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The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1809-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities

Dear Administrator Brooks-LaSure:

I am writing on behalf of the Alliance of Safety-Net Hospitals (ASH), a group of private community safety-net hospitals that serve diverse and economically disadvantaged and underserved communities, to provide feedback in response to the Centers for Medicare & Medicaid Services' (CMS) FY 2025 Outpatient Prospective Payment System proposed rule published in the *Federal Register* on July 22, 2024.

In this letter we comment on three aspects of the proposed rule:

- Proposed rate update
- Proposed Obstetrical Services Conditions of Participation
- Medicaid Provisions

Proposed Rate Update

In ASH's view, CMS's proposed outpatient rate increase of 2.6 percent in CY 2025 is insufficient. It neither fully recognizes the increase in hospital costs nor reflects the continuing migration of so much health care from inpatient to outpatient settings.

CMS can begin a process of calculating a more appropriate rate increase by reconsidering the data source it uses for workforce costs in the calculation of such adjustments in light of fundamental changes in how hospitals staff their operations since the pandemic and the need for hospitals to increase employee wages so they can retain their workers amid the inflation of recent years.

Currently, CMS uses a four-quarter rolling average of change in compensation and benefits as measured through the ECI survey of hospital workers but there is a lag in that data that leaves the proposed update behind by at least one year. Even more critically, the ECI survey of hospital employment costs includes only employed hospital staff and not contracted or contingent workers. The increased use of contracted staff that was sparked by the pandemic has proven not to be transitory and the current rate calculation methodology does not reflect this new reality. We believe this methodology needs to be revised to recognize these costs so that Medicare outpatient payments can keep up with hospital needs and ensure patient access to outpatient care. This is especially vital for community safety-net hospitals because they approach their work with far fewer resources than the typical American hospital and are far more dependent on public payers than those other hospitals, which serve far larger numbers of commercially insured patients for whom they are much better reimbursed.

The current methodology CMS employs does not, in our view, reflect the true cost of labor, which is one of the major drivers of hospital costs, and this shortcoming has led to a proposed rate increase of 2.6 percent that is inadequate. We urge CMS to reconsider this proposal and to increase its annual rate adjustment to better reflect the true increases in the cost of providing outpatient care.

Obstetric Services Conditions of Participation Proposals

CMS has proposed amending or adding new conditions of participation (CoPs) in the areas of obstetrical care (OB), emergency readiness, and transfers of care. In this section, ASH provides feedback only on the CoP changes that involve OB services.

The Challenges Inherent in Offering Obstetrical Care in 2024

Community safety-net hospitals stand as the health care anchors in their communities and often are the only source of labor and delivery services for underserved or rural communities. They serve the most challenging, disadvantaged, and medically vulnerable patients, often with the support of very limited resources, and in few areas is the challenge this poses clearer than in the care of pregnant women and the delivery of their newborns.

Maintaining expensive OB services is a growing financial burden for hospitals, and especially for community safety-net hospitals. Many small and rural providers throughout the country, in particular, have had to make the difficult choice to discontinue providing OB services rather than risk the failure of their entire institution. According to one source,

> … more than 400 maternity programs closed nationwide between 2006 and 2020. In rural communities, the disappearance of OB services has been particularly impactful. Between 2011 and 2021, 267 rural hospitals closed OB services, representing 25% of all rural OB units in the U.S.

Response to Proposed Regulatory Changes

ASH appreciates CMS's focus on improving maternal health outcomes but we are concerned that the proposed regulations will only contribute to the growing crisis of inadequate access to care. All communities, regardless of socioeconomic factors or geographic location, deserve person-centered, reliable OB care and ASH does not believe the proposed revised or new CoPs will enhance access to OB services or move the health care industry closer to health equity in maternal care and urges CMS to withdraw all of them

Organizational changes and increased staffing to ensure compliance with these new CoPs may even detract from the pursuit of this aim because it will draw administrative and financial resources away from the care collaboratives and innovations that many safety-net systems and their community and academic partners are pursuing. For community safety-net hospitals and many others, improving access to and the quality of OB care is a matter of resources, not regulation, and we urge CMS to invest greater resources in this care, not more regulation.

While we suggest that CMS withdraw all the OB-related proposed CoPs in favor of providing hospitals more resources to pursue innovation in OB care, we also offer CMS suggestions to improve the CoP language as proposed. From our perspective, it appears that CMS is attempting to give hospitals flexibility in its proposed regulatory language but the lack of nuance and specificity, in our view, does more harm than good when it comes to planning for compliance. ASH requests that if CMS moves forward with the proposed CoPs for OB it either postpones the effective date for at least 12 months or allows for discretionary enforcement while hospitals initiate the work needed to comply with these new regulations.

In the proposed delivery of service CoP, the requirement to provide equipment such as cardiac monitors does not adequately address the complications of cardiovascular disease during pregnancy. Monitors supplement well-trained caregivers at the appropriate level of care. The cost to outfit and train all OB personnel to be competent and confident to read a cardiac monitor is a misuse of resources. What community safety-net hospitals need is to ensure that all such hospitals have a clear scope of service and level of care, connection to a tertiary or quaternary center, and transfer arrangements. Level I/II facilities should have access to a cardiac monitor (one in house); access to cardiology/maternal fetal medicine services (acceptable through telehealth); and the ability and training to stabilize and transfer patients to a higher level of care if needed.

Medicaid Proposals

Continuous Coverage

In this proposed rule, CMS calls for updating Medicaid and CHIP regulations to codify the requirements of the Consolidated Appropriations Act of 2023 by making Medicaid and CHIP coverage continuously available to children under the age of 19 regardless of changes in eligibility such as the failure to pay program premiums. We enthusiastically support this change because this population is the most vulnerable to suffering disenrollment and because disruptions in health coverage for children can have a deleterious impact on access and health outcomes. We also urge CMS to monitor state CHIP programs' response to the elimination of the premium nonpayment option for disenrollment because it could create incentives to increase CHIP premiums to make up for lost revenue from nonpayment.

Four Walls Exceptions

CMS also proposed amending the Medicaid clinic services regulation to authorize federal reimbursement for services furnished outside the four walls of a freestanding clinic by IHS/Tribal clinics. In addition, at a state's option, federal reimbursement can be available for services provided by behavioral health clinics and clinics located in rural areas. ASH strongly supports this proposal and the opportunity it would give states to ensure equitable access to telehealth for mental health and substance use disorder for all Medicaid beneficiaries.

ASH also supports a broad definition of "rural" that will enable states to accommodate this option based on their specific needs. We are likewise grateful that CMS did not propose to burden states and providers with

a requirement to confirm an individual's behavioral health diagnosis before this exception could be applied to their telehealth care options.

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ASH appreciates the opportunity to provide feedback on the proposed rule and welcomes any questions CMS may have about the views we have expressed in this letter.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director