American Hospital Association™
Advancing Health in America

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September 20, 2023

The Honorable Bernie Sanders
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Re: The Bipartisan Primary Care and Health Workforce Expansion Act

Dear Chairman Sanders and Ranking Member Cassidy:

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 comment on provisions included in the Bipartisan Primary Care and Health Workforce Expansion Act.

While we appreciate that the bill contains numerous policies to address health care workforce shortages, we are concerned that these investments come directly at the expense of the hospitals, health systems and caregivers that need this support in the first place. **Put another way, provisions in the legislation to cut hospitals and health systems *are cuts to the health care workforce,* as more than half of hospital expenses reimburse the nurses, physicians, technicians and other team members who make hospital care possible.**

Hospitals and health systems continue to face historic challenges. A recent report released by the AHA details the extraordinary financial pressures affecting hospitals and health systems, as well as access to patient care. The report found double digit increases in expenses for 2022 compared to pre-pandemic levels, including for workforce, drugs, medical supplies and equipment, as well as other essential operational services such as IT, sanitation, facilities management, and food and nutrition.

Therefore, we urge **you to remove sections in the bill to eliminate the use of facility fees for telehealth and evaluation and management services, require a separate identification number for each off-campus outpatient department of a provider, and prevent providers from negotiating reasonable agreements with commercial health insurance plans. These policies would result in billions of dollars in additional cuts to hospitals and health systems, which would exacerbate the current challenges facing the field and reduce access to care, especially for patients in rural and other underserved areas.**

ELIMINATING FACILITY FEES FOR CERTAIN SERVICES

The AHA opposes Section 303, which would cut hospital reimbursements by eliminating facility fees for telehealth and evaluation and management services, including some outpatient behavioral health services. These payments are for the direct and indirect costs that allow a hospital to continue to provide services to patients and serve the needs of their community. They support the high acuity, 24/7 standby capacity that only hospitals provide and for which payers do not cover the full cost.

The cost of care delivered in hospitals and health systems recognizes the unique benefits they provide to their communities, which are not provided by other sites of care. This includes investments made to maintain standby capacity for natural and man-made disasters, public health emergencies and unexpected traumatic events, as well as delivering 24/7 emergency care to all who come to the hospital, regardless of ability to pay or insurance status. In addition, hospital facilities also must comply with a more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care. These costs can amount to over $200 per patient, resulting in hospitals losing money when providing certain services.

This is especially true for telehealth services. The expansion of telehealth over the past few years has transformed care delivery, improved access for millions of Americans and increased convenience for patients. Given the current health care challenges across sites of care, including major clinician shortages, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. The telehealth value propositions of improving access for geographically dispersed patients and maximizing provider capacity apply equally to facility settings (including hospitals and hospital outpatient departments) as well as non-facility professional settings. We are deeply concerned that the proposed elimination of the originating site facility fee for telehealth visits will further limit administration of virtual services for patients and communities.

The originating site facility fee supports reimbursement for staff time (for nurses or other clinical staff to set up the video visit/equipment and proctor the visit), facility space and technology. For example, a patient physically located at a rural health clinic may require a specialty consult from a remote hospital-based provider, in which case the rural health

clinic would be able to bill for the originating facility site facility fee to help cover the costs of the technology used in the visit (like secure software), the overhead for facility space (and therefore not available for other in person appointments) and staff time to support the visit.

Imposing these cuts would endanger the critical role hospitals and health systems play in their communities, including providing access to care for patients.

REQUIRING A SEPARATE IDENTIFICATION NUMBER FOR OFF-CAMPUS OUTPATIENT DEPARTMENTS

The AHA opposes Section 302, which would prohibit group health plans and health insurance issuers from paying a claim for items and services furnished to an individual at an off-campus HOPD unless the claim is submitted by the provider using a separate unique identifier for the off-campus HOPDs where the items and services were furnished. It also establishes civil monetary penalties for failing to comply with this requirement.

We appreciate the opportunity to clarify that the notion that hospitals engage in “dishonest billing” practices is inaccurate and intentionally misleading. This section is unnecessary since hospitals are already transparent about the location of care delivery on their bills. Hospitals and other providers bill according to federal regulations, which require them to bill all payers — Medicare, Medicaid and private payers — submitting information and codes that indicate the specific location of where the service is provided. There is nothing “dishonest” about billing according to the law. This provision also would be a significant administrative burden to providers and the health care industry at large. It would require overhauling current billing practices and systems, which would substantially burden providers, as well as payers and third-party vendors.

DISALLOWING CONTRACT TERMS BETWEEN PROVIDERS AND HEALTH PLANS

Section 301 would prevent providers from negotiating reasonable agreements with commercial health insurance plans. The AHA opposes these contracting restrictions — known as tiering or steering — that would lead to fewer choices for patients and further limit access to care, particularly for patients in urban, rural, and other vulnerable communities.

These restrictions would encourage insurers to make it more difficult for patients to choose their own doctors and hospitals by steering them to the providers the insurers owned or favored and selectively deciding the hospitals patients could use. This could provide an incentive for insurers to exclude facilities in lower-income communities. These provisions could undermine value-based care by enabling health plans to negotiate favorable terms under such arrangements only to undermine providers’ performance by then steering patients elsewhere for care.

Additionally, these restrictions are unnecessary because commercial insurers have market power in every state they operate in, which was recently underscored by a tentative settlement in a private antitrust class action and ongoing litigation by a number of large employers to further challenge the anticompetitive impacts of that power.

CONCLUSION

The AHA appreciates the opportunity to share our comments on the Bipartisan Primary Care and Health Workforce Expansion Act. We look forward to working with you to strengthen the health care workforce while maintaining hospitals' ability to provide quality care for all patients.

Sincerely,

/s/

Stacey Hughes
Executive Vice President