Kansas Hospital Association

June 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1808-P; 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

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

On behalf of our 121 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the Medicare Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Long-Term Care Hospitals (LTCH) for fiscal year (FY) 2025.

KHA is a non-profit membership organization. Our membership includes 82 Critical Access Hospitals, 3 Rural Emergency Hospitals, 19 Rural Sole Community and Medicare Dependent Hospitals, and 18 Urban Hospitals.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals.

Office of Management and Budget (OMB) Core-Based Statistical Areas (CBSAs)

KHA recognizes that §§ 412.103(a)(6) and 485.610(b)(5) provide for a two-year transition period for CAHs that may be impacted by counties shifting from rural to urban classifications. We believe this transition period is appropriate for those hospitals, including one in Kansas, in counties that will be transitioning from a rural to urban county classification to reclassify as rural to retain their CAH status. KHA additionally thanks CMS for the 5% cap on all wage index decreases that CMS finalized in policy last year.

Low-Wage Hospital Wage Index Policy

Due to the PHE and lasting challenges due to labor costs, KHA appreciates and supports CMS' proposal to extended the bottom quartile policy for at least three more years. This policy has appropriately addressed

concerns that the wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals by reducing the disparity between high and low wage index hospitals. We believe this will allow labor costs to stabilize and prevent significant disruptions and variance in the wage index for Kansas hospitals. **KHA encourages CMS to extend this policy through at least FY 2030.**

Proposed Changes to the Medicare Disproportionate Share Hospitals (DSHs) for FY 2025

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is updated as the percentage of uninsured individual's changes and is distributed based on the proportion of total uncompensated care (UCC) each Medicare DSH hospital provides.

In calculating the uncompensated care payment, CMS uses projections on the percent of uninsured individuals nationwide from the Office of the Actuary (OACT). OACT projects that for calendar year (CY) 2025 the rate of uninsured individuals will be 8.7%. This projection was 8.3% for FY 2024. **KHA disagrees with this percentage and urges CMS to review its data sources and factors considered before the final rule is released.** Accurate projections of uninsured and Medicaid enrollment is vitally important for accurate DSH and UCC payments to hospitals.

In the past year, states like Kansas have experienced the unwinding of the Medicaid continuous enrollment requirement. As we continue to grapple with many Kansans removed from the Medicaid rolls, and with there being much unclarity in the CMS calculation of the uninsured rate and overall DSH payments, **we urge CMS to reconsider its data sources and methodologies used to estimate the rate of uninsured, to publish detailed methodologies of the calculations of Factor 2, and to use real-world data from key stakeholders and researchers to arrive at a more appropriate estimate of the uninsured.**

KHA thanks CMS for once again proposing to use the three-year average of uncompensated care data from the three most recent years in which audited S-10 data is available for the per-discharge calculation amount for interim uncompensated care payments. We believe this will help minimize the impacts of year-to-year fluctuations in uncompensated care payments.

Low Volume Hospital Program & Medicare Dependent Hospital Program

KHA thanks Congress for extending both the Low-Volume Hospital and Medicare-Dependent, Small Rural Hospital Programs. Additionally, we appreciate CMS' previous policy changes that would allow MDHs to apply for Sole Community Hospital (SCH) status if the MDH designation lapses in January 2025. **We reaffirm our support for the permanent extension of the Low-Volume Hospital program and the Medicare Dependent Hospital, Small Rural Hospital program.** Not only should these programs be

extended into the future, but it is imperative for the base rates to increase for these programs to work truly as intended to support hospitals that have low volumes, and that have Medicare as a significant portion of their respective payer mix.

KHA is concerned with the proposal by CMS to only extend the benefits of the low-volume adjustment (LVA) to hospitals with less than 200 discharges. We believe that this does not adequately support low-volume hospitals throughout Kansas and the country at a time when many of these facilities face financial challenges that place many at risk of closure. **KHA urges CMS to expand the LVA to include hospitals that have fewer than 800 total discharges.**

Proposed Changes to the Inpatient PPS Payment Update

KHA thanks CMS for the 2.6% increase in payments to IPPS hospitals. **However, this update is inadequate given inflation, workforce shortages, recent cyberattacks on health care entities, and labor and supply cost pressures that hospitals continue to face.**

As MedPAC referenced in their March 2024 Report to the Congress, nationally, the aggregate all-payer operating margin among acute care hospitals paid under IPPS declined to the lowest level since 2008, and the fee-for-service Medicare margin declined to a historic low. Kansas hospitals are additionally concerned about CMS setting 2025 Medicare Advantage payments to increase by 3.7%, while only proposing to increase IPPS payments by 2.6%. **KHA urges CMS to increase payments to IPPS hospitals by more than the proposed 2.6% increase, and would encourage consideration of, at a minimum, matching the 3.7% increase that Medicare Advantage will receive.**

Additionally, KHA recommends CMS consider how it can use its regulatory authority to boost payments to hospitals. Given the historical discrepancies between the projected and actual market basket indexes, hospitals need an adjustment to account for past inadequate payments. Section 1886(d)(5)(I)(i) of the Social Security Act gives the Secretary the authority to make any additional exceptions or adjustments to payments under subsection (d) as deemed necessary.[1] This would include the IPPS standardized payment amounts. **KHA urges CMS to consider updating the final payment rate to reflect the difference between prior years' actual and forecasted market basket increases through its exceptions and adjustments authority.**

Congress granted the Secretary broad authority through this provision and KHA maintains that the current financial pressures that hospitals are experiencing warrant use of this provision. Swift legislative and regulatory action are needed to protect hospitals and mitigate more hospital closings. **KHA urges CMS to contemplate use of its exceptions and adjustment authority to improve reimbursement for hospitals.**

[1] 42 U.S.C. § 1395ww(d)(5)(I)(i) ("The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate").

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Transforming Episode Accountability Model (TEAM)

KHA recognizes the importance of improving the care of Medicare beneficiaries and reducing the cost of care when feasible. However, this broad sweeping new bundled care model would potentially impact many Kansas hospitals and KHA has concerns that there are unintended consequences that CMS should mitigate in the final IPPS rule.

Firstly, **KHA urges CMS to make the TEAM model participation voluntary**. Most CMMI models are voluntary, however, the TEAM model is proposed to be mandatory. Additionally, KHA has heard concerns from Kansas hospitals that are uncertain that they would be able to transition this volume of procedures to mandatory bundles in such a rapid timeframe. KHA encourages CMS to make the TEAM Model voluntary in the final rule to align with the other CMMI models.

KHA is also concerned that while this model is only applicable to PPS hospitals, that there are also unintended consequences that will detrimentally impact Critical Access Hospitals (CAHs). Many Kansas CAHs partner with larger facilities in urban areas to gain access to providers that offer specialty services, including surgery, so patients can receive care close to home. Kansas hospitals have expressed concerns that this kind of bundled payment model may result in more surgeries being referred to urban partner facilities instead of CAHs in order to meet the bundled payment. This impacts both the CAH, and more importantly the patient by having to travel a much further distance to obtain care. KHA believes CMS can take steps in the final rule to mitigate these concerns to protect all hospitals, including those that are not directly in the TEAM model but would nonetheless face impacts.

The proposed rule also includes a 3% discount factor in which CMS will take 3% of cost savings right off the top, regardless of whether the episode achieves cost savings. There is less opportunity for savings in this model given that for each of the five clinical episode categories, the majority of episode spending is accounted for by the anchor hospitalization or outpatient procedure. In fact, three of the five episodes have at least three-quarters of spending accounted for by the anchor hospitalization or outpatient procedure. This will become even more true over time, as target prices decline further, and hospitals must compete against their own best performance. CMS must provide hospitals with a fair opportunity to achieve enough savings to garner a reconciliation payment. **We recommend that a discount factor of no more than 1% be applied.**

Additionally, KHA encourages CMS to review new research that has come out from the University of Pennsylvania that indicates that in previous bundled care models, while nursing home care goes down, home health use goes up. This is a positive result. However, these findings also show that at the end of the patient's home health episode, "patients needed more help from their caregivers than they did before the bundled payment was used".[2] If patients face additional costs after the episode of care ends and resort to requiring more assistance from caregivers, CMS should review opportunities to ensure that care is paid for

[2] Werner, et al, *The Effects of Post-Acute Care Payment Reform on the Need for and Receipt of Caregiving,* American Journal of Health Economics (Jan. 3, 2024) https://www.journals.uchicago.edu/doi/abs/10.1086/729337?journalCode=ajhe.

to prevent burdening the patient, the patient's family, or other stressed health care resources in communities. The full cost of care must be considered by CMS when initiating new bundled payment models.

KHA also recommends CMS consider model design changes to mitigate the risk on providers and opportunities for reward in the form of shared savings. CMS should modify the risk adjustment factors. As proposed, CMS' TEAM risk adjustment factors are insufficient to adequately account for differences in patient complexity and resource use across Kansas hospitals. Indeed, such a lack of a robust risk-adjustment methodology penalizes hospitals treating the sickest, most complicated patients. **At a minimum, the risk adjustment factor should capture complication or comorbidity flags from the anchor hospitalization, hierarchical condition codes (HCC) flags prior to the hospitalization as well as hierarchical condition codes flags for 36 months prior to the hospitalization (as opposed to the 90 days proposed). Additionally, target prices should be adjusted based on more granular factors than just Medicare-severity diagnosis-related group (MS-DRG).** There is a high degree of variability in the clinical complexity of cases even within MS-DRGs, such as for emergent and elective and fracture and non-fracture cases. In addition, in some instances outpatient procedures are included in the same episode categories as inpatient. All these cases can vary significantly in terms of complexity, care pathways and recommended post-discharge treatment.

We also do not believe that the proposed one year of upside-only risk for all hospitals is sufficient given the infrastructure investment required and risk versus reward equation. CMS' other APMs have provided much longer glidepaths to two-sided risk, such as the Medicare Shared Savings Program that allows organizations inexperienced with performance-based risk to access upside-only risk for the first five years of participation. **Considering CMS is proposing to oversample from markets with low previous exposure to bundles, we recommend extending the upside-only glidepath to a minimum of two years. Additionally, safety-net hospitals, rural hospitals and special designation hospitals should receive upside only risk for the duration of the model.**

Furthermore, KHA encourages CMS to revise the low-volume threshold. The proposed threshold of 31 cases across five different clinical episodes across three years is extremely low and ignores principles of statistical significance. It would unnecessarily expose low-volume hospitals to, for example, outlier cases and volatility. **As such, we urge CMS to increase the low-volume threshold to ensure statistical significance, establish separate thresholds within each clinical episode category, and fully exclude organizations not meeting those thresholds from participation.** At a bare minimum, the threshold should be increased to 40 cases within an individual episode category, like the BPCI Advanced model.

Lastly, in response to CMS' question on if Rural Emergency Hospitals should be included in the definition of TEAM collaborators, KHA suggests that yes, **REHs should be included in the TEAM model as collaborators.**

Kansas Hospital Association

Proposed Changes to Graduate Medical Education (GME)

KHA believes it is crucial to strengthen the Medicare direct Graduate Medical Education (GME) and Indirect Medical Education (IME) funding to educate, train, and equip the physician workforce in Kansas and beyond to ensure our communities have access to care for years to come. KHA appreciates CMS' requests for information and proposals relating to GME, but we believe there are additional considerations appropriate for CMS that can reduce the nation's significant physician shortage.

Distribution of Additional Residency Positions

To distribute the 200 new Medicare funded Graduate Medical Education (GME) slots to enable current residency programs to expand their training, CMS has proposed a method to meet the statutory mandate to distribute the slots based on a pro rata distribution followed by distribution by prioritization of HPSA score. **KHA has concerns with the current proposal of distribution by HPSA score and we urge CMS to reconsider using HPSA scores alone to identify which hospitals receive the remaining slots after pro rata distribution.**

We believe the current HPSA formula that calculates scores is flawed and does not appropriately account for provider need in communities, particularly in rural areas. The existing components that factor into a HPSA score are not reflective of rurality or unique access problems that many rural areas of Kansas face. Additionally, HPSA scores reflect population health measures such as low birthweight rate and infant mortality rate. While these are important metrics to consider, rural areas in Kansas have a much higher proportion of older adults as opposed to newborns and infants. The older adult populations of rural Kansas result in higher utilization of health services, and their respective risk factors are not accounted for in the existing HPSA formula. Unless the HPSA methodology is updated to reflect these concerns, we do not believe that basing distribution of the additional residency slots on the HPSA score alone will provide for GME funding to go to areas that could most use the additional resources from CMS.

Proposed Modifications to the Criteria for New Residency Programs and Requests for Information

KHA appreciates CMS' commitment to review criteria to determine whether a new residency program can be considered "new" and receive additional GME funding. **KHA supports CMS' proposed definition of a small program being 16 or fewer residents as this meets the minimum number of residents required by ACGME for many specialties. However, KHA urges CMS to clarify that for the proposed requirement that 90% of individual resident trainees in a new residency program must not have had previous training in the same specialty as the new program, that it would be effective on or after October 1, 2024.** We believe this will better mitigate impacts to new residency programs that are currently in their building process.

Additionally, KHA encourages CMS to **exempt small and rural residency programs from the proposal that new programs must have 90% of residents that have not had training in the same specialty as**

the new residency program. Kansas residency programs may occasionally take PGY-2s or PGY-3s to ensure that there are more senior residents when launching a new program. **KHA believes that a 90% threshold will unnecessarily burden the creation of new residency programs and deter the expansion of training of new physicians and thus, if CMS defines a small program, we encourage CMS does so for the purposes of exempting such program from the new program definitions.**

Regarding the Requests for Information on various GME topics issued in the proposed rule, KHA has concerns that there may be unintended consequences if CMS were to implement components referenced in the below questions.

- *Why hospitals might want to train residents in separately accredited programs, but in the same specialty, and the degree to which this happens in general, in both sparsely populated and more densely populated areas.*

Kansas has hospitals that do have two residency programs in the same specialty. Some of these are Rural Training Track programs, but others are not. One health system offers three Family Medicine residency programs and two Internal Medicine programs. The system believes it important to expand GME into a rural track given that Kansas is a very rural state. The non-rural track programs in the same specialties will launch next year. They were created with the intent to provide more residency slots at sites that can still offer valuable experiences for residents while also serving slightly different populations with one site serving an urban population and the other site serving more suburban or rural-suburban populations. KHA has heard of other sites that may offer multiple residency programs in OB since this can allow them to more clearly identify candidates looking for rural care training.

- *What amount, if any, of commingling is appropriate among residents in an existing residency program?*

Commingling of residents is appropriate in an existing residency program. Commingling may occur for many reasons such as the ability to share didactic experiences, fulfilling specialty experiences that many residents need to take part in that might have limited specialists available, or to service needs such as requiring a certain number of residents to staff an inpatient service and getting those numbers from two different programs.

In a Rural Training Track, Kansas programs have more commingling because of the nature of the program. In this setting, it is helpful for the smaller program with smaller faculty to have the opportunity to present during didactics, but not have to recreate the wheel with more limited resources. The commingling also increases idea sharing and differing perspectives which builds greater discussion amongst residents.

Another benefit of commingling is to allow opportunities for electives at each other's sites. For example, one Kansas program has a resident rotating at a rural site to more of a rural exposure during a block, while another resident from a rural site is rotating at an urban facility to get more robust dermatology exposure.

KHA believes it important to take this time to reiterate that ACGME supports programs sharing faculty, especially for sub-specialties that can be very difficult to find. Aside from potential new restrictions on commingling of residents, **KHA urges CMS not to place restrictions on faculty members being commingled**. With residents from multiple types of programs needing to rotate through specific specialties, in some areas, including in urban areas, residents may need to rotate through a specific specialty physician, and KHA believes that is entirely appropriate as long as programs have sufficient patient volumes to take on additional residents.

- *What is a reasonable threshold for the relative proportions of experienced and new teaching staff? Should there be different thresholds for small, which may include rural, residency programs?*

New residency programs should desire having staff with as much experience as possible, particularly because the program is a new program. Requiring a new program to have a certain percentage of faculty who have not been teaching in other programs seems to be educationally backwards. There are programs that may be forced to start with brand-new faculty due to circumstances outside of their control, such as challenges starting from scratch at the baseline or if the residency program is in a more isolated area. This should be an exception to the goal rather than the mandated requirement to have all or a significant proportion of brand-new teaching staff.

Physicians are trained in the practice of medicine, not how to be an educator. Developing an education skillset takes time and it can be crucially helpful when a new faculty member can be surrounded by experienced faculty in a residency program.

KHA recommends against setting specific numerical thresholds for the relative proportions of experienced and new teaching staff both for urban programs and rural residency programs. Strict limits should be avoided since small programs or rural programs may have additional struggles to comply due to limited resources or a smaller pool of potential faculty and staff available. KHA encourages CMS to continue to ensure new residency programs meet ACGME standards but limit any new requirements that may impede a new residency program from opening. The physician shortage in the United States is a challenge that will not be met by making it harder to train new residents via new residency programs.

- *Should a threshold for determining newness of teaching staff for a new program consider only Core Faculty, or non-core faculty (or key non-faculty staff) as well?*

KHA recommends against the implementation of a numerical threshold in the first place, but if there is a threshold, it should only consider core faculty. Many programs must share non-core faculty, particularly for various sub-specialties as was previously mentioned, especially for programs that are not in massive major metropolitan areas. If newness is considered for non-core faculty, then that will greatly limit opportunities for new residency programs.

Additionally, **KHA opposes the consideration of key non-faculty staff members when determining newness.** Many institutions that sponsor residency programs share professional staff that support the

operations of the program and the education of the faculty and residents. It would severely impede the creation of new programs if the threshold for determining newness of teaching staff included key non-faculty staff.

- *We seek feedback on our suggestion that 50 percent of the teaching staff may come from a previously existing program in the same specialty, but if so, the 50 percent should comprise staff that each came from different previously existing programs in the specialty.*

KHA strongly opposes the suggestion that 50 percent of the teaching staff cannot come from the same existing programs in the same specialty. This suggestion is not wise if CMS desires residency programs to thrive. While we recognize that the intent of this suggestion may be to prevent new programs from capturing older programs staff, we believe this proposal would make it much harder for new programs to succeed and would unnecessarily burden the creation of new programs which may prevent the expansion of residency programs across Kansas and across the country. It would be reasonable for a hospital to start a new small program with more than 50 percent of the teaching staff coming from existing faculty from a larger program, while intentionally backfilling the large existing program with new faculty as the large program would be better equipped to absorb and develop the new faculty.

Additionally, KHA believes that limiting the number of physicians and non-physician staff members who can leave one program and join a new residency program may run afoul of the recent Federal Trade Commission final rule 16 CFR Part 910 which mandates a comprehensive ban on new non-compete agreements in many industries including health care. KHA agrees that there is value in competition and immense value in removing barriers to enable the creation of new residency programs to train more physicians for states like Kansas and many others across the country. Any suggestion that would not enable multiple staff coming from the same previously existing residency program in the same specialty will severely limit options for new programs to open.

- *In considering whether the presence of a faculty member might jeopardize the newness of a new program, would it be reasonable to consider whether 10 years or 5 years, or some other amount of time, has passed during which that faculty member has not had experience teaching in a program in the same specialty?*

KHA does not believe it would be reasonable to consider whether some amount of time has passed since the faculty member has not had experience teaching in a program in the same specialty. We question why a Program Director would desire to intentionally recruit faculty who have had teaching experience, but not been teaching for the past 5 to 10 years. KHA has heard from Kansas program directors that have indicated that faculty that fit this requirement do not truly exist at scale. While there may be some faculty who went from residency into private practice and then decide to begin teaching later in their career, there are few to none that teach for a while, decide to leave teaching, and then later decide to begin teaching again after such a large gap of time. **If CMS is intending to propose a time requirement, KHA urges CMS to not implement anything more than two years.** We believe a one-to-two-year requirement could be justified as long as the experienced faculty are allowed to work on developing the new program during this gap.

At the bottom line, we do not believe "newness" should be defined by the absence of teaching and leadership experience within a specific timeframe. It is important for a new program to have faculty and a program director to have experience, so they know how to navigate the challenges of recruitment, evaluation, curriculum design, dealing with struggling learners, among other points. KHA has concerns about any kind of proposed rule that would emphasize faculty needing to be new or "rusty" in order to be considered for funding. That kind of program would not likely have the experience in education necessary to make it successful in the long run.

- *Would it make sense to define a similar period of time (for example, 10 years or 5 years) during which an individual must not have been employed as the program director in a program in the same specialty? Should there be a different criterion for small, which may include rural, residency programs?*

KHA does not believe it would make sense to define a period of time which an individual must not have been employed as the Program Director in a program in the same specialty. We believe this would set new programs up for failure. Five or ten years is an incredible amount of time as a program director, particularly for disciplines like Family Medicine. If someone has been out of a job for five to ten years, that raises serious questions that raise concerns over someone's performance and abilities in the job.

Kansas program directors have shared with KHA that the median length of service as a program director is four or five years. Therefore, if CMS defined a period of time that someone could not have been working as a program director in the same specialty elsewhere, it would require new programs to hire first time program directors or look for PDs who have been out of the job for just as long, or longer, than as they were in the job on average. Additionally, it is crucial for a new program director to have recent experience in order to meet ACGME's accreditation requirements for a new residency program. **KHA again urges CMS to not define a period of time, but if CMS does, that it is not more than one to two years.**

KHA believes that if CMS were to impose this kind of requirement, it would deprive new residency programs of the benefit of an experienced program director. Our country has physician shortages, and new residency programs are essential to supply the demand of our communities. If we want new programs to be equipped for success and flourish into programs that provide excellent training, we should want the new programs to be filled with experienced educators.

Overall, KHA believes it is important to frame each of these questions by understanding what communities across the country need. Nearly 70% of Kansas' counties are considered Primary Care Health Professionals Shortage Areas.[3] Kansas hospitals and health care organizations are short by hundreds of physicians. It is our view that new restrictions will only prevent the opening of new residency programs, which does not advance the goal of providing more qualified physicians to supply

[3] Kansas Hospital Association, *2024 Kansas Health Care Workforce Report, (*April 2024). https://www.kha-net.org/DataProductsandServices/DataPublic/d165169.aspx?type=view

the demands of our communities. We desire to work collaboratively with CMS and other partners to identify new ways to support and maintain our existing residency programs while also removing unnecessary barriers to training more physicians in the United States.

Maternity Care – Request for Information

KHA shares CMS' commitment to reducing maternal health disparities and improving maternal health outcomes during pregnancy, childbirth, and the postpartum period. Medicare is unusual in the pregnant population but hospitals in Kansas do have these patients and they typically have prior comorbidities, thus requiring more resources to provide maternity care. Pregnant Medicare individuals are almost always seen in a high-risk clinic or provider setting and require frequent ultrasound and social work visits. Kansas claims data indicates that the average length of stay for a Medicare beneficiary with MDC 14 or 15 is 3.55 compared to non-Medicare beneficiaries that have an average length of stay of 3.11.

KHA encourages CMS to pursue payment models that adequately compensate maternal care to keep low risk patients in their own communities. We also encourage CMS to provide adequate reimbursement for the subspeciality care that can be provided remotely to these high-risk Medicare pregnant patients so the patients don't need to travel. Rural and urban hospitals are not currently being adequately reimbursed for maternity care, particularly under global billing payment models, to keep labor and delivery units open with staffing or retain practitioners in Kansas communities.

KHA strongly encourages CMS to conduct listening sessions with OB-GYNs, maternal fetal medicine specialists, family physicians and clinicians who deliver babies, and hospital and clinic leaders to understand the impact of low reimbursement rates on maternal care and how CMS payment policies have created maternity care deserts. A deep exploration of CMS payment policies and how those policies can be updated is needed, with the experts who take care of these patients, and the leaders and managers who lead these facilities that care for pregnant persons.

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

KHA encourages CMS to increase reimbursement for maternity care provided to Medicare beneficiaries. Additionally, we encourage State Medicaid programs to cover maternity care at 100% of Medicare rates or higher. While it is recognized that maternity care in Medicare beneficiaries is relatively rare compared to in Medicaid and commercial populations, many state Medicaid programs set payment rates at a percentage of Medicare rates, e.g., 80 – 85%. This results in Medicaid reimbursement rates for maternity care being far below hospitals' costs. Additionally, many other payers follow Medicare's lead on payment. Subsequently, Medicare should ensure reimbursement is increased to set the tone of other payers, Medicaid included, which would enable hospitals that have maternity services to continue

offering those services for years to come and may incentivize hospitals that have closed their maternity services to reopen due to improved financial sustainability.

- *How can CMS support hospitals in improving maternal health outcomes?*

One way CMS can support hospitals in improving maternal health outcomes is to provide an incentive payment to hospitals for the "Birthing Friendly" designation which currently requires participation in a state or national perinatal quality collaborative. CMS additionally should provide reimbursement or funding for emergency OB training provided to rural PPS hospitals. Other opportunities to advance this goal is to encourage the federal Department of Health and Human Services investment in increasing the number of OB-GYN physicians nationally and provide incentive dollars for OB-GYN residency slots. Separately, CMS should consider payment for Certified Doula and Certified Nurse Midwife perinatal care which can further improve access to care.

- *What, if any, payment models have impacted maternal health outcomes, and how?*

Payment rates that do not cover hospitals' costs to provide maternal care are a significant challenge. KHA urges CMS to increase Medicare payment rates and work with State Medicaid programs to increase maternity care rates for Medicaid beneficiaries as well. We strongly encourage CMS to model the unbundling of OB care and allow providers to bill and be reimbursed for the care provided and at a rate that covers the providers' and facilities' costs. Additionally, CMS should review improved reimbursement and access to telehealth services which also promotes access to maternity care, and increased reimbursement and access to behavioral health services.

- *What, if any, payment models have been effective in improving maternal health outcomes, especially in rural areas?*

Besides addressing Medicare and Medicaid rates, a significant challenge is the lack of OB-GYNs, as well as a lack of physicians and other providers who deliver babies. Additional financial investment at the federal level to assist with increasing the number of trained providers who deliver babies is necessary. This ensures access is available to patients in rural areas, which improves outcomes.

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

There are a variety of factors that influence the number of vaginal deliveries and cesarean deliveries. KHA members have expressed interest in seeing perinatal outcomes such as the Nulliparous, Term, Singleton, Vertex (NTSV) cesarean birth rate to be adjusted to be based on comorbidities that are known to modify the risk of cesarean delivery.

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Obstetrical Services Standards for Hospitals – Request for Information

KHA recognizes the importance of health and safety requirements for all facilities that provide obstetrical services and appreciates CMS requesting information on the topic of standards for all hospitals, including CAHs and REHs.

KHA does not believe CMS needs to implement requirements for OB standards for CAHs and REHs. Baseline standards for OB services for CAHs and REHs would be unnecessarily redundant. Many hospitals currently follow the American College of Obstetrics and Gynecology (ACOG) standards for providing maternity care. If CMS were to propose standards separate of that, hospitals would face questions of which standards to follow. This would be made even more difficult in situations where the standards were not aligned together. Since there are already well vetted standards in place, **KHA encourages CMS to rely on existing standards, such as the ACOG standards, rather than to develop new standards.**

Additionally, CMS should thoroughly research maternity care in rural and frontier areas to understand the impact that CMS policy and CoP changes have or may have on rural maternity care. Additionally, CMS should provide add-on payments to CAHs and REHs that provide maternity care, in recognition of the cost of training, equipment, and retention of clinical personnel trained to provide maternity care.

- *Should minimum OB staff training requirements (both initial and ongoing) be included in an obstetric services CoP?*

Many hospitals in Kansas, including rural hospitals that do not offer maternity services, already have training implemented to prepare staff and providers for delivering emergency obstetrics care. KHA has concerns if CMS were to propose additional requirements that would be unnecessarily redundant and burdensome for healthcare facilities.

The Conditions of Participation are not considered "optional" but are required to be met for participation in the Medicare and Medicaid programs. **KHA believes that additional regulatory burden implemented via CoPs in future rulemaking will result in additional hospitals ceasing to offer OB services.** The possible inclusion of additional training and equipment required as a "baseline" for OB services appears to be another unfunded mandate that cash strapped, and workforce challenged hospitals will struggle to meet. KHA fears this may result in the opposite effect of CMS's intent to improve outcomes and decrease maternal/fetal mortality and morbidity, especially in rural areas. Expectant mothers will be forced to travel longer distances to receive care (or chose not to drive to receive pre-natal care) or have someone deliver their baby.

- *What are the barriers to accessing such obstetrical training, including in rural areas? What are policy options to mitigate any potential unintended consequences or provider burden of such a requirement?*

Training via simulation is important for skills maintenance. Funding to rural and frontier states such as Kansas to train rural hospital emergency department staff in obstetrical emergencies is critically needed. There should be universal funding made available to rural hospitals to provide ongoing training on OB emergencies. **In addition, we strongly encourage CMS to provide funding for statewide transportation systems in rural states that enables the transportation of these patients from rural emergency departments to a higher level of care institution.** Transportation programs are costly, fragmented, and not available in many rural or frontier communities.

- *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?*

Two existing acceptable standards of practice for obstetrical services are the American College of Obstetrics and Gynecology (ACOG) and AIM (Alliance for Innovation on Maternal Health), which has created the maternal health and safety bundles that birthing hospitals in most states participate in. ACOG was awarded a four-year cooperative agreement in 2014 from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) to implement the Alliance for Innovation on Maternal Health (AIM) program. Today, AIM continues with additional funding awarded through a subsequent cooperative agreement. AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improving maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles. AIM works through state teams and health systems to align national, state, and hospital level engagement efforts to improve overall maternal health outcomes. In addition to ACOG and MCHB, find a list of all AIM partner organizations. **KHA encourages CMS to work with AIM and continue to foster quality and safety innovations in maternal health through this program, especially since most states are participating in AIM.**

- *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?*

As mentioned previously, **KHA reiterates the importance of increasing funding to support labor and delivery across all hospitals, but particularly in low volume, rural hospitals**. Similarly, another barrier is inadequate funding to support increased GME to help increase OB-GYN residency slots, funding for OB training for family physicians and advanced practice providers who want to deliver babies in rural communities. Additionally, inadequate reimbursement to provide highlight skilled labor and delivery trained nursing staff 24/7 continues to be a barrier.

- *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?*

While KHA strongly supports efforts to ensure quality care for all pregnant, laboring, and postpartum patients across all care settings, we do not believe establishing new regulatory standards advances that goal. There are already standards in place. **KHA encourages CMS instead to focus on establishing proper funding to enable all care settings to achieve this goal.** Funding enhancements for labor and delivery services are the most effective way to improve access and quality of care for all patients.

- *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?*

KHA recommends CMS hold listening sessions with AIM and AIM-participating hospitals to understand how this might be accomplished and how AIM can help provide lessons learned in this area.

- *How would an obstetrical services CoP impact access to care for pregnant, birthing, and postpartum individuals? How will the CoP impact hospitals with respect to factors that have led some facilities to close their maternity units, including high costs, labor shortages, and declining birth rates?*

KHA has strong concerns that an obstetrical services CoP would negatively impact access to care for pregnant, birthing, and postpartum individuals. Additional regulatory burden without adequate reimbursement and funding could lead more hospitals to close OB services or deter facilities from opening new OB services, particularly in underserved communities.

- *What policy options would help alleviate any potential unintended consequences of an obstetrical services CoP and the impact on maternity care access and workforce? How should these policy options account for variation in hospital size, volume, and complexity of services? What other hospital-specific factors should be accounted for?*

KHA reiterates our belief that the central policy option to help alleviate any potential unintended consequences of an obstetrical services CoP is to enhance funding for labor and delivery services and unbundle care so hospitals can better cover costs. Improving Medicare reimbursement will

enable hospitals to sustain maternity care services which includes establishing and sustaining a strong labor and delivery workforce. In addition to enhanced funding from Medicare, **KHA suggests new add-on payments for low volume and rural hospitals are necessary to maintain access to OB services in critically underserved areas, which is vital in states like Kansas and many others across the country.**

- *What should minimum oversight requirements be for an obstetrical unit? We also welcome comments on whether there should be similar or different oversight requirements for small hospitals, CAHs, and REHs.*

KHA believes that input from ACOG and AIM to help guide minimum oversight requirements for an obstetrical unit would be helpful. Reiterating though, that additional regulatory burden with no increase in reimbursement or funding could further exacerbate the lack of access to maternal care in rural areas. **It is imperative for CMS to consider different oversight requirements for small hospitals, CAHs, and REHs.** Staffing is often much different at these facilities, and it is not reasonable to require a CAH, REH, or small rural PPS hospital to be able to meet the same requirements as placed upon a large urban hospital.

- Beyond what is already required for emergency department (ED) patients under EMTALA, should a hospital obstetrical services CoP include a requirement for transfer protocols for when a non-ED patient needs care that exceed the capability of the hospital (that is, inpatient to inpatient transfers)? Should a similar requirement apply to hospitals and CAHs without emergency services and/or obstetrical services?

KHA does not believe that a hospital obstetrical services CoP should include a requirement for transfer protocols. Hospitals under EMTALA and existing hospital policies and procedures for patient transfers already cover this, and there is not a need to provide duplicative requirements within the CoPs.

- *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?*

KHA reiterates the importance for increased Medicare and Medicaid reimbursement for obstetrics care. CMS should **enhance funding for labor and delivery services and unbundle care.** Improving Medicare reimbursement will enable hospitals to sustain maternity care services which includes establishing and sustaining a strong labor and delivery workforce. In addition to enhanced funding from Medicare, **KHA suggests new add-on payments for low volume and rural hospitals are necessary to maintain access to OB services in critically underserved areas, which is vital in states like Kansas and many others across the country.**

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Severity Levels: Social Determinants of Health – Inadequate Housing/Housing Instability

KHA thanks CMS for its consideration of inadequate housing and housing instability that are circumstances that can impede patient cooperation or management of care, or both. Lack of housing can also result in extended lengths of stay for patients. **KHA supports changing the severity level designation of seven ICD-10-CM diagnoses codes that describe inadequate housing and housing instability from NonCC to CC, and encourages CMS to ensure that the increased reimbursement adequately covers the cost of acute hospital care for unhoused individuals or individuals with inadequate housing.**

Additionally, KHA encourages greater alignment between CMS's health equity and SDoH quality reporting requirements and SDoH Z-code capture to ensure that adequate reimbursement is provided to hospitals to complete SDOH-related requirements. We also urge CMS to work with federal agencies such as the Office of the National Coordinator to ensure electronic health record vendors to include SDoH data elements in their products: SDoH assessment, goals, interventions, and problems/health concerns.

Medicare Promoting Interoperability Program

KHA has concerns with leveraging the Medicare Promoting Interoperability Program to enforce public health reporting when hospitals, particularly our small rural facilities, are challenged to meet the requirements that exist now. KHA urges CMS to consistently consider the benefits to patients and the burden hospitals face to meet new requirements on all current and potential future rulemaking.

Regarding the scoring threshold proposal to increase from 60 points to 80 points beginning in CY 2025, KHA has concerns that since there are expected to be some hospitals that do not currently meet the threshold of 80 points, CMS should push back the reporting period start date to CY 2027 to enable these hospitals to adjust to the reporting requirements.

Conditions of Participation Requirements for Hospitals and CAHs to Report Acute Respiratory Illness

KHA encourages CMS to change the respiratory reporting to voluntary after October 1, 2024. The reporting burden that CMS has placed upon hospital is onerous, resource-intensive, costly and detracts from direct patient care time. **In lieu of making the reporting voluntary, we urge CMS to increase payment rates for all conditions for which reporting is required to cover the labor costs for reporting that currently take away from patient care.**

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Additionally, KHA recommends that CMS review opportunities to standardize the collection of Race, Ethnicity and Language (REAL) data across programs. This will enable the public to better analyze REAL data to make better data driven decisions.

Health Care Reporting to the National Syndromic Surveillance Program – Request for Information

KHA believes it is crucially important to have a strong National Syndromic Surveillance Program and agrees that refinements are beneficial to make the program better for those that provide information into the program, and for those that are informed by the insights of the program.

- *How can CMS further advance hospital and CAH participation in CDC's NSSP?*

In Kansas, most hospitals participate in the state surveillance program. KHA encourages CMS to work with CDC and state surveillance programs to determine where they may be gaps in participation, and the reason, which is likely the cost to participate, which is on top of the required CMS reporting burden already impacting hospitals.

- *Should CMS require hospitals and CAHs to report data to CDC's NSSP, whether as a condition of participation or as a modification to current requirements under the Promoting Interoperability Program?*

KHA strongly encourages CMS to support voluntary reporting in state surveillance programs and to stop adding reporting requirements without removing any. If the requirement becomes mandatory, reimbursement such as an add-on payment should be provided to hospitals to cover the cost of this additional required reporting.

- *Should CMS explore other incentives or existing quality and reporting programs to collect this information?*

KHA supports the use of incentives to collect this information but would encourage CMS avoid the use of penalties. We strongly urge CMS to recognize the labor costs hospitals face to comply with CMS reporting requirements instead of adding more unfunded mandates.

- *What would be the potential burden for facilities in creating these connections in state and local public health jurisdictions that have not yet established syndromic programs and /or where state and local public health are not presently exchanging data with CDC's NSSP? Are there unique challenges in rural areas that CMS should take into consideration?*

The primary challenges in all areas, regardless of urban or rural, are the labor costs, which are not covered by CMS. Turnover in positions makes it increasingly difficult to train new staff and keep up with

the demands in reporting. Additionally, rural and frontier areas specifically do face broadband issues which would impact digital connectivity. KHA believes CMS should take these issues and others into consideration.

Hospital Quality Reporting and Value Programs

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measures

KHA appreciates that CMS is working to modernize the HCAHPS survey. However, we question the validity and reliability of the newly proposed hospital patient experience of care questions. Specifically with regard to "Restfulness of Hospital Environment", patients who require care in an inpatient setting will be treated and monitored, which by necessity will likely cause disruption in a patient's rest based on the patient's acuity, frequency of required monitoring, medication, therapies and other services.

Further, KHA questions adding more to an already lengthy survey. KHA maintains that questions asked on all surveys, particularly the HCAHPS survey, must provide data that can be acted upon to improve quality of care, access to care, cost of care, the patient experience, or staff satisfaction and safety. KHA is uncertain how data gleaned from these new sub-measures could be used to improve performance, as the preliminary analysis noted through the pre-rule making review process showed that the measures are not based upon clinical practice guidelines. The questions regarding how well clinicians worked together to provide care or were up-to-date on the patients care are highly subjective and will be presumably based on incomplete information. **KHA requests that all of the newly proposed hospital patient experience of care measures undergo further validity and reliability testing before they are proposed for a CMS program.**

Inpatient Quality Reporting Program

KHA appreciates that CMS is removing four episode-based measures, however, there is still a net increase of three more quality reporting measures. **We strongly encourage CMS to re-engage the meaningful measures initiative, remove measures that do not improve care; increase payment rates to cover the additional cost of reporting; evaluate the effectiveness of the reported measures requirements and make that information available to hospitals.**

KHA also agrees wholly that hospitals should prioritize patient-centered care for aging patient populations, especially those with multiple chronic conditions. Kansas' population that is over age 60 is growing while the proportion that is under 60 is shrinking. The U.S. Census Bureau estimates that nearly 25 percent of Kansas' population will be over age 60 by the year 2030, and this trend will likely continue as the overall U.S. population rapidly ages.[4] Additionally, the rural communities continue to see an increasing age in their population. As such, KHA agrees that focusing on optimizing care for older adults is an important goal for

[4] Jonathan Vespa, *The Graying of America: More Older Adults Than Kids by 2035*, U.S. CENSUS BUREAU (Mar. 13, 2018) https://www.census.gov/library/stories/2018/03/graying-america.html.

hospitals. **KHA agrees that hospitals should focus on protecting and ensuring good health outcomes for older adults.** In particular, older Kansans' are more likely to have complex care needs, more social risk factors, and multiple chronic conditions that require high-quality care. This means that rural states such as Kansas may see higher resource utilization when caring for older adults. **Due to the proposed Age Friendly Hospital Measure being attestation based and not publicly reported, KHA supports the implementation of the proposed structural measure.**

<u>Other Proposed Changes</u>

Improving Cybersecurity Practices

With cybersecurity a top concern and an increasing number of health care organizations being attacked, KHA supports the sharing of best practices for health care facilities to take note of, but implementation of many of these best practices require funding to support the implementation of the cybersecurity recommendations. **KHA recommends that CMS looks into future payments for health care facilities to support the acquisition, implementation, and maintenance of cybersecurity tools to better protect patients from cyber-attacks from malicious actors.**

Separate Inpatient PPS Payment for Establishing and Maintaining Access to Essential Medicines

KHA appreciates CMS' recognition of the costs to establish and maintain access to essential medications, as well as the substantial labor costs hospitals experience due to the time and resource-intensive nature of identifying alternative suppliers and drugs during this time of sustained and extensive drug shortages. These costs are not exclusive to PPS hospitals; therefore **we encourage CMS to include CAHs as eligible under this payment.** Many CAHs are the sole health care provider for their communities and should receive these kinds of supports from CMS to mitigate ongoing challenges.

According to the proposed rule, CMS estimates that 493 hospitals across the country would be eligible under the proposed criteria of an independent, small hospital. The proposed rule also indicates CMS will pay $300,000 total for this separate IPPS payment. KHA is concerned that under this funding scheme, each hospital would only be eligible for $608.52 annually. We do not believe this is an appropriate amount of money per hospital to truly allow a hospital to build a resilient supply of essential medications. **KHA encourages CMS to increase the amount of funding provided for this separate IPPS payment. KHA also urges Congress to minimize administrative burden associated with this change and make the add-on payment based on the facility's total Medicare drug spend versus requiring per beneficiary accounting for medication use.** We believe that CMS should also consider making upfront payments to eligible hospitals to support the acquisition of a buffer stock to better enable hospitals to achieve the goal intended by this proposal.

Technology Add-On Payments

CMS proposes to continue the new technology add-on payment and increase the percentage from 65 to 75 percent for certain gene therapies approved for the treatment of sickle-cell disease. KHA thanks CMS for this proposal and encourages CMS to increase the marginal payment rate to at least 80 percent to better account for the high costs of these therapies.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We urge CMS to consider the changes outlined above in the FY 2025 proposed rule in order to serve our Medicare patients to our best ability.

If you would like additional information, please contact Shannan Flach at sflach@kha-net.org or Jaron Caffrey at jcaffrey@kha-net.org.

Sincerely,

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