AMERICA'S ESSENTIAL HOSPITALS

Feb. 14, 2025

America's Essential Hospitals' Legislative Priorities in the 119th Congress

To the Honorable Members of the 119th Congress:

America's Essential Hospitals represents more than 350 hospitals and health systems across the country that provide high-quality care to millions of patients, including those who face social and economic barriers to care. Our hospitals train physicians, nurses, and other health care professionals; coordinate care across large ambulatory networks; meet public health and emergency response needs; and advance high-quality care to communities across the country. Many of our members are the only facilities offering level I trauma care, burn units, and neonatal intensive care services in their service area. The average essential hospital employs over 3,500 people.[1] Together, our members account for almost 900,000 jobs nationwide and contribute $283 billion annually in economic activity.[2]

As the year begins with consideration of a reconciliation package alongside government funding needs and various health policy issues facing a March 31 deadline, we highlight our key priorities that require your attention and support. We also emphasize our support for the bipartisan, bicameral health care provisions that were part of early negotiations in December 2024. We encourage congressional leaders to take up this package on the House floor or use another legislative vehicle to address these crucial priorities.

Medicaid and Essential Hospitals

The Medicaid program is a lifeline to our nation's most under-resourced communities. In 2024, 79 million people were enrolled in Medicaid, with more than 7 million enrolled in the Children's Health Insurance Program.[3] The importance of the Medicaid program for all—regardless of political party, ideology, or geographic location—cannot be understated.

Essential hospitals' mission of caring for all people, including those facing severe financial challenges, results in providing care to a high share of individuals enrolled in Medicaid, our

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[1] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed Jan. 31, 2025.
[2] Ibid.
[3] *October 2024 Medicaid & CHIP Enrollment Data Highlights*. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=79%2C308%2C002%20people%20were%20enrolled%20in,people%20were%20enrolled%20in%20CHIP. Accessed Jan. 31, 2025.

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nation's health insurance program for low-income children, adults, and people with disabilities. In addition, essential hospitals serve a high share of uninsured individuals, including many who cannot afford coverage and are not eligible for Medicaid. To sustain their mission of providing care for all people, essential hospitals rely on a patchwork of support from the federal, state, and local governments. Some of the largest sources of support for essential hospitals include Medicaid disproportionate share hospital (DSH) payments, which help offset uncompensated care for Medicaid and uninsured patients, and Medicaid supplemental payments and state directed payments, which help to close gaps in payment rates between Medicaid and other payers.

While the Medicaid program has an expansive role, it still offers the lowest reimbursement rates among payers by far.[4] This creates financial difficulties for essential hospitals. Payments do not accurately reflect the cost or critical nature of the care that essential hospitals provide to Medicaid patients, resulting in large shortfalls between what Medicaid pays and a hospital's actual cost of care. In 2022, essential hospitals reported a total of $10.4 billion in Medicaid shortfall, even after DSH payments and other adjustments intended to support essential hospitals.[5]

America's Essential Hospitals is concerned about policy recommendations from the House Budget Committee and various considerations by committees of jurisdiction that would drastically change the Medicaid program in a manner that could hurt essential health care providers and patients and hinder access to care. One concern is the proposed per capita caps on federal Medicaid funding. These caps would shift significant costs and risks to states, which would cause states to end Medicaid expansion, reduce Medicaid benefits, and reduce Medicaid provider payments. In addition, we are concerned with the limits on state directed payments (SDPs). Many states use SDPs to close the payment gap for essential hospitals and improve access to care for Medicaid beneficiaries. Proposals requiring work requirements and changing federal medical assistance percentage rates also threaten access to care and essential services.

Medicaid DSH Payment Cuts

We urge Congress to achieve a permanent solution to the threat of Medicaid DSH funding cuts by acting before the April 1, 2025, deadline to eliminate the remaining three years of cuts and preserve this vital safety net support. The association also supports the language on Medicaid DSH in Section 110 of the health care title of the initially negotiated year-end package.

Essential hospitals provide a disproportionate share of unreimbursed care. They constitute about 5 percent of all U.S. hospitals but provide more than a quarter of charity care nationally.[6] This leaves them with an average operating margin of -9 percent, more than three times lower than for other U.S. hospitals at -2.8 percent.[7] Essential hospitals rely on a patchwork of public support, including Medicaid DSH payments, which Congress created to stabilize these financially fragile hospitals.

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[4] Zuckerman S, Skopec L, Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. *Health Affairs*. 2021;40(2):343–348. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00611. Accessed Jan. 31, 2025.
[5] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Jan. 31, 2025.
[6] Ibid.
[7] Ibid.

The Affordable Care Act reduced Medicaid DSH payments to hospitals under the assumption their uncompensated care costs would decrease as health care coverage increased. But the expected coverage increases did not occur, and an estimated 25.3 million Americans remain uninsured.[8] We are grateful that Congress has acted in a strongly bipartisan fashion more than a dozen times to delay or eliminate Medicaid DSH cuts, including in March 2024, when lawmakers eliminated the $8 billion cut scheduled for fiscal year (FY) 2024. Congress also delayed the $8 billion FY 2025 cut until April 1, 2025, allowing time to address the impending cuts in the start of the 119th Congress.

Protecting Dually Eligible Patients

The association supports the language in Section 111 of the health care title of the initially negotiated end of year package on protecting dually eligible patients. The language reflects the Save Our Safety-Net Hospitals Act of 2024 (H.R. 9351), introduced in the 118th Congress. This legislation would mitigate the unintended effects of Section 203 of the Consolidated Appropriations Act (CAA), 2021, that would cut Medicaid DSH payments for hospitals that serve a high share of patients dually eligible for Medicaid and Medicare, including many essential hospitals.

H.R. 9351 would have corrected the unintended consequences of previous legislation that changed the process for calculating Medicaid DSH uncompensated care limits. The policy intended to help hospitals that serve a high share of patients dually eligible for Medicaid and commercial insurance (e.g., children's hospitals), but it inadvertently placed burdensome limits on the DSH support hospitals receive to offset their uncompensated costs of caring for patients dually eligible for Medicaid and Medicare.

The CAA includes a small exception for hospitals that serve a high share of patients dually eligible for Medicaid and Medicare, but in practice, this exception process is not working. The Centers for Medicare & Medicaid Services (CMS) did not issue regulations implementing this exception process until February 2024, even though the changes are retroactively effective for DSH payments made in 2022. Moreover, according to CMS' own analysis, the number of hospitals that qualify for the exception varies widely each year, making it difficult for hospitals to anticipate how much DSH funding they are eligible to receive. Hospitals will start feeling the effects of these cuts in 2025 when their FY 2022 DSH payments are audited, and some hospitals that do not qualify for the exception might face large, retrospective recoupments of funding that could threaten their financial viability.

Introduced on Aug. 13, 2024, by Reps. Nick LaLota (R-N.Y.), Yvette Clarke (D-N.Y.), Larry Bucshon (R-Ind.), Doris Matsui (D-Calif.), Mike Lawler (R-N.Y.), and Frank Mrvan (D-Ind.), H.R. 9351 would allow hospitals to continue to receive Medicaid DSH payments for unreimbursed costs for patients who are dually eligible for Medicaid and Medicare or other non-commercial, third-party payers (e.g. no-fault insurance, worker's compensation, liability insurance). This is similar to the policy that was in place for years before the CAA. The costs and payments for this dually eligible population would be included in the DSH cap *only* if the hospital incurs uncompensated costs for their care, and so the new proposed definition would

[8] Tolbert J, Cervantes S, Bell C, et al. Key Facts about the Uninsured Population. *Kaiser Family Foundation*. Dec. 18, 2024. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=As%20a%20result%2C%20in%202022%2C%20the%20number,to%20a%20record%20low%209.6%%20in%202022.&text=In%202022%2C%2025.6%20million%20nonelderly%20individuals%20were,a%20decrease%20of%203.3%20million%20from%202019. Accessed Feb. 13, 2025.

not affect DSH funding for children's hospitals and other hospitals that were intended to benefit from the initial Section 203 policy.

Telehealth Flexibilities

As Congress considers extending effective public policies to expand access to care through telehealth services, we ask lawmakers to make permanent those policies, which are set to expire in March. The association supports the language in Section 209 of the health care title of the initially negotiated end-of-year package on extending telehealth flexibilities for two years.

Telehealth services are a growing part of the health care landscape and a crucial aspect of how essential hospitals serve their patients. In communities that otherwise lack access to care, essential hospitals reach outside their walls to meet patients' needs, using telehealth services as a valuable tool in the provider arsenal to increase access to care for rural and underserved populations. The COVID-19 pandemic revealed the value of telehealth services to improve care and expand access. The Secretary of Health and Human Services waived many restrictions on telehealth services in 2020, resulting in broader usage of these services. Since then, essential hospitals have built on their investment in this technology, offering routine and specialized care via telehealth, remote patient monitoring after discharge, and remote chronic care management at rates about double that of other acute-care hospitals.[9] Today, Medicare beneficiaries use telehealth services at twice the rate of pre-pandemic levels.[10]

The use of telehealth has been and continues to be crucial for patients' continuity of care with their primary and specialty care providers. Access to internet and broadband services is crucial to ensuring access to care and supports essential hospitals' safety net role. For example, the Affordable Connectivity Program supports access to the high-speed internet necessary for work, school, and telehealth for 23 million Americans.[11] Essential hospitals continually work to expand coverage and improve health outcomes. Legislation in the 118th Congress, such as the association-endorsed Affordable Connectivity Program Extension Act of 2024 (S. 3565/H.R. 6929), led by Sen. Peter Welch (D-Vt.) and Rep. Yvette Clarke (D-N.Y.), is crucial to connecting health care providers to all people, regardless of socioeconomic and geographic barriers to treatment.

America's Essential Hospitals is grateful that Congress extended pandemic-era telehealth flexibilities in the CAA, 2023, which expanded the services and locations Medicare enrollees could access through telehealth. Before this flexibility, telehealth utilization in traditional Medicare was low, as coverage generally was restricted to beneficiaries in rural areas and to specific providers, facilities, and services. Flexibility to provide patient-centered care that best meets the unique needs and circumstances of individuals and communities is crucial to meet the needs of both urban and rural communities.

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[9] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed Jan. 31, 2025.
[10] Cottrill A, Cubanski J, Neuman T. What to Know About Medicare Coverage of Telehealth. *Kaiser Family Foundation*. Oct. 2, 2024. https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-coverage-of-telehealth/#. Accessed Feb. 11, 2025.
[11] *Affordable Connectivity Program Consumer FAQ*. Federal Communications Commission. https://www.fcc.gov/affordable-connectivity-program-consumer-faq. Jan. 31, 2025.

Hospital-at-Home

The association urges Congress to extend for five years Hospital-at-Home program flexibilities and waivers, set to expire in March, that allow Medicare-certified hospitals to continue providing inpatient-level care at home. The association supports the language in Section 211 of the health care title of the initially negotiated end-of-year package on extending acute hospital-at-home care waiver flexibilities for five years.

The Hospital-at-Home program was a large part of providing care during the public health emergency, and CMS provided flexibility through Acute Hospital Care at Home waivers to allow Medicare-certified hospitals to treat patients with inpatient-level care in their homes.[12] Essential hospitals across the United States have leveraged hospital-at-home programs to create capacity while also addressing social determinants of health and ensuring everyone has access to care.[13] For qualifying patients, hospital-at-home models can replace care otherwise provided in an inpatient setting, but a historic lack of reimbursement from both public and private payers hindered the wider adoption of such programs. Essential hospitals depend on telehealth services and the Hospital-at-Home program to care for their communities, and congressional support of these priorities is necessary to continue serving patients across the country.

340B Drug Pricing Program

The 340B Drug Pricing Program continues to work as Congress intended. America's Essential Hospitals urges Congress and the administration to protect the 340B program and ensure all stakeholders comply with the law.

The 340B program is a key component of the patchwork federal support essential hospitals rely on to meet their safety net mission. Congress established the 340B program to enable essential hospitals and other covered entities "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[14] With 340B savings, essential hospitals target resources to services and programs that meet their community's unique challenges at nearly no cost to taxpayers. It is important to emphasize that this program was created so that hospitals can stretch their scare resources to provide the best care and improve services. In the 119th Congress, we ask you to support providers, patients, and other allies defending the 340B program and oppose efforts by drug manufacturers seeking to weaken it.

In the 118th Congress, the Senate 340B Bipartisan Working Group's SUSTAIN 340B Act was a discussion draft of legislation that would have made significant changes to the program. In feedback to the working group, America's Essential Hospitals praised the draft's provisions that affirm the program's original intent to support hospitals serving low-income and disadvantaged patients and raised concerns regarding provisions that would threaten access to the country's most under-resourced populations.

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[12] Centers for Medicare & Medicaid Services. CMS Announces Comprehensive Strategy to Enhance Hospital Capacity amid COVID-19 Surge. Nov. 25, 2020. https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge. Accessed Oct. 8, 2024.

[13] Guinan M, Painchaud A. Essential Hospitals Advance Equity through Hospital-At-Home Model. *America's Essential Hospitals*. April 2022. https://essentialhospitals.org/wp-content/uploads/2022/04/Hospital-at-Home-Policy-Brief-April-2022.pdf. Accessed Oct. 8, 2024.

[14] H.R. REP. 102-384(II), p. 12.

Hospital Outpatient Department (HOPD) "Site-Neutral" Payment Cuts

We urge Congress to protect access to care in underserved communities and support the safety net by rejecting so called "site-neutral" payment policies, which would disproportionately harm essential hospitals, their patients, and the communities they serve.

Millions of people in the United States lack sufficient access to health care services because they live in "health care deserts"—communities with too few health care practitioners. Health care deserts persist in rural and urban areas across the entire country. Left without access to basic care services, many people turn to costlier care in hospital emergency departments. Hospitals overcome this problem by opening clinics in neighborhoods underserved by private-practice clinicians. They also provide specialty care in community clinics so that patients can receive needed care closer to home. But HOPD payment cuts badly undermine these efforts.

Essential hospitals operate large ambulatory networks to bring care to people where they live and work. These clinics often are the only source of primary and specialty care for medically and socially complex patients. This reach into communities is key to ensuring continuity of care for patients whose health is shaped by inadequate transportation and housing and other social risk factors. Onerous "site-neutral" payment policies jeopardize access to care by making clinic expansion into underserved communities financially unsustainable.

Essential hospital outpatient departments play a fundamental role in ensuring access to care. These policies are not neutral— they are a cut to essential hospitals and would harm the patients they serve.

Essential Health System Designation

We urge Congress to pass legislation to support the nation's health care safety net and to define essential hospitals.

The 118th Congress saw the introduction of bipartisan House legislation that would establish a federal definition of "essential health system" to give Congress a new tool to target support to those foundational members of the nation's health care safety net. These hospitals and health systems share a mission to care for everyone, including the uninsured and underinsured, low-income patients, and other marginalized people. Entire communities rely on these essential health systems for lifesaving services, such as trauma and burn care; public health and safety; and health professionals training. Yet, despite this critical role, no statutory definition exists to define these safety net providers.

We are grateful for the work of Reps. Lori Trahan (D-Mass.) and David Valadao (R-Calif.), who introduced this bipartisan legislation in the 118th Congress, which would support essential hospitals across the country. We are working with these offices to reintroduce the legislation in the 119th Congress.

Workforce and Graduate Medical Education (GME)

America's Essential Hospitals urges Congress to expand, protect, and fund the health care workforce through policies that will enable essential hospitals to continue caring for Americans with the greatest health and socioeconomic needs and through the expansion of Medicare GME caps.

Essential hospitals play a key role in training and supporting the provider pipeline and ensuring the next generation of clinicians and allied health professionals is equipped to meet the health

and socioeconomic needs of the communities they serve. Our member hospitals are at the forefront of training the next generation of physicians, training nearly three times as many physicians as nonmember teaching hospitals in 2021 (231 physicians per essential hospital compared with 84 physicians per other hospital on average).[15] Despite the lack of adequate funding, many essential hospitals train a number of residents above their Medicare GME cap to meet the needs of their communities.

According to our analysis of Medicare cost reports, essential hospitals trained 30 percent more residents than their Medicare GME caps fund. In total, nearly 10,000 resident positions at our member hospitals were unfunded in 2022.[16] Given this funding gap, we support legislation that would reinforce essential hospitals' ability to train physicians, including the Substance Use Disorder Workforce Act (H.R. 7050), sponsored by Reps. Brad Schneider (D-Ill.), David Valadao (R-Calif.), Annie Kuster (D-N.H.), Mike Carey (R-Ohio), and Mike Kelly (R-Pa.) in the 118th Congress**.** This legislation aims to train more doctors equipped to combat the substance use disorder and overdose epidemic by creating 1,000 additional Medicare residency positions over five years in hospitals with addiction medicine, addiction psychiatry, or pain management programs.

Violence against and intimidation of the health care workforce remains an issue nationwide, including among essential hospitals. In support of the health care workforce, the association endorsed the Safety from Violence for Healthcare Employees (SAVE) Act of 2023 (H.R. 2584/S. 2768), introduced by Reps. Larry Bucshon (R-Ind.) and Madeleine Dean (D-Pa.) and Sens. Marco Rubio (R-Fla.) and Joe Manchin (D-W.Va.) in the 118th Congress. This legislation would provide legal penalties for individuals who knowingly and intentionally assault or intimidate hospital employees, like those now in place for flight crews.

In addition, America's Essential Hospitals endorsed the Keeping Obstetrics Local Act (S. 5236) sponsored by Sen. Ron Wyden (D-Ore.) in the 118th Congress. This legislation would confront ongoing workforce shortages at rural and urban hospitals that serve many Medicaid patients, improving access to maternal care in underserved communities. From the very beginning of their lives, many Americans have a relationship with our member hospitals—one in 12 U.S. residents are born at an essential hospital, and Medicaid covers nearly 60 percent of live-birth deliveries at these hospitals.[17] This legislative proposal includes measures that would assist hospitals that invest in the maternal health care needs of their communities.

As workforce recruitment and retention have become urgent concerns, maintaining a robust and mentally and physically healthy workforce at sufficient levels has become a top concern. The American Association of Medical Colleges forecasts a shortage of 86,000 physicians by 2036.[18] Almost half of working physicians in the United States are 55 and older, which means a

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[15] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed Jan. 31, 2025.
[16] Centers for Medicare & Medicaid Services. Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data Files FY 2022. May 2024 release.
[17] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Accessed Jan. 31, 2025.
[18] Dall T, Reynolds R, Chakrabarti R, et al. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. American Association of Medical Colleges. March 2024. https://www.aamc.org/media/75236/download?attachment. Accessed Oct. 8, 2024.

significant number of physicians will reach retirement age within the next decade.[19] Ensuring the future availability of workers is a vital step in building a strong and resilient workforce.

Cybersecurity

We urge Congress to engage with stakeholders and pass comprehensive legislation that helps essential hospitals improve their digital infrastructure, meets cybersecurity needs, and protects hospitals across the country and their patients from future attacks.

In 2024, there was a notable increase in cyberattacks that have breached patient privacy and caused major disruptions to care across the country. The ripple effects of the cyberattack on Change Healthcare devastated the nation's health care system, and created severe challenges for hospitals, physicians, pharmacists, and other providers nationwide. America's Essential Hospitals appreciates legislation that seeks to improve cybersecurity in the U.S. health care system and target funding for low-resource essential hospitals to improve cybersecurity measures.

America's Essential Hospitals and our members urge Congress to act on these critical issues in the 119th Congress. Your support is vital to providing services and care to the communities that depend on Congress to keep the nation's health care safety net intact.

If you have any questions, or would like to learn more about these issues, please contact Jason Pray, vice president of legislative affairs, at jpray@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

[19] American Association of Medical Colleges. *2022 Physician Specialty Data Report Executive Summary*. 2023;4. https://www.aamc.org/media/63371/download?attachment. Accessed Oct. 8, 2024.