Charles N. Kahn III
President and CEO

February 4, 2022

The Honorable Rick Allen
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin Hern
U.S. House of Representatives
Washington, DC 20515

The Honorable Victoria Spartz
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Allen, and Hern, and Spartz:

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

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.

The FAH and our member hospitals share the Task Force's goal of promoting a market-driven health care system that empowers patients with more choice and control over their health care decisions. We agree that a more informed and engaged consumer will drive competition that accelerates progress towards higher quality and more affordable health care.

To that end, our goal is to build on what's working in America – starting with the strength of the employer-provided health coverage that millions of Americans rely on today, and rejecting more government-run plans such as a public option, or dismantling our current pluralistic system and replacing it with a one-size-fits-all government-controlled single payer system.

We look forward to working with the Task Force and appreciate the invitation to provide input on several key policy platforms that will help ensure affordable coverage and patient care is available to all Americans.

Health Care Coverage

The FAH urges Congress and the Administration to build on and improve what's working, where employer-sponsored insurance, individual markets / exchanges, Medicare and Medicaid work together to expand access to coverage and care, and fix what's not. We believe the model of the current health care system is the best building block for new reforms.

We want to work with Congress to lower costs, protect patient choice, expand access, improve quality and foster innovation. We agree, whether it's called Medicare for All, Medicare buy-in, or the public option, one-size-fits-all health care will never allow us to achieve those goals.

That is why we support building on the strength of employer-provided health coverage and preserving Medicare, Medicaid, and other proven solutions that hundreds of millions of Americans depend on – to expand access to affordable, high-quality coverage for every American.

Creating a new, unfunded health insurance bureaucracy like a public option will likely have a minimal impact in terms of achieving its intended goal, while simultaneously threatening access to care for millions of patients.

Analysis shows paying for a public option could require new taxes on American families and would represent the third largest government program at a cost of $700 billion.[1] At the same time, health care providers may find it increasingly difficult to deliver quality care sufficient to meet patients' needs as they are forced to accept lower reimbursement rates, which could disproportionally impact rural communities and communities of color. The public option could also threaten the existing private health care insurance market on which Americans rely, eliminating options for health care outside of the government-controlled health insurance system.

Workforce and Staffing Shortages

Among the greatest challenges facing hospitals today is maintaining an adequate workforce. FAH members are experiencing staffing shortages that existed prior to the PHE and have become significantly more pronounced and problematic due to the strain and ongoing nature of the PHE.

For example, our members are experiencing shortages of medical technicians, laboratory assistants, and nurses, as well as food service, housekeeping, and sanitation staff, and in some instances, hospitals do not have enough staff to operate at full capacity. At the same time, to ensure patient care and overall hospital operations during the PHE are not compromised hospitals have been forced to significantly increase reliance on contract labor and staffing companies that have proliferated for a variety of health care staff, especially nursing care, and which are charging exorbitantly higher rates. This is all resulting in increased costs to the health care system.

[1] Lanhee J. Chen, Ph.D., Tom Church and Daniel L. Heil, "The Fiscal Effects Of The Public Option," Partnership for America's Health Care Future, 1/24/20

It has been widely reported that nurse-staffing agencies are exploiting the COVID-19 crisis with predatory price increases. Bipartisan Members of the House and Senate have expressed concerns over these practices and, in particular, worry that hospitals will be unable to sustain these exorbitant staffing costs. We join those in Congress that are urging the Administration to enlist the support of federal agencies to investigate nurse-staffing agencies' conduct during the pandemic.

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

- Extending the Medicare-funded residency training slots cap building period to ten years, as opposed to the current five years, for new teaching hospitals
- Enacting the *Healthcare Workforce Resilience Act* to recapture 25,000 unused immigrant visas for nurses and 15,000 unused immigrant visas for doctors that Congress has previously authorized and allocate those visas to international doctors and nurses
- Enhancing investment in provider loan repayment programs, including the Nurse Corps., to incentivize providing care in rural and underserved communities
- Enacting the *Technical Reset to Advance the Instruction of Nurses (TRAIN) Act*, which would prohibit the Centers for Medicare and Medicaid Services (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
- Ensuring any policy that increases Pell Grant funding makes certain that nursing students are eligible to receive such benefits to attend high-quality nursing schools, regardless of the educational institution's tax status.

Insurer and Medicare Advantage Unfair Practices

The FAH is increasingly concerned by the alarming practices of Medicare Advantage (MA) and other insurance plans that harm patients by eroding access to and affordability of medically necessary care, in part by requiring hospitals and caregivers to divert precious resources and time to respond to these tactics. These actions include excessive use of prior authorization, inadequate provider networks, extended observation care, retroactive reclassification of patient status (i.e., inpatient versus observation), and aggressive pre- and post-payment denial policies.

Some of these concerns were highlighted by the HHS Office of Inspector General (OIG), as far back as September 2018, in its report on MA plan prior authorization policies and appeals. The OIG found high rates of overturned prior authorization and payment denials and identified problems related to denials of care and payment. Among other recommendations, the OIG urged HHS to address inappropriate denials and insufficient denial communications. While CMS agreed with the OIG findings and needed changes, these practices have continued and worsened.

We urge Congress to investigate these practices and, at a minimum, exercise its oversight authority to help ensure MA behaviors that protect patients through, for example, prior authorization reforms, comprehensive provider networks, and requiring MA plans to follow traditional Medicare's two-midnight rule for patient admissions.

The FAH has made numerous recommendations to CMS to achieve these goals, which we have attached to this letter, and we look forward to working with Congress to address these pressing problems.

Surprise Billing

The FAH and its members proudly worked alongside Congress in support of enacting the *No Surprises Act,* which first and foremost ensures that patients have the protection of in-network coverage in circumstances where the patient has no reasonable control over the network status of the facility or health care providers administering care. The FAH has maintained that surprise medical bills of all types (including those that result from improper payer denials or limitations on coverage) burden our health care delivery system and should be eliminated in a manner that preserves market negotiation of network rates between health plans and providers, consistent with Congress's intent.

The FAH, however, is deeply concerned that the independent dispute resolution (IDR) process, as implemented, to resolve disputes between payors and providers, effective January 1, 2022, improperly overrides the bipartisan Congressional compromise contained in the *No Surprises Act* by imposing a presumption that the qualified payment amount (QPA) is the appropriate out-of-network rate for an item or service.

Congressional committees spent two years consulting with stakeholders, including the FAH, on surprise billing issues, weighing policy considerations, and reaching an ultimate compromise that protects the consumer from surprise bills and financial uncertainty through the use of median contracted rate data while establishing the need for an independent process that balances the interests of providers, facilities, plans, and issuers in resolving payment disputes through a Federal IDR process that considers the full range of facts and circumstances presented by the parties (excluding three prohibited factors). As noted in the December 11, 2020, press release announcing the congressional compromise, the *No Surprises Act* "takes patients out of the middle, and allows health care providers and insurers to resolve payment disputes without involving the patient" in an IDR process where the independent arbiter "is required to consider the median in-network rate, information related to the training and experience of the provider, the market share of the parties, previous contracting history between the parties, complexity of the services provided, and any other information submitted by the parties."[2]

Against this backdrop, HHS, the Department of Treasury, and the Department of Labor lack the authority to impose a presumption that the QPA is the appropriate out-of-network rate and to otherwise transform the IDR effectively into a rate-setting process. Therefore, the FAH has filed a brief in support of a challenge to the Surprise Billing IDR Rule that seeks to restore the neutral IDR process that Congress intended.

[2] House Committee on Energy & Commerce, Press Release, Congressional Committee Leaders Announce Surprise Billing Agreement (Dec. 11, 2020), at https://energycommerce.house.gov/newsroom/press-releases/congressional-committee-leadersannounce-surprise-billing-agreement.

The FAH stands in support of the over 150 bipartisan Members of Congress who sent a letter to the tri-agencies in November 2021 urging the Administration to amend the IFR in order to align the law's implementation with the legislation Congress passed. We urge this strong bipartisan group to continue to advocate, by all means possible, for the implementation of the law to reflect Congress' intent.

Transparency

The FAH has long supported transparency on information that is clear, meaningful and actionable for consumers, especially their cost-sharing burdens. Yet, disclosure of payer-specific, competitively negotiated rates, is of little utility to patients because the disclosed rates cannot enable apples-to-apples comparisons among providers and do not correlate to the patient's expected out-of-pocket costs. This misleading data, provided without any corresponding quality data, could also result in patients choosing higher cost, lower quality care, either because the patient perceives the higher cost to correlate with higher quality or because the payer-specific negotiated rate data are skewed by the typical acuity of a patient.

Therefore, the FAH urges Congress and HHS to work with stakeholders—providers, health plans, employers, and consumers—to identify opportunities to improve consumers' access to clear, accurate, and actionable information concerning their copayment, coinsurance, and deductible obligations (i.e., cost-sharing information), which is what patients really need to make informed decisions.

Physician-Owned Hospitals

The issue of self-referral to physician-owned hospitals and the inherent conflict of interest it presents has been a concern for bipartisan policymakers for well over a decade. Physician-owned hospitals have existed because of a loophole — which is now closed — that allowed physicians to self-refer patients to hospitals they own. Reopening the loophole would have serious negative consequences for our health care system.

According to the Congressional Budget Office (CBO), Medicare Payment Advisory Commission (MedPAC) and independent researchers, self-referral resulted in higher utilization of services and higher costs for the Medicare program. MedPAC and GAO also found that these physician-owned hospitals were treating far fewer Medicaid patients.

The net result of these behaviors: More costly, complex, uninsured, underinsured and indigent patients were left to be treated at competing full-service community hospitals. The cherry-picking of patients to maximize financial gain creates a destabilizing, unsustainable and anti-competitive environment which has been especially damaging to full-service community hospitals. Self-referring threatens full-service hospitals' ability to continue to serve the needs of the community.

Furthermore, the HHS OIG issued a report regarding the ability of physician-owned hospitals to manage medical emergencies. The study found that, in part, physician-owned hospitals frequently use #911 as part of their emergency response procedures, thus funneling

critical patients to full-service community hospitals. Patient safety is at risk when a physician-owned hospital is unable to provide proper care.

The current law represents a compromise that protects established physician ownership arrangements, promotes financial and patient safety transparency and permits expansion of certain physician-owned hospitals based on demonstrated community need. Efforts to repeal or weaken the current law would not only take our health care system in the wrong direction on health care spending, patient safety and conflict of interest, but undermine the full-service community hospitals that are the bedrock of health care across America.

Further, the FAH strongly opposes a regulatory provision that CMS finalized, effective January 1, 2021, that essentially removes all limits on expansion by physician-owned "high" Medicaid facilities, including the frequency with which such a facility can request a capacity expansion; the caps on the number of operating rooms, procedure rooms, and beds that can be approved; and the requirement that expansion must only occur on the main campus. For multiple reasons, the proposal is much broader than purported in the final rule and its impact will far surpass only Medicaid patients, while opening the door for significant gaming by physician-owned hospitals. There is no requirement that a high Medicaid facility in fact serve a high number of Medicaid patients. Instead, a "high" Medicaid facility is one that simply has a higher percentage of Medicaid admissions than the other hospitals in the same county – and there are no limits to how often, how much, and what services this "high" Medicaid physician-owned hospital could expand, nor even that the physician-owned hospital must remain a "high" Medicaid facility under the new relaxed standard. Thus, the provision undermines Congressional intent to strictly limit physician-owned hospital expansion.

Prescription Drug Pricing

The FAH strongly supports market-based approaches that will address the skyrocketing rise in prescription drug prices. This could include stimulating competition by addressing loopholes in patent laws and facilitating the introduction of generic equivalent drugs.

In 2019, the FAH, American Hospital Association (AHA), and American Society of Health-System Pharmacists (ASHP) released a report that found that hospital budget pressures resulting from the continued dramatic increases in drug prices have negative impacts on patient care, with hospitals being forced to delay infrastructure investments, reduce staffing, and identify alternative therapies. Hospitals also struggle with drug shortages, which can disrupt typical work patterns and patient care, and often require significant staff time to address.

Specifically, the report showed that:

- Average total drug spending per hospital admission increased by 18.5% between FY 2015 and FY 2017
- Outpatient drug spending per admission increased by 28.7% while inpatient drug spending per admission increased by 9.6% between FY 2015 and FY 2017
- This 9.6% increase was on top of the 38% increase in inpatient drug spending between FY 2013 and FY 2015 included in the previous report
- Very large percentage increases (over 80%) of unit price were seen across different classes of drugs, including those for anesthetics, parenteral solutions, and chemotherapy

- Over 90% of surveyed hospitals reported having to identify alternative therapies to manage spending
- One in four hospitals had to cut staff to mitigate budget pressures
- Almost 80% of hospitals found it extremely challenging to obtain drugs experiencing shortages, while almost 80% also said that drug shortages resulted in increased spending on drugs to a moderate or large extent.

Medical Lability Reform

The FAH urges Congress to take action to reduce unnecessary costs in the system by adopting comprehensive medical liability reform (MLR) legislation, with caps on non-economic damages and allowing courts to limit attorneys' contingency fees. MLR reform would increase patient safety, ensure that injured patients are compensated quickly and fairly, improve provider-patient communications, and ensure affordable and accessible medical liability insurance.

Hospital Consolidation

The FAH respectfully disagrees with the RFI's assertion that "hospital consolidation leads to higher prices with no measurable improvement in quality." On the contrary, there have been multiple studies that point to the positive effect on quality as well as reduction in mortality associated with hospital mergers.

For example, a study recently published in JAMA Network Open concluded that hospital mergers improve health outcomes in rural hospitals. The researchers, who are affiliated with IBM Watson Health and the Agency for Healthcare Research and Quality, compared data from 172 merged rural hospitals and 266 comparison hospitals and found that in-hospital mortality rates were lower after the rural hospitals completed mergers. Researchers noted that "Mergers may enable rural hospitals to improve quality of care through access to needed financial, clinical, and technological resources, which is important to enhancing rural health and reducing urban-rural disparities in quality."

In addition, in 2013, the Center for Healthcare Economics and Policy released a comprehensive analysis of hospital integration studies, including 75 studies spanning the years 1996-2013, as well as 36 primary sources. The Center's analysis outlines improvements in health care for communities that result from mergers, including:

- Significant benefits to communities and patients in markets where hospitals remain open
- Preserved and expanded access to essential medical care
- Improved service offerings and quality of care
- Sustained and necessary investment in technology, facilities and health IT
- Sensible reduction in excess capacity
- More competitive health care markets

The nation's health care landscape is, by necessity, shifting towards integrated systems and coordinated care, and mergers do create sustainable market conditions for hospital care and

services. This shift has naturally occurred within the health care industry and has been further fueled by health care policies that promote a more patient-centered, value-based health care delivery and payment system. Additionally, increasingly complex health care regulatory and administrative requirements such as compliance, electronic health records and cyber security, and payer administrative hurdles, are extremely resource-intensive and difficult for an individual hospital or a physician group to navigate.

Increased hospital integration also is a response to inadequate, below the cost-of-care, public sector funding for hospitals, forcing hospitals to adapt to real-world economic and financial factors. The priority of any integration is to keep hospitals open, preserve or expand patients' access to care and continue to provide consistent, quality care 24/7 to every patient treated in a hospital. By pursuing mergers and other integration efforts, hospitals are able to maintain their presence in the community and protect patient access to essential and affordable quality care.

As the health care landscape continues to evolve and the industry moves increasingly towards the goals of coordinated care and integrated health systems, the FAH will continue its efforts to inform Congress about health care competition and hospital integration. It is imperative that this issue is put in proper context, and focus is placed more holistically on the total landscape. The FAH is happy to discuss in further detail the positive effects of integration.

Regulatory Burden

Over-regulation of hospitals is a driver of cost increases and integrated systems can lessen the burden on standalone hospitals. As noted in a recent study, regulatory requirements impose $39 billion in annual costs for hospitals, health systems, and post-acute care providers – costs that flow through the broader health care system. The study also notes that hospitals alone must comply with 341 mandatory regulatory requirements, while post-acute care providers must comply with an additional 288 requirements. In addition to the financial compliance burden, providers expend considerable staff resources complying with these requirements, leaving less time for patient care and innovation.[3]

There are numerous steps Congress can take to alleviate this burden and enable providers to refocus their attention and reallocate their resources toward high-quality patient care. Our members are committed to ensuring patients receive high-quality care and believe a comprehensive review and repeal or revision of regulations that are outdated, ineffective, or otherwise overly burdensome will further our shared goals of improving health outcomes and efficiencies in care delivery. State and federal laws, regulations, guidance, requirements and policies are often at the core of what limits the full potential for patients and communities of a competitive marketplace.

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[3] American Hospital Association, Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals, and Post-Acute Care Providers, October 2017

We appreciate the opportunity to provide our views on these important issues 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,