Nassau-Suffolk Hospital Council
Northern Metropolitan Hospital Association
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Dear New York Congressional Delegation:

On behalf of the Nassau-Suffolk Hospital Council and Northern Metropolitan Hospital Association, I thank you for your steadfast support of the hospitals and health systems in the suburban regions and the patients they serve.

Healthcare providers' workforce and operations continue to be deeply stressed by the pandemic; these stresses are now compounded by the rapid spread of influenza and the pediatric respiratory syncytial virus (RSV) in our communities.

Hospitals also face steep financial challenges. The cost of drugs, energy, supplies and contract labor have increased exponentially, while the workforce shortage exerts continued upward pressure on wages. Medicare and Medicaid patients account for more than two-thirds of hospital services provided in the suburban regions; under these programs' fixed reimbursement rates, it's not possible to absorb these rising costs or raise prices to adjust for inflation.

As you return to Washington for the post-election session, we urge you to support our hospitals' key priorities in year-end legislation, including:

Reverse the Medicare sequestration cut and address impending PAYGO reductions. In July, the 2 percent reduction across all Medicare claims, which had been temporarily paused, was allowed to resume. The Congressional Budget Office also estimates that a statutory PAYGO cut of approximately 4 percent cut to Medicare will be required for the 2023 federal fiscal year. Taken together, a 6 percent reduction in Medicare reimbursements will be devastating to hospitals that are either barely breaking even or operating in the red. **We ask Congress to eliminate the 2 percent sequestration cut and prevent the statutory PAYGO reduction.**

Modify the harmful Medicaid Disproportionate Share Hospital (DSH) cap policy. Section 203 of Title II of the Consolidated Appropriations Act of 2021 changed how hospital-specific Medicaid DSH funding caps (the maximum amount of Medicaid DSH funding a hospital can receive) are calculated. This new policy severely impacts access to essential federal supplemental support for many of New York's public safety net hospitals, including those on Long Island and in the Hudson Valley, that care for the highest share of low-income and uninsured individuals in the state. The new policy, which took effect on October 1, disallows Medicaid dual-eligible enrollees from DSH cap calculations, removing from consideration services that hospitals often provide at a financial loss. **We urge Congress to amend Section 203 and allow hospitals the flexibility to include in their DSH cap calculations payment shortfalls for services provided to all Medicaid dually-eligible patients.**

Address the backlog of patients awaiting discharge from hospitals. Significant workforce shortages, particularly in behavioral health and post-acute care, are making it more difficult for hospitals to discharge patients to the appropriate care settings. This means that patients must remain in inpatient beds longer than is necessary, reducing available capacity and putting additional strain on hospitals' finances. Hospitals bear the costs of caring for those patients for excess days without reimbursement. **We ask Congress to establish a temporary per diem payment targeted to hospitals to address this issue.**

Extend successful regulatory flexibilities beyond the end of the Public Health Emergency (PHE). Healthcare providers have successfully leveraged flexibilities authorized under the PHE to provide care safely, efficiently and more conveniently to patients in their homes or other alternate settings through telehealth and the Medicare Acute Care Hospital at Home program. The Hospital at Home program will expire at the end of the PHE; most telehealth provisions will expire 151 days after the end of the PHE. **Enactment of the Advancing Telehealth beyond COVID-19 Act (H.R. 4040) and the Hospital Inpatient Services Modernization Act (S.3972/H.R 7053) would allow these important initiatives to temporarily continue beyond the PHE while Congress considers whether to make these flexibilities permanent.**

Reduce unnecessary administrative burdens by addressing Medicare Advantage (MA) plans' prior authorization practices. Although the MA program is designed to cover the same services as traditional Medicare, an HHS Office of the Inspector General report earlier this year confirmed what hospitals have long known: the plans engage in inappropriate and excessive denials for prior authorization, delaying care, risking patient harm and creating unreasonable administrative and financial burdens for healthcare providers. The Improving Seniors' Timely Access to Care Act (S.3018/H.R.3173) would streamline MA prior authorization requirements. **We urge Congress to enact S.3018/H.R.3173**.

Increase the supply of physicians. The physician workforce is facing a retirement cliff – nearly half of practicing physicians are aged 55 or older – at the same time that demand for physician services is increasing due to an aging population and near-universal insurance coverage. In some areas of practice, especially primary care and behavioral health, we are already facing a crisis. Congress can bolster the supply of physicians by increasing graduate medical education (GME) funding. **We ask for your support for an increase in the number of Medicare-support GME positions.**

Thank you again for your continued commitment to quality care in our communities and the stability of local healthcare institutions. If you have any questions on these or other policy matters, please do not hesitate to contact me.

Best regards,

Wendy D. Darwell
President and CEO