PREMIER TRANSFORMING HEALTHCARE TOGETHER®

August 30, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1809-P

Submitted electronically to: http://www.regulations.gov

Re: 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 [Docket Number: CMS-1809-P]

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2025 Outpatient Prospective Payment System (OPPS) proposed rule, which was published in the July 22, 2024 *Federal Register*.

In our detailed comments below, Premier urges CMS to:

- Adopt new or supplemental data sources to ensure labor costs are adequately reflected in the Medicare hospital payment update;
- Finalize its proposal to pay separately for diagnostic radiopharmaceuticals above the $630 threshold;
- Work with stakeholders to evaluate whether $10 is an adequate level of reimbursement to offset increased costs of sourcing domestically produced non-highly enriched uranium (Non-HEU);
- Expand the inpatient and outpatient payment adjustments for domestically sourced personal protective equipment (PPE) to include additional PPE, including non-surgical N95 masks and isolation gowns.
- Abandon its proposal to establish a new obstetrics services condition of participation (CoP) for hospitals and critical access hospitals (CAHs);
- Work with stakeholders to finetune its portfolio of health-equity related measures, including continuing to test its screening for social drivers of health measures prior to requiring reporting or adopting into additional programs; and
- Delay mandatory reporting of the two hybrid measures in the Hospital Inpatient Quality Reporting (IQR) Program for at least two years.

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II. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 325,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 2.7 billion hospital outpatient and clinic encounters and 177 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

III. OPPS PAYMENT UPDATE AND IMPACT OF RISING LABOR COSTS

Background and Proposals

CMS bases the annual OPPS payment update off the inpatient hospital market basket, which is an input price index that measures the average percentage change in the price of goods and services hospitals purchase to provide care. As a fixed-weight index, the hospital market basket measures changes in prices over time of the same mix of goods and services purchased during a base period. CMS updates the market basket annually by forecasting costs using available historical data. The proposed market basket update utilizes the IHS Global Inc.'s (IGI's) fourth quarter 2023 forecast, which includes historical data through third quarter of CY 2023. Following past practice, Premier anticipates the final rule will be based on more recent data and include historical data through second quarter of CY 2024.

CMS proposes a 2.6 percent increase in OPPS payments in CY 2025 relative to CY 2024. This proposed update is based on the proposed inpatient hospital market basket update of 3.0 percent less 0.4 percentage points for the productivity adjustment. Since publication of the OPPS proposed rule, CMS has released its Inpatient Prospective Payment System (IPPS) final rule, which finalized a slightly higher hospital market basket update of 3.4 percent and a productivity adjustment of -0.5 percentage points. As a result, Premier anticipates that the final OPPS payment update will be 2.9 percent once the final rule is published in November.

Premier's Recommendations

Premier continues to have significant concerns that the proposed payment update does not adequately reflect the rising costs that hospitals have faced over the last few years, especially as it relates to labor costs.

A PINC AI™ analysis found that labor costs have increased by more than 18 percent since the start of CY 2020 through CY 2023 and do not show signs of returning to a lower level. To determine changes in hospital labor costs, PINC AI™ analyzed the data within its workforce optimization solutions, one of the nation's largest and most robust sources for standardized geographically diverse payroll data and benchmarks. The data comes directly from a hospital's general ledger and is collected and validated by health system users daily.

Our analysis found that increased labor costs are significantly higher than what CMS has estimated and finalized over the last few years and is currently estimating as part of its market basket update for 2025. CMS updates labor costs using data from the U.S. Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI).[1] Specifically, CMS uses a four-quarter rolling average of change in compensation and benefits as measured through the ECI survey of hospital workers. As noted above, there is a lag in the data that CMS uses to update the market basket annually, and the proposed update is based on historical data through third quarter of CY 2023. This compares to the Premier data that comes directly from hospital payroll in real time. Another critical difference between Premier's analysis and the ECI data is that the ECI survey of hospital employment costs only includes employed hospital staff, not contracted or contingent workers.[2]

The significant increases in labor expenses over the last several years are largely driven by two factors:

- *Increased utilization of contract staff:* Over the past few years, many hospitals have relied on contract staff – especially contract nurses – to help alleviate workforce shortages. Based on PINC AI™ data, the use of contract labor (as a percentage of total staff hours) nearly doubled from the start of 2021 through 2022. With increased demand, we also saw a significant increase in compensation for contract labor. According to PINC AI™ data, the average salary for contracted nurses nearly doubled between the start of FY 2020 and the first half of FY 2022, when salaries for contract labor peaked. Our data indicates that while salaries for contract nurses have decreased some from this peak in certain geographical areas, salaries remain nearly 60 percent higher as of the end of FY 2023 as compared to the start of FY 2020. While this increase in the use of contracted staff may be temporary, it does suggest a reason why the hospital market basket for 2021 and 2022 understated hospital increases in costs.

- *Growth in employee salaries:* Premier's data also indicates significant growth in salaries for employed workers over the last few years; this growth does not show signs of slowing as employers leverage increased salary and benefits as a retention strategy to address workforce shortages. According to PINC AI™ data, salaries for employed staff have increased by 14.3 percent overall since the start of CY 2020 through CY 2023, with employed nurses seeing a more than 18.3 percent increase in salaries on average overall.

The use of contract labor and overall increased labor costs have been driven by significant workforce shortages. Before the pandemic, many clinical staff were in short supply and growing closer to retirement age. According to pre-pandemic research published in 2018, healthcare was projected to be short more than 1 million nurses by 2020 as a result of nurse retirements, an aging U.S. population and a stagnant

[1] Approximately 67.6 percent of the market basket is related to labor costs, often referred to as the labor-related share. Wages and salaries and fringe benefits for civilian workers in hospitals – which is updated based on the BLS ECI data – account for 53 percent of the market basket. The remaining 14.6 percent of labor costs is accounted for by professional fees, administrative and facilities support, installation, maintenance and repair and all other labor costs.
[2] Per discussions with CMS Office of the Actuaries (OACT)

talent pipeline.[3] Since that time, the pandemic has only exacerbated matters, prompting a significant increase in clinician resignations and retirements; for example, more than 500,0000 nurse retirements were expected in 2022.[4] An analysis finds that by 2025, it is expected that the United States may have a gap of between 200,000 to 450,000 nurses available for direct patient care, equating to a 10 to 20 percent gap.

This significant and growing deficit in the workforce supply indicates that it is unlikely these increased labor costs are transitory, but rather a new normal that reflects shifting market dynamics. As talent shortages become more severe, providers are paying more to attract and retain scarce staff, and our analysis indicates it is likely that these wage increases have set a new floor. However, the BLS' ECI does not accurately reflect the increased and persistent labor costs resulting from these projected ongoing shortages.

Given the significant delta between the increased cost of labor calculated by PINC AI™ versus what CMS is estimating, ***Premier has significant concerns that CMS' data source for estimating the cost of labor does not capture current market dynamics and woefully underestimates the true cost of healthcare labor across the country.*** This gross underestimate by CMS will result in a fifth consecutive year where the Medicare hospital payment update is not reflective of the actual cost increases hospitals are experiencing. This comes at a time when many acute care providers are struggling to stay afloat after years of COVID-related financial losses, high inflation and increased labor expenditures. ***Premier continues to strongly urge CMS to adopt new or supplemental data sources, such as PINC AI™ data, to ensure labor costs are adequately reflected in the payment update in the final rule.*** It is imperative that CMS diversify its data sources to ensure a more accurate, blended labor impact rate for 2025 and beyond.

IV. DIAGNOSTIC RADIOPHARMACEUTICALS

Background and Proposals

CMS packages drugs, biologicals and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure with the payment for the related procedure or service. Since 2008, CMS has packaged diagnostic radiopharmaceuticals. Since then, many stakeholders have raised concerns that the current OPPS packaging policy has contributed to a lack of patient access to certain technologies after the radiopharmaceutical's pass-through status expires, especially in cases where there is no clinical alternative to the radiopharmaceutical.

CMS proposes a separate payment for radiopharmaceuticals with per day costs above a threshold of $630, which represents approximately two times the volume weighted average cost amount currently associated with diagnostic radiopharmaceuticals. CMS proposes to update the threshold for CY 2026 and subsequent years based on the Producer Price Index for pharmaceutical preparations.

Premier's Recommendations

Premier supports CMS' proposal to pay separately for diagnostic radiopharmaceuticals above the $630 threshold. In the proposed rule, CMS appropriately acknowledges the high costs of certain diagnostic

[3] Zhang, Ziaoming, et al., "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit,"*Americna Journal of Medical Quality,* 2018, Vol. 33(3) 229–236, https://edsource.org/wp-content/uploads/2019/02/Zhang-Daniel-Pforsich-Lin-2017-United-States-Registered-Nurse-Workforce-Report-Card-and-Shortage-Forecast_-A-Revisit.pdf
[4] American Nurses Association, "Nurses in the Workforce," https://www.nursingworld.org/practice-policy/workforce/

radiopharmaceuticals and the potential access barriers that cost may create when payment is packaged into the cost of an associated imaging procedure. ***Premier agrees that a separate payment is warranted to ensure continued patient access to diagnostic radiopharmaceuticals.*** While the payment threshold and proposed annual update methodology appear reasonable, Premier encourages CMS to continue to evaluate its methodology for setting the threshold as additional radiopharmaceuticals enter the market. Premier also encourages CMS to monitor for any unintended consequences that may occur, including manufacturers purposely pricing diagnostic radiopharmaceuticals just above the payment threshold to take advantage of the separate payment. Both are critical to maintaining adequate reimbursement and access.

V. RADIOISOTOPES DERIVED FROM NON-HIGHLY ENRICHED URANIUM (NON-HEU) SOURCES

Background and Proposals

Since CY 2013, CMS has provided an additional $10 payment for the marginal cost of radioisotopes from non-HEU sources while the industry has continued to transition to alternative methods of producing these critical materials. As part of 2023 rulemaking, CMS indicated that the Department of Energy expected that the last HEU reactor that produces Mo-99 for medical providers in the U.S. would finish its conversion to a non-HEU reactor by the end of CY 2022. Non-HEU radioisotopes are generally more expensive than HEU isotopes. As a result, CMS believed it was necessary to extend the extra $10 payment for non-HEU isotopes through CY 2024 to ensure Medicare claims data used to value the APCs fully reflected these additional costs. In 2024 rulemaking, CMS acknowledged that the conversion of the last converter did not happen until March 2023. As a result, CMS extended the additional $10 payment through CY 2025 to ensure sufficient time for the costs to be reflected in claims data used for rate setting.

Since then, the Department of Energy and other stakeholders have raised concerns around foreign governments subsidizing foreign supplies of Mo-99 and Tc-99, resulting in artificially low prices creating a barrier to entry for new producers. Based in part on the differences in pricing models, U.S. companies have experienced challenges in competing with foreign producers for customers. Currently, there is no domestic production of Mo-99.

To address the difference in costs between purchasing domestically produced Mo-99 and imported Mo-99, CMS proposes to establish a new add-on payment of $10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99, beginning CY 2026. CMS plans to provide additional guidance on this policy as part of next year's rule.

Premier's Recommendations

While Premier supports a new add-on payment for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99 and appreciates CMS' diligence in monitoring this transition, we are concerned that the $10 amount may not be adequate. The amount was set more than a decade ago and circumstances may have changed significantly during that period. Accordingly, ***Premier requests that CMS work with stakeholders to evaluate whether $10 continues to be an adequate level of reimbursement to offset increased costs of sourcing domestically produced non-HEUs.*** At a minimum, Premier requests that CMS provide additional analysis in the final rule to support continuing to set the payment at $10.

VI. PAYMENT ADJUSTMENTS FOR DOMESTIC PERSONAL PROTECTIVE EQUIPMENT

Background and Proposals

As part of 2023 rulemaking, CMS adopted an OPPS and IPPS payment adjustment to offset the marginal costs hospital face in obtaining domestically made NIOSH-approved and FDA-certified surgical N95 respirators. In this year's rule, CMS notes that uptake of the adjustment has been limited and that market data indicates that the majority of surgical N95 respirators purchased by hospitals are not wholly domestically made. As a result, CMS seeks feedback to better understand barriers to utilizing the adjustment and potential modifications to the policy to reduce reporting burden and achieve the policy goal of maintaining a baseline domestic production capacity of personal protective equipment (PPE).

CMS also seeks feedback on potentially expanding the policy to domestically manufactured non-surgical N95 masks and nitrile exam gloves.

Premier's Recommendations

Premier thanks CMS for the opportunity to comment on further payment adjustments for domestically sourced PPE. Ensuring that providers have access to sufficient PPE and other medical supplies is an issue on which we have shown leadership since the beginning of the COVID-19 public health emergency (PHE), including but not limited to:

- Acquiring a minority stake in and making purchasing commitments to Prestige Ameritech, the nation's largest domestic producer of face masks located in Texas, to produce 8 million N95s and more than 45 million other PPE products annually.
- Creating a joint venture partnership with DeRoyal Industries Inc. that is expected to produce more than 40 million domestically manufactured gowns annually in Knoxville, TN. The gowns are now coming off the line and deliveries have begun.
- Acquiring a minority stake and committing to product purchasing in Exela Pharma Sciences to secure vital supply of 20+ pharmaceutical products, including several generic injectables that frequently appear on the FDA's drug shortage list. Exela manufactures in Lenoir, NC.

Premier has strongly supported the existing payment adjustment under IPPS and OPPS for domestically produced N95s and has urged that it be expanded to other critical medical supplies and pharmaceuticals. It is important to note that many providers may not be taking advantage of the differential reimbursement at this time because they still have stockpiles available to them from the time of the pandemic. Premier provided additional data to the White House in April 2024 regarding current uptake of this policy highlighting barriers, including current excess inventory on hand. However, that will undoubtedly not always be the case and therefore the payment adjustment is the right policy to ensure future supplies are sufficient in the event of another public health emergency.

In our response to the FY 2023 IPPS comment solicitation, Premier urged CMS to adopt a payment adjustment methodology that is least burdensome to the hospital community, including limiting frequency of reporting and seeking to utilize existing reporting processes. We applauded CMS for utilizing the existing cost report process and available data, while minimizing new reporting to the extent possible. Premier also encouraged CMS to work with the hospital and supply chain communities to automate reporting in the future. For example, to help alleviate provider burden, it is possible to build infrastructure that would allow purchases made from a GPO contract to be reported directly to CMS on behalf of providers. ***Similarly, Premier believes that CMS should move to a national benchmark calculation for the payment***

adjustment to ensure the payment is equitable while minimizing the burden to providers and ensuring success of the policy itself. For example, there is one domestic manufacturer who qualifies for differential reimbursement under this policy, but due to investments and efficiencies in the manufacturing process, their price point is competitive with global sources and therefore the differential reimbursement does not apply. By moving to a global benchmark, healthcare providers could continue to be rewarded for purchasing from this domestic source.

Regarding CMS' inquiry as to whether the policy should be expanded to non-surgical N95 masks, Premier strongly supports the expansion. Non-surgical N95 masks represent most of the N95 masks purchased by healthcare providers, and Premier believes that CMS would see greater uptake of the differential reimbursement policy.

Regarding CMS' inquiry as to whether the policy should be expanded to domestically manufactured nitrile exam gloves, Premier urges CMS to not move forward with this policy as there are currently no known sources of domestically manufactured nitrile exam gloves. While many investments have been made by both the government and private sector to initiate manufacturing of domestically manufactured nitrile exam gloves, unfortunately none of those initiatives have come to fruition thus far. In addition, to Premier's knowledge, none of those initiatives would meet the Berry Amendment definition of domestic as not all components are wholly made in the US. Premier urges CMS to revisit the possibility of expanding this policy to domestically manufactured nitrile exam gloves in the future.

However, there are several other PPE items (e.g. isolation gowns, hair nets, beard covers, bootie covers, etc.) that have good domestic sourcing available that do meet the Berry Amendment requirements. Therefore, Premier urges CMS to expand this policy to additional PPE categories in CY 2025.

Premier also encourages CMS to work with Congress to give CMS authority to apply this payment policy in a non-budget neutral manner under the OPPS or find another authority for subsidizing hospitals that does not require a budget neutrality adjustment. Applying a budget neutrality adjustment significantly reduces the effectiveness of this policy, especially as more hospitals acquire domestically-produced products. Such an adjustment would be counterproductive and would essentially remove the incentive that is being provided with the additional payment through a payment reduction elsewhere. Additionally, applying a budget neutral adjustment could have a detrimental effect on safety net or smaller hospitals, which may be less able to absorb the higher costs of acquiring domestically-produced medical supplies. Finally, applying a budget neutral adjustment may in fact truncate the expansion of the policy to additional domestically-produced critical medical supplies and drugs, as CMS clearly supports, further disincentivizing domestic manufacturing and supply chain resilience – which, after all, is the ultimate goal.

Finally, many of the 30 million Medicare Advantage (MA) enrollees have access to an over-the-counter (OTC) benefit through their health plan. Typically, MA plans create a formulary or catalog of approved OTC products, which are available for enrollees to purchase using an allocated allowance. Many MA plans have elected to allow enrollees to use their OTC benefits to purchase COVID-19 preparedness supplies, including at-home testing products and PPE, such as N95 masks. Premier agrees that reliance on overseas manufacturing for medical supplies contributes to shortages, and we support CMS' efforts to stabilize the national supply chain by incentivizing the domestic production of PPE. ***CMS could require all MA plan sponsors participating in the MA Value-Based Insurance Design (VBID) model to cover domestically-manufactured N95 masks or similar supplies in any supplemental OTC benefits that the plan intends to offer.*** Additionally, Premier urges CMS to reflect in the 2026 MA bid instructions that plans are strongly encouraged to cover domestically-manufactured N95 masks in any supplemental OTC benefit offerings.

VII. HEALTH AND SAFETY STANDARDS FOR OBSTETRICAL SERVICES

Background and Proposals

In the FY 2025 IPPS proposed rule, CMS requested public comment on establishing CoPs specific to labor and delivery, prenatal and post-partum care for newborn infants.[5] In response to that comment solicitation, Premier responded that ***any policy change to improve maternal health care outcomes must ensure that it does not exacerbate access to care issues.*** An obstetric services CoP would carry far too harsh a penalty, in that failure to comply with the new CoP would result in the loss of Medicare certification. Alternatively, the burden of compliance could also result in at least some hospitals deciding to no longer furnish obstetrical care. This result would further limit access to obstetrical care and could potentially exacerbate rates of maternal morbidity/mortality.

Despite our comments, CMS has moved forward and proposed standards for hospitals that furnish labor and delivery services, prenatal and post-partum care for newborn infants. Under CMS' regulations, the requirements are optional in that hospitals are not required to provide these services — except for hospitals that deliver emergency services. However, if a hospital does provide labor and delivery services, prenatal and post-partum care for newborn infants services outside of the emergency room, the hospital must comply with the requirements of the CoP specific to these services. If a hospital delivers emergency services, CMS is proposing to add CoPs specific to obstetrical emergencies. Immediate post-delivery care would always apply.

Premier's Recommendations

In our earlier comments on the FY 2025 IPPS proposed rule, Premier indicated concern about the potential burden additional CoPs would place on hospitals that could result in hospitals no longer offering delivery services, prenatal and post-partum care for newborn infants. Given that the new CoPs are associated with an optional service on the part of the hospital, Premier remains concerned that the risk of non-compliance with the CoPs or the burden of complying with the provision may result in hospitals no longer providing these services contributing further to the maternal health crisis through lack of access to these essential services. These risks are more apparent in the CY 2025 OPPS proposed rule. Following each new CoP, CMS provides the associated estimated burden and compliance costs with the new regulations. Totaling these costs together, CMS' own estimates – which are likely low – suggest that the additional costs could be as much as $180,000 per hospital per year.

In lieu of adopting these new CoPs, Premier recommends that CMS work with stakeholders to create a less onerous policy that balances these concerns. If CMS decides to finalize its policy, it is important the agency provide sufficient time for hospitals to come into compliance. The proposed rule is not specific as to when any of the new CoP requirements are effective. Absent a specific effective date, Premier presumes that CMS plans to make these new CoP requirements effective Jan. 1, 2025 consistent with the default effective date for other provisions of the CY 2025 OPPS rule.

As the final rule will be published by Nov. 1, 2024, hospitals providing labor and delivery services, prenatal and post-partum care for newborn infants will only have 60 days to come into compliance with these new

[5] 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, May 2, 2024, p. 36498

CoPs. ***Premier requests that if CMS moves forward with this policy that it either postpones the effective date for application of these new optional CoPs (mandatory for hospitals that provide emergency services) for at least 12 months or allow for discretionary enforcement while hospitals undertake efforts to be in compliance with these new regulations.***

Premier Stands Ready to Use Our Extensive Resources to Help CMS Improve Obstetrical Care.

As noted above, Premier recommends that CMS work with stakeholders to create a less onerous policy than the adoption of new CoPs. Premier's research, data analytics and on the ground member efforts are all working together to understand what elements are leading to the obstetrical and infant mortality concerns that CMS has outlined in the FY 2025 IPPS proposed rule and again in the CY 2025 OPPS proposed rule. Premier stands ready to offer our resources to address this problem head-on with the Department of Health and Human Services (HHS).

As noted in our 2025 IPPS proposed rule comments, the Office of Women's Health (OWH) through the Maternal Morbidity and Mortality Data and Analysis Initiative has tapped into Premier's extensive data to understand why disparate maternal outcomes occur. The HHS Perinatal Improvement Collaborative, a multi-year collaborative comprised of more than 220 hospitals from all 50 states and the District of Columbia, leverages standardized data and proven performance improvement methodology to scientifically identify root causes of maternal-infant mortality and morbidity. With these resources, the collaborative is implementing and analyzing evidence-based interventions to drive clinical quality improvement, advance health equity and help make America the safest place to have a baby.

Premier supports the standardization of data collection and measurement as it relates to obstetrical services. Through our intensive maternal work, Premier recognizes that reliable, comparable, and comprehensive data is needed to achieve real improvement in maternal morbidity and mortality. Premier agrees with CMS that obstetrical care delivery standards can help address the maternal morbidity, mortality and maternity care access issues in the United States, and we referenced several existing consensus documents throughout our comments on the FY 2025 IPPS proposed rule.

Premier asks CMS to carefully consider the responses below as alternative policies to advance maternal health in lieu of new CoPs. ***Premier's comments are intended to help inform CMS' thinking of how it can improve data collection, standards and other elements of obstetrical care in the United States.***

1. Organization, Staffing, and Delivery of Services

CMS proposes to require that if a hospital or a CAH offers obstetrical services, the services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for physical and behavioral (inclusive of both mental health and substance use disorders) healthcare of pregnant, birthing, and postpartum patients. The services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

Nationally recognized acceptable standards of practice may be based on medical and nursing professional society and/or accrediting organization standards. While these CoPs would not require adherence to a specific organization's guideline or recommendations, CMS expects that facilities would be able to articulate their standards and the source(s) and to demonstrate that their standards are based on evidence and nationally recognized sources.

Premier notes that a consensus document defining the levels of maternal care was released in August of 2019 with the goal to reduce maternal morbidity and mortality, and disparities, by standardizing and defining

risk-appropriate care.[6] However, there remains considerable variation in the adoption of these maternal levels of care across the United States.[7] The Association of Women's Health, Obstetrical and Neonatal Nurses (AWHONN) published standards for registered nurse staffing for perinatal units in 2022[8] and implementation of these standards is still variable across the United States. Unfortunately, significant workforce challenges have severely impacted the ability to adopt these standards.

Prior to finalizing its proposed new CoP regarding staffing, organization or delivery of obstetrical services, Premier urges CMS to study and understand barriers to implementation of existing recommendations related to staffing standards for perinatal units.

CMS also proposed to establish minimum standards for equipment. For example, labor and delivery room suites would be required to have a call-in-system, cardiac monitor, and fetal doppler or monitor. ***Premier supports the requirements published in the Guidelines for Perinatal Care, 8th Edition, in addition to the capabilities and equipment recommendations defined in the Levels of Maternal Care Consensus statement.***

2. Training and Oversight of Obstetrical Staff

CMS proposes that hospitals and CAHs that provide obstetrical services would be required to develop policies and procedures that would ensure that relevant obstetrical services staff would be trained on select topics for improving the delivery of maternal care. Training topics would have to reflect the scope and complexity of services offered, including, but not limited to, facility-identified evidence-based best practices and protocols to improve the delivery of maternal care within the facility.

Premier supports the credentialing published in the Guidelines for Perinatal Care, 8th Edition, which was created with input from multiple professional societies, noting that registered nursing staffing for perinatal units has been updated. Standardization across states would benefit the interpretation of data for consistency in delivery and implementation.

3. Quality Assessment and Performance Improvement (QAPI) Program

CMS proposes that a hospital or CAH that offers obstetrical services would be required to use its QAPI program to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis.

Premier has experience collecting and standardizing data, as is done in the PINC AI Healthcare Database (PHD). It is one of the most comprehensive electronic healthcare data repositories in the country. More than 1,300 hospitals/healthcare systems contribute data to the PHD. It provides a unique source of real-world data to conduct evidence-based and population-based analyses of drugs, devices, other treatments, disease states, epidemiology, resource utilization, healthcare economics and clinical outcomes. The PHD comprises United States service-level, all payer information on inpatient discharges and outpatient encounters, primarily from geographically diverse non-profit, non-governmental, and community and teaching hospitals and health systems from rural and urban areas.

[6]Obstetric Care Consensus: levels of Maternal Care, Number 9, Vol 134, No.2, August 2019. Obstetrics and Gynecology
[7]State Implementation | ACOG
[8] AWHONN *Standards for Professional Registered Nurse Staffing for Perinatal Units,* 2022.

Premier also utilizes QualityAdvisor™ (QA), which is a clinical benchmarking solution that enables users to identify opportunity for improvement, analyze resource utilization at the item level and mitigate unjustified variation through self-service analytics and executive-ready dashboards. Through Premier's robust QA database and Perinatal Quality Dashboard, Premier supports over 1,350 hospitals with capability to report on birthing populations including through customizable benchmarks and ability to drill down to many features, including the following, and more. This same standardized database has been used to support multiple perinatal collaboratives.

CMS can work with various stakeholders who have already created comprehensive data processes, such as Premier, to effectively design data collection practices that hospitals providing obstetrical services may use in their QAPI programs.

4. Emergency Services Readiness

CMS is proposing a new standard entitled ''Emergency Services Readiness'' within the existing Emergency Services CoP for hospitals and CAHs. Under the proposed new CoP, hospitals and CAHs that offer emergency services would be required to have adequate provisions and protocols to meet the emergency needs of patients in accordance with the complexity and scope of services offered. Facilities may utilize national medical professional society, accrediting organization, credentialling body, or other national guidelines to develop appropriate protocols for their emergency services patient populations.

CMS further proposes that hospitals offering emergency services have available the equipment, supplies, and medication used in treating emergency cases. Hospitals would have flexibility in identifying and determining the type and necessary quantity of drugs, blood products, biologicals, equipment and supplies commonly used in emergency procedures needed to meet the needs of their patients.

As CMS notes, the Alliance for Innovation on Maternal Health's (AIM; a partnership between HRSA and American College of Obstetricians and Gynecologists (ACOG) and other stakeholders) has developed resources which include example protocols and training resources for responding to obstetrical hemorrhage, severe hypertension, perinatal mental health conditions, sepsis, substance use disorder, and cardiac conditions, among others.[9] ACOG has also developed resources for Obstetric Emergencies in Non-obstetric Settings.[10] Similarly, the HRSA-supported Emergency Medical Services for Children Innovation and Improvement Center has resources for emergency departments seeking to improve ''pediatric readiness.''[11]

Premier supports providing hospitals and CAHs with the resources that will allow them to be in compliance with the current emergency readiness requirements in the existing CoPs. If CMS is to finalize the proposed new readiness requirements, Premier requests CMS allow hospitals the flexibility to use any of the resources identified in the proposed rule as its guide for maintaining emergency readiness.

5. Transfer Protocols

CMS proposes to amend its discharge planning CoP regulation to impose transfer protocols. Hospitals and CAHs would be required to have written policies and procedures for the transfer of patients under their care, including hospital inpatients. The standard would apply to transfers from the emergency department

[9] AIM | Alliance For Innovation On Maternal Health (saferbirth.org)
[10] Obstetric Emergencies in Nonobstetric Settings | ACOG
[11] National Pediatric Readiness Project • EIIC (emscimprovement.center)

to inpatient admission or transfers between inpatient units in the same hospital as well as to transfers between inpatient units at different hospitals.

Premier does not support creating a new CoP for transfer protocols. However, Premier does support hospitals following the guidelines for the transfers published in the Guidelines for Perinatal Care, 8th Edition, in addition to the capabilities and equipment recommendations defined in the Levels of Maternal Care Consensus statement.

Ongoing Improvements to Obstetrical and Maternity Care.

Below, Premier reiterates the comments we made in response to the FY 2025 IPPS rule comment solicitation on resources that Premier has available to assist CMS with improving the quality of obstetrical care, maternal and newborn services in hospitals.

1. Patient Experience with Maternity Care

To better understand patients' experience of maternity care, CMS can leverage various tools and instruments designed to capture individuals' perspectives and feedback. These tools include patient satisfaction surveys, such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which assesses patients' experiences with their hospital stay, including aspects specific to maternity care.

Specifically, Premier recently responded to an RFI from the Agency for Healthcare Research and Quality (AHRQ) regarding the potential implementation of a CAHPS survey to assess patients' prenatal care and childbirth care experiences in ambulatory and inpatient care settings. Currently, no CAHPS instrument is available that is specifically designed to measure prenatal and childbirth care from the patient's perspective in these settings. In its comments, Premier supported a dedicated survey tool designed to measure prenatal and childbirth care from the patient's perspective and recommended methodologically sound approaches to capture this data in healthcare settings, including:

- Creating survey questions that include communication with providers, access to services and patients' perceptions of bias in receiving care.
- Developing different delivery mechanisms for the survey tool, as well as various language versions and survey questions posed in a manner that is suitable for individuals with varying health literacy levels to reflect the diverse birthing population.
- Creating a unique survey for maternity care, but if AHRQ does not pursue the creation of a unique survey, Premier urges that a path be explored for integrating questions into the existing inpatient CAHPS surveys that explicitly address prenatal and childbirth care experiences.

Premier urges CMS to work with AHRQ to expeditiously develop, test and implement a CAHPS survey instrument that is specifically designed to measure prenatal and childbirth care from the patient's perspective.

Additionally, CMS can utilize patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) tailored to maternity care. PROMs focus on assessing patients' health status and functional outcomes following childbirth, while PREMs capture patients' perceptions of the care they received during pregnancy, labor, delivery and postpartum care.

Furthermore, qualitative research methods, such as focus groups and interviews, can provide valuable insights into patients' experiences, preferences and unmet needs in maternity care.

CMS can also encourage healthcare organizations to implement real-time feedback mechanisms, such as patient portals or mobile applications, to solicit ongoing input from maternity patients throughout their care journey.

2. Improving Outcomes and Lowering Costs

The Maternal Levels of Care Consensus Document already represents a professional expert consensus of what is necessary to address outcomes and lower costs. In addition, the effectiveness of prenatal and postnatal care using telehealth[12] and remote patient monitoring is emerging in the published literature. A study published in 2023 concluded that at the state level telehealth use increased during the pandemic without variation in practice type with implications for learning and designing innovative solutions for providers and patients[13]. One current example is the Maven Clinic[14] virtual care model which has improved outcomes and lowered costs.

3. Improving Data Collection

Identifying common critical data elements is essential for improving maternal health data. CMS should work with relevant stakeholders to determine these elements, ensuring that they encompass a wide range of factors affecting maternal health outcomes. A report in 2021 by the Commonwealth Fund[15] describes several of the opportunities available to improve measurement of maternal morbidity crisis across the United States.

To ensure data collection encompasses all demographics, CMS must prioritize equity and inclusivity in data collection efforts. This may involve implementing strategies to reach underserved populations, addressing language and cultural barriers, and incorporating demographic variables in data collection tools and processes.

Examples of such strategies to support comprehensive demographic data collection include:

- *Collection for urbanicity and location/distance traveled for care from primary zip code.* Women in rural areas have had a consistently higher predicted probability of Severe Maternal Morbidity (SMM), such as sepsis, pulmonary edema and acute renal failure, as well as mortality, even after accounting for sociodemographic factors and clinical conditions. Rural and urban health disparities have continued to widen over time.
- *Standardization of data collection with an equity lens for outcomes by location/distance travelled for care from primary zip code.* Exploring resource allocation by location may confirm and allow for close monitoring of outcome inequities by local of care provision.
- *Additional guidance to support accurate coding of SDOH Z-codes.* As noted above, for these codes to adequately capture resources needs, hospitals must report corresponding Z-codes. However, only a small fraction of claims incorporate SDOH Z-code. Additional guidance and education is needed on how to accurately document SDOH and capture Z-codes in claims.
- *Gender identity data collection.* Not all patients who give birth identify as female. Data should be collected for gender identity to allow reporting across genders and investigation of inequities.

[12] Shmerling, A., Hoss, M., Malam, N., Staton, E. W., & Lyon, C. (2022). Prenatal Care via Telehealth. *Primary care*, *49*(4), 609–619. https://doi.org/10.1016/j.pop.2022.05.002

[13] Mallampati, D. P., Talati, A. N., Fitzhugh, C., Enayet, N., Vladutiu, C. J., & Menard, M. K. (2023). Statewide assessment of telehealth use for obstetrical care during the COVID-19 pandemic. *American journal of obstetrics & gynecology MFM*, *5*(6), 100941. https://doi.org/10.1016/j.ajogmf.2023.100941

[14] Maven Clinic – The next generation of care for women and families

[15] Severe Maternal Morbidity in the United States: A Primer | Commonwealth Fund

- *Age.* Data should be collected for the age of the patient to allow for a greater understanding of the relationship between age and outcomes, and to determine the impact of interventions on outcomes related to patient age. Data collection and research should allow for expanded age groupings as the overall population ages. Many national measures exclude patients falling outside of a standard age grouping, which limits the ability to analyze patients outside of the specified range.

VIII. HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAMS

Background

The Hospital Outpatient Quality Reporting (OQR) Program is a pay-for-reporting quality program. Hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a 2.0 percentage point reduction in their annual payment update.

Proposals and Premier's Recommendations - Measures Proposed for Adoption

CMS proposes to adopt four measures into the OQR Program:

(1) Hospital Commitment to Health Equity (HCHE) measure.

CMS proposes to adopt the HCHE measure into the Hospital OQR Program, beginning with the 2025 reporting period/2027 payment determination, in alignment with the agency's goals of advancing health equity. The HCHE measure is an attestation-based structural measure that assesses hospitals' commitment to health equity across five domains: (1) equity in a strategic priority, (2) data collection, (3) data analysis, (4) quality improvement, and (5) leadership engagement. Hospitals are awarded a point for each domain that they attest affirmatively to. The goal of the measure is to incentivize hospitals to collect and use data to identify equity gaps, implement plans to address the gaps and provide for resources for initiatives on health care equity. The HCHE measure, which was initially developed for the Hospital Inpatient Quality Reporting (IQR) Program, is currently included in the Hospital IQR and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) programs. A similar facility-based measure is in place for the End-Stage Renal Disease Quality Incentive Program and Inpatient Psychiatric Facility Quality Reporting Program.

Premier continues to support adoption of this structural measure as a first step in addressing health equity. Leading hospitals and other healthcare providers have long engaged in efforts to address health equity within their communities. This measure will incent providers to continue and expand these efforts. Premier also supports CMS' efforts to adopt standardized measures across multiple settings.

However, ***Premier continues to urge CMS to work with stakeholders to finetune its portfolio of health-equity related measures.*** CMS should prioritize adopting a streamlined measure set that is consistent across settings and that provides meaningful and actionable data aimed at addressing social determinants of health and advancing health equity.

Premier urges CMS to move past structural measures and reassess the ongoing need for the HCHE measure in the future as it works to expand its portfolio of health equity measures. As part of that, CMS should monitor for ongoing success of the measure and finetune the measure across programs if it no longer yielding desired results. Finally, Premier urges CMS to explore

developing measures that use data that CMS already collects through claims or could be collected through other digital measurement sources.

(2) And (3) Screening for Social Drivers of Health (SDOH) and Screen Positive Rate for SDOH measures

CMS proposes to adopt both the Screening for SDOH measure and the Screen Positive Rate for SDOH measure into the Hospital OQR Program beginning with voluntary reporting for the 2025 reporting period and mandatory reporting starting with the 2026 reporting period/2028 payment determination.

The Screening for SDOH measure is a process measure that assesses the total number of patients who are 18 years of age or older that the hospital screened for five health-related social needs (HRSNs): (1) food insecurity, (2) housing instability, (3) transportation needs, (4) utility difficulties and (5) interpersonal safety). Hospitals would be able to self-select a survey instrument. Hospitals would not be required to submit patient-level data but would instead report aggregated numerator (i.e., number of patients 18 years or older who were screened during receipt of hospital services) and denominator (i.e., number of patients admitted to a hospital outpatient department (HOPD) who are 18 years or older) data.

The Screen Positive Rate for SDOH process measure is a companion measure to the Screening for SDOH measure noted above. The measure captures the percent of patients 18 years or older who were screened for all five HRSNs and who screened positive for at least one of the domains. Hospitals would report the measure as five separate rates, one for each screening domain, calculated as the number of patients who screened positive divided by the number of patients who were screened.

CMS adopted both measures into the Hospital IQR Program starting with voluntary reporting during the CY 2023 reporting period, followed by mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination.

As part of the OPPS rule, CMS proposes that hospital outpatient departments could confirm the current status of a patient's previously reported HRSNs in another care setting during the reporting period and inquire about others not previously reported, instead of rescreening a patient. Additionally, if information on HRSNs is in the electronic health record (EHR) from another health setting during the same reporting period, CMS proposes that the facility could use that information to report the measure instead of screening.

Premier strongly recommends that CMS continue to test these measures through voluntary reporting in the programs where they have already been adopted prior to expanding them as mandatory in those programs and adopting them into additional programs. While many providers have already implemented processes to screen patients for social drivers, providers continue to face challenges with aggregating and reporting results for their entire patient population. For example, CMS recently clarified that while all patients should be screened at every visit only the last visit should be reported for purposes of the measure. Additionally, providers are still awaiting additional guidance from CMS on how to report certain cases. For example, there is no published guidance as to what constitutes a "positive" screen which means the results are not able to be accurately compared. As a result, ***Premier strongly urges CMS to maintain the measure***

as voluntary as it continues to work through these technical reporting challenges with providers.

Expanding this measure in the outpatient setting will significantly increase the population size that hospitals must report. It is critical that CMS address the existing reporting challenges prior to expanding the measure. Additionally, given ongoing staffing challenges at hospitals and the burden associated with screening, Premier strongly cautions CMS from expanding the measure to the outpatient setting. While Premier appreciates the flexibility that CMS is granting by allowing facilities to use information either collected through the EHR or at another setting during the reporting period, confirmation of HRSNs may take staff as much time and resources as rescreening a patient, so likely will have minimal impact on reducing burden.

During pre-rulemaking, Premier along with other stakeholders had recommended that CMS allow hospitals to report the measure jointly for both the IQR and OQR Programs. CMS notes that it considered this recommendation, however it opted for separate reporting because the patient populations (and therefore the denominator and measure calculation) for each program are different. Additionally, CMS believes that it may be useful to split out the information for purposes of the Care Compare tool, which separates data by inpatient and outpatient department.

Premier disagrees with CMS' assessment that the measures are capturing different patient populations across settings. Some hospitals already note that they are reporting the measure across inpatient and outpatient as part of their inpatient reporting. Additionally, as noted above, CMS is proposing that facilities could use HRSNs collected from other settings during the reporting period instead of rescreening a patient. So long as hospitals use the same methodology for identifying their patient population for the numerator and denominator, they should be allowed to aggregate reporting based on the process that works best for the facility.

CMS proposes to allow hospitals to self-select a survey instrument but has previously indicated that it may look to standardize the survey in the future. Premier is concerned that over time this could lead to inconsistent reporting and make it challenging for CMS and other stakeholders to accurately evaluate and utilize the data. However, many hospitals have designed survey processes that best meet the needs of their patients. For example, some hospitals have elected to ask the questions at different points in the care experience, such as asking more sensitive questions in the privacy of the exam room versus at check-in. ***Premier urges CMS to work with stakeholders to develop consistent survey questions, but continue to maintain the flexibility for how and when facilities screen patients so that facilities can be best design their survey protocols to meet the needs of their patients and the capacity of their staff.***

Premier also continues to caution CMS from publicly reporting on certain metrics, such as the screen positive rate. Publicly reporting the rate of positive screening could make hospitals that serve a larger population of marginalized and underserved communities appear as though they are lower performing, without adjusting for the impact of serving patients who are affected by multiple social drivers of health. Further, if patients see a high rate of positive screenings attributed to a hospital, they may avoid going to that hospital for care, which could reduce access. There is a myriad of benefits to hospitals collecting data on the rate of positive screenings and using those data to inform their programs and policies addressing health equity. However, Premier does not see the benefit of this measure as a public reporting tool. While CMS notes that this measure is not intended for hospital comparison, publicly reporting the results will encourage doing so.

Premier also urges CMS to work with stakeholders to continue to evolve this measure to reduce burden on providers and patients. For example, CMS should consider ways to develop an electronic clinical quality measure that allows providers to pull directly from electronic medical records. Additionally***, Premier encourages CMS to work with stakeholders to develop a measure that is meaningful for hospitals as they design interventions to address HRSNs in partnership with their communitie***s. For example, under the existing measures, a patient that is considered at "low-risk" for HRSNs is still considered a positive need, since the only answer that counts as a negative screen is if that patient is at no risk. It is likely more valuable for providers to have a screening tool that captures a more granular scale of need which would allow them to identify the patients with the greatest need for follow-up referrals or to vary interventions based on patient need.

Additionally, as noted above, Premier appreciates CMS providing flexibility to providers if a patient has been previously screened and the information is available in the EHR. However, since the survey is a point-in-time evaluation and an individual's circumstances may change over time, Premier is concerned that this measure could simply become a check-the-box exercise that may provide minimal value to facilities. We do not advocate for CMS to require facilities to re-screen patients at every visit. However, ***Premier urges CMS as it works with stakeholders to design surveys or metrics that more adequately identify patients most at-risk in a meaningful way, especially as patients' circumstances may evolve.***

Finally, ***Premier urges CMS to explore additional ways to support hospitals in addressing the HRSNs of their patients.*** Many facilities are working alongside community-based organizations to try and address their patients' HRSNs. However, this takes time and resources, which are not currently accounted for in Medicare payments to hospitals. As CMS continues to work with stakeholders on its initiatives to advance health equity, Premier urges it to evaluate ways to better support providers and community-based organizations in addressing HRSNs, including through Innovation Center model tests and flexibilities in Medicare statute.

(4) Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery Patient Reported Outcome-Based Performance Measure (Information Transfer Pro-PM)

CMS proposes to adopt the Information Transfer Pro-PM into the Hospital OQR Program beginning with voluntary reporting for the 2026 reporting period, followed by mandatory reporting beginning with the 2027 reporting period/2029 payment determination. The Information Transfer PRO-PM assesses the level of clear, personalized recovery information provided to patients 18 years of age or older who had surgery or a procedure in a hospital outpatient department (HOPD). The measure reports the average score of a patient's survey, which consists of three domains and nine corresponding items for patients and their caregivers to rate the clarity of information received about their post-discharge recovery. The three domains look at (1) whether recovery information considered a patient's health needs (applicability to patient needs); (2) clarity of medication information provided (medication); and (3) clarity of guidelines provided around diet, physical activity, returning to work, and driving (daily activities). The measure would be calculated based on patient-reported outcome data collected either by the HOPD directly or through a third-party vendor through a web-based survey instrument distributed to patients or their caregivers. CMS proposes that the survey would be administered two-seven days after the procedure or surgery and that there would be a 65-day window for patient response.

While Premier is supportive of patient-reported outcome measures (PROMs) and acknowledges that PROMs can be the impetus for initiating conversations between patients and providers and improving shared-decision making, we caution CMS from adopting a new PROM into the OQR Program at this time. As part of last year's rulemaking, CMS had adopted the Risk-Standardized Patient-Reported Outcome-Based (PRO) Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the HOPD Setting (THA/TKA PRO–PM) measure, beginning with two voluntary reporting periods (2025 and 2026), followed by mandatory reporting in 2027 (for 2030 payment determinations.) Our members have highlighted a number of challenges with reporting this measure both in the inpatient and outpatient settings. ***While Premier believes there is value in the proposed measure, we strongly caution CMS from adopting another PROM into the OQR Program at this time to ensure facilities have sufficient time to implement the recently adopted THA/TKA PRO-PMs.*** As noted above, hospitals continue to face staffing challenges and resource constraints and do not have sufficient resources to implement this measure at this time.

Proposals and Premier's Recommendations - Measures Proposed for Removal

CMS proposes to remove two OQR measure:

(1) MRI Lumbar Spine for Low Back Pain measure

The MRI Lumbar Spine for Low Back Pain measure is a claims-based measure evaluating the percentage of magnetic resonance imaging (MRI) of the lumbar spine for low back pain performed in the outpatient setting without any previous conservative therapy attempted first. The measure was adopted into the OQR program beginning with the 2010 payment determination. CMS proposes to remove the measure beginning with the 2025 reporting period/2027 payment determination under its measure removal factor 2: performance or improvement on a measure does not result in better patient outcomes. CMS notes that national performance on the measure has remained stable with low average volumes. Additionally, studies have found that the measure may not have any correlation with improving the appropriate use of imaging, leading CMS to conclude that the measure provides limited ability to improve the quality of care for patients.

Premier agrees with CMS' assessment of the MRI Lumbar Spine for Low Back Pain measure and supports removal from the Hospital OQR Program.

(2) Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measure

The Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measure is a claims-based measure that assesses the percentage of stress echocardiography, single photon emission computed tomography myocardial perfusion imaging (SPECT MPI), stress MRI or computed coronary tomography angiography (CCTA) performed at each facility in the 30 days before an ambulatory non-cardiac, low-risk surgery performed at any location. The measure was adopted into the OQR Program beginning with the 2012 payment determination. CMS proposes to remove the measure beginning with the 2025 reporting period/2027 payment determination under its measure removal factor 2: performance or improvement on a measure does not result in better patient outcomes. CMS notes that the range of cases per HOPD has varied greatly and that variation in performance between the 10th and 25th performance has not been distinguishable. As a result, CMS concludes that there are limitations for interpreting the

performance trends because of the range of cases and that the measure may not be providing meaningful data.

Premier agrees with CMS' assessment of the Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery measure and supports removal from the Hospital OQR Program.

IX. HYBRID HOSPITAL-WIDE ALL-CAUSE READMISSION AND STANDARDIZED MORTALITY MEASURES

Background and Proposals

Mandatory reporting for both the Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (Hybrid HWM) measures is set to begin for FY 2026 payment determinations based on performance data from July 1, 2023 through June 30, 2024. Both measures use core clinical data elements (CCDEs), which are clinical variables derived from EHRs that can be used to risk-adjust hospital outcome measures, as well as claims data and linking variables, which are administrative data that can be used to link the CCDEs and claims data for measure calculation. To meet the reporting requirements, hospitals must submit linking variables on 95 percent of hospital discharges and CCDEs on 90 percent of discharges in a reporting period.

Based on its monitoring of data collected through voluntary reporting, CMS found that approximately three-quarters of participating hospitals were unable to meet the reporting thresholds for CCDEs and linking variables and would not meet the reporting requirements for the Hospital IQR Program and would therefore be subject to a one quarter reduction to their annual payment update for the fiscal year. As a result, CMS is proposing to continue voluntary reporting for both hybrid measures for an additional year, for FY 2026 payment determination. Under this proposal, mandatory reporting would not begin until FY 2027 payment determination based on performance data from July 1, 2024 through June 30, 2025.

Premier's Recommendations

Premier supports CMS' proposal to delay mandatory reporting of the Hybrid HWR and Hybrid HWM measures. However, Premier strongly urges CMS to modify the policy to extend voluntary reporting for at least two years, given the ongoing challenges that hospitals face with reporting these measures and the fact that three-quarters of hospitals that elected to report were unable to successfully report the measure.

One of the most significant challenges for reporting CCDE has been around non-standard units of measurement. CMS had issued guidance that it would be acceptable for hospitals to report all units that were not missing. If a hospital uses a non-standard unit for any of the required elements that is not able to be converted to a standard unit, then the unit would be considered null and the median value for that unit would be imputed for measure calculation by CMS. Additional guidance is needed on whether the result for a non-standard unit can be converted or not so that hospitals know where to focus their attention as it relates to mapping units to one of the units found in the Unified Coder for Units of Measure (UCUM) library.

Reporting weight (a required element) is another challenge for reporting. Typically, weight is only taken on arrival. However, the lookback period for the measure is only 24 hours from time of admission. If there is a prolonged emergency department stay or the patient is admitted under observation status, this look back period is too short. The same challenges also apply for reporting vital signs, as vitals may not be done

within two hours of the admission, especially for direct admissions. CMS should work with stakeholders to evaluate the timing of certain variables, either to extend the timeframe to align with clinical protocols and practice or to allow for a lesser percentage to be reported.

Challenges also exist with the hospital-specific reports that hospitals receive as part of voluntary reporting. During prior years' voluntary reporting periods, CMS had erroneously included some claims that should not have been included in the reports, such as Medicare fee-for-service beneficiaries under the age of 65 and Medicare Advantage beneficiaries. Additionally, CMS was delayed in releasing hospital-specific reports this past year. Reports had been expected in May but were not delivered under late June. This has not provided hospitals with sufficient time to analyze and make improvements to their reporting prior to mandatory reporting.

Finally, hospitals lack visibility into their submission percentages until months after the deadline to submit. It would be useful for CMS to provide greater insight into hospitals reporting sooner so that they can better project and track their progress towards complying with the reporting requirements.

Given these issues, Premier urges CMS to maintain the measure as voluntary for a minimum of two years to ensure CMS has sufficient time to work with stakeholders to address ongoing reporting challenges and to provide hospitals with enough time to evaluate hospital-specific reports and make necessary changes to their reporting processes.

X. POTENTIAL FUTURE OPTIONS TO EMPHASIZE PATIENT SAFETY IN THE HOSPITAL QUALITY STAR RATING

Background and Proposals

In alignment with its goals around advancing patient safety, CMS is considering future adjustments to the Overall Hospital Quality Star Ratings ("Star Ratings") methodology that would place more emphasis on the measures within the Safety of Care measure group. Specifically, CMS seeks feedback on whether hospitals performing in the bottom quartile in the Safety of Care measure group should be eligible to receive a 5-star rating and several potential options for modifying the Star Ratings methodology, including:

1. *Reweighting the Safety of Care Measure Group.* Under this option, CMS would increase the Safety of Care measure group's weight from 22 to 30 percent and the weights for the other groups would each be proportionally reduced (i.e., Mortality, Readmission, and Patient Experience would each be reweighted to 19.7 percent and Timely and Effective Care would be reweighted to 10.8 percent).
2. *Policy-Based 1-Star Reduction for Poor Performance on Safety of Care.* Under this option, CMS would reduce the star rating of any hospital in the lowest quartile of the Safety of Care measure group by 1 star. The current minimum star rating of one star would still apply, so no hospital would get reduced below 1 star. Under this policy, even if hospitals were to perform well in all other measure groups, they would still be subject to the 1-star reduction.
3. *Reweighting the Safety of Care Measure Group Combined with Policy-Based Star Rating Cap*. CMS considers a combination of the two policies noted above.

CMS seeks feedback on the options described above and other suggested methodological approaches to emphasize the Safety of Care measure group. Additionally, CMS seeks feedback on if special considerations should be given to small, rural or safety net hospitals.

Premier's Recommendations

While Premier strongly supports initiatives to improve patient safety, we do not support CMS' proposal to modify the Star Ratings program at this time. Modifying the program to place greater weight on the Safety of Care Measure Group will deemphasize the other measure groups (mortality, readmission, patient experience, and timely and effective care), which are also critical areas of focus in quality measurement. Additionally, CMS has other programs, such as the Hospital-Acquired Condition (HAC) Reduction and Hospital Value-Based Purchasing (VBP) programs, which also are focused on patient safety. Premier encourages CMS to consider other avenues for advancing patient safety. Additionally, as part of that, Premier encourages CMS to weigh the benefits against the potential challenges that frequent updates to programs may create for providers and patients. Frequent changes can make it difficult for consumers to interpret and understand differences in performance across facilities and over time.

If CMS moves forward with this policy, Premier encourages the agency to segment small and rural hospitals for purpose of reporting and rating given their differing services lines and populations served. Failure to do so could result in these hospitals being penalized under this policy change.

XI. ENSURING APPROPRIATE PAYMENT FOR AI TECHNOLOGIES

As CMS considers future Medicare payment updates in light of ever-evolving costs and new technologies, ***Premier urges CMS to proactively address how to incorporate incentives and appropriate reimbursement models for AI technology into Medicare payment systems.*** While it has been thoroughly established that AI tools can provide life-saving insights to physicians, optimize workflow and reduce time spent on administrative tasks away from patients, these technologies have a prohibitively high up-front cost and current payment schemes do not adequately capture the value AI provides. ***Premier urges CMS to issue a formal Request for Information to learn from healthcare stakeholders how AI can be used to optimize the delivery of healthcare for Medicare beneficiaries and how CMS can properly incentivize the adoption of new AI technology in future rulemaking.***

XII. CONCLUSION

In closing, Premier appreciates the opportunity to submit comments on the CY 2025 OPPS proposed rule. If you have any questions regarding our comments or need more information, please do not hesitate to contact me at 732-266-5472 or soumi_saha@premierinc.com.

Sincerely,

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