Federation of American Hospitals®

Charles N. Kahn III
President and CEO

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The Honorable Richard Hudson
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim Banks
U.S. House of Representatives
Washington, DC 20515

The Honorable Tom Cole
U.S. House of Representatives
Washington, DC 20515

Delivery via email cc: Molly Brimmer, Andrew Keyes, and Shane Hand

Dear Representatives Hudson, Banks, and Cole:

On behalf of the Federation of American Hospitals (FAH), thank you for the opportunity to comment on the Request for Information from the Healthy Future Task Force Security Subcommittee.

The FAH is the national representative of more than 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 areas across 46 states, plus Washington, DC and Puerto Rico. Our members include 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.

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Question 5:

The COVID-19 pandemic highlighted the efficacy of removing inefficient regulatory barriers that may stall public health and recovery responses. While many federal barriers to the immediate risk were addressed, long-term impediments remain that could discourage State, local, and private sector investment in pandemic preparedness.

a. What regulatory barriers could be modified, consolidated, harmonized, or repealed to better ensure Federal and State public health agencies are better situated to quickly adapt and efficaciously respond to protect public health in a future PHE?
b. What barriers exist that impede private sector investment in resources and capabilities – such as early warning systems, vaccine development, and domestic

manufacturing – which could prove beneficial in future pandemics and public health emergencies?

c. What regulatory barriers and burdens could be allayed, consolidated, repealed, or otherwise modified that would better situate local communities to remain economically viable and resilient in the face of future public health emergencies?
d. What revisions and updates to public health and communicable disease law may be required in light of issues raised during the public health response to the COVID-19 pandemic?

Response:

Overall Recommendations to Optimize Public Health Emergency (PHE) Response

The mitigation of a PHE demands quick and coordinated federal, state, and local action to support hospitals and other health care providers, along with the patients they serve. As hospitals activate and operate under emergency plans and continue preparing for COVID-19 surges, we ask Congress to urge the Administration to implement proposals – including those outlined below – for regulatory flexibility to help ensure hospitals are fully prepared and equipped to respond to future PHEs:

- Ensure federal and state coordination, with appropriate and consistent requirements across state and local governments, with federal pre-emption in the event that a state is not able to take action on a timely basis (in particular as it relates to accessing state and national stockpiles)

- Develop a blanket waiver approach, based on experiences and best practices developed during the current COVID-19 PHE, that can be activated immediately during a future PHE, for example, section 1135 waivers, CMS Category 3 and non-Category 3 temporary telehealth waivers, and legislated waivers that have been available. These waivers are extensive and critical for providing patient care during a PHE. They range, for example, from allowing rural hospitals to expand using swing beds for skilled nursing care to providing physician self-referral law blanket waivers, to behavioral nursing and discharge planning waivers, and permitting at home hospital outpatient department services to be provided remotely.

  We also note the importance of waivers that allow the post-acute care community to contribute to the shortage of beds during the PHE (e.g., waiver of the 60 percent and three hour rules for inpatient rehabilitations facilities ((IRFs)), which eliminate restrictions on access to rehabilitation services; waiver of both the 25-day rule for long-term care hospitals ((LTCHs)), allowing them to exclude emergency admits/discharges from their 25-day average length of stay requirement, and restrictive site neutral payment policies that would otherwise penalize LTCHs for providing critically needed intensive care that they are uniquely able to offer).

- Lend CMS support for legislative action when needed.

Remove Geographic / Originating Site Requirements and Other Barriers to Telehealth

There has been unprecedented change in the use of telehealth to provide much needed access to health care services across the country during the current PHE, for example, telehealth waivers permit remote patient monitoring for new or established patients with any single chronic or acute conditions; virtual check-ins and e-visits for new patients; audio-only evaluation and management services; and direct supervision via the virtual presence of a physician. These waivers are especially important for behavioral health counseling, including audio-only services.

More action by Congress is needed to ensure that, post COVID-19 and in preparation for future emergencies, the full potential of telehealth is available for patients to have greater and more seamless access to the care they need. *The CARES Act* provided the HHS Secretary the authority to waive certain requirements during the PHE, including allowing greater expansion of health care services provided via telehealth.

The FAH urges additional Congressional action to remove barriers to patient access to telehealth services, for example, by permanently removing the geographic and originating site requirements and expanding the list of eligible practitioners who may furnish clinically appropriate health care services via remote technology.

In addition, we urge Congress to ensure additional funding for the Federal Communications Commission's (FCC) recently launched COVID-19 Telehealth Program, while also requiring expanded program eligibility criteria to ensure full participation from a broad number of health care stakeholders, including tax-paying hospitals. As currently defined by the FCC, the eligibility criteria for the COVID-19 Telehealth Program makes tax-paying hospitals ineligible for participation. This unjustly penalizes patients living in communities across the United States that are served by a tax-paying hospital and should be remedied by Congress.

Parity for Tax-Paying Hospitals is Needed Regarding Eligibility for Health-Related Federal Programs

We urge Congress to expand the eligibility of many health-related federal programs that currently and unjustly exclude taxpaying hospitals to the detriment of our patients and communities. For example, excluding tax-paying hospitals from direct FEMA eligibility as well as other Health Resources and Services Administration (HRSA) programs that provide assistance during emergencies and PHEs undermines the ability of local communities to provide broad-based, efficient and rapid response resources to the community and their patients.

Question 14:

Social determinants of health are another key driver of healthcare spending. Individual behavior and social and environmental factors are estimated to account for 60% of health care costs.

a. To what extent do federal health programs already account for and address social determinants of health?
b. How can Congress best address the factors that influence overall health outcomes in rural, Tribal, and other underserved areas to improve health outcomes in these communities?

c. What flexibilities or authorities are needed to promote the adoption of policies and strategies in federal health programs to address these social determinants?
d. What innovative programs or practices, whether operated by non-governmental entities or local, State, or Tribal governments, might Congress examine for implementation on a national scale?

Response:

Social Determinants of Health

The FAH and its members are keenly aware of the undeniable health disparities uncovered by the COVID-19 PHE, including the increased rates of infections, complications, and death among Black, Hispanic, and Native Americans compared to White patients. We strongly agree that closing the health equity gap is an essential part of transitioning as a nation towards a value-based health care system. Addressing social determinants of health is a critical part of understanding health disparities since they exacerbate and can lead to inequitable care outcomes. While not directly "healthcare-related," food insecurity, homelessness, poverty, and poor education can dramatically harm health outcomes.

CMS recently began providing confidential hospital-specific reports (HSRs) of facility-level performance on measures from Medicare's Hospital Readmissions Reduction Program (HRRP) stratified by dual eligibility for Medicare and Medicaid programs – a leading indicator of poverty and other social determinants of health. CMS is seeking to add race and ethnicity as stratification parameters to its quality programs, focusing attention on standardized definitions and indirect estimation statistical methods for those parameters.

The FAH agrees with the choice of race and ethnicity as the initial parameters for future stratified reporting and the absolute necessity of standardized definitions of these terms across all sources of performance measurement data (e.g., claims, EHRs, Social Security Administration [SSA] database). CMS does not itself routinely collect race, ethnicity, and other social risk factor data, and substantial information gaps in its source, the SSA database, are widely known. Self-reporting of race and ethnicity is established as the gold standard but complete and reliable collection of information accessible to CMS does not currently occur.

Robust, accurate, stratified equity reporting could be facilitated by collecting a standardized set of social, psychological, and behavioral interoperable data elements by hospitals at the time of inpatient admission. Additional hospital resources would be necessary to create optimal conditions for a large set of sensitive data to be collected.

Hospitals already often collect certain demographic data (e.g., date of birth) and some information that could link to certain social risk factors (e.g., place of residence). But current collection is quite variable, driven by demands from states, insurers, and public health agencies, amongst others. The FAH believes that standards and specifics for improved data collection on social determinants is needed for successful implementation in health programs to improve care and outcomes. Clearly defined and standardized data elements, specific methods of data submission and validation, and the additional costs of the associated collection burden must first be addressed.

We strongly urge Congress to advocate an incremental approach to better understand and collect data on social determinants of health developed through deliberate and transparent collaboration with hospitals, patient groups, and other stakeholders.

Rural Hospital Payment Programs

Rural hospitals continue to be disproportionately impacted by the COVID-19 PHE and workforce shortages. We urge Congress to take steps now that will help ensure the long-term fiscal viability of rural hospitals and the services they provide to patients in their communities by:

- Making permanent the current Low Volume Hospital (LVH) and Medicare-Dependent Hospital (MDH) programs set to expire in September 2022.
- Ensuring equitable payment policies for treating low-income rural Americans by, for example, removing the current 12% Disproportionate Share Hospital (DSH) payment cap that currently applies to rural hospitals (with some exceptions).

Health Care Workforce

The struggle to maintain a sufficient, healthy workforce has been exacerbated in recent months as Omicron rapidly spreads. The pandemic continues to have lingering effects on health care providers, as we are seeing rising instances of burnout and resignation.

We urge Congress to prioritize measures, including those listed below, to support frontline health care providers and maintain a robust workforce in both the short and long term:

- Extend the Medicare-funded residency training slots cap building period to ten years, as opposed to the current five years, for new teaching hospitals
- Enact the *Healthcare Workforce Resilience Act* to recapture 25,000 unused immigrant visas for nurses and 15,000 unused immigrant visas for physicians that Congress has previously authorized and allocate those visas to international physicians and nurses
- Enhance investment in provider loan repayment programs, including the Nurse Corps, to incentivize providing care in rural and underserved communities
- Enact the *Technical Reset to Advance the Instruction of Nurses (TRAIN) Act*, which would prohibit CMS from recouping overpayments made in past years to hospital-based nursing and allied health education programs when CMS failed to make technical annual updates to the program, and instead invest those resources in training the next generation of caregivers.

Question 29:

How might certain tax incentives help to spur, encourage, and/or increase domestic production of medical devices; active pharmaceutical ingredients (APIs); drugs; and other medical supplies, products, and countermeasures? What current or future tax policies might hinder adoption of domestic production for these products?

Response:

The FAH is the national association representing over 1,000 of America's tax-paying hospitals. Our hospitals are leading payors of state and local taxes across the country, funds that are vital to supporting community services.

Therefore, we believe it is critically important to maintain a globally competitive domestic corporate tax rate. Raising the rate would have a negative impact on our industry and limit patient access to affordable care.

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We appreciate the opportunity to respond to the RFI and look forward to working with you in 2022 to meet the significant challenges that hospitals face in treating patients during these unprecedented times. If you have any questions or wish to discuss these issues further, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,