September 7, 2023

The Honorable Cathy McMorris Rodgers
Chair, House Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20510

The Honorable Virginia Foxx
Chair, House Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20510

The Honorable Jason Smith
Chair, House Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20510

Response to Committee on LCMT Act

Essential hospitals form the fabric of the nation's health care safety net. Their mission-driven focus means they shoulder a disproportionate share of uncompensated care for low-income and marginalized patients. They constitute about 5 percent of all U.S. hospitals but provide more than 27 percent of charity care nationally. This leaves them with an average operating margin 60 percent less than that of other U.S. hospitals. As a result, essential hospitals rely on a patchwork of federal support, including Medicaid disproportionate share hospital (DSH) payments.

We are grateful for the significant bipartisan support for H.R. 2665, championed by four members of the House Committee on Energy and Commerce—Reps. Yvette Clarke (D-N.Y.), Dan Crenshaw (R-Texas), Diana DeGette (D-Colo.), and Michael Burgess (R-Texas), and we thank the committee for including this crucial legislation in the Lower Costs, More Transparency Act. The scheduled DSH cuts include an $8 billion reduction on October 1, 2023—more than two-thirds of all federal DSH spending annually. This cut and another in fiscal year 2025—$16 billion overall—would undermine essential hospitals and cause an enormous strain on the health care safety net.

However, we object to including site-neutral hospital payment cuts in the Lower Costs, More Transparency Act. These cuts would disproportionately harm essential hospitals and diminish their ability to provide care, given their patient mix and the role community clinics play in furthering their missions. Sec. 203, Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus; and Sec. 204, Requiring a Separate Identification

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Number and an Attestation for Each Off-Campus Outpatient Department, are policies that will hinder access to services for communities of underserved patients nationwide and cause an undue administrative burden on hospitals. Off-campus community clinics of essential hospitals provide convenient access to desperately needed high-quality, culturally and linguistically competent care. They often are the only source of primary and specialty care in their communities for medically and socially complex patients.

America's Essential Hospitals opposes site-neutral payment policies. Essential hospitals' all-payer operating margins are less than half that of the average hospital. Looking specifically at Medicare Outpatient Prospective Payment System (OPPS) margins, which would be directly affected by the proposed site-neutral policies, our analysis shows essential hospitals operate on a negative 24 percent Medicare outpatient margin—13 percentage points lower than OPPS hospitals nationally. Expanding the scope of site-neutral cuts to include drug administration services, as proposed in Sec. 203, would further undermine essential hospitals and threaten access to care in their communities.

Site-neutral policies fail to account for the fundamental differences in the cost of providing services in hospital settings and the additional benefits obtained from doing so, and they will clearly lead to a loss of access to ambulatory care, as hospitals nationwide rethink the scope of the outpatient services they can offer. For hospitals operating on narrow (often negative) margins, the proposed cuts are unsustainable and will affect patient access in areas with the greatest need for these services.

We are concerned about the administrative burden Sec. 204 would impose on essential hospitals. Sec. 204 would require each off-campus hospital outpatient department (HOPD) to obtain and use a unique identifier for Medicare billing and attest to meeting the provider-based requirements. Under Medicare regulations, HOPDs are considered to be part and parcel of the main hospital. To qualify as part of the hospital (provider-based) and begin billing for services, the HOPD must meet strict requirements, such as being integrated clinically, financially, and administratively with the main hospital. Current rules do not require provider-based attestations for each HOPD, but hospitals may attest voluntarily. Requiring provider-based attestations for each off-campus HOPD is unnecessary and burdensome for hospitals.

Also, requiring each HOPD to have a unique identifier and to bill using this separate identifier would be resource-intensive, require changes to hospital IT and billing systems, and would affect staff workflows. Currently, hospitals bill for all claims for services provided at HOPDs on the institutional claim form, as if they were provided in the main hospital. Once the HOPD meets the provider-based regulations, it is considered part of the hospital. Not only does requiring separate identifiers run counter to current Medicare billing practices, in which all hospital claims are billed under one form—the UB-04—but complying with this new requirement would be burdensome and costly for essential hospitals. Imposing a new requirement would require hospitals to invest significant time and money into updating their billing and IT systems to generate separate bills from each off-campus HOPD. Any requirement that these claims be billed on a professional claim form, instead of the institutional claim form, also would violate uniform billing requirements. We also are concerned about these policies ultimately being used as justification for damaging reductions to outpatient payments. For these reasons, we oppose the addition of a unique national provider identifier for off-campus HOPDs.

The Lower Costs, More Transparency Act seeks to support patients, health care workers, community health centers, and hospitals. We ask that the committee include a federal

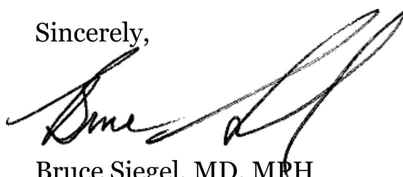
designation for essential hospitals to ensure a strong and dependable health care safety net and continued access to care for underserved communities nationwide. No statutory definition exists for hospitals that fill the vital community role or offer the breadth of services that characterize essential hospitals. Congress has acted multiple times to identify hospitals with unique characteristics or those serving specific populations or regions—for example, Prospective Payment System–Exempt Cancer Hospitals (PCHs), sole community hospitals, and Critical Access Hospitals (CAHs). In each case, Congress recognized the need to formally codify defining criteria and policy incentives to stabilize and protect these important providers within the larger health care ecosystem. Today, essential hospitals lack similar—and necessary—benefits.

Essential hospitals are distinguished by the diverse patients they treat, serving high proportions of Medicaid, Medicare, and uninsured patients and historically underserved communities. Essential hospitals provide more than seven times as much uncompensated care as other hospitals, and three-quarters of their patients are uninsured or covered by Medicaid or Medicare. Our proposed definition uses a methodology that leverages publicly available data that points to a hospital's mission in caring for disadvantaged patients, such as the hospital's portion of Medicaid and low-income patients or the amount of uncompensated care provided. Eligibility is based on metrics that measure the hospital's safety net mission and includes urban and rural hospitals, realizing that rural hospitals serve an important safety net role in their communities, as well.

America's Essential Hospitals appreciates Congress' support of safety net hospitals in proposing to eliminate two years of Medicaid DSH cuts in the Lower Costs, More Transparency Act. However, we ask that Congress remove the hospital site-neutral payment proposals in sections 203 and 204 that would disproportionately and negatively impact essential hospitals. Congress could strengthen its support of essential hospitals by codifying a federal definition of these providers.

We look forward to continuing to work together on these matters. If you have questions, please contact Jason Pray, vice president of legislative affairs, at 202-412-2491 or jpray@essentialhospitals.org.

Sincerely,



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