CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

September 9, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1809-P**
P.O. Box 8010
Baltimore, MD 21244–1850

Re: CMS-1809-P Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; etc.

Submitted electronically via Regulations.gov

Dear Administrator Brooks-LaSure:

On behalf of *Consumers First*, an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care clinicians working to realign and improve the fundamental economic incentives and design of our health care system, thank you for the opportunity to comment on the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2025.

The members of *Consumers First* work together to hold the nation's health care system accountable to providing everyone with affordable, high-quality, cost-effective care. One essential lever to achieve this goal is the enactment of improved Medicare payment policy, which in turn establishes a standard that is often adopted by commercial payers and Medicaid. *Consumers First* offers these comments to both strengthen hospital outpatient payment and to acknowledge this rule as an important step toward realigning the fundamental economic incentives in our health care system to meet the needs of all families, children, seniors, adults, and employers by lowering health care costs and improving health. These proposed payment changes could catalyze the transformational change that is needed to ensure our payment systems drive high value care across the country.

The comments in this letter represent the views of the *Consumers First* steering committee and other signers. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments are focused on two significant omissions from this year's proposed rule regarding **hospital price transparency** and **comprehensive site neutral payment policies,** as well as the following two sections:

- **XV. Hospital Outpatient Quality Reporting (OQR) Program,**

- **XXI. Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals.**

Hospital Price Transparency

Consumers First has long supported CMS's efforts to increase hospital price transparency as a key tool to address the growing trend of health care industry consolidation across U.S. health care markets, particularly among hospitals, and its outsized impact on driving up health care prices and costs.[1] Hospital price transparency would unveil how irrational health care prices have become as a result of health care industry consolidation and would promote healthy competition across and within U.S. health care markets. Moreover, unveiling the underlying prices of health care services and pairing them with meaningful health care quality information would allow consumers and purchasers to make more informed choices about their care while enabling researchers to identify which health care markets are generating low-value care and policymakers to deploy targeted policy solutions to increase competition and drive high-value health care.

While we applaud the steps CMS has taken in previous rulemaking to achieve that goal, we are disappointed that CMS did not propose additional improvements to the hospital price transparency policy in this year's annual rulemaking. It is essential that CMS continue to strengthen the hospital price transparency rule to achieve meaningful price transparency in the health care system.

Every person should be able to know upfront what different hospitals charge for health care services, whether it's an X-ray, MRI, surgery, or other procedure. Yet health care is one of the only sectors in the U.S. economy where costs are hidden from consumers and other purchasers until *after* they receive the service and a bill for care.[2]

The pricing information that is most critical to achieving price transparency is the rate that is negotiated between specific payers and specific hospitals, referred to as the negotiated rate. Yet these rates have long been hidden in proprietary contracts between private insurers and providers that do not allow for any insight into or oversight over the price of health care services by policymakers, the public, and other health care purchasers. While health plans are the ones directly negotiating prices with hospitals, it is consumers and employers that are ultimately paying for health care through insurance premiums, deductibles, and copays. The fact that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been delivered must change.

Ultimately, price transparency is the first step to halt the trend of rapid and destructive consolidation across our health care system that has enabled the proliferation of harmful business practices and the price gouging of American families. For nearly 20 years, researchers have been alerting us to the fact that the underlying drivers of high U.S. health care costs are high and variable health care prices resulting from consolidation across and within health care markets.[3]

Health care consolidation occurs among hospitals, insurers and other health care organizations that battle for relative market power and control to set prices that have little to nothing to do with the quality of care delivered or the health outcomes of their patients.[4] IIn doing so, they deploy anti-competitive

practices that prevent data from being shared and undermine affordable, high-quality health care for our nation's families, workers and employers.[5]

Hospital Price Transparency Rule

The Hospital Price Transparency Rule requires hospitals to disclose standard charges for all items and services they provide, including negotiated rates by insurer and health plan, gross charges, discounted cash prices, and a de-identified maximum and minimum negotiated rate for each service.[6] The rule also requires hospitals to make public, in a machine-readable and consumer friendly format, standard charges for the care they provide.[7] Despite the rule being in effect since January 2021, the vast majority of hospitals continue to be out of compliance with the federal requirements, and only 34.5% of our nation's hospitals are considered in compliance according to recent estimates.[8] Some hospitals have failed to post any negotiated rates at all. Others display incomplete information or post data in ways that are difficult for most people to understand, such as listing prices as a percentage of Medicare rates (i.e. 200% of Medicare).[9] Notably, despite the low rates of compliance, CMS has issued only 15 civil monetary penalty (CMP) notices since the policy was implemented, with four still under review.[10]

In early 2023, CMS strengthened its enforcement by imposing CMPs automatically if a hospital fails to submit a corrective action plan (CAP) within 45 days of receiving a notice of noncompliance – and streamlined the compliance process by no longer issuing warning notices before requesting a CAP. The CY2024 OPPS final rule made additional changes, such as requiring hospitals to publish their pricing information using one of two standard formats (CSV format or JSON schema) and to provide a written affirmation that the pricing information posted on their websites is accurate and complete.[11] CMS also finalized plans to post additional public information on its enforcement and compliance actions, among other important changes.[12]

While *Consumers First* applauds these past changes, there is considerably more work to do to ensure hospitals meaningfully comply with the hospital price transparency rule, including by publishing their negotiated prices in actual dollars and cents. As such, we are concerned that CMS did not take subsequent steps in the CY2025 OPPS proposed rule to further strengthen hospitals' compliance with the price transparency rule. We strongly urge CMS to take the following actions in their final rule:

- **Explicitly require hospitals to display all negotiated rates in dollars and cents without exception and prohibit posting these negotiated prices solely as algorithms or as a percentage of Medicare.** This requirement should include removing a significant loophole that CMS finalized in previous rulemaking which allows hospitals to post "expected allowed amounts" when negotiated prices are presented as algorithms or percentages of Medicare rates. CMS could also require that hospitals post *additional* pricing information in addition to the negotiated rate in dollars and cents, as applicable, including the methodology used to arrive at the negotiated rate and the percentage of Medicare rates.
- **Require hospitals to post data in *one* CMS-specified format – either CSV or XLS –** and **use a standardized code format** in the data submission that specifically prevents hospitals from using facility-specific codes and requires the use of commonly used code sets such as HCPCS, CPT, or DRG codes.

- **Strengthen compliance with hospital price transparency rules by increasing the civil monetary penalty** to $300 per day per hospital bed for hospitals with 31 beds or more, **and by requiring a senior official to attest to the completeness and accuracy of the published information.**
- **Require hospitals to report quality data and pair that data with hospital pricing information** so that consumers, researchers, and lawmakers can make meaningful cost and quality comparisons between hospitals. CMS should establish a new process, or build on existing processes, to determine the kinds of quality information that would be most appropriate and meaningful to pair with published prices.

Below are additional details on each of these recommendations:

Requirements for posted prices

We strongly urge CMS to require hospitals to display all negotiated rates in dollars and cents without exception, and to prohibit hospitals from posting standard charges solely in the form of algorithms, percentages of Medicare rates, or "N/A's". Only the negotiated rate, displayed in dollars and cents, should be considered complete and accurate information. CMS could also require that hospitals post additional pricing information in addition to the negotiated rate in dollars and cents, as applicable, including the methodology used to arrive at the negotiated rate and the percentage of Medicare rates.

Hospitals use various tactics to avoid reporting requirements and make the information they disclose hard to understand and evaluate. The percentage of gross charges, percentage of Medicare rates, and algorithms are not meaningful pieces of pricing information. In fact, these are not prices at all. Anyone hoping to use that data must understand Medicare base rates, gross rate charge, or algorithms and then make mathematical calculations to arrive at a meaningful dollar amount, often necessitating the support of a third party.[13,14] Allowing hospitals to post their pricing information in this way undermines the very intent of the price transparency regulations and puts further burden on consumers and health care purchasers. If hospitals can generate a bill based off the negotiated rates for each item and service, then they should be able to share those prices with the actual purchasers of health care.[15]

For this reason, we continue to be deeply concerned about the loophole created by last year's final OPPS rule allowing hospitals to submit algorithms or percentages in place of the true dollar amount for hospital services when accompanied by an "expected allowed amount."[16] CMS acknowledged the limitations of this approach in the CY2024 OPPS proposed rule stating that the expected allowed amount is an "estimate" and is "not the final exact amount in dollars that would actually apply to each group member."[17] It is critical for the negotiated rate – widely recognized as the underlying price of health care services and goods – to be publicly available in order to allow consumers and purchasers of health care to make informed decisions, promote healthy competition in health care markets, and realize the full potential of hospital price transparency.[18]

Standardized reporting requirements

Consumers First **recommends that CMS choose one standard submission format for hospitals to follow, either CSV or XLS, instead of the three standardized formats the agency currently allows. The file**

should be both machine-readable and consumer friendly so that policymakers and researchers can easily compare prices within and across hospitals.

In the final CY2024 rule, CMS required hospitals to submit their data file in one of three formats — a JSON (plain) format or CSV "wide" or "tall" formats. [15] These are the formats hospitals use most often in data submissions and each offers pros and cons in terms of reducing file size, incorporating related information like payer and plan name, and minimizing opportunity for standardization errors.[19] While this was an important step in the direction of standardizing the data files, we believe CMS should go one step further by choosing either a CSV or XLS format (not JSON) as the only permissible format for submitting pricing data. This file should be both machine-readable and consumer friendly and offer policymakers and researchers the opportunity to effectively compare prices within and across hospitals. JSON files require a tech developer to convert and are therefore not consumer friendly.[20] Better uniformity will make it easier for the public to make meaningful price comparisons across different hospitals by service and would reduce the ability for hospitals to take advantage of any regulatory flexibility and game these reporting requirements under the rule.

***Consumers First* urges CMS to establish a standardized code format that requires the use of commonly used code sets such as HCPCS, CPT, and DRG codes to ensure that consumers and employers can easily compare price data for specific services across hospitals and facilities.**

The Hospital Price Transparency regulation gives hospitals the flexibility to use different code sets, including Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT), when they display services with corresponding pricing data. The rule does not require a standardized coding format or prohibit hospitals from using other code sets, such as facility-specific codes, or codes used for internal billing or accounting. This overly broad approach makes it nearly impossible to analyze prices across and within U.S. health care markets, which is inconsistent with the goals of hospital price transparency.

<u>Enforcement, oversight, and compliance</u>

Far too many hospitals fail to comply with the federal hospital transparency rule. This lack of compliance strongly suggests that the enforcement and oversight mechanisms of this federal rule are simply not strong enough. The fact that thousands of U.S. hospitals would rather risk paying a $2 million per year fine not only suggests that the civil monetary penalty in particular is not strong enough to achieve meaningful compliance, but also is further evidence that these hospitals have a powerful financial interest in keeping health care prices—and the anticompetitive practices that lead to high prices—hidden.[21] In fact, hospitals have spent years fighting price transparency regulations, including through litigation, to avoid regulatory oversight of and accountability over their prices.[22] CMS monitoring and enforcement must be strong and consistent to fully realize the potential of the Hospital Price Transparency rule. To that end, *Consumers First* has two recommendations:

1) ***Consumers First* recommends that CMS require a senior official (Chief Executive Officer, Chief Financial Officer, or their equivalent) to attest to the accuracy and completeness of the hospital data file.** In 2023, CMS required hospitals to affirm that the data they post is accurate—

a major step toward holding hospitals accountable for their compliance with the regulation. Requiring hospitals to identify a senior officer who is accountable for the accuracy of that data will make it even more difficult for them to evade their responsibility to post accurate data.

2) ***Consumers First* recommends that CMS increase the civil monetary penalty for non-compliance to $300 per bed per day for hospitals with 31 or more beds.** This will send a stronger message to hospitals that it is imperative that they post complete, accurate pricing information.

Requirements for quality data

***Consumers First* recommends that CMS require, over time, that hospitals pair quality information with pricing information. To do this, CMS should establish a process, or build on existing processes, to engage a wide range of non-industry stakeholders to determine what kinds of quality information would be most appropriate and meaningful to pair with published prices.**

As health care price transparency efforts evolve, *Consumers First* supports requiring hospitals to disclose quality data alongside existing price data. This is a critical step in providing meaningful transparency into value and cost-effectiveness of hospital care, and ultimately the health care system more broadly.[23] While we understand that additional work is needed to arrive at and report on a harmonized set of quality measures, it is important for CMS to build quality data into price transparency data over time. Requiring price and quality information to be displayed together would ensure that hospitals and industry players across the health care system compete based on fair and accurate information and would empower consumers and purchasers to make more informed decisions about their health care. To be clear, *Consumers First* does not want CMS to slow its efforts to improve hospital compliance with price transparency requirements while it waits for quality data to be more readily available. Any delay would undermine CMS's efforts to achieve meaningful price transparency.

Comprehensive Site Neutral Payment Policy

Consumers First continues to recommend that CMS expand its site neutral payment policy to additional services and sites of service to end the longstanding distortion in Medicare reimbursement that incentivizes vertical integration and contributes to the country's health care affordability crisis. We have supported and encouraged CMS to expand its site neutral payment policy as detailed in our CY 2020, 2021, 2022, 2023 and 2024 OPPS comment letters.[24] We are deeply concerned that CMS did not propose any updates to the policy in the CY2025 proposed rule.

Currently, Medicare pays higher rates to Hospital Outpatient Departments (HOPDs) and other provider-based outpatient facilities for many of the services that physician offices offer at lower prices with comparable quality and outcomes.[25] This payment differential based on the site where the care is provided has created a financial incentive for hospitals to shift patients into higher cost care settings and to acquire physician practices and rebrand them as HOPDs or other outpatient facilities in order to generate the higher reimbursement.[26] This arbitrary payment disparity is therefore a major driver of the growing trend of consolidation between hospitals and physician practices and is a significant root cause of high U.S. health care costs.[27]

Over the last decade, our nation has seen a trend of formerly independent physician practices becoming affiliated with major hospital systems.[28] The purchasing of physician practices by hospital systems has resulted in services shifting to outpatient facilities where the costs of care are substantially higher. MedPAC has documented how this trend has had a direct negative financial impact on Medicare beneficiaries, who have higher copays at HOPDs than they do in physician offices.[29] Moreover, this payment differential has affected overall Medicare expenditures: HOPDs are paid more than twice as much as physicians under the Medicare physician fee schedule (MPFS).[30] These trends run directly counter to the interests of Medicare beneficiaries and the solvency of the Medicare Trust fund. Instead, providers should be reimbursed at a level that supports the most efficient, highest quality care irrespective of the location in which it is provided. This is a foundational principle in the efficient allocation of resources and an essential component of a shift to a value-based health care system.[31]

Congress and CMS have taken steps to address this issue in the past. The Bipartisan Budget Act (BBA) of 2015 mandated that new off campus provider-based hospital departments be paid at the MPFS rate. However, this legislation included a number of exemptions for sites of care from its site-neutral payment policy including emergency departments, ambulatory surgery centers, on-campus outpatient departments, and off-campus physician offices that were built prior to November 2, 2015, referred to as "grandfathered" provider-based departments.[32] This broad exemption from the site neutral payment policy resulted in the BBA only applying to a small number of health care facilities. For example, MedPAC reported the BBA of 2015 site neutral payment policy accounted for less than 1% of total OPPS spending.[33] These exemptions preserved the broken financial incentive for large health systems to shift patients to higher cost care settings and vertically integrate with independent physician practices to generate a higher reimbursement.[34] Additionally, preserving the payment disparity for emergency departments also led to the building of more standalone emergency departments due to the ability to receive higher Medicare payments.[35] Subsequently, CMS implemented the BBA through the CY 2019, 2020 and 2021 OPPS rules with an important amendment which extended the application of site-neutral payment – the MPFS rate – to clinic visits delivered by off-campus provider-based departments "grandfathered" under the BBA.[36]

Despite this progress, much work is needed to enact site neutral payments and ensure that Medicare beneficiaries and families that rely on private health insurance pay the same price for the same service. **To that end, *Consumers First* recommends that CMS expand site-neutral payments to all off-campus provider-based departments across a broader set of services. We also recommend that CMS implement site-neutral payment not just for off-campus hospital-based departments but also for on-campus provider-based departments, freestanding and non-freestanding emergency departments, and off-campus provider-based entities. CMS should maximize the use of its regulatory authority in carrying out these recommendations, and, if needed, work with Congress to obtain additional authority. Specifically, we recommend:**

- **Eliminating the "grandfathering" of higher OPPS payment rates for existing off-campus provider-based departments for all services, not just clinic visits.** The Congressional Budget Office previously estimated that closing this loophole would save $13.9 billion between 2019 and 2028.[37]

- **Extending site-neutral payments for clinic visits to all on-campus provider-based departments.** MedPAC's 2017 report estimated that implementing site-neutral payments for clinic visits at on-campus and off-campus provider-based departments would save Medicare almost $2 billion per year.[38]
- **Extending site-neutral payments across a broader set of 66 clinical services including:**
    - **The 57 Ambulatory Payment Classifications (APCs) identified in the June 2022 MedPAC Report (and following reports) to Congress, to align the OPPS and alternate care site payment rates with those set in the MPFS;[39] and**
    - **The 9 APCs that should align the OPPS payment rates with the Ambulatory Service Center (ASC) payment rates and continue to use the MPFS rate when the service is provided in a freestanding office.[40]**

Enacting comprehensive site neutral payment policies would result in significant savings for consumers and Medicare: In early 2020, the Congressional Budget Office estimated that a site- neutral policy would save Medicare approximately $140 billion.[41] And the Committee for a Responsible Federal Budget estimated in 2023 that implementing a comprehensive site neutral payment policy for Medicare would reduce cost-sharing for Medicare beneficiaries by $94 billion.[42]

XV. Hospital Outpatient Quality Reporting (OQR) Program

The Hospital Outpatient Quality Reporting (OQR) Program is a quality data reporting program implemented by CMS for outpatient hospital services. Hospitals are required to report data using standardized measures of care to receive the full payment update to their OPPS payment rate.

To make the Medicare program more effective, Consumers First believes that Medicare should be a leader among other payers in driving equity into payment and care delivery, particularly as we strive to build a high-value health care system. There continues to be millions of people – Medicare beneficiaries in particular – who live with the burden of poor health, who systematically cannot access the right care at the right time, and who receive low-quality care.[43]

Those facing systemic health inequities disproportionately include people of color, people with low incomes, people with disabilities, and people living in distressed neighborhoods.[44] In 2022, 13.7% of Medicare beneficiaries lived below the federal poverty level (FPL) and 32.7% lived below 200% of the FPL.[45] Further, more than a quarter of Medicare beneficiaries are people of color, including Black, Hispanic, Asian/Native Hawaiian or Pacific Islander, American Indian or Alaska Native, and multi-racial individuals.[46] it is essential that the Medicare program incorporates strong quality components into hospital payments that hold hospitals accountable to delivering high-quality and equitable health care for all people.

In the CY2025 OPPS proposed rule, CMS proposes a number of new measures to include in the OQR program, including: 1) *The Hospital Commitment to Health Equity* (HCHE) measure, a structural measure that seeks to assess the extent to which hospital leadership are committed to driving the delivery of equitable health care along the five key domains: equity as a strategic priority, data collection, data analysis, quality improvement, and leadership engagement; 2) The *Screening for Social Drivers of Health (SDOH)* measure, a process measure that seeks to assess the extent to which hospitals are screening for a select group of health-related social needs (HRSNs) including food insecurity, housing instability, utility difficulties, and interpersonal safety; and 3) *The Screen Positive Rate for SDOH* measure, a process

measure that requires hospitals to determine the percentage of patients who are screened for HRSNs that have at least one health-related social need.[47]

***Consumers First* supports CMS's ongoing efforts to improve quality reporting programs –including the OQR program – and applauds CMS's proposal to add several health equity related measures to the OQR.** *Consumers First* encourages CMS to continue to make important changes to the OQR program by strengthening requirements for hospitals to report on a more comprehensive set of quality and equity measures. To that end, ***Consumers First* recommends that CMS:**

- **Strengthen the attribution process associated with the *Hospital Commitment to Heath Equity* measure** by requiring independent verification or follow-up by CMS to ensure that hospital's stated commitments to health equity in the five key domains are being implemented in a way that drives meaningful change. It is insufficient to rely on hospital attribution and self-reporting alone.
- **Require individual level reporting of the "*Screening for Social Drivers of Health (SDOH)*" and the *"Screen Positive Rate for Social Drivers of Health (SDOH)*" measures**. CMS proposed that hospitals aggregate information collected for these measures, but we believe that this information should be reported at the individual patient level through claims and administrative data systems. These data should then be made public – with strong privacy and patient safeguards, including through de-identification – so researchers, advocates, lawmakers, and purchasers of health care can evaluate whether hospitals and large hospital systems are adequately evaluating health related social needs (HRSNs). It is important to understand how HRSNs contribute to health care spending, quality, and outcomes at the individual *and* community levels.
- **Require standardized collection of HRSNs information using *one* uniform data collection instrument for the "*Screening for Social Drivers of Health (SDOH)*" and the *"Screen Positive Rate for Social Drivers of Health* (SDOH)" measures.** CMS's proposal would allow hospitals to choose the screening tool they wish to use in both the "Screening for SDOH" and "Screen Positive" measures. However, standardization is important to help ensure that these measures can be appropriately compared and shared across health systems and providers. This is critical to leveraging this data to improve patient care delivery and to address health disparities at the individual and population level.
- **Require an additional measure on social need interventions to ensure hospitals connect patients with a positive SDOH screening with resources that address the underlying SDOH captured in the screening tool.** Specifically, *Consumers First* recommends that CMS develop, validate, and adopt a measure to account for social need interventions following a positive SDOH screening into the program, such as the HEDIS Social Needs Screening and Intervention measure (SNS-E).

XXI. Health and Safety Standards for Obstetrical Services in Acute Care and Critical Access Hospitals

The United States is in the midst of a severe maternal health crisis, which has been building for decades and is evidenced by a persistently high maternal mortality rate. The maternal mortality rate in the U.S. is higher than the rate of all other high-income countries.[48] More than 80 percent of maternal deaths in the U.S. are preventable and people of color disproportionately experience poor maternal health outcomes.[49] For example, the maternal mortality rate for non-Hispanic Black women (49.5 deaths per 100,000 live births) is more than twice the rate for non-Hispanic white women (19 deaths per 100,000 live births).[50]

We strongly support CMS's efforts to establish standards for maternity care across hospitals to ensure pregnant and postpartum people and their babies have access to the high-quality and equitable care they need and deserve. Currently, there are no specific national baseline care requirements for health care providers that commonly provide maternal health care, including for acute care hospitals and critical access hospitals (CAHs). To that end, *Consumers First* applauds CMS for its proposal to establish, for the first time, federal health and safety standards through new conditions of participation (COPs) for the delivery of obstetric (OB) services in acute care hospitals and CAHs. If finalized, these changes would mark a significant step towards addressing our nation's maternal health crisis and holding the health care system accountable for ensuring that our nation's moms and babies are guaranteed health care that meets critical health and safety standards. To continue to strengthen our maternal and prenatal health care system and meet the needs of moms and babies, *Consumers First* encourages CMS to further strengthen the proposed COP and existing COPs by:

- **Assessing all opportunities to address barriers to high-quality perinatal health care, including through inclusion of doulas and midwives.**
- **Applying the new organization, delivery, and training requirements to rural emergency hospitals (REHs) in addition to acute care and CAHs.**
- **Continuing to explore additional ways to empower maternal mortality review committees (MMRCs) in their roles overseeing health care quality and outcomes related to maternal health.**

<u>Establishing a new COP</u>

***Consumers First* strongly supports CMS's proposal to establish a COP creating national health and safety standards for OB services in acute care hospitals and CAHs.**

COPs are the terms or standards that health organizations must meet in order to participate in and receive reimbursement from Medicare and Medicaid.[51] They are a powerful enforcement mechanism for safety and health standards because failure to meet COPs can result in exclusion from the Medicare program.[52] In addition to finalizing the newly proposed COP, ***Consumers First* urges CMS to explore all opportunities to address barriers to high-quality perinatal health care, including barriers to patients accessing doulas and midwives.**

There are important efforts across the country taking place to improve access to high-quality maternal health care, such as the new Transforming Maternal Health (TMaH) Model, which aims to expand access to more holistic, high-quality care in Medicaid and the Children's Health Insurance Program (CHIP).[53] Further, a growing number of states are working to expand access to a variety of perinatal providers to help improve pregnancy outcomes and bridge provider gaps.[54] Despite these efforts, roadblocks to improved access and quality of perinatal care persist.[55] One persistent and significant challenge is the failure to integrate midwives and doulas into the clinical perinatal health care system.

Doulas are non-clinical support workers who provide informational, emotional, and physical support for pregnant patients.[56] Despite ample evidence that doulas are effective at improving birth outcomes and addressing disparities in maternal health, doulas across the country report exclusion from hospital rooms and labor and delivery units, obscure doula integration policies, disrespectful interactions with providers

and hospital staff, and difficulty communicating with hospital administration.[57] As a result, many doulas are unable to support patients during critical moments in their pregnancy, including labor and delivery.[58]

Midwives are trained and educated health care professionals specializing in pregnancy, childbirth, postpartum health, and newborn care, as well as gynecological health, reproductive health, and family planning services.[59] Midwifery care and services are associated with improved maternal health outcomes and reduced risk of medical intervention during birth, unnecessary C-section, preterm birth, infant mortality, and a variety of negative birthing experiences.[60] Despite being licensed health care professionals, midwives continue to face barriers participating in hospital-based maternity care due to inconsistent hospital policies that prevent midwives from receiving hospital credentials or privileges or being included as hospital staff.[61] Without eligibility for hospital credentialing or privileging, midwives are unable to practice in the hospital setting. Many hospitals remain unwilling to credential, privilege, or otherwise include midwives as hospital staff.[62] As with doulas, this prevents patients from receiving critical forms of care associated with improved health outcomes and lower costs.[63]

Doulas and midwives are critical to addressing the maternal morbidity and mortality crisis facing pregnant people in the U.S. In recognition of the key role they play in improving maternal health outcomes, ***Consumers First*** **encourages CMS to evaluate how COPs can be leveraged to improve integration of doulas and midwives in the hospital setting.**

Changes to emergency services COPs

Consumers First **applauds CMS's proposal to revise existing COPs for emergency services to improve baseline emergency readiness and care for patients, including those who are pregnant, birthing, or postpartum, particularly when a facility does not have an OB unit. We strongly recommend that CMS extend the proposed updates related to provisions, protocols, and staff training to Rural Emergency Hospitals (REHs).**

As maternity wards across the country continue to close, women are often forced to drive longer distances for obstetric care, including labor and delivery services.[64] While many pregnant people, particularly those who live in rural counties, must plan their pregnancy care around long drives to the hospital, pregnant people in emergency situations are often forced to seek medical care from hospitals without birthing units.[65] As policymakers grapple with a growing number of maternity ward closures, it is critical to ensure all hospitals meet high standards of care for pregnant patients. This is particularly important for providers in rural, Black and Indigenous communities, which are most likely to be impacted by maternity ward closures.[66] Though rural providers face significant workforce and resource challenges, they still should be prepared to provide high-quality care to pregnant people and babies.[67]

It is critical that our nation's pregnant people receive high-quality and equitable OB care, regardless of the provider delivering the care. Therefore, CMS should continue to explore additional opportunities to implement national standards that ensure pregnant people have access to quality care, particularly in facilities that do not have OB units. For example, there should be baseline training and other standards for medical staff who care for pregnant and postpartum patients even when those patients are seeking

care for non-OB related health needs. This would ensure that clinicians understand how a patient's OB-related diagnoses may interact with other health concerns that may be the focus of their treatment.

Ensuring the delivery of high-quality and safe OB care — regardless of whether a hospital has a dedicated OB unit — is particularly important in the wake of recent events, including state activity related to access to reproductive health care since the U.S. Supreme Court overturned *Roe v Wade* in 2022..[68]

In an instance where a patient must be transferred to a different health care facility to receive a higher level of care, the Emergency Medical Treatment Labor Act (EMTALA), which requires emergency departments to provide emergency medical services to all individuals, including pregnant people, outlines guidelines for hospitals to follow when initiating a transfer.[69] It is critical that transfer and discharge procedures be inclusive of the needs of OB patients to ensure all patients are getting access to the health care they require in emergency circumstances. In this year's proposed rule, CMS raises important considerations about timely and appropriate care, particularly when hospitals and other providers consider transferring patients. ***Consumers First*** **applauds CMS's proposal to explicitly require that hospitals implement standard policies and procedures and staff training for patient transfers into the existing discharge COP. And we encourage CMS to explore additional ways to further specify clinical best practices that may be a part of such transfer procedures and training for OB patient care.** It is critical that CMS consider the impacts of external factors on maternity care in emergency departments as part of CMS's efforts to ensure hospitals provide lifesaving care to pregnant people.

Improving quality assessment and performance improvement (QAPI) standards

Consumers First **applauds CMS's proposal to revise existing COPs related to QAPI standards to include additional requirements specific to the delivery of OB services in hospitals and CAHs.** Under current federal law, hospitals are required to develop and run QAPI programs to assess and improve a facility's quality of care.[70] CMS proposes to require that hospitals with OB units focus ongoing QAPI efforts, in part, on assessing and improving health outcomes and disparities among OB patients, stratified by subpopulations and demographic characteristics. The agency also proposes to require that a system or facility's leadership "be engaged in the facility's QAPI activities."[71] It is critical that health outcomes for birthing people are included in the evaluation of the quality of care in a health care facility. Hospitals must assess the extent they are able to meet the needs of, and reduce health disparities for, pregnant people and babies. To that end, ***Consumers First*** **further encourages CMS to require all hospitals and CAHs to use their QAPI programs to assess and improve health care quality, health outcomes, and disparities among their OB patients by the following demographic characteristics, at minimum: race, ethnicity, gender, sexual orientation, language, geographic location, socioeconomic status, age, and ability status.**

Specifically, we applaud CMS for proposing to require hospitals to use insights and findings from maternal mortality review committees (MMRCs) to improve their internal quality improvement activities. MMRCs are important sources of information on the maternal mortality crisis and preventable maternal deaths, and their findings, when available, should be incorporated into assessments of quality and access to maternal health care in hospitals. ***Consumers First*** **encourages CMS to continue to explore**

additional ways to empower MMRCs in their roles in overseeing health care quality and outcomes related to maternal health.

On behalf of Consumers First and our undersigned partners, we thank you again for the opportunity to comment on the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2025, and for considering the above recommendations. Please contact Aaron Plotke, Senior Policy Analyst at Families USA at aplotke@familiesusa.org for further information.

Sincerely,

Consumers First Steering Committee

American Benefits Council
American Federation of State, County & Municipal Employees (AFSCME)
American Federation of Teachers
Families USA
Purchaser Business Group on Health

Supporting Partners

ACA Consumer Advocacy
Clear Healthcare Advocacy
Colorado Consumer Health Initiative
Consumers for Affordable Health Care
Democratic Disability Caucus of Florida
The ERISA Industry Committee (ERIC)
Health Care Voices
Iowa Citizen Action Network
National Disability Rights Network (NDRN)
Pennsylvania Health Access Network
Samuel Rodger Health Center
South Carolina Appleseed
The Coalition for Hemophilia B
Third Way
U.S. PIRG

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