Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC TRANSMISSION

June 17, 2022

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P (Maternal Health)

Dear Secretary Becerra and Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Proposed Rule - CMS-1771-P (Maternal Health). The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes through Medicaid and CHIP. Our comments will focus on the proposed establishment of a publicly-reported hospital designation to capture the quality and safety of maternity care and the addition of two maternity-specific measures to the Inpatient Quality Reporting (IQR) program for optional, then mandatory reporting.

We appreciate the Biden-Harris Administration's focused attention to maternal health and its efforts to take a whole-of-government approach to advance health equity and improve maternal health outcomes. This CMS proposal is an important first step towards greater public transparency and accountability for hospital-based birth care and outcomes. The vast majority of

births each year–98.4 percent in 2017–occur in hospitals, including an even greater share of births financed by Medicaid.[1] [2] We strongly support the administration's efforts to leverage the Medicare inpatient quality reporting program to drive better outcomes for Medicaid beneficiaries and other people giving birth in hospitals. This transparency is long overdue.

Due to the nation's ongoing maternal mortality crisis that disproportionately affects Black women, and repeated, well-documented instances of mothers experiencing racial bias, rough handling, and insurance-related bias during hospital maternity care, focused attention on improving the quality of maternity care delivered in hospitals will further the goal of achieving health equity.[3] Creating a publicly-reported hospital designation will also recognize hospitals that have been proactive in improving maternity care, drive improvement among hospitals that have not taken steps to improve maternity care, and lay the groundwork to begin to provide consumers with actionable information to help them choose a birth hospital.

A structural measure is a reasonable first step to build a framework for public data, but consumers need clarity on what the designation means

Using the Maternal Morbidity structural measure to create the publicly-reported hospital quality designation is a logical choice to get the designation program up and running, as the measure is already in place and hospitals are beginning to report it this year.[4] However, CMS should ensure that when the designation is first reported on its public website, as well as in marketing materials or other communications, the public understands exactly what the designation means–and what it does not.

This is especially important in the initial phase of awarding the designation based on the Maternal Morbidity structural measure, which only requires hospitals to attest that they are currently participating in a structured state or national Perinatal QI Collaborative and implementing patient safety practices or bundles as part of these QI initiatives. While these steps are important demonstrations of the hospital's commitment to quality and safety, these actions on their own do not offer information on the health outcomes of the pregnant people who give birth

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[1] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Division of Behavioral and Social Sciences and Education; Board on Children, Youth, and Families; Committee on Assessing Health Outcomes by Birth Settings; Backes EP, Scrimshaw SC, editors. "Birth Settings in America: Outcomes, Quality, Access, and Choice." Washington (DC): National Academies Press (US); 2020 Feb 6. 2, Maternal and Newborn Care in the United States. Available at https://www.ncbi.nlm.nih.gov/books/NBK555484/

[2] Medicaid and CHIP Payment and Access Commission, "Medicaid's Role in Financing Maternity Care," (January 2020), available at https://www.macpac.gov/wp-content/uploads/2020/01/ Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf.

[3] Sakala C. et al., "Listening to Mothers in California:A Population-Based Survey of Women's Childbearing Experiences, Full Survey Report," Nat'l Partnership for Women and Families 20 (Sep. 2018). Available at https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf?utm_source=National%20Partnership&utm_medium=PDF_Link&utm_campaign=Listening%20to%20Mothers.

[4] Centers for Medicare & Medicaid Services. (August 2, 2021), *Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F)* [Press release]. Available at https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-0

at the hospitals. It will take the future addition of outcomes-focused measures, as the agency proposes, to give consumers a fuller picture of the type of care they may experience if they give birth at a particular hospital. This will be especially important for Medicaid beneficiaries, who give birth almost exclusively in hospitals.[5] Once these metrics are established and the data validated, CMS should post whether the hospital is awarded the designation, and the full data on a hospital-specific basis so that the public can understand which facilities are delivering good care and which are not. Clear guidance for consumers on what the hospital designation does–and does not–mean, in each iteration of the designation, will help build public trust in the designation for the long term.

The public designation should be implemented objectively

Because the Maternal Morbidity structural measure relies on participation in perinatal quality collaboratives, CMS should be mindful of the varying ways hospitals may be participating in quality improvement collaboratives, and offer support to hospitals that may not have the same access to participation. For instance, not all states have state-based perinatal quality collaboratives, and even among states with collaboratives, their capacity varies dramatically.[6]

CMS should make clear if there are alternative ways for hospitals to attest to their quality improvement efforts in states without perinatal quality collaboratives, so they are not disadvantaged in receiving the designation. CMS should also consider regional differences in participating in collaboratives, since regional variations (such as the availability of collaboratives) may disfavor some hospitals through no fault of their own. While this may not create a practical problem for two hospitals on opposite sides of the country, CMS may need to develop an approach to deal with hospitals in the same geographic region, but where one state has a perinatal quality collaborative and the other does not.

Likewise, CMS should assess if there is any reason that safety net hospitals may be unfairly disadvantaged to achieve the first round of designations, due to lack of available collaboratives or a similar resource issue (unrelated to patient population characteristics or health outcomes). This is particularly important for measuring and improving the quality of care for Medicaid beneficiaries, as safety net hospitals are often the primary source of maternity care for Medicaid beneficiaries in their communities. CMS can look to the lessons learned from implementing other IQR metrics in similar domains, such as heart attack care or sepsis care, to set standards that both protect patient safety, and do not lower expectations for hospitals that serve patient populations with greater needs.[7]

Future metrics should focus on outcomes, patient experience and health equity

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[5] Op. cit. (2)
[6] Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion (April 13, 2022). *State Perinatal Quality Collaboratives.* Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html
[7] U.S Centers for Medicare & Medicaid Services (December 1, 2021). *Hospital Inpatient Quality Reporting Program.* Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU

We are supportive of the administration's intention to propose a more robust set of criteria for awarding the designation that may include other maternal health-related measures that may be finalized for the Hospital IQR Program measure set in the future. We also support the proposal to phase in voluntary reporting of the ePC-02 Cesarean Birth and ePC-07/SMM Severe Obstetric Complications in CY 2023 reporting period/FY 2025 payment determination, then require reporting for all hospitals except those hospitals that do not perform deliveries or have an obstetrics department for the CY 2024 reporting period/FY 2026 payment determination and for subsequent years.

Reporting these two metrics in particular will be an important step forward towards understanding the quality of maternity care delivered in hospitals, and begin to understand and address the differences in maternal health outcomes by race and ethnicity. Black women continue to experience rates of maternal mortality more than twice as high as the national average, and maternal mortality rates for Black women have increased significantly in recent years, at a faster pace than the national average.[8] Black women, Indigenous women, and women living in rural areas are all at higher risk of experiencing severe maternal morbidity.[9]

Research shows there is significant variation in low-risk cesarean delivery and severe maternal morbidity by race, ethnicity, geography and other demographic factors.[10] For instance, averaged over the 2018-2020 period, cesarean delivery rates were highest for Black infants (35.8%) in the US, compared with 31.8 percent of all births.[11] Black women were also the most likely group to experience severe maternal morbidity, which is defined as, "unexpected outcomes of labor or delivery that have serious short- or long-term health impacts."[12] Additionally, women whose births were covered by Medicaid were 1.5 times more likely to experience severe maternal morbidity.[13]

As CMS adds these metrics in the IQR program, hospitals should be required to report the data in disaggregated formats, including by race, ethnicity, age, language, health insurance status, and source of payment (i.e., Medicaid, private insurance, uninsured). Disaggregating data can help agencies, hospitals, and other large institutions better target resources and funding for improvement. For instance, in a recent review of maternal mortality and SMM outcomes in rural and underserved areas, the Government Accountability Office recommended that CDC and HRSA disaggregate and analyze program data by rural and underserved areas to better direct

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[8] Hoyert DL. "Maternal mortality rates in the United States, 2020." NCHS Health E-Stats. 2022. Available at https://dx.doi.org/10.15620/cdc:113967

[9] Kozhimannil, K. "Risk of Severe Maternal Morbidity and Mortality among Medicaid Beneficiaries," [conference presentation]. January 2020 MACPAC Public Meeting, Washington, D.C. Available at https://www.macpac.gov/wp-content/uploads/2020/01/Maternal-Morbidity-among-Women-in-Medicaid.pdf

[10] Brown, Clare C. et. al. Associations Between Comorbidities and Severe Maternal Morbidity, *Obstetrics & Gynecology*, 136(5), 892-901 (2020). Available at 10.1097/AOG.0000000000004057.

[11] National Center for Health Statistics, final natality data. Retrieved June 16, 2022, from www.marchofdimes.org/peristats.

[12] Declerq E. and Zephyrin L. "Severe Maternal Morbidity in the United States: A Primer", Commonwealth Fund (October 2021). Available at https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer

[13] Brown, Clare C. et. al. Race, Medicaid Coverage, and Equity in Maternal Morbidity. *Women's Health Issues*, 31(3), 245-253 (2021) Available at https://doi.org/10.1016/j.whi.2020.12.005.

funding to areas with the greatest need.[14] Implementing new IQR metrics with equity-focused data collection practices at the outset will help hospitals make meaningful improvements towards reducing these disparities, and highlight ongoing disparities in health outcomes that need focused attention.

As CMS implements initial and subsequent IQR measures, CMS should again consider how the burdens of measure collection and reporting (as distinct from measure outcomes) may disadvantage participation by safety-net hospitals. With respect to measure outcomes, if in the future CMS chooses to use risk adjustment in awarding the designation, CMS should ensure that all raw data (i.e., not adjusted) is publicly reported, and disaggregated by race, ethnicity, language, age, geography, insurance status, source of payment, and other demographic factors.[15] The agency can take lessons learned from its history of hospital quality measurement and risk adjustment, such as in the Hospital Readmissions Reduction Program, to implement hospital quality measures that promote transparency and accountability for hospitals and drive better patient outcomes, without lowering standards for hospitals that serve higher volumes of Medicaid beneficiaries or patient populations with significant social risk factors, such as low income, food insecurity and housing instability.[16]

The NPRM asks for additional metrics to add to the hospital quality designation in the future. There is a significant need to address the well-documented, consistent experiences of racism encountered by women giving birth in hospitals.[17] While current measurement tools are limited, CMS can leverage its authority to encourage new quality metric development and elevate work happening to improve the measurement of structural racism to achieve antiracist health policy.[18] We also note that important developmental work relating to respectful maternity care measures and addressing obstetric racism during hospital-based labor, birth, and postpartum, is being done within the birth justice community.[19] The Cycle to Respectful Care is one such framework that, "acknowledges the development and perpetuation of biased healthcare delivery, while providing a solution for dismantling healthcare providers' socialization that results in biased and discriminatory care."[20] We also encourage CMS to work with the Agency for Healthcare Research and Quality (AHRQ) to revise the existing HCAHPS (Hospital Consumer Assessment

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[14] Government Accountability Office (2021). "MATERNAL MORTALITY AND MORBIDITY Additional Efforts Needed to Assess Program Data for Rural and Underserved Areas" (GAO Publication No. 21-283). Washington, D.C.: U.S. Government Printing Office. Available at https://www.gao.gov/assets/gao-21-283.pdf

[15] Measures Management System, Centers for Medicare &Medicaid Services. *Risk Adjustment and Stratification* (May 2022). Available at https://mmshub.cms.gov/measure-lifecycle/measure-testing/evaluation-criteria/scientific-acceptability/risk

[16] Medicare Payment Advisory Commission (June 2018). *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 1: "Mandated report: The effects of the Hospital Readmissions Reduction Program".* Available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch1_medpacreport_rev_nov2019_v2_note_sec.pdf

[17] Jackson, F.M. et. al. Introduction: The Quest for Birth Equity and Justice—Now is the Time. *Matern Child Health J* **26,** 659–660 (2022). Available at https://doi.org/10.1007/s10995-022-03436-z

[18] Hardeman, R. et. al. Improving the Measurement of Structural Racism to Achieve Antiracist Health Policy. *Health Affairs, 41*(2), 179-186 (2022). Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01489.

[19] Scott, K. and Davis, D-A. Obstetric Racism: Naming and Identifying a Way Out of Black Women's Adverse Medical Experiences. *American Anthropologist*, 123(3), 681-684 (2021). Available at https://doi.org/10.1111/aman.13559

[20] Green, CL, et. al. The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities. *Int. Environ. Re. Public Health* 18(9), 4993 (2021). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8141109/.

of Healthcare Providers and Systems) survey to include questions that reflect the quality of hospital maternal and newborn care.[21]

CMS should also consider ways to recognize hospitals that support high-quality, team-based models of care that incorporate maternity care and support provided by midwives and doulas.[22] As highlighted by an expert panel to CMS in, "Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program," these women-centered models of care are associated with lower rates of cesarean sections without compromising the health of women or infants.[23] Increasing women's access to nonmedical interventions such as doula support during labor and delivery has been shown to reduce cesarean birth rates.[24] CMS has approved state plan amendments to reimburse doula care in Medicaid from several states, and more are planning on implementing Medicaid reimbursement for doula care this year.[25] Additional research shows that women who give birth in hospitals with more midwife-attended births had lower odds of giving birth by cesarean and lower odds of episiotomy.[26] As recommended by the expert panel, CMS can facilitate greater access to non-physician maternity care providers by issuing guidance on authorities available to states to provide payment to support increased access to doulas and midwives.[27]

Hospital-level data can help drive improvement in health disparities, promote greater accountability in Medicaid

In addition to helping consumers choose a birthing hospital, the hospital-level data reported for the birthing-friendly designation can also help state Medicaid programs and Medicaid managed care companies identify which hospitals perform well for Medicaid patients on maternity care metrics and which do not. Medicaid also covers a disproportionate share of births among women of color, young women and women living in rural areas—all populations that are at greater risk of experiencing severe maternal morbidity and mortality.[28] Research shows that Medicaid beneficiaries are almost twice as likely as privately insured patients to suffer severe maternal morbidity or mortality during childbirth hospitalization.[29]

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[21] National Partnership for Women and Families (March 2015). "The Priority of Developing and Implementing CAHPS Maternity Care Facility, Clinician and Health Plan Surveys." Available at https://www.nationalpartnership.org/our-work/resources/health-care/maternity/cahps-maternity-care-fact-sheet.pdf

[22] Bigby, J. and Anthony, J., et. al. "Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program," (Mathematica, December 18, 2020), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-expert-workgroup-recommendations.pdf.

[23] Op. cit. 22

[24] Kozhimannil, K. et al. Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American journal of public health* vol. 103,4 (2013): e113-21. doi:10.2105/AJPH.2012.301201

[25] Guarnizo, T. "Doula Services in Medicaid: State Progress in 2022". Georgetown University Center for Children and Families (June 2022), available at https://ccf.georgetown.edu/2022/06/02/doula-services-in-medicaid-state-progress-in-2022/

[26] Attanasio, L. and Kozhimannil, K. (2018) Relationship Between Hospital-Level Percentage of Midwife-Attended Births and Obstetric Procedure Utilization. *Journal of Midwifery and Women's Health, 63*(1), 14-22. Available at https://onlinelibrary.wiley.com/doi/10.1111/jmwh.12702.

[27] Op. cit. 22

[28] Op. cit. 8

[29] Op. cit. 9

As the nation's single largest payer of maternity care, the Medicaid program has a clear interest in understanding how individual hospitals are performing on the proposed Cesarean Birth (ePC-02) eCQM and Severe Obstetric Complications eCQM IQR metrics as well as future metrics.[30] State Medicaid programs could also use the data to facilitate access to higher-performing hospitals, both for birth care and care in the postpartum period. With the passage of the American Rescue Plan Act, more than half the states have taken the new state plan amendment option to extend Medicaid postpartum coverage for a year after the end of pregnancy.[31] This longer coverage period will promote greater access to care to new mothers, particularly for those that experience severe obstetric complications or need more intensive follow-up care after a low-risk cesarean birth. The hospital designation's requirement to publicly report hospital-level data on maternal health outcomes, ideally disaggregated by race, ethnicity, payer and other factors, will help beneficiaries choose a birth hospital and promote greater transparency and accountability for Medicaid spending in maternity care.

Improvement in maternal health outcomes will help mothers as well as their children. Experiencing severe obstetric complications during pregnancy, delivery or the immediate postpartum period has been associated with greater risk of developing postpartum depression, which, if left untreated, has significant effects on the health of the mother as well as the social and emotional development of the infant.[32] Children cared for by parents experiencing depression are more likely to have developmental delays and miss out on critical bonding experiences that support their brain development.[33] A cost model created by researchers at Mathematica finds that untreated mood and anxiety disorders among pregnant women and new moms cost about $14.2 billion for births in 2017, when following the mom and child pair for five years after birth.[34]

Addressing hospital-level maternity care quality data is a critical step to improving health outcomes for mothers and infants, as well as improving the effectiveness of Medicaid as a health insurance program and ensuring that the billions of dollars that the federal government is investing in it each year are going towards providing high-quality care.[35]

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[30] Op. cit. 2

[31] Kaiser Family Foundation. "Medicaid Postpartum Coverage Extension Tracker," accessed at https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

[32] Koutra, K., Vassilaki, et. al. Pregnancy, perinatal and postpartum complications as determinants of postpartum depression: the Rhea mother-child cohort in Crete, Greece. *Epidemiology and psychiatric sciences*, *27*(3), 244–255 (2018). Available at https://doi.org/10.1017/S2045796016001062; Verdoux H et. al. Obstetrical complications and the development of postpartum depressive symptoms: a prospective survey of the MATQUID cohort. *Acta Psychiatr Scand*. 106(3), 212-9 (2002). Available at doi: 10.1034/j.1600-0447.2002.02398.x.

[33] Center on the Developing Child at Harvard University, "Maternal Depression Can Undermine the Development of Young Children: Working Paper 8," (2009), available at https://developingchild.harvard.edu/wp-content/uploads/2009/05/Maternal-Depression-Can-Undermine-Development.pdf

[34] Mathematica, "New Study Uncovers the Heavy Financial Toll of Untreated Maternal Mental Health Conditions," (April 29, 2019), available at https://www.mathematica.org/news/new-study-uncoversthe-heavy-financial-toll-of-untreated-maternal-mental-healthconditions?HP_ITN.

[35] Schneider, A. "A Guide for Child Health Advocates: Medicaid Managed Care Accountability Through Transparency," Georgetown University Center for Children and Families (July 16, 2021). Available at https://ccf.georgetown.edu/2021/07/16/a-guide-for-child-health-advocates-medicaid-managed-care-accountability-through-transparency/.

Additional Activities to Advance Maternal Health Equity—Request for Information

Thank you for the opportunity to provide information on how CMS can address the U.S. maternal health crisis through policies and programs, including, but not limited to, the Conditions of Participation (CoPs) and through measures in the agency's quality reporting programs. While many of the questions are outside our scope of expertise, as a general recommendation we suggest that, following the implementation of the Maternal Morbidity Structural measure, and later the proposed Cesarean Birth (ePC-02) eCQM and Severe Obstetric Complications eCQM IQR metrics, that CMS should review the lessons learned and progress achieved consider adding them to the program data required to be submitted to CMS under the "Condition of Participation: Quality assessment and performance improvement program."[36] Using hospital CoPs to focus hospital attention on maternal health care quality would be a powerful way for CMS to use its regulatory authority to drive systemic improvement in the quality of care delivered to mothers and infants in hospitals.

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Thank you again for the opportunity to make the above comments in support of the proposed rule. Please contact us at Maggie Clark (Maggie.Clark@georgetown.edu) and Andy Schneider (Andy.Schneider@georgetown.edu) if you have any questions or if we can be of further assistance.

Respectfully submitted,

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[36] Condition of participation: Quality assessment and performance improvement program, 42 C.F.R. § 482.21 (2019). Available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.21.