WISCONSIN HOSPITAL ASSOCIATION

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May 18, 2023

The Honorable Cathy McMorris Rodgers
Chair
House Committee on Energy & Commerce
Washington, DC 20510

The Honorable Frank Pallone
Ranking Member
House Committee on Energy & Commerce
Washington, DC 20515

The Honorable Brett Guthrie
Chair
House Committee on Energy & Commerce,
Subcommittee on Health
Washington, DC 20510

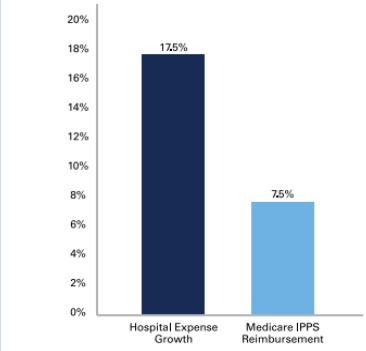
The Honorable Anna Eshoo
Ranking Member
House Committee on Energy & Commerce,
Subcommittee on Health
Washington, DC 20515

Dear leaders of the House Energy & Commerce Committee and Subcommittee on Health:

I write to express concern over recent hearings and the May 17 markup by the House Energy and Commerce Subcommittee on Health.

The Wisconsin Hospital Association represents more than 135 hospitals and integrated health systems across the state, from small, rural, Critical Access Hospitals to large, urban academic medical centers, and everything in between. While our members may differ greatly in the size of the communities they serve, one consistent challenge they all face is how they will continue to provide life-saving services in the face of immense fiscal pressures.

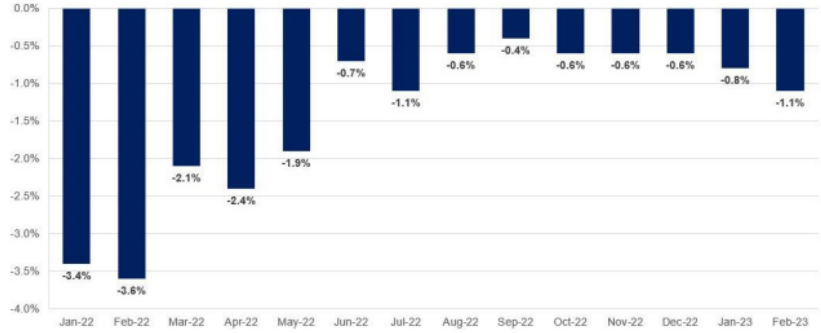
Figure 1. Cumulative Hospital Expense Growth is More Than Double the Cumulative Increases in Medicare IPPS Reimbursement, 2019-2022



Source: FY 2020-2022 IPPS Final Rule

Hospitals have continued to face supply chain shortages, inflation, a sustained health care workforce shortage driving rising labor costs, and steep increases in drug costs, particularly given drugmakers' actions to deny 340b discounts at community pharmacies hospitals contract with. This combination of factors has driven growth in hospital expenses at a time when revenue has remained stagnant (see chart, right, developed by the American Hospital Association), largely due to inadequate payment adjustments from Medicare and flat funding from Medicaid, two government programs that pay well below the cost of what it provides hospitals to provide care.

Figure 2. Kaufman Hall Operating Index YTD by Month



Adapted from the March 2023 Kaufman Hall National Flash Report

As a result of this, hospitals are piling up a long string of unsustainable monthly operating losses, as shown by this chart from Kaufman Hall's National Flash Report, which looks at hospitals all over the country, including Wisconsin. While Wisconsin hospitals strive to run efficiently (Wisconsin has the 16th lowest Medicare per-beneficiary spending according to the Kaiser Family Foundation) they are not rewarded for this high-value health care. In fact,

Wisconsin hospitals receive, on average, only about 73% of what it costs them to provide care from Medicare, well below the national average of 84%. Due to this, annual Medicare underpayments for WI hospitals grew from $1.77B in 2016 to $2.53B in 2021 – a 42% increase. This trend is only projected to increase given that Wisconsin is an aging state. In fact, as of 2018, Wisconsin was tied for 16th among states with the highest percent of their population covered by Medicare, at 20%.[1]

It is with this backdrop that I wish to express severe concerns over policies being pursued by this subcommittee and legislation that has been marked up and advanced by the subcommittee on May 17.

Medicare Site-Neutral Payment Policies Should be Rejected

As mentioned previously, Medicare already pays below the cost of providing care. It is therefore inaccurate to view higher payments hospital outpatient departments (HOPDs) receive as some sort of improper scheme by hospitals to fleece Medicare. As CMS itself has previously acknowledged, these payments exist for legitimate reasons, namely:

> *"When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively."*[2]

It is also important to remember that HOPDs provide safety-net services that many independent clinics do not offer, or offer in much smaller quantities. Consider a report done by KNG Health that sampled patients at HOPDs, independent physician offices (IPOs) and ambulatory surgery centers (ASCs) between 2019 and 2021. It concluded patients treated in HOPDs had higher needs compared to other settings because of social determinants of health and higher clinical complexity. Among the findings of Medicare beneficiaries served were:

- HOPD patients were almost two times as likely to be dually eligible for Medicare and Medicaid, indicating both a higher rate of poverty and/or a long-term disability.
- HOPD patients were almost two times as likely to have a major complication or comorbidity as defined by the Centers for Medicare and Medicaid Services (CMS), indicating the need for more intense staffing to manage chronic conditions.
- HOPD patients were more than two times as likely to have had an emergency department or hospital inpatient stay in the last 90 days, indicating the need for more resources to care for these patients.

While we are pleased that the May 17 markup did not advance many of the more harmful proposals previously introduced and discussed by the subcommittee, we remain concerned that the Manager's Amendment that was recommended by the subcommittee included site-neutral payment policies for prescription drugs administered in an HOPD, as well as potentially more burdensome billing paperwork that will add to hospitals' already extensive regulatory burden. Furthermore, we are likewise concerned that the committee may take up additional site-neutral payment policies at a later date.

[1] Wisconsin Department of Administration. Percent of Projected Population Ages 60 and Older. [Online] 2017. https://www.dhs.wisconsin.gov/publications/p01803.pdf

[2] CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.

WHA is sympathetic to statements made by subcommittee Chair McMorris Rodgers, and I would like to highlight one in particular.

> "I reject the premise that the only way to make hospital financials work is to cross subsidize loss leaders by making patients and Medicare overpay on certain services, especially when we know that these policies come with unintended consequences of consolidation and less competition. Figuring out how to more directly and accountably subsidize hospital services without unintended consequences is difficult, and we have more work to do on these proposals to ensure access to care is preserved."

It is critically Important to remember that hospitals did not design the complex, convoluted Medicare payment structure that currently exists – but nevertheless must plan their budgets based on it. It is also important to remember that *even with* the higher HOPD payments hospitals are still losing money serving Medicare patients, not to mention the even higher losses hospitals take serving Medicaid patients.

Taking away any form of HOPD payments without concurrently raising hospital payments elsewhere will exacerbate and deepen the losses safety-net hospitals experience for being our nation's safety-net. We strongly urge this committee to reject these piecemeal site-neutral payment cuts to hospitals. Instead, the subcommittee and other policymakers should pursue comprehensive payment reform that incentivizes payment for value and helps encourages the type of high quality, high value care Wisconsin is known for and that our nation desperately needs.

It is equally inaccurate to view these payments as incentivizing hospitals to buy up independent clinics in a bid to increase costs for Medicare, encouraging more consolidation and less competition. Instead, it must be recognized that higher HOPD payments have been used to sustain critical access to services for Medicare beneficiaries in their local communities. For instance, Wisconsin has an example of one of our members being approached by an independent clinic that would have otherwise shut down because it could not remain solvent with its high-Medicaid & Medicare payor mix. In this case, the hospital was able to purchase that clinic and keep it financially viable in part due to these higher provider-based payments. Eliminating those payments would threaten the viability of this now HOPD and likewise threaten access to care for the local community it serves.

More Regulations on 340B are Unnecessary; will Only Add to Hospitals Already Excessive Regulatory Burden

In 2017, the American Hospital Association came out with a report on hospitals' excessive regulatory burden and found a number of alarming examples of how regulation is harming hospitals and increasing costs for patients. It found, among other things, that:

- Health systems, hospitals and post-acute care providers must comply with 629 discrete regulatory requirements across nine domains.
- Health systems, hospitals and PAC providers spend nearly $39 billion a year solely on the administrative activities related to regulatory compliance in these nine domains.
- An average size hospital dedicates 59 FTEs to regulatory compliance, over one- quarter of which are doctors and nurses.

For this reason, WHA has been asking for Congress to extend some of the regulatory flexibility granted during the public health emergency.

WHA has disappointed to see a proposal that aims to increase regulations on hospitals under the 340B prescription drug discount program recommended favorably by this subcommittee. 340B hospitals already face strict internal audits and oversight from the Health Resources and Services Administration (HRSA). While hospitals would no doubt find a way to comply with additional regulatory requirements proposed regarding the 340B program, compliance would come as a result of hospitals spending additional time and resources on attorneys and other compliance personnel. It would also likely take additional clinician time away from patient care and toward compliance when hospitals are already facing a workforce shortage, partly due to clinician burnout that results from too much paperwork and too little time spent in front of patients.

It is important to remember that the 340B prescription drug discount program already requires no federal funding. The only conceivable benefit to these proposed regulations is to discourage growth of a program that saves hospitals money by lowering what it costs them to acquire outpatient prescription drugs. The intended benefit would be to generate even more profits for a pharmaceutical industry that is already benefiting at the expense of hospitals from decisions to deny 340B discounts for hospitals that contract with community pharmacies.

The 340B prescription drug discount program is one of the few tools hospitals have to offset skyrocketing drug prices. Hospitals must be a safety-net provider to qualify for the program, and already file extensive community benefits reports detailing the important programs they are able to provide thanks to the savings from 340B. These programs include low-cost or free dental clinics, health care clinics, behavioral health services, remote dispensing sites – and other important services their local communities depend on that operate at a loss to the nonprofit hospital but exist as a benefit to the local community.

WHA urges the Energy & Commerce Committee to abandon proposals that unnecessarily add red tape to this program and instead focus on ways to strengthen the program to help it fulfill its mission of helping hospitals stretch scarce federal resources as far as possible.

Thank you for the opportunity to weigh in on these important proposals.

Sincerely,

Eric Borgerding
President and CEO

Cc: WI Congressional Delegation