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Testimony

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Of the

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"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

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Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to testify and provide the hospital field's perspective on how to address rising health care costs. I am Rick Pollack, president and CEO of the American Hospital Association (AHA). I am pleased to be here today on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well as our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers.

America's hospitals and health systems — and the women and men who care for patients and families every day — are the backbone of our country's health care system. Hospital care teams support newborn babies and their families during the first moments of life, provide compassionate care to people at the end of their lives, and are there to support patients in many moments in between. The "blue and white H" symbol conveys hope, healing and refuge in times of need, and it means highly skilled help is near for people 24 hours day, seven days a week, 365 days a year. This enormous

responsibility is just part of what distinguishes hospitals and health systems from all other parts of the health care system.

Hospitals and health systems understand the importance of making sure high quality care is affordable and accessible. As such, hospitals have long been leaders in advancing meaningful solutions to complex health care challenges, including the issue of affordability. That spirit continues today as hospitals across the country are working to reduce the cost of care by improving efficiency, embracing innovative technologies like AI and redesigning how services are delivered. Many are investing in preventive care and care coordination programs that help patients manage chronic conditions, avoid unnecessary hospital visits and stay healthier at home. These efforts not only improve patient outcomes but also lower overall costs for patients, families and the health care system.

However, we know that there is more that we can do. We also know that to truly make care affordable for Americans, all stakeholders, including government, commercial health insurers, drug companies, providers and patients, must work together. The following statement outlines the current landscape hospitals face and offers solutions for making care more affordable and accessible so we can continue to advance the health of individuals and communities.

CURRENT LANDSCAPE FACING HOSPITALS

Hospitals and health systems share Congress' commitment to improving health care affordability, lowering costs and maintaining access to health care services. As we discuss ways to accomplish these goals, it is important to recognize the environment that hospitals are operating in.

Hospital care today is more advanced, more effective and more resource intensive than ever before. It is powered by the skill of the nation's clinical caregivers, breakthroughs in medical technology and sustained investments in the infrastructure needed to deliver modern care. The result is that patients are living longer, recovering faster and benefiting from treatments that would have been unimaginable just a generation ago.

At the same time, hospitals are balancing significant cost pressures as they treat a sicker and more medically complex, aging patient population, all while operating with persistent misalignments in how care is financed and reimbursed.

Investing in Our Nation's Care Teams. Hospitals and health systems exist and function because of the doctors, nurses, technologists, facilities management specialists and many other professionals who dedicate their lives to helping others. We cannot take care of patients without these caregivers and team members who are always there to care. Hospitals and health systems are committed to supporting the workforce, including by expanding training and education programs, reimagining workforce models, investing in upskilling and providing non-traditional supports for health care workers.

At the same time labor costs are the most significant driver of what it costs to operate a hospital. Labor and workforce expenses account for roughly 60% of total hospital costs. Over the past five years, labor costs have risen sharply. This growth was initially driven by the extraordinary strain of the pandemic, but it is increasingly shaped by persistent workforce shortages. Many experienced clinicians have left the workforce, burnout remains high, and the pipeline of new physicians, nurses and other health care providers has not kept pace with demand. To address these issues, hospitals have ramped up investments in recruitment and retention efforts while maintaining essential community services, even as many hospitals have operated at or below breakeven financial levels. Hospitals also have leveraged technologies like AI to reduce administrative burden. While hospitals have been proactive in leveraging these AI tools, additional investment is needed to address infrastructure barriers like workforce training and digital literacy.

Sharp Increases in Costs of Medical Supplies and Drugs. Hospitals also have faced faster growth in the cost of goods and services required to care for patients. Spending on medical supplies, equipment and technology has increased significantly as hospitals, like others in the broader community, have had to contend with inflation and global supply chain pressures. Hospitals' total spending on supplies increased 9.9% in 2025[1], reflecting higher prices for everything from disposable medical gloves to pacemakers, ventilators and other technology that clinicians rely on every day, as well as lifesaving medical innovations like advanced imaging systems, implants and new surgical devices.

In addition, as is the case for patients, prescription drugs represent another significant, direct expense for hospitals. Hospital drug expenses increased 13.6% in 2025[2]. Hospital spending on drugs has grown faster than inflation, driven by both price increases on existing medications and the rapid adoption of new, high-cost therapies. Breakthrough treatments, particularly in oncology and other specialty areas, can be clinically transformative, but they often cost tens or hundreds of thousands of dollars per patient, with some costing in the millions.

Caring for More Patients Who Are Sicker, Leading to Increased Spending. Another important trend to recognize is that hospitals are caring for more patients who are older, sicker and have more complex medical needs. Recent analyses show that Americans are spending more years of their lives in poor health, reflecting a growing occurrence of chronic disease across the population. This is occurring along with significant demographic shifts, including an aging population with more persistent and complex medical needs who then require hospital treatment.[3] These clinical pressures are accompanied by the fact that hospital utilization was temporarily interrupted in 2020 and 2021 when people avoided or deferred care. Recent growth in hospital visits reflects a

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[1] www.aha.org/costsofcaring
[2] www.aha.org/costsofcaring
[3] https://www.trillianthealth.com/hubfs/2025%20Trends%20Shaping%20the%20Health%20Economy%20Report%20%7C%20Trilliant%20Health.pdf

return to historical trends. Those two factors — higher complexity of care and more volume — have been the primary driver of costs in recent years.

The latest data from the federal government's own actuaries reinforce those findings. Analysis from the Centers for Medicare & Medicaid Services (CMS) shows that recent increases in health care spending are overwhelmingly driven by higher use and intensity of services, not necessarily higher prices. In 2023 and 2024, medical inflation stayed roughly in line with overall inflation, indicating that the rise in spending reflects more patients getting care rather than rising prices.[4] Hospital prices are certainly a component, but they are not the only driver. While the entire system, including the government, employers and patients have seen increased spending, it's imperative that we look at the deeper structural issues that are truly driving health care costs.

Commercial Insurer Policies Adding Patient Costs, Increasing Provider Burden and Burnout. One factor that has increasingly affected both costs and access for patients and providers is the growing administrative burdens placed on them by large commercial health insurers. These include payment denials and delays, as well as skyrocketing prior authorization requirements. These burdens have been felt acutely in the Medicare Advantage program and with the Medicare Advantage patients as enrollment in the program has grown.

In the most recent CMS-reported year, Medicare Advantage plans made nearly 53 million prior authorization requests.[5] Hospitals must devote substantial staff time and resources to prior authorization, claims denials, delayed payments and repeated documentation requirements. These activities can increase costs without improving patient outcomes. They also pull clinicians away from direct patient care and create tremendous stress for patients, families and caregivers. For example, one mid-sized health system said it employs about 200 people to manage issues with prior authorizations and denials for inpatient services alone. Of this number, 10 are physicians who do nothing but work with insurers to secure authorizations for patient care. Another mid-sized health system reported that it spends more than $9 million annually to obtain prior authorizations and more than $13 million appealing denials, the vast majority of which are overturned. The AHA estimates that in 2025 hospitals spent over $43 billion[6] trying to collect payment insurers owe for care already delivered. To make matters worse, commercial insurers' use of AI to determine disposition of claims and prior authorization has exacerbated inappropriate denials. The AHA has advocated for administrative and congressional action to ensure that clinicians — not just AI tools — are included in denial decision making.

These harmful administrative practices also have very real consequences for health care providers. It is not unusual to hear from doctors and nurses about how they spend

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[4] https://www.healthaffairs.org/content/forefront/growth-national-health-expenditures-s-not-prices-stupid
[5] https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a
[6] www.aha.org/costsofcaring

hours of their day away from the bedside while sitting on the phone urging a patient's insurance company to cover essential medical care. It is no surprise that administrative burden is one of the top contributors to clinician burnout.[7] Nearly 90% of physicians report that prior authorization somewhat or significantly increases physician burnout, which adds to the workforce shortages facing hospitals across the country.[8]

Underpayment for Care Services. These rising costs come at a time when public programs continue to underpay for care services. Medicare and Medicaid payments generally do not cover the full cost of providing care. In 2024, Medicare underpayments to hospitals totaled more than $100 billion.[9] According to a recent report from the Medicare Payment Advisory Commission, Medicare margins for hospitals have dropped to -12%.[10] At the same time, many of the essential services communities depend on the most, such as behavioral health, obstetrics, trauma care, and burn services, operate at low or negative margins. These growing Medicare underpayments are threatening many hospitals' ability to continue providing these services.

Excessive Malpractice Costs. Many physicians will face a medical malpractice suit over the course of their career, and the overwhelming majority of those litigated are dropped, denied or dismissed. The data suggests that the rise in these lawsuits stems not from an increase in actual malpractice but rather a legal environment that incentivizes and enables these suits, and the costs are borne by the entire U.S. health care system. The last comprehensive analysis of the cost associated with malpractice pegged it at 2.4% of all U.S. health care spending.[11] Using the National Health Expenditure's estimate of 2025 spending, this would amount to $135 billion in 2025.

Malpractice is costly on multiple fronts. First, when physicians' time and attention is directed toward these lawsuits and away from patient care, patient access to health care services is severely hampered. Second, research shows that this medical malpractice risk environment incentivizes providers to order more tests, recommend more invasive procedures and prescribe more medicine than they might otherwise due to the fear of malpractice suits. Third, the rapid increase of medical malpractice suits and the high figures successful suits command raise the rates for medical malpractice insurance unsustainably high, forcing hospitals and physicians to either charge higher prices to manage those increased costs or cease providing high-risk medical services altogether.

Navigating Challenges and Responding. Taken together, these dynamics highlight the incredibly challenging environment that hospitals must manage. These pressures have mounted even while hospital prices have increased moderately in the aggregate.

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[7] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[8] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[9] www.aha.org/costsofcaring
[10] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch3_MedPAC_Report_To_Congress_SEC.pdf
[11] https://www.commonwealthfund.org/publications/newsletter-article/medical-liability-costs-estimated-556-billion-annually

Looking ahead, recent changes to Medicaid and the health insurance marketplaces will further add to the financial and operational challenges hospitals and health systems and the communities they serve already face. Reducing federal Medicaid funding and limiting key state financing mechanisms will widen existing payment gaps and increase the number of uninsured patients. Together, with the expiration of the enhanced premium tax credits, these policy shifts will lead to higher levels of hospital uncompensated care and bad debt. Those costs will make it harder for hospitals to sustain services and preserve access to care in their communities. In addition, as more uninsured individuals rely on emergency departments for routine primary and preventive care, communities can expect longer waiting times and added strain on the entire health care system, affecting all patients.

Due to these ongoing pressures, some hospitals facing financial hardships turn to affiliation with other hospitals or health systems. These partnerships, which can range from clinical collaborations to mergers, can help maintain services, expand access to specialists, improve care coordination and provide the scale needed to remain viable. Affiliation can be especially helpful in rural areas where hospitals often operate with thin margins, inconsistent patient volumes, and limited access to capital and workforce.

In a continually changing environment, these partnerships help some hospitals with the support needed to overcome increases in the cost of caring, adjust to changing patient and community demographics, and innovate for the future.

Opportunities and Actions to Improve Health Care Affordability

Despite these ongoing financial challenges, hospitals and health systems understand the importance of making sure high-quality care is affordable and accessible. Hospitals are committed to advancing meaningful solutions to make care more affordable, and we call on purchasers, drug and supply manufacturers, insurance providers, policymakers, and individuals to collaborate with us on these efforts.

The four primary areas where the U.S. health care system could make demonstrable improvements in value and affordability are:

- Improving the health of individuals and communities.
- Advancing value through care transformation.
- Reducing regulatory and administrative waste.
- Innovating to improve care quality and outcomes.

Each of these areas is described below with specific examples of steps the health care system could take. However, these examples are not exhaustive, and we welcome the opportunity to work with Congress, the Administration, patients and other health care stakeholders to identify additional ways we can advance these and other strategies.

Improving the Health of Individuals and Communities

One of the most promising opportunities to reduce health care spending is to mitigate the need for high-cost interventions by preventing the onset of illness and injury. The U.S. has some of the highest rates of obesity, diabetes, kidney disease, liver disease, mental health conditions and multimorbidity in the developed world. Chronic disease management requires frequent — and often redundant — testing and imaging, medication titration, and episodic, often very costly, acute interventions. In addition, medical and pharmaceutical advances allow many individuals to survive conditions that historically would have been fatal, often resulting in greater care needs over longer periods of time, including near the very end of life.

While the root causes of illness and injury often are outside the health care system, providers, health plans, drug manufacturers and other stakeholders play important roles in supporting patients and communities in achieving their best health. For example, the challenges patients face navigating the financial aspects of care create barriers to getting the services they need to stay healthy. As such, this Committee has spent considerable time on solutions to provide patients with certainty about their health care costs, and since 2021, hospitals have expended substantial resources to increase the availability of pricing information. Unfortunately, these efforts have not resulted in meaningful benefits for patients. Complex and excessive cost-sharing requirements imposed by health insurers have left many patients confused about what they owe and facing bills they cannot pay. In fact, most bills that patients cannot pay are for the co-pays, deductibles and co-insurance their insurer requires they contribute toward their care. Too many Americans are disadvantaged by health insurance benefit designs that expose them to high out-of-pocket costs that providers are then expected to try to collect from them. These are some of the greatest challenges patients face when understanding their costs and are problems the current price transparency policies do not address. Patients deserve certainty about what their medical care will cost them, and we look forward to continuing to work with Congress to identify solutions that ensure patients have accurate, reliable, upfront pricing information, as well as coverage that they can afford.

Examples of opportunities to improve overall health and reduce excess utilization include:

- Increase capacity for preventive and other primary care and incentivize patients to use these services to better prevent and manage illness.
- Reduce patients' financial barriers to care by using income-related enrollment in high-deductible health plans to ensure that high co-pays and deductibles do not serve as a deterrent to accessing care.
- Provide additional support for patients navigating the financial aspects of care by improving access to reliable, relevant, upfront pricing information, as well as updating billing and financial assistance practices to be more patient-friendly.

Advancing Value Through Care Transformation

The U.S. health care system can deliver high quality care more efficiently by helping patients better access preventive services and intervene in illness earlier; supporting providers in minimizing low-value care and enacting medical malpractice reforms that reduce pressures on providers to order additional tests or procedures; and reducing excess costs for certain medical supplies and prescription drugs.

Examples of opportunities to improve affordability through value-based care transformation include:

- Deploy intensive care coordination and patient navigation for the highest-need patients who constitute a disproportionate amount of care utilization and spending. According to 2022 data from the Agency for Healthcare Research and Quality, the costliest 5% of the population accounts for about half of all health care spending, and the most expensive 1% of the population is responsible for over 21% of costs.
- Support providers in transitioning to value-based models to provide the resources and regulatory flexibilities needed to promote prevention and wellness.
- Increase access to palliative care services and adopt end-of-life conversations as a routine part of care.
- Reform malpractice laws and implement tort reform, especially to provide protections for providers who adhere to evidence-based medicine.

Reducing Regulatory and Administrative Waste

The modern U.S. health care system operates with extensive compliance, reporting and documentation requirements, many of which have been introduced in the past 20-30 years. While some administrative systems and costs are necessary and recognize the need for accountability through balanced regulation, there is substantial opportunity to streamline these through standardization, as well as targeted elimination of low-value third-party vendors.

For example, while there is great utility in electronic health records, quality reporting metrics and cybersecurity tools, there also are substantial costs, including due to redundancies that could be eliminated. Also costly are the contracting and revenue cycle infrastructure needed to manage increasingly complex coverage, billing and prior authorization processes, as well as the advanced analytics, reporting and clinical integration across independent providers that are needed to implement value-based purchasing arrangements. The cost for this administrative staff and technology is now estimated at 25%-35% of all health care spending. Administrative burden is a key contributor to staffing shortages and burnout. AI is one tool in the toolkit to reduce administrative burden for things like documentation and scheduling.

Examples of opportunities to reduce administrative costs include:

- Reduce unnecessary burdens associated with outdated and redundant regulations, such as duplicative surveys and documentation requirements. The AHA has compiled a comprehensive list of suggestions to help reduce burden on hospitals and health systems.
- Pursue direct contracting arrangements between providers and purchasers to bypass the costs associated with insurers and other middlemen in contracting and administration.
- Standardize the processes for plans and providers to request and transmit clinical information needed to adjudicate claims, improve prior authorization and complete other revenue cycle processes to eliminate duplication due to insurer variation.
- Pursue AI policies that strike the appropriate balance of being flexible to enable innovation with ensuring patient safety.

Innovating to Improve Care Quality and Outcomes

Every day we further expand our medical knowledge, the factors contributing to health and wellbeing, and better ways to prevent and cure disease. Hospitals and health systems have always been at the forefront of medical science, often leading in the development of new drugs, devices, digital tools and care delivery models that make care safer, more efficient and more effective. For example, Rady Children's Hospital in San Diego uses Whole Genome Sequencing to quickly identify rare disease in children to guide immediate, targeted treatments. These innovations reduce spending by preventing illness and injury, shortening the length of hospital stays and enabling more care to be delivered safely in lower-cost settings.

In another example, hospitals have been at the forefront of developing advanced stroke systems of care that include use of less-invasive mechanical thrombectomy to remove blood clots, specialized neuro-interventional teams who provide care and treatment on the brain and spine, rapid imaging protocols and regional stroke transfer networks. These interventions have dramatically increased stroke patients' likelihood of achieving functional independence and reduced rates of severe disability. CAR-T therapy is another example of a hospital-led intervention that has been transformational for individuals with certain kinds of cancers. CAR-T has enabled many patients with previously fatal cancers to have a markedly higher rate of remission, as well as avoid years of chemotherapy, repeated hospitalizations and, in some cases, transplants.

Sustained progress, however, requires active partnership with the government and other stakeholders to accelerate medical advancement and affordability of care.

Examples of opportunities to improve affordability include:

- Accelerate prevention and early intervention through expanded access to predictive analytics, advanced screening technologies and early detection models — such as AI-assisted imaging or genomic testing — to catch disease before it becomes costly.

- Strengthen the digital and data infrastructure by investing in broadband access, interoperable electronic health records and cybersecurity, as well as safe and transparent AI.
- Redesign regulatory structures to facilitate new care models, such as hospital-at-home, remote patient monitoring and advanced telehealth, ensuring adequate payment for proven digital innovations.

AVOID POLICIES THAT WOULD REDUCE ACCESS TO CARE

While the recommendations above would meaningfully improve affordability and expand access to care, there are ongoing discussions around several policies that would undermine hospitals' ability to care for patients and communities. These proposals would deepen the financial challenges facing many hospitals and could force them to scale back, limit or even eliminate essential services. To protect patients and preserve the stability of hospitals and health systems, we urge Congress to safeguard the 340B Drug Pricing Program and reject so-called site-neutral payment policies that would impose billions of dollars in Medicare cuts.

Protect the 340B Drug Pricing Program

For more than 30 years, the 340B program has served as a critical tool to help eligible hospitals expand access to care and reduce overall health care costs for underserved patients and communities. The program enables eligible hospitals to stretch limited federal resources by purchasing outpatient drugs at discounted prices, allowing them to reinvest savings directly into patient care and essential community services.

Importantly, 340B is not a federal spending program. It does not rely on taxpayer appropriations and does not increase federal health care expenditures. Instead, it operates by requiring pharmaceutical manufacturers that choose to participate in Medicaid and Medicare Part B to provide discounts to hospitals that care for a disproportionate share of low-income, uninsured, rural and medically complex patients. In addition, the 340B program helps keep drug prices lower for all patients. The law requires a penalty to be levied against any drug manufacturer that raises the price of a drug faster than inflation. This acts as a critical disincentive for rampant drug price increases and thereby keeps prices lower than they would be otherwise.

Hospitals use 340B savings to increase access to care in ways that directly lower system-wide costs. These investments include providing free or reduced-cost medications for uninsured patients, maintaining outpatient oncology and specialty clinics, expanding mental health and substance use disorder services, funding medication management programs, and offering preventive services. By supporting early intervention, continuity of care and medication adherence, 340B helps prevent avoidable hospitalizations and emergency department visits — actions that drive up costs for patients, payers and communities.

Despite claims to the contrary, the 340B program remains a relatively small component of the pharmaceutical market. In 2022, 340B discounts accounted for approximately 3% of global drug manufacturer revenues. Growth in the program has been driven not by misuse, but by broader health system trends, including rising drug prices, the increasing use of specialty medications and a shift from inpatient to outpatient care settings.

Weakening the 340B program would not reduce health care costs. Instead, it would have the opposite effect. It would force hospitals to scale back services, close clinics and reduce access points. The impact on patients would be particularly acute in rural and underserved areas, leading to delayed care, higher uncompensated care and increased reliance on emergency services.

Despite its proven track record, some of the largest drug manufacturers in the world continue to undermine the 340B program through unilateral efforts to drastically reduce the benefits that eligible hospitals, patients and communities receive from it. For example, partnerships with community and specialty pharmacies have long served as a critical extension of 340B hospitals, ensuring that vulnerable patients can conveniently access the outpatient drugs they need without traveling long distances to a hospital. These contractual arrangements are especially vital for rural hospitals, many of which lack in-house pharmacies and rely almost entirely on contract pharmacy networks to dispense medications. Contract pharmacies also ensure access to certain specialty drugs that hospitals cannot keep in continuous inventory due to their limited distribution.

Despite contract pharmacies' clear statutory grounding and longstanding recognition from the Health Resources and Services Administration, drug manufacturers have imposed unlawful restrictions that threaten hospitals' ability to stretch scarce resources, resulting in millions in losses and reduced access to essential services. Protecting contract pharmacy arrangements is crucial to safeguarding patient access, controlling rising drug costs and maintaining a strong health care safety net.

More recently, some drug manufacturers have attempted to diminish the program by attempting to convert the way covered entities access discounted 340B pricing from an upfront discount to a back-end rebate. Under this "rebate" model, hospitals must first purchase drugs at full price and then seek a rebate from manufacturers after dispensing them. Hospitals would be required to submit unprecedented amounts of claims data, wait for manufacturer validation and rely on post-purchase rebates to recover the statutorily-required discount. This approach violates longstanding federal policy, fundamentally changes how the program operates, jeopardizes patients' access to drugs, and ultimately will add considerable and unnecessary burden and cost to the health care system.

340B hospitals need access to predictable upfront discounts. Many lack the cash reserves to pay the full cost of high-priced specialty drugs, which can delay treatment, limit drug availability, or force providers to stop offering certain therapies altogether. In addition, manufacturer-imposed conditions increase hospitals' administrative burden

and financing costs, increasing the likelihood of disputes and delays that directly affect patients' ability to receive timely, life-saving medications.

We urge Congress to oppose efforts to move 340B pricing to a rebate model. More broadly, we ask Congress to protect the 340B program from repeated efforts to diminish its benefits to 340B hospitals and the patients and communities they serve.

Reject Site-neutral Payment Cuts

Hospital outpatient departments (HOPDs) serve as vital extensions of hospitals, offering patients convenient, accessible and coordinated outpatient care directly within their communities. While these HOPDs may appear similar to independent physician offices, the level and complexity of care they deliver are fundamentally different. Current Medicare reimbursements — which still fall well below the cost of caring for Medicare beneficiaries — appropriately recognize the differences between these sites of care.

A key distinction between HOPDs and other care settings, such as physician offices or ambulatory surgical centers, is the patient population they serve. HOPDs consistently see patients who are sicker and more medically complex than those treated in other settings. These patients are more likely to experience severe chronic illnesses, dual eligibility for Medicare and Medicaid, and recent hospitalizations or emergency department visits, as well as live in lower-income communities.[12] Caring for these individuals requires advanced clinical capabilities, multidisciplinary support and integrated resources uniquely available in hospital-based settings.

The reliance on HOPDs is even more pronounced in rural communities. Medicare beneficiaries living in more rural counties are significantly more likely to receive care in HOPDs, and in many cases, these facilities serve as the only accessible option for essential outpatient services.[13]

In addition to treating more complex patients, HOPDs must comply with far more rigorous regulatory and safety requirements than independent physician offices. These include strict infection control standards and fire and life safety codes, as well as compliance with oversight from The Joint Commission, the Food and Drug Administration, U.S. Pharmacopeia, and other accrediting or regulatory bodies. While these standards are essential to ensuring patient and provider safety, they also substantially increase operating costs.

Additional Medicare cuts would further place these services at risk. If Congress imposes additional site-neutral cuts, hospitals will have to make difficult decisions to reduce or

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[12] https://www.aha.org/comparison-care-hospital-outpatient-departments-and-independent-physician-offices

[13] https://www.aha.org/system/files/media/file/2024/01/analysis-hospitals-health-systems-are-critical-to-preserving-access-to-care-for-rural-communities-report.pdf

even eliminate care they provide to patients, especially in rural and other underserved areas.

To protect access to care for patients, the AHA urges Congress to reject Medicare site-neutral payment cuts.

CONCLUSION

Thank you again for the opportunity to testify today to share challenges facing hospitals and health systems and the steps we can take together to improve health care affordability. I look forward to working with you as Congress continues its efforts to address these critical issues.