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June 28, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1752-P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: CMS–1752-P - Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; published at Vol. 86, No. 88 Federal Register 25070-25790 on May 10, 2021

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

Dear Administrator Brooks-LaSure,

UnityPoint Health appreciates this opportunity to provide comments on this proposed rule related to Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates. UnityPoint Health is one of the nation's most integrated healthcare systems. Through more than 33,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 8.4 million patient visits.

In addition, UnityPoint Health is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Accountable Care is the ACO affiliated with UnityPoint Health and has value-based contracts with multiple payers, including Medicare. UnityPoint Accountable Care is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program (MSSP) as well as providers from the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

UnityPoint Health appreciates the time and effort of CMS in developing this proposed Inpatient Prospective Payment System (IPPS) rule. UnityPoint Health is a member of the American Hospital Association and generally supports their formal comment letter to CMS-1752-P dated June 28, 2021. UnityPoint Health respectfully offers the following comments:

Inpatient Prospective Payment System Update (IPPS)

For FY 2022, CMS is proposing to update the IPPS payment rates by 2.8%. In addition, CMS is proposing to use FY 2019 claims rather than 2020 claims and FY 2018 cost report rather than FY2019 cost report. Finally, CMS is proposing to update the market basket using 2018 data from 2014 data as well as update labor related share to 67.6% for hospitals with wage index values greater than 1.0 and 62% for hospitals with wage index values less than/equal to 1.0.

Comment: UnityPoint Health is appreciative of this update and agrees with utilizing FY 2019 data rather than 2020.

Market-based DRG Data Collection and Weight Calculation

CMS is proposing to repeal both requirements made in the FY 2021 IPPS final rule: (1) collect, through the Medicare cost report, the median negotiated charge that a hospital has negotiated with its MA payers and (2) use median negotiation charges among MA organizations to calculate new relative weights in the MS-DRG system, beginning in FY 2024.

Comment: Given the requirement challenges of additional administrative burden and inconsistency with cost reporting data, **UnityPoint Health is pleased to see CMS repeal the market-based MS-DRG relative weight methodology.**

Medicare Disproportionate Share Hospital (DSH) Payment Changes

Under the DSH program, CMS is proposing hospitals receive 25% of the program funds they would have received under the former statutory formula with remaining 75% in a funding pool for DSH hospitals. Pool funding is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides. Uncompensated care payments for FY 2022 will be determined based on CMS audited FY 2018 cost reports.

Comment: While **UnityPoint Health is pleased to see audited cost reports within the proposal**, we continue to remain concerned with the calculation of DSH uncompensated care payment utilizing a single year. **UnityPoint Health reiterates our request that CMS reinstate the three-year average** to aid in normalizing fluctuations.

Graduate Medical Education

CMS proposes to implement several provisions of the Consolidated Appropriations Act, including its requirement for 1,000 new Medicare-funded medical residency positions. Specifically, CMS proposes to, beginning in FY 2023, phase in no more than 200 positions each year. Additionally, CMS proposes to prioritize applications for residency positions in programs serving underserved populations. Finally, CMS proposes to implement the Promoting Rural Hospital GME Funding Opportunity, which would allow certain rural training hospitals to receive a GME cap increase. Specifically, the agency would make changes related to the determination of both an urban and rural hospital's resident limit with regard to residents training in an accredited rural training track. Furthermore, the agency would implement changes to the determination of direct GME per-resident amounts and certain FTE resident limits for hospitals that host a small number of residents for a short duration.

Comment: The demand will be strong for additional residency positions each year as provider recruitment in health care remains a priority. **UnityPoint Health is pleased to see the proposal to release additional residency positions; however, the magnitude of the increase will have a negligible impact as structured.** Limiting hospitals to one position per year is a drop in the bucket. There are well over 1,000 institutions across the country that sponsor GME, both university and community-based, and this means approximately one in five institutions per year might get one position to add to their complement. Prioritizing underserved areas is a step in the right direction. Prioritizing primary care, which is not included in this proposal, would be an even more important step in the right direction.

UnityPoint Health wholeheartedly supports the Promoting Rural Hospital GME Funding Opportunity. There is a need for more rural physicians, especially more primary care/OBGYN/psychiatry providers in rural areas. **The effectiveness of this funding is dependent upon how "rural status" is defined. Fundamentally, financial support should target strategic re-commitment and deployment of physicians into high-need areas in underserved and rural regions, AND the level of financial support must reflect 2021, not mid-1990s, costs of educating residents.**

Rural Provisions

For Rural Referral Center in FY 2022, CMS is proposing to use FY 2019 data to calculate case mix index, and FY 2018 cost report to calculate discharge volume. CMS is also proposing to extend the Rural Community Hospital Demonstration Program by 5 years.

Comment:

Rural Referral Center Calculation Updates: **UnityPoint Health supports this update**.

Rural Community Hospital Demonstration Program: UnityPoint Health has two Iowa hospitals (Grinnell Regional Medical Center in Grinnell; and Trinity Regional Medical Center in Fort Dodge) participating in the Rural Community Hospital Demonstration Program. **We support the continuation of this program** but, as a demonstration, this program does not offer long-term financial sustainability needed to maintain health care access in rural areas.

To promote long-term sustainable access to care, we encourage CMS to continue to examine and develop an alternative separate and distinct payment structure for the portion of cost-based reimbursement that pays for the costs associated with access in rural areas. By separating the "cost of access" from the "cost of care," reimbursement incentives and high-value care can be aligned in rural areas. The "cost of care" concept is the equivalent of traditional medical care and could be reimbursed through Medicare Fee For Service rate schedules. Like all health care facilities, small/rural hospitals should be held accountable for reducing the cost of care while maintaining quality standards. A value-based payment program could also be implemented for cost of care services with the potential to be rewarded through a shared savings or other quality program. "Cost of access" refers to services that maintain/improve access for beneficiaries in rural areas that are proven to lower the total cost of care. These items should be encouraged. Examples of access costs include emergency medicine, maternal health services, care coordination teams, palliative care, telehealth, home health, hospice, eVisits, and urgent care clinics. These cost items could be reimbursed using an incremental rate founded on cost-based reimbursement and proposed adjustments could be made via cost reports or similar mechanisms. UnityPoint Health is invested in our rural communities and residents and enhancing their overall health and well-being. We would be pleased to

partner with CMS or your Innovation Center to further discuss this concept and flesh out actuarial modeling to support formula/adjustment details.

Inpatient Quality and Reporting Programs

CMS is proposing to add five new measures to the IQR program, while removing five other measures. Most notably, CMS proposes a new measure reflecting COVID-19 vaccination coverage among health care personnel. Furthermore, CMS is proposing that beginning in CY 2023, hospitals would be required to report the IQR's electronic clinical quality measures using certified EHR technology consistent with 2015 Edition Cures Update. Finally, CMS is proposing a measure suppression policy excluding measure data affected by the COVID-19 and Public Health Emergency.

Comment: UnityPoint Health supports developing future quality measures and appreciates that CMS has signaled some areas of interest so that providers may be engaged more downstream in this process.

Readmission and HAC Measure Suppression & Exclusion of COVID-19 Diagnosed Patients: UnityPoint Health is supportive.

Proposed New IQR Measures:

- COVID-19 Vaccination Among Health Care Personnel. UnityPoint Health opposes measuring COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) as a quality measure for a number of reasons as outlined here. **First, the proposed measure is premature as the COVID-19 vaccine is currently approved only under an emergency use authorization (EUA).** We are unaware that HHS has mandated COVID-19 vaccines; however, through a number of CMS proposed rules currently within the public notice and comment period, it appears that CMS is indirectly mandating vaccines for health care workers via its proposal to measure, and potentially tie, COVID-19 vaccination adherence to reimbursement. Today, UnityPoint Health reports this information under the HHS COVID-19 reporting requirement as directed through the federal public health emergency (PHE) and thus, additional reporting of this measure becomes duplicative. In addition, hospitals typically keep employee health records outside of their electronic health record (EHR) due to health privacy concerns. With that said, attempting to identify and collect data on employee vaccine adherence is inherently difficult and burdensome. **UnityPoint Health appreciates CMS' attempts to curb the devastating impact of the COVID-19 pandemic; however, we have concerns with operationalizing this through the proposed quality measure.**
- Maternal Morbidity Structural Measure. UnityPoint Health agrees the continued rising statistics of maternal mortality is concerning and **supports inclusion of this measure as a national priority**.
- Hybrid Hospital-Wide Mortality Measure. **UnityPoint Health opposes the addition of this measure** as hospitals generally do not have insight into claims data. This limits hospitals ability to (1) take a proactive approach in understanding where variation in quality exists, (2) improve processes, and (3) monitor performance after the deployment of potential solutions throughout reporting periods. In addition, matching up clinical EHR (QRDA) data to claims data with low match rates presents hospitals with challenges, limiting value the data is providing.
- Hypoglycemia and Hyperglycemia Control eCQMs. **UPH supports these measure additions as long as they remain optional metrics for reporting, rather than required.**

Proposed Removal of IQR Measures:

- PSI-04 Deaths Among Surgical Inpatients with Serious Treatable Conditions. This measure, while not a broad look at hospital-wide mortality, does provide a more focused look at surgical outcomes. **UnityPoint Health recommends keeping this measure**, rather than the impending and newly proposed Hybrid Hospital-Wide Mortality Measure, for reasons outlined in the above comments under the "Proposed New IQR Measures" section.
- PC-05 eCQM Exclusive Breast Milk Feeding – **UnityPoint Health supports measure removal** and believes measurement focus should shift toward reducing maternal morbidity.
- ED-02 Admit to Departure Time in ED. **UnityPoint Health supports measure removal**. We do not believe the time from admit to departure is an accurate reflection of the quality of care delivered by providers in the emergency department.
- STK-03 eCQM Anticoagulation's Therapy for Atrial Fibrillation & STK-06 eCQM Discharged on Statin Medication**. UnityPoint Health supports removal of both the STK-03 and SKT-06 measures.** Although UnityPoint Health utilizes this information for our stroke center accreditation, we are able to obtain accreditation information in multiple ways and feel removal of these measures will not impact high quality care delivery.

UnityPoint Health is encouraged to see CMS uphold concepts of meaningful measures in streamlined measure sets. This includes balancing current and new measures to maintain consistency and reduce reporting burden.

Hospital Value-Based Purchasing (HVBP) Program Updates

CMS is proposing to suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures, Medicare Spending per Beneficiary, and five health care associated infection measures and as a result, all hospitals would receive neutral payment adjustments under the HVBP for FY 2022. In addition, CMS is proposing to suppress the pneumonia mortality measure, and to remove the claims-based patient safety indicator (PSI 90) from the HVBP program permanently.

Comment: UnityPoint Health appreciates CMS wanting to remove PSI-90 given the burden it has placed on the agency to maintain different software versions. However, the inclusion of PSI-90 within this program has helped drive a focus on safety. It makes sense to retain this measure in fulfillment of a robust and diverse safety domain, rather that fulfilling the domain through infection measures alone. **UnityPoint Health opposes removal of PSI-90.**

Promoting Interoperability Program

For FY 2022, CMS is proposing to continue the 90-day reporting period for CY 2023 as well as proposed a number of other changes to the program as outlined below.

Comments:

180-day reporting period for CY 2024 – **UnityPoint Health is supportive of increasing the reporting period to 180 days** for returning hospitals and critical access hospitals for CY 2024.

Public Health and Clinical Data Exchange Objective Measures - UnityPoint Health has a number of concerns with implementation of additional health and clinical data exchange measures:

- Not all states are using the same configurations to receive data for each of the proposed

categories, Case Reporting is an example.

- Some states require fees to third-party vendors for implementation as many states do not have resources available to support or use a third-party vendor to report data.
- Many states do not accept Syndromic surveillance, such as Iowa. It is unclear if exclusion reporting will be allowed if states do not have capacity.
- Concerns exist regarding maintenance around use of public health registries and clinical data registries for submission as those tasks could lend to an unproductive level of administrative burden.

To reduce burden of reporting, UnityPoint Health recommends allowing required submissions for other programs such as NHSN count under clinical data registry. In addition, UnityPoint Health recommends not requiring all four measures rather increasing optional selection to three measures.

Increasing the minimum required score for objectives and measures. As a fully integrated health system that spans across 3 states, UnityPoint Health has experienced state variation in Prescription Drug Monitoring Program's (PDMP) build and data submission. As such, **UnityPoint Health agrees the PDMP measure should remain optional and as bonus points.** Until there is standardization of PDMP build across states and systems, updating this as a performance measure would be challenging for hospitals to implement, especially multi-state health systems. Therefore, **UnityPoint Health opposes making the PDMP a required measure.**

Modify Technical Specifications and Requirements of Provide Patients Electronic Access - **UnityPoint Health has concerns with CMS' proposal** to have all data from 2016 to present available for a patient's immediate access via a portal account for a number of reasons outlined below:

- When hospitals move from old record systems to new, often times they do not convert all data discretely. In addition, for large health systems acquiring numerous size hospitals over time, variation exists on data conversion and, in many cases such as small rural community hospitals, legacy system data was not converted at all. For these cases, it becomes a financial burden to maintain legacy systems.
- It is unclear if data can be in Common Clinical Data Set (CCDS) or if it must be in USCDIv1, which is not required to be used until 2023. In addition, clarification is needed on what data sets will be required from 2016. For example, with the implementation of Open Notes, many hospitals did not include historical notes as it was not required under the CMS Interoperability and Patient Access proposed rule. This becomes additional work and requires substantial resourcing.
- For security and resource concerns, many hospitals turn off access to a patient's portal if they are not active for a set timeframe. While access can be reactivated, often times it requires additional administrative and security support.

New HIE Bi-Directional Exchange Measure - **UnityPoint Health opposes this measure**. With CMS's current challenges in uploading content to the National Plan & Provider Enumeration System (NPPES) in a bulk fashion, the lack of availability and ease of sharing digital content poses additional challenges for large health systems to comply with this measure.

Remove attestation statements regarding information blocking - **UnityPoint Health is supportive** of this, however requests hospitals receive information regarding the audit processes and fiscal penalties associated with information blocking as set forth in the 21st Century Cures Act.

Organ Acquisition Payments

CMS is proposing that Medicare's organ acquisition payment policy includes the presumption that some organs are not transplanted into Medicare beneficiaries. As a result, Medicare currently shares in the organ acquisition costs for some organs that are not actually transplanted into Medicare beneficiaries. CMS proposes that transplant hospitals must accurately track, count and report Medicare usable organs and total usable organs on their Medicare hospital cost reports to ensure that costs to acquire Medicare usable organs are accurately allocated to Medicare.

Comment: The proposed Medicare share calculation would significantly decrease the Medicare percentage as it would no longer count organs excised and sold to Organ Procurement Organizations (OPO) in the numerator (unless they were transplanted to Medicare patients) but still include them in the total count denominator. While we anticipate the financial impact of this proposal to be vast, we are unable to estimate loss as OPOs do not provide documentation to support the number of transplanted organs to Medicare beneficiaries. This change would have a negative impact on many transplant programs across the nation for the following reasons: (1) high administrative burden; (2) uncertainty related to the number of organs going through the OPO to Medicare patients, and (3) challenges in calculating reporting requirements that rely on OPOs for protected patient demographic and health insurance information, information not easily obtained. As such, **UnityPoint Health opposes the proposed changes to the Medicare shared calculation for organ acquisition.**

Other Provisions

In November 2020, CMS announced the Acute Hospital Care at Home waiver, building upon the Hospital Without Walls program. Acute Hospital Care at Home is for beneficiaries with defined acute conditions who require acute inpatient admission to a hospital and who require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis.

Comment: UnityPoint Health, under the leadership of UnityPoint at Home (our Home Health arm), was one of the first six health systems with extensive experience providing acute hospital care at home approved for the new waiver. Many more hospitals have been approved to participate in the meantime. Despite this, UnityPoint Health was the first to bill and be reimbursed for a patient under this waiver. By shifting care to home with the proper supports, we have maintained high patient satisfaction rates as well as achieved outstanding clinical outcomes, including extremely low readmission rates. This was accomplished through a post-acute care bundling strategy in which appropriate services are wrapped around the patient. Our bundles include a hospital to home (2-hour response time), primary care at home (4-hour response time), ambulatory care bundles, palliative care at home, and skilled nursing facility at home. While we recognize that this waiver came into being as a result of the COVID-19 pandemic, its efficacy beyond the pandemic is undeniable. This program is a difference maker. **UnityPoint Health is a national leader and would welcome being included in CMS conversations about the future of the Acute Hospital Care at Home program. We also encourage CMS to consider expanding the suite of post-acute care bundles to drive improved health outcomes, heightened patient satisfaction and reduced health care costs.**

Requests for Information

A. Fast Healthcare Interoperability Resource

CMS is seeking feedback on future plans to define digital quality measures for the Inpatient Quality Reporting Program (IQRP). CMS is also seeking feedback on the potential use of Fast Healthcare Interoperable Resources (FHIR) for dQMs within the IQRP aligning where possible with other quality programs. To enable transformation of CMS' quality measurement enterprise to be fully digital, CMS has posed specific questions.

Comment: With health care systems historically being the first to implement electronic health records (EHRs) and FHIR, our biggest concerns lie within the variation of FHIR versions, lack of version requirements, and variation in industry timelines. With three different versions of FHIR and no version requirements, this puts limitations on a provider's ability to connect to certain application interfaces. There is no consistency in who is required to have FHIR, how to submit data, and when to submit data. This becomes a large challenge for providers who attempt to submit data utilizing these vendors and payors. UnityPoint Health uses a combination of DSTU 2, STU 3 and R4 FHIR Versions to meet our requirements for sending data. Since 2017, four main versions have been released in addition to sub-versions released to correct errors or issues in technological builds, meaning vendors and providers have had to sort through up to six version updates to land at v4.1.0, the most recent "Permanent Home" version of FHIR. It should be noted that not all hospitals are at v4.1.0 yet because vendors and providers are not required to meet ONC CURES Edition CEHRT.

While UnityPoint Health appreciates the attempt to align health care interoperability resources, integrated health systems have competing information technology builds and priorities across care settings, which is true on a smaller scale for individual providers and smaller hospitals. When UnityPoint Health rolled out an EHR through Meaningful Use requirements in the hospital inpatient setting, it was a multiyear process. **Overall, UnityPoint Health recommends slowing down the implementation and updates of new standards in health care interoperability, allowing all parties, including CMS' technology, to catch up and align as an industry**. Specifically, we urge CMS to consider:

- A **stair step approach to implementation**, first incentivizing milestones along the way and, at an appropriate point in the timeline, introducing a negative incentive to promote long-term adherence.
- **Biennial updates to FHIR for all providers**. If releases are consistent and across the board, providers can better plan for resourcing, allocations, and cost.
- **Incorporating social determinates of health (SDOH) as part of the standardized CCD documentation applicable to all providers**. This will allow the integration of such information into a patient's chart and ultimately promote transparency in health equity.
- **Standardized reporting requirements across all programs** to enable utilization of software and quality measures across all care settings allowing better continuity of care. This will facilitate vendors and providers to concentrate efforts universally and lessen the chances for some providers and/or care settings to be left behind.
- **Program incentives for stakeholders to partner with vendors in pilot programs and models.** Payment or flexibilities to participating providers would encourage a robust testing

environment in which stakeholder input is included.

B. Proposed Health Equity Score

CMS is requesting information on several proposals in advancing health equity. Specifically, CMS is seeking comment on additional measure stratification, data collections, and a health equity summary score.

Comment: UnityPoint Health values health equity and focuses on reducing care variation with all patients no matter race, ethnicity, gender, sexual orientation, or other demographic or social risk characteristics. UnityPoint Health appreciate CMS' commitment to addressing health equity and looks forward to partnering with CMS in advancing this important focus. UnityPoint Health is an active member of The Academy Advisors and generally supports comments provided in The Academy Advisors' comment letter to CMS-1752-P, which targets the health equity topic. We have provided additional comments as it relates specifically to UnityPoint Health below:

- Additional Measure Stratification. In order to accurately focus on driving palpable change in health equity, measure stratification becomes vital to the process. **Stratification must be robust to high variations in local market populations, including imbalanced race/ethnicity distributions or other identified equity attributes.** For less densely populated areas where imbalanced populations tend to exist, results can be disproportionately impacted by sentinel events to minority populations as compared to highly populated urban locations with greater balance. Existing quality measure serve well to define health care quality, but equity should be defined as gaps in these measure amongst attributes and targeted for improvements. UnityPoint Health recommends "descriptive" modeling using traditional predictive modeling techniques to study equity imbalance by only including equity attributes as models features with the health measure as the target, fitting a predictive model, and then examining the feature importance. Highly predictive features in this context suggest the type and magnitude of equity imbalance in a given population. In conclusion, **UnityPoint Health strongly discourages use of an algorithm to estimate race and ethnicity and recommends using existing quality measures utilizing predictive modeling techniques to study health disparities.**

- Expanded Demographic Data Collection/Reporting. In order to accurately measure data, the data itself must be of high quality. Challenges exist today in effectively capturing this type of information. Manual collection by health providers leads to high administrative burden and would require standardized data collection protocols, many of which do not exist today. However, UnityPoint Health agrees collection of self-reported data is the most precise method to capture current and accurate race and ethnicity information. Data lag can be significant between census surveys and performance periods and high variance, even at the census block level, given social determinates of health (SDOH) factors. Using a proxy would still require patient addresses to map to census locations identifiers. UnityPoint Health has a 55%-60% match rate when taking patient addresses, geocoding to a census block, and joining results. While proxies are not ideal for capturing data, should CMS choose to continue development utilizing this method, it will be imperative for hospitals to have the opportunity to address self-identified inaccuracies as well as

a process to appeal data and outcome results should they deem appropriate. **UnityPoint Health urges CMS to consider offering hospitals financial assistance to develop and deploy health equity efforts, including funding support in addressing the capture of self-reported data,** a gold standard as noted by CMS**.**

- Health Equity Summary Score. UnityPoint Health is supportive of health equity and developing a framework for measuring so that hospitals can be transparent and accountable in closing the gap in health equity. That said, we have concerns and recommendations with the proposed facility health equity summary score. Developing a score, while potentially effective in the future, may not be as helpful at this time in advancing efforts in this space nor closing the gap in health equity. Variation in process exists today:
  - Data collection and measurement stratification efforts are unclear and have not been appropriately analyzed to ensure accuracy and effectiveness. **UnityPoint Health strongly urges CMS to develop standard data definitions as well as continue to partner closely with stakeholders in identifying measures that effectively and accurately measure health equity for diverse patient populations and a variety of geographical regions.**
  - In general, developing a "facility score" that is inadequate or too early in the process can inadvertently lead to a negative impact on health equity as a whole. We are not convinced that a score targeted for payors is adequate or appropriate for providers. In fact, we are aware of other hospitals, organizations, and national groups with more robust and researched efforts underway to develop a facility/provider score. We urge CMS to tap into these resources. **UnityPoint Health strongly recommends that CMS establish a diverse stakeholder taskforce to partner with CMS on any future facility health equity score to ensure a comprehensive measurement will yield an effective, accurate and actionable score. A health equity summary score should only be implemented after development and through testing with stakeholders.**
  - If scored on race, ethnicity, and dual eligibility alone, gaps would still exist in other equity categories including gender, sexual orientation, health literacy, language barriers, and other social risk factors. **UnityPoint Health supports and recommends that CMS standardize the use of 'equity" as defined in the Executive Order on Advancing Racial Equity and Support for Underserved Communities.** In particular, "(a) The term "equity" means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (b) The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the

preceding definition of "equity."[1] While UnityPoint Health supports a broader definition of health equity, we also support a consistent definition. An approach that phases in equity categories or social risk factors over time has the potential to penalize facilities early on that will perform better under a more comprehensive definition.

While UnityPoint Health appreciates the Administration's pervasive emphasis on health equity through the rulemaking process and its interest in closing disparity gaps, the measurement framework is still within the early development phase and its impact on reimbursement and operations is unclear. We encourage CMS to be thoughtful of these provider implications and to use a carrot approach, not a stick approach. We recommend CMS to study the large variation in defining health equity as well as additional ways in which to accurately collect and measure demographic and social risk factors. UnityPoint Health looks forward to partnering closely with CMS in future efforts driving health equity.

We are pleased to provide input on this proposed rule and its impact on our hospitals and health system, our patients and communities served. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director, Government & External Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,

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[1] (https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/)