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June 10, 2024

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

RE: CMS-1808-P, RIN 0938-AV34 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

Dear Administrator Brooks-LaSure:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed FY 2025 rule related to the Medicare Program Hospital Inpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Payment Update

For FY 2025, CMS proposes an overall market basket update of 2.6%, which is even lower than the last two year increases of 2.8 and 2.7%. This update continues the trend of CMS issuing woefully inadequate payment updates that are not keeping up with the true level of inflation impacting health care and the country as a whole. It fails to account for the record-high inflation and persistent labor, supply and drug costs the hospital field has experienced in the last two years and continues to face.

A May 2024 report by the American Hospital Association highlights some of the cost increases hospitals are bearing right now:

- Overall inflation grew by 12.4% from 2021 through 2023 — more than twice as fast as Medicare reimbursement for hospital inpatient care, which increased by 5.2% during the same time.
- Labor costs increased by more than $42.5 billion from 2021 through 2023 to a total of $839 billion.
- Meanwhile, hospitals have had little choice but to turn to contract labor to fill shifts, spending approximately $51.1 billion on contracted staff in 2023.

In addition to this, from 2022 through June 2023, the number of days cash on hand for hospitals and health systems declined by 28.3%.[1] And other costs such as for prescription drugs and prior authorization policies are only adding to hospitals' financial burden. A recent report by the Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation found that in 2022 and 2023, prices for nearly 2,000 drugs increased faster than the rate of general inflation, with an average price hike of 15.2%.[2] And a 2021 study by McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations.[3] Additionally, a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials — more than half which was wasted on claims that should have been paid out at the time of submission.[4]

With these challenges, it's no surprise that hospitals are facing some of the hardest financial times in recent memory. According to data from WHA's most recent fiscal survey, in 2022, 86% of Wisconsin hospitals experienced decreasing margins and, in fact, 40% of Wisconsin hospitals operated at a negative margin.

The underpayments from Medicare have been driving these recent challenges. In Wisconsin, hospitals are paid only about 73% of what it costs to provide care to Medicare patients according to that same fiscal survey. And because Wisconsin is an aging state, it is seeing a large shift in people moving off private insurance and onto Medicare. From 2016 to 2022, the average payor mix for a Wisconsin hospital has seen Medicare grow from 45% to 50%, while commercially insured patients have shrunk from 37% of the payor mix to only 32% concurrently, according to claims data analyzed by WHA's Information Center. In fact, as of 2022, Wisconsin was tied for 11th among states with the highest percentage of their population covered by Medicare, at 21%. Due to this, **annual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.3 billion in 2022, an 86% increase in 6 years.** This problem can be particularly challenging for rural areas which tend to have a higher percentage of their population at a Medicare eligible age.

What's more, hospitals are increasingly are not being reimbursed for long patient stays and post-acute care they are providing. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019, leading hospitals to have to devote more staff time and expenses per patient episode. On top of this, according to a Baker Tilly report commissioned by the Wisconsin Department of Health Services, Wisconsin hospitals lost an estimated $465 million in uncompensated care from patients they have not been able to discharge due to the lack of available nursing home beds – patients hospitals are not receiving reimbursement for after their hospital care concludes.

Despite numerous financial pressures, hospitals have worked hard in recent years to keep costs down and do not seem to be driving price increases - in 2022 (the last year for complete data and first year post pandemic), medical inflation was 4.0%, hospital prices went up 2.2% but insurer prices increased 5.9%.

With these historic fiscal challenges facing hospitals, **we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

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[1] Syntellis. Hospital Vitals: Financial and Operational Trends Q1-Q2 2023. https://www.syntellis.com/sites/default/files/2023-11/aha_q2_2023_v2.pdf

[2] ASPE. (Oct 2023). Changes in the List Prices of Prescription Drugs, 2017-2023. https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs

[3] McKinsey & Company. (2021). Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf

[4] Premier. (2024). Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

Disproportionate Share Hospital (DSH) Payments

We are concerned with CMS' lack of transparency in how it calculates the uninsured rate as it is applied to DSH payments. In the FY 2024 final rule, CMS used an uninsured rate of 8.3% for FY 2024. In this rule, CMS proposes to use an uninsured rate of 8.7% for FY 2025. Yet, **millions of people are losing Medicaid coverage and becoming uninsured as the Medicaid continuous coverage requirements continue to unwind. As such, we expect to see a *larger increase* in the number of the uninsured in FY 2025. For instance,** the Kaiser Family Foundation finds that over a quarter of adults disenrolled from Medicaid are now uninsured. Yet, without seeing the methodology CMS used to calculate its estimates, it's difficult to understand how they came up with such estimates.

Area Wage Index

The area wage index is designed to adjust payments based on local differences in labor costs. WHA has often noted concerns about manipulation of the Medicare Area Wage Index in the prospective payment system. CMS has echoed these concerns in recent proposed rules, noting that results of making the rural floor budget neutral on a national basis, as required by the Patient Protection and Affordable Care Act Section 3141, is that all hospitals in some states receive an artificial wage index that is higher than the what the single highest urban hospital wage index would otherwise be. WHA has previously joined with associations in other states to garner support from Congress to address this patently unfair payment manipulation, which has specifically benefited hospitals in states on the east and west coasts and has been commonly referred to as the "Bay State Boondoggle."

WHA applauds CMS for continuing policies designed to restore fairness to the wage index, such as bringing up those hospitals in the bottom quartile and excluding urban hospitals that reclassify as rural from the overall calculation of each state's rural floor.

WHA opposed efforts by Congress to manipulate the rural floor by restoring the imputed rural floor for all-urban states. It was unfortunate that Congress included this blatant earmark in the American Rescue Plan Act of 2021, as it now continues to unfairly manipulate the wage index to benefit a handful of only-urban states and territories. With the Medicare Trust Fund facing more solvency concerns than ever, states should not be artificially steering a finite amount of Medicare taxpayer dollars by manipulating Medicare payment formulas.

WHA has also been made aware that certain Medicare Audit Contractors (MACs) may be taking different stances on whether to allow or how to calculate the allowable portion of contract labor when determining a hospital's wage index. Though it seems some MACs have taken steps to correct this after hospitals have appealed such actions, we urge CMS to ensure a uniform process is followed. For instance, WHA has a member health system that has submitted the same documentation regarding its contract labor and initially received different responses from the same MAC for some hospitals compared to other hospitals in its health system about whether contract labor would be allowed to be utilized for the wage index calculation.

This could have vastly unfair consequences given that the wage index is applied on a budget-neutral basis across the country if CMS does not find a uniform way to apply this. Since contract labor is inherently more expensive, it would unfairly advantage hospitals that are allowed to include a greater share of their contact labor compared to hospitals whose MACs who apply a different allowance for the use of contract labor in their hospital wage index calculation. **CMS must ensure this discrepancy is fully corrected in the final rule.**

Rural Hospital Provisions - Medicare-Dependent and Low-Volume Hospitals

The Consolidated Appropriations Act 2024 extended the current Medicare-Dependent (MDH) and Low-Volume Hospital (LVH) adjustment programs through the end of 2024. These programs serve hospitals with low volumes by giving them slightly enhanced payments above the PPS rate, but below the cost-based rate CAHs

receive. These enhanced payments are critical in sustaining "tweener" hospitals – those that are both too large to be eligible for critical access hospital status but too small to have the volumes that would otherwise help them offset the losses they experience treating Medicare and Medicaid patients.

WHA continues to advocate for a permanent extension of these important programs. In the meantime, we urge CMS to use its legal authority to make LVH payments to all current LVH hospitals. If Congress fails to act and CMS goes through with its current proposal, LVH payments would only extend to hospitals with less than 200 discharges, leaving only 21 of the current 585 LVH hospitals eligible for such payments. This could cut nearly $380 million annually in critical funding from these essential rural safety-net providers, threatening their financial viability. Losing these two programs would mean a nearly $20 million cut to approximately fifteen Wisconsin hospitals.

Graduate Medical Education - Distribution of Additional Residency Positions and Modifications to the Criteria for New Residency Programs

In adhering to the requirements of Section 4112 of the Consolidated Appropriations Act 2023, CMS proposes to prioritize hospitals serving health professional shortage areas in order to meet the requirement that at least 10 percent of slots go to each of the four categories of 1) rural areas; 2) hospitals operating above their residency cap; 3) hospitals in states with new medical schools; and 4) hospitals serving health professional shortage areas (HPSAs).

WHA is concerned that this proposal will unnecessarily end up excluding hospitals that unfortunately no longer reside in HPSAs due to HRSAs misguided shortage designation modernization project that, while well-intended, is exacerbating challenges for rural hospitals. For instance, around 25 Wisconsin hospitals lost their HPSA designations at the start of 2024 due to the way the Health Resources Services Administration updated its HPSA renewal process. Ironically, this is coming at a time when hospitals report growing – not shrinking – health care workforce staffing challenges. Additionally, some applicants for these GME slots have reported their concerns that relying too much on HPSA scores has unfairly led to the exclusion of their GME slot applications from consideration and has further discouraged other interested applicants from expending resources on an application that is unlikely to result in an award.

Wisconsin has currently seen no new slots awarded, despite having multiple entities who clearly fit at least one, if not more, of the 4 criteria in statute. Indeed, data shows the majority of slots CMS awarded so far were not distributed to geographically rural hospitals, but rather, urban and suburban hospitals that serve rural patients. This is clearly not following Congressional intent.

Additionally, WHA is concerned about CMS's proposal to modify criteria for new residency programs that would require hospitals to fit three primary criteria: 1) 90% of the residents are new; 2) the program director is new; and 3) the teaching staff are new.

We are concerned these criteria are too specific, and may inadvertently restrict legitimate new programs as well as penalize existing new residency programs that are currently in their five-year cap building process. CMS should clarify that such a proposal would only be effective for programs that begin after October 1, 2024.

Additionally, we urge CMS to provide more flexibility. For instance, due to the blind residency matching program, some programs may be unable to control whether they meet the 90% threshold. CMS should allow such programs to submit documentation supporting their intent to meet such a threshold in a way that would still allow them to qualify. Additionally, CMS should not finalize policies that restrict qualified program directors and teaching staff from joining new programs. It seems unwise to expect a new program to pass over a candidate that has successfully directed or taught in other residencies when trying to build a new program.

Hospital Quality Reporting and Value Programs

CMS monitors, rewards and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospital IQR Program, Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, Hospital Acquired Condition (HAC) Reduction Program, Medicare and Medicaid Promoting Interoperability Programs, and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. The FY 2025 IPPS proposed rule aims to promote accountability, transparency, and continuous improvement in hospital care delivery, ultimately enhancing patient outcomes and satisfaction while reducing costs. Our Wisconsin hospitals remain in a good position to reinforce the necessary tools and approaches to support quality improvement.

Hospital Inpatient Quality Reporting (IQR) Program

Hospitals are required to report data on measures and meet other administrative requirements to receive the full annual percentage increase (and avoid a reduction) for IPPS services. The IQR program also includes a requirement to report on selected EHR-derived electronic clinical quality measures (eCQMs) using CMS-mandated reporting standards. The IQR eCQM reporting requirements align with the eCQM reporting requirements in the Promoting Interoperability Program.

CMS proposes to add seven new measures: Two new electronic clinical quality measures (eCQMs), one claims-based measure, two structural measures and two healthcare-associated infection measures

Hospital Harm – Falls with Injury eCQM - CMS proposes to add a Hospital Harm – Falls with Injury eCQM measure to the menu of available IQR eCQMs beginning with the CY 2026 reporting/FY 2028 payment years.

The measure assesses the risk-adjusted ratio of hospitalizations with at least one fall with moderate or major injury. The measure includes a risk adjustment model that CMS asserts would ensure hospitals that care for sicker and more complex patients are evaluated fairly. The risk adjustment model accounts for age and certain clinical risk factors for falls, such as weight loss or malnutrition, delirium, dementia and other neurological disorders.

WHA supports the creation and use of options surrounding eCQMs. However, it will be important to first identify if hospitals have the technological capability to appropriately implement consistent screening technologies. CMS may consider allowing an additional year for hospitals to align technologies from both human and capital resource avenues. Thinking of a carrot vs a stick mentality, improved mobility is an approach to help reduce patient falls and therefore a measure could be considered that instead focuses on an increase in patient mobility.

Hospital Harm – Postoperative Respiratory Failure eCQM - CMS proposes to add this measure to the menu of eCQMs available for the IQR beginning with the CY 2026 reporting/FY 2028 payment years. The measure calculates the risk-adjusted rate of elective inpatient hospitalizations for patients aged 18 years and older without an obstetrical condition who have a procedure resulting in postoperative respiratory failure. Complementing our comments above, WHA supports having a menu of options for eCQMs. However, this will take time, and it is important that CMS first align the data capture across a variety of vendors to allow ample time for hospitals to evaluate their EHR capabilities.

Failure-to-Rescue Measure – CMS proposes to add this claims-based measure to the IQR beginning with the FY 2027 program year. The measure calculates the rate of deaths among certain inpatients following a preventable hospital-acquired complication. The measure would replace PSI-04 (Death Among Surgical Inpatients with Serious Treatable Complications) that CMS has proposed to remove from the IQR. WHA supports the replacement and agrees it would serve a broader patient population but would exclude patients whose complications preceded a surgical event. Having this measure claims-based would eliminate the

availability of clinical components of care and would pose a significant time lag like other claims-based measures ultimately leading to another measure with extremely lagged results.

Patient Safety Structural Measure - WHA asks CMS to reconsider the Patient Safety Structural measure being recommended. While patient safety is a top priority, asking hospitals to complete an all-or-nothing attestation is not a reliable measure nor a direct correlation for monitoring improvement in patient safety. Bundled attestations are difficult to show progress when multiple measures are called out in the all-or-nothing format. WHA is confident that our hospitals remain steadfast with their eye on quality and patient safety as evidenced by Wisconsin's CheckPoint website which provides WI hospital quality and patient safety data for the past 20 years for over 40 prominent measures.

While our hospitals weren't any different than hospitals nationally during the height of the pandemic, WI hospitals have rebounded to pre-pandemic quality levels in most measures (namely the hospital acquired conditions measures) even given the workforce challenges that all of healthcare is experiencing. WHA also feels that requirements around hospitals having and developing a quality and patient safety program are already covered in CMS' Conditions of Participation (CoPs) and assessed by accrediting and governing agencies. Several Wisconsin hospitals voluntarily choose to work with a Patient Safety Organization (PSO) and have additional data, education, tools, and networking at their disposal. The structural measure as written scores hospitals based on their response to a question if they submit safety events to PSO's for data reporting to AHRQ. This system is in conflict, awarding zero points to organizations that reply "no" thus no longer seemingly making the reporting of events to PSO voluntary. WHA will continue to reinforce the preference to only use outcome measures in CMS Value-Based programs and not structural or process measures.

Age-Friendly Hospital Structural Measure - WHA supports the focus CMS is reinforcing around Age-Friendly Health System processes. We have worked closely with our hospitals for several years around the implementation of the 4M's with many hospitals presenting their work at the state capitol during WHA's Advocacy Day events with a few hospitals winning state-based awards for quality and patient safety practices as leaders of the 4M's implementation system-wide. We recognize that this structural measure combines two measures previously under consideration by CMS which would appear to streamline the number of measures, however, we do not recommend the use of a structural measure that is then attestation-based and open to interpretation by the hundreds or thousands of users responding to those questions which leads to comparing apples to oranges and not apples to apples.

HAI Measures for Inpatient Oncology Locations - The IQR has long reported HAI measures such as catheter-associated urinary tract infections (CAUTI) and central-line associated blood stream infections (CLABSI). Further stratifying them by oncology unit is an easy way to hone in on caring for those patients and is accepted; however, the data should not be confused with each other when posting multiple measures of this clinical magnitude, it could lead to confusion among patients and community members trying to identify and accurately compare data.

HCAHPS Changes

CMS proposes to change several of the questions included in the HCAHPS patient experience survey for patients discharged on or after Jan. 1, 2025. CMS would in total add seven new questions, while removing four others. As a result, CMS would modify the composite sub-measures used to calculate overall HCAHPS performance in both the IQR and the HVBP programs. WHA supports the growing efforts to refine measuring patient satisfaction which is often linked to the quality of care received. While healthcare is progressively improving upon a patient-centered approach, measuring satisfaction allows providers to better understand patient and family experiences and tailor care accordingly.

WHA would like to ask CMS to consider if the new measure components were tested thoroughly enough and would be representative of a hospital making improvements. Asking a question with only one numerical

response for several healthcare providers at once will be difficult to discern and make changes upon. This is the reason there need to be separate and distinct questions regarding provider communication and nurse communication. CMS should consider that not every person a patient or family encounters is involved in knowing up-to-date information on a patient.

Modify the reporting and submission requirements for eCQMs

CMS proposes to add patients ages 18 to 64 to the current cohort of patients 65 years or older to the Global Malnutrition Composite Score eCQM with the CY 2025 reporting period. WHA agrees with the expansion of the Global Malnutrition Composite score.

Measure Removals
CMS proposes to remove five measures, beginning with the FY 2026 payment determination, including four payment measures because of the availability of more broadly applicable measures in the Medicare Spending Per Beneficiary Hospital Measures. WHA supports the measure removal due to redundancy of the measures in the IQR and HVBP programs as represented by the Medicare Spending per Beneficiary measure.

eCQM Reporting Requirements
CMS proposes a step-based increase in the total number of mandatory eCQMs reported by hospitals and cross-program modifications to the HCAHPS survey measure from six to 11. WHA would recommend for the step-wise addition of mandatory eCQM reporting a delay in order to analyze the broad applicability to the majority of hospitals prior to mandating that either 9 or 11 eCQMs be required (with only 3 being self-selected). This constitutes a huge jump in the number of required eCQMs and the capturing of those measures internally might not yet have a robust enough structure to demonstrate they are not yet feasible across a variety of hospitals. Also keeping in mind that IT staff in hospitals is often very limited in addition to EHR vendor lead-times to implement changes can often take several years to go-live. In the grand scheme of things and the sheer number of new measure requirements, this question is not realistic.

IQR data validation
CMS proposes to modify the current data validation scoring to implement two separate validation scores, one for clinical processes of care measures and one for eCQMs, and equally weighting them at 50% each (this has previously been weighted at zero to allow hospitals to gain familiarity with the eCQM reporting and validation) Given this approach, WHA would also recommend the delay of IQR validation changes with eCQM data tied to a large % penalty. WHA recommends a slower tiered approach that would start in CY 2026 or later given the number of eCQMs that are coming out as well as ensuring vendor data integrity.

<u>Promoting Interoperability Program</u>

Antimicrobial Use and Resistance - CMS proposes separating the Antimicrobial Use and Resistance (“AUR”) Surveillance measure into two distinct measures: (1) Antimicrobial Use (“AU”) Surveillance and (2) Antimicrobial Resistance (“AR”) Surveillance, beginning with the EHR reporting period in CY 2025, to encourage reporting of information if a hospital does not have sufficient data for one of them. CMS also proposes adding an exclusion for eligible hospitals or CAHs that lack discrete electronic access to data elements that are required for AU or AR Surveillance reporting. Additionally, CMS proposes modifying the applicability of the existing exclusions for the AUR Surveillance measure to apply to the proposed AU Surveillance and AR Surveillance measures, respectively.

WHA does not oppose these proposed changes given the additional burden to eligible hospitals is not significant and separating the measures makes sense given each measure’s differing specifications.

Scoring Threshold - CMS proposes increasing the minimum scoring threshold for eligible hospitals and CAHs from 60 points to 80 points due to 98.5% of hospitals reaching the 60-point threshold and changing to the

Global Malnutrition Composite Score eCQM to include a cohort of patients ages 18 to 64 in addition to the current 65-plus cohort.

WHA does not support the quick move to penalize over 1,000 hospitals not meeting the new threshold of 80 points in this next rule finalization. This does not allow ample time for hospitals to reevaluate their requirements and thus make necessary changes. This recommendation could be reconsidered later or placed in the final rule with an extension to CY 2027.

Separate IPPS Payment for Establishing and Maintaining Buffer Stocks of Essential Medicines

CMS has previously sought comments on the creation of a separate payment under the inpatient PPS for hospitals to establish and maintain access to a three-month buffer stock of one or more of 86 essential medicines prioritized in HHS' Administration for Strategic Preparedness and Response (ASPR) report Essential Medicines Supply Chain and Manufacturing Resilience Assessment.

In this rule, CMS proposes to make payments to small independent hospitals for the additional costs establishing and maintaining access to a six-month buffer stock of one or more of the essential medicines, referred to in the proposed rule as the "ARMI list" drugs. The purpose would be to act as a buffer in the event of an unexpected increase in product use or supply-chain issues.

WHA appreciates CMS' recognition of the challenges hospitals face in maintaining reliable access to medications that support the life and health of their patients. Yet, we are concerned about how this proposal would likely add complexity and increase the burden on a hospital workforce that is already stretched thin. WHA believes this program should have maximum flexibility for both hospital eligibility (including opening it up to CAHs) and hospital reporting, and CMS should consider up-front payments so that hospitals do not run into cashflow issues in setting up stocks.

CoP Requirements for Hospitals and CAHs to Report Acute Respiratory Illnesses

In 2020, CMS adopted a condition of participation via an interim final rule requiring hospitals to submit numerous data fields related to COVID-19 and other acute respiratory illnesses. CMS updated these requirements in 2022 to require this reporting from the conclusion of the public health emergency (PHE) through April 30, 2024. Now, CMS is stating it continues to need to monitor the impact of acute respiratory illnesses across the country to inform federal surveillance efforts, despite there being a reporting gap from April 30 until whenever this rule is finalized.

WHA has consistently expressed concerns over the need for CMS to enforce this via CoPs, especially considering hospitals were able to voluntarily report and share data via the federally funded healthcare emergency preparedness program utilizing tools like EMResource. Additionally, neither CMS nor other HHS officials were transparent about how the data hospitals reported was used by policymakers. For instance, Wisconsin hospitals seemed to be at a disadvantage compared to other regions of the country when it came to how allocations of federal supplies such as vaccines, therapies, and personal protective equipment were distributed during the height of the pandemic.

While it makes rational sense to think there may be value for federal policy makers having such data, unfortunately, said policy makers have yet to detail exactly what the utility of them having access to that data would be when it comes to assisting hospitals or other parts of the health care infrastructure in responding to respiratory disease outbreaks. Furthermore, WHA is concerned that CMS seems to be giving itself broad authority to make ongoing changes to reporting without following the notice and comment rulemaking process, particularly if the secretary perceives a "significantly likely" public health emergency even when it has not yet been declared.

For these reasons, WHA opposes making this data a CoP for hospitals. Time and again, hospitals have shown their ability to be nimble in responding to the various challenges thrown their way. CMS should recognize this and opt for a voluntary reporting process rather than a heavy-handed CoP. CMS could also explore ways to make the reporting process easier for all hospitals, should hospitals volunteer to share such data, such as utilizing seamless, automated reporting via electronic medical records.

RFI: Obstetrical Services Standards for Hospitals, CAHS and REHS

CMS notes that it intends to propose new COPs for Obstetrical services in the proposed 2025 outpatient (OPPS) rule and is looking for feedback on how it might design such COPs. CMS says its goal is to "ensure that any policy change to obstetrical services improves maternal health care outcomes and addresses preventable disparities in care but does not exacerbate access to care issues."

WHA agrees that for obstetrical care, the highest priority should be supporting hospitals that strive to continue to provide labor and delivery services for their communities, and not creating overlapping and overly prescriptive requirements to the provisions already in the hospital CoPs. Creating "baseline" requirements for care that has been in place for decades, and for a specialty like obstetrics with a well-established structure to guide measure and improvement of care, may just create an unnecessary layer of additional requirements that does not offer an advantage over current efforts.

Wisconsin is acutely aware of the disparities our population experiences in birth and maternal outcomes. Our birthing hospitals and obstetrics hospitals, in partnership with our community partners and supported by our state government, is directing great effort to address these disparities. Having to analyze, action-plan and comply with another set of requirements such as CMS proposes will take significant time without added benefit, and the time required may very well be taken away from the efforts already underway. Most dire, WHA is concerned that adding COPs may duplicate, or worse, conflict with requirement already in place, and that this may be the breaking point for hospitals that are already having difficult conversations surrounding whether they can sustain birthing services.

In other words, WHA is concerned that CMS will not realize its goal by adding COPs, and that such COPs will inadvertently exacerbate access to care – the very concern CMS is looking to avoid. ***As such, we request that CMS not move forward with adoption of CoPs for hospital OB services.***

Wisconsin hospitals, health systems and obstetrical teams have a great tradition of collaboration. As such, CMS' efforts to support hospitals and health systems coalescing around improvement efforts, as is already happening, is what will help make the most difference for maternal and newborn outcomes in our state. We agree there is always room for improvement, and obstetrics care is no exception. Instead of new heavy-handed regulations, CMS should be providing incentives that allow the greatest flexibility to support the unique community, provider and hospital needs with the aim to keep care as available and local as possible, especially in a state as rural as Wisconsin.

In addition, we are concerned that new hospital CoPs would only exacerbate the challenges hospital OBs currently face given the unlevel playing field that already exists with competition from stand-alone outpatient birthing centers. The regulatory burden on non-hospital birthing centers is already significantly less than on hospitals, even though hospitals are the safety net for out-of-hospital home and birth center deliveries when a mom or baby needs the specialty and emergency services of their community hospital. QSO-22-05-Hospitals notes this occurs in 18% of non-hospital deliveries.

Instead of new hospital CoPs, CMS should consider a novel approach aimed at leveling this playing field, such as expanding existing process or maternal and newborn outcome metrics to non-hospital birthing centers. Even though many of these providers, unlike hospitals, do not accept all patients, especially patients covered by Medicaid, adding this requirement for the birthing centers that do take their state's most vulnerable patients would provide CMS with an additional and helpful view of labor and delivery services across the

continuum of care. CMS might also require birth centers to answer a question hospitals that provide labor and delivery services already answer, "*Does your birthing center participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during ~~inpatient~~ labor, delivery and postpartum care, and has implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?*"

In addition, we support CMS exploring innovative payment and care delivery outcomes that strengthen, and incentivize rather than financially harm hospitals for providing OB services. Too often, the high costs associated with OB combined with the workforce shortages hospitals continue to face make them difficult to sustain, particularly when they are located in areas with high Medicaid & Medicare payor mixes and low volumes of commercially insured patients. CMS should be exploring how they might incentivize or assist states with offering higher Medicaid reimbursement or other ways to shore up losses and incentivize the provision of coordinated care across the maternal health continuum.

WHA appreciates the opportunity to provide comments on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO