Testimony
Of
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CommonSpirit Health
For the
Ways & Means Committee
Of the
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Chairman Smith, Ranking Member Neal and Members of the Committee, thank you for the opportunity to testify on an issue that affects every individual: health care affordability.

I'm Wright Lassiter, president and CEO of CommonSpirit Health. Our Catholic nonprofit health system has 158 hospitals across 24 states, including 41 rural facilities, among them 29 critical access hospitals and 1 rural emergency hospital in San Augustine, Texas. Our rural footprint makes us one of the largest rural providers in the United States. I am proud to be here representing our more than 25,000 affiliated physicians and advanced practice practice providers, 160,000 employees including 45,000 nurses and thousands of volunteers who everyday touch patient's lives and provide healing and hope.

Guided by a mission to serve all, especially those who are most vulnerable, we provide 25 million patient visits each year. This includes care for 3.3 million Medicaid patients each year, making us one of the largest Medicaid providers in the country. We also deliver one out of every 42 babies born in the United States.

CommonSpirit continuously looks for ways to meet the evolving health needs of the communities we serve. One way we do this is through our investments in community benefit.We reinvest in our communities that range from remote towns like Williston, North Dakota, to major urban centers like Los Angeles. Last year alone, we provided more than $5 billion in community benefit, including unreimbursed government programs, which is at least 2.5 times the value of local, state, and federal forgone taxes.

We tailor our investments to meet the health needs of each community. For example, there is a high prevalence of breast cancer rates in Yolo County, California, so we offer free preventative screenings to the community. In McMinnville, Tennessee, 25 percent of the town's residents smoke. Due to the rural location, McMinnville does not have a health facility that can offer lung cancer screenings, so our caregivers travel there to provide them. At our first screening, more

than 20 percent of patients had a lung abnormality. Now we go back every quarter. That is what we mean by mission-based health care committed to community benefit.Other investments range from providing car seats to low-income families in Park Rapids, Minnesota, to expanding substance use recovery and behavioral health support in Council Bluffs, Iowa.

In addition to the direct services we provide in communities across the country, we serve an essential role in educating and training the next generation of health care professionals. Our organization provides extensive medical education to nearly 3,200 residents and fellows each year, including 1,700 that train in CommonSpirit facilities. We also provide critical education and clinical training for nurses, radiation and laboratory technologists, phlebotomists, respiratory therapists, and many other allied health professionals. At a time when provider shortages are placing growing strain on the health care system and limiting access to care in many communities, this workforce development mission is a vital extension of our public service. By strengthening the pipeline of trained clinicians and caregivers, we are helping meet both today's health care needs and the challenges ahead.

What CommonSpirit is doing to lower cost and preserve access

We share the Committee's priority to make healthcare more affordable. As CEO of a large nonprofit health system, I take the responsibility of maintaining affordability and accessibility very seriously. Our scale allows us to integrate hospitals, clinics and care teams to reduce duplication, improve coordination and strengthen the efficiency of care delivery. It allows us to invest in technology, expand access in rural and underserved areas, stabilize essential services, strengthen our ability to recruit and retain clinicians, and negotiate more effectively with suppliers, which helps control costs across the system. Most importantly, it helps preserve local access to care.

For example, CommonSpirit Mercy Hospital in Durango, CO, provides crucial pediatric oncology care. This care is vital for children, including an 8–year-old we will refer to as Alex for privacy purposes, who is battling leukemia. Because of our services he can receive treatment closer to home and avoid the 6.5–hour drive to a specialized hospital. This local access significantly reduces the emotional, financial, and logistical burdens on rural families.

My philosophy is that we have to be two things at once: large enough to bring scale, resources and stability, and local enough to respond to the unique needs of each community we serve. Rural and community hospitals face the same market pressures as their urban and academic counterparts, only with fewer resources. They confront workforce shortages, declining patient volumes, rising labor and supply costs and an increasingly complex regulatory environment, often while operating on extremely thin margins. By bringing the resources of a larger system to those communities, we can help smaller hospitals manage expensive technology requirements, difficult payer contracting negotiations, workforce shortages and other pressures while addressing local gaps in care and preserving access in the 41 rural communities we serve.

Rural hospitals aren't simply places to receive health care. These hospitals serve as economic anchors for their communities. They support local jobs, sustain small businesses and contribute to the stability of schools, banks and civic institutions.

When one closes, the impact is immediate: jobs disappear, physicians and other clinicians leave, local businesses lose economic activity and families are forced to travel farther for care. Businesses are less likely to invest in or relocate to a community without a hospital. Over time, that loss can trigger a ripple effect that weakens the economic and social fabric of an entire region and ultimately leads to poorer health outcomes. For CommonSpirit, closing a hospital is the last resort. We have not closed a hospital in 13 years and even then we did not abandon the community. CommonSpirit repurposed the acute-care hospital to an outpatient center to meet the evolving needs of the patient population as there were three other hospitals in a 10–mile radius.

We put our scale to work through innovation, which expands access, strengthens the workforce and helps lower the cost of care. Our size allows us to direct resources where they are needed most and spread best practices quickly. As a result, patients gain access to a broader range of specialties and services closer to home, while clinicians benefit from stronger support systems and more sustainable career pathways.

As an integrated system, we equip our hospitals, clinics and rural facilities with capabilities they could not build or sustain on their own. For example:

- **We deploy virtual care models** like our Virtual Integrated Care program, which provides real-time remote support to bedside teams. Virtual nurses helped to safely discharge more than 16,000 patients, freeing bedside nurses from thousands of hours of paperwork. This approach allows on-site nurses to perform at the top of their license, improve patient outcomes and reduce administrative burden on clinicians.

- Telehealth flexibilities supported by this Committee have been critical to creating pathways for enhanced clinical care in rural and underserved communities. These flexibilities allow us to extend specialty care into rural and underserved communities. These capabilities ensure patients receive timely care without the added cost of travel or delayed treatment. Telehealth has allowed CommonSpirit to create a **virtual team of physicians who support Critical Access Hospitals on nights and weekends** to admit patients remotely. Most Critical Access Hospitals do not have a physician on-site for nights and weekends, so patients cannot be admitted and must be transferred to another hospital farther away. This program allowed 16 percent more patients to stay local.

- **We invest in advanced technology and infrastructure** that smaller standalone facilities often could not access on their own. CommonSpirit's outpatient care centers, clinics and community and rural hospitals have access to technological tools that they would not have the resources or staff to implement alone. For example, we have implemented Care Base, a virtual hospital program that integrates virtual nurses and providers and AI-enhanced technology to support nurses at the bedside and monitor patients remotely—enabling earlier discharge. Care Base benefits patients like a grandmother from Washington state who was able to go home from the hospital just six hours after deep brain stimulation, whereas patients would typically have to stay overnight. Patients rest and recover better in their own environment having the reassurance that they are being monitored. Care Base also gives new moms peace of mind by providing postpartum remote blood pressure monitoring, reducing readmissions and ER visits.

- We are also creating efficiencies to reduce cost through operations and supply chain. Standardization in supply chain contracts helps larger organizations like CommonSpirit keep costs down, and the scale of a large system provides greater stability for communities across the country.

  Faced with an IV fluid shortage due to a weather-related disruption, CommonSpirit facilities were again able to share and redirect supplies when other hospitals had to transfer or delay care.

  During a recent nationwide saline shortage, our 108–bed hospital, serving rural Yolo, Solano and Colusa Counties in California secured a vital supply of sterile saline due to the large-system purchasing power of CommonSpirit Health, ensuring uninterrupted patient care without paying a premium for this high-demand item.

- CommonSpirit has also made investments in artificial intelligence that generate more than $100 million in annual savings by improving efficiency that we can reinvest directly into patient care. Our AI tools have also significantly reduced the administrative burden on our physicians, one of the leading causes of clinical burnout. In some of our regions clinicians were spending over 1,000 hours per month to answer questions from patients via the online electronic health record patient portal. AI has allowed us to filter these messages so those requiring a clinician reach one directly, while messages better suited for other care team members are routed to them. This has reduced charting time for our clinicians and given them more time with patients

  We use advanced automation tools to identify care gaps. For example, AI-enabled chart review has helped us identify tens of thousands of patients with risk factors who need cancer screenings. This has helped us detect disease earlier, when treatment is often more effective and less costly.

- We invest in workforce pipelines. Our year-long nurse residency program helps new graduates transition into practice and has achieved a 91 percent retention rate, which reduces costly turnover and helps stabilize care delivery.

  We created a national internal travel nurse program that allows nurses to serve in regions of our system where they are most needed, while reducing reliance on expensive contract traveling nurses. While still relatively new, the internal travel nurse program is projected to save our health system $18 million, returning dollars to direct patient care.

  CommonSpirit's size allows us to offer competitive compensation, expand training and reduce burnout, which are key drivers of affordability. A stable workforce reduces reliance on high-cost travelling labor, lowers turnover, and improves continuity of care.

  In addition, CommonSpirit has 42 graduate medical education programs across our 24 states. This means we graduate 1,731 physicians every year that are placed into the health care workforce, oftentimes in rural areas where shortages persist.

CommonSpirit understands that in order to achieve continued affordability we must create innovative solutions. Since forming in 2019, CommonSpirit has reduced costs by $3 billion through scale, efficiency and innovation. Some of these innovative solutions have included:

- **Operational Alignment**. We consolidated our original operational structure from twelve regions into five, and streamlined the associated executive governance accordingly.

- **We recently reached a three-year national agreement with Humana** to help preserve patient access, secure more appropriate rates and improve payment timeliness to providers.

- **We have begun to insource a significant amount of our revenue cycle management operations**, aiming to boost efficiency and improve patient experience. We believe this move will reduce our cost to collect by 50 percent.

Understanding the drivers in rising health care costs

Health care is inherently complex. Unlike most industries, it involves highly specialized labor, decision-making to improve the health status of those who serve, rapidly evolving science and technology, and it is one of the highest regulated industries. It's important to note that our operating margins are very slim, even in financially stable years. Over the last five years CommonSpirit has lost $3 billion and the losses continue to rise. We believe our financial challenges are strained by four powerful forces:

- **Labor costs and workforce shortages continue to rise.** Health care is a uniquely human endeavor. The federal government has estimated that the U.S. will be short 141,000 physicians, including 70,000 primary care physicians and 109,000 registered nurses, within 12 years. Certain specialties like behavioral health will be hit especially hard: by 2038, the U.S. will only have 61 percent of the needed child and adolescent psychiatrists, 50 percent of the needed adult psychiatrists and 30 percent of the needed addiction counselors. Rural states like Texas, Arizona and Florida are also harder hit than the U.S. at-large.[1]

  Labor accounts for over 54 percent of CommonSpirit's operating expenses, and labor costs across our health system have risen by more than 20 percent over the last five years.

- **The price of pharmaceuticals, medical supplies and advanced technologies continue to climb.** Health care delivery today demands both clinical excellence and financial resilience—and the reality is that the cost of delivering that care continues to rise at an unsustainable pace. Pharmaceutical prices, essential medical supplies, and advanced technologies have increased by 10 percent. An example of supply increase, our systemwide spending on IV fluids alone has grown substantially over the past two years. This surge was initially driven largely by a supply disruption from a major manufacturer following Hurricane Helen in 2024, which resulted in price increases exceeding 14 percent, but prices have not reduced when the plant came back online. For one manufacturer, the price of a 1000mL bag of sterile saline solution increased by 13%, or $1.45, between 2024 and 2025. But because CommonSpirit uses over 420,000 bags annually, this equated to a $522,357 cost increase in one year. This is just one product out of hundreds of thousands we purchase each year. Events like this underscore the fragility of the health care supply chain and the direct impact external forces can have on patient care costs. It also highlights one of the strengths of being a large system as we were able to move around our supplies and prevent the cancellation of surgeries unlike many smaller systems.

  At the same time, we are making critical investments in technology. Advanced diagnostic capabilities—such as MRI, CT, PET, and ultrasound—along with life-saving therapeutic platforms including surgical robotics, radiation therapy systems, and cardiac catheterization labs, are essential to delivering high-quality, timely care. These technologies, however, come with extraordinary costs—not only in acquisition, but in installation, maintenance, and the continuous upgrades required to keep pace with innovation and safety standards.

[1] National Center for Health Workforce Analysis, Health Resources Services Administration. *Workforce Projections, 2023-2038.* December 2025.

Equally significant are the investments required to sustain a secure and integrated digital infrastructure. Hospitals today rely on sophisticated electronic health records, complex billing platforms, and expansive data management systems to operate effectively. Layered onto this is the growing necessity for robust cybersecurity capabilities to protect sensitive patient information in an increasingly complex threat environment. These systems require ongoing capital, specialized expertise, and constant vigilance.

- **Administrative complexities and inefficiencies imposed by health insurers continue to drive up costs:** Payer pressure continues to intensify and it comes at a significant administrative cost. For example, managing the billing process for Medicare Advantage (MA) patients costs approximately 25 percent more than for patients covered by traditional Medicare. This is especially challenging when MA makes up 28.1 percent of our payer mix.

  Also costly are the contracting and revenue cycle infrastructure needed to manage increasingly complex coverage, billing and prior authorization processes, along with the advanced analytics, reporting and clinical integration required to support value-based purchasing across independent providers. We spend more than $360 million each year to address denials and patient responsibility, both of which could be handled more efficiently by the payer. We also must interface with more than a dozen different Medicaid payment platforms, which creates significant administrative burden and is extremely inefficient. And we must communicate with many proprietary platforms used by commercial insurers. Together, these layers of complexity help explain why the American Hospital Association now estimates that 25–35 percent of all health care spending goes to administrative staff and technology.

  In addition, commercial insurers increasingly deny claims and underpay for services. MA plans are among the most challenging in this regard. Currently, we have $4.3 billion on our balance sheet from unpaid claims from MA. Nearly $1 billion in unpaid claims is older than 150 days.

  MA was a program designed to be a more efficient and effective version of traditional Medicare. Yet, it has turned into the exact opposite and putting patient access at risk. We thank many members of this Committee for their bipartisan effort to address timely payments from Medicare Advantage. The measures that have been introduced in this Committee would ensure providers are paid timely for the care delivered.

  Lastly, government reimbursement remains below the actual cost of care. Medicare and Medicaid represents nearly 70 percent of our patient volume, yet Medicare only reimburses about 80 percent of the cost to care for Medicare patients. Medicaid underpayment is also an access issue, especially in rural communities that typically have

higher rates of unemployment and poverty. At CommonSpirit, 56 percent of the babies we deliver are covered by Medicaid. When public coverage falls short and more people become uninsured, uncompensated care rises, pressure on hospitals intensifies and access becomes harder to sustain.

- **Regulatory burden adds $1 billion in additional costs:** Health care is one of the most heavily regulated industries, and complying with state and federal requirements carries a significant administrative cost. An American Hospital Association study found that hospitals spend approximately $50,000 per inpatient bed each year to manage and comply with federal regulations. For CommonSpirit, that means nearly $1 billion annually, much of it tied to outdated requirements duplicative of state law that drive up the cost of care.

  For example, electronic health records, quality reporting metrics and cybersecurity tools create tremendous value for our patients and clinical teams. But the regulations governing these tools were developed independently and for different purposes, often resulting in duplication or even contradiction. Numerous quality measures are reported across multiple quality programs, which is duplicative and costly to administer. Other quality measures have essentially topped out, meaning that nearly all hospitals are achieving very high scores. Yet those measures are still designed to classify one-quarter of hospitals as below average, one-half as average and one-quarter as above average. The result is lower reimbursement for high-performing hospitals and a disincentive for continued improvement.

  Hospitals are complex, highly regulated buildings. Construction, maintenance, utilities, including electricity, water and specialized gases, and repairs are enormous costs. Hospitals require specific ventilation, infection control and sterile environments. We have reduced our vendor costs by bringing much of our clinical engineering teams in-house, but maintaining a hospital and all of its equipment will always be an expensive endeavor. Even though this does not fall into Congressional jurisdiction, it's important to note that hospitals operate in states with unfunded mandates related to our buildings, for example specific retrofitting that costs hospitals billions of dollars to comply.

How we can partner together to make health care more affordable

This Committee's focus on affordability is essential. But hospitals cannot solve this challenge alone, and affordability is not solely a provider issue. Providers, payers and government all have to be part of the solution. Specifically, that means:

- timely payment from Medicare Advantage and stronger accountability for health plans;
- sufficient reimbursement from Medicare and Medicaid; and
- relief from unnecessary regulatory burden.

Timely payment from Medicare Advantage and stronger accountability for health plans:

As noted above, CommonSpirit has $4.3 billion in unpaid claims from Medicare Advantage and nearly $1 billion of that is over 150 days old. We commend the leadership from many of the members from this Committee to ensure Medicare Advantage returns to being an efficient and effective program for seniors, as it was designed. We believe the health care system should be good stewards of taxpayer dollars and we urge the Committee to pass the following pieces of legislation:

- Medicare Advantage Prompt Pay Act led by Reps. Jodey Arrington (R-Texas) and Linda Sanchez (D-Calif.)
- The Prompt and Fair Pay Act led by Reps. Greg Murphy (R-N.C.) and Lloyd Doggett (D-Texas)
- The Medicare Advantage Improvement Act led by Rep. John Joyce (R- Pennsylvania)

Other policy ideas include:

- Standardizing the process 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.
- Requiring stronger insurer coverage for mental health services and network adequacies.
- Pursuing direct contracting arrangements between providers and purchasers to bypass the costs associated with insurers and other middlemen in contracting and administration.

Sufficient reimbursement from Medicare and Medicaid:

Nearly 70 percent of CommonSpirit's patient volumes come from Medicare and Medicaid. However, we continue to face shortfalls from these government programs that don't cover the cost of care. Historically we have relied on commercial insurers to help supplement the shortfall, but over the last few years we have seen double-digit premium increases for patients yet very nominal, 2 to 4 percent, reimbursement increases for providers, which are not keeping pace with basic inflation. Hospitals and health systems today have to rely on the patchwork of various programs to achieve sustainability.

In addition, the Medicaid changes from H.R. 1 will reduce CommonSpirit Health's Medicaid reimbursement by $5 billion over the next 10 years. At full implementation we anticipate a loss of $1 billion annually.

We urge the Committee to preserve the safety-net and support hospitals' ability to maintain access, especially in rural areas. Until reimbursement levels from Medicare and Medicare are more commensurate with the approximate cost of care, the patchwork of programs that currently make the system work need to be protected.

Relief from unnecessary regulatory burden:

Health care is one of the most regulated industries and we have estimated we spend an average $1 billion a year in managing various regulations across our footprint. There is an opportunity for this Committee to examine which regulations can be deemed low value and streamlined to ease the administrative and financial burden on hospitals.

Examples of opportunities to reduce administrative costs include:

- The American Hospital Association has compiled a list of suggestions to help reduce the burden on hospitals and providers. We support this list and urge the Committee to remove some of these outdated and redundant regulations.
- Support AI policies that allow for innovation and protect patient safety.
- Create one claims system for Medicaid across the country. We spend a significant amount of resources and time adjudicating claims and interfacing with different platforms, not to mention all the private plans who administer Medicaid managed care plans.

More specifics on reducing administrative costs include:

- Reduce and simplify the number of quality and efficiency measures required in various hospital quality programs. There are too many unique measures in general across and within quality programs—the more measures, the more administrative burden and cost to collect, code, validate, and report. While each quality program has between 2–16 measures, the total burden is greater than 40 when added together.
- Streamline care plan documentation requirements. We are trying to provide higher quality, more holistic care to our patients through interdisciplinary teams. These teams may include a range of clinical professionals, such as nurses, therapists and social workers. When used, these teams develop what is known as an interdisciplinary care plan. Yet, outdated regulations require nursing-specific care plans.
- Redesign the Medicare GME program to allow successful, existing education programs to grow their resident caps rather than making new hospitals create new programs. If the reimbursement rules were changed to allow for growth, well-established programs could increase the number of residents being trained without duplicating program management costs.

Conclusion

As a national nonprofit health system, our responsibility is to use our scale to expand access, improve quality and make care more affordable. That requires strong governance, transparent accountability and decisions grounded in mission, stewardship and the needs of the communities we serve. I commend the Committee's focus on affordability and we look forward to partnering with you on ways we make health care more affordable and accessible for all.