American Hospital Association™
Advancing Health in America

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The Honorable Mike Johnson
U.S. House of Representatives
Speaker of the House
568 Cannon House Office Building
Washington, DC 20515

The Honorable Hakeem Jeffries
U.S. House of Representatives
Democratic Leader
2433 Rayburn House Office Building
Washington, DC 20515

Dear Speaker Johnson and Democratic Leader Jeffries:

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 regarding provisions in the Lower Costs, More Transparency Act (H.R. 5378).

The AHA supports the elimination of the Medicaid disproportionate share hospital (DSH) reductions for two years. **However, hospitals and health systems strongly oppose efforts to include permanent site-neutral payment cuts in this bill.** In addition, the AHA has concerns about the added regulatory burdens on hospitals and health systems from the sections to codify the Hospital Price Transparency Rule and to establish unique identifiers for off-campus hospital outpatient departments (HOPDs).

There is nothing neutral about site-neutral payment policies — not the level or quality of care, not the patient complexity, and not the enhanced regulatory oversight of hospitals. Unfortunately, Section 203 of the Lower Costs, More Transparency Act would disregard these important differences in care sites by implementing harmful site-neutral payment cuts for drug administration services furnished in off-campus provider-based departments. This policy would result in a cut of over $3.7 billion over 10 years to HOPDs that provide essential drug administration services, including for vulnerable cancer patients who may require a higher level of care than is available at other care settings. Expanding site-neutral cuts would endanger the critical 24/7 role hospitals and health systems play in their communities, including providing access to care for patients.

This proposal to cut reimbursements for drug administration services in HOPDs inappropriately equates care provided in these hospital clinics with less complex care

provided at freestanding physician offices. The care is not equivalent and current payment rates appropriately take into account these important differences.

Hospitals are committed to providing high quality and safe care to patients. Unlike other sites of care, hospitals are required to take many additional measures to make certain that medications are prepared and administered safely while also providing important care coordination services for their patients. For example, hospital pharmacists confirm safe dosing and check for drug-drug interactions and physicians must be available on-site to promptly respond to any adverse reactions. In addition, hospitals must remain in compliance with important safety standards such as those required by the Food and Drug Administration, U.S. Pharmacopeia, and The Joint Commission.

We are concerned that this provision fails to recognize these longstanding safety and quality requirements for drug administration services at HOPDs, which do not apply to physician offices.

Additionally, the cost of care delivered in hospitals and health systems appropriately takes into account the unique benefits they provide to their communities, and which are not provided by other sites of care. This includes investments made to maintain standby capacity for natural disasters, public health emergencies and unexpected traumatic events, as well as delivering 24/7 emergency care to all who come to the hospital.

Existing site-neutral payment cuts have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries. Government underpayment is a long-standing issue that needs to be addressed, not exacerbated. This proposal would expand upon these shortfalls, further exacerbating the financial challenges facing many hospitals and threatening patients' access to quality care. We would urge you not to prioritize commercial insurers' interests that would jeopardize access to hospital-based care. Congressional action on this issue, along with the continued government underfunding of hospital and health systems, puts patient care at risk, particularly in rural and undeserved areas. **Therefore, the AHA urges Congress to reject Section 203 of the Lower Costs, More Transparency Act.**

The AHA also is concerned that Section 101, which would codify the Hospital Price Transparency Rule that went into effect on Jan. 1, 2021, would unfairly penalize hospitals that have spent significant capital to comply with the regulation. While the AHA supports efforts to provide clarity about hospital prices, this section would no longer recognize price estimator tools as a method to meet the shoppable services requirement. Hospitals that have invested considerable time and resources in developing these tools to provide patients with a user-friendly summary of their potential out-of-pocket costs would no longer be compliant. The legislation also greatly increases to $10 million the maximum civil monetary penalty for hospitals that are deemed to be

out of compliance with the statute, which is well in excess of the current maximum of $2 million set by CMS. **The AHA urges changes to this section to deem the use of price estimator tools as eligible to meet the shoppable services requirement and allow CMS to continue to determine the maximum penalty assessed to noncompliant hospitals.**

Section 204, which would require that each off-campus HOPD of a provider be assigned a separate unique health identifier from its provider also is concerning. This provision 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 — using codes that indicate the location of where a service is provided. As a result, this provision would impose an unnecessary and onerous administrative burden on providers and needlessly increase Medicare program administrative costs.

This section also would require that as a condition of payment, hospitals submit an attestation of compliance with the Medicare provider-based regulations for each of their off-campus HOPDs within two years of enactment. Given hospitals' experience with review and approval of similar attestations in the past, we are concerned that this requirement would be extremely burdensome for hospitals and Medicare contractors. **The AHA urges Congress to remove Section 204 of the Lower Costs, More Transparency Act.**

Finally, we oppose provisions included in Section 202 to require 340B Drug Pricing Program entities to report the difference between their acquisition cost and payments from Medicaid managed care organizations. Such reporting would not only overstate how much 340B hospitals save from the program for their Medicaid beneficiaries but also would be unnecessarily burdensome and costly to 340B entities. **The addition of burdensome reporting requirements is problematic and of no benefit to patients or patient care, and we urge Congress to strike this language.**

Thank you for your consideration of these proposed changes to the Lower Costs, More Transparency Act. We look forward to working with you to ensure patients continue to have access to quality care in their communities.

Sincerely,

/s/

Stacey Hughes
Executive Vice President