Kansas Hospital Association

September 9, 2024

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

RE: CMS-1809-P; 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

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 Outpatient Prospective Payment System (OPPS) for calendar year (CY) 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 Updates to the Outpatient PPS Payment

KHA thanks CMS for a payment increase to OPPS hospitals **however this update of 2.6% is vastly inadequate given inflation, workforce shortages, recent cyberattacks on health care entities, and labor and supply cost pressures that hospitals continue to face.**

In July 2024, the Consumer Price Index for hospital services was 6.1%.[1] Medicare reimbursement continues to fall behind the actual cost of providing care which further increases sustainability issues of hospitals. For example, one Kansas health system has experienced ***a 5.2% increase in salary expense per FTE****, an* ***11.0%***

[1] Press Release, Bureau of Labor Statistics, Department of Labor, Consumer Price Index – July 2024 (Aug. 14, 2024), https://www.bls.gov/news.release/pdf/cpi.pdf.

***increase in drug supplies**, and a **16.7% increase in Contract/Purchased services**.* With Medicare representing 50-55% of this hospital's payer mix, a 2.6% increase is clearly not sufficient. Another Kansas hospital with a 76% Medicare payer mix has seen their operating expenses since the end of the 2022 fiscal year increase by 23%. A 2.6% payment increase is simply inadequate and inappropriate.

Using historical data from 2022 to calculate the market basket increase of only three percent is also inappropriate. There have been significant changes in operating conditions since 2022 including vast increases in labor costs, costs for drugs and pharmaceuticals, and new federal requirements on hospitals. Our hospitals are experiencing much higher input costs and costs to mitigate new challenges like preventing cyberattacks which is very expensive. **This proposed payment increase is not responsive to actual market factors and we urge CMS to provide additional support in the final rule.**

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 across inpatient and outpatient services declined to a historic low of -11.6 percent. Kansas hospitals are additionally concerned about CMS setting 2025 Medicare Advantage payments to increase by 3.7%, while only proposing to increase OPPS payments by 2.6%. **KHA urges CMS to increase payments to OPPS 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 plans will receive.**

Additionally, we encourage CMS to require ASCs to submit cost reports similar to how hospitals must submit them. They can be simpler, but it is important that ASCs begin reporting this information in order for CMS to truly understand costs of ASCs when determining updates to payment policies.

<u>Payment Increase for Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACH)</u>

KHA supports CMS' proposal to increase payment for Rural Sole Community Hospitals (SCHs) by 7.1%. **KHA encourages CMS to extend this payment increase to Medicare Dependent Hospitals (MDHs),** which by definition are rural hospitals that play an essential role in their community. It is within CMS' authority to make this change without need for congressional action through a study of costs incurred by rural hospitals compared to urban hospitals. CMS should perform another study to look at the costs that MDHs incur and make an adjustment similar to what SCHs receive to increase support to the rural safety net.

<u>Proposed OPPS Payment for Hospital Outpatient Visits</u>

KHA supports CMS' proposal to continue the exemption of rural SCHs from its policy to pay for hospital outpatient clinic visits furnished at off-campus provider-based departments at the Medicare Physician Fee Schedule rate, or 40% of the OPPS rate. We encourage CMS to consider exempting small rural hospitals with less than 100 beds, MDHs, and Low-Volume Hospitals in a future rulemaking cycle. The same rationale that led CMS to propose to exempt SCHs also applies to all small rural hospitals. Factors other than the payment

differential can be attributed to the volume of services in provider-based clinics of rural hospitals. Extending this site neutral exemption to MDHs would ensure rural hospitals receive more adequate reimbursement and thus support access to care for beneficiaries in rural areas. **CMS must finalize its proposal to continue to exempt rural SCHs and extend the same relief to MDHs.**

Packaged Services & Add-On Payment for Non-Opioid Treatments for Pain Relief

KHA supports CMS' proposal to continue to unpackage and pay separately with an add-on payment the cost of non-opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting. In 2021, sixty-four percent of all drug overdose deaths in Kansas were from opioid overdose. From 2011 to 2021, the age-adjusted death rate due to opioid overdose increased from 4.3 per 100,000 to 15.7 per 100,000 in Kansas[2]. We believe that unpackaging these drugs is imperative as an incentive to decrease the utilization of non-opioid pain management drugs and to encourage their use rather than opioids.

KHA encourages CMS to reevaluate this add-on payment for continued utilization after CY 2027. We support the extension of this add-on payment for additional years past CY 2027. A longer active duration of this payment will continue to incentivize providers and facilities to prescribe non-opioid drugs to treat pain. Additionally, KHA will plan to educate members of this add-on payment with the goal of greater uptake of prescription. An extension of this add-on payment through at least CY 2030 will enable stronger widespread acknowledgment and utilization, which will meet CMS' goal of this payment. KHA also encourages CMS to educate providers that this add-on payment is available. We do not believe it is widely known, and therefore could expand the prescription of these non-opioids to treat pain if CMS expanded educational efforts.

Radioisotopes Derived from Non-Highly Enriched Uranium (non-HEU) Sources

KHA thanks CMS for its proposal of an add-on payment for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99. We are supportive of efforts like this that increase the domestic supply chain resiliency. However, we have concerns that the amount of the add-on payment is insufficient to make a realistic difference in. KHA recommends CMS consider increasing the dollar amount of this add-on payment to better incentivize radiopharmaceuticals that use Tc99m to be derived from domestically produced M0-99.

Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy When Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communications Technology

We appreciate CMS extending this provision to allow for outpatient therapy, DSMT, and MNT services to be furnished remotely by institutional staff to beneficiaries in their homes via telehealth and to bill for these services, and we encourage Congress to take legislative action to extend these provisions after 2024. An

[2] https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/kansas/

extension to expand the range of practitioners eligible to furnish telehealth services is essential to improving access to care, and is a common sense policy that should be extended.

Payment for Partial Hospitalization (PHP) and Intensive Outpatient (IOP) Services

KHA supports CMS' proposed payment rate increase for payment for partial hospitalization and intensive outpatient services at $279.97 for 3-service days and $428.39 for 4-service days.

Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients.

KHA thanks CMS for the proposal to continue flexibility in allowing the availability for virtual direct supervision of CR, ICR, and PR services through CY 2025. Many Kansas hospitals have benefited from this flexibility, and it is important that it remains in effect. **KHA encourages CMS to consider making this flexibility permanent**. The pandemic showed that flexibilities like this can deliver great benefits for both patients and providers and should continue to be offered following CY 2025.

Request for Comment on Payment Adjustments under the IPPS and OPPS for Domestic Personal Protective Equipment

KHA supports the goal of CMS to improve supply chain resiliency by encouraging the growth of domestic manufacturing of personal protective equipment. Payment adjustments to offset the marginal costs faced by hospitals in acquiring domestically made surgical N95 respirators are a step in the right direction, but there are nonetheless issues present.

This adjustment only serves the Medicare FFS population. Future proposals should consider how help can be delivered to hospitals that also serve a high Medicaid population and would also benefit from a payment adjustment. Additionally, we urge CMS to make this provision in a non-budget neutral manner.

We recognize that any real long-term solution will require rethinking how the supply chain should function. Addressing this issue will require action that goes well beyond Medicare reimbursement. CMS could play a role in coordinating public and private sector collaboration to review the national medical supply chain. However, in the short term, we are supportive of any efforts to strengthen the otherwise fragile supply chain that currently exists.

KHA appreciates CMS' consideration of reducing reporting burden in this program, and we encourage CMS to explore subjecting supply manufacturers to labeling requirements instead of requiring providers to track this information. Shifting the reporting burden should not be done just to shift a problem around, but it truly makes the most sense for the manufacturers to attest to the production of domestic-made respirators rather than having providers do this for the manufacturers. Additionally, we believe that hospitals would be more easily

able to utilize the payment adjustment if CMS modified the adjustment to enable hospitals to attest as opposed to requiring hospitals to obtain a written statement from the manufacturer.

There are meaningful ways that CMS can truly assure that hospitals make use of higher quality respirators, but this requires recognition of the real costs of domestic respirators, ensuring that there is payment to account for this real cost, and a reconfiguration of the medical supply chain.

Medicaid Clinic Services Four Walls Exceptions:

KHA supports CMS' proposal to expand the exceptions to the four walls requirement to enable clinics in rural areas, IHS and tribal clinics, and behavioral health clinics the ability to offer Medicaid clinic services offsite. We believe that these new exceptions will expand access to care for rural and tribal communities throughout Kansas.

Regarding CMS' request for comments on what the definition of rural should be, **KHA recommends that CMS allow states to choose a state or federal definition of rural to meet their unique geographic needs.** KHA appreciates federal programs that provide support to rural providers; however, a challenge has been that many federal programs offer non-standard definitions of rural, and when a program does have a rural definition, it is a one-size-fits-all definition that does not recognize unique aspects of each state that may make some geographic areas truly rural but are not recognized in federal definitions. For example, federal definitions that are based on Metropolitan Statistical Areas (MSAs) often improperly group rural counties with urban counties, even though that is not an accurate reflection of our rural communities.

Kansas as a state has largely resolved this problem, and our state has adopted a definition of rural that provides greater recognition of what rural looks like in Kansas. We believe our state definition is more appropriate for the rural four walls exception than any potential federal definitions under consideration.

If CMS does not allow states to adopt a state or federal definition of rural and instead finalizes a policy using a federal definition of rural, KHA encourages CMS to utilize the Federal Office of Rural Health Policy definition of rural to establish exception criteria.[3]

Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process

KHA strongly supports CMS' proposal to shorten the prior authorization timeline for Medicare fee-for-service outpatient requests to seven calendar days. We appreciate that CMS is aligning the timeline for standard

[3] *See* Health Resources and Services Administration, *Defining Rural Population*, last updated January 2024, https://www.hrsa.gov/rural-health/about-us/what-is-rural.

outpatient department requests with that of other payers. This proposal will create equity for all patients waiting to access care and may help reduce provider burden by streamlining processes across all payers.

Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs:

KHA appreciates CMS' commitment to health outcomes and ensuring every patient receives exceptional care, every time. We are concerned that the four new proposed quality metrics across the OQR, REHQR, and ASCQR programs are not adequately developed to be finalized in this rulemaking cycle, and we encourage CMS to not finalize these four measures without modification.

Kansas hospitals, particularly REHs and rural PPS hospitals, lack the bandwidth to report these additional measures without accompanying reimbursement. Kansas REHs and many rural PPS hospitals are small facilities with staff that wear many hats. The departments that are responsible for reporting these measures are often one-person departments and extracting and reporting this data is a significant challenge. Many rural and frontier communities do not have community-based organizations or supports and services to address health related social needs. Taking into account the impact any requirements have on rural and frontier communities is critical. CMS reporting requirements around screening for social determinants of health (SDOH) and screen positive for SDOH must recognize that in many rural and frontier communities, the population is so small that these requirements could jeopardize patient privacy and put patients in danger with regard to interpersonal safety. Additionally, requiring providers to screen for SDOH when there are not supports to address those SDOH in a community can add to negative patient response and the already escalated workplace violence situations post-pandemic. **We encourage that the newly proposed measures undergo further validity and reliability testing before they are proposed for a CMS program. We additionally urge CMS to provide appropriate reimbursement levels that cover provider costs as a foundational requirement to supporting health related social needs; while also realizing that operationalization of SDOH screening and addressing HRSNs is very different in rural and frontier communities and reporting requirements may need to differ.**

Regarding the Screening for Social Drivers of Health Measure, we applaud the intent of the measure as it is in alignment with CMS and many hospitals' and health systems' goals to close the gap on health equity challenges. However, the proposed requirement and measurement need additional work. Many programs in hospitals have set up screenings, so the provision to allow for a patient to not have to be rescreened if the patient was screened recently is very welcome. However, there would be a challenge to build this into the existing EMRs in order to save time for clinicians. It is important for reporting burden and implementation be accompanied by increased reimbursement from CMS. **We urge CMS to increase payment rates to cover the additional cost of reporting.**

The frequency of screening needs to be reasonable. The current ambulatory requirement is once per year, while the inpatient requirement is once per admission. CMS could consider initiating these requirements with a

smaller outpatient population like ED which could provide valuable information and drive improvement initiatives, especially if demonstrated that providing resources could prevent admission to the hospital.

Required screening in all HOPDs will be a significant lift for implementation and ongoing reporting. KHA encourages CMS to consider starting on a smaller level and learn from that process before spreading to larger patient populations. We believe that this approach would be in greater alignment with process improvement principles and to achieve true success.

Lastly, KHA is concerned with CMS' adoption of measures that have not been endorsed by consensus-based entities (CBE). It is important that quality metrics are well thought out, developed with consideration of stakeholders, and refined through public comment. While the aims of these proposed measures are well intended, the lack of endorsement from a consensus organization is an issue. **We encourage CMS to delay the reporting periods of these proposed measures until a CBE provides their review and endorsement.**

Hospital Outpatient Quality Reporting Program (OQR)

We thank CMS for removing two measures to reduce reporting burden in the OQR program. KHA is concerned that there is a much greater reporting burden associated with the proposed new measures in the OQR program than what CMS indicates. In the proposed rule, CMS wrote that these changes are a minimal burden, and that the intent of these updates is not to increase the burden of data and measurement collection and submission for CMS quality programs. However, Kansas hospitals believe this proposal would be a significant burden to their hospitals and health systems. It is important to recognize that any new measure often requires an IT build that is a large burden, particularly in the form of surveys. Hospitals could contract with third parties to mitigate this burden, however there is a financial cost associated with that, which increases the cost of health care. An example of this is the new THA/TKA PROMS surveys. This has been a heavy lift for hospitals to undertake and is still in its voluntary period. **KHA recommends CMS requests feedback on that rollout to better understand the burden of adding another survey before voluntary reporting.**

Additionally, we are concerned that many of the survey questions mimic those that already exist in the OASCAHPS survey. If CMS does finalize this proposed measure, we recommend that there should be a minimum two-year voluntary period with appropriate feedback reports similar to other CMS measures.

Publicly report on Care Compare the Median Time from ED Arrival to ED Departure (Psychiatric/Mental Health Patients stratification)

KHA has strong concerns with CMS' proposal to publicly report on Care Compare the Median Time from ED Arrival to ED Departure with stratification for psychiatric and mental health patients. Measuring ED length of stay for the psych population is not a true measure of the hospital and/or emergency department

performance due to external factors that are far beyond the control of the hospital or emergency department. These external factors play a major role in the overall length of stay for the psychiatric population.

These external factors include variable delays to state screening for involuntary patients, bed availability and the extent of the waiting list for inpatient psychiatric facilities located outside of the hospital, patient preference regarding the psychiatric facility, time to arrival of transport to psychiatric facility, the admitting psychiatric preference on lab result thresholds to accept admission despite medical clearance by the ED physician, and more. Because of these external factors that are not within the control of the hospital/ED, this quality metric fails to assess the actual hospital/emergency department performance and provides no meaningful data to base future quality improvements.

It has become increasingly difficult to provide patients with a timely and proper psychiatric evaluation. Rural regions in Kansas often lack mental health services and telepsych consultations can be time-consuming. Additionally, many Kansas communities struggle with access to ambulance services to transport patients, even when an appropriate bed opens up somewhere in the state for placement. Many rural EMS services are beginning to reject transferring patients from a hospital ED to a psychiatric facility because the EMS service must have enough local coverage to respond to local EMS calls. EMS services with a lack of staffing and resources thereby increase the median time from ED arrival to ED departure. Without addressing issues associated with the lack of patient transfer capabilities and the lack of inpatient psychiatric beds, reporting this measure will only provide a misleading number that patients will not derive any benefit from, while hospitals will bear the brunt of negative unintended consequences.

Additionally, Kansas hospitals report that patients will often use substances (alcohol and drugs) that cause metabolism delays for clearance to appropriately provide a mental health evaluation. These delays further add to the overall ED length of stay time and are out of the control of the ED.

KHA urges CMS to not finalize this proposal to publicly report this stratification of this measure. There are many factors that go into the median time of psych/mental health patients in our emergency rooms, and publicly reporting this stratification does not provide meaningful benefit to patients. Patients would not be provided with relevant information, and rather misleads them due to lack of knowledge on these factors that go into the time it takes from ED arrival to departure. There are unintended consequences that we do not believe CMS has thoroughly considered, and it is our strong urging that this proposal is not finalized.

Rural Emergency Hospital Quality Reporting Program (REHQR)

KHA thanks CMS for recognizing key differences in a Rural Emergency Hospital compared to hospitals reporting in other CMS quality reporting programs. We welcome the extension of the reporting period for the Risk Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure from one year to two years beginning with the CY 2027 program determination. REHs are hospitals with low volumes, and one year of data is not appropriately sufficient to provide data to drive quality improvement efforts. Additionally, we appreciate CMS' clarification for when REHs are required to report data under the REHQR program after status conversion.

Kansas Hospital ASSOCIATION

Hospital Inpatient Quality Reporting Program (IQR)

KHA supports CMS' continuation of voluntary reporting of the core clinical data elements (CCDEs) and linking variables for both the Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Standardized Mortality (HWM) measures, for the performance period of July 1, 2023, through June 30, 2024, impacting the FY 2026 payment determination for the Hospital IQR Program. KHA members believe in the intent of the measure to use clinical data along with claims to improve risk adjusted methodologies for the Readmissions and Mortality outcomes measures.

KHA urges CMS to provide clear guidance or interpretation of results in a timely manner moving forward. This is necessary to assist hospitals in making appropriate corrections to meet the requirements for successful submission of the first mandatory reporting period. The latest feedback report was delivered after June 30, 2024, several months later than originally stated by CMS. An extra year of voluntary reporting with timely feedback reports from CMS is needed for hospitals to implement valid and reliable data.

KHA also encourages CMS to lower the threshold of successful submission of linking variables to 90% or lower, which is the same for the submission of vital signs and labs. We believe this is particularly of importance in the infancy of this measure. There are outstanding technical issues and definitions in the specifications that are not clearly published. CMS should allow a gradual increase year over year of expected matching which would allow hospitals to best send the data as intended.

Overall Hospital Quality Star Rating

KHA appreciates CMS reviewing the Star Rating methodology to ensure that it accurately reflects quality of care for the benefit of improving patient access to information. We are pleased to be able to provide comments regarding the request for information on potential modifications to the Safety of Care measure group in the Overall Hospital Quality Star Rating methodology.

- *Do you agree with the potential new weights for each measure group?*

No, KHA does not agree with the potential new weights for each measure group. We question if CMS took into consideration that there is a re-weighting if a hospital did not quality for enough measures in each of the five categories. How might this affect the overall re-weight of the safety of care category if that occurs?

- *Do you support reducing the Star Rating for hospitals with a low Safety of Care score as described in option 2? Do you agree with the potential policy to apply a 1-star reduction to all hospitals in the lowest quartile of Safety of Care?*

No, KHA does not agree with this potential policy whatsoever. We believe that a 1-star reduction to all hospitals in the lowest quartile of Safety of Care is far too harsh of a penalty. Rural or low-volume hospitals are penalized with a low volume of incidents. For example, one incident over a three-year performance period, when compared to zero incidents in the baseline period, can negatively impact an organization's overall quality rating. This would negatively impact hospitals without providing accurate depictions of safety of care.

- *Do you support a combination of reweighting the Safety of Care measure group with a 4-star maximum on Star Rating as described in option 3?*

No, we do not support a combination of reweighting the Safety of Care measure group with a 4-star maximum on Start Rating as described in option 3.

- *With respect to the potential changes to the Overall Hospital Quality Star Rating methodology, are there any special considerations for small, rural or safety net hospitals (including Critical Access hospitals)?*

Yes, KHA emphatically urges special considerations for small, rural, and safety net hospitals including Critical Access Hospitals. There are substantial concerns of further negative impacts to rural or low-volume facilities that need to be considered. These facilities with low incidents can have one event in a three-year period which can lead to a negative impact on the quality-of-care rating and a negative public image. We have already seen this occur with rural organizations that were performing at a 4-star rating and became regional referral centers during the peak of the COVID pandemic and were negatively impacted by the Star Rating and community perception of care. For some of these facilities, it led to a two Star drop because of special cause variation of known COVID complications (Readmissions and mortality rates – Sepsis, Pneumonia) that CMS did not remove to existing measures. Organizations with larger volumes are better equipped to absorb variations than rural and low-volume facilities. A reweighting or a reduction in Star Rating does not accurately reflect the true quality of care rating in these situations.

Additionally, KHA recommends CMS reconsider the methodology used to determine peer groups. One small rural Kansas hospital is included in the same peer group as a large academic medical center for the past two years. This is clearly not comparing apples to apples and are not appropriate peer groups.

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

KHA recognizes the importance of health and safety requirements for all facilities that provide obstetrical services and appreciates CMS' continued focus on reducing maternal health disparities. As stated in the proposed rule, research indicates that over 80 percent of pregnancy-related deaths in the U.S. are preventable. The US maternal mortality rate for 2022 is 22.3 deaths per 100,000 live births, one of the highest ratios among developed countries. This is a concerning issue and one that we strongly believe in working towards lowering. KHA shares CMS' commitment to ensuring that all Medicare and Medicaid participating hospitals and CAHs offering obstetrical services are held to a consistent standard of high-quality maternity care and patient health and safety.

Between 2011 and 2021, 267 rural hospitals ceased providing obstetrical (OB) care, representing 25% of rural America's OB units.[4] These closures are threatening access to care and contributing to the rural maternal health crisis. Unfortunately, as rural hospitals face difficult financial situations, closing service lines is an intermediary step before closing the hospital. Given the low volume of births in rural areas, coupled with financial challenges and workforce shortages generally experienced by rural hospitals, OB units are one of the first service lines to be ended.

The estimated financial note on these provisions according to the proposed rule are close to $4.5 billion over 10 years with an average annual cost of $70,671 to individual hospitals. This unfunded mandate, while good intentioned, poses risks to many hospitals, particularly CAHs, that are already struggling financially. While we provide feedback on many of the proposals in subsequent paragraphs, we implore CMS to review how the agency can provide adequate support via reimbursement to OB providers to ensure access to maternity care is not further eroded.

Over 40% of births are paid for by Medicaid, and Medicaid has historically reimbursed less than the cost of providing care. Payment rates from public payers have not kept pace with inflation, and the cost of providing care has increased dramatically over the last four years. On average, hospitals experienced negative margins (-18% across all payers) for labor and delivery services in 2023. **KHA reiterates the importance of increasing funding to support labor and delivery across all hospitals, but particularly in low volume and 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.

Along with enhanced funding from Medicare, **KHA recommends the creation of 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.**

In the proposed rule, CMS requested comments on if these proposed CoPs should also apply to Rural Emergency Hospitals (REHs). **KHA recommends that CMS does not apply the OB and related CoPs to REHs.** REHs already have their own distinct set of CoPs that in many places align with CAH CoPs. The REH designation was created as a lifeline for certain rural hospitals that may otherwise close. As such, REHs have their own distinct payment methodology and CoPs and should not be required to comply with CoPs that other rural hospitals do.

Organization, Staffing and Delivery of Services

[4] Topchik, et al., *Rural America's OB Deserts Widen in Fallout From Pandemic*, Chartis (2024), 1, https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf.

KHA appreciates CMS' recognition of our comments in the 2025 IPPS Proposed Rule RFI that, while there are not currently national standards regulated on OB services, that many Kansas hospitals follow standards from the American College of Obstetrics and Gynecology (ACOG) and AIM (Alliance for Innovation on Maternal Health) on providing maternity care. We believe the proposal for hospitals to provide care in accordance with nationally recognized acceptable standards of practice for physical and behavioral (inclusive of both mental health and substance use disorders) health care of pregnant, birthing, and postpartum patients is good policy.

KHA recommends CMS also consider adding flexibility to the requirements for equipment for CAHs and rural hospitals offering OB services. While many facilities already have this equipment on hand, we believe it would be helpful to allow CAHs and rural hospitals to be considered in compliance with this section if the hospital has the proposed required equipment available to the OB unit based on patient census, rather than required for every labor and delivery room. Due to many small and CAH hospitals having low OB censuses and therefore may not already have this equipment on hand for every OB room, this proposed section without our suggested modification would unnecessarily place financial strain on rural hospitals to purchase equipment that may never be used.

One way CMS can help improve rural maternal health outcomes is to assist rural hospitals with OB readiness. KHA asks that CMS provide resources, such as technical assistance, to help rural hospitals achieve this goal. For example, S. 4079/H.R. 8383, the Rural Obstetric Readiness Act[5] would help prepare rural hospitals and providers to handle the obstetric emergencies that come into their emergency rooms. This would be achieved through supporting facilities with the purchase of necessary equipment and developing a workforce that is able to respond, creating a pilot program to support statewide or reginal networks of obstetric care teams to provide tele-consultation, and creating an obstetric emergency training program for rural facilities that do not have a labor and delivery unit. While this program would be housed in the Health Resources and Services Administration, it can serve as a model for the kind of technical assistance that CMS could help provide.

<u>Quality Assessment and Performance Improvement (QAPI) Program</u>

KHA supports the goal of using quality assessment and performance improvement to reduce disparities and improve quality of care. There are low-volume and rural considerations that CMS should take into account before finalizing these proposals.

- *To what extent do facilities already stratify, measure, analyze, and track quality data and indicators over time by diverse subpopulations or conduct performance improvement projects focused on reducing maternal health disparities as part of their QAPI activities? What are examples and outcomes of such work to date?*

[5] Rural Obstetrics Readiness Act, S. 4079, 118th Cong. (2024) https://www.congress.gov/bill/118th-congress/senate-bill/4079.

KHA has been a member of the Kansas Maternal Mortality Review Committee (KMMRC) and the Kansas Perinatal Quality Collaborative (KPQC) since their inception. Both advisory groups/initiatives are funded with CDC and HRSA dollars aimed at improving maternal health. The KPQC utilizes data from the KMMRC to inform the quality and safety work, and almost all birthing hospitals in Kansas participate in KPQC's initiatives. The current initiative is the Fourth Trimester Initiative and uses the AIM post-partum bundle. That work concludes at the end of 2024 and then focus will be on a different AIM safety bundle, selected with input from both committees, participating hospitals, and informed by KMMRC data.

KHA encourages that CMS provides flexibility around the requirement to incorporate MMRC data and recommendations into hospitals' QAPI programs to ensure that data accessed and used is relevant to the type of facility, particularly for rural hospitals.

- *What challenges do facilities (including those in rural areas or geographically isolated areas) face in performing such data stratification (for example, administrative recordkeeping processes, information systems, patient willingness to disclose information, and staff time/expertise) and implementing maternal health equity related QAPI projects? How can such challenges be overcome? What is needed for facilities to collect and stratify data by diverse sub-populations?*

CMS could provide reimbursement for staff time to perform such data stratification and to build the systems necessary to appropriately meet these requirements and then utilize the results. A mandate without reimbursement jeopardizes the sustainability of health care facilities.

- *What types of data stratifications/subgroups/categories are key to ensuring the health and safety of all pregnant, birthing, and postpartum patient subgroups? How can facilities best ensure their subgroup data collection and analysis reflects the diverse subpopulations served? What is the benefit versus possible unintended consequences of CMS defining and requiring a minimum set of data stratifications/subgroup/categories in facilities' maternal health QAPI program analyses?*
    - *For example, should facilities be required to, at minimum, collect and stratify data by the subgroups included in MMRIA? How can facilities meaningfully acquire and disseminate subpopulation data in a way that avoids disclosure (that is, protecting individual privacy and confidentiality of their data), which can lead to increased vulnerability for underserved populations? How should facilities address stratifying small populations?*

There are hospitals in Kansas that serve rural communities where stratifying data by subgroups could likely lead to easy identification of who that patient is. KHA encourages CMS to provide flexibilities for rural and low-volume hospitals to enable hospitals to best protect individual privacy of patient information and confidentiality of the data. A one-size-fits-all approach in this situation not only is an ineffective approach, but it also risks infringing on patient privacy.

<u>Emergency Services Readiness</u>

CAHs are currently already meeting a nearly identical standard to what is proposed as part of existing CoPs, and we urge CMS avoid adding duplicative requirements which increases financial, administrative and staff burdens.

Additionally, KHA encourages CMS to review the proposal that requires CAHs to have a physician immediately available by phone on a 24/7 basis to receive emergency calls, provide information on treatment, and refer patients to the CAH or another location. CAHs currently must comply with a similar requirement which requires that a practitioner be on call or immediately available by phone and available onsite within 30 minutes on a 24-hour basis, and available within 60 minutes in frontier areas. CMS' proposal would require that a physician, rather than a non-physician practitioner, be available by phone 24/7, which is more difficult to meet in the face of the workforce shortages that many CAHs experience. **We encourage CMS to fix this discrepancy and finalize a requirement that is in line with § 485.618(d) to enable CAHs to continue to have a practitioner on call or immediately available onsite within 30 minutes on a 24-hour basis, or within 60 minutes in a frontier area.**

CMS further proposes hospitals have provisions used in treating emergency cases kept at the hospital and readily available, including blood and blood products. While these supply requirements are similar to existing CAH and REH standards for emergency services as well as the surgical services CoP, KHA stresses the concerns that our hospitals have with maintaining appropriate quantities of blood. Some rural hospitals have their blood supply controlled by the Red Cross, so therefore the hospital's ability to comply with this proposed requirement is out of their control. We thank CMS for providing some flexibility to hospitals to tailor their equipment and supplies to meet the needs of their patient populations but encourage CMS to take this into consideration when reviewing compliance of these provisions should this proposal be finalized.

Transfer Protocols

Hospital transfer protocols are necessary to ensure safe and effective care is provided to patients, however the proposed update to these CoPs should ensure that duplication is minimized and that the burden placed on providers is not undue. While CMS is considering improvements related to patient transfer, KHA stresses that CMS should **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.

- *How often should staff be trained in transfer protocols?*

Relevant staff should be trained upon hire and an annual refresher thereafter.

- *What definitions or criteria exist to determine if a transfer is carried out 'promptly and without undue delay'?*

While we are not commenting on the definitions/criteria that may exist, we urge CMS to keep in mind the enormous challenges that exist in states like Kansas with patient transport. As mentioned in a previous section, there are many challenges that impact promptness of a patient transfer. These limiting factors include bed availability at a receiving facility and resource availability of the local EMS that would be needed to transfer the patient.

- *Should all hospitals (inclusive of CAHs and REHs) be required to have a documented partnership with another hospital that provides OB services, as well as has a Medical Fetal Medicine (MFM) specialist available for consultations in urgent situations, if such service(s) are already offered directly by the hospital? What would be the benefits versus burden of such a policy? How could any burden be mitigated?*

We do not believe a hospital should be required to have a documented partnership in place for OB services, nor have a MFM specialist available if they already have those services at their facility. Additionally, there are not enough MFM specialists in Kansas to have a specialist available, or for rural hospitals consults in an emergency. If this was required, it would exacerbate workforce challenges by eroding already stressed call schedules and increase burnout. Efforts must be made towards reducing or preventing further maternity deserts, not feeding the issues that factor into closing OB services.

Thank you for the opportunity 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 CY 2025 proposed rule in order to serve our 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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