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President and CEO

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The Honorable Lamar Alexander  
Chairman  
Committee on Health, Education, Labor and Pensions  
428 Senate Dirksen Office Building  
United States Senate  
Washington, DC 20510

Chairman Alexander,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services.

Access to quality and affordable health care continues to be a significant concern for patients across the nation, and we share your commitment to address the rising cost of health care. In this letter, we have identified numerous policies and measures for your consideration that can both reduce costs and improve health care outcomes. The FAH appreciates the opportunity to submit recommendations on how best to reduce the rising cost of health care in the United States, while ensuring the quality and safety of health care delivery.

### ***Investment in Coverage & Marketplace Stabilization***

The ability to shop for and purchase coverage through a marketplace has been an important success for America's previously uninsured. The Affordable Care Act's (ACA) coverage expansion has meant millions more Americans can now receive needed health care services. It is important that these successes be sustained by making investments now that will support access to care.

We encourage Congress to resume the bipartisan discussions it was conducting in 2018 to find common ground on policy solutions to help stabilize the insurance markets. Two

steps Congress should consider are funding the cost-sharing reduction (CSR) payments and establishing a reinsurance program to help cover the costs of individuals with high health care costs.

Investment in coverage through the marketplaces or through Medicaid expansion is an investment in better health for millions of Americans. Coverage is important to ensure that Americans have access to the preventive and regular care that is so important in avoiding the more acute and often times more expensive care required when conditions go undiagnosed and become critical. It is also crucial to reducing an individual's out-of-pocket expenses when they seek care.

### ***Prescription Drugs***

The price of prescription drugs has rapidly increased over the past several years. These price increases have negative impacts throughout the health care system. They not only threaten patient access to drug therapies, but also challenge providers' ability to provide the highest quality of care. Drug costs also are a major factor in the rising cost of health care coverage.

Hospitals bear a heavy financial burden when drug costs increase and must make tough choices about how to allocate scarce resources. Managing these rising costs forces difficult choices between providing adequate compensation to employees; upgrading and modernizing facilities; purchasing new technologies to improve care; or paying for drugs, especially when these price increases are not linked to new therapies or improved outcomes for patients.

With the American Hospital Association (AHA), the FAH completed a report this year that found that hospital budget pressures resulting from the continued dramatic increases in drug prices have negative impacts on patient care, with hospitals being forced to delay infrastructure investments, reduce staffing, and identify alternative therapies. Hospitals also struggle with drug shortages, which can disrupt typical work patterns and patient care, and often require significant staff time to address.<sup>1</sup>

Specifically, the report showed that:

- Average total drug spending per hospital admission increased by 18.5% between FY2015 and FY2017.
- Outpatient drug spending per admission increased by 28.7% while inpatient drug spending per admission increased by 9.6% between FY2015 and FY2017. This 9.6% increase was on top of the 38% increase in inpatient drug spending between FY2013 and FY2015 included in the previous report.
- Very large percentage increases (over 80%) of unit price were seen across different classes of drugs, including those for anesthetics, parenteral solutions, and chemotherapy.
- Over 90% of surveyed hospitals reported having to identify alternative therapies to manage spending.
- One in four hospitals had to cut staff to mitigate budget pressures.

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<sup>1</sup> [https://fah.org/fah-ee2-uploads/website/documents/AHA\\_Drug\\_Pricing\\_Study\\_Report\\_FINAL\\_01152019.pdf](https://fah.org/fah-ee2-uploads/website/documents/AHA_Drug_Pricing_Study_Report_FINAL_01152019.pdf)

- Almost 80% of hospitals found it extremely challenging to obtain drugs experiencing shortages, while almost 80% also said that drug shortages resulted in increased spending on drugs to a moderate or large extent.

The FAH is committed to supporting market-based reforms that help combat these rising prices by increasing transparency, promoting competition and innovation, and improving value. We encourage Congress to move quickly to enact policies that will address these rising costs which dramatically impact patients.

### ***Ending Surprise Billing***

The FAH is committed to protecting patients from surprise bills and supports federal legislative action to do so. In a recent [letter to Congress](#), the FAH, together with five other hospital associations, detailed the scenarios that lead to surprise bills for patients, along with recommendations to assist Congress in legislating a solution. As outlined in the letter, the three most typical scenarios leading to surprise bills are when: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient has acted in good faith to obtain care within their network but unintentionally receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary.

In order to protect patients from surprise bills, and the associated unexpected out-of-pocket medical costs, it is crucial to ensure that patients cost-sharing obligations are based on an in-network amount and that providers do not balance bill (*e.g.*, send the patient a bill for an amount beyond the patient's cost-sharing obligation). In addition, patients should not be caught in the middle of insurers' and providers' negotiations; instead, health plans and providers should work directly with one another, with health plans transmitting payment to the provider rather than placing that responsibility on the patient. And, any solution to surprise billing should retain the ability for health plans and providers to negotiate appropriate payment rates. A fixed payment amount for out-of-network services would fail to capture the factors that go into rate negotiations between plans and providers and could undermine patient access to in-network physicians.

Other considerations to protect patients from surprise bills, which can be found in the letter, include: ensuring patients have access to emergency care by requiring health plans to adhere to the "prudent layperson" standard; helping patients understand their health care coverage and benefits; ensuring patients have access to comprehensive provider networks and accurate network information; and taking into account the interaction between federal and state laws by defaulting to state laws that meet the federal minimum for consumer protections.

### ***Delivery System Reform***

Improving quality, retaining and improving access, and addressing cost for patients should be at the core of America's health care innovation strategy. The FAH and its members are committed to advancing innovations that improve the care our patients receive. Hospitals play an integral role in today's health care system and will continue to do so as the provider community and policymakers work together to adopt new, voluntary innovations that improve patient care.

The FAH has long held that CMS only has the authority to test models on a voluntary basis, as we do not believe that Congress intended to delegate its lawmaking authority to CMS through implementation of mandatory models. As such, we would appreciate Congress's support in encouraging CMS to commit only to test models on a voluntary basis. We believe that such a commitment will not stifle innovation but instead ensure that those most ready to test new models will participate and their success will offer guidance and encouragement to other providers while protecting patient care.

In particular, we believe the voluntary bundled payment models offered by CMS hold promise. For example, the Bundled Payment for Care Improvement Advanced (BPCI-Advanced) which offers providers a number of pathways, on a voluntary basis, to test bundled payment arrangements has the potential not only to improve care for patients, but also to reduce the costs of the tested procedures. Our members support this program and are continuing to work directly with CMS to ensure its success.

Beyond bundled payment arrangements, FAH members are also participating in the Medicare Shared Savings Program – by far, CMS's most popular Accountable Care Organization (ACO) program. While hospitals have made a commitment to this program, recent CMS regulations governing the program will make it harder for hospitals to participate. We encourage Congress to work with CMS to reconsider regulatory policies that advantage one set of providers over another in this valuable program.

#### ***Modernize the Stark Physician Self-Referral Law and Medicare Anti-Kickback Statute***

The transition to value-based and coordinated care arrangements requires modernizing the Stark physician self-referral law (Stark Law) and Medicare anti-kickback statute (AKS). The current piecemeal approach to bundled payment program fraud and abuse waivers should be replaced with a single, overarching alternative payment model (APM) waiver of the Stark Law and AKS, applicable to all gainsharing, shared savings, and other similar arrangements between hospitals and other providers (Incentive Payment Arrangements) and administered pursuant to the terms of any CMS-led APM – with the necessary parity for non-CMS-led APMs, such as commercial payer arrangements.

Incentive payment arrangements stand at the heart of many APMs and serve to align participating providers' otherwise disparate financial interests to incentivize improved quality and cost outcomes. These arrangements are not developed overnight and require careful deliberation on the part of numerous stakeholders, involving time-consuming negotiations with potential partners and painstaking drafting of Incentive Payment Arrangements. The development of a single waiver would streamline the process in addition to providing additional legal certainty for program participants.

#### ***Maintain Current Ban on Self-Referral to Physician-Owned Hospitals***

To help achieve the important goal of lowering health care costs, it is important that Congress continue to reject efforts by those who would seek to weaken the Stark Law ban on self-referral to physician-owned hospitals. Such arrangements are mired in conflicts of interest, and years of independent data show such arrangements result in over-utilization of Medicare services at significant cost to patients and the Medicare program. There is a substantial history of Congressional policy development and underlying research on the impact of self-referral to physician-owned hospitals. The empirical record is clear that these

conflicts of interest arrangements of hospital ownership and self-referral by owner physicians result in cherry-picking of the healthiest and wealthiest patients, excessive utilization of care, and patient safety concerns. This policy development includes 15 years of work by Congress, involving numerous hearings, as well as analyses by the HHS OIG, the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC).

Seven years ago, after a decade of studies and congressional hearings showing the adverse impact of these arrangements, Congress acted to protect the Medicare and Medicaid programs and the taxpayers that fund them by imposing a prospective ban on self-referral to new physician-owned hospitals. The FAH strongly believes that the foundation for the current law must be fortified, not weakened. It is noteworthy that Congressional Budget Office scoring of proposals to modify existing law consistently demonstrates that self-referral to physician-owned hospitals increases utilization, which increases Medicare costs and health care costs generally. The law helps ensure that full-service hospitals can continue to meet their mission to provide quality care to all the patients in their communities.

### ***Interoperability***

Improved interoperability is crucial to realizing lasting improvement in the quality and efficiency of patient care delivery, increased patient engagement, and improved outcomes. For example, the sharing of usable information across health care providers and between providers and patients can help ensure patients receive appropriate tests and medications – and avoid duplicative services – improving safety and reducing costs. It can also help patients, providers, and caregivers make fully informed care decisions based on up-to-date patient information, as well as reduce the time and resources clinicians spend collecting and piecing together their patients’ health histories.

The FAH supports advancing interoperability among health information technology (HIT) systems to realize these important benefits across the health care sector. Last month, the FAH, along with six other hospital associations, released [\*Sharing Data, Saving Lives: The Hospital Agenda for Interoperability\*](#), a report urging stakeholders to work together to accelerate interoperability. The report examines the current state of interoperability and outlines current challenges, as well as the benefits of interoperability, including improved care coordination, safety, and quality; increased efficiency and reduced costs; empowered patients and families; and robust public health registries. The report also puts forth a pathway to advance interoperability to realize the goal of improved, more efficient health for individuals, including: 1) security and privacy; 2) efficient, usable solutions; 3) cost effective, enhanced infrastructure; 4) standards that work; 5) connecting beyond electronic health records (EHRs); and 6) shared best practices. More detail on each of these elements can be found in the report.

### ***Hospital Star Ratings***

For patients and families to make informed decisions about their care, they need access to valid and meaningful information on quality of care. The FAH and its members have long supported transparency of quality measures. Through the Overall Hospital Quality Star Ratings, CMS seeks to provide patients with a measure that is easy for consumers to understand that is reflective of the quality of hospital care.

The FAH supports this goal yet remains concerned that the current star ratings is providing patients with potentially biased and misleading information. The complexity of hospitals in conjunction with the variability of individual patient needs contribute to the inherent difficulty in attaining this goal. For instance, the star ratings, comprised from a subset of quality measures, may not reflect the type of care a particular patient is seeking if no measure pertinent to that aspect of care is included in the measure set.

The star ratings have a history of being driven by methodology rather than hospital performance. The statistical methodology utilized, the Latent Variable Model, applies loading factors for measures which have been shown to swing widely from one reporting period to another, causing hospital star ratings to lose or gain up to three stars with little change between performance periods to account for the change. CMS has on two occasions had to postpone public reporting to address these methodological issues. The shifts in loading factors that leads to star rating swings are not proactively known to hospitals and depending on how the algorithm applies these weights improvement in any one area may not contribute to an improved score. Changes in ratings from one performance period to another have been driven by changes in single measures rather than a balanced view across all measures. Until these issues are addressed, the FAH believes that Overall Hospital Quality Star Ratings should be discontinued as they inaccurately portray hospital quality performance and potentially mislead patients and families.

### ***Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey***

The HCAHPS survey of patient experience provides transparency of measures of patient perceptions on the care they received, the hospital environment and their interactions with staff during their inpatient admission. The FAH and its members value the HCAHPS and the dual role it plays in gathering the patient voice and making it publicly available for consumer use.

The HCAHPS survey is delivered to patients by phone or mail after their discharge from the hospital. There is currently no electronic version of the survey. The lack of an e-survey leads to long lag times between patient report and public posting, rendering the public scores outdated and potentially misleading as soon as they are reported. In addition, survey response rates in the paper and phone version of the surveys are decreasing, leaving hospitals to shoulder the cost and burden for increased outreach of the paper and phone versions to attain minimum response rates.

The FAH hosted a roundtable in December 2018 in collaboration with four other hospital associations, bringing together patient experience leaders, CMS and AHRQ to discuss hospital perceptions of the HCAHPS. This roundtable helped highlight that aspects of the survey need to be updated and modernized to include electronic surveying and to improve on questions that have been reported by patient advisory councils to be confusing. We believe the HCAHPS plays an important role in hospital quality measurement and urge that the HCAHPS survey have an electronic mode added and be evaluated for the need for updates based on user feedback.

### ***Telehealth Services***

Much more can and should be done to support the expansion of services delivered via telehealth. For patients living in all areas – rural, suburban, and urban – the benefits of care delivered via current and developing telehealth technologies should be supported and expanded.

The opportunity to deliver patient care via technology is already delivering results for patients. For example, the opportunity to use telehealth to diagnose and treat stroke patients, cutting down on the time between the stroke event and treatment, is beneficial for both patient mortality and for long-term patient outcomes. In rural areas, the option for hospitals to partner with physicians outside of their communities allows patient access to services they would otherwise have to travel great distances to receive. For patients with chronic conditions, the ability to use remote patient monitoring technology to monitor a chronic disease improves overall health and ensures patients seek medical attention before their conditions worsen.

Services delivered via telehealth improve care to patients and have the potential to save costs for both patients and the health care system, generally. However, artificial barriers, vestiges of a time when the technology was new, are hampering the appropriate expansion of telehealth. Congress should consider reforming Medicare’s restrictive telehealth payment policies, correct the disparity in payment for services delivered in-person versus those delivered via telehealth, remove technology specific preferences in reimbursement and remove geographical reimbursement restrictions.

Beyond these provisions, Congress should also consider the broadband investment required in rural communities to make these services a reality. Specifically, Congress also should address the arbitrary restriction of broadband funds to rural providers based on tax-status.

### ***Reduce Regulatory Burden***

Hospitals and post-acute care (PAC) providers, such as inpatient rehabilitation facilities and long-term care hospitals, must comply with extensive regulatory requirements, and often are unnecessary or duplicative. These regulations increase the cost of health care while taking time away from patient care.

An October 2017 study showed that providers spend approximately \$39 million annually to comply with 629 requirements across nine domains. The FAH has submitted multiple recommendations to [Congress](#) and the [Administration](#) to reduce the regulatory burden on hospitals so that they can focus better and more efficiently on patient care. We greatly appreciate the Administration’s current Patients over Paperwork initiative to reduce regulatory burden for health care providers (for which the FAH submitted [comments](#) to CMS), and we urge continued focus by Congress and the Administration to further reduce regulatory burden for hospitals.

### ***Graduate Medical Education***

According to a recent study prepared for the Association of American Medical Colleges (AAMC), the United States faces an estimated shortage of between 42,600 and 121,300 physicians by 2030. This physician shortage is occurring at the same time as an expanded aging population needs access to care. It is therefore imperative for Congress to

invest in the education and training of the next generation of physicians and other health care providers.

The FAH supports *S. 348, Resident Physician Shortage Reduction Act of 2019*, which authorizes 15,000 new Medicare-supported medical residency positions over five years (from 2021-2025, with 3,000 allotted per year). Expanding the physician workforce can best be achieved by adequately and appropriately financing graduate medical education (GME) training in teaching hospitals. Increasing the number of physicians practicing will thereby provide for more competition and choice in the marketplace.

***Conclusion***

The FAH applauds your leadership on this initiative, and thanks you for devoting the Senate HELP Committee's time and attention to addressing rising health care costs. We look forward to working with the Committee and staff in the 116th Congress. Should you have any questions, please feel free to contact me or a member of my staff at (202) 624-1500.

Sincerely,

