Purchaser Business Group on Health

1611 Telegraph Avenue, Suite 210
Oakland, CA 94612
(415) 281-8660

pbgh.org

June 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes (CMS-1808-P)

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the Centers for Medicare & Medicaid Services' ("CMS") hospital inpatient prospective payment system ("IPPS") proposed rule for fiscal year ("FY") 2025. The Purchaser Business Group on Health ("PBGH") wholeheartedly supports your commitment to addressing the maternal health crisis and effort to gather information on how CMS can drive better maternal health outcomes, address disparities in care and ensure access for both Medicare and non-Medicare patients.

PBGH is a nonprofit organization that represents 40 public and private purchasers that collectively spend $350 billion annually on health care and cover over 21 million employees and their beneficiaries. PBGH's mission is to advance a health care system that delivers quality outcomes and a seamless patient experience that is equitable and affordable for consumers and purchasers. Our goal is to be a change agent by creating and enabling increased value in the health care system through purchaser collaboration, innovation, and action and through the adoption of best practices. PBGH's members represent diverse private sector industries as well as public sector purchasers.

The cost of maternity care represents American employers' second-highest annual health care expenditure. Yet U.S. maternal infant health outcomes remain among the worst in the developed world. That's why PBGH works with employers, providers and health plans to develop a maternity care system that embraces high-value services, reduces outcomes

variation and incentivizes safety across the prenatal, perinatal and postpartum care continuum. PBGH's Comprehensive Maternity Care Workgroup is working to define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. To help identify hospitals and practices that have implemented these attributes, PBGH utilized a multistakeholder process to define a measure set focused on equity, patient experience of care and health outcomes. These measures were selected based on their alignment with national measure sets and accreditation organizations and their ability to identify and evaluate high-performance in maternity care.

In May 2024, the working group released the first edition of their Comprehensive Maternity Care (CMC) Common Purchasing Agreement, outlining comprehensive maternity care attributes, purchasing principles, a measure set and a common purchasing agreement. These purchasing standards can be implemented by public and private purchasers in partnership with health plans and/or providers directly. The goal is to accelerate the advancement of maternity care and birth equity in the employer-sponsored insurance market. See below our specific comments in response to the RFIs; we welcome additional dialogue on this vital topic.

Maternal health RFI

What policy options could help drive improvements in maternal health outcomes?

Ensuring robust and aligned quality and safety data for birthing people is mission critical. As the largest payer in the U.S., CMS's approach to quality measures has a cascading effect across the entire system. We thank CMS for its efforts to date – such as through its Meaningful Measures Initiative – to ensure alignment across CMS programs, as well as steps toward reducing the burden of quality reporting across programs. Purchasers have long advocated for meaningful measures of health care quality to help patients choose providers and hospitals and to help employers choose health plans and reward provider networks that deliver superior care. Today providers, health plans and governments report an abundance of measures, yet most do not tell patients and health care purchasers what they need to know about whether people are getting high quality care. We need expanded meaningful measures around maternal health specifically, which are severely lacking despite the urgent need to address issues with quality and access, in addition to adequate transparency around outcomes and quality measures as well as transparency of prices and equity data. This should be done not just at the hospital or system level, but by the provider, to truly shine a light on the quality of care a patient should expect to receive.

Additionally, we urge CMS to ensure that purchasers are at the table when metrics and purchasing standards are developed. In May 2023, PBGH released its Comprehensive Maternity Care Measures Set, articulating attributes that define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. PBGH

utilized a multistakeholder process to define a measure set focused on equity, patient experience of care and health outcomes, selected based on their alignment with national measure sets and accreditation organizations and their ability to identify and evaluate high-performance in maternity care. We hope that these, in addition to our Comprehensive Maternity Care (CMC) Common Purchasing Agreement – discussed more below – serves as a useful resource to CMS.

How can CMS support hospitals in improving maternal health outcomes?

In addition to ensuring streamlined, meaningful measures for hospitals to focus on, another critical area is ensuring consistency and leadership on race, ethnicity and language ("REaL") and sexual orientation and gender identity ("SOGI") indicators and methods of stratification to ensure equitable access to care. All outcomes and quality measures should be stratified by REaL and SOGI data where available. This is an important step to ensure targeted interventions to improve inequities. To support these efforts, CMS could also consider ways to reward hospitals who are making marked improvement in quality and outcomes for vulnerable populations and support hospitals in their efforts to not only screen for, but to help address birthing people's mental and social needs, including integration into care plans and connections with social, community-based supports.

What, if any, payment models have impacted maternal health outcomes, and how? What, if any, payment models have been effective in improving maternal health outcomes, especially in rural areas?

PBGH has long worked with its members to reverse the upward trend in cesarean births and continues to seek ways to improve maternity outcomes. Some of our lessons learned are outlined in our Building Maternity Bundles Lessons Learned document. At a high level, PBGH and our members have had success with value-based payment models that enhance the patient experience by focusing on maternal mental health and increasing the availability of midwifery, among other learnings. Studies have shown that integrating midwives into the care team increases the rate of vaginal births, reduces obstetric interventions and reduces the rate of adverse neonatal outcomes. An emphasis on maternal mental health disorders is also important because it is the most common medical complication during and after childbirth, affecting one in seven pregnant and postpartum women in the U.S., and one in six in California.

PBGH serves as a strategic and technical partner for purchasers looking to advance innovative maternity payment models beyond the traditional global professional fee and/or the existing blended case rate for vaginal and C-section births. For example, some payment models PBGH engaged in (outlined in the above resources) included bundling all prenatal services, labor and delivery and postpartum care into a value-based prospective payment to:

- improve the entire experience for the mother-to-be and family members, including broadening choice in their care team and care location;
- provide latitude for care teams to be innovative to deliver the highest quality care and best possible outcomes;
- expand the availability of certified nurse midwives;
- identify other ways to "de-medicalize" the entire experience; and
- encourage early detection and treatment of postpartum depression and other perinatal mood and anxiety disorders that challenge new mothers.

What factors influence the number of vaginal deliveries and cesarean deliveries?

Today's maternity care is over-medicalized and lacks adequate choice for birthing people who want additional options for their birthing experience, including choice in care team and location. One key factor is the lack of adequate payment and access to midwives and birth centers. In addition, current fee-for-service payment models incentivize c-sections, which is also exacerbated by a dwindling maternal health workforce that can incentivize scheduling of c-sections. While some of this has been improved recently, PBGH believes boosting midwifery utilization is a key strategy for improving maternal quality, affordability and the patient experience – in addition to reducing inappropriate c-sections. PBGH is working to de-medicalize the entire experience (when appropriate) and improve quality of care through alternative payment models and purchasing principles, including driving broader adoption of the midwifery model.

Evidence shows the use of midwives enhances maternal and infant health and decreases costs. It also helps address a growing shortage of perinatal health providers. Despite these benefits, certified nurse-midwives ("CNMs") are vastly underutilized, delivering only 9% of babies nationally. From a provider perspective, PBGH believes there is also opportunity to provide education to labor and delivery staff regarding the opportunities and benefits associated with physician-midwife collaboration and the key principles of team-based care. CMS could also consider rewarding and incentivizing the status of facility-level integration of midwives, and encourage improvements where needed, in addition to existing measures focused on c-section rates specifically.

Obstetrical services standards RFI

What are existing acceptable standards of practice, organization, and staffing for obstetrical services (including staff qualifications and scope of practice considerations) in hospital obstetrical wards, emergency departments, CAHs, and REHs?

Comprehensive maternity care should include choice of care team, location and education regarding appropriateness of care, and birthing options. Both public and private purchasers should remove payment and administrative barriers and incentivize

coordination across the maternal care team, pediatrics, family medicine, primary care and behavioral/mental health providers (e.g., prenatal summary delivered to hospital, discharge summary delivered to outpatient provider, comprehensive postpartum care plan developed). These efforts should include access and payment for navigators, coordinators or doulas to coordinate care, especially for high-risk patients (chronic conditions management, behavioral health referrals, social services, nutrition services, etc.).

PBGH's Comprehensive Maternity Care Workgroup has articulated attributes to define Comprehensive Maternity Care, which ensures high-quality, equitable maternal and infant health outcomes. Some of these care attributes include:

- **Team-based**: Patients receive care from a primary maternity care provider, such as an OBGYN, midwife or family medicine doctor, who is supported by and supports members of an interdisciplinary care team, such as doulas, mental health specialists, maternal fetal medicine specialists, lactation consultants, pediatricians, family planning specialists, primary care providers or community health workers. Under the direction of the maternity care provider, care team members communicate and coordinate to address patients' needs and provide care appropriate to their training and expertise.

- **Integrated**: Patients' physical, mental and social needs are assessed, screened and communicated across their maternity, pediatric and primary care teams and with other care providers and settings. Care teams reach out proactively to identify and address patients' care needs and to offer additional support for patients at high or rising risk. Health information and care activities outside of the maternity care team are integrated into patients' care plans

- **Whole-person**: Maternity care should focus not just on the maternity episode but also consider other factors, including social determinants of health, to promote health and treat diseases. Maternity providers should coordinate with primary care, mental health specialists and social services to provide special consideration for high-risk patients with mental health needs and/or substance use disorders. Comprehensive maternity care includes restoring health, promoting resilience and preventing diseases in the lives of the birth participant, children and supporting spouse/family.

As outlined in PBGH's Midwifery Care Policies brief, collaborative, integrated team-based care improves health outcomes and the patient experience for mothers and babies. Not only does team-based care introduce a wider variety of perspectives and backgrounds, but it also increases the likelihood that the patient's wishes are at the center of care, enhancing the patient experience and improving health equity. Consumer demand for

midwifery care has also steadily increased in recent years as more women have become aware of the different methods of care available to them during their prenatal and postpartum periods. Implementing new hospital policies to include midwives and improving current processes to support hospital and community provider collaboration can be an effective way to reduce health disparities. It is an opportune time for hospitals to develop relationships with community midwives and grant them admitting privileges in response to consumer demand. In addition to the numerous health benefits for patients, there is an ongoing OB/GYN shortage that is expected to increase substantially by 2030. A team-based care model that allows both physicians and midwives to work at the top of their license is likely to improve collaboration and satisfaction in practice for physicians, preventing burnout.

What are existing regulatory barriers to quality care for pregnant and postpartum patients in hospital obstetrical wards, hospitals and CAHs that do not operate obstetrical wards, emergency departments, and in REHs?

Despite the demonstrated benefits of team-based care and inclusion of midwives in comprehensive maternity care, the lack of consistency in licensing of midwives and birth centers across the U.S. makes building and promoting national networks difficult for purchasers. Similarly, it makes it more difficult for hospital and other provider group to include them in their practices. For example, CMs are only licensed in 9 states and D.C. today. Hospitals and OB/GYN practices may also have various credentialing and licensing processes, adding to the complexity.

What regulatory changes are needed to ensure quality care for all pregnant, laboring, and postpartum patients across all care settings? Would establishing regulatory standards for organization, staffing, and for delivery of services for obstetrical units, similar to the existing standards for surgical services, advance this goal? What additional standards should be considered?

As discussed above, transparency and additional focus and development of meaningful metrics around the quality, safety and equity of care is needed for patients and purchasers to select facilities and providers that meet their birthing needs. We propose leveraging PBGH's Comprehensive Care Measures Set as a resource, which aims to leverage meaningful measures to help identify hospitals and practices that have implemented attributes which ensure high-quality, equitable maternal and infant health outcomes. The measure set is focused on equity, patient experience of care and health outcomes, selected based on their alignment with national measure sets and accreditation organizations and their ability to identify and evaluate high-performance in maternity care. PBGH encourages both public and provide purchasers to consider modifying payments to providers based on performance, in addition to discouraging low-value care practices, among the other comprehensive maternity care principles outlined above.

CMS should also explore additional regulatory standards that ensure timely patient-centered care, including for those living in maternity deserts. Some proposed health care purchaser and provider requirements are outlined in our Common Purchasing Agreement, such as:

- Ensuring accessible care, which includes same-day care for urgent needs through in-person and virtual services with care teams, care provider availability, after appointment hours, secure messaging with the team and an online medical record.

- Expanding the number of in-network midwife providers, ensuring an adequate number of providers that perform vaginal birth after cesarean ("VBAC"), and enabling access to maternity care navigators, care coordinators, community health workers and a range of other services to support patient's physician, mental and social needs.

- Promoting accountability and transparency through the use of data on quality, patient-reported outcomes and patient experience stratified by REaL and SOGI indicators.

How could CMS better understand patients' experience of maternity care? What tools or instruments exist to understand individuals' experience of maternity care? How might CMS incorporate these tools or instruments into an obstetrical CoP?

New maternity patient experience measures are being developed and should be adopted when available. We encourage CMS to talk to employers and other purchasers who are working on these same issues to ensure collaboration and streamlining of meaningful metrics. In the meantime, PBGH suggests that purchasers utilize Consumer Assessment of Healthcare Providers & Systems ("CAHPS") and Hospital Consumer Assessment of Healthcare Providers & Systems ("HCAHPS") for their maternity population.

Are there additional ways the CoPs could improve or address the health and safety of pregnant and postpartum patients across all care settings?

Severe obstetric complications should not be limited to over 20 weeks of pregnancy. Pregnancy has become unsafe for many birthing people in the U.S. with severe complications from miscarriages and stillbirths, which are still not being adequately captured in the data. A future measure of interest and development is the measurement of severe obstetric complications prior to 20 weeks of birth.

Are there refinements to Medicare and/or Medicaid payment structures for obstetrics care, and/or perinatal care that could improve the delivery of maternal care, and also address existing disparities?

As outlined in our Common Purchasing Agreement and Building Maternity Bundles Lessons Learned document, PBGH supports value-based payments that enable maternity care providers to deliver equitable, timely, affordable, high-quality, patient-centered maternal and infant care and that hold providers accountable for delivering coordinated, evidence-based services and for reducing avoidable complications. This may include:

- Monthly payments to support care management, navigation and behavioral health support services through maternity care homes and other evidence-based care models.

- Clinical risk adjustment to ensure the payment does not dis-incentivize the appropriate use of medically necessary, higher intensity care for high-risk and complex pregnancies and for individuals with barriers to accessing care.

- Payments that support extended postpartum care with integrated behavioral health care services for all pregnancies.

- Blended case rates for labor and delivery (i.e., paying the same amount for both a cesarean section and a vaginal delivery for pregnancies and deliveries with similar risk factors).

- Identical payments for physicians and licensed midwives performing normal vaginal deliveries.

- Adequate payments for labor support services provided prior to a necessary transfer for delivery by a different provider or in a different facility.

- Reductions in payments to providers when there are avoidable complications, when unnecessary or low-value services are delivered, when the provider fails to deliver evidence-based care and when the provider performs poorly on quality metrics.

- Standby capacity payments designed to support minimum fixed costs.

Additionally, purchasers could consider payment structures to incentivize access to doulas, midwives and birthing centers; care coordination services and other wrap-around services such as lactation supports and nurse home visits; mental health and substance use disorder screenings and referrals; and implementation of effective clinical models to

better serve members living in maternity care deserts, such as hub and spoke models, telemedicine, remote monitoring (e.g., blood pressure cuffs, glucose monitors) and virtual prenatal and postpartum care (including virtual and in-person home visits).

Should such additional staff training include separate training on: methods for providing respectful care for pregnant, birthing, and postpartum patients in an effort to improve maternal health outcomes?… implicit bias, trauma-informed care, or other specific training topics aimed at addressing bias and reducing disparities in maternity care?… the screening, assessment, treatment, and referral for maternal depression and related behavioral health disorders by staff?

PBGH believes providers should ensure provider training for cultural humility/diversity, equity and inclusion ("DEI"), implicit bias, trauma informed or trauma-responsive respectful care, care for people with disabilities, in addition to training for mental health providers to enhance their proficiency in diagnosis and treating perinatal mood and anxiety and substance use disorders. CMS could also consider a designation in provider directories for those providers who have been trained in these critical areas as well as other payments or incentives to encourage participation.

How could CMS help improve data collection related to maternal morbidity and mortality across all demographics?

As discussed above, it is critical to ensure consistency on REaL and SOGI indicators and methods of stratification to ensure equitable access to care. All maternal health measures should be stratified by REaL and SOGI data where available. This is an important step to identify and address inequities that are identified through stratified data. To help improve data collection, CMS should consider ways to reward hospitals who are making marked improvement in quality and outcomes for vulnerable populations and to support hospitals in their efforts to not only screen for, but to help address birthing people's mental and social needs, including integration into care plans and connections with social supports. In addition, ensuring enhanced transparency of this data would likely drive additional adoption and compliance and is invaluable to purchasers.

Are there common critical data elements that would be most important and appropriate to collect through a CoP aimed at improving maternal health data? Are there data standards currently available or under development that can support standardized reporting? How do we ensure data collection encompasses all demographics?

As discussed above, we propose leveraging PBGH's Comprehensive Care Measures Set as a resource, which encompasses vetted, industry-aligned, meaningful measures to help identify hospitals and practices having implemented attributes that ensure high-quality, equitable maternal and infant health outcomes. We also support various measures under development, such as severe obstetric complications prior to 20 weeks of birth and a

maternity-specific consumer experience measure. Ensuring alignment across payers, focusing on the most meaningful measures and reducing duplication of reporting, in addition to ensuring consistency on REaL and SOGI indicators and methods of stratification, and tying measures to payment or reward systems would be a meaningful step forward.

Thank you again for the opportunity to comment, and we look forward to working with you and the CMS team on these important issues. If you have any questions or wish to collaborate on these issues further, please contact Bill Kramer, Senior Advisor for Health Policy, at wkramer@pbgh.org.

Sincerely,

William E. Kramer, Senior Advisor for Health Policy
Purchaser Business Group on Health