

**Statement
of the
American Hospital Association
for the
Committee on Energy and Commerce
Subcommittee on Health
of the
U.S. House of Representatives
May 17, 2023**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field’s comments on legislative proposals that are to be considered before the Energy & Commerce Health Subcommittee on May 17.

We would like to provide feedback on the following legislative proposals that are to be addressed by the Subcommittee, both as part of the amendment in the nature of a substitute (AINS) to H.R. 3281 (HEALTHMARK-SC-AINS_01_xml to H.R. 3281) as well as a freestanding bill.

MEDICAID DSH LEGISLATION

- **Delaying Certain Disproportionate Share Hospital Payment Reductions under the Medicaid Program.**

The AHA supports Section 203 of the AINS to address the Medicaid disproportionate share hospital (DSH) reductions.



Congress established the Medicaid DSH program to provide financial assistance to hospitals serving a disproportionate number of low-income patients to ensure Medicaid and uninsured patients have access to health care services. These hospitals also provide critical community services, such as trauma and burn care, maternal and child health care, high-risk neonatal care and disaster preparedness resources. The patients they serve are among those that need care the most and often experience challenges accessing it, including children, the poor, the disabled and the elderly.

Reductions to the Medicaid DSH program were enacted as part of the Affordable Care Act, with the reasoning that hospitals would have less uncompensated care as health insurance coverage increased. Under current statute, the Medicaid DSH cut is \$8 billion for each of the next four fiscal years (2024-2027, for a total of \$32 billion for all four years). Unfortunately, the projected coverage levels have not been realized and hospitals continue to care for patients for whom they are not receiving payment. Consequently, the need for the Medicaid DSH payments is still vital for the hospitals that rely on the program.

PRICE TRANSPARENCY LEGISLATION

- **Price Transparency Requirements.**

We appreciate the Subcommittee working to provide improvements in Section 101 of the AINS that is focused on hospital price transparency and we look forward to continuing to work on these efforts. The hospital field has shown its commitment to adhering to the Hospital Price Transparency Rule. The Centers for Medicare & Medicaid Services (CMS) found that in [2022](#), 70% of hospitals complied with both components of the Hospital Price Transparency Rule, including the consumer-friendly display of shoppable services information, as well as the machine-readable file requirements. 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).

MEDICARE SITE NEUTRAL LEGISLATIVE PROPOSALS

- **Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus.**

The AHA opposes Section 302 of the AINS. This provision would create additional site-neutral payment cuts over four years for the administration of drug services furnished in an off-campus provider based department. We are especially concerned that this would result in a major cut for hospital outpatient departments (HOPDs) that provide essential drug administration services, including for vulnerable cancer patients, who may require a higher level of care as they receive their essential treatments.

This legislative effort would expand existing site-neutral payment cuts, which have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries. According to the Medicare Payment Advisory Commission

(MedPAC), overall Medicare hospital margins were negative 6.3% in 2021 after accounting for temporary COVID-19 relief funds. Without these funds, the overall Medicare margin for 2021 remained depressed at negative 8.2% after hitting a staggering low of negative 12.3% in 2020. On average, Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. Moreover, overall median hospital operating margins were negative throughout 2022 and into the beginning of 2023. Site-neutral cuts have already contributed to these shortfalls and any further expansion of these policies will exacerbate this situation and threaten patients' access to quality care.

This legislation also fails to account for the fundamental differences between HOPDs and other sites of care. The cost of care delivered in hospitals and health systems takes into account the unique benefits that they provide to their communities. This includes the investments made to maintain standby capacity for natural and man-made disasters, public health emergencies and unexpected traumatic events, as well as deliver 24/7 emergency care to all who come to the hospital, regardless of ability to pay or insurance status. This standby role is built into the cost structure of hospitals and is supported by revenue from direct patient care – a situation that does not exist for any other type of provider. Expanding site-neutral cuts to HOPDs and the outpatient services they provide would endanger the critical role they play in their communities, including access to care for patients.

Additionally, hospital facilities treat patients who are sicker and have more chronic conditions than those treated in physician offices or ambulatory surgical centers. Hospitals are better equipped to handle complications and emergencies but this often requires the use of additional resources that other settings do not typically provide. Hospital facilities also must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care.

- **Requiring a Separate Identification Number and an Attestation for Each Off-Campus Outpatient Department of a Provider.**

The AHA opposes section 103 of the AINS that requires that each outpatient department of a provider be assigned a separate unique health identifier from its provider. The Department of Health and Human Services (HHS) Secretary would be required to issue rulemaking to establish a process to review each separate unique health identifier assigned to each outpatient department of a provider and confirm the provider is compliant with the provider-based requirements in the Social Security Act. This also would require that hospitals with outpatient departments submit an attestation of compliance with the provider-based regulations for each of their outpatient departments as a condition of payment.

We are very concerned about this requirement given that past CMS review and approval of similar attestations has been extremely burdensome and difficult. For example, CMS contractors did not complete their audits for the “mid-build” exception to the current site-neutral payment rates until over two years after the statutory deadline.

In addition, it soon became clear that these audits were conducted in an extremely inaccurate fashion – such an inaccurate fashion that CMS itself rescinded all audit denials and re-reviewed all exception applications.

HEALTH-RELATED OWNERSHIP INFORMATION

- **Mandatory Reporting with Respect to Certain Health-Related Ownership Information.**

The AHA opposes Section 104 of the AINS. The AHA has serious concerns about this provision. It is overly burdensome – for example, it would require certain hospitals to report every time a physician chooses to take a job elsewhere. It also is redundant to other reporting. CMS already imposes reporting requirements on private equity transactions and the Federal Trade Commission and the Department of Justice require information regarding large mergers and acquisitions before they occur through antitrust Hart, Scott, Rodino Act reporting. In addition, the HHS Secretary would have unrestricted discretion to add other reporting requirements, which will lead to additional burdens for hospitals and health systems.

340B DRUG PRICING PROGRAM

The AHA opposes H.R. 3290. While we appreciate the Subcommittee's longstanding support for the 340B program and interest in increasing program transparency, H.R. 3290 would impose onerous transparency requirements that will not provide policymakers with meaningful information on the true value of the program to providers and their patients. The proposal would impose new and burdensome reporting requirements that would require hospitals to implement a number of new programs and systems to collect data at each outpatient location where 340B drugs may be dispensed or administered. Specifically, the proposal would require 340B hospitals to report by location the total number of individuals receiving 340B drugs by payer, total costs, payments and savings. None of these data points individually or collectively will tell the full story of how 340B hospitals use the program to benefit the patients and communities they serve.

For example, charity care numbers only indicate the amount of care provided to patients who qualify for the hospital's financial assistance policy and is therefore provided to the patient free of cost. It does not account for the costs that hospitals incur in caring for underinsured patients or patients covered by government programs that chronically underpay the cost of care. Looking at charity care would undermine the breadth of programs and services that are often supported by 340B savings, such as behavioral health treatment, trauma care and diabetes counseling programs.

Requiring these measures to be reported at each outpatient location is overly burdensome and will not reflect the value 340B provides to the patients and communities eligible hospitals serve. Savings from each location are used to establish and support a variety of programs that benefit entire communities. In addition, hospitals will be forced to incur additional costs to be able to report at the level of detail required – costs that will be difficult to bear for many hospitals that are already facing myriad

financial challenges. Over half of hospitals in the country ended 2022 operating in the red, in large part due to double-digit increases in expenses from labor, drugs, as well as supplies and equipment. Imposing additional costs on hospitals would be egregious and unsustainable for the field.

Furthermore, the bill would not only add unnecessary cost and burden but also fail to consider the fact that 340B hospitals already report a number of data on how much they invest in resources to benefit the community. 340B hospitals must annually recertify their eligibility to participate and attest to meeting all the program requirements; participate in audits conducted by the Health Resources and Services Administration (HRSA) and drug manufacturers; and maintain auditable records and inventories of all 340B and non-340B prescription drugs. In addition, 340B hospitals report data on the benefits they are providing to their communities through the IRS tax form 990 submitted by all non-profit hospitals. These data show that in 2019 alone, 340B hospitals provided nearly \$68 billion in community benefits. Finally, 340B hospitals also already report their total charity care costs as well as their uncompensated and unreimbursed care costs on the Medicare cost reports filed annually with CMS.

Instead, the AHA encourages the Subcommittee to address the alarming efforts by many of the largest drug companies' to restrict or outright deny access to 340B discounted drugs through lawful arrangements 340B hospitals have established with community and specialty pharmacies to improve access to care. Since July 2020, over 20 drug companies have adopted these restrictive policies to the severe detriment of 340B hospitals and their patients. The financial impact on 340B hospitals is significant. For 340B critical access hospitals, AHA's survey reports average annual losses of over \$500,000 and 340B disproportionate share hospitals have average annual losses of nearly \$3 million. These impacts have meant reduced access to the many programs and services that patients rely on for care, and for some rural hospitals, has put their financial health in jeopardy. The AHA continues to actively support HRSA in its efforts to enforce the law and hold drug companies accountable. The 340B program is a lifeline for hospitals across the country, no more evident than during the pandemic when hospitals and their staff served on the frontlines, and such actions by drug companies threaten the program's viability for providers and their patients.

CONCLUSION

Thank you for your consideration of the AHA's comments on these legislative proposals. We look forward to continuing to work with you to address these important topics on behalf of patients and communities.