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President and CEO

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President-elect Joe Biden
Transition Team
Washington, DC

Dear President-elect Biden:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH offers our congratulations to President-elect Biden, Vice President-elect Harris, and the members of the Transition Team. The challenges facing your new Administration are unprecedented, and we look forward to your determined and focused leadership.

The FAH recently submitted a letter to the COVID-19 Task Force detailing the many challenges related to this public health emergency (PHE) and offering recommendations to address these challenges. We look forward to continuing to work with the Task Force to ensure a solid foundation for meeting these challenges as COVID-19 continues its surge into 2021.

The purpose of this letter to the Transition Team is to focus on the myriad issues that, along with COVID-19, are critical for supporting our nation's health care system through (1) access to health care coverage and medical services; (2) protecting patients in accessing care; (3) a level-playing field for all hospitals; (4) advancing health system, quality, equity, and efficiency; (5) a robust health care workforce; and (6) adequate health system resources. To this end, we offer the recommendations discussed below.

ACCESS TO HEALTH CARE COVERAGE AND MEDICAL SERVICES

Patient Protection and Affordable Care Act Coverage

Enactment of the *Patient Protection and Affordable Care Act* (ACA) was intended to ensure that millions of Americans have true comprehensive health coverage, including protections for those with pre-existing conditions. The law has dramatically reduced the number of uninsured Americans, and more than 90 percent of Americans now have health coverage through their jobs, the ACA, Medicare, Medicaid, and other programs. However, nearly 29 million nonelderly individuals remain uninsured and, as millions of Americans are losing jobs due to the dramatic and prolonged economic fallout from the COVID-19 PHE and ensuing recession, many are losing their health care too. As caregivers, our member hospitals want patients to have increased access to affordable coverage. **The ACA framework provides the platform to accomplish this goal, and we urge the incoming Administration to build and improve upon the framework of the ACA, which has increased coverage for approximately 20 million Americans. We offer the following recommendations to achieve this goal:**

- ***Expanded/Special Open Enrollment:*** Extend open enrollment beyond the current 45 days (November 1 – December 15). Further, offer a special enrollment period in 2021 of at least several months, while engaging in increased marketing and outreach of the ACA, with restored federal spending for navigators. This would allow individuals, including those who have lost coverage during the COVID-19 PHE, to enroll regardless of a qualifying event.
- ***Tax Credits and Cost-Sharing Reductions:*** Increase, and expand eligibility for, premium tax credits and cost-sharing reductions to increase affordability.
- ***Section 1332 Waivers:*** Reverse guidance for Section 1332 state waivers that could cause a decline in coverage or affordability and withdraw the recent proposal under the Department of Health & Human Services (HHS) *Notice of Benefit and Payment Parameters for 2022* that would codify these waiver standards in regulation.
- ***Healthcare.gov:*** Ensure availability of healthcare.gov and strengthen standards for web brokers and brokers selling marketplace plans.
- ***Non-ACA Plans:*** Roll back access to non-ACA compliant plans, such as association health plans and short-term health insurance plans, and limit opportunities for renewal of these short-term plans.
- ***Essential Health Benefits:*** Revise current regulations that provide insurers with the flexibility to substitute benefits across essential health benefit categories.
- ***Family Glitch:*** Eliminate the requirement that a family's premium subsidy eligibility depends on whether available employer-sponsored insurance is affordable for the employee only, even if it is not actually affordable for the whole family.

- ***Automatic and Facilitated Enrollment:*** Engage in robust automatic enrollment efforts as well as facilitated and simplified enrollment for any remaining uninsured individuals.

Medicaid Eligibility and Coverage

Disproportionate Share Hospitals

The ACA reduced payments to the Medicaid disproportionate share hospital (DSH) program under the assumption that uncompensated care costs would decrease as health care coverage increased. Unfortunately, the coverage rates envisioned under the ACA have not been fully realized, and tens of millions of Americans remain uninsured. The COVID-19 PHE has only worsened the situation. In addition, Medicaid underpayment continues to pose ongoing financial challenges for hospitals treating our nation’s most vulnerable citizens.

As such, scheduled DSH cuts pose a significant risk to the Medicaid safety net at a time when demands on the program are growing and the responsibilities of hospitals to care for the uninsured are increasing. **The FAH appreciates that Medicaid DSH cuts will be delayed through September 2023 but believes that policymakers must continue to work to permanently eliminate these harmful cuts.**

Medicaid Eligibility/Waivers

The FAH urges discontinuation of current eligibility and waiver policies that are intended to limit Medicaid rather than sustain or increase coverage to low-income citizens. Policies that create barriers to coverage have the result of leaving citizens uninsured and financially vulnerable, while increasing the burden of uncompensated care for providers. The impact is particularly devastating during periods of high unemployment such as during the present PHE. **Instead, we encourage greater use of policies that boost enrollment or keep people on Medicaid, especially for individuals without other coverage options.**

- ***Retroactive Eligibility:*** At least seven states have moved to limit, or eliminate altogether, Medicaid retroactive eligibility under section 1115 research and demonstration waivers (although some of those policies have been stayed as part of litigation challenging the legality of waivers that include work requirements.) We encourage reversing the approval of these waiver provisions.
- ***Public Charge:*** The current Administration’s public charge rule significantly expanded the standard for what constitutes a public charge to apply to anyone who would be “more likely than not” to use certain public benefits at any point in the future. While recently declared illegal by a U.S. district court judge, we strongly encourage the new Administration to reverse that rule.
- ***Auto-Enrollment:*** States should automatically enroll individuals into Medicaid based on their participation in other programs or by computer matching. These policies could help reach uninsured individuals who may not realize they are Medicaid eligible. Financial incentives could be provided for states to establish auto-enrollment matching systems.

- ***Continuous Eligibility for Adults:*** Continuous eligibility makes Medicaid coverage more reliable for beneficiaries over the course of a year. It prevents fluctuations in monthly income from churning individuals on and off program rolls during a year and reduces the burden on enrollees to re-enroll during the year. States already have the option to provide 12 months of continuous coverage for children. This should be extended for all enrollees.
- ***Extend Post-Partum Coverage for Women:*** Under existing Medicaid law, states are required to cover pregnant women with incomes below 133 percent of the federal poverty level for a period that extends to 60 days post-partum. We support a state plan option to extend Medicaid coverage for pregnant women for 12 months post-partum.
- ***Rescind Waiver Guidance:*** We encourage elimination of waiver guidance inviting states to implement work requirements and impose budget caps on state Medicaid spending, as well as withdrawal of such existing waivers. Medicaid research and demonstration waivers should be focused on legitimate experiments intended to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services consistent with the program’s statutory objectives, not to eliminate or cut Medicaid coverage, benefits, or eligibility.

Medicaid Fiscal Accountability Regulation

The FAH is pleased that the *Medicaid Fiscal Accountability Regulation* (MFAR) proposed rule, which sought to limit common state Medicaid financing arrangements – such as provider taxes, intergovernmental transfers, and donations – has been formally withdrawn from the Trump Administration regulatory agenda. **The FAH firmly opposes MFAR and urges the new Administration to refrain from pursuing any similar regulation, the effect of which would impede access to Medicaid services, and threaten the fiscal health of states and many health care providers.**

Medicaid Expansion

The ACA provided states with the option to extend Medicaid coverage to parents and childless adults with income below 138 percent of the federal poverty level. To date, only 13 states have not yet done so. The FAH strongly supports policies to encourage those remaining states to expand Medicaid. Along those lines, *The Incentivizing Medicaid Expansion Act*, for example, would allow those states to receive 100 percent Federal Medical Assistance Percentages for the first three years a newly eligible individual is enrolled in the Medicaid program; 95 percent for the fourth year, 94 percent for the fifth year, 93 percent for the sixth year, and 90 percent each year thereafter. **We urge the incoming Administration to work with Congress to incentivize state expansion of Medicaid programs.**

Medicaid Institutions for Mental Disease

The development and distribution of vaccines provide hope for the end of the PHE. Yet, the COVID-19 era will have long-lasting ramifications as Americans continue to struggle with behavioral health and substance use disorders that have only been exacerbated over the past year. As such, the FAH urges the incoming Biden Administration and Congress to ensure access to

funding for behavioral health providers, including inpatient and outpatient providers, as well as residential treatment centers.

As an important first step, the incoming Administration should prioritize reducing barriers that will then increase access to much-needed behavioral health services. **Specifically, the FAH supports the repeal of the Medicaid Institutions for Mental Disease (IMD) exclusion to allow state Medicaid programs to cover and pay for care provided to adult Medicaid beneficiaries between the ages of 21 and 64 in inpatient psychiatric facilities with more than 16 beds.** The elimination of the IMD exclusion, along with the elimination of the 190-day lifetime limit on Medicare coverage of services in free-standing psychiatric facilities will allow patients to continue to receive care during and after this PHE.

Mental Health Parity

There is not yet a level-playing field for the treatment of behavioral health conditions and physical health conditions. We appreciate that Congress has approved legislation that would support achieving parity in mental health benefits. **We look forward to working with the incoming Administration to step up enforcement to help ensure access to the care that Americans suffering from mental illness need and deserve.**

Prescription Drug Pricing

We appreciate the incoming Biden Administration's focus on high prescription drug costs. The rapid rise in prescription drug prices has generated negative impacts throughout the health care system, with hospitals bearing a heavy financial burden and forced to make difficult choices about how to allocate scarce resources. These pressures are underscored by two studies commissioned by the FAH and the American Hospital Association (AHA)¹. Key results demonstrate, for example, that average total drug spending per hospital admission increased by 18.5 percent between FYs 2015 and 2017; hospitals experienced price increases in excess of 80 percent across different classes of drugs, including those for anesthetics, parenteral solutions, opioid agonists, and chemotherapy; and one in four hospitals had to cut staff to mitigate budget pressures. **The FAH is committed to supporting market-based reforms that help combat these rising prices by promoting competition and innovation and improving value.**

PROTECT PATIENTS IN ACCESSING CARE

Surprise Billing

No patient should have the added stress and financial burden of receiving a bill for unanticipated out-of-network care. **The FAH appreciates that Congress passed the *No***

¹ [https://www.fah.org/fah-ee2-uploads/website/documents/Trends in Hospital Inpatient Drug Costs Issues and Challenges %281%29.pdf](https://www.fah.org/fah-ee2-uploads/website/documents/Trends%20in%20Hospital%20Inpatient%20Drug%20Costs%20Issues%20and%20Challenges%202019.pdf); [https://www.fah.org/fah-ee2-uploads/website/documents/AHA Drug Pricing Study Report FINAL 01152019.pdf](https://www.fah.org/fah-ee2-uploads/website/documents/AHA%20Drug%20Pricing%20Study%20Report%20FINAL%2001152019.pdf)

Surprises Act to protect patients by prohibiting balance billing and limiting their cost-sharing to an in-network amount. The FAH also appreciates that the newly passed legislation will avoid rate-setting and preserve the ability of health care providers and health insurers to negotiate fair payment rates. We look forward to working with the incoming Administration to ensure appropriate and fair implementation of the law that reflects hospital workflow and minimizes regulatory burden.

Transparency and Disclosure of Hospital and Payer-Negotiated Rates

The FAH supports HHS's goal of ensuring that patients have access to clear, accurate, and actionable cost-sharing information. The HHS policies requiring disclosure of hospital and payer negotiated rates, however, do not accomplish this goal. Such disclosure does not support the interests of consumers and is based on flawed operational assumptions and gross underestimation of the costs and feasibility of compliance with the requirements. **The FAH urges the incoming Administration to state publicly that CMS will exercise its discretion and refrain from enforcing this provision while evaluating whether to rescind the onerous and anticompetitive requirement to publish hospital and commercial health insurer negotiated rates. Further, we urge the Administration to work with stakeholders – providers, health plans, employers, and consumers – to refine the policy and eliminate requirements to disclose negotiated rates, while identifying opportunities to improve consumers' access to clear, accurate, and actionable cost-sharing information.**

Medicare Advantage/Managed Care

The incoming Administration should pursue and enforce policies ensuring that Medicare Advantage (MA) and Medicaid Managed Care plans are not inappropriately denying or delaying enrollees' access to care, as well as payments to health care providers. The growth in the use of various pre-payment and post-payment "tools" by plans is proliferating, including increased use of arbitrary and inefficient prior authorization, inappropriate denials, and "downcoding" of medically necessary services provided to enrollees. While some of these tools are meant to ensure program integrity, the FAH is concerned about the trend toward aggressive strategies that go beyond the legitimate scope of program integrity efforts, and instead result in the improper delay or denial of payments and excessive administrative burden.²

We urge the Centers for Medicare and Medicaid Services (CMS) to fully implement the Office of Inspector General (OIG) recommendations to reduce the incidence of inappropriate denials by: enhancing oversight of MA contracts and taking corrective action; addressing persistent problems regarding inappropriate denials and insufficient denial letters; and providing enrollees with easy-to-understand and easily accessible information about serious MA plan violations. The FAH also urges CMS to direct plans to use CMS-endorsed standards for determining coverage for inpatient procedures and inpatient rehabilitation facility (IRF) coverage (e.g., the two-midnight rule for inpatient Medicare admissions). In addition, our members routinely report delays and inconsistencies with authorization processes for both emergency and

² These concerns are reflected in a 2018 report from the HHS OIG. *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018), <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf> (noting that "MAOs may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits" and recommending, *inter alia*, addressing persistent problems regarding inappropriate denials).

elective admissions across plans. When plans deny the authorization requests, providers struggle to understand why (e.g., based on what guidelines) the request was denied. And when providers make it through the authorization process and receive an approval, they are increasingly finding that some plans do not honor that approval at the time of payment. CMS should work to simplify and streamline the authorization process and ensure plan enrollees and the providers who care for them can rely on authorization determinations. CMS's recent release of a prior authorization proposed rule is a start toward addressing these issues, however it would not affect MA plans, which would dramatically limit the impact of the proposed policies. In addition, the less than 30-day comment period (comments due on January 4, 2021) simply does not provide sufficient time to meaningfully evaluate and comment on the proposals contained in the regulation.

Regulatory Flexibility for Patient Access to Patient Care

The FAH supports efforts to transform certain temporary waivers, including those for telehealth, into permanent Medicare policy. An overarching principle to take into account when developing these new policies is that payment for health care services provided remotely through technology should reflect differences in the cost-structure of the entity providing the service. The FAH looks forward to working with the new Administration to achieve meaningful and lasting policy changes across our health care system. In some cases, Congressional action may be needed to ensure a smooth transition (e.g., removing geographic and originating site constraints), and we urge the incoming Administration to work expeditiously with Congress to act on policies that require such action to become permanent Medicare policy.

Inpatient Rehabilitation Facility Claim Review Demonstration

CMS should withdraw the *Review Choice Demonstration for IRF Services* announced on December 14, 2020 and scheduled to begin in 2021. Requiring 100 percent claims review, often by reviewers without the necessary training and experience in rehabilitation medicine, will impose additional staffing and administrative burdens, disrupt care during the PHE and as IRFs struggle to stabilize operations, and lead to denied patient access to care.

HOSPITAL LEVEL-PLAYING FIELD

Physician-Owned Hospitals

Self-Referral to Physician-Owned Hospitals

The current moratorium on self-referral to physician owned hospitals (POHs) should remain firmly in place. There is a substantial history of congressional policy development and underlying independent research demonstrating that these conflict-of-interest arrangements of hospital ownership and self-referral by physicians result in cherry-picking of the healthiest and wealthiest patients, excessive utilization of care, and patient safety concerns. This policy development includes decades of work by Congress, numerous hearings, and analyses by the HHS OIG, Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC). **Efforts to weaken or overturn the ban would harm patients, community hospitals, and local businesses. Further, expansion of POHs during the COVID-19 PHE should remain temporary and expire at the end of the PHE.**

“High” Medicaid Facilities

The physician self-referral law permits limited expansion of certain grandfathered hospitals, including “high” Medicaid facilities, that meet demonstrated community need. CMS recently finalized a provision – under the calendar year (CY) 2021 Outpatient Prospective Payment System (OPPS) final rule – effectively removing all limits on expansion by these facilities. For multiple reasons, the proposal is much broader than purported and its impact will far surpass only Medicaid patients, while opening the door for significant gaming by POHs, thus undermining Congressional intent to strictly limit POH expansion. **The FAH opposes this expansion and urges the incoming Administration to roll back this provision consistent with long-standing Congressional intent.**

Funding and Eligibility for FCC and HRSA Health Care Programs

The FAH supports additional funds to support the Federal Communications Commission (FCC) health programs. **The FCC should expand the eligibility criteria for its health care programs to ensure full participation from a broad number of health care stakeholders – including tax-paying hospitals – to best meet the needs of patients, especially in rural and underserved communities.** Otherwise, patients living in communities across the U.S. that are served by a tax-paying hospital are unjustly penalized.

Further, *The Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) expands eligibility criteria so that nurses employed at a tax-paying health care facility that otherwise falls within a Health Resources & Services Administration (HRSA)-designated shortage area can participate in the Nurse Corps Loan Repayment Program. This vital eligibility change allows communities in HRSA-designated shortage areas served by tax-paying hospitals to have access to the same recruitment and retention tools as other vulnerable communities. **The FAH encourages the incoming Administration to seek additional funding for the Nurse Corps Loan Repayment Program to reflect the increased number of eligible placement sites for nurses wishing to participate in the program.**

The CARES Act also modified and expanded eligibility requirements for several other HRSA-administered programs relating to telehealth and rural health care services, no longer restricting these programs to public and nonprofit entities only. **The FAH encourages the incoming Administration to pursue additional opportunities to expand eligibility for programs administered by HRSA to tax-paying entities that provide crucial care in underserved communities.**

Federal Emergency Management Agency Emergency Funding

Eligibility criteria used by the Federal Emergency Management Agency (FEMA) excludes tax-paying hospitals from directly receiving financial assistance during declared emergencies. This exclusion disadvantages approximately 20 percent of hospitals nationally, as well as the patients in the communities they serve, as they are prohibited from obtaining direct funding for certain covered resources that are critical for responding to pandemics and other emergencies. **There should be a level-playing field for all hospitals in regard to eligibility for necessary**

assistance during declared emergencies.

ADVANCE HEALTH SYSTEM QUALITY, EQUITY, AND EFFICIENCY

Center for Medicare & Medicaid Innovation

The Center for Medicare & Medicaid Innovation (CMMI) is an important proving ground to test innovative patient care models that Congress could eventually adopt and apply as permanent changes to the Medicare program. **The FAH does not believe, however, that CMMI's organic statute authorizes CMS to mandate provider participation in these experiments. As such, CMS should ensure that all models are voluntary.** In addition, the authority to permanently expand existing models rests solely with the policy-making authority of Congress. This is particularly important as few value-based payment reform models have, as yet, demonstrated clear-cut success in improving efficiency measured as significantly lower costs and improved patient quality and access to care.

Star Ratings Program

The FAH urges the incoming Administration to continue to support CMS in its efforts to improve the overall hospital star ratings program. The FAH supports provisions in the CY 2021 OPPS final rule that will help ensure the star ratings methodology is transparent, with clear cut-points and targets, and accurately reflects the quality of care provided in the facilities, however, more work is needed. While we continue to hold that a single five-star measure is not sufficient to convey the quality of hospital care, these provisions include improvements we support, such as the discontinuation of the use of the latent variable modeling approach to measure group scores. We also agree with the intent behind the provision in the OPPS final rule that will peer group hospitals by the number of reported measure groups, though we encourage the incoming Administration to support CMS in continuing to explore additional alternative approaches that allow appropriate comparisons among hospitals. Finally, we urge the incoming Administration to support CMS in its exploration of appropriate risk adjustment and stratification methods to support health equity.

Hospitals Consumer Assessment of Healthcare Providers and Systems

The FAH urges the incoming Administration to support CMS in continuing its efforts to modernize the Hospitals Consumer Assessment of Healthcare Providers and Systems (HCAHPS) by adding a digital mode of delivery to existing modalities and revising the content of the survey in light of today's shift to value-based care and emerging technologies and innovations.

Measures for Value-Based Care

The FAH urges the incoming Administration to leverage a methodology to identify appropriate measures based on a set of criteria that includes the intended application (use in quality improvement or a payment program, including various CMMI demonstrations),

consideration of burden, and fulfilment of measure gaps. These measures should be able to be used across appropriate initiatives and across different payers.

Health Equity

Current disparities in health outcomes, exacerbated by the COVID-19 PHE, leave certain populations bearing disproportionate disease burden and mortality. **We urge the new Administration to empower the HHS Secretary to lead an effort that will address health inequities across all areas of health policy and target the social and structural determinations of health.** This effort should include a focus on the development of a framework that allows standardized and appropriate collection of social risk data that may inform disparities as well as appropriate risk adjustment in quality measures and programs.

Interoperability

Information Blocking

The FAH continues to believe in the potential of health information technology (health IT) to improve the quality and efficiency of care provided to patients, reduce provider burden, and advance population health management and breakthroughs in health care research.

The regulations implementing the *21st Century Cures Act* were released in the midst of the COVID-19 PHE, and the time hospitals and other providers set aside to prepare for and implement these significant changes have been overtaken by the all-hands-on-deck effort to address the ongoing PHE. While the FAH appreciates the Office of the National Coordinator for Health Information Technology (ONC) amending the effective date of the “information blocking” requirements until April 5, 2021, the additional five months is simply not enough time for hospitals and other providers to come into compliance. **As such, the FAH urges ONC to amend the compliance date to the later of January 1, 2022 or at least six months after the end of the PHE and to make corresponding amendments to the other dates in the ONC regulation and corresponding policies in the CMS regulations.**

Given the significant penalties for information blocking of up to \$1 million per violation, there is an urgent need for clear guidance to hospitals and other providers regarding what is considered compliant behavior and how they should document their compliance with any requirements and information blocking exceptions. In addition, the FAH strongly encourages the OIG and the Secretary to utilize enforcement discretion such that any enforcement action against health care providers focuses first on education and outreach and then transitions to a gradual application of enforcement actions, such as a corrective action plan, before assessing monetary penalties.

Establish Appropriate Adoption/Deployment Timelines for CEHRT

CMS establishes timelines under which health care providers must adopt/deploy certified electronic health record technology (CEHRT) while ONC establishes timelines under which vendors must develop CEHRT. **It is vital that vendor development deadlines be earlier than**

the CMS adoption/deployment timelines to provide sufficient time for hospitals to receive, evaluate, and implement the updated technology, including staff and clinician training.

Patient Matching

There is no consistent approach to accurately matching a patient to their health information, which has led to significant costs to health care providers, hindered the advancement of health information exchange across the care continuum, and has patient safety implications. **CMS should leverage its authority to improve patient matching to facilitate improved patient safety, enable better care coordination, and advance interoperability.**

Admission, Discharge, and Transfer or Related Conditions of Participation

Improving patient transfers and the efficient and effective exchange of information between providers, is an important goal. This condition of participation (CoP), however, will significantly increase burden on health care providers while failing to achieve the desired goals due to: the inability for hospitals to clearly understand what it is they must achieve and how they will be measured to determine compliance; significant operational issues; and lack of technological functionality. Failure to comply with CoPs carries serious penalties for hospitals and patients, as they may lose the ability to receive treatment in their communities. **As such CMS should not implement the CoPs requiring hospitals and critical access hospitals to send electronic patient event notifications of a patient’s admission, discharge and transfer (ADT) to other facilities, providers, or community providers. CMS should instead work together with the provider community to improve the exchange of such information using incentives and regulatory relief rather than harsh penalties.**

Provide Consumer Education and Support a Vetting Process for Third-Party Applications

The FAH remains concerned about the privacy and security of third-party applications (third-party apps) having fairly open access to patient digital health data through the ONC final rule without patients fully understanding how these apps might use that data. **ONC should work with other agencies to undertake a joint education campaign.** In addition, as these apps are generally not governed by the Health Insurance Portability and Accountability Act (HIPAA), ONC, CMS, and other agencies should support an independent, industry-backed “vetting” process for third-party apps to ensure they are: meeting all relevant security standards; using data appropriately and in line with consumer expectations; and clinically sound (for those applications that offer medical advice).

Hospital Consolidation to Maintain Efficiency and Coordinated Care

Patient access to care hinges on ensuring that community hospitals have the resources they need to provide lifesaving care for anyone who walks through their doors 24/7. Many hospitals are struggling to maintain critical service lines, coping with large pandemic-related revenue losses on top of Medicare and Medicaid payments that are deeply and chronically below the cost of care. Studies conducted on hospital systems have found statistically significant

improvements in quality, and that mergers produce important cost savings, do not increase revenues, and keep hospitals open to serve patients.³

Hospital consolidation reduces overhead costs and increases efficiencies through clinical integration and coordination of care for patients. Health system investments in technology, quality improvement, and care coordination can be leveraged across more sites of service, which is particularly important for expanding the capacity of smaller and rural hospitals. **As we have experienced the relentless need for hospital staff, supplies, and equipment during the COVID-19 PHE, the benefits of tightly integrated hospital systems of care have been amply demonstrated as systems efficiently and effectively are able to move staff, supplies, and equipment to meet these demands.**

ROBUST HEALTH CARE WORKFORCE

Graduate Medical Education

Expand Residency Slots

The Association of American Medical Colleges (AAMC) estimates a looming shortage of 54,100 to 139,000 physicians by 2033,⁴ including shortfalls in both primary and specialty care, which was especially evident throughout the COVID-19 PHE. **We appreciate the recently passed legislation to increase residency slots and look forward to working with the incoming Administration to continue to ensure a robust graduate medical education program. Though the legislation is an important step, the FAH supports additional expansion and funding of residency slots to help ensure access to medical care and that tomorrow's physicians are fully equipped with the training and skills necessary to treat patients.**

CMS Nursing and Allied Health Direct Graduate Medical Education Recoupment Delay

CMS soon will begin recouping an estimated \$2 billion from hospital-based nursing and allied health schools in past payments, as well as lowering the annual nursing school support payments. This devastating cut is due to a CMS recalculation of Part C components of nursing and allied health and direct graduate medical education payments to hospitals for calendar years 2002 through 2018. **The FAH supports postponement of this recoupment – including, but not limited to, a 180-day delay on the Transmittal Notice – to allow hospital-based nursing schools and CMS to determine how best to resolve this issue without implementing severe payment cuts to hospitals and nursing schools, especially during a pandemic.**

Immigration Policy for Clinicians

Hospitals throughout the country face staffing shortfalls that directly affect their ability to provide the high-quality care their communities deserve. While this situation was true prior to the COVID-19 PHE, this pandemic has brought this issue into sharp focus. Many hospitals utilize and rely on immigrant visas in order to ensure appropriate levels of qualified clinical staff.

³ <https://www.healthleadersmedia.com/sites/hlmp/files/cra-hospital-merger-benefits-1218.pdf>

⁴ <https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage>

Immigrant Visa Backlogs

Despite the clear advantages of leveraging immigration policy to fill vacant clinical positions, significant backlogs have diminished the effectiveness of these programs. Nurses that have already passed extensive screening procedures wait overseas as backlogs continue to delay entry. Highly skilled physicians similarly sit overseas due to both delays in processing and arbitrary per-country caps on immigration. In addition, every year, visas that could be used to mitigate the provider shortage go unused.

Green Card Delays

Physicians that are already practicing in the U.S. with approved immigrant petitions are caught up in green card delays that prevent them from serving in the areas where they are most needed, which is especially burdensome as facilities grapple with COVID-19. For example, temporary visa restrictions have prevented physicians from traveling to COVID-19 hotspots or working additional shifts at alternate facilities.

The Biden Administration should take urgent steps to reduce backlogs and address green card delays in the immigration system for foreign clinicians as one of several measures to address provider shortages within the U.S. Where necessary, the new Administration also should work with Congress to enact meaningful reforms and recapture unused visas.

ADEQUATE HEALTH SYSTEM RESOURCES

Provider Relief Fund

The Provider Relief Fund (PRF) has been critical in providing hospitals with the financial support needed to maintain their ability to provide vital services for their patients and communities. Yet, at the very moment that patient caseloads and hospitalizations reach new peaks, there is an increasing danger that the fund will be depleted. **We must ensure, at least until the vaccination program reaches a critical mass and through the entirety of the PHE, that the PRF is replenished and remains funded at a level that will sustain providers.** Along those lines, while we appreciate Congress recently adding \$3 billion, the PRF will need an infusion of substantially more funding to help hospitals and other providers respond to the ongoing impact of the pandemic.

Further, given the unique challenges hospitals face, including large capital costs, escalating labor costs, and financial losses from a reduction in non-emergent clinical care, a significant percentage of PRF distributions should be directed to hospitals.

Medicare Provider Payment

COVID-19 is the most significant national PHE since the establishment of the Medicare program and certainly since the adoption of Medicare prospective payment systems. Since the

PHE was declared in January 2020, hospitals have experienced significant and unprecedented changes in utilization, case mix, and relative costs that have broadly destabilized finances. At this time, the long-term effects of the COVID-19 PHE on hospital operations is still unknown. **Therefore, especially as Medicare operating margins remain deeply and chronically negative, predictable Medicare payment is imperative and cuts, whether from reductions to market basket updates or specific payment policies such as so-called “site neutral” payments, must be avoided.**

In addition, recent projections of an acceleration in the Medicare Trust Fund depletion date is more a function of declining revenues due to the pandemic-caused economic downturn rather than an acceleration in Medicare spending. In fact, Medicare spending specifically, and health care spending more generally, have declined in 2020. **Therefore, these new Trust Fund depletion dates should not be the basis for provider payment cuts.**

Finally, while we appreciate Congress extending through March 31, the moratorium on Medicare sequestration cuts to providers, we urge the Biden administration to support efforts to further extend the moratorium until the end of the PHE.

Medicare Bad Debt

Coverage of Medicare beneficiary bad debt is considered an essential component of payment in full for the services provided and was designed to prevent other payers, such as the commercial insurers, from having to cross-subsidize the Medicare program due to beneficiary underpayments. With private health insurers, hospitals are able to negotiate payment rates that account for expectations of bad debt. However, under the Medicare program hospitals are not able to negotiate payment rates and must instead accept Medicare-administered prices. Congress has twice reduced Medicare bad debt payments to providers. **Further cuts are ill-advised.** The majority of bad debt is incurred by dual-eligible patients for whom states are, in effect, not required to reimburse providers, and from whom providers are prohibited from seeking collection.

340B Payment Policy

The FAH strongly supports CMS’s current policy under the Medicare OPPS to reduce the payment rate on a budget neutral basis for separately payable drugs and biologicals acquired with a substantial discount under the 340B program. Not only does the policy significantly reduce beneficiary copayments for these drugs, but it helps level the playing field across all hospitals and provides a net payment benefit to as many as 82 percent of all hospitals paid under the OPPS, including 89 percent of rural hospitals, 74 percent of government hospitals, and even 42 percent of 340B hospitals. Further, uncompensated care services measured as a percent of operating costs were comparable in non-340B and 340B hospitals, as discussed in an FAH [amicus brief](#) filed before the DC Circuit Court of Appeals.

Unified Post-Acute Care Payment PPS

The FAH urges the new Administration to support an immediate refresh of the Unified Post-Acute Care (PAC) Prospective Payment System (PPS) mandate outlined in the *Improving Medicare Post-Acute Care Transformation Act (IMPACT Act)*. The IMPACT

Act mandated the design of a Unified PAC PPS for the four PAC settings and included a timeline for the collection and reporting of substantial amounts of quality and patient data, followed by an eventual report from CMS to Congress on a technical PAC PPS prototype. In the wake of the COVID-19 PHE, along with the changing dynamics of post-acute health care in recent years, and missed deadlines by the agency, it is imperative that CMS thoroughly re-evaluate its utilization of certain data and further pilot the required PAC PPS prototype, including robust testing and modeling by PAC providers in real-world settings, before submitting its report to Congress.

We appreciate your leadership, along with the Transition Team, in responding to these important issues facing our nation and we look forward to working with the incoming Administration to address these significant concerns so that hospitals are able to continue providing the best care possible to patients and their communities. If you have any questions or wish to speak further, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Reinhart". The signature is fluid and cursive, with a large, sweeping flourish at the end.