Purchaser Business Group on Health

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September 9, 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: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (CMS-1809-P)

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the Centers for Medicare & Medicaid Services' ("CMS") hospital outpatient prospective payment system ("OPPS") proposed rule for calendar year ("CY") 2025. The Purchaser Business Group on Health ("PBGH") wholeheartedly supports your commitment to addressing the maternal health crisis and your proposal to establish standards for maternity care across hospitals to ensure all pregnant and postpartum people and their babies have access to high-quality and equitable care. In addition, we are concerned about the omission of proposals to improve price transparency compliance and utility, as estimates suggest compliance remains alarmingly low among hospitals.

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 dependents. PBGH's members represent diverse private sector industries as well as public sector purchasers. 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 best practice adoption. Two areas of significant importance to PBGH and our members are increasing price transparency and improving maternal health care in the U.S. Our comments focus on the omission of price transparency proposals from this year's proposed rule and CMS's newly proposed Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals.

Hospital Price Transparency

PBGH strongly supports CMS's hospital and payer price transparency rules. We believe that full and transparent information about provider performance on cost, quality outcomes and patient experience is imperative for a healthy competitive marketplace. Our purchaser members want to ensure their health care dollars are spent on high-value care, and that they have access to the full spectrum of data to make informed benefit design and health care purchasing decisions. Furthermore, without data availability, patients cannot determine what their out-of-pocket cost will be or make informed choices. Consumers and purchasers need to see meaningful price transparency that reflects total cost of care and simplifies the complexities of our payment and cost-sharing systems.

We applaud CMS for its continued efforts to increase hospital price transparency, including those aimed at standardizing files and data elements and strengthening enforcement and oversight. Full transparency of all price data is critical to ensuring market competition. However, additional action is needed to make this information more usable for purchasers, patients and other stakeholders and we are disappointed CMS did not include new price transparency provisions in this year's proposed rule. We believe this is a significant omission, particularly as the latest evidence suggests hospital compliance with the rules is as low as 6%.[1] Hospitals' noncompliance should be viewed as malfeasance, and we strongly urge CMS to consider additional rulemaking to build upon and strengthen existing price transparency rules to ensure the data are accessible and usable.

First, we urge CMS to consider additional requirements to improve the usability of price transparency data. The mandatory reporting of charge master detail and a machine-readable file with a massive list of contracted pricing information is insufficient to drive affordability and market competition. While health plans and hospitals are using this information to optimize their competitive standing (and not to the benefit of self-funded employers or their workers), purchasers require a more robust data set to fully assess total cost of care, including the volume of services, length of stay, inclusive of all types of contractual payment structures, and carveout provisions.

[1] Meade and Ibrahim (Aug. 2024) "Over- and Under-Reporting of Prices: Most Hospitals Are Not Compliant with the Hospital Price Transparency Rule" *Health Affairs Scholar, Accepted Manuscript* [Link]

Hospital Price Transparency and Transparency in Coverage ("TiC") data must be used in conjunction with a reference data base and self-funded employer data to be relevant. Initial observations from publicly available datasets show rate differentials based on product lines (Individual and Family Plans ("IFP"), Medicaid Managed Care, Medicare Advantage and commercial). However, IFP and commercial products include a wide range of broad and narrow network configurations, as well as exclusive provider arrangements. Preliminary analysis by PBGH shows significant variation by carrier, region (urban/rural, Northern/Southern California) and hospital type (academic, systems, community and critical access hospitals).

Additional action is needed to improve the quality and integrity of data reporting to support the utility of the transparency data sets for self-funded employers and consumers. Examples include improved classification of product types and payment structures, including designation of drugs, prosthetics and other supplies that are carved out from negotiated rates. Self-funded employers and their covered employees and families will benefit from increased price transparency that gives them clear access to how their money is being spent to better inform health plan selection, network negotiations, benefit design, and provider network design. Additionally, self-funded employers are hopeful that further access to transparent price data will root out unfair pricing practices.

Second, we urge ongoing monitoring of compliance and strengthening of enforcement of price transparency. It was reported in industry press that some hospitals are backsliding on their compliance with current requirements.[2] As an example, at the outset, a hospital system's search tool was user friendly and navigable but later, required a patient to go through a portal and input personal identifiable information to get access to the pricing data. This is contrary to the goals of the requirements by limiting the "shoppability" functionality of the patient.[3] We urge CMS to take additional action to strengthen enforcement, such as by imposing higher civil monetary penalties for non-compliance to discourage hospitals from scaling back transparency efforts. Without enhanced penalties from CMS, we do not expect to see any meaningful improvements in compliance, which means purchasers will be limited in using important information like total cost of care to make decisions impacting members and patients.

Third, we urge HHS to consider ways to expand price transparency requirements to non-hospital sites including HOPDs, ASCs and free-standing physician offices. This is arguably even more important for consumers, as they are more likely to have choice and ability to shop across care at these types of outpatient facilities than in a hospital. True

[2] Wooldridge (May 30, 2024) "Most Hospitals Not in Compliance with Federal Price Transparency Rules" *Benefits Pro* [Link]

[3] Notably, the Hospital Price Transparency Rule uses the phrase "consumer-friendly" in its price comparison tool requirements, which is defined in part as having the information "prominently displayed," "without charge," and "**without having to register or establish a user account or password**" *(emphasis added)*.

transparency across all sites of care is critical to ensure patients and employers have the full picture of pricing across their market, spurring competition and driving value. We thank CMS for its past work to improve the usability of price transparency data and strongly urge the agency to consider additional rulemaking to make meaningful use of this data to ensure consumers have access to high-value, appropriately priced health care.

Fourth, we urge CMS to support employers' efforts to make use of existing price transparency data. In their current form, the data requires a tremendous amount of technical expertise to be made useful and actionable. PBGH has spent considerable time and effort scouring the data vendor marketplace on behalf of our members to better understand if, and how, data vendors are using the new health care price transparency data. We have found that few data vendors are incorporating both into their work with the price transparency data.

PBGH is currently convening half a dozen jumbo employers and public purchasers who have joined together on a joint transparency data project. The project is testing the utility of the data in providing insights plan sponsors can use to make more informed health care purchasing decisions in the commercial market. However, this effort has proven exceptionally difficult to start, as the existing data sets are at a relatively immature stage and require significant resources to access and analyze. **We encourage CMS to explore opportunities to make financial investments that help employers and public purchasers use the available transparency data to reduce their health care costs, consistent with bipartisan Administrative intent.** This could be most effectively done through making financial investments in 501(c)(3) non-profit entities – like PBGH – that coordinate, support, and provide technical assistance to employers in this pioneering work.

Health and Safety Standards for Obstetrical Services in Acute Care and Critical Access Hospitals

The United States' maternal health crisis is an area of particular importance to PBGH and a key area of focus for our organization. The cost of maternity care represents American employers' second-highest annual health care expenditure.[4] Yet U.S. maternal and infant health outcomes remain among the worst in the developed world. That's why PBGH works to align employers, providers and health plans in developing a maternity care system that embraces high-value services, reduces outcomes variation, and incentivizes safety across the prenatal, perinatal, and postpartum care continuum.

As part of these efforts, PBGH established a Comprehensive Maternity Care Workgroup to define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. In May 2024, the working group released the first edition of

[4] Carlson (Jun. 2024) "Uncovering the Unpredictable Costs of Maternity Care" *Kaiser Permanente* [Link]

PBGH's Comprehensive Maternity Care ("CMC") Common Purchasing Agreement, outlining comprehensive maternity care attributes, purchasing principles, a measure set and common purchasing standards to improve maternal care and birth equity among employers and public purchasers of health care. While the goal is to accelerate the advancement of maternity care and birth equity in the employer-sponsored insurance market, these purchasing standards can be implemented by both public and private purchasers in partnership with health plans and/or providers directly. We are convening a multi-stakeholder Maternal Health and Birth Equity Summit that will take place in September in Denver, Colorado, to discuss both innovative employer solutions and potential policy solutions that Congress and the administration can take to improve the maternal health crisis in the U.S.

As an organization deeply invested in improving U.S. maternal health outcomes, PBGH applauds CMS's proposal to establish, for the first time, federal health and safety standards for obstetrical services and maternal care across hospitals. Currently, the U.S. lacks national baseline care requirements for health care providers that commonly provide maternal health care. CMS's proposed conditions of participation ("CoPs") for the delivery of obstetric ("OB") services are a critical step to ensuring access to high-value, equitable care in the U.S. If finalized, the proposals would hold hospitals accountable for ensuring the care that pregnant and postpartum people and their babies receive meets federal health and safety standards.

As CMS considers finalizing the new CoPs, PBGH encourages the agency to take additional steps to strengthen the proposed CoPs and improve access to high-quality, equitable maternal health care.

Organization and staffing

PBGH's Comprehensive Maternity Care Workgroup has articulated attributes to define Comprehensive Maternity Care that support high-quality, equitable maternal and infant health outcomes. Those attributes include an interdisciplinary care team and whole-person care that incorporates not just the maternity episode but also considers other factors, including social drivers of health, to promote health and treat diseases.

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. PBGH applauds CMS for including "certified midwife" in the staffing conditions for OB patient care units and the emphasis on relying on a collaborative, integrated team to deliver maternal health services. Currently, many states fail to recognize certified midwives (CM) and limit care to certified nurse midwives (CNM), although some recognize certified professional midwives. Across the country, PBGH members are demonstrating the success of including midwives in the care delivery team. Consumer demand for midwifery care has 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 improve outcomes and reduce health disparities. CMS could further facilitate this effort by supporting state efforts to eliminate physician supervisions requirements for CNMs, as California has recently done, to ensure hospitals have the regulatory clearance needed 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. Despite these benefits, certified nurse-midwives ("CNMs") are vastly underutilized, delivering only 9% of babies nationally.[5]

We believe CMS's inclusion of midwives will go a long way to ease some of the barriers midwives face in participating in hospital-based maternity care teams and will encourage hospitals to revise policies that block midwives from hospital credentials or privileges. However, we also urge CMS to think more broadly in its definition of a care team to include doulas and other support professionals, who can play a vital role in providing support for pregnant and post-partum patients and their families.[6] An emphasis on maternal mental health disorders is also important because perinatal mental health disorders also are a leading cause of maternal mortality, accounting for 23% of such deaths.[7] We applaud CMS for its work to support states in their efforts to enhance systems of care to improve maternal mental health and substance use, including through technical assistance and the new Transforming Maternal Health ("TMaH") Model.

In light of the important role midwives and doulas can play in ensuring patient care is supported by an interdisciplinary team, we encourage CMS to examine how CoPs and other CMS policies can improve the integration of doulas and midwives in the hospital setting.

We also urge you to consider how best to incentivize a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during and after pregnancy.

[5] American College of Nurse-Midwives (May 2019) "Essential Facts About Midwives" [Link]

[6] For example, see Walmart's program to accelerate doulas expansion nationwide for its members in 2023 here.

[7] CDC (Sep. 2022) "Four in 5 Pregnancy-Related Deaths in the U.S. are Preventable" [Link]

Staff Training

The maternal health crisis disproportionately impacts low-income and minority populations who also are more likely to experience health-related social needs.[8] PBGH applauds efforts CMS has taken to date to include additional metrics on social drivers of health and to better connect patients to the services needed to address their social needs.

As part of those efforts, **PBGH urges CMS to ensure hospitals provide staff 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 treatment of perinatal mood and anxiety and substance use disorders.

Training on these sensitive topics will improve providers' ability to deliver culturally competent care that builds patient trust, which is essential to identifying health-related social needs. Further, hospitals need incentives to not only identify the social drivers of health but make the necessary referrals to address birthing people's mental and social needs, including integration into care plans and connections with social, community-based supports. Hospitals in rural or underserved areas where access to maternity care is most limited also often operate on narrow margins that could present barriers to completing the training. Therefore, PBGH asks CMS to consider funding opportunities or technical support for those entities.

Transfer Protocols

We support CMS's proposal to update the Discharge Planning CoP to include documented requirements for transfer protocols. However, we **encourage CMS to consider policies that would facilitate better collaboration between hospitals and birthing facilities, such as birth centers**. Currently, birthing facilities face challenges when transferring pregnant or postpartum people and newborns to hospital settings, including limited payment for their efforts stabilizing and transferring the patients. Birthing centers play a vital role in the U.S. maternal health care system, and it is essential to ensure safe and seamless transfers for pregnant or postpartum people and newborns who require hospital-level care.

Quality Assessment and Performance Improvement ("QAPI") Program

PBGH applauds CMS's proposal to require hospitals and critical access hospitals that offer OB services to incorporate maternal health data, quality indicators, and outcomes by diverse subpopulations served by a facility into their QAPI programs. However, it is

[8] MMHLA (May 2023) "Fact Sheet: Black Women, Birthing People, and Maternal Mental Health" [Link] *("Black women are twice as likely as white women to experience MMH conditions but half as likely to receive care.")*

essential that these programs incorporate 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 disparities.

CMS also must look beyond QAPI as there are no current federal requirements for facilities to share QAPI data with CMS or others. We encourage CMS to look to hospital quality reporting programs and adopt streamlined, meaningful measures for hospitals to focus on. We welcome CMS engaging with employers and other purchasers who are working on these issues to ensure public-private sector collaboration and streamlining of meaningful metrics.

For example, in 2023, PBGH released its Comprehensive Maternity Care Attributes and Measure Set, articulating attributes that define comprehensive maternity care which ensures high-quality, equitable maternal and infant health outcomes. The Measure Set encompasses vetted, industry-aligned, meaningful measures to help identify hospitals and practices that have implemented these attributes. These two documents are valuable resources for CMS to use as it looks to streamline and improve data collection related to maternal morbidity and mortality.

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. Further, we encourage CMS to improve measurement of stillbirths and support development of such a measure.

RFI on Rural Emergency Hospitals

PBGH strongly believes that all consumers, regardless of where they reside, should have access to high-quality, equitable health care. Therefore, we support extending the proposed CoPs to Rural Emergency Hospitals ("REHs"). CMS in past rulemaking has stated that REHs are expected to provide various outpatient services, including "low-risk labor and delivery supported by any emergency surgical procedures necessary." [9] Further, media reports indicate that when emergency situations arise, pregnant people located in rural areas often are forced to seek medical care from hospitals without dedicated birthing units.[10] Therefore, it is important that those patients receive the same

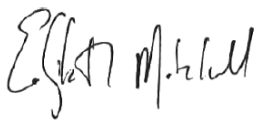
[9] CMS (Nov. 2022) "Hospital Outpatient Prospective Payment System Final Rule, CY 2023" [Link]

[10] Rush and Ungar (Sep. 2023) "Rural Hospitals Are Closing Maternity Wards. People are Seeking Options to Give Birth Closer to Home" *AP News* [Link]

high-quality care as those in non-rural areas. However, PBGH encourages CMS to explore other policies to address maternity deserts and ensure new CoPs do not exacerbate existing shortages. For example, CMS could support state-led efforts to elevate midwives and work with Congress to support federal funding to build the workforce in areas where there is a high need for maternal care. Additionally, we urge CMS to consider what other enhanced support may be necessary for REHs, as well as other rural or vulnerable facilities experiencing workforce or funding issues to meet these and other maternity care requirements, ensuring high-quality care for all.

Thank you again for the opportunity to comment, and we look forward to working with the CMS on these important issues. If you have any questions or wish to collaborate, please contact Elizabeth Mitchell, President and CEO, at emitchell@pbgh.org.

Sincerely,



Elizabeth Mitchell, President and CEO
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