American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

March 5, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor & Pensions
United States Senate
Washington, DC 20510

RE: Strategies to address health care costs

Dear Chairman Alexander:

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) appreciates the opportunity to respond to your request for information about strategies to address the cost of health care in America. We also applaud the efforts taken by your committee to address this important issue.

The cost – and affordability – of health care in America affects all stakeholders, including patients and their families, employers, policymakers and care providers. Hospitals and health systems understand the importance of making health care more affordable for everyone. Hospitals and health systems have been tackling the issue head on, taking steps to redesign care and implement operational efficiencies. However, to make care more affordable, every stakeholder – hospitals, other providers, insurers, drug companies, device makers, the government and patients – have a role to play in this effort.

Although the rate of growth in health expenditures has slowed in recent years, in 2017 health spending accounted for 18 percent of Gross Domestic Product (GDP) and is projected to reach 20 percent of GDP by 2026. Hospitals' share of total health expenditures has gradually decreased over time. As a percentage of total national health expenditures, hospital care declined from 43 percent in 1980 to 34 percent in 2017. By comparison, during that same period, retail prescription drug spending, which

does not include drugs administered in institutional settings, doubled as a share of total national health expenditures.[1]

Hospitals and health systems have made great strides in improving patient quality of care. For instance, preliminary estimates for 2015, the most recent data available, show a 21 percent decline in hospital-acquired conditions (HACs) since 2010.[2] There also has been a significant decline in hospital-acquired infections (HAIs), with the standardized infection ratio for central line-associated bloodstream infections showing a more than 40 percent decrease between 2009 and 2014.[3]

Any steps to lower health care costs should be taken in a way that avoids unintended consequences, such as worse health outcomes, barriers to access, or short-term savings at the expense of long-term spending. For example, it is important to note that patients treated in hospitals tend to be sicker and more complex than those in other settings, and that reductions in coverage for hospital care can affect access for vulnerable populations. A comparison of Medicare beneficiaries treated in hospital outpatient departments (HOPDs) to those treated in independent physician offices found that beneficiaries treated in HOPDs were more likely to be:

- Under age 65 and eligible for Medicare based on disability.
- Over age 85.
- Dually eligible for Medicaid.
- From lower-income areas.
- Burdened with more severe chronic conditions.
- Previously hospitalized.[4]

There are two primary ways to reduce health care spending: Decrease per unit costs or reduce the amount of care provided. Policymakers could pursue a number of approaches within these two broad categories. For example, policymakers could help hospitals reduce unit costs by advancing policies that reduce input costs, such as the cost of prescription drugs. Other policy actions could help reduce what hospitals spend to comply with outdated regulations that do not contribute to the safety or efficacy of care. To reduce utilization, policymakers could advance public health and social service

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[1] National Health Expenditure Data, 1980-2017. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

[2] National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data From National Efforts To Make Health Care Safer. Content last reviewed December 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html

[3] Chartbook on Patient Safety. Content last reviewed September 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/chartbooks/patientsafety/index.html

[4] Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices. KNG Health Consulting, prepared for the AHA. https://www.aha.org/system/files/2018-09/hopd-independent-physician-offices-care-comparison3.pdf

interventions that help prevent the incidence of illness, as well as support providers in developing new models of care that drive waste from the system.

Below, we discuss approaches to reducing unit costs and unnecessary utilization and incentivizing care that improves the health and outcomes of patients. We also highlight recommendations for implementing those steps, as well as overcoming obstacles to their implementation.

REDUCING UNIT COSTS

The cost of providing hospital care is subject to a number of inputs, such as the cost of prescription drugs, new technologies and labor expenses, as well as a range of administrative costs associated with managing complex organizations, such as billing for services and negotiating with health plans. In addition to ensuring that their staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions, hospitals must provide 24/7 access to care, including access to specialized services. And unlike other health practitioners and facilities, hospitals and health systems provide emergency care for all patients who seek it, regardless of ability to pay. Despite its importance, the standby role of hospitals is not explicitly funded. Until a patient arrives with an emergency need, there is no payment for the staff and facility to be at the ready. Without explicit funding, the standby role is built into the cost structure of full-service hospitals and supported by revenues from direct patient care. High rates of uninsured and underinsured patients also drive up per unit costs for paying patients as the cost of such care must be borne by others in the system.

Despite rising input costs, both hospital price and spending growth has slowed in recent years. According to the Centers for Medicare & Medicaid Services (CMS), price growth for hospital care services was just 1.7 percent in 2017.[5] This trend continued in 2018 with year over year price growth still at 1.7 percent, according to the Altarum Center for Value in Health Care. Altarum also found that hospital spending growth in 2018 was lower than all other categories of services, including physician and clinical services and prescription drugs.[6]

The AHA urges Congress and the Administration to take further action to help reduce input and administrative costs, as well as maximize the number of insured patients. Specifically, we recommend you focus your efforts on ways to:

- Reduce the cost of prescription drugs.
- Reduce regulatory burden and pursue administrative simplification.

[5] National Health Expenditure Data, 1980-2017. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html
[6] Health Sector Spending. Altarum. https://altarum.org/solution/health-sector-spending

- Support hospitals in improving patient quality and safety.
- Maximize enrollment in comprehensive coverage.
- Enact liability reform.

More detailed recommendations on each follows.

Reduce the Cost of Prescription Drugs. The high cost of prescription drugs is putting a strain on Medicare, Medicaid and the entire health care system. The primary driver behind increased drug spending is higher prices, not increases in utilization. Within the health care field, "pharmaceuticals" were "the fastest growing category" in terms of pricing for every month of 2016 and for most months of 2017. And while some reports suggest that prices have moderated, we continue to see both high launch prices for new drugs and increases in prices for existing drugs. Limited competition and drug shortages have facilitated this price growth.

Hospitals and health systems are major purchasers of prescription drugs, and the high and rising cost of critical medicines is putting patient access to care at risk. Given the lack of data available on providers' experience as drug purchasers, the AHA, along with the Federation of American Hospitals and the American Society of Health System Pharmacists commissioned a study to evaluate our members' experience with drug pricing. This study was released in January and follows on a 2016 study that looked at hospital and health systems' experience with drug prices in the inpatient setting specifically. The most recent study found that after historic increases in hospital spending on drugs in the inpatient space of 38.7 percent per admission from 2013 to 2015, total inpatient and outpatient spending then continued to rise by an additional18.5 percent per adjusted admission from 2015 to 2017. Hospitals experienced price increases in excess of 80 percent across certain classes of drugs, including those for anesthetics, parenteral solutions, opioid agonists and chemotherapy. Unsurprisingly, hospitals reported that increased drug spending affects many aspects of their operations. Hospitals described having to take a number of measures to address budget pressures associated with changing drug prices, such as identifying alternative therapies, doing more in-house compounding, delaying investments in or replacement of equipment, reducing staffing and reducing services offered.[7]

The AHA is working with a number of stakeholders, including insurers and consumers, to raise awareness of and develop solutions to help rationalize drug prices while still supporting innovation.

The AHA urges Congress and the Administration to support patients and providers by taking immediate action to rein in the rising cost of drugs, including by taking steps to increase competition among drug manufacturers; improve transparency in drug pricing; advance value-based payment models for drugs;

[7] "Recent Trends in Hospital Drug Spending and Manufacturer Shortages," NORC at the University of Chicago for the AHA, the FAH, and the ASHP, January 15, 2019.

and increase access to drug therapies and supplies. We also continue to advocate for passage of the Creating and Restoring Equal Access to Equivalent Samples Act (CREATES Act).

In addition, we urge Congress and the Administration to take action against anti-competitive tactics, including by denying patents for evergreened products, increasing oversight regarding "pay-for-delay" tactics and deeming them to be presumptively illegal, and limiting orphan drug incentives to true orphan drugs.

We applaud recent efforts taken by the Food and Drug Administration (FDA) to address drug prices and shortages. However, if the FDA is to continue and expand its oversight of drug manufacturers, it will need resources to do so. We encourage policymakers to ensure that the FDA has the funding and tools it needs to ensure proper oversight.

Another practical obstacle to effectively managing rising drug costs is the lack of a clear picture of the true impact of rising drug costs. There is currently no standardized collection and reporting on total drug spending in the United States. A significant portion of drug spending is masked due to how input costs, such as drugs, are bundled into a single provider reimbursement, such as diagnosis-related groups (DRGs) in the Medicare program. National health expenditure data released annually by CMS reflect retail drug spending only and do not account for these input costs. Therefore, these data do not reflect instances when drug manufacturers specifically target provider-administered drugs for price increases. **The AHA strongly supports development of an approach for collecting and reporting total drug spending data.**

Reduce Regulatory Burden and Pursue Administrative Simplification. Hospitals and health systems face a high number of regulatory requirements, some of which increase administrative expenses and staffing needs for compliance without improving the quality or safety of patient care. Nationally, it is estimated that hospitals, health systems and post-acute care providers spend nearly $39 billion annually on the administrative aspects of regulatory compliance. An average-sized community hospital spends $7.6 million per year, or $1,200 per admission, to support compliance with regulations from just four federal agencies.[8] Compounding the burden associated with this patchwork of federal regulatory requirements, hospitals also must contract with more than 1,000 commercial insurers nationally, each with their own reporting and administrative requirements.

The AHA has supported recent efforts taken by the Administration to reduce unnecessary burdens and reporting requirements. However, the hospital field still faces duplicative regulation and compliance burdens, along with myriad requirements from insurance plans, each of which have different claims processing, recordkeeping and medical necessity requirements.

[8] "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers," Manatt for the American Hospital Association, October 2017.

Reducing administrative burden would enable providers to focus on patients, not paperwork, and reinvest resources in improving care, improving health and reducing costs. The AHA supports strategies to reduce administrative requirements without compromising patient outcomes. Policymakers should:

- Reduce administrative activities related to regulatory compliance so that clinicians can spend more time on patients rather than paperwork and ensure a level regulatory playing field.
- Examine the inpatient rehabilitation facility "60% Rule," which requires 60 percent of admissions to have one of 13 qualifying medical conditions.
- Safeguard against unnecessary burden in billing and other transaction standards related to HIPAA and ensure an achievable roadmap toward greater adoption.
- Advance efforts to minimize the burdens associated with prior authorization, such as lack of uniformity on requirements, transparency and regulation, along with improvements in technology and electronic transmission of information.
- Eliminate the Recovery Audit Contractor (RAC) contingency fee structure and instead direct CMS to pay RACs a flat fee, as every other Medicare contractor is paid. In addition, CMS should rationalize payments to RACs by lowering payments for poor RAC performance due to high rates of incorrect denials.
- Permanently remove the 96-hour physician certification requirement as a condition of payment for critical access hospitals.

Support Hospitals in Improving Patient Quality and Safety. Over the past decade, hospitals and health systems have significantly reduced the incidence of many HACs and HAIs, reduced avoidable readmissions, dramatically reduced early-elective deliveries and improved outcomes for patients. Further, patients have reported more favorable experiences with their hospitals.

To sustain and accelerate progress, changes are needed to alleviate complexity, burden and lack of alignment. The AHA makes the following recommendations for policymakers to consider:

- Build on important progress made by the Administration by continuing to streamline and coordinate quality measures to focus on the "measures that matter" most to improving health and outcomes while reducing burden on providers.
- Advance integrated and coordinated care by modifying standards and the conditions of participation and ensuring the regulations are clear, well-vetted and consistent.
- Support effective care integration through research and policies that support systems as they reinvent care delivery.
- Modify the post-acute care value-based payment program so it is more equitable and less complex.

- Monitor the impact of the implementation of the physician payment programs on quality and care coordination.
- Promote adjustment for sociodemographic factors in quality measurement programs where appropriate to improve fairness and reduce health care disparities.
- Promote advanced illness management to better honor patients' wishes at the end-of-life and remove barriers to expanding access to palliative care services.
- Ensure patients' access to accurate quality information by suspending and modifying the faulty hospital star ratings.

However, as hospitals and health systems look to improve care further, they face significant challenges as a result of the burden imposed by current requirements and confusion because the policies are not aligned. A dizzying array of quality measures, inconsistencies in reporting requirements, and concerns about the validity of electronic clinical quality measures (eCQMs) threaten progress and, in some cases, can have a negative impact on quality of care. In addition, conditions of participation (CoPs) outline foundational requirements that ensure that patient care is appropriate and safe; however, significant work is necessary to ensure CoPs are evidence-based and place rigorous, but realistic, expectations on providers. Lastly, policymakers have implemented quality measurement, quality improvement and CoPs in a siloed fashion. Advancing quality requires a more cohesive framework that aligns all three of these core elements.

Maximize Enrollment in Comprehensive Health Care Coverage. Health insurance is intended to help individuals and families access and finance their health care and to prevent them from experiencing catastrophic financial hardship when illness or injury occurs. However, broad enrollment in coverage also can reduce unit costs since fixed costs for infrastructure and other overhead can be shared across a larger pool of people. This is true not only for hospital care, but for health plans and the cost of coverage as well.

Over the past decade, we have made significant strides in enrolling more individuals in coverage. However, approximately 28 million people remain uninsured, and that number has increased in each of the last two years. Simultaneously, the number of people who are *underinsured* is growing – people who have coverage but cannot afford their co-pays and deductibles. Gaps in health care coverage is one of the primary drivers of high rates of uncompensated care, and America's hospitals and health systems provided $38.4 billion in uncompensated care in 2017 alone.[9]

The AHA supports bolstering our current public/private framework for coverage. We encourage policymakers to preserve and build on the strong foundation of employer-sponsored coverage and further strengthen the individual market while

[9] AHA Uncompensated Care Fact Sheet, January 2019

ensuring that Medicare and Medicaid are available to our most vulnerable populations. Specifically, we encourage Congress to:

- Promote enrollment in all forms of coverage through a robust public relations and educational campaign. Hospitals and health systems already do considerable work to connect the uninsured to coverage, and the AHA would be an eager contributor in any public/private partnership to promote enrollment in health coverage.
- Ensure the stability and affordability of the Health Insurance Marketplaces by fully funding the cost-sharing reduction subsidies, implementing a national reinsurance program, ensuring accurate risk adjustment, and protecting consumers from health plans that do not meet all of the consumer protections established in federal law.
- Ensure patients can access all of the services necessary to get and stay healthy by protecting access to a minimum set of essential health benefits and enforcing existing federal parity laws to ensure coverage for physical and behavioral health benefits, including substance use disorder treatment.
- Encourage states that have not expanded Medicaid to do so, including through new, innovative waivers.
- Fix the "family glitch" to ensure that working families have access to affordable coverage, and expand access to federal subsidies for middle class workers who otherwise do not have access to affordable coverage.

Enact Liability Reform. The high costs associated with the current medical liability system not only harm hospitals and physicians, but also their patients and communities. Across the nation, access to health care is being negatively impacted as high insurance costs and risk of litigation affect physicians' willingness to continue providing services. The Congressional Budget Office and others have found that medical liability reform could save $50 billion over 10 years, depending on the policies implemented. The AHA supports reducing unnecessary costs in the system by passing comprehensive medical liability reform, including caps on non-economic damages and allowing courts to limit attorneys' contingency fees.

REDUCING UNNECESSARY UTILIZATION

As you noted in your letter, some analysts suggest that there is a significant amount of waste in the health care system that, if removed, could result in significant spending reductions. Hospitals and health systems are working to reduce waste by redesigning clinical care pathways and helping patients navigate the health care system. **America's hospitals and health systems are fully committed to and engaged in the ongoing transformation of health care from a volume-based to a value-based care system.**

These efforts include multiple accountable care organization (ACO) initiatives across all payer types, advanced primary care models and episode-based payments, such as the Bundled Payments for Care Improvement (BCPI) program. These programs encourage

providers to move away from fee-for-service toward integrated and innovative delivery models that may improve care and lower cost. However, more can be done to work toward this objective.

Below we recommend several actions Congress can take to support access to high-value care while reducing low-value or redundant care, including:

- Support continued innovations in care delivery and payment reform.
- Advance adoption and use of telehealth capabilities.
- Invest in public health and non-medical social interventions to prevent onset of disease and injury.
- Increase access to behavioral health care.

More detailed recommendations on each follows.

Support Continued Innovations in Care Delivery and Payment Reform. From 2013 to 2017, the number of hospitals that reported having established an ACO increased by 102 percent. In 2017, hospitals participated in 297 of the 472 ACOs in the CMS Medicare Shared Savings Program (MSSP), and hospital-affiliated ACOs accounted for 56 percent of net savings in the program.

Hospitals and health systems are testing new approaches to delivering higher-quality care at lower cost through alternative payment models. This includes the use of resources to cover health-related, non-medical services and experimenting with the use of technology in new and innovative ways. We also support promoting voluntary rather than mandatory payment and care delivery models through the Center for Medicare and Medicaid Innovation (CMMI) to advance high-value care that improves quality and efficiency. Specifically, we support:

- Balancing risk vs. reward in a way that encourages providers to take on additional risk but does not penalize those that need additional time and experience before they are able to do so.
- Providing maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals. This entails waiving certain Medicare program regulations that frequently inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.
- Ensuring participants have readily available, timely access to data about their patient populations. CMMI should actively explore and dedicate resources to determining methods that would provide participants with more complete and timely data.
- Including adequate risk adjustment methodologies to ensure that models do not inappropriately penalize participants treating the sickest, most complicated and most vulnerable patients.

- Minimizing regulatory burden to the greatest extent possible, such as those related to quality reporting requirements, as discussed in our report on the regulatory burden faced by hospitals, health systems and post-acute care providers.[10]

Invest in Public Health and Non-medical Social Interventions. One of the best ways to reduce health care utilization is to prevent the incidence of disease and injury. The primary mechanisms to do this are through public health interventions and addressing the social determinants of health. Indeed, studies indicate that social and environmental factors have a substantially larger impact on health outcomes than medical interventions. These factors include whether people have safe and stable housing; safe water and nutritious food; transportation to get to work, school or health care providers; meaningful social interactions; and personal safety. Public health interventions such as vaccinations, smoking cessation efforts, and the promotion of the use of helmets and seat belts have had significant impacts on the incidence of disease and injury. However, more must be done to ensure a robust public health infrastructure and that supportive environments are available in all communities across the U.S.

Hospitals and health systems are working with other stakeholders to coordinate and, in some instances, deliver public health and non-medical social interventions. We specifically recommend:

- Increased flexibility in funding and program design to address social factors through the blending and braiding of funds from various agencies/programs and/or utilizing waivers of, and flexibilities surrounding, administrative requirements so as to better coordinate services funded through state and federal programs and reduce unnecessary red tape.
- Creation of a model to bridge the gap between clinical care and community services, such as the recommendations developed by the AHA Task Force on Vulnerable Communities,[11] including:
    - **Screening and information** – Providers screen patients for particular social determinants of health needs prevalent in their communities and provide patients with information on community resources to address those needs.
    - **Navigation** – Providers act as navigators, proactively assisting patients in overcoming barriers to accessing community services by creating patient-specific action plans and tracking the implementation of the plan.
    - **Alignment** – Providers would partner with community stakeholders to more closely align the services that are available with the needs of community members.

[10] AHA Regulatory Overload Report, https://www.aha.org/guidesreports/2017-11-03-regulatory-overload-report
[11] Emerging Strategies to Ensure Access to Health Care Services: Addressing the Social Determinants of Health, https://www.aha.org/system/files/2018-02/social-determinants-health.pdf

Increase Access to Behavioral Health Care. Behavioral health issues – including, but not limited to, mental illness and substance use disorders (SUD) – affect nearly one in five Americans. In 2016, 10.4 million adults had a serious mental illness (SMI), which is defined as a mental, behavioral, or emotional disorder (excluding developmental and SUD) that results in serious functional impairment. In addition, 13 to 20 percent of children have a mental health disorder. In all, 20.1 million people aged 12 or older had a SUD in the past year. Further, while 29 percent of adults with any medical condition also have some type of mental health disorder, close to 70 percent of behavioral health patients have a medical co-morbidity. These co-occurring conditions result in worse outcomes, increased risk of other conditions, and higher utilization of costly services.

Despite the prevalence of these disorders and severity of their effects on health outcomes, only 43 percent of adults with a mental illness received behavioral health services in 2016. Less than 20 percent of adults with SUD received treatment. Access to behavioral health services is especially challenging for low-income and minority communities. According to the 2014 National Healthcare Quality and Disparities Report, black (62.1 percent) and Latino (55.6 percent) adults were less likely than white adults (72 percent) to receive behavioral health treatment.

One of the biggest barriers to access to behavioral health care is inadequate coverage for these services. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans that offer coverage for behavioral health services to provide the same level of benefits for mental health and/or substance use treatment and services as they do for medical/surgical care. However, the MHPAEA does not require that insurers provide behavioral health services, and the law has not been strictly enforced.

Other payment limitations make it difficult for providers to offer or sustain behavioral health services. Unlike many physical health procedures and conditions, there are currently no federally administered bundled payment models that provide reimbursement for holistic behavioral health or SUD treatment. Medicare also limits lifetime coverage of inpatient psychiatric hospital care. No other Medicare specialty inpatient hospital service has this type of cap on benefits. Medicaid contains two major payment limitations that preclude states from using federal funds to pay for certain behavioral health services. Although CMS recently announced new opportunities to claim federal Medicaid matching funds for services provided in institutions for mental disease (IMD), states have traditionally been unable to receive Medicaid reimbursement for care provided in certain psychiatric facilities. In addition, fee-for-service payments in Medicaid use the same procedure-based payment schemes as for physical health payments, which do not recognize the time-based nature of behavioral health.

In order to facilitate access to behavioral health services, we encourage you to:

- **Include behavioral health in value-based payment or total cost of care models** – As health systems are asked to take on greater risk for caring for populations through value-based payment models, behavioral health services should be included to encourage integration of care across settings.
- **Eliminate regulatory barriers to care coordination** – Policymakers must address the barriers to coordinated, effective care posed by the restrictions under 42 CFR Part 2, which limits the ability of providers to share important information regarding care and treatment for SUDs.
- **Reimburse for Transitional Care** – Transitional care that helps patients from inpatient to home and community-based settings is not reimbursed sufficiently despite its importance in reducing readmissions and maintaining individuals in community-based settings.
- **Provide Access to the Full Continuum of Services** – Congress should eliminate the 190-day limit on care in inpatient psychiatric facilities in Medicare and eliminate or permanently limit the scope of the Medicaid IMD exclusion to ensure access to inpatient and residential behavioral health care when clinically appropriate.

Advance Adoption of Telehealth. Telehealth connects patients to vital health care services through videoconferencing, remote monitoring, electronic consults and wireless communications. By increasing access to physicians and specialists, telehealth helps increase health care value and affordability. Virtual care technology saves patients time and money, reduces patient transfers, emergency department and urgent care center visits, and delivers savings to payers.

Currently, 76 percent of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology.[12] Almost every state Medicaid program has some form of coverage for telehealth services, and private payers are embracing coverage for many telehealth services. However, there are barriers to wide adoption of telehealth.

For the most part, Medicare limits coverage and payment for many telehealth services, lagging behind other payers. The Medicare program recently expanded coverage for telehealth services for stroke patients and substance use treatment in response to statutory changes. Medicare also expanded payments to clinicians for virtual check-ins. While promising, these incremental steps are not sufficient. In addition, limited access to adequate broadband services hampers the ability of some rural facilities to deploy telehealth. The challenge of cross-state licensure also looms as a major issue. Other policy and operational issues include credentialing and privileging, online prescribing, privacy and security, and fraud and abuse. The federal government needs to do more to increase the use of telehealth.

[12] AHA Annual Survey IT Supplement, 2011-2018

The AHA supports the expansion of patient access created by hospitals' efforts to deliver high-quality and innovative telehealth services. Specifically, we are advocating for:

- Expansion of Medicare coverage with adequate reimbursement that takes into consideration the nursing and other costs incurred at the site where the patient is located (originating site). CMS also should include telehealth waivers in all of its demonstrations and adopt a more flexible approach to adding new telehealth services to Medicare.
- Resolution of legal and regulatory challenges that hinder the provision of telehealth services.
- Additional federal research on the cost-benefits of telehealth.
- Improved access to broadband technology for rural areas by improving the Federal Communications Commission Rural Health Care Program.

These recommendations represent tangible strategies to further system transformation. In recent years, America's hospitals and health systems have been actively engaged in adapting to the changing health care landscape and new value-based models by eliminating silos and replacing them with a continuum of care to improve the health of their communities and overall affordability. Standing in the way of success, however, are portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the "Stark Law") and certain civil monetary penalties. **The AHA urges Congress to create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements so that physicians and hospitals can collaborate to improve care. Additionally, we support eliminating compensation from the Stark Law to return its focus to governing ownership arrangements.**

CONCLUSION

As the national voice for hospitals and health systems, the AHA knows that it is vital that we do our part to support the transformation of care delivery to value-based care. We have created The Value Initiative to provide leadership to the hospital field on the issue of affordability. Through The Value Initiative, the AHA provides hospital and health system leaders with the education, resources and tools they need to advance affordable health care and improve value within their communities. We also are gathering the data, information, and hospital experiences necessary to develop and support federal policy solutions that reduce health care costs, improve quality and enhance the patient experience. In addition, The Value Initiative will serve as a platform for hospitals and health systems to engage in dialogue and foster change on this important issue with key stakeholders, policymakers, think tanks and advocacy groups.

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the issues concerning the cost of health care in America. We are committed to working with Congress, the Administration and other

health care stakeholders to ensure that all individuals and families have the health care coverage they need to reach their highest potential for health.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President