FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

June 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

Re: CMS-1808-P, Calendar Year (CY) 2025 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:

As a leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to respond to the Medicare Hospital Inpatient Prospective Payment System (IPPS) regulation for Calendar Year 2025. For more than 40 years, Families USA has been dedicated to the achievement of high quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation — improvements that make a real difference in people's lives.

We support policies that advance health equity and racial justice across the health care system so that no person living in the United States faces barriers to living a healthy life because of who they are, where they live or how they identify. Medicare payment policy establishes a standard often adopted by other payers, including commercial insurers and Medicaid. Changes made through the Hospital IPPS rule offer an important opportunity to both strengthen the Medicare program and to signal to other payers the need to realign the economic incentives of health care payment and delivery to reduce inequities and drive towards a higher value health care system.

The following policy recommendations would go a long way to catalyze the transformational change needed in our payment system to drive equitable, high-value care in health care markets throughout the U.S. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments are focused on the following sections of the proposed rule:

- II.C.12(c)(1). Proposed Changes to the Severity Level Designation for Z Codes Inadequate Housing and Housing Instability
- IX.C. Requirements for and Changes to the Hospital Inpatient Quality Reporting (IQR) Program
- X.A. Proposed Transforming Episode Accountability Model (TEAM)
- X.C. Maternity Care Request for Information (RFI)
- X.D. Request for Information on Obstetrical Services Standards for Hospitals, CAHs, and REHs

II.C.12(c)(1). Proposed Changes to the Severity Level Designation for Z Codes Inadequate Housing and Housing Instability

Families USA supports CMS's proposal to change the severity level designation of seven ICD-10-CM Z codes that describe inadequate housing and housing instability from "non-complication or comorbidity" (nonCC) to "complication or comorbidity." (CC)

ICD-10-CM Z codes are diagnosis codes that health care providers can use to document social drivers of health (SDOH) data[1]. These codes allow providers to capture the health-related socioeconomic, psychosocial and environmental circumstances that drive variations in people's health outcomes, such as housing instability, food insecurity, transportation difficulties and unemployment.[2] Given that 80-90% of what drives variations in people's health is determined by these circumstances, collecting SDOH data and mapping that data to Z codes is an essential tool for building a reimbursement system that enables and financially incentivizes clinicians to deliver the services that drive health improvements.[3] Not only are these codes integral to data collection, Z codes can also influence the payment amount a health care system receives for treating a patient.[4] IPPS payments are generally made based on the use of hospital resources in the treatment of a patient's illness or injury, reflecting the complexity of the diagnosis and the utilization of goods and services for their care.[5] Designating a diagnosis code at a higher severity level results in higher payments to reflect a more resource-intensive episode of care.[6] As a result, increasing the severity designation of Z codes within the IPPS can result in larger payments to health systems for care provided to individuals with distinct social needs.[7]

Homelessness and housing instability are widely acknowledged by policymakers and researchers to be among the most crucial social drivers of health.[8] As of 2022, over 580,000 Americans were experiencing homelessness, with nearly a third of these individuals being members of families with children.[9] Both homelessness and housing instability (which may include difficulty paying rent, moving frequently and living in overcrowded conditions[10]) give rise to and exacerbate health conditions.[11] Homeless individuals are far more likely to experience diabetes, hypertension, HIV, serious mental illness and substance use disorders than those who are stably housed. [12] Homelessness also complicates recovery from injury and illness and homeless individuals, on average, die twelve years earlier than the general U.S. population. Housing instability has also been associated with poorer mental health, higher stress levels and increased risk of infectious disease.[13]

Families USA strongly supports CMS's proposal to change the severity designation of the Z codes associated with housing instability which will increase reimbursement for providers who treat people experiencing housing instability and incentivize hospitals to address housing instability among the patient populations they serve. It will also encourage providers to ask more detailed questions of patients to better understand their housing status, improving overall data quality.

In addition to adopting a higher severity level for Z codes related to housing instability, CMS should asses the severity level designations of other SDOH diagnosis codes that may impact hospital resource use, such as lack of adequate food and drinking water, problems related to employment and unemployment, extreme poverty and problems related to psychosocial circumstances (such as imprisonment and other incarceration). Each of these factors has been demonstrated to influence health outcomes and health risk behaviors.[14]

As part of CMS's effort to improve the collection and reporting of SDOH, it is critical to improve the collection of disaggregated data by a broad set of sociodemographic characteristics to drive

reductions in health disparities and improvements in health outcomes. Families USA strongly urges CMS to require all hospitals to collect and report on disaggregated data by a comprehensive set of sociodemographic factors, such as race, ethnicity, preferred language, gender identity, sexual orientation, age, ability status, geographic location and socioeconomic status. This data should be collected using the evidence-based best practice of self-reported data.[15] There are two key approaches hospitals should consider in operationalizing self-reported data methods:

1. Planned Procedures: Conduct surveys with patients prior to admission as part of the pre-contact, check-in process where patients are asked to complete and verify demographic information, medical history and insurance status;
2. Emergency Visits: Conduct surveys with patients when the patient is stable during the time of insurance verification.

Finally, while we applaud CMS for these policy changes that will make it easier for clinicians to address the social drivers of health, we also believe it is imperative that CMS continue to take steps towards more fundamental payment and delivery reforms, including a complete reorientation away from the current health care payment system and its overreliance on fee-for-service (FFS) economics. FFS incentivizes a very narrow view of health and health care by signaling to providers that they can only be reimbursed for delivering the clinical care that drives only 10-20% of health.[16] Reorienting the health care system to advance health equity by directly addressing the social drivers of health can be better accomplished under alternative payment models (APM). APMs shift the economic incentives of health care payment away from fee-for-service and hold the promise of ensuring health care providers are accountable for high value, whole person care.

IX.C. Requirements for and Changes to the Hospital Inpatient Quality Reporting (IQR) Program

Hospitals are essential to the U.S. health care system, often serving on the frontlines of diagnosing, treating, and managing patient illness and disease — and therefore play a significant role in driving individual and population health improvements for our nations families and communities. Unfortunately, too many hospitals have become large corporate entities focused on maximizing revenue at the expense of improving health, which has distorted health care access, delivery, and outcomes nationwide and exacerbates the deep inequities experienced by marginalized communities.[17] Hospitals across the nation have closed maternity wards, cut behavioral health services and ended contracts with nurses to maximize profits.[18, 19, 20,21]

Given the essential role of hospitals in our health care delivery system, it is essential to build a robust infrastructure to hold hospitals accountable for driving improvements and reducing inequities in health outcomes in the communities they serve. One of the most important tools to unveil and hold hospitals accountable for providing high quality, equitable care that improves health outcomes are equity, quality, and outcome measures. These measures should be integrated into all hospital quality reporting programs, including the Hospital Inpatient Quality Reporting (IQR) program.

CMS has made significant strides in incorporating health equity into the Medicare IQR program and other quality reporting programs with the adoption of the Screening for Social Drivers of Health measures and the formation of the MAP Health Equity Advisory Group. Despite these gains, racial and ethnic health disparities in maternal health, chronic health conditions, and life expectancy remain and continue to grow.[22, 23, 24] Quality and outcome metrics collected by hospitals are a key tool in identifying these disparities and developing solutions to achieve health equity.

Families USA recommends that CMS make the following changes to the IQR program to ensure all hospitals are held accountable for closing the equity gap for Medicare beneficiaries across hospital inpatient care:

1. **Require all hospitals participating in the IQR program to collect patient-reported demographic data** disaggregated by race and ethnicity, as mandated in the Office of Management and Budget's Policy Directive No. 15, as well as primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and ability status through the adoption of an evidence-based standard for data collection.

2. **Standardize the collection of the Social Drivers of Health measures** to be in line with research based best practices. We applaud CMS for mandating the collection of both SDOH-1, "Screening for Social Drivers of Health" and SDOH-2, "Screen Positive Rate for Social Drivers of Health", measures in the IQR program. However, steps must be taken to ensure that this data is standardized across health systems by providing guidelines on how hospitals must code SDOH measure data in their electronic health records. Standardization of the SDOH-1, SDOH-2 and any future SDOH intervention measure, will ensure that this data is interoperable across health systems. Further, interoperability of SDOH data with community partners, namely partners who do and can provide social resources to patients, will ensure that patient's comprehensive needs are being met and communities are better understood. In Alameda County, California, a care coordination and data-sharing model was developed that brings together clinical, behavioral health care, housing and crisis response data to improve care management and coordination.[25] **Families USA recommends that CMS identify best-practices around SDOH measure collection by partnering with stakeholder groups such as the Gravity Project - who have worked to establish consensus on SDOH measures and build data standards for the interoperability and use of this data.**[26]

3. **Require all hospitals participating in the IQR program to report on social need interventions** to promote actions to address social drivers of health. Both SDOH measures within the IQR program, SDOH-1 and SDOH-2, fail to collect data on how hospitals respond to positive social needs screenings.[27, 28] For example, SDOH-1 measures the facilitation of a screening for social drivers of health, and SDOH-2 measures whether that screening result was positive. However, these measures do not account for whether hospitals connect patients with a positive SDOH screening to additional health care services to address the underlying social driver of health captured in the screening tool.[29] As a result, there is insufficient data and quality measurement to ensure that hospitals are using the SDOH screening tools to make appropriate referrals and connect patients to needed health care. This is a major barrier to effectively managing the health outcomes of a population and an individual, and the ability to drive meaningful improvements in health equity. **We therefore recommend that CMS develop, validate, and adopt a measure to account for social need interventions following a positive SDOH screening into the IQR program, such as the HEDIS Social Needs Screening and Intervention measure (SNS-E).**[30]

4. **Add disparities-sensitive measures into the electronic clinical quality measures (eCQM) set** to enable more immediate remediation of disparities. eCQMs allow CMS to streamline the assessment of quality metrics and drive improvements through submission of measure data directly into an electronic health record.[31] In their "Health Equity Final Report," the Core Quality Measures Collaborative found 19 measures to be highly disparities-sensitive, meaning they are measures that are of high clinical priority or are associated with high disparities, and include many patients

affected by one or more social risk factors.[32] Adding several of these measures to the eCQM would allow CMS to more immediately assess measures that negatively affect certain communities and allow hospitals to more swiftly address those disparities in care delivery. **Families USA specifically recommends the adoption of the "controlling high blood pressure" measure and the "HIV viral load suppression" measure, for which there are notable disparities for communities of color and the LGBTQ+ community, respectively.[33,34]**

5. **Adopt two key geriatric-specific care measures to improve geriatric health.** While current IQR measures include geriatric populations in data samples, they fail to identify shortcomings specific to the health care delivered to older adults and therefore likely mask gaps in care and geriatric needs more broadly.[35] **We recommend that CMS adopt the Geriatric Hospital (MUC2022-112) and Geriatric Surgical (MUC 2022-032) measures either individually or in a combined format to reduce administrative burden.**

X.A. Proposed Transforming Episode Accountability Model (TEAM)

Families USA strongly supports the establishment of the mandatory Transforming Episode Accountability Model (TEAM). The TEAM is a five-year, mandatory, episode-based payment reform model that would hold selected hospitals responsible for the quality and cost of care for beneficiaries undergoing certain high-cost surgical procedures.[36] Episode-based payments, also known as bundled payments, provide capitated reimbursement for all treatment costs over the course of a defined clinical period.[37] Bundled payments are an example of value-based payments that hold providers accountable to delivering effective, efficient, and appropriate care.[38] The development of TEAM and the proposal to make the model mandatory, reflect CMS's continued investment in shifting Medicare reimbursement away from the perverse incentives of FFS economics towards alternative payment models, as well as a commitment to increase the number of mandatory payment models across the health care system.

While the Center for Medicare and Medicaid Innovation (CMMI) has tested more than 50 payment models over the past decade, the vast majority of these models opt for voluntary provider participation.[39] Voluntary payment models allow providers to self-select into a model, and can lead to "selection bias" where providers participate in the model that is most lucrative to them, rather than the model that is best for patients or Medicare spending.[40] By removing this potential for distortion in results, mandatory payment models are more likely to achieve results that could be scalable across the health care system and could therefore increase Medicare savings. [41,42]

As a result, Families USA strongly supports CMS's efforts to implement more mandatory payment models including the proposed mandatory bundled payment model. [43] We are also supportive of CMS offering flexibility to hospitals that care for a higher proportion of underserved individuals, such as safety net hospitals, by allowing several tracks for participation in the model, which have varying levels of financial risks and rewards. Additionally, we commend CMS for including a social risk adjustment in the model's target pricing methodology and for requiring participating hospitals to submit a health equity strategy and sociodemographic data to CMS.

In addition to TEAM's existing health equity components, **we request that CMS ensure financially vulnerable health care providers, such as rural, safety net and community hospitals are adequately protected from the financial risks associated with participating in an alternative payment model by**

providing upfront infrastructure payments to qualified hospital participants. Upfront infrastructure payments could be used by rural, safety net, and community hospitals to support development of data analysis and collection capacity, therefore allowing for more effective stratification of health outcomes and social needs data by sociodemographic factors.[44]

Families USA also requests that CMS ensure that care provided under TEAM is person-centered and designed with the beneficiary perspective in mind. CMMI evaluations have demonstrated that while the Bundled Payments for Care Improvement Advanced (BPCI Advanced) and the Comprehensive Care for Joint Replacement (CJR) models, which provide the foundation for this model, decreased readmissions, "neither model showed improvement in patient experience or reductions in emergency department use."[45] To ensure that TEAM does not replicate these results, CMS should:

- **Incorporate a patient-reported quality measure related to shared decision making[46], as well as other validated process and outcome metrics related to person-centered care;[47]**
- **Develop a 'patient ombudsman role' or contract with patient navigators to provide beneficiaries with answers to any inquiries about the model;**
- **Ensure that community and beneficiary perspectives are incorporated into the model's participant selection and evaluation processes.**

Furthermore, CMS proposes the clinical episodes included within the TEAM model would end 30 days after the individual leaves the hospital.[48] However, recovery time for the procedures included in the model can vary widely and a 30-day episode duration will make it difficult for providers to address social risk factors. **We urge CMS to consider adopting the 90-day episode of duration for clinical episodes that was used in the CJR and BCPI Advanced models**.

The TEAM Model is designed to support CMS's broader efforts to promote health equity and includes numerous health equity and SDOH-related components, including a social risk adjustment incorporated within the target pricing methodology. Though we commend CMS for incorporating social risk adjustment into the model, we caution CMS against relying exclusively on the Area Deprivation Index (ADI) as a measure of social risk. Though ADI can be a useful measure for identifying underserved communities, research has demonstrated that it is weakly correlated with self-reported social needs and with health care costs.[49] ADI can also provide distorted results and mask inequities in communities where there are high levels of wealth disparities.[50] **CMS should investigate other community-level measures of social risk when designing the social risk adjustment methodology for this model.** For example, Massachusetts and Minnesota have developed methods of using administrative and claims data, including Z-code data to adjust for social risk.[51]

Families USA also urges CMS to use TEAM to advance health equity and for the collection of social needs data by:

- **Mandating that the model's hospital participants submit a health equity plan in each performance year of the model**.
    - CMS should also consider issuing additional guidance on how health equity plans should be designed and what mechanisms for accountability and enforcement might exist to ensure these plans most effectively address health disparities and health related social needs.
- **Requiring the collection and reporting of sociodemographic data in each performance year of the model. CMS can minimize provider burden and avoid data duplication by exploring methods to**

best facilitate information sharing among providers and encouraging alignment with national data standards.

- **Requiring that participants report aggregated social needs screening data and screened-positive data, and data on completed referrals to organizations that may support patients in addressing unmet social needs.**

Finally, Families USA commends CMS for its proposal of a voluntary Decarbonization and Resilience Initiative within TEAM to assist hospitals in reducing carbon emissions and improving data reporting around emissions. Climate change poses a major threat to health, especially in historically marginalized and under-resourced groups.[52]

X.C. Maternity Care Request for Information (RFI)

Families USA applauds the continued commitment of the Biden-Harris Administration and CMS to reducing racial and ethnic disparities in maternal health and improving outcomes throughout the perinatal period for all women and children. The included maternal health RFI seeks vital information about the differences in hospital and health care resources needed by Medicare and non-Medicare beneficiaries seeking care throughout the perinatal period. We have shared our responses below in the order they are addressed in the RFI text.

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

To improve outcomes for women, and in particular women of color, CMS and individual state Medicaid programs must reimagine maternal health care. Care must be holistic, patient-centered and equally accessible to every pregnant person who relies on Medicaid or Medicare. States must therefore consider the breadth of barriers and opportunities that exist within the Medicare program, state Medicaid programs, Medicaid Managed Care Organizations (MCOs) and Community-based Organizations (CBOs) to expand covered benefits, improve health care infrastructure and expand eligibility of the clinical provider and community-based workforce. **We urge CMS to**:

- **Encourage every state to implement the 12-month Medicaid Postpartum extension.** As of May 2024, 46 states and DC have taken state action to implement a 12-month extension of postpartum Medicaid. Of the four remaining states that have not extended, only Arkansas has not announced any intention to move forward with a 12-month extension.[53] In 2022, 39% of the recorded births in Arkansas (13,793 total births) were financed by Medicaid.[54] Research on outcomes across the state has shown high rates of medical vulnerability among pregnant people because of a lack of access to health care, among other concerns.[55] Families USA strongly supports CMS continuing to encourage the final few states to take up the extension and improve coverage for pregnant and postpartum people.[56]

- **Provide guidance to hospitals and health care providers on the role of the community-based workforce.** Recent efforts to integrate the community-based health workforce, including doulas and community health workers (CHWs), into existing health care systems has highlighted underlying tensions between clinical providers and non-clinical health workers. In spring 2024, Families USA and our partners hosted a series of listening sessions with members of the community-based workforce, during which participating CHWs repeatedly pointed to the existing education gap around their role.[57] In their experience, many clinical providers and

hospitals who serve both Medicare and Medicaid beneficiaries struggle to understand how to utilize CHWs as a resource.[58] And this education gap extends beyond CHWs to other community-based health workers, such as doulas who have reported being barred from labor & delivery units or prevented from even entering the hospital with their patients. To fully utilize the community-based health workforce and improve health outcomes, CMS must consider how to provide guidance and education to health systems and clinical health care providers on the role of the community-based health workforce and how best to integrate them into care teams. Greater integration will lead to improved patient outcomes and a stronger focus on whole person care.

- **Follow Medicare's lead and incentivize state Medicaid agencies to include integral community-based services as covered benefits.** For the first time, as part of the CY24 Medicare Physician Fee Schedule, CMS created two new service codes for community health integration (CHI) services. CHI services provide an opportunity for CHWs, under the supervision of a billing practitioner, to be reimbursed for the support and navigation assistance that they provide to patients. We applaud CMS's commitment to the inclusion of CHI services within Medicare and encourage greater utilization of the community-based health workforce through Medicaid.

  Many Medicaid programs fail to cover community-based services consistently and adequately for pregnant beneficiaries. For example, doulas are non-clinician patient advocates who provide support to people throughout their pregnancy. Data shows that the support of a doula leads to lower rates of Cesarian deliveries (C-sections) and preterm birth, in turn reducing risks of maternal mortality and morbidity.[59] Yet only 11 state plans include doula services as a covered pregnancy-related benefit.[60] [61] Further, CHWs, who are able to provide critical navigation services and support to patients, including pregnant and postpartum people, can only receive payment through Medicaid in 29 states.[62] [63]

  By expanding the array of reimbursable care providers, including doulas and CHWs, health care systems and hospitals can offer tailored and culturally responsive support that aligns with the patient's preferences and needs.

- **Provide opportunities for hospitals, community-based organizations (CBOs) and accountable care organizations (ACOs) to partner in the delivery of perinatal support, care and resources.** The national maternal health crisis has underscored the need to explore comprehensive solutions that lie beyond the boundaries of traditional medical services. Traditional health care providers are often ill-equipped to address complex social drivers contributing to inequities in perinatal care, such as nutrition, housing, transportation and language barriers. The Transforming Maternal Health (TMaH) model announced by CMS in December of 2023 aims to facilitate the integration of CBOs into the health care system by providing state Medicaid agencies with greater support in improving access to resources that address whole person care. In addition, the model improves information sharing and creates referral pathways between CBOs and providers to ensure service delivery.[64]

  CMS should build on the work of the TMaH model and strengthen opportunities for Medicaid to fund CBO-provided services by making the inclusion of sustainable funding for CBOs in Medicaid permanent in all states. This will provide stability for CBOs offering maternal health services and allow for significant workforce, infrastructure and administrative growth. Further, through Medicare, CMS should consider opportunities to utilize the Medicare Shared Savings Program

Advance Investment Payments to engage CBO and ACO support of pregnant people who rely on the program.[65]

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

The national rate of C-sections continues to rise, having reached about one in three births in 2023.[66] While C-sections are routinely conducted in high-risk pregnancies to improve outcomes for both pregnant people and their babies, there has also been an increase in low-risk C-section deliveries.[67] Notably, C-sections mitigate some complications, but they come with their own set of risks for the patient. Research shows that there are a number of non-medical factors that are contributing to the growing C-section rate, such as repeat C-sections, financial incentives and malpractice aversion.[68] One avenue to reduce the rate of C-sections for those that rely on Medicare and Medicaid is to integrate doulas and midwives into care teams.

- **CMS should provide guidance to states interested in implementing a Medicaid doula benefit to ensure a strong benefit and explore other opportunities to offer reimbursement for doula services.** Data shows that the support of a doula leads to lower rates of C-sections and preterm birth, in turn reducing risks of maternal mortality and morbidity.[69] Though C-sections may be necessary in some pregnancies to reduce risk and ensure a positive birth outcome, there are several non-medical reasons a physician may move forward with a C-section, such as a language disparity between the clinical provider and the patient. Studies have shown that doulas provide more physical intervention (e.g. position changes) than obstetricians and are more likely than certified nurse midwives to answer questions during labor and delivery.[70]
    - As of 2023, only 11 state plans have moved to include doula services within their Medicaid pregnancy benefit, and each state plan has taken different approaches to reimbursement, doula engagement and implementation processes.[71] CMS should provide guidance to states as they develop their state plan amendments (SPAs) to ensure a strong benefit and the integration of feedback from the doula workforce. Further, CMS should explore opportunities to offer reimbursement through Medicare.[72]

- **CMS should provide guidance to states on the need to license all qualified midwives to ensure participation through Medicaid.** Since 2011, with the passage of the Patient Protection and Affordable Care Act, certified nurse-midwives (CNMs) have received equitable reimbursement for their services through Medicare.[73] Similar to doula care, midwifery care improves maternal health outcomes by reducing unnecessary medical interventions. As of 2023, only 32 state Medicaid plans provide reimbursement for CNMs, and 19 state Medicaid plans cover both CNMs and midwives.[74] To ensure that there is sufficient access to midwifery care, state Medicaid plans should follow Medicare's lead and license certified nurse-midwives. Further, to ensure access to a larger workforce, CMS should provide guidance on going a step further to include certified professional midwives and direct-entry midwives.

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

Across the United States, health care payment and delivery reform models are being used to move away from the perverse incentives of FFS economics towards a system that holds providers accountable for delivering high-quality and affordable health care that addresses health disparities.[75] Perinatal models specifically have demonstrated how innovation in health care payment and delivery can confront

barriers to maternal health care access and address disparities in maternal health outcomes. [76] This is particularly true for pregnancy care models, such as:

- The North Carolina Pregnancy Medical Home Model (PMHM). North Carolina Medicaid pays for pregnancy services through bundled obstetric packages for services prior to birth, postpartum, or for the entire perinatal period.[77] Beginning in 2011, the PMH model built off of this payment structure using value-based payment arrangements in which providers receive enhanced payment rates for service packages and lump sum payments in return for providing risk assessments, investing in care coordination and meeting a higher standard of care.[78] Notably, PMH providers must agree not to perform elective deliveries prior to 39 weeks gestations and are paid higher rates for vaginal births than cesarean births, which works to counteract existing incentives to provide C- sections that may have otherwise been avoided.[79] As a result of this model, 80% of women in the PMH program underwent risk screenings, 30% more women received prenatal care in the first trimester compared to non PMH Medicaid beneficiaries, fewer births occurred before the 39-week gestational mark and fewer infants were born underweight.[80] [81] In addition to positive maternal and infant health outcomes, pregnancy medical home models have been associated with notable cost savings through reductions in preterm births, cesarean births and ER visits during pregnancy. [82,83]

- Group prenatal care models, such as South Carolina's CenteringPregnancy is another example of promising maternal health models being utilized on the state level. CenteringPregnancy and models like it are designed to reduce poor health outcomes during pregnancy and address racial disparities in birth outcomes through the integration of patient education and social supports. [84] Under this model, providers offer traditional physical health care services for pregnant patients while also convening groups of patients to participate in facilitated discussions on parenthood, stress management, breastfeeding and more.[85] Providers are paid per visit and receive additional payments for patient retention and a bonus payment when they reach a certain number of cohorts or patients participating in the group care services. [86] Evaluation of CenteringPregnancy found the model was associated with a significant decrease in emergency department utilization, negative birth outcomes and infant mortality. [87] CenteringPregnancy was also associated with $2.3 million in cost savings for South Carolina.[88]

Both pregnancy medical homes and group prenatal care demonstrate significant promise in reforming how we pay for and deliver health care to pregnant people. Notably, these models leverage payments to address the health needs that our traditional system often neglects, such as education, care coordination and social drivers of health.

Families USA is excited to see the development of models like the TMaH model, which aims to deliver whole-person care and address barriers to community-based resources proven to improve maternal health outcomes, including though better utilization of doulas and CHWs.[89] Future models should build off the successes and lessons learned from previous models to inform strategies that address the variety of factors that influence a patient's health, incentivize high quality and culturally congruent care and reduce costs for pregnant patients.

X.D. Request for Information on Obstetrical Services Standards for Hospitals, CAHs and REHs

Are there additional ways the CoPs could improve or address the health and safety of pregnant and postpartum patients across all care settings?

Conditions of Participation (CoPs) are the terms or standards that health organizations must meet in order to participate in Medicare and Medicaid.[90] CoPs are a powerful enforcement mechanism for safety and quality standards as failure to meet standards can result in full exclusion from the Medicare program.[91] Despite the potential of CoPs to promote high quality care, research on the effectiveness of CoPs continues to be mixed, indicating they can be better leveraged to drive improvements in health care quality and health outcomes.[92] **CMS should work to ensure any new labor and delivery related CoPs efficiently and effectively target areas for quality improvement through the following considerations**:

- **Develop a labor and delivery CoP in alignment with existing efforts to improve quality of perinatal services, such as the Birthing Friendly Hospital Designation.** MedPAC recommends CoPs be updated in alignment with existing quality initiatives to have a greater influence on provider uptake of research backed clinical practices and processes.[93] Consequently, any new labor and delivery CoPs should align with and build off the existing CMS Birthing Friendly Hospital designation, to create a clear national standard for obstetric care.[94] By aligning a new labor and delivery CoP with existing quality efforts, CMS can help streamline provider requirements and create greater opportunity to promote provider uptake of evidence-based quality standards. [95]
- **Further, CMS should assess all opportunities, including the development of a new CoP, to address barriers to high-quality perinatal health care.** Across the country, major strides have been made in improving access to high-quality maternal health care. Through payment and delivery reform efforts, like the new TMaH model, CMS is working to leverage health care payment to expand access to more holistic, high-quality care.[96] Further, a growing number of states are working to expand access to a variety of perinatal providers, including doulas and midwives, to help improve pregnancy outcomes and bridge provider gaps.[97] Despite these efforts, roadblocks to improved access and quality of perinatal care persist.[98] One notable challenge is the integration of community workforce members into the clinical maternal health care system. For example, Families USA's conversations with doulas across the country, surfaced the considerable challenges doulas face when attempting to work with hospitals to provide high-quality care to their clients. Reported challenges include exclusion from hospital rooms and labor and delivery units, obscure doula integration policies, disrespectful communication from providers and hospital staff and difficulty communicating with hospital administration. [99, 100,101]As CMS evaluates policies to support improvements in perinatal health care, they should evaluate how levers like CoPs can address barriers such as this and ensure hospital systems incorporate evidence-based health care practices, such as doula care.
- **Lastly, CMS should ensure labor and delivery CoPs apply to all inpatient and outpatient settings where emergency services and labor and delivery services are provided, including those without maternity or labor and delivery wards.** As maternity wards across the country continue to close, women are forced to drive further distances for obstetric care and inpatient childbirth.[102] While many women, particularly women in rural counties, are forced to plan their pregnancy care around long drives to the hospital, in times of emergency many pregnant women are forced to seek medical care from hospitals without birthing units.[103] As policymakers grapple with growing rates of maternity ward closures, ensuring all hospitals maintain standards

of care for pregnant patients is critical to health and well-being of pregnant people, in particular rural, Black and Indigenous communities who are some of the most likely to be impacted by maternity ward closures.[104,105] Because of this, **a new labor and delivery CoP should, at a minimum, apply to hospital obstetric units, critical access hospitals, rural emergency hospitals, emergency departments and free-standing birth centers.**

Thank you again for the chance to comment on this important array of critical issues impacting the health and well-being of people across the country who use inpatient hospital care. Please contact Jane Sheehan (JSheehan@familiesusa.org), Deputy Senior Director of Government Relations at Families USA, with any questions.

Sincerely,

Sophia Tripoli
Senior Director of Health Policy

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