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Sent: Tuesday, April 25, 2023 12:05 PM
Subject: GNYHA Positions on House Energy & Commerce Committee Hospital Proposals

Congressional Staff:

On April 26, the Health Subcommittee of the House Energy and Commerce Committee will hold a hearing entitled "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The hearing will address legislative proposals relating to health care costs, service delivery, and transparency.

Several of the Committee's proposals will severely harm hospitals. Hospitals face enormous financial and workforce challenges that put vital patient services at grave risk. GNYHA has developed the below toolkit with information about the bills GNYHA opposes and a bill we strongly support,

Medicare Site-Neutral Cuts
GNYHA is extremely concerned about three bills that propose dangerous Medicare "site-neutral" cuts. These bills cut reimbursement for hospital-based outpatient services by making it equal to the lower rate paid to physician offices.

Hospitals are reimbursed at a higher rate than physician offices to account for the higher costs of providing services in a hospital setting. Hospitals are open 24/7, care for medically complex and underserved patients, and comply with myriad regulatory requirements that do not apply to physician offices. Hospital-based outpatient services are a lifeline for communities with scarce health care options. Additional cuts will force hospitals to reduce vital services or put them at risk of permanent closure.

The Committee will consider three site-neutral legislative proposals during the hearing:

- Site-neutral cuts to **all hospital off-campus services**: the draft bill removes the exception that allows certain off-campus outpatient department (OPD) providers to bill for covered OPD services under the Medicare outpatient prospective payment system (OPPS).
- Site-neutral cuts that align rates across **hospitals, ambulatory surgical centers, and physician offices**: the draft bill directs the Health and Human Services (HHS) Secretary to specify which ambulatory payment classifications (APCs) should be furnished in a hospital OPD by comparing the volume of services delivered over the preceding four years for each setting. CMS must pay for items and services under the PPS tied to the setting in which the respective items and services were delivered at the highest volume over the preceding four years. A similar recent MedPAC proposal would have cut payment rates to hospital OPDs for 66 of 169 APCs furnished in both on- and off-campus sites, cutting Medicare reimbursement to hospitals nationally by $7.5 billion per year.
- Site-neutral cuts for **drug administration**: the draft bill includes covered OPD services in the APC groups for drug administration services furnished by an off-campus OPD starting in 2024, with a four-year phase-in.

GNYHA Position: GNYHA strongly opposes any site-neutral proposals. Medicare site-neutral cuts do

not account for the legitimately higher costs of providing services in a hospital setting and will compromise access to care. GNYHA's policy paper can be found here.

H.R. 2691 – Hospital Price Transparency

Since January 1, 2021, every US hospital has been required to provide clear, accessible pricing information about their items and services. Hospitals must post their data in two formats: 1) as a "machine-readable" file with all items and services and 2) in a consumer-friendly format that displays 300 shoppable services and/or a patient out-of-pocket cost estimator. H.R. 2691, the Transparent PRICE Act, codifies this Federal rule.

Hospitals have come under increased scrutiny for perceived "non-compliance" with the Federal rule requiring hospital price transparency. These unfounded claims rest on fundamental misunderstandings of how hospitals operate and misinterpretation by outside groups of the price transparency regulations. In fact, the Centers for Medicare & Medicaid Services (CMS) has estimated that almost three-quarters of the nation's hospitals have achieved full compliance with the rule since it took effect in 2021.

GNYHA Position: Hospitals are making sincere efforts to comply with the rule and are committed to ensuring that patients and their loved ones can make informed health care decisions. GNYHA's policy paper can be found here.

340B Transparency

The 340B Drug Discount Program helps safety net hospitals maintain high-quality patient care despite rising drug costs. Hospitals use savings from purchasing discounted drugs under the program to provide free and low-cost prescription drugs and vaccines to uninsured patients, enhance primary care services, offer low-cost mammograms, and preserve many other vital community services.

The draft bill adds requirements that increase oversight of the 340B program. The legislation requires participating entities to report to HHS the total number of individuals who were dispensed or administered drugs during the preceding year at each site and the cost incurred for providing these services at each site, minus any payments provided to the entity (the "net revenue").

GNYHA Position: GNYHA opposes any policies that diminish the 340B program's benefits to safety net hospitals. The data the draft bill requests are unrelated to the purpose of the 340B program and would impose significant administrative burdens on already strained institutions.

Phase-Out of Inpatient-Only List

The proposed bill prohibits the HHS Secretary from classifying a "musculoskeletal hospital service" as an inpatient-only (IPO) procedure as of January 1, 2025. IPO procedures are services that Medicare will only pay for if delivered in the inpatient setting due to patient safety concerns related to the clinical complexity of the procedure and the expectation that the patient will remain in the hospital overnight. It also requires HHS to study and report on services designated as IPO and use the report to justify the continued classification of any services as inpatient.

GNYHA Position: GNYHA opposes the proposed bill. In 2020, CMS finalized a proposal to eliminate the IPO list entirely, but later reversed the rule due to patient safety concerns. In addition, CMS removes procedures from the IPO list every year and has authority to eliminate the IPO list if new evidence suggests that it would not pose safety concerns for patients.

Unique ID Number

The proposed bill requires CMS to assign unique IDs (and for hospitals to report the IDs) on claims. Hospitals would also be required to submit separate provider-based attestations for each location every two years.

GNYHA Position: GNYHA opposes the proposed bill. It imposes enormous administrative burdens on hospitals that are already subject to provider-based requirements with potential recoupments if they are found to be out of compliance. Hospitals are also required to identify the exact facility address where the service was performed (and it must match their provider enrollment) for off-campus provider-based sites. The existing requirements are sufficient to ensure that providers remain in compliance.

H.R. 2665 - Medicaid DSH Cuts

The Medicaid disproportionate share hospital (DSH) program provides payments to safety net hospitals that serve a high proportion of Medicaid beneficiaries and uninsured patients. The Affordable Care Act (ACA) cut Federal Medicaid DSH funding under the assumption that fewer uninsured Americans would result in hospitals providing less uncompensated care—but that simply has not been the case.

Congress has delayed and restructured Medicaid DSH cuts several times since the ACA's enactment. Under current law, the $8 billion per year cuts are scheduled to occur from fiscal year (FY) 2024 through 2027. New York State alone would absorb approximately 17% of the national reduction—a catastrophic $1.4 billion annual loss that could force struggling voluntary and public hospitals to reduce services or even close their doors for good. H.R. 2665, the Supporting Safety Net Hospitals Act, addresses the looming DSH cuts by further delaying the cuts until FY 2026.

GNYHA Position: GNYHA strongly supports H.R. 2665 and encourages Congress to further delay or eliminate DSH cuts. DSH funding ensures that financially struggling safety net hospitals can continue to serve low-income and uninsured patients.

Please contact us with any questions.

Thank you.

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