Federation of American Hospitals®

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President and CEO

May 12, 2025

The Honorable Russell Vought
Director
Office of Management and Budget
Executive Office of the President
725 17th Street NW
Washington, DC 20503

RE: FAH Recommendations for Deregulatory Action – Targeted Reforms to CMS Conditions of Participation and Quality Programs

Dear Administrator Vought,

On behalf of the Federation of American Hospitals (FAH), I am writing in response to the Office of Management and Budget's (OMB) request for public input on regulatory reform opportunities. We commend the Administration's efforts to identify federal rules that impose excessive costs, lack statutory grounding, or result in unintended burdens on regulated entities, particularly those in essential public service sectors like health care.

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 access to high-quality, affordable care in 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.

As we have articulated in prior rulemaking comment letters submitted, including the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) proposed rules, several specific Centers for Medicare & Medicaid Services (CMS) regulations are ripe for rescission. These rules either exceed the scope of authority provided by statute, impose burdens disproportionate to their benefits, or are no longer necessary in light of other existing frameworks. Below, we provide detailed recommendations and statutory rationale for rescission of key Conditions of Participation (CoPs) and structural quality reporting measures.

CMS Conditions of Participation on Respiratory Illness Reporting

The COVID-19 public health emergency prompted CMS to establish new requirements under 42 C.F.R. § 482.42(e), mandating that hospitals report data on respiratory illnesses such as COVID-19, influenza, and RSV. While appropriate in the context of a national emergency, these provisions were extended beyond the statutory emergency authority and now continue without a clear statutory mandate under Section 1861(e) of the Social Security Act. That section authorizes the Secretary to impose hospital Conditions of Participation to ensure the health and safety of patients receiving services, not to require duplicative, long-term epidemiological surveillance.

FAH has highlighted in prior IPPS rulemaking (FY 2023) that these CoPs duplicate data submissions already required by the CDC under the National Healthcare Safety Network (NHSN) and add administrative burden without improving patient care or clinical operations. Hospitals must dedicate health information technology (HIT), clinical, and compliance resources to maintain daily reporting, which is an inefficient use of personnel post the public health emergency. **We urge OMB to rescind § 482.42(e) as an outdated and burdensome provision inconsistent with statutory authority.**

Maternal Health Conditions of Participation

CMS has finalized new CoPs for maternal health under 42 C.F.R. § 482.82, which require hospitals to establish and maintain policies and procedures addressing obstetric emergencies such as severe hypertension and obstetric hemorrhage. While these are critical issues, Section 1861(e) of the Social Security Act does not authorize CMS to impose clinical protocol mandates under CoPs. That section provides facility standards to protect patient health and safety but does not empower CMS to standardize clinical decision-making across vastly diverse hospital settings.

In comments on the CY 2024 and 2025 OPPS proposed rules, the FAH cautioned that such regulations disproportionately affect small, low-volume, or rural hospitals that may not offer labor and delivery services or have the infrastructure to comply with one-size-fits-all mandates. These hospitals are already engaged in evidence-based maternal safety work through the Alliance for Innovation on Maternal Health (AIM) or state perinatal collaboratives. The proposed CoPs risk closure of obstetric services in areas where maternal care access is already limited, thus undermining the very safety goals the rule seeks to advance. **These provisions should be withdrawn to align with CMS's statutory limits.**

Nursing Staff Ratio Interpretations in Conditions of Participation

CMS has issued interpretive guidance under 42 C.F.R. § 482.23(b), governing nursing services, that increasingly reflects rigid expectations around nurse-to-patient ratios. The FAH strongly opposes any move toward implementing specific ratios in regulation or sub-regulatory guidance. Section 1861(e) of the Social Security Act allows CMS to ensure that hospitals maintain adequate nursing services to meet patient needs. Still, it does not authorize the agency

to mandate fixed ratios irrespective of staffing realities, patient acuity, or local market conditions.

As detailed in our FY 2023 IPPS comments, the imposition of nurse staffing ratios would severely burden hospitals struggling with nursing workforce shortages. Such mandates may lead to care delays or temporary closures of units, particularly in rural and underserved areas. Rather than improving care, rigid ratios reduce flexibility and could result in unintended safety risks. CMS should rescind interpretive guidance implying ratio requirements and confirm hospital discretion in establishing staffing plans responsive to patient needs.

Hybrid Clinical/Claims-Based Quality Measures

CMS implemented hybrid measures in the Hospital Inpatient Quality Reporting (IQR) Program under the authority of Section 1886(b)(3)(B)(viii) of the Social Security Act. These measures, including the Hybrid Hospital-Wide Readmission and Mortality Measures, require hospitals to extract and report structured clinical data elements from electronic health records (EHRs) alongside claims data.

The FAH stated in comments on the FY 2023 IPPS proposed rule that these measures present a disproportionate burden with little evidence of added clinical value. Data elements such as troponin levels, blood pressure, and oxygen saturation are often not captured in structured fields, necessitating costly manual abstraction. **These measures unfairly penalize smaller, resource-constrained hospitals and should be withdrawn until standardized EHR interoperability and infrastructure are universally available.**

Low-Value Structural Measures in the Hospital IQR and VBP Programs

CMS has adopted a range of structural measures in the Hospital IQR and Value-Based Purchasing (VBP) Programs, also authorized under Section 1886(b)(3)(B)(viii) of the Social Security Act. While initially intended to incentivize quality infrastructure, these measures now impose a significant reporting burden with little utility for hospital performance differentiation.

Key structural measures currently implemented in the IQR Program include:

- Maternal Morbidity Structural Measure (hospital participation in PQCs and use of safety bundles)
- Patient Safety Structural Measure (attestation of safety culture strategies across five domains)
- Age-Friendly Hospital Measure (five-domain assessment of geriatric care practices)

Although these measures are well-intentioned, the FAH's IPPS comments noted that they present limited variation across hospitals and add burdensome documentation requirements. Many hospitals already meet the basic expectations of these measures, and there is minimal evidence that they lead to improved outcomes. For example, the Age-Friendly Hospital measure is primarily a self-attestation exercise, prone to subjective interpretation and lacking rigorous validation.

CMS's continued use of these structural measures raises questions about statutory alignment. Section 1886(b)(3)(B)(viii) authorizes the collection of "measures of quality of care," which are more accurately represented by patient outcome measures rather than attestation-based infrastructure inputs. **The FAH recommends that the measures be removed and that outcomes-based, actionable quality indicators be implemented.**

Patient-Reported Outcomes Measure for Hip/Knee Arthroplasty (PRO-PM)

The PRO-PM for Total Hip and Knee Arthroplasty, adopted under the Hospital IQR Program, requires hospitals to collect and submit survey-based patient-reported outcomes before and after surgery. Although CMS adopted this under the same statutory authority as other IQR measures, the FAH has raised strong concerns in multiple IPPS comment cycles regarding its feasibility, fairness, and alignment with statutory intent.

The implementation of this measure is complex and costly. Hospitals must procure survey platforms, maintain consistent follow-up processes, and manage response rate bias. Moreover, these data are heavily influenced by social and demographic variables unrelated to hospital care quality. Smaller and rural hospitals may lack the technical or staffing capacity to comply, raising significant rural-urban equity issues. These challenges render the measure incompatible with Section 1886(b)(3)(B)(viii), which envisions accurate and equitable quality assessment across all hospitals. **Until methodological concerns are addressed, CMS should withdraw the PRO-PM.**

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We look forward to working with you to address these policy recommendations, which will help improve the Medicare and Medicaid programs, remove unnecessary regulations, and provide long-term stability to hospitals across America so 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 get in touch with me or any member of my staff at (202) 624-1500.

Sincerely,