



Charles N. Kahn III  
President and CEO

February 22, 2021

Norris Cochran  
Acting Secretary  
U.S. Department of Health & Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Acting Secretary Cochran:

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, 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 understands that defeating the COVID-19 pandemic is the highest health and economic priority for our country, the Biden Administration, and Department of Health and Human Services (HHS). We are committed to working with the Administration and HHS to meet this challenge first and foremost. In addition, we face other serious health care challenges on a multitude of fronts across the country, as hospitals continue their front-line, around the clock care for COVID-19 patients. We also want to work with HHS and the Administration to meet these additional challenges together with determination and focused leadership that puts patients first and eliminates health inequities, builds towards universal health care coverage through the framework of the *Patient Protection and Affordable Care Act* (ACA), and ensures hospital and health care providers have the support needed to ensure our patients receive comprehensive services across the continuum of care in these extraordinary times.

The FAH recently submitted letters to President Biden's [Transition Team](#), as well as the [COVID-19 Task Force](#), and [Congress and the Administration](#) detailing the many challenges in policy and other areas related to the COVID-19 public health emergency (PHE) and offering recommendations to address these challenges. This letter builds upon these policy issues and focuses on recommendations for specific policy changes that are critical for supporting our nation's health care system, including: (1) achieving coverage for all Americans through the

ACA framework; (2) advancing health equity; (3) maintaining or improving existing, effective regulatory policies that ensure access to affordable care; (4) suspending, modifying, or striking policies that are excessively burdensome and/or counterproductive with the pressure of the pandemic in mind; and (5) ensuring adequate health system resources and adoption of policy interpretations to enhance access to high quality care. To this end, we offer the recommendations discussed below.

### **EXECUTIVE SUMMARY**

*Key recommendations for specific policy changes that are critical for supporting our nation's health care system, as discussed below, are summarized as follows.*

#### **IMPROVE COVERAGE AND ACCESS TO CARE**

- ***ACA Coverage:*** Build and improve upon the ACA framework to achieve coverage for all Americans, for example, through tax credits and cost-sharing reductions.
- ***Medicaid Eligibility and Coverage:*** Embrace regulatory and legislative policies that help ensure that states that have not expanded Medicaid coverage do so. Discontinue current eligibility and waiver policies that limit Medicaid coverage, such as Medicaid work requirement programs.

#### **ADVANCE HEALTH EQUITY**

- ***Health Equity:*** Assess the impact of regulations across all areas of health policy, while aggressively working to remove social and structural barriers to improve health via regulatory and/or legislative action.

#### **MAINTAIN OR IMPROVE EXISTING, EFFECTIVE REGULATORY POLICIES THAT ENSURE ACCESS TO AFFORDABLE CARE**

- ***Outpatient Hospital Payment Policy:*** Continue the current policy that reduces beneficiary copayments and Medicare payments for drugs purchased under the 340B program and reinvests savings into higher base payments for primary care and other services. Reversing that policy would harm some 89 percent of outpatient prospective payment system (OPPS) rural hospitals.
- ***Treatment of 1135 Waivers:*** Transform certain section 1135 and other temporary waivers, such as telehealth among others, into permanent Medicare policy.
- ***Medicaid Fiscal Accountability Regulation (MFAR):*** Continue to refrain from pursuing any regulation similar to that of the previous Administration's MFAR proposed rule.
- ***Medicaid Institutions for Mental Disease (IMD):*** Further reduce barriers that impede access to behavioral health services provided in Medicaid IMDs.

**SUSPEND, MODIFY, OR STRIKE POLICIES THAT ARE EXCESSIVELY  
BURDENSOME AND/OR COUNTERPRODUCTIVE**

- **Transparency and Disclosure of Hospital and Payer-Negotiated Rates:** Exercise enforcement discretion regarding requirements for disclosure of hospital and payer negotiated rates, especially during the COVID-19 PHE, and work with stakeholders to develop a streamlined, coherent approach that is informative for consumers.
- **Outpatient Hospital Payment Policy:** Eliminate current site neutral payment policy for clinic visits and refrain from implementing further similar policies, which ignore fundamental differences between hospitals and other settings, and the unique, mission-critical services communities rely on hospitals to provide.
- **Physician-Owned Hospitals (POHs):** Continue the current ban on self-referral to POHs and roll back any expansion opportunity for grandfathered “high Medicaid” facilities.
- **Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act):** Support a refresh of the Unified Post-Acute Care (PAC) Prospective Payment System (PPS) mandate and timeline outlined in the IMPACT Act.
- **Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD):** Withdraw the proposed RCD for IRFs.
- **Most Favored Nation Model (MFN):** Withdraw the MFN interim final rule and advance policy proposals that address the fundamental issues driving drug price increases.
- **Comprehensive Care for Joint (CJR) Replacement Model:** Conclude the CJR Model and hold participating CJR hospitals financially harmless in performance year 5 due to the disruptive effects of COVID-19.
- **Calculation of Medicare Part C Days Proposed Rule:** Do not adopt the “Medicare Part C Days” proposed rule, which addresses a policy that has been repeatedly rebuffed by federal courts and engages in retroactive rulemaking that is unlawful in this instance.
- **Information Blocking Rule Implementation:** Amend the Information Blocking final rule compliance date, along with alignment of dates and requirements across corresponding Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) policies.

**ENSURE ADEQUATE HEALTH SYSTEM RESOURCES AND ADOPT POLICY  
INTERPRETATIONS THAT ENHANCE ACCESS TO HIGH QUALITY CARE**

- **Provider Relief Fund:** Expedite distribution of provider relief funds so that they can help providers respond to the ongoing impact of the COVID-19 pandemic, prioritizing providing uninsured and underinsured patients with access to no-cost COVID-19 testing, treatments, and preventive services, and supporting hospitals in rural and high-impact areas.
- **Surprise Billing Implementation:** Ensure appropriate and fair implementation of the No Surprises Act that reflects hospital workflow and minimizes regulatory burden.
- **Medicare Advantage (MA) and Managed Care:** Pursue policies ensuring that MA and Medicaid Managed Care plans are not inappropriately denying or delaying access to, and payment for, necessary care through arbitrary prior authorization and inappropriate denials and “downcoding” of medically necessary services.

- **COVID-19 Aberrant Data – Quality Performance and Payment:** Waive payment penalties for hospital quality performance programs due to distorted COVID-19 data that does not accurately reflect 2020 quality performance.
- **Reduce Reporting Burden:** Reduce COVID-19 data reporting burden through standardized data entry solutions that prevent duplicative reporting and support hospital enterprise level reporting.

*Below is a more detailed discussion of these and other policy issues and recommendations.*

## **IMPROVE COVERAGE AND ACCESS TO CARE**

### Patient Protection and Affordable Care Act Coverage

- **The ACA framework provides the platform to increase patient access to affordable health care coverage, and we urge the Administration to build and improve upon the ACA framework through the recommendations discussed below.**
- 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 more are losing their health care too.
- On January 28th, President Biden issued an Executive Order (EO) on *Strengthening Medicaid and the Affordable Care Act* instructing HHS and other agencies to evaluate policies to strengthen the ACA and Medicaid and to suspend, revise and rescind actions from the previous four years that limit or hamper the ACA’s insurance and Medicaid coverage provisions. In response to the EO, HHS has announced a special enrollment period from February 15, 2021 through May 15, 2021 and a commitment to spend \$50 million on outreach and education. The Kaiser Family Foundation estimates that 9 million people could benefit from the special enrollment period. The FAH applauds this special enrollment period and the Administration’s actions to offer coverage to millions of Americans through Healthcare.gov.
- **As HHS and the Administration looks to other ways to strengthen and build back the ACA, the FAH supports numerous additional ACA improvements, including:**
  - **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 *HHS Notice of Benefit and Payment Parameters for 2022* that would codify these waiver standards in regulation (as discussed further below).
  - **Healthcare.gov:** Ensure access to 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 depend 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

- The Medicaid program, especially as expanded by the ACA, offers lifesaving health coverage for America's most vulnerable. **The FAH strongly supports President Biden's EO on *Strengthening Medicaid and the Affordable Care Act*.**
- **The FAH supports embracing regulatory and legislative policies that help ensure that states that have not expanded Medicaid coverage do so. In addition, we urge 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 result in leaving individuals 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 COVID-19 PHE. **Instead, we encourage greater use of policies that maintain and boost Medicaid enrollment, especially for individuals without other coverage options, as follows:**
  - **Auto-Enrollment:** The FAH urges HHS to provide financial incentives for states to establish auto-enrollment matching systems that 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.
  - **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.

- **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 previous 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 appreciate the President’s EO directing review of this rule and strongly encourage HHS to reverse the rule promptly.
- **Rescind Waiver Guidance:** We appreciate and support the CMS’s recent actions to start to unwind policies that permit states to implement programs, including Medicaid work requirements, that make it difficult for individuals to access or afford Medicaid coverage. 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.

**ADVANCE HEALTH EQUITY**

- **We appreciate the Biden Administration’s COVID-19 Health Equity Task Force.** Current disparities in health outcomes, exacerbated by the COVID-19 PHE, leave certain populations bearing disproportionate disease burden and mortality.
- **Therefore, we urge HHS to lead an effort that will address health inequities across all areas of health policy, including assessment of the impact of each regulatory policy on health equity, while aggressively working to remove social and structural barriers to improve health via regulatory or legislative action.** This latter 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.

**MAINTAIN OR IMPROVE EXISTING, EFFECTIVE REGULATORY POLICIES THAT ENSURE ACCESS TO AFFORDABLE CARE**

Outpatient Hospital 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 and reinvesting those savings into higher payments to all hospitals for primary care and other outpatient services.**

- The current policy significantly reduces beneficiary copayments for expensive chemotherapy and other drugs and helps level the playing field across all hospitals. Along those lines, reversing the policy would not only increase the beneficiary cost burden for drugs acquired under the 340B program, it also would penalize with lower payments – in an already underfunded system – approximately 89 percent of OPPS rural hospitals.
- It also is worth noting that uncompensated care services measured as a percent of operating costs are comparable in non-340B and 340B hospitals.<sup>1</sup>

#### Treatment of 1135 Waivers

- **The FAH urges HHS to work with hospitals and other stakeholders to transform certain section 1135 and other temporary waivers into permanent Medicare policy** (including, but not limited to telehealth and other remote services provided through the use of technology or permitting advance practice nurses, including behavioral health nurses, to serve in the attending role for Medicare patients without physician supervision to address physician shortages). **HHS also should work expeditiously with Congress where congressional action is needed (e.g., removing telehealth geographic and originating site constraints).**
- 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.
- We urge the use of a "glide path" for phasing out temporary policies put into effect during the PHE, rather than a hard stop. Appropriate and sufficient advance notice of the end of the PHE is needed to allow hospitals planning time to ensure continuity of care for patients when hospital operations transition from COVID-19 trauma care back to normal operations.

#### Medicaid Fiscal Accountability Regulation

- **HHS should refrain from pursuing any regulation similar to that of the previous Administration's MFAR proposed rule**, which was ultimately withdrawn by CMS following significant opposition from health care providers and stakeholders, along with bipartisan Governors and Members of Congress.
- Had it been implemented, MFAR would have impeded access to Medicaid services and threatened the fiscal health of states and many health care providers.

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<sup>1</sup> Brief of Amicus Federation of American Hospitals, American Hospital Ass'n. v. Azar, No. 0:2019-cv-05198 (D.C. Cir. Sep.10, 2019).

## Prior Authorization Final Rule

- The FAH supports requiring Medicaid and CHIP fee-for-service programs, as well as Qualified Health Plans (QHPs) on the Federally-Facilitated Exchanges (FfEs) to improve electronic health care data exchange as well as prior authorization processes.<sup>2</sup>
- **The FAH also strongly urges HHS to expand the applicability of the rule to include MA organizations and prohibit payers from making post-service claim denials for services granted a prior authorization.**

## Medicaid Institutions for Mental Disease

- **The FAH urges HHS to prioritize reducing barriers that will increase access to much-needed behavioral health services.** The ongoing opioid crisis and COVID-19 PHE 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. Accessing behavioral health care can be especially challenging for Medicaid enrollees who are among the most vulnerable.
  - **The FAH supports the repeal of the 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 the PHE.
  - **The FAH urges HHS to expand the 15-day limit on Medicaid managed care enrollees' inpatient stay provided to adult enrollees who have a short-term stay in an IMD.** There is a critical need to improve access to short-term inpatient psychiatric and substance use disorder treatment for the Medicaid population and Medicaid enrollees between the ages of 18 and 64, who have limited inpatient treatment options because of the IMD exclusion.

## Immigration Policy

- We urge HHS to take immediate 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 United States. **HHS also should work with Congress to prioritize enacting meaningful reforms and recapturing unused visas, for example, through the *Healthcare Workforce Resilience Act*, which would “recapture” and repurpose up to 25,000 unused immigrant visas for nurses and 15,000 unused visas for physicians.**

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<sup>2</sup> The *Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information* final rule was put on display on CMS's website on January 15, 2021 but has since been removed, and it did not publish as final in the Federal Register.



- 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, the pandemic has brought this issue into sharp focus. Many hospitals utilize and rely on staff with immigrant visas to ensure appropriate levels of qualified clinical staff, yet significant backlogs and delayed entries persist and each year visas that could be used to mitigate the provider shortage go unused.

#### Physician Self-Referral and Medicare Anti-Kickback Statute Modernization Final Rules

- **The FAH supports the CMS Stark physician self-referral and Office of Inspector General (OIG) Medicare anti-kickback statute final rules** that modernize these laws, reduce regulatory barriers to care coordination, and accelerate the transformation of the health care system into one that pays for value and promotes care coordination.

#### **SUSPEND, MODIFY, OR STRIKE POLICIES THAT ARE EXCESSIVELY BURDENSOME AND/OR COUNTERPRODUCTIVE**

#### Transparency and Disclosure of Hospital and Payer-Negotiated Rates

- **The FAH urges HHS to exercise enforcement discretion regarding HHS policies requiring disclosure of hospital and payer negotiated rates and refrain from issuing any citations or imposing any penalties while further evaluating the rule. Hospitals should be permitted to direct their already strained resources to care for the increased volume of COVID-19 patients and distribute life-saving vaccines to health care workers and patients.**
- The FAH supports HHS's goal of ensuring that patients have access to clear, accurate, and actionable cost-sharing information. The hospital negotiated rate disclosure policy, however, does 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.
- There are considerable gaps in federal guidance on the hospital transparency rule, creating significant compliance uncertainty. In addition, an overlay of further transparency requirements for health care insurers and new transparency requirements in recently enacted surprise billing legislation only adds to the confusion, uncertainty, and potentially conflicting rules.
- **Due to these factors, we urge HHS to work with stakeholders – providers, health plans, employers, and consumers – to develop a new streamlined and coherent approach that rescinds the anticompetitive and confusing requirements while identifying opportunities to improve consumers' need for access to clear, accurate, and actionable cost-sharing information.**

## Outpatient Hospital Payment Policy

- **The FAH opposes site neutral payment policies, such as the current reduction for clinic services performed in hospital provider-based departments.** They ignore fundamental functional and cost structure differences between hospitals and physician offices, among other settings, and the unique, mission-critical services communities rely on hospitals to provide. For example, hospitals provide 24/7 access to emergency care and disaster relief, serve as safety net providers, and treat more medically complex patients who are more often chronically ill, disabled, and indigent. In addition, regulatory requirements such as EMTALA, hospital Conditions of Participation, hospital state licensure, and complex cost reports impose substantial resource and cost burdens that physician offices and ambulatory surgery centers do not have, and therefore are not reflected in their payments.

## Physician-Owned Hospitals

### *Self-Referral to Physician-Owned Hospitals*

- **The current ban on self-referral to 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 and community hospitals. Further, waivers that permit the expansion of POHs during the COVID-19 PHE should remain temporary and expire at the end of the PHE.**

### *“High” Medicaid Facilities*

- **The FAH opposes the expansion of certain grandfathered hospitals, including “high” Medicaid facilities, and urges HHS to roll back this provision consistent with long-standing Congressional intent.**
- CMS recently finalized this provision – under the calendar year (CY) 2021 OPPS final rule – effectively removing all limits on expansion by these “high” Medicaid 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.

### Improving Medicare Post-Acute Care Transformation Act

- **The FAH urges HHS to support an immediate refresh of the Unified PAC PPS mandate outlined in the 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 based on post-pandemic data and lessons learned, and robustly test and model the prototype by PAC providers in real-world settings before it is presented to Congress.

### Inpatient Rehabilitation Facility Review Choice Demonstration

- **The FAH strongly opposes the Trump Administration’s proposed RCD for IRFs and urges CMS and the Administration to withdraw this program from development.**
- The proposed RCD would require either 100 percent pre-claim review or 100 percent post-payment review for all Medicare IRF patients in select states to prevent and identify potential fraud. However, it ignores myriad other auditing programs, high overturn rates in those audit programs, and the excessive burden of the demo on IRFs treating Medicare patients. At a minimum, the RCD should be re-evaluated, revamped, and delayed until well after the COVID-19 PHE.

### Most Favored Nation Model

- **CMS should formally withdraw the *MFN* interim final rule and move forward with policy proposals that address the fundamental issues driving drug price increases.**
- The FAH supports CMS’s goals of reducing Part B drug costs for Medicare beneficiaries, maintaining financial stability, reducing burden for physicians and hospitals, and addressing the disparity in drug prices between the U.S. and other countries. However, the system CMS planned to implement under its MFN Model would have been highly disruptive to the current Part B drug distribution system and would have been more burdensome, rather than less burdensome, to the hospitals and physicians mandated to participate in the model.
- Beyond the procedural irregularities cited by several federal courts in halting implementation of the interim final rule, the MFN Model suffers from major policy

deficiencies including: the expansion in scope to a mandatory nationwide program, the risk that the model may increase international prices rather than lower U.S. drug prices, (as CMS itself notes), the potential for Part B drug prices to increase outside the model and for access problems that may result from hospitals and physicians being unable to obtain drugs at the prices paid by Medicare.

#### CY22 Notice of Benefit and Payment Parameters Final Rule

- **The FAH urges CMS to rescind and/or revise several policies in the *HHS Notice of Benefit and Payment Parameters for 2022* final rule, which published in the Federal Register on January 19, 2021. Specifically, the FAH urges CMS to:**
  - Not allow states to replace their centralized health insurance Exchanges with enrollment through private insurers and brokers that may have a financial conflict of interest;
  - Remove from the regulatory framework and rescind the October 2018 Section 1332 guidance to states, which promotes waivers that would enroll individuals into ACA non-compliant plans that exclude coverage for pre-existing conditions;
  - Ensure special enrollment periods and any associated verifications are not overly burdensome or otherwise impede coverage;
  - Take a closer look at plans' network adequacy to ensure patients can actually access health care providers; and
  - Avoid unnecessary increases in the annual cost-sharing limit, as high cost-sharing burdens patients and can result in hospital bad debt.

#### Grandfathered Group Health Plans Final Rule

- **The FAH urges the Departments of HHS, Labor, and Treasury (the Departments) to rescind and/or revise several policies in the *Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage* final rule, which published in the Federal Register on December 15, 2020. Specifically, the FAH urges the Departments to:**
  - Reverse policies allowing grandfathered group health plans to raise deductibles and fixed amount copayments without losing their grandfathered status; and
  - Reverse policies allowing allow high-deductible health plans to retain grandfathered status when implementing the maximum annual cost-sharing adjustments permitted under Internal Revenue Service (IRS) rules even if those amounts exceed the limits permitted under the Departments' final rule.

#### Comprehensive Care for Joint Replacement Model

- **The FAH urges CMS to conclude the CJR with no further extensions and hold participating CJR hospitals financially harmless in performance year (PY) 5.**

- The disruptive effects of the COVID-19 PHE on health care affect the feasibility of sustaining extensions of this model and the use of data from 2020.
- In addition to ending the program, CMS could establish a pathway allowing a CJR hospital to voluntarily become an Episode Initiator for the BPCI-Advanced site-neutral lower extremity joint replacement episode that is already underway.

#### Calculation of Medicare Part C Days Proposed Rule

- **The FAH strongly opposes adoption of the *Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage* proposed rule.**
- The proposed policy has been repeatedly rebuffed by the Federal courts. Instead, the courts have consistently recognized CMS's pre-2005 practice of excluding Part C days from the Medicare fraction of the disproportionate patient percentage. Moreover, the proposed policy would impose a substantial, multi-billion dollar economic cost on hospitals that provide a vital safety net for Medicare beneficiaries. Prompt and proper payment of these long withheld disproportionate share hospital funds is particularly vital in the context of the present PHE. The FAH urges CMS to comply with the binding decisions of the D.C. Circuit Court of Appeals and the U.S. Supreme Court, pay these safety-net hospitals the money it owes based on these court cases, and not finalize its proposal to readopt its previously vacated Part C days policy on a retroactive basis. Retroactive rulemaking cannot cure the defects in the vacated 2004 rule, and CMS's limited authority to retroactively change rules does not authorize retroactive rulemaking here.

#### Merit-Based Incentive Payment System Value Pathways

- **The FAH urges CMS not to implement the Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs), another big change to the frequently changing Quality Payment Program (QPP), and instead focus on supporting providers and lessening the burden of their participation. If CMS moves forward with implementation, the MVPs should be voluntary, with clinicians retaining the option to participate via the current process in which they have already invested significant time, energy, effort, and funds.**

#### Information Blocking Rule Implementation

- **Given the continuing PHE and the time and attention it requires, the FAH urges the ONC to amend the information blocking compliance date to the later of January 1, 2022 or at least six months after the end of the COVID-19 PHE.**
- The FAH also urges alignment of dates and requirements across corresponding CMS and ONC policies and clear regulatory requirements and ongoing guidance to hospitals regarding what is considered compliant behavior and documentation.

## Regulatory “Sunset” Final Rule

- **The FAH urges HHS to reexamine the policies in the *Securing Updated and Necessary Statutory Evaluations Timely* final rule**, published in the Federal Register on January 19, 2021. Having HHS regulations subject to possible expiration if they are not assessed every ten years, and then reviewed within five years, could place a significant burden on the agencies and regulated entities and risk destabilization of the regulatory structure. The rule was proposed and finalized under an incredibly truncated comment period, which did not allow for meaningful stakeholder review. In addition, the objectives of the proposed rule – mitigating the economic impact of burdensome regulations – are achievable through use of the existing legal processes.

## Good Guidance Final Rule

- **We urge HHS to rescind the *Good Guidance Practices* final rule.** While hospitals support the need for clear and readily accessible guidance from HHS, populating a the “repository” (i.e., a central access point for HHS guidance documents) in the expedited manner, as required by the rule, is premature and may add confusion and a significant burden to hospitals and other stakeholders, especially during the surging PHE.
- More clarity is needed about how the repository would work, as well as more time for meaningful stakeholder review and comment, and increased resources that can be dedicated to the design, development, population, organization, improvement, and effective implementation of the guidance repository.

## **ENSURE ADEQUATE HEALTH SYSTEM RESOURCES AND ADOPT POLICY INTERPRETATIONS THAT ENHANCE ACCESS TO HIGH QUALITY CARE**

## Provider Relief Fund

- The Provider Relief Fund (PRF) has been, and remains today, critical in providing hospitals with the financial support needed to maintain their ability to provide vital services for their patients and communities and support frontline caregivers. **Therefore, we urge the Administration to expedite the distribution of these funds so that they can be put to the use Congress intended in appropriating them – helping providers respond to the ongoing impact of the pandemic.**
- While hospital caseloads remain elevated and rural hospitals continue to struggle, GAO reports that as of 12/31/2020 approximately \$40 billion remained to be allocated and approximately \$35 billion previously allocated had not yet been distributed.<sup>3</sup>

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<sup>3</sup> GAO Report: *COVID-19 Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention*; GAO-21-265 (Jan. 2021); <https://www.gao.gov/reports/GAO-21-265/>

- **A key priority is ensuring that uninsured and underinsured patients have access to no-cost COVID-19 testing, treatments, and preventive services through the COVID-19 Claims Reimbursement Fund, administered by the Health Resources and Services Administration (HRSA).** This fund, which relies on the PRF for treatment costs, is critical. We are pleased that the Biden Administration has already indicated its intent to maintain the funds, **and we urge that sufficient funding from the PRF be reserved for this program through the end of the PHE.**
- In addition, 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, especially rural hospitals and “high-impact” hospitals. The first surge was only a fraction of the volume and burden hospitals have since experienced. The second and third surges all occurred after the June 10<sup>th</sup> ending date to report cases on which PRF dollars were allocated to high-impact hospitals, and well after the May 6<sup>th</sup> date targeted distributions to rural hospitals were scheduled to begin. Those later surges resulted in an unprecedented burden through an increase in both the number of hospitalizations, which more than doubled, and confirmed cases across all states, including rural America.

#### Surprise Billing Implementation

- 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 Surprises Act* to protect patients by prohibiting balance billing and limiting their cost-sharing to an in-network amount while preserving the ability of health care providers and health insurers to negotiate fair payment rates. **The FAH urges appropriate and fair implementation of the law that reflects hospital workflow and minimizes regulatory burden.**

#### Medicare Advantage/Managed Care / COVID-19 Utilization Management Tools

- **The FAH urges CMS to pursue and enforce policies ensuring that MA and Medicaid Managed Care plans are not inappropriately denying or delaying enrollees’ access to care, as well as payments to health care providers. We also urge CMS to fully implement the OIG recommendations to reduce the incidence of inappropriate plan denials.**
- 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.<sup>4</sup> 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

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<sup>4</sup> FAH Comment Letter re: Center for Program Integrity Request for Information on the Future of Program Integrity, November 20, 2019, see pages 5-7: [https://www.fah.org/fah-ee2-uploads/website/documents/112019\\_FAH\\_Program\\_Integrity\\_RFI\\_-\\_FINAL.pdf](https://www.fah.org/fah-ee2-uploads/website/documents/112019_FAH_Program_Integrity_RFI_-_FINAL.pdf).

services and payments and excessive administrative burden.<sup>5</sup>

- The use of these “tools,” particularly prior authorization, by plans during the COVID-19 PHE is particularly concerning, as it leads to delays in access to necessary services and, particularly with regard to post-acute care, prevents overburdened acute care facilities from appropriately discharging patients.

#### COVID-19 Aberrant Data – Quality Performance and Payment

- **Data derived during the COVID-19 PHE is distorted and does not accurately reflect a hospital’s 2020 quality performance. Therefore, the FAH urges CMS to waive payment penalties from the Hospital-Acquired Condition Reduction Program (HACRP), Hospital Readmission Reduction Program (HRRP), and Value Based Purchasing Program (VBP) for all fiscal years associated with performance periods impacted by the COVID-19 PHE, in particular 2020 data that goes into the programs’ measures.**

#### Reduce Reporting Burden

- **The FAH urges CMS to reduce reporting burden associated with the COVID-19 PHE by developing standardized data entry solutions that: prevent unnecessary duplicative data reporting by hospitals to both the states and federal government; and support hospital enterprise level reporting.**
- The COVID-19 PHE has increased the amount of data hospitals need to report for purposes of surveillance, equitable distribution of vaccine and therapeutics, and quality measurement. Many of these data also are duplicates of what are required by states or across multiple agencies. A standardized approach to all data reporting related to COVID-19 that is developed in coordination with jurisdictions would ensure comparable data and reduced burden on providers.

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<sup>5</sup> 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).



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We look forward to working with HHS, CMS, and the Administration to ensure that hospitals are able to continue providing the best care possible to their patients. If you have any questions or wish to discuss 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 "Shirley M. [unclear]". The signature is fluid and cursive, with a large initial 'S' and a distinct ending flourish.