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September 9, 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-1809-P] Medicare Program: 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 *(Vol. 89, No. 140), July 22, 2024.*

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 CY 2025 rule related to the Medicare Program Hospital Outpatient 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.

CMS's Proposed Payment Update is Inadequate Given Continued Inflation and Other Cost Increases

In this rule, CMS proposes to update outpatient rates by 2.6% for calendar year (CY) 2025. Together with other changes in the rule, hospitals would see a net increase of 2.4%. This update continues CMS's recent trend of payment policies that do not acknowledge the true level of inflation and cost increases impacting health care and the country as a whole. It fails to account for the persistent labor, supply and drug costs the hospital field has experienced in the last three years and continues to face. ***Given such cost increases caused by inflation over the last few years, the market basket is inadequate, particularly when taken together with the insufficient increases that greatly lagged true inflation in CY2022, CY 2023, and CY 2024.***

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 care, which increased by 5.2% on the inpatient side 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. After going more than a decade without any hospital closures, in 2024, two Wisconsin hospitals closed their doors as a result of experiencing losses of $56 million in the preceding two years.

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%.

[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

With these continued 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.***

Proposed Payment Change for Diagnostic Radiopharmaceuticals

WHA appreciates CMS' proposal to pay separately for diagnostic radiopharmaceuticals with per-day costs above $630. Prescription drug costs are among some of the fastest rising costs facing hospitals on both the inpatient and outpatient side, and are mostly outside a hospital's control. This is especially true for specialized diagnostic radiopharmaceuticals, of which there may be no alternative treatment options when such products are required. Overall drug costs increased by 37% from 2019-2021 according to a 2023 Report by the American Hospital Association, and by even more for 340B hospitals who are no longer receiving the full level of discounts for patients served by community contract pharmacies, or who are increasingly seeing pharmacy benefit managers siphoning away 340B savings intended for hospitals.

Access to Non-opioid Treatments for Pain Relief As directed by the Consolidated Appropriations Act of 2023.

In accordance with the Consolidated Appropriations Act 2023, CMS proposes to implement temporary additional payments for specific non-opioid treatments for pain relief dispensed in the HOPD and ASC settings from Jan. 1, 2025, through Dec. 31, 2027. The agency proposes six drugs and one medical device that would qualify for these payments, which would be paid separately.

WHA Supports CMS's proposal to implement these changes designed to combat the opioid epidemic. WHA supports congressional and CMS payment policies that recognize the full spectrum of approaches to treating pain, including non-opioid drugs and devices.

Telehealth Policies

WHA continues to advocate for a permanent or long-term extension for Medicare coverage of telehealth, and urges CMS to work with Congress to extend the COVID-19 PHE waivers that made the current gains in telehealth possible. CMS notes in this rule, that barring Congressional action, providers will no longer be able to bill for remote outpatient therapy, diabetes self-management training and medical nutrition therapy beginning Jan. 1, 2025.

Telehealth has been a vital tool for hospitals attempting to combat workforce shortages. Hospitals are currently utilizing telehealth to extend specialty care to more remote areas of the state and to staff essential services like hospitalists and ICUs when other providers are unavailable, often during late-night shifts.

Likewise, WHA applauds CMS's proposal to extend virtual supervision flexibilities through 2025 for cardiac rehabilitation services, intensive cardiac rehabilitation, and pulmonary rehabilitation. With workforce challenges continuing to be a top concern for hospitals, this type of flexibility is crucial for maximizing access to patient care, particularly with aging demographics continuing to lead to projections of an undersupply of qualified health care providers necessary to treat a growing patient population.

Outpatient Quality Reporting (OQR) Program - Proposed New Health Equity Measures

CMS proposes to add three health equity measures to the OQR program: the HCHE measure, the Screening for SDOH measure, and the Screen Positive Rate for SDOH measure.

CMS proposes the adoption of three health equity measures across three programs: the Hospital Outpatient Quality Reporting (OQR) Program, the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, and the

Rural Emergency Hospital Quality Reporting (REHQR) Program. CMS also proposes to modify its policies for measures that raise patient safety concerns by imposing an immediate measure suspension policy.

1. Hospital or Facility Commitment to Health Equity Measure

CMS proposes to add an attestation-based structural measure —Hospital Commitment to Health Equity (HCHE) for outpatient hospital departments and Facility Commitment to Health Equity (FCHE) for ASCs and rural emergency hospitals (REHs)—starting with the CY 2025 reporting period/CY 2027 payment determination. The HCHE measure is currently included in the Hospital IQR and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) programs and the FCHE measure is included in the inpatient psychiatric facility QRP and end-stage renal disease quality incentive program. Both measures require attestation to health equity across five domains: strategic priority, data collection, data analysis, quality improvement, and leadership engagement, with some domains having multiple components.

WHA appreciates the focus on health equity and the standardization across programs but notes a few inconsistencies that could be aligned for clarity. First, the HCHE measure specifications reference hospitals while the FCHE measure specifications reference facilities. Additionally, domain 2C of the HCHE measure requires hospitals to use certified EHR technology (CEHRT) for attestation, whereas FCHE requires only EHR technology without specifying CEHRT.

WHA urges CMS to allow hospitals to report the measure for the entire organization, rather than separately for inpatient and HOPD parts of the organization, as CMS has allowed for other measures such as health care personnel vaccination.

2. Screening for Social Drivers of Health (SDOH) Measure

CMS proposes adopting the SDOH measure for the OQR, ASCQR, and REHQR programs, starting with voluntary reporting in 2025 and mandatory reporting in 2026. This measure, which assesses screening for five health-related social needs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) among patients 18 and older, has already been implemented in the hospital IQR program, where mandatory reporting began in 2024.

WHA appreciates the alignment of this measure across programs and recognizes its value in identifying and addressing gaps in care for vulnerable populations. WHA recommends allowing hospitals and facilities to use their own screening tools while being provided recommended tools and processes. Additionally, since screening will take place in both inpatient and outpatient populations, CMS should clarify the denominator for outpatient populations to focus on those receiving office visits rather than "receiving services from an HOPD, as not all involve appropriate environments for screening. Lastly, CMS should evaluate the effectiveness of data collection, including consistency across care settings. It should consider keeping IQR reporting separate from OQR, which may add extra burden, but will help ensure a more accurate data picture initially allowing for improved consistency in data collection over time.

3. Screen Positive Rate for SDOH Measure

The Screen Positive Rate for SDOH process measure is a companion measure to the Screening for SDOH measure. While the Screening for SDOH measure identifies individuals with health-related social needs (HRSNs), the Screen Positive Rate for SDOH measure assesses the prevalence of these needs and their impact on healthcare utilization. CMS proposes to adopt this measure for the OQR, ASCQR, and REHQR programs, starting with voluntary reporting in 2025 and mandatory reporting in 2026.

The Screen Positive Rate for SDOH measure reports the percentage of patients, aged 18 or older, at HOPD, REH, or ASC settings who were screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) and tested positive for one or more

HRSNs. Hospitals and facilities would report the measure as five separate rates, one for each screening domain, calculated by the number of screen-positive patients divided by the number of patients screened.

WHA is concerned that data collection alone will not address existing care gaps without actionable steps. Capturing and addressing patients' needs, connecting services and closing the loop will be challenging without an IT infrastructure to support tracking mechanisms, which will be necessary to make meaningful progress over time. The current lack of clarity on the link between positive HRSN screens and actual service utilization or service availability, combined with ambiguous data interpretation and expectations for health care facilities also will create challenges.

Given these concerns, WHA recommends reporting of this measure be voluntary initially, with mandatory reporting implemented only after the measure has proven to be valid, reliable, and useful for advancing health equity. Hospitals should also only be required to report de-identified and aggregate data to CMS, without providing patient-level data.

Proposed Information Transfer Pro-PM

CMS proposes adopting the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery (Information Transfer PRO-PM) measure, starting with voluntary reporting in CY 2026 and mandatory reporting in CY 2027 for CY 2029 payment determinations.

The Information Transfer PRO-PM evaluates how clearly patients aged 18 or older receive recovery information following surgery or procedures in an HOPD. It measures average survey scores based on three domains: Applicability to Patient Needs, Medication, and Daily Activities, using a survey administered 2-7 days post-procedure and nine corresponding items for patients and their caregivers to rate the clarity of information received about their post-discharge recovery.

WHA has concerns that the same information is repeatedly asked across multiple surveys. Over-surveying patients may cause confusion about what aspect of their care is being assessed. Additionally, the measure does not account for the quality of information provided, general literacy, or health literacy. The subjective nature of the questions also does not reveal what information is missing or how it could be clarified.

WHA recommends CMS use methods like 'teach-back' before the procedure to ensure effective understanding of recovery information, as direct discussions are more reliable than surveys alone. CMS could also consider conducting follow-up surveys during provider appointments if feasible. Due to our concerns, WHA recommends CMS keep this measure voluntary for the foreseeable future. As patient-reported measures become more common, we expect improvements in data capture and action. The voluntary reporting period allows time for setting up collection systems or engaging with third-party vendors, such as those used for HCAHPS.

Proposed Removal of Measures

CMS proposes removing two measures starting with the CY 2025 reporting period/CY 2027 payment determination:

- **MRI Lumbar Spine for Low Back Pain Measure:** CMS has found that national performance remains stable with low average volumes and that the measure may not correlate with improved imaging use. The agency proposes removal due to limited potential for improving patient care.
- **Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery Measure:** CMS notes that the measure has limitations in interpreting performance trends and may not provide meaningful data, with no significant room for national performance improvement.

WHA supports the removal of these measures, as they no longer hold CBE endorsement and expert evidence indicates they are not meeting their intended purpose.

EHR Certification Requirements for eCQMs

The hospital IQR program and Medicare Promoting Interoperability Program require EHRs to be certified to all available eCQMs in the measure set of the respective program to ensure that the technology is up to date and tested on each eCQM. CMS proposes that starting with the 2025 reporting period/2027 payment determination, HOPDs must use EHR technology certified to the ONC health IT certification criteria for all eCQMs available under the Hospital OQR program. Additionally, HOPDs would need to use the most recent eCQM measure specifications from the Electronic Clinical Quality Improvement Resource Center website.

WHA supports the promotion of eCQMs, provided there is sufficient lead time for facilities that are not currently using them to prepare their infrastructure.

Public Reporting of Measure Data

The Median Time from ED Arrival to Departure for Discharged ED Patients measure, which currently is chart-abstracted and stratified by diagnosis, evaluates the time from ED arrival to departure stratified into four different calculations based on patient diagnosis. In the CY 2024 OPPS final rule, CMS included data for three strata but excluded the psychiatric/mental health stratum. CMS notes that variations in throughput times across strata suggests additional room for improvement for patients seeking care in the ED for behavioral health concerns and now believes that including data for psychiatric/mental health patients could drive improvement and help patients and caregivers make informed decisions. CMS proposes to display this data on Care Compare starting in 2025, which was previously available on data.medicare.gov but not on Care Compare.

WHA opposes the proposal to include the psychiatric/mental health patients' stratum in the Care Compare display as mental health emergencies differ significantly from physical health emergencies, and the ED is not usually the best setting for such crises. There is insufficient evidence that changes in wait times impact mortality or other outcomes for this diagnosis. Additionally, publicly reporting this data alongside overall rates would be confusing and counterproductive, likely having little effect on decision-making during a mental health crisis.

Hospital Inpatient Quality Reporting Program – Hospital IQR

In the hospital IQR program, CMS previously established two hybrid quality measures under the Hospital Inpatient Quality Reporting (IQR) Program: the hybrid hospital-wide readmissions (HWR) and hybrid hospital-wide mortality (HWM) measures. Hybrid measures use several data sources: 1) core clinical data elements (CCDEs), which are clinical variables derived from EHRs that can be used to adjust hospital outcome; 2) linking variables from administrative data that can be used to link the CCDEs and administrative claims data for measure calculation; and 3) claims data. Hospitals are required to submit linking variables on 95% of hospital discharges and CCDEs on 90% of discharges in a reporting period. CMS established initial voluntary reporting periods for both measures. CMS previously finalized mandatory reporting beginning with the FFY 2026 payment determination — based on performance data from July 1, 2023, through June 30, 2024 — with data submission required by September 30, 2024. However, based on its experience during the voluntary reporting periods, CMS has noted that that about three-fourths of the participating hospitals would not have met the reporting thresholds.

WHA supports CMS' proposal to delay mandatory reporting for a minimum of 1 year to address issues and develop experience with reporting CCDEs and linking variables. This will remain voluntary for the FFY 2026 payment determination and becomes mandatory beginning with the FFY 2027 payment determination.

A hospital's annual payment determination would not be affected by the voluntary reporting of CCDEs and linking variables, but CMS would evaluate and assess the claims data portion of the measures (and those

measures would be publicly reported based on claims data). In the spring, as a preview of public reporting, hospitals would continue to receive confidential hospital-specific reports, which would reflect the CCDEs and linking variables if hospitals chose to report them. WHA supports the reports being provided to hospitals for further assessment.

Hospital Quality Star Rating Request for Information (RFI)

The Overall Hospital Quality Star Rating assigns hospitals a rating from one to five stars based on publicly reported hospital performance on quality measures in five categories: Safety, Mortality, Readmissions, Patient Experience, and Timely & Effective Care. CMS is considering changes to this methodology, as the current system occasionally awards five-star ratings to hospitals that performed in the bottom quartile in Safety of Care measures.

Here are the three options being considered for modifying the Star Rating methodology:

1. **Reweighting the Safety of Care Measure Group:** Increase the Safety of Care group's weight to 30%, reducing the weights of other groups proportionally (so that Mortality, Readmission, and Patient Experience would each be weighted to 19.7% and Timely and Effective Care to 10.8%). This change could lower the number of hospitals with poor safety ratings achieving a five-star rating but may also lessen the influence of the other measure groups.

   WHA recommends exploring this change to see if it resolves the issue of low safety ratings coexisting with high overall ratings. Consideration should be given to equal weighting for Safety of Care and Mortality for determining a hospital's star rating, because for instance, it could create a situation where a hospital that reduces mortality rates is making a significant improvement, but could still be penalized if fewer patients expire.

2. **Policy-Based One-Star Reduction for Poor Performance on Safety of Care:** Reduce the star rating of any hospital in the lowest quartile of Safety of Care by one star, without dropping below one star. Even hospitals that perform very well in all other measure groups would still be subject to the one-star reduction.

   WHA is cautious about this approach but is interested in seeing data comparisons to assess, for example, if a hospital receiving a 4-star rating still holds merit and doesn't significantly downgrade them for low safety-of-care ratings.

3. **Reweighting the Safety of Care Measure Group Combined with Policy-Based Star Rating Cap:** Reweight the Safety of Care group as described in option 1 and cap the star rating at four stars for hospitals in the lowest quartile of Safety of Care. CMS' analysis showed this option provided a more targeted approach that restricted the five-star rating to hospitals that achieve a minimum threshold in Safety of Care.

   Key considerations for star ratings include:
   - Bias Towards Larger Hospitals: Ratings may favor larger hospitals with more resources and better data collection capabilities.
   - Impact of Social Risk Factors: Hospitals serving high-risk populations might be unfairly penalized despite providing high-quality care under challenging conditions.
   - Complexity and Transparency: The rating methodology can be complex and opaque, making it difficult for hospitals to understand and improve their scores.
   - Measure Relevance: Some measures may not apply equally to all hospitals, especially those specializing in specific types of care or serving unique patient populations.
   - Potential for Gaming the System: Hospitals might focus on improving scores for specific measures rather than overall care quality, leading to misaligned incentives.

As CMS has itself acknowledged, overall Star Ratings do not provide a comprehensive view of quality but reflects performance on selected measures chosen by the agency. In other words, Star Ratings alone do not determine the best hospital, so altering the weighting of specific measures may not necessarily make higher-rated hospitals safer. WHA is interested in reviewing any further analysis CMS has on these proposed modifications and their potential effects on various types of hospitals.

Conditions of Participation for Obstetrical Services Standards for Hospitals, CAHS and REHS

CMS noted in its 2025 IPPS rule that it intended to propose new COPs for Obstetrical services in this proposed 2025 outpatient (OPPS) rule and solicited feedback on how it might design such COPs. CMS said 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."

As stated in our 2025 IPPS comment letter, 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 withdraw its proposal to add new CoPs for hospital OB services. While Wisconsin hospitals view themselves as enthusiastic partners in trying to improve outcomes for OB and maternal health services, CMS should be seeking a carrot rather than a stick approach.***

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.

Proposed Changes to Review Timelines for HOPD Prior Authorizations

In this rule, CMS proposes to change the response timeline for standard prior authorization (PA) requests for outpatient department services from 10 business days to 7 calendar days, aligning the policy with the CMS Interoperability and Prior Authorization final rule from January 2024 that requires impacted payers to respond to a standard PA request within 7 calendar days.

***WHA strongly supports efforts to improve the prior authorization (PA) process, which is increasingly having negative impacts on health care providers and the patients they serve*.** The flaws in current PA policies exacerbate workforce shortages by taking clinicians out of the role of providing care and into the role of denying, reviewing, and overturning claims – it also is a significant factor in clinician burnout.

In fact, Data from Crowe RCA Consulting's *Time for a Commercial Break* report showed that 15.1% of all commercial/managed care hospital claims are initially denied, while most end up being overturned after hospital staff, including clinical staff, appeal the denial. And, according to a WHA survey of its members from 2023:

- 87% of commercial claims initially denied get overturned.
- Certain payers can routinely take 6 months or more to process claims.
- Some payers require appeals to be paper-mailed which can take at least 60 days.

Furthermore, n article published by HFMA in 2021 and written by Dr. Alan Kaplan, CEO, and Abigail Abongwa, VP Revenue Cycle at UW Health identified that prior authorization processes cost the Wisconsin health system $18.2 million and requires at least 65 FTEs.

While WHA understands CMS's reservations about changing its existing requirement that MACs respond to expedited prior authorizations in no more than two business days, fearing such a change could increase PA delays, nevertheless, WHA urges CMS to address PA requests that occur immediately preceding a holiday or weekend. Hospitals do not take off weekends or holidays, nor do the illness experienced by the patients they treat. CMS must find a reasonable policy to ensure patients do not experience untimely delays

Medicaid Clinic Services and Four Walls Exceptions

Current federal Medicaid policies prohibit Medicaid from paying for clinic services provided outside the four

walls of a clinic, except when providing care to unhoused individuals. CMS proposes to add three exceptions: Indian Health Services/Tribal Clinics, behavioral health clinics, and clinics located in rural areas.

WHA supports these efforts to expand access to care and recognize innovations in care. Recent programs such as the Acute Hospital Care at Home program (which WHA urges CMS to work with Congress in seeking a permanent extension) have shown a willingness by CMS to give hospitals and health care providers more flexibility in treating patients with innovative new care models, often decreasing costs and improving patient outcomes in the process. WHA and its members support continued efforts like this to increase options for providers and patients alike.

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

Sincerely,

Eric Borgerding
President & CEO