American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Education and the Workforce

Subcommittee on Health, Employment, Labor, and Pensions

of the

U.S. House of Representatives

"Reducing Health Care Costs for Working Americans and Their Families"

April 26, 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) appreciates the opportunity to submit this statement for the record as the Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions examines ways to reduce health care costs.

We appreciate the Subcommittee's interest in ensuring all Americans have access to affordable health care. The AHA and its members are committed to promoting affordability and value to advance the health of our patients. Given the hearing's focus of reducing health care costs, we provide comments on a number of policies aimed at increasing access to quality care at reduced costs. .

HOSPITAL PRICE TRANSPARENCY

Hospitals and health systems are committed to empowering patients with all the information they need to live their healthiest lives. This includes ensuring they have access to accurate price information when seeking care. Hospitals and health systems

are working to comply with both state and federal price transparency policies, which are varied and sometimes conflicting. At the federal level, these include:

- **Hospital Price Transparency Rule.** As of Jan. 1, 2021, hospitals are required to publicly post via machine-readable files five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. The rule also requires hospitals to provide patients with an out-of-pocket cost estimator tool or payer-specific negotiated rates for at least 300 shoppable services.
- **Good Faith Estimates.** The No Surprises Act requires hospitals and other providers to share Good Faith Estimates with uninsured/self-pay patients for most scheduled services. Future regulations will require unaffiliated providers to combine their estimates for an uninsured/self-pay patient into a single, comprehensive Good Faith Estimate for an episode of care.
- **Advanced Explanation of Benefits.** The No Surprises Act requires insurers to share advanced explanations of benefits with their enrollees, though implementation is currently on hold pending rulemaking. Hospitals will need to provide Good Faith Estimates to health insurers to operationalize this policy.

Hospital Price Transparency Rule

Over the past several years, the AHA has engaged hospitals and health systems in substantial education and engagement on the Hospital Price Transparency Rule. This includes:

- Establishing a CEO-level Price Transparency Task Force that helped guide the AHA in developing policies and sharing best practices with respect to price transparency and patient billing;
- Conducting education through multiple webinars, bi-weekly "office hours" with AHA and Healthcare Financial Management Association technical experts, issue briefs, case studies and podcasts;
- Providing an implementation guide, including implementation checklists and FAQs;
- Conducting a three-part webinar series on health care consumer expectations and experiences with Kauffman Hall;
- Hosting a multi-stakeholder intensive design process, which included providers, payers, patient advocates, technology vendors and others, to develop solutions to improve the patient financial experience of care;
- Supporting the Centers for Medicare & Medicaid Services' (CMS) efforts to establish voluntary sample formats that hospitals may use to meet the federal requirement to make certain standard charges publicly available through a machine-readable file by connecting the agency with experts from the hospital field; and
- Updating the AHA's Patient Billing Guidelines, which include a focus on helping patients access information on financial assistance.

CMS has a process in place to ensure hospital compliance with the Hospital Price Transparency Rule. This includes a review, usually involving direct discourse with the hospitals; if deficiencies are identified, a warning letter is sent from the agency; and if the deficiencies are not corrected, a corrective action plan is requested. Should a hospital continue to fail to come into compliance, CMS then applies a civil monetary penalty.

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).

These numbers show significant progress on the part of hospitals and health systems — while acknowledging the work that remains — in implementing these requirements. The lower compliance rate in 2021, however, should not be interpreted as a lack of hospital commitment to transparency. Instead, it reflects the incredible challenges hospitals were experiencing in 2020 and 2021 in addressing the most acute phases of the COVID-19 public health emergency, which strained hospitals' staffs and required the diversion of personnel and financial resources. As the pandemic phase of COVID-19 winds down and hospitals have been able to resume more standard operations, they are able to dedicate the resources necessary to build the full suite of price transparency tools.

CMS also shared information regarding how it has interacted with hospitals to support compliance and the issuance of penalties:

> "As of January 2023, CMS had issued nearly 500 warning notices and over 230 requests for corrective action plans since the initial implementing regulation went into effect in 2021. Nearly 300 hospitals have addressed problems and have become compliant with the regulations, leading to closure of their cases. While it was necessary to issue penalties to two hospitals in 2022 for noncompliance (posted on the CMS website), every other hospital that was reviewed has corrected its deficiencies."

Unfortunately, some third parties continue to issue reports mischaracterizing whether hospitals are complying with the Hospital Price Transparency Rule, as was detailed in a recent AHA letter to the House Energy and Commerce Committee. These reports fail to acknowledge CMS' requirements, such as how to fill in an individual negotiated rate when such a rate does not exist due to patient services being bundled and billed together. In this instance, CMS has said a blank cell would be appropriate since there is no negotiated rate to include. Despite this, some outside groups still count any file with blank cells as "noncompliant." This fundamental misrepresentation of the rules has only served to advance misinformation and confusion on the issue and distract from genuine

productive discussions and efforts around what patients want in terms of transparency data and how best to provide that information.

In addition to the CMS report on compliance, we would draw your attention to a recent report from Turquoise Health that found about 84% of hospitals had posted a machine-readable file containing rate information by the end of first-quarter 2023, up from 65% the previous quarter.

Hospitals and health systems are eager to continue working toward providing the best possible price estimates for their patients. We ask Congress and the Administration to take the following steps to support these efforts, including:

- Review and streamline the existing transparency policies with a priority objective of reducing potential patient confusion and unnecessary regulatory burden on providers;
- Continue to convene patients, providers and payers to seek input on how to make federal price transparency policies as patient-centered as possible; and
- Refrain from advancing additional legislation or regulations that may further confuse or complicate providers' ability to provide meaningful price estimates while adding unnecessary costs to the health care system.

SURPRISE MEDICAL BILLING

Congress enacted the No Surprises Act (NSA) to provide critical patient protections against unexpected medical bills for certain types of health care services when provided by out-of-network providers. The AHA strongly supports these patient protections. Congress intended for plans and other payers to appropriately reimburse providers for these services and included an independent dispute resolution (IDR) process, should negotiations between the two parties break down. Patients are fully removed from this process, and the outcome has no bearing on their cost-sharing obligations. However, this does not mean that the IDR process does not impact patients. Specifically, inappropriate reimbursement by payers can impact providers' ability to continue offering services or offering them in the timeframe or of the quality that patients deserve. In short, stripping the health care system of necessary resources ultimately impacts patients. A properly functioning IDR process is crucial for realizing the NSA patient protections.

The IDR process was intended to serve as a deterrent to inappropriate behavior by both payers and providers. Unfortunately, providers have seen payers use tactics such as delays in payments, knowing that providers can only serve patients for a limited time with constrained cash flow. This can be an effective method for dissuading providers from disputing inappropriate payments even when their claims are strong.

Certain policy decisions and implementation challenges also have undermined the unbiased and timely nature of the IDR process and contributed to the higher-than-anticipated volume of disputed claims. One of our primary concerns related to the

overweighing of the qualifying payment amount (QPA) was recently validated again by the U.S. District Court for the Eastern District of Texas. The AHA has encouraged the relevant oversight agencies to comply with the court's recent ruling and refrain from placing any constraints on IDR entities that were not authorized by Congress.

In addition, we urge Congress to encourage the agencies to consider the other reforms to the IDR process, such as:

- Revising the batching and bundling guidance to allow for a more rational process for facilities to dispute inappropriate reimbursement;
- Reducing the IDR administrative fee, which increased 600% in 2023, making the IDR process cost prohibitive for many facility claims when coupled with the current batching and bundling policies;
- Ensuring greater transparency and oversight regarding the calculation of the QPA;
- Monitoring and incentivize payer participation in the open negotiation process;
- Mandating that payers use the departments' Remittance Advice Remark Codes (RARCs) when communicating information about claims to providers and facilities;
- Requiring payers to include information on the patient's plan type at the time of initial payment or payment denial; and
- Ensuring timeliness of payments.

The AHA looks forward to continuing to work with Congress to ensure the NSA operates as intended in order to fully protect patients.

TELEHEALTH

At the outset of the COVID-19 pandemic, the federal government moved quickly to ensure hospitals and health systems were able to respond efficiently and effectively to a wave of unprecedented need. These actions included CMS waiving certain regulatory requirements and Congress providing significant legislative support to ensure hospitals and health systems could manage the numerous challenges facing them, including by an increased ability to administer virtual care. These swift actions provided hospitals and health systems with critical flexibilities to care for patients during what has been a prolonged and unpredictable pandemic.

Spurred in large part by these waivers and legislative support, virtual care and telehealth services have increased dramatically over the course of the pandemic. A report from the Department of Health and Human Services found that in 2020, telehealth services increased by over 51 million encounters, representing a 63-fold increase from 2019. There is a growing body of evidence to suggest that for the vast majority of specialties, telehealth services provided during the pandemic were not duplicative of in-person services. For example, most recently, a study of over 35 million records by Epic found that for most telehealth visits across 33 specialties, there was not

a need for an in-person follow-up visit within 90 days of the telehealth visit. In many cases, telehealth served as an effective substitute for in-person care and did not result in duplicative care.

Expansion of virtual care has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients. Given some of the current health care challenges, such as major clinician shortages, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. We applaud efforts by Congress to reduce barriers to care delivery by extending many telehealth flexibilities through the end of 2024 as a part of the Consolidated Appropriations Act that passed in December 2022. AHA continues to urge that certain telehealth waiver provisions be made permanent.

Hospitals, health systems, providers and patients have seen firsthand the benefits and potential that telehealth has in increasing access and transforming care delivery. We look forward to working with Congress to ensure legislation reflects the post-pandemic lessons learned, permanently adopts waivers that have improved access to care, and establishes a sustainable framework for the future of telehealth and care delivery as a whole.

HOSPITAL MERGERS AND ACQUISITIONS

Mergers and acquisitions are one of the most important tools that some hospitals use to increase access, provide quality care and manage financial pressures and risk. These partnerships enable hospitals to expand service offerings, broaden networks and access to specialists, improve quality and better serve patients where they live. They also provide scale to help reduce costs associated with obtaining medical services, supplies and prescription drugs, and enable health systems to reduce other operational costs. Ultimately, hospital mergers and acquisitions expand and preserve access to care.

Emerging research has demonstrated a clear association between consolidation and quality improvement. For example, one study found that a full-integration approach is associated with improvements in mortality and readmission rates, among other quality and outcome improvements.[1] Another study found significant reductions in mortality for a number of common conditions — including acute myocardial infarction, heart failure, acute stroke and pneumonia — among patients at rural hospitals that had merged or been acquired.[2]

Mergers and acquisitions help hospitals improve access to care by expanding the types of specialists and services available to patients. According to an analysis by Kaufman Hall, nearly 40% of affiliated hospitals added one or more services post-acquisition.

---

[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652
[2] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open, thereby averting bankruptcy or even closure.[3] When hospitals become part of a health system, the continuum of care is strengthened for patients and the community, resulting in better care and decreased readmission rates.

Mergers and acquisitions also have played a critical role in preserving access to care in rural areas. An AHA analysis of the UNC Sheps Center data on rural hospital closures between 2010 and 2020 shows that slightly more than half of the hospitals that closed were independent. Health systems typically acquire rural hospitals when these hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[4] Acquired hospitals typically form new collaborations or partnerships with larger health systems, which promotes access to specialists, telehealth and other care for rural patients.[5]

CONCLUSION

The AHA appreciates your efforts to examine opportunities to reduce health care costs for Americans and looks forward to working with you on this important issue.

[3] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/
[5] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf