Charles N. Kahn III
President and CEO

January 28, 2025

President Donald J. Trump
The White House
1600 Pennsylvania Ave, NW
Washington, D.C. 20500

Dear President Trump:

On behalf of the Federation of American Hospitals (FAH), we congratulate you on your inauguration as the 47th President of the United States and we look forward to the opportunity to work with you and your Administration over the next four years to improve health care choice, affordability, and quality for patients across the country.

The FAH is the national representative of nearly 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 purpose of this letter is to focus on the landscape of regulatory issues that are critical for supporting our nation's health care system and your stated goal of simplifying the regulatory morass of federal requirements that divert limited resources away from patient care to wasteful "paperwork" burdens. This letter centers on key areas, as follows: (1) protecting patient access to health care coverage and medical services through Medicare and Medicaid; (2) strengthening and supporting rural health care; (3) curbing Medicare Advantage abuses, especially as related to prior authorization; and (4) lifting regulatory burdens and unleashing private sector innovation. To this end, we offer the recommendations discussed below.

Prevent Cuts to Medicare and Medicaid and Protect Patient Access to Care

We thank President Trump and the Administration for its stated commitment to protect the Medicare program.

We agree that cuts to Medicare reduce access to essential health care services for seniors, increase out-of-pocket costs, and lead to worsened health outcomes. On average, Medicare pays only 82 cents for every dollar of hospital care provided to Medicare beneficiaries, leaving hospitals with nearly $100 billion in Medicare shortfalls in 2022 alone.[1] Any reductions to Medicare payments would further contribute to Medicare's chronic failure to cover hospitals' cost of caring for beneficiaries.

Stable and predictable payment systems are needed to ensure hospitals can sustain 24/7 access and care for Medicare and Medicaid patients across the country. Making these hospital and provider payment systems work more efficiently and effectively is critical to the long-term sustainability of the program and for the vulnerable and senior Americans who rely on Medicare and Medicaid for access to care.

Medicare payment systems must recognize the unique costs and services offered by acute-care hospitals, behavioral health facilities, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs), and other providers. Hospitals offer care on a 24/7/365 basis – unlike any other provider – and the costs of maintaining that crucial infrastructure and providing that expansive level of care to the most complex patients are spread across all hospital services.

Similarly, Medicaid payments to providers fall well below the cost of care, which creates an unsustainable financial structure for the health care safety net. Any policy proposals that reduce Medicaid funding, whether through cuts to provider payment rates or changes in federal funding for Medicaid, threaten access to health care for America's most vulnerable individuals.

Medicaid and the Children's Health Insurance Program (CHIP) are sources of health care coverage for more than 79 million individuals, including:

- Children
- Low-wage workers and their families
- Persons with physical and mental disabilities
- Pregnant women, and
- Low-income seniors.

For most Medicaid beneficiaries, Medicaid is their sole health coverage option and the gateway to accessing providers and services to address their medical needs.

It is imperative that federal funding for Medicaid, including mission-critical supplemental and state directed payments, remain stable so that states can focus on maintaining coverage and ensuring provider payments are "consistent with efficiency, economy, quality and access"[2], as ensuring access to care is inextricably intertwined with ensuring that efficient providers are paid adequately for the costs they incur when serving Medicaid enrollees.

[1] https://www.aha.org/system/files/media/file/2024/01/medicare-significantly-underpays-hospitals-for-cost-of-patient-care-infographic.pdf

We call on you and the Congress to support Medicaid beneficiaries and providers by eliminating or further delaying the implementation of reductions to the Medicaid Disproportionate Share Hospital (DSH) payments. The Medicaid DSH program is vital in assisting hospitals that serve high numbers of Medicaid and uninsured patients. More than 2,500 hospitals in the U.S. receive DSH payments to address Medicaid underpayment and uncompensated care. These payments ensure patients have access to critical services including trauma, burn care, high-risk neonatal care, and hospital access throughout natural disasters and pandemic events.

Strengthen and Support Rural Health Care

Rural hospitals play a pivotal role in providing access to care for over 60 million Americans in underserved communities. These hospitals often operate on slim financial margins and depend on critical payment programs like the Low-Volume Hospital (LVH) and Medicare-Dependent Hospital (MDH) programs to provide financial stability and maintain the health infrastructure of rural areas.

We support permanently extending LVH and MDH payment programs to ensure stability for the facilities that serve a high proportion of older, sicker patients on Medicare and those in rural communities. We urge the new Administration to support the permanent extension of these programs and ensure access to care in rural areas by seeking solutions to our country's rural health care problems.

Rein in Abuses of Prior Authorization in Medicare Advantage Plans

The FAH and our members support the Medicare Advantage (MA) program and the way the program can offer private options and flexibility beyond the benefit structure of the Traditional Medicare program. Our members increasingly serve more seniors with MA coverage than through Traditional Medicare fee-for-service. However, we are increasingly concerned by the alarming practices of MA plans that harm patients by eroding access to and affordability of medically necessary care. Abusive practices by MA plans include systematically inappropriately denying, limiting, and delaying the delivery of services and care. This behavior often requires hospitals and caregivers to divert precious resources and time to respond to care denials and delay tactics and away from their core mission of patient care.

MA delays and denials through prior authorization and inconsistent administrative processes add tremendous costs to the health care system. Hospitals and physicians must hire teams of clinical and non-clinical staff, as well as costly information systems, to keep up with the prior authorization and payment hurdles that plans erect to slow down patient care and payment. These practices also mean that seniors covered by MA do not receive the same care as seniors in Traditional Medicare. We urge the Administration to improve MA by taking steps that would simplify these administrative barriers by requiring plans to ensure that MA patients receive at least the same levels of coverage as patients in Traditional Medicare. One easy way to do this that would significantly reduce burdensome paperwork, processes, and costs would be to ensure that plans comply with the Medicare Two-Midnight Rule and Inpatient Only List. We also urge the new Administration to track and report prior authorization denials and appeals at the service

levels and provide this information to Medicare enrollees. Doing this will add transparency to the MA prior authorization processes and allow seniors to be informed and choose plans they know will cover the care they need.

Lift Regulatory Burdens and Unleash Private Sector Innovation

We look forward to a regulatory environment that seeks to ease unnecessary burdens in the private sector. Freedom from unnecessary regulatory structures would unleash innovation in the private sector and allow hospitals and health care providers to dedicate more time and resources towards streamlining and improving patient care and experience. The FAH recommends the following steps the Administration and Congress can quickly take that at a minimum as a starting point would begin to pull back unnecessary regulations and requirements that deflect limited hospital resources to administrative burdens instead of patient care.

Eliminate Mandatory Centers for Medicare and Medicaid Innovation (CMMI) Models: The FAH urges the Administration to eliminate recently created mandatory participation requirements under CMMI models for Transforming Episode Accountability Model (TEAM), Increasing Organ Transplant Access Model (IOTA), and the Episode-based Payment Model (EPM). These models add significant costs to the affected hospitals and their broad scale extends well beyond the statutory mandate to "test" potential new innovations. We urge the Administration to return the CMMI to an innovative laboratory of voluntary programs that seek to address affordability, quality, and accessibility.

Reverse Nursing Home Minimum Staffing Requirements: CMS recently set new nursing home staffing standards that mandate a one-size-fits-all staffing model that will exacerbate the workforce crisis, jeopardize access to care, and increase costs for seniors and the Medicare and the Medicaid programs. Mandated ratios are a flawed approach that impedes, rather than promotes, providers' ability to deliver quality care, flex to meet changing needs and care guidelines, and retain an adequate workforce. We urge the Administration and Congress to withdraw this costly and overly prescriptive requirement.

Eliminate the IRF Review Choice Demonstration (RCD): The Administration should eliminate CMS' IRF RCD program that requires pre-payment review of 100 percent of all IRF admissions in Alabama and Pennsylvania. The IRF RCD program began in Alabama with 100 percent prior authorization review of all IRF admissions. More than 85 percent of claims received during the first one and a half years of this program receive approval – and appeals raise the total approval rate even higher. This program is administratively burdensome for CMS and IRFs and is unnecessary. The program is slated to be expanded to California and Texas IRFs and will ultimately be expanded to IRFs in other states that use the same MACs in the four RCD states. The Administration should eliminate this costly and unnecessary program.

Remove Permanent Reporting of Hospital COVID-19 Data: CMS implemented permanent respiratory illness reporting for COVID-19, RSV, and Influenza beginning November 1, 2024. We urge the new Administration to remove the mandatory year-round respiratory illness

reporting requirements for COVID-19, RSV, and influenza that are currently imposed on hospitals, IRFs, and Inpatient Psychiatric Facilities (IPFs). While the FAH recognizes the value of data-driven strategies during public health emergencies, these costly and labor-intensive mandates are no longer justified now that the COVID-19 pandemic has concluded. Eliminating these permanent reporting obligations would reduce unnecessary regulatory burdens, allowing providers to redirect critical resources toward direct patient care and other pressing health care needs.

Remove the New Maternity Care Hospital Conditions of Participation (CoPs): We urge the Administration to remove recently finalized CoPs specific to labor and delivery, prenatal and post-partum care for newborn infants and mothers. While the FAH strongly supports efforts to improve labor and delivery, prenatal, and post-partum care for newborns and mothers, we have significant concerns about the potential unintended consequences of adding these new CoP requirements. We believe the additional requirements could be counterproductive to CMS' goal of improving maternity care by increasing the regulatory burden on hospitals, particularly in rural areas where resources are limited. Hospitals unable to meet the new CoPs may face the loss of Medicare certification, while others may choose to stop offering obstetric services altogether. This outcome would exacerbate the growing issue of "OB deserts"—areas where no maternity care is available—especially in rural and underserved regions, further limiting access to essential obstetrical services and potentially increasing maternal morbidity and mortality.

Eliminate Reporting of Burdensome Hospital Quality Measures: We urge the Administration to remove or significantly modify hospital quality reporting requirements related to the use of existing patient-reported outcome performance measures (PRO-PMs), structural measures, hybrid measures, and readmission measures. While the FAH strongly supports robust and transparent quality measurement as vital to patient safety and continuous improvement, we have serious concerns about the burdensome and costly nature of these measure constructs to field and implement. Specifically, the existing readmission measures have shown little variation between hospitals for several years, providing no meaningful ability to distinguish between good versus poor performers. These measures appear to be topped out, suggesting that some level of readmissions is expected based on patient acuity. Therefore, we encourage the Administration to explore a more targeted focus on preventable readmissions, rather than continuing to rely on measures that offer limited insight into genuine performance differences.

Additionally, the complexity introduced by the hybrid measures—requiring the difficult task of matching patient data between claims and electronic health records—have imposed administrative burdens that outweigh the value of the information collected. Reevaluating these reporting requirements would allow hospitals to devote more resources to direct patient care, potentially improving outcomes rather than fulfilling mandates of marginal clinical benefit. We remain committed to collaborating with the Administration to develop evidence-based, meaningful measures that truly enhance care quality without undermining provider capacity or patient access.

Enforce Surprise Billing IDR Process: Hospitals fully support the surprise billing patient protections under the *No Surprises Act*. We urge the Administration, however, to enforce health payer compliance with the *Act*, including the independent dispute resolution (IDR) process which establishes a mechanism intended to resolve payer-provider disputes over payment for certain out-of-network services. Appropriate incentives must be implemented to ensure that health plans: provide greater payment transparency; meaningfully participate in the IDR 30-day open negotiation process; and timely, appropriately, and efficiently pay out-of-network amounts and any related IDR awards; and are subject to enforcement for noncompliance with the *Act*.

Rescind Non-Compete Final Rule: We urge the Administration to rescind any Federal Trade Commission (FTC) prohibition on non-compete agreements in employer-employee contracts and withdraw the final rule issued April 23, 2024, and previously scheduled to take effective September 4, 2024. However, in August 2024, a federal district court in Texas set aside the rule and prohibited the FTC from enforcing it on a nationwide basis, concluding that "the FTC lacks statutory authority to promulgate the Non-Compete Rule, and that the Rule is arbitrary and capricious." Appeals are now pending before the US Court of Appeals for the 5th and 11th Circuits. Noncompete agreements play a crucial role in health care, securing physician services in communities and encouraging investment in employee training and development. Therefore, the Trump Administration should oppose any FTC non-compete agreement prohibition and rescind the final rule.

Rescind Antitrust Final Merger Guidelines: We urge the Administration to rescind the FTC and Antitrust Division of the Department of Justice (DOJ) final 2023 Merger Guidelines, as adopted on December 18, 2023. These final guidelines rewrite decades of antitrust policy by declaring structural presumptions against mergers that increase market concentration and by downplaying the possibility of merger efficiencies. They do not accurately reflect the state of the law or mainstream economic thinking, specifically with respect to hospital mergers or generally for the overall economy.

Withdraw Hart-Scott-Rodino (HSR) Pre-Merger Notification Rule: We urge the Administration to withdraw the FTC October 10, 2024, final rule that implements changes to the premerger notification rules, form and instructions under the HSR Antitrust Improvements Act, and becomes effective February 10, 2025. The unlawful final rule unnecessarily and significantly increases the HSR reporting requirements and essentially acts as a tax on mergers and will have a chilling effect on thousands of routine mergers and acquisitions, thereby undermining our economy. The rule currently is being challenged in federal court in the Eastern District of Texas.

Withdraw HHS Office for Civil Rights (OCR) the HIPAA Cyber Security Proposed Rule: We urge the Administration to withdraw the HHS OCR *HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information*, proposed on December 27, 2024, with comments due on March 7, 2025. The rule proposes cybersecurity standards for HIPAA-covered

entities and their business associates. However, many provisions in the proposal are not operationally feasible and do not recognize the nuance and complexities of applying cyber protections in a complex health IT environment; are not scalable to multiple types and sizes of hospitals and health care systems; drastically underestimate implementation costs; and impose prohibitively costly and unnecessary burden. We urge the Administration to withdraw the proposed rule for review and work with the health care industry to develop a more incremental and sensible approach.

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We look forward to working with you to address these policy recommendations that will help improve the Medicare and Medicaid programs, remove unnecessary regulations, and provide long-term stability to hospitals across America to ensure they can continue to fulfill their mission of providing patients with access to the quality care they need 24/7/365. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,

cc:
Dorothy Fink, Acting Secretary, HHS
Robert F. Kennedy, Jr. Nominee, Secretary, HHS
Andrew N. Ferguson, Chair, FTC
Jeff Wu, Acting Administrator, CMS
Mehmet Oz, MD, Nominee, Administrator, CMS