stabilizing the health insurance marketplaces.

CONCLUSION

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the issues concerning the cost of health care in America. We are committed to working with Congress, the Administration, and other health care stakeholders to ensure that all individuals and families have the health care coverage they need to reach their highest potential for health.