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Federal Update
HFMA Mid America Summer Institute
Region 8

August 10, 2022

Agenda

- **Political Update**
- **Legislative Update**
- **Regulatory Update**

2022 Midterm Election

- Three months until midterm elections
- Factors to consider
  - Historical Trends
  - Presidential Approval Ratings
  - Turnout
  - Voter Satisfaction
  - Inflation, COVID-19, Crime etc.
- Unknowns

Historical Midterm Trends in the House

- **President Clinton**
  - 1994 – Lost 52 seats
  - 1998 – Gained 5 seats
- **President George W. Bush**
  - 2002 – Gained 8 seats
  - 2008 – Lost 30 seats
- **President Obama**
  - 2010 – Lost 63 seats
  - 2014 – Lost 13 seats
- **President Trump**
  - 2018 – Lost 40 seats

House and Senate Outlook

- Current Breakdown
  - House – 220 Ds/211 Rs
  - Senate – 48 Ds/2 Ind/50 Rs
- Upcoming Primaries
  - 10 states with upcoming primaries between now and election day.
- Senate seats to watch – PA, NV, GA, AZ, WI, NC

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Legislative Update

What is Congress working on?

- **Recent Activity**
  - Inflation Reduction Act/Build Back Better (BBB)/Reconciliation Bill
  - CHIPS Act/USICA/America COMPETES Act
- **Must pass legislation**
  - FY 2023 Appropriations
  - FDA User Fee Reauthorization
  - National Defense Authorization Act (NDAA)
- **Legislation that could pass**
  - Pandemic Preparedness legislation
  - Behavioral health legislation

Reconciliation Process

- Legislative process that makes it easier to pass a bill in the Senate
- Only requires a simple majority instead of the typical 60 vote threshold
- Cannot be filibustered
- Can only be used to change spending or revenues
- Items in bill must pass “Byrd rule” or be waived with a 60 vote threshold

How did we get here?

- **March/April 2021:** Two separate $2T+ packages, "American Jobs Plan"
- **July 2021:** Congressional Democrats and White House reach agreement on $3.5T package
- **September 2021:** Sen. Manchin announces he's not ready to support anything over $1.5T
- **November 2021:** House passes $1.2T bipartisan infrastructure bill along with $2.2T party-line "Build Back Better Act"
- **December 2021:** Sen. Manchin announces opposition to BBB

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How did we get here . . . continued

- **Spring/Summer 2022:** Rumored negotiations between Sens. Schumer and Manchin
- **July 15, 2022:** Sen. Manchin announces support for health care provisions only – drug pricing/ACA subsidies
- **July 22, 2022:** Sen. Manchin announces support for "Inflation Reduction Act"
- **August 7, 2022:** Bill passes Senate
- **August 2022:** House passage expected

Inflation Reduction Act

- **Rx drug policies**
  - Allows negotiation between government and drug companies
  - Phased in beginning with 10 Part D drugs in 2026
  - Cap out-of-pocket costs in Part D at $2,000/year
  - Cap cost-sharing for insulin at $35 for Medicare beneficiaries

Inflation Reduction Act

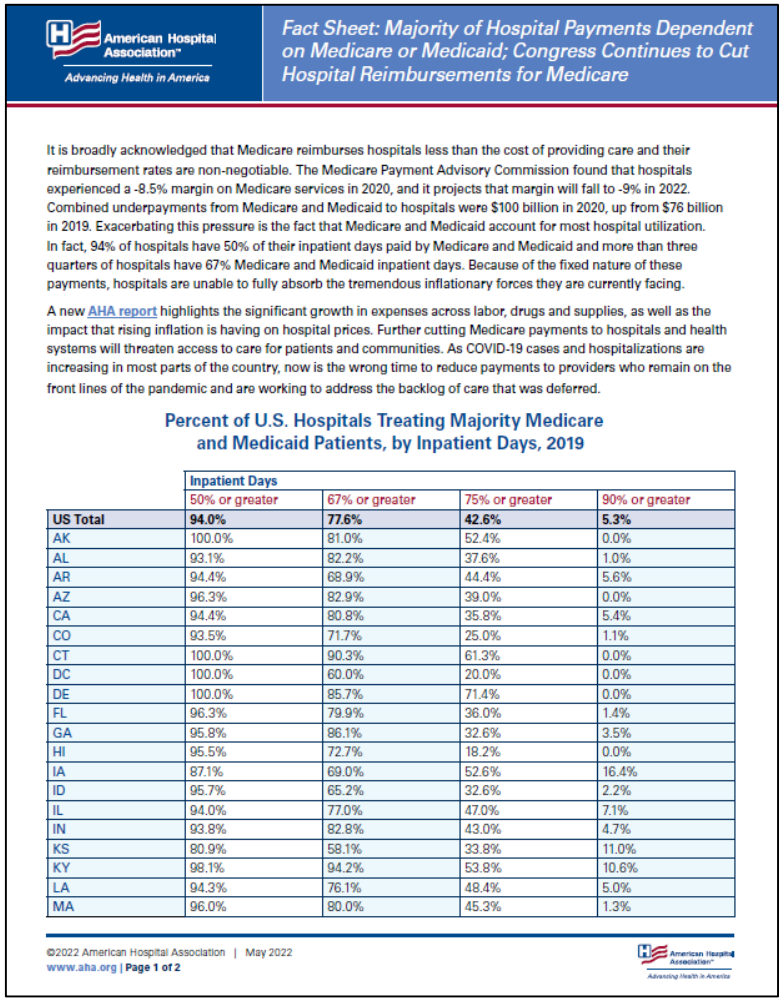
- **Tax provisions**
  - 15% Corporate Minimum Tax
  - $80B for tax enforcement to IRS

- **Other issues**
  - ACA premium assistance extended through 2025
  - Climate / energy provisions

Issues in Focus

- Financial Support
- Rural Extenders
- Protecting Health Care Workers
- Medicare Advantage/Insurer Issues
- Extension of Public Health Emergency/Waivers (Telehealth, Hospital at Home)

Hospital Costs and Federal Programs



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Fact Sheet: Majority of Hospital Payments Dependent on Medicare or Medicaid; Congress Continues to Cut Hospital Reimbursements for Medicare

It is broadly acknowledged that Medicare reimburses hospitals less than the cost of providing care and their reimbursement rates are non-negotiable. The Medicare Payment Advisory Commission found that hospitals experienced a -8.5% margin on Medicare services in 2020, and it projects that margin will fall to -9% in 2022. Combined underpayments from Medicare and Medicaid to hospitals were $100 billion in 2020, up from $76 billion in 2019. Exacerbating this pressure is the fact that Medicare and Medicaid account for most hospital utilization. In fact, 94% of hospitals have 50% of their inpatient days paid by Medicare and Medicaid and more than three quarters of hospitals have 67% Medicare and Medicaid inpatient days. Because of the fixed nature of these payments, hospitals are unable to fully absorb the tremendous inflationary forces they are currently facing.

A new AHA report highlights the significant growth in expenses across labor, drugs and supplies, as well as the impact that rising inflation is having on hospital prices. Further cutting Medicare payments to hospitals and health systems will threaten access to care for patients and communities. As COVID-19 cases and hospitalizations are increasing in most parts of the country, now is the wrong time to reduce payments to providers who remain on the front lines of the pandemic and are working to address the backlog of care that was deferred.

Percent of U.S. Hospitals Treating Majority Medicare and Medicaid Patients, by Inpatient Days, 2019

	Inpatient Days			
	50% or greater	67% or greater	75% or greater	90% or greater
US Total	**94.0%**	**77.6%**	**42.6%**	**5.3%**
AK	100.0%	81.0%	52.4%	0.0%
AL	93.1%	82.2%	37.6%	1.0%
AR	94.4%	68.9%	44.4%	5.6%
AZ	96.3%	82.9%	39.0%	0.0%
CA	94.4%	80.8%	35.8%	5.4%
CO	93.5%	71.7%	25.0%	1.1%
CT	100.0%	90.3%	61.3%	0.0%
DC	100.0%	60.0%	20.0%	0.0%
DE	100.0%	85.7%	71.4%	0.0%
FL	96.3%	79.9%	36.0%	1.4%
GA	95.8%	86.1%	32.6%	3.5%
HI	95.5%	72.7%	18.2%	0.0%
IA	87.1%	69.0%	52.6%	16.4%
ID	95.7%	65.2%	32.6%	2.2%
IL	94.0%	77.0%	47.0%	7.1%
IN	93.8%	82.8%	43.0%	4.7%
KS	80.9%	58.1%	33.8%	11.0%
KY	98.1%	94.2%	53.8%	10.6%
LA	94.3%	76.1%	48.4%	5.0%
MA	96.0%	80.0%	45.3%	1.3%

- **Medicare and Medicaid make majority of hospital payments**
- **The programs reimburse hospitals less than the cost of providing care and their rates are non-negotiable**
- **These fixed costs don't allow hospitals to absorb or deflect the impact of historic inflation levels**
- **Share the negative impact that Medicare payment cuts will have on your organization's ability to provide care**

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Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems

Hospitals are experiencing significant increases in expenses for workforce, drugs and medical supplies

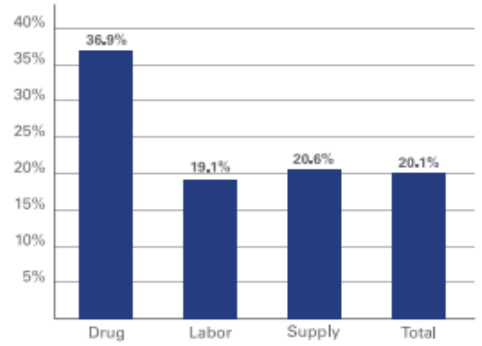
Introduction

For over two years since the outset of the COVID-19 pandemic, America's hospitals and health systems have been on the front lines caring for patients, comforting families and protecting communities.

With over 80 million cases[1], nearly 1 million deaths[2], and over 4.6 million hospitalizations[3], the pandemic has taken a significant toll on hospitals and health systems and placed enormous strain on the nation's health care workforce. During this unprecedented public health crisis, hospitals and health systems have confronted many challenges, including historic volume and revenue losses, as well as skyrocketing expenses (See Figure #1).

Hospitals and health systems have been nimble in responding to surges in COVID-19 cases throughout the pandemic by expanding treatment capacity, hiring staff to meet demand, acquiring and maintaining adequate supplies and personal protective equipment (PPE) to protect patients and staff and ensuring that critical services and programs remain available to the patients and communities they serve. However, these and other factors have led to billions of dollars in losses over the last two years for hospitals, and over 33% of hospitals are operating on negative margins.

Figure #1: Increase in Hospital Expenses Per Patient from 2019 to 2021



Source: January 2022 Kaufman Hall National Hospital Flash Report

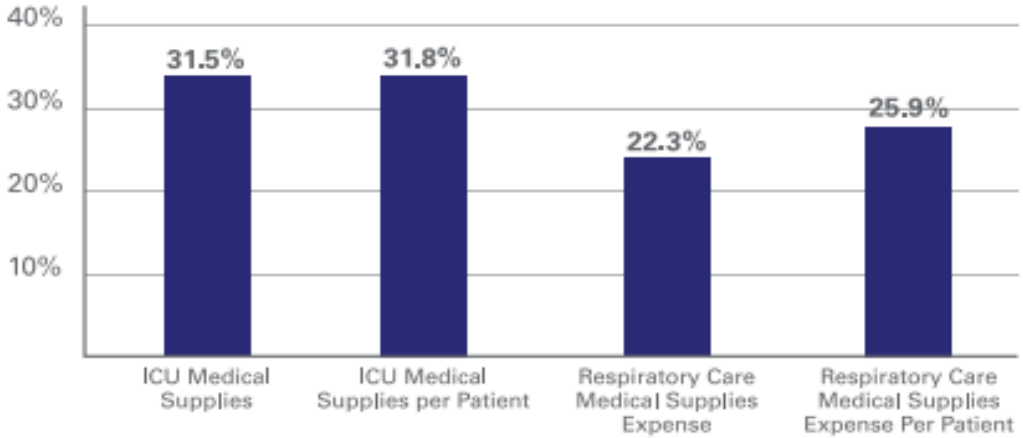
The most recent surges triggered by the delta and omicron variants have added even more pressure to hospitals. During these surges, hospitals saw the number of COVID-19 infected patients rise while other patient volumes fell, and patient acuity increased. This drove up expenses and added significant financial pressure for hospitals. Moreover, hospitals did not receive any government assistance through the COVID-19 Provider Relief Fund (PRF) to help mitigate rising expenses and lost revenues during the delta and omicron surges. This is despite the fact that more than half of COVID-19 hospitalizations have occurred since July 1, 2021, during these two most recent COVID-19 surges.

At the same time, patient acuity has increased, as measured by how long patients need to stay in the hospital. The increase in acuity is a result of the complexity of COVID-19 care, as well as treatment for patients who may have put off care during the pandemic. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019.[4]

As hospitals treat sicker patients requiring more intensive treatment, they also must ensure that sufficient staffing levels are available to care for these patients, and must acquire the necessary expensive drugs and medical supplies to provide high-quality care. As a result, overall hospital expenses have experienced considerable growth.

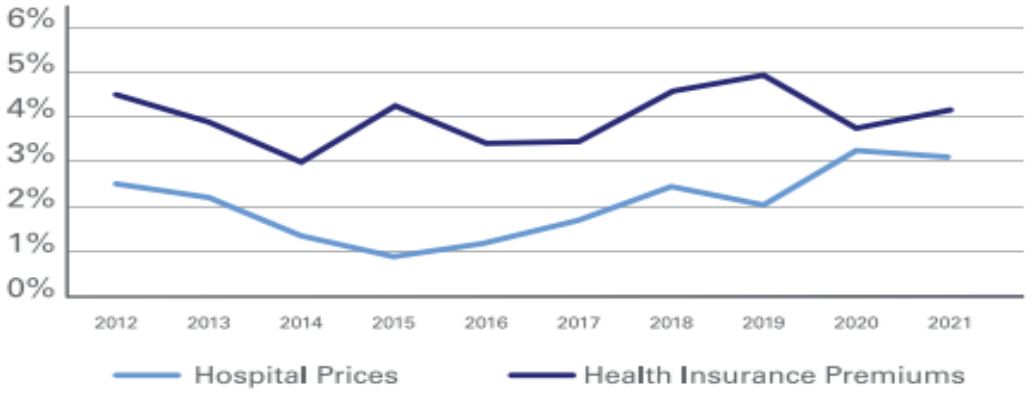
Data from Kaufman Hall, a consulting firm that tracks hospital financial metrics, shows that by the end of 2021, total hospital expenses were up 11% compared to pre-pandemic levels in 2019. Even after accounting for changes in volume that occurred during the pandemic, hospital expenses per patient increased significantly from pre-pandemic levels across every category. (See Figure #1)

Figure #6: Increase in Medical Supply Expenses in 2021 Compared to 2019 Baseline



Source: Syntellis Performance Solutions

Figure #7: Health Insurance premiums have constantly grown faster than hospital prices over the last decade.



Source: Health insurance premiums represent premiums for a family of four, from KFF Employer Health Benefits Survey, 2018-2021, and Kaiser/HRET Survey of Employer Health Benefits (2012-2017). Hospital prices: Bureau of Labor Statistics, annual average Produce Price Index data, 2012-2021 for Hospitals (series ID 622).

Inpatient Prospective Payment System (IPPS) Rule

- **Focus on "net decrease" in proposed rule for FY 2023**
- **Dear Colleague in House and Senate**
  - **112 signers in the House and 30 in the Senate**
- **Asked Congress to weigh in with CMS to make adjustments to final rule**
  - Inflationary pressures
  - Fixed reimbursement

Sequester Cuts

- **Statutory Pay-As-You-Go (PAYGO) sequester**
  - Resulting from American Rescue Plan

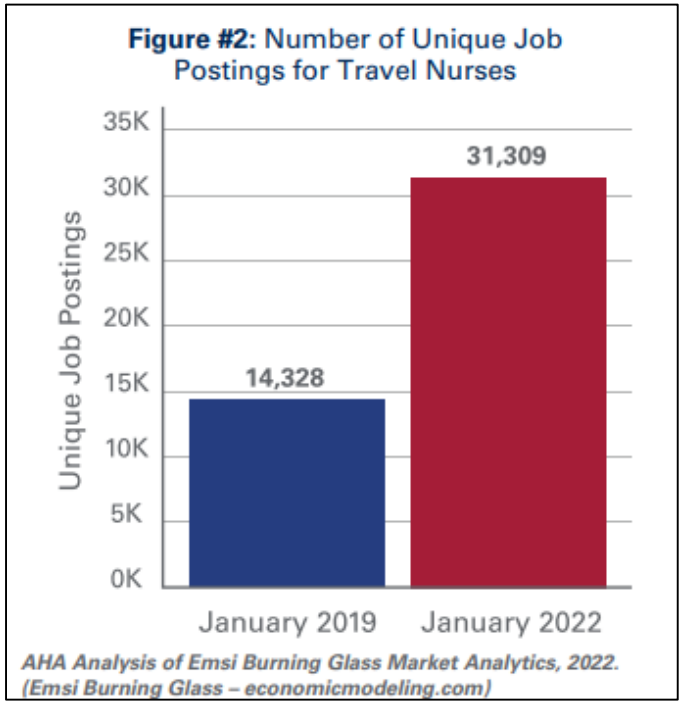
- **Medicare sequester**
  - Cuts were delayed during 2020 and 2021
  - April 1st: 1% cut went into effect
  - July 1st: Additional 1% cut, raising total cut to 2%

Rural Extenders

- Medicare Dependent Hospital (MDH) Program and Low Volume Adjustment (LVA) Program expiring Sept. 30th
- Bills in the House and Senate
  - Rural Hospital Support Act (S. 4009/H.R.1887) Sens. Grassley (IA) and Casey (PA), Rep. Sewell (AL)
  - Expecting updated legislation in the House

Travel Nurse Legislation

- **95% of health care facilities hired nurse staff from contract labor firms during the pandemic**
- **Staffing firms have tripled their revenues compared to 2020 levels**
- **"Travel Nursing Agency Transparency Study Act" (S. 4352/H.R. 8576)**
  - Sen. Cramer (ND), Rep. Murphy (NC) & Miller-Meeks (IA)
  - Government Accountability Office (GAO) study on the dynamics and business practices of travel nurse staffing agencies during the pandemic



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Protecting Health Care Workers

- **Recent studies**
  - **<u>44%</u>** of nurses reported experiencing physical violence
  - **<u>68%</u>** of nurses reported experiencing verbal abuse

- **No federal law protects health care employees from workplace assault or intimidation**

- **Letter to Attorney General Garland** (March 23)
  - Support legislation that would provide similar protections as those for flight crews and airport workers

- **Bipartisan legislation**
  - "Safety from Violence for Healthcare Employees" (SAVE) Act / H.R. 7961
  - Reps. Madeleine Dean (D-PA) / Larry Bucshon (R-IN)

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March 23, 2022

The Honorable Merrick Garland
Attorney General
U.S. Department of Justice
950 Pennsylvania Ave. NW
Washington, DC 20530-0001

Dear Attorney General Garland:

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) requests your support for legislation that would protect health care workers from assault and intimidation.

Fact Sheet: Workplace Violence and Intimidation, and the Need for a Federal Legislative Response

The Issue

The health care field has experienced an increase in workplace violence since the beginning of the COVID-19 pandemic. The pandemic has placed significant stress on the entire health care system, and front-line caregivers and teams at hospitals and health systems have worked tirelessly during the past two years to provide life-saving care to their patients and communities. Unfortunately, in some situations, patients, visitors and family support members have attacked health care staff and jeopardized our workforce's ability to provide care. Hospitals, health systems and their employees have expressed a strong interest in the passage of a federal law that would protect health care workers from violence and intimidation, just as current federal law protects airline and airport workers.

Background

Hospitals and health systems have long had robust protocols in place to detect and deter violence against their team members. Since the onset of the pandemic, however, violence against hospital employees has markedly increased — and there is no sign it is receding.

Day after day, the media reports about patients or family members physically or verbally abusing hospital staff. For example, a patient recently grabbed a nurse in Georgia by the wrist and kicked her in the ribs.[1] A nurse in South Dakota was thrown against a wall and bitten by a patient.[2] A medical student in New York who came from Thailand was called "China Virus," kicked, and dragged to the ground, leaving her hands bleeding and legs bruised.[3]

Data supports these news reports. Recent studies indicate, for example, that 44% of nurses reported experiencing physical violence and 68% reported experiencing verbal abuse during the COVID-19 pandemic.

Workplace violence has severe consequences for the entire health care system. Not only does violence cause physical and psychological injury for health care workers, workplace violence and intimidation make it more difficult for nurses, doctors and other clinical staff to provide quality patient care. Nurses and physicians cannot provide attentive care when they are afraid for their personal safety, distracted by disruptive patients and family members, or traumatized from prior violent interactions. In addition, violent interactions at health care facilities tie up valuable resources and can delay urgently needed care for other patients. Studies show that workplace violence reduces patient satisfaction and employee productivity, and increases the potential for adverse medical events.

AHA Take

Despite the incidence of workplace violence and its harmful effects on our health care system, no federal law protects health care employees from workplace assault or intimidation. By contrast, there are federal laws on the books criminalizing assault and intimidation against airline employees, and Attorney General Merrick Garland recently directed Department of Justice prosecutors to prioritize prosecutions under that statute given the rise in violent behavior on commercial aircraft during the COVID-19 pandemic. Vigorous enforcement of these federal laws creates a safe traveling environment, deters violent behavior, and ensures that offenders are appropriately punished. Our nation's health care workers who have tirelessly helped care for and treat the sick and dying while facing increased violence – especially during the last two years of the pandemic – deserve the same legal protections as airline workers. **Congress should enact legislation, modeled after 18 U.S.C. § 46504, that would provide similar protections as those that currently exist for flight crews, flight attendants and airport workers.**

[1] Shoshana Ungerleider and Sarah Warren, Nurses get spit on, kicked, assaulted. Stop hurting us. We are here to help you, USA Today (Jan. 10, 2022), www.usatoday.com/story/opinion/voices/2022/01/10/covid-nurses-assaulted-pandemic/9177310027/?gnt-cfr=1.

[2] Bart Pfankuch, Rising anger and violence toward health care workers hampering patient care in South Dakota, Argus Leader (Feb. 28, 2022), www.argusleader.com/story/news/2022/02/28/rising-anger-violence-toward-healthcare-workers-hurt-patient-care/6827480001/.

[3] Sydney Pereira, 'White Coats Don't Protect Us:' Asian Health Care Workers Speak Out Against Rise In Hate Crimes, Gothamist (Apr. 22, 2021), gothamist.com/news/white-coats-dont-protect-us-asian-health-care-workers-speak-out-against-rise-in-hate-crimes.

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Medicare Advantage Legislation

- **Improving Seniors' Timely Access to Care Act**
  - H.R. 3173: **309** cosponsors / S. 3018: 39 cosponsors
  - Focus on improving prior authorization processes

- **Legislation marked up in House Committee on Ways & Means on July 27th**

- **House Energy and Commerce Committee could consider, as well**

- **HHS Office of Inspector General findings**

HHS-OIG Report on MA Prior Auth/Claims Denials

Findings

- 13% of denied prior authorization requests met Medicare coverage rules
- 18% of claims denials met Medicare coverage rules and MAO billing rules
- Reasons for inappropriate denials:
  - Clinical criteria used by plan did not follow Medicare coverage
  - Inaccurate claims by MA plan that the provider had not provided sufficient medical records
  - Human error during manual claims processing reviews
  - Plan processing errors

HHS-OIG Recommendations to CMS

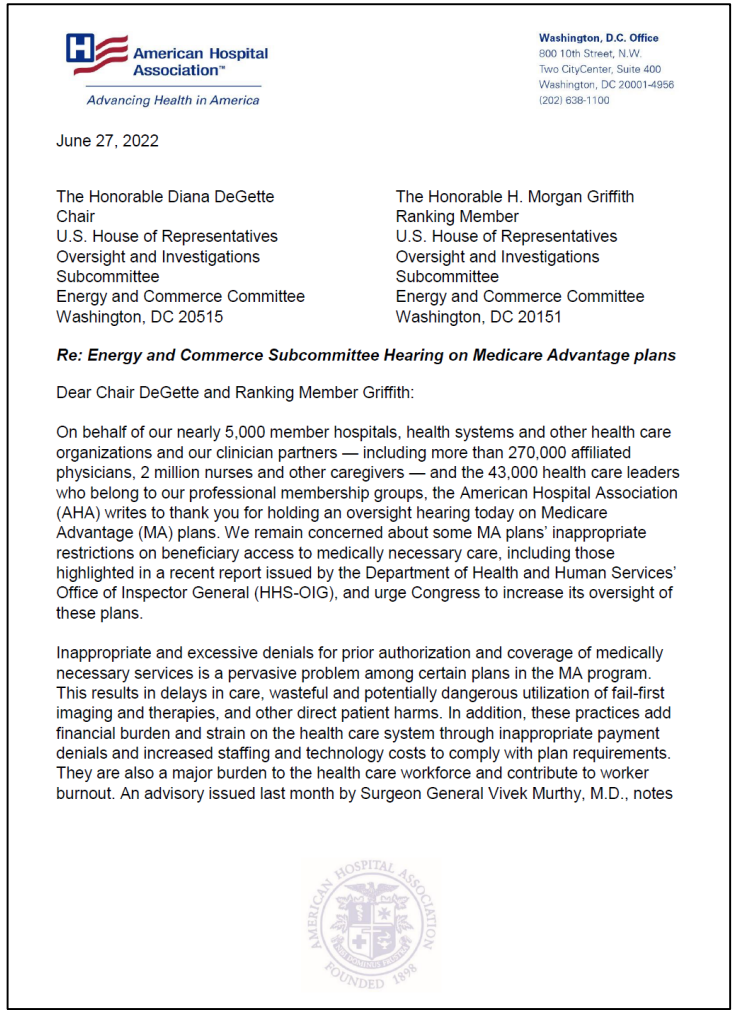
- Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews;
- Update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types; and
- Direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors

Medicare Advantage Hearing

- **House Energy and Commerce Oversight & Investigations Subcommittee – June 28th**
  - "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"

- **Focus on delays or denials of medically necessary care, access to specialty care, increased cost, disparities of care**

- **Witnesses: HHS OIG, GAO, MedPAC**



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June 27, 2022

The Honorable Diana DeGette
Chair
U.S. House of Representatives
Oversight and Investigations Subcommittee
Energy and Commerce Committee
Washington, DC 20515

The Honorable H. Morgan Griffith
Ranking Member
U.S. House of Representatives
Oversight and Investigations Subcommittee
Energy and Commerce Committee
Washington, DC 20151

Re: Energy and Commerce Subcommittee Hearing on Medicare Advantage plans

Dear Chair DeGette and Ranking Member Griffith:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and 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 to thank you for holding an oversight hearing today on Medicare Advantage (MA) plans. We remain concerned about some MA plans' inappropriate restrictions on beneficiary access to medically necessary care, including those highlighted in a recent report issued by the Department of Health and Human Services' Office of Inspector General (HHS-OIG), and urge Congress to increase its oversight of these plans.

Inappropriate and excessive denials for prior authorization and coverage of medically necessary services is a pervasive problem among certain plans in the MA program. This results in delays in care, wasteful and potentially dangerous utilization of fail-first imaging and therapies, and other direct patient harms. In addition, these practices add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan requirements. They are also a major burden to the health care workforce and contribute to worker burnout. An advisory issued last month by Surgeon General Vivek Murthy, M.D., notes

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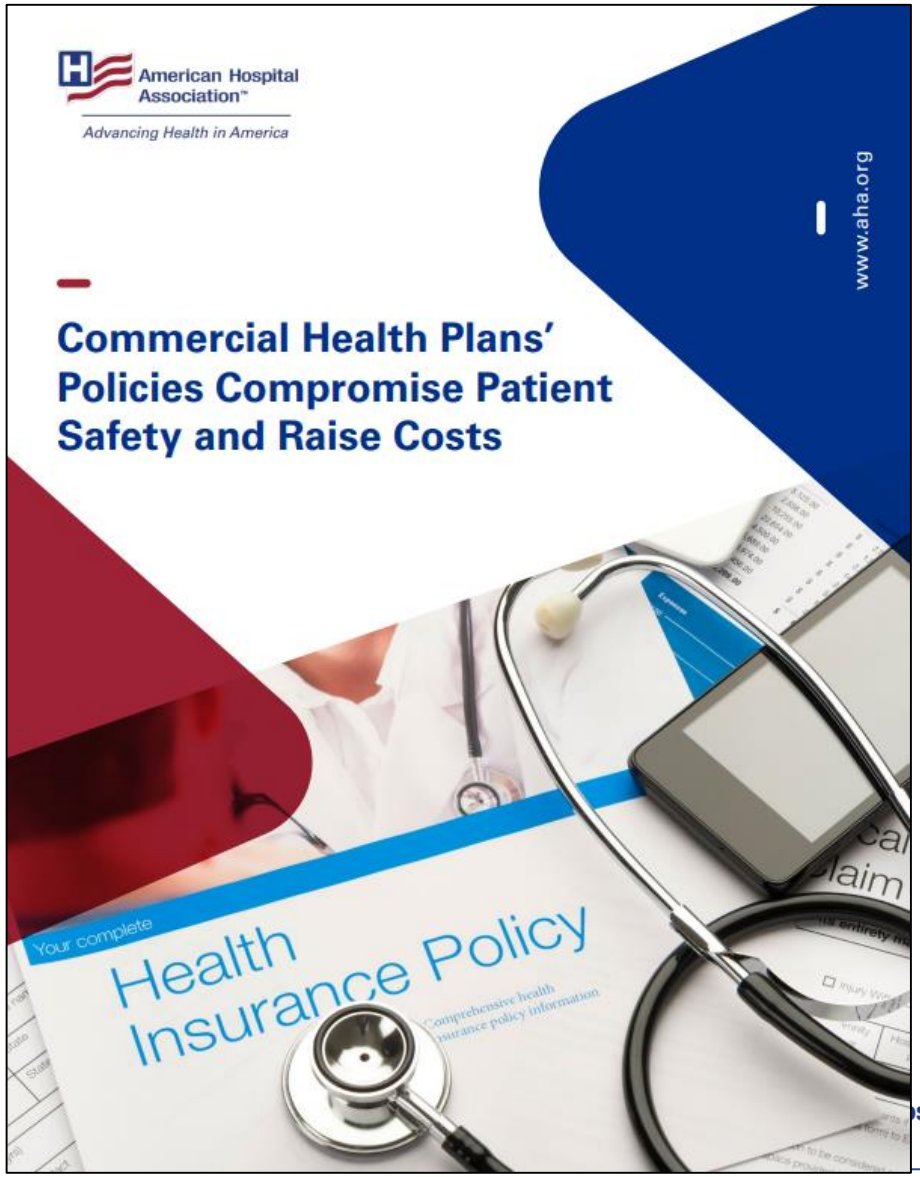
New AHA Report

- Delaying authorizations for patient care
- Fail first / step therapy policies
- Denying medically necessary care
- Insurer business conflicts of interest
- White bagging compromises safety
- Transaction fees
- Need for reform



CMS RFI on Medicare Advantage

- Covers a wide range of topics including MA program design, patient access to care, health equity, behavioral health, prior authorization/UM tools, VBP models, plan payment and quality ratings, and Medicare program sustainability.
- Responses due **August 31, 2022**
- AHA model letter for members will be forthcoming

Public Health Emergency + Waivers

- **Public Health Emergency (PHE) has provided many helpful flexibilities.**
  - Current PHE set to expire mid-October
  - Administration has promised a 60 day heads up before ending
- **Asking Congress to extend waivers**
  - Telehealth waivers will be extended for 151 days after the end of the PHE
  - Recent House-passed bill would extend many telehealth waivers through 2024.
  - Hospital Inpatient Services Modernization Act (S.3792/H.R. 7053) would provide a two year extension of the Hospital at Home program.

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Regulatory Update

IPPS Proposed vs. Final Rule - Payment

Policy	Impact on Payment
Market-basket update	+ 3.1%/+4.1%
Productivity cut mandated by the ACA	- 0.4%/-0.3%
Partial restoration of documentation and coding cut mandated by ATRA	+ 0.5%
Sub-Total	+ 3.2%/+4.3%
Outlier payment adjustment	- 1.8%/-1.7%
Total	+2.6%

2.6% net payment increase in final rule for 2023

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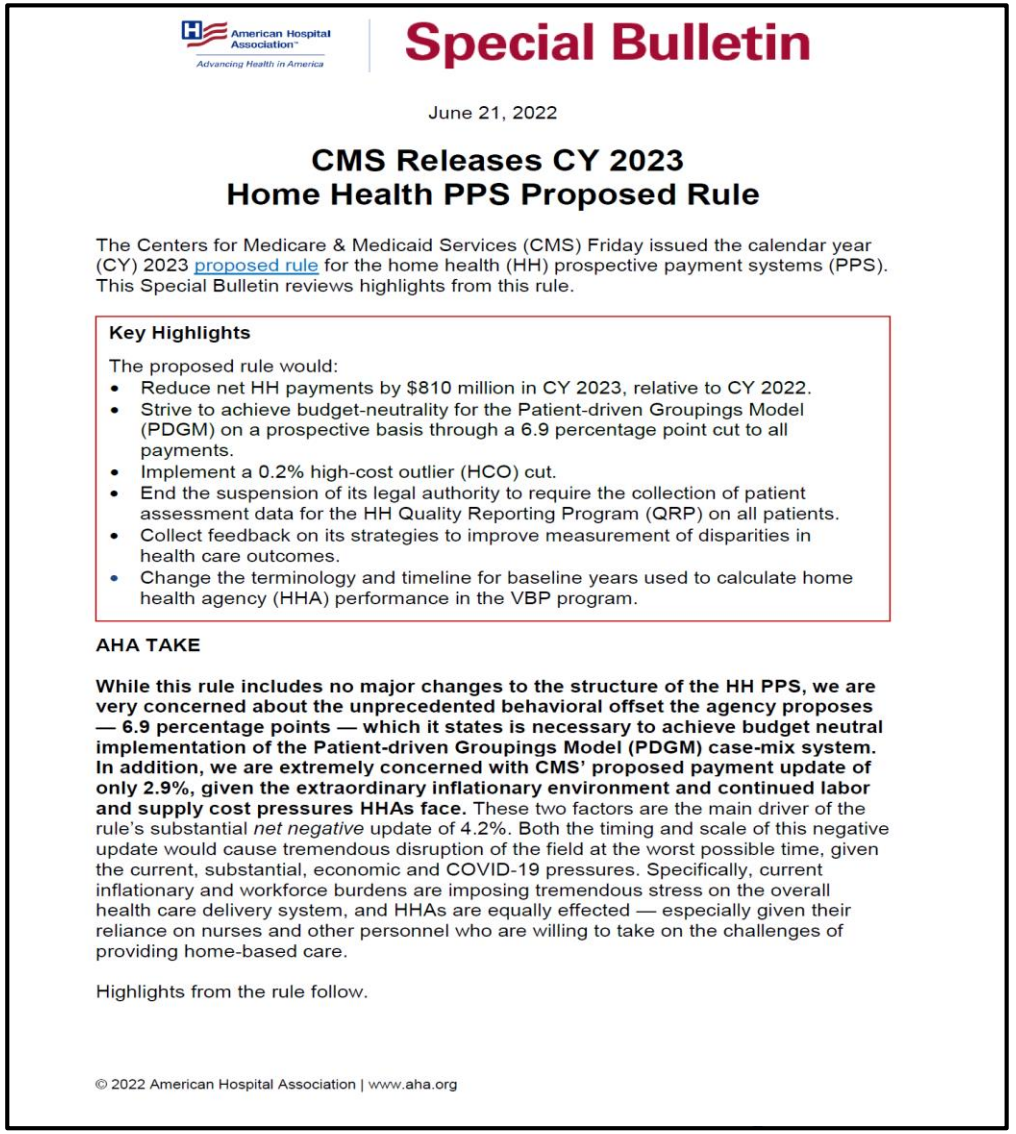
CY 2023 Proposed Payment Rules

- **Outpatient PPS**
  - 340B
  - Site Neutral
  - Rural Emergency Hospital
  - Quality Proposals (Equity)
- **Physician Fee Schedule**



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Special Bulletin

June 21, 2022

CMS Releases CY 2023 Home Health PPS Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) Friday issued the calendar year (CY) 2023 proposed rule for the home health (HH) prospective payment systems (PPS). This Special Bulletin reviews highlights from this rule.

Key Highlights

The proposed rule would:

- Reduce net HH payments by $810 million in CY 2023, relative to CY 2022.
- Strive to achieve budget-neutrality for the Patient-driven Groupings Model (PDGM) on a prospective basis through a 6.9 percentage point cut to all payments.
- Implement a 0.2% high-cost outlier (HCO) cut.
- End the suspension of its legal authority to require the collection of patient assessment data for the HH Quality Reporting Program (QRP) on all patients.
- Collect feedback on its strategies to improve measurement of disparities in health care outcomes.
- Change the terminology and timeline for baseline years used to calculate home health agency (HHA) performance in the VBP program.

AHA TAKE

While this rule includes no major changes to the structure of the HH PPS, we are very concerned about the unprecedented behavioral offset the agency proposes — 6.9 percentage points — which it states is necessary to achieve budget neutral implementation of the Patient-driven Groupings Model (PDGM) case-mix system. In addition, we are extremely concerned with CMS' proposed payment update of only 2.9%, given the extraordinary inflationary environment and continued labor and supply cost pressures HHAs face. These two factors are the main driver of the rule's substantial *net negative* update of 4.2%. Both the timing and scale of this negative update would cause tremendous disruption of the field at the worst possible time, given the current, substantial, economic and COVID-19 pressures. Specifically, current inflationary and workforce burdens are imposing tremendous stress on the overall health care delivery system, and HHAs are equally effected — especially given their reliance on nurses and other personnel who are willing to take on the challenges of providing home-based care.

Highlights from the rule follow.

American Hospital Association v. Becerra

- June 15, unanimous win for 340B hospitals
  - Declared nearly 30% cuts to reimbursement "illegal"

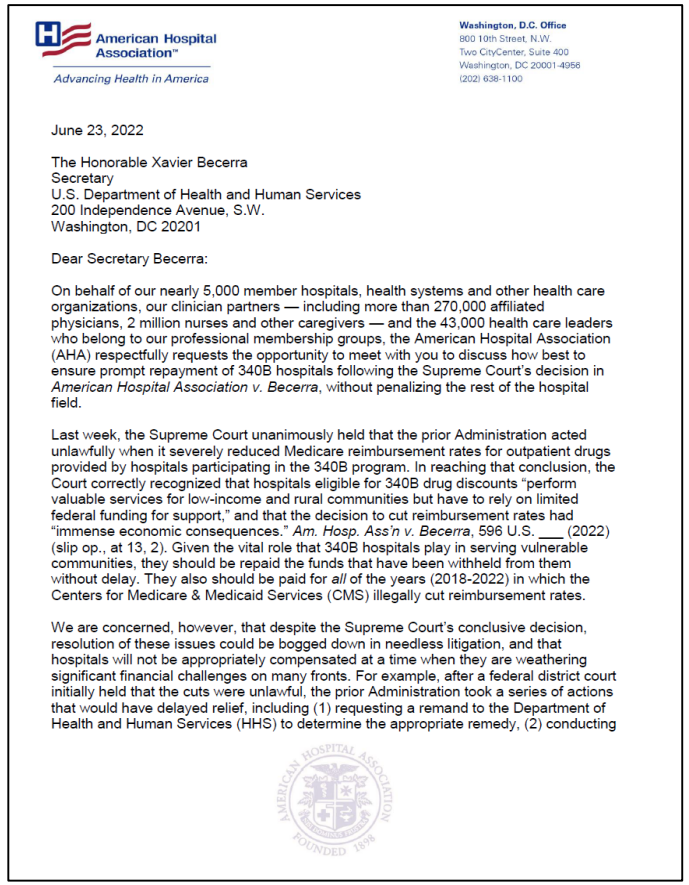
- "Under the text and structure of the statute, this case is . . . straightforward"

- "340B hospitals perform valuable services for low-income and rural communities but have to rely on limited federal funding for support."

American Hospital Association v. Becerra

- Next Steps on Remedy
  - Remand to lower courts
  - District court judge will likely consult HHS on remedy

- AHA Letter to Secretary Becerra
  - AHA letter to Becerra on remedy
  - AHA's position:
    - Promptly repay 340B hospitals for all years of cuts
    - Hold non 340B hospital harmless



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June 23, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Becerra:

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) respectfully requests the opportunity to meet with you to discuss how best to ensure prompt repayment of 340B hospitals following the Supreme Court's decision in *American Hospital Association v. Becerra*, without penalizing the rest of the hospital field.

Last week, the Supreme Court unanimously held that the prior Administration acted unlawfully when it severely reduced Medicare reimbursement rates for outpatient drugs provided by hospitals participating in the 340B program. In reaching that conclusion, the Court correctly recognized that hospitals eligible for 340B drug discounts "perform valuable services for low-income and rural communities but have to rely on limited federal funding for support," and that the decision to cut reimbursement rates had "immense economic consequences." *Am. Hosp. Ass'n v. Becerra*, 596 U.S. ___ (2022) (slip op., at 13, 2). Given the vital role that 340B hospitals play in serving vulnerable communities, they should be repaid the funds that have been withheld from them without delay. They also should be paid for *all* of the years (2018-2022) in which the Centers for Medicare & Medicaid Services (CMS) illegally cut reimbursement rates.

We are concerned, however, that despite the Supreme Court's conclusive decision, resolution of these issues could be bogged down in needless litigation, and that hospitals will not be appropriately compensated at a time when they are weathering significant financial challenges on many fronts. For example, after a federal district court initially held that the cuts were unlawful, the prior Administration took a series of actions that would have delayed relief, including (1) requesting a remand to the Department of Health and Human Services (HHS) to determine the appropriate remedy, (2) conducting

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No Surprises Act - Update

- **Federal Independent Dispute Resolution Process**
  - Guidance
  - Portal Open
  - Awaiting Final Rule

- **Uninsured/Self-pay Good Faith Estimates**
- **AHA suit in DC District Court awaiting decision**

Price Transparency

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Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems

Hospitals are experiencing significant increases in expenses for workforce, drugs and medical supplies

Introduction

For over two years since the outset of the COVID-19 pandemic, America's hospitals and health systems have been on the front lines caring for patients, comforting families and protecting communities.

With over 90 million cases[1], nearly 1 million deaths[2], and over 4.6 million hospitalizations[3], the pandemic has taken a significant toll on hospitals and health systems and placed enormous strain on the nation's health care workforce. During this unprecedented public health crisis, hospitals and health systems have confronted many challenges, including historic volume and revenue losses, as well as skyrocketing expenses (See Figure #1).

Hospitals and health systems have been nimble in responding to surges in COVID-19 cases throughout the pandemic by expanding treatment capacity, hiring staff to meet demand, acquiring and maintaining adequate supplies and personal protective equipment (PPE) to protect patients and staff and ensuring that critical services and programs remain available to the patients and communities they serve. However, these and other factors have led to billions of dollars in losses over the last two years for hospitals, and over 33% of hospitals are operating on negative margins.

Figure #1: Increase in Hospital Expenses Per Patient from 2019 to 2021

Source: January 2022 Kaufman Hall National Hospital Flash Report

The most recent surges triggered by the delta and omicron variants have added even more pressure to hospitals. During these surges, hospitals saw the number of COVID-19 infected patients rise while other patient volumes fell, and patient acuity increased. This drove up expenses and added significant financial pressure for hospitals. Moreover, hospitals did not receive any government assistance through the COVID-19 Provider Relief Fund (PRF) to help mitigate rising expenses and lost revenues during the delta and omicron surges. This is despite the fact that more than half of COVID-19 hospitalizations have occurred since July 1, 2021, during these two most recent COVID-19 surges.

At the same time, patient acuity has increased, as measured by how long patients need to stay in the hospital. The increase in acuity is a result of the complexity of COVID-19 care, as well as treatment for patients who may have put off care during the pandemic. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019.[4]

As hospitals treat sicker patients requiring more intensive treatment, they also must ensure that sufficient staffing levels are available to care for these patients, and must acquire the necessary expensive drugs and medical supplies to provide high-quality care. As a result, overall hospital expenses have experienced considerable growth.

Data from Kaufman Hall, a consulting firm that tracks hospital financial metrics, shows that by the end of 2021, total hospital expenses were up 11% compared to pre-pandemic levels in 2019. Even after accounting for changes in volume that occurred during the pandemic, hospital expenses per patient increased significantly from pre-pandemic levels across every category. (See Figure #1)

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- **CMS Compliance Actions**
- **New Insurer Rules – effective July 1**

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