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August 27, 2021

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1747-P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: CMS –1747-P Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements published at Vol. 86, No. 127 Federal Register 35874-36016 on July 7, 2021.

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

Dear Administrator Brooks-LaSure,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Home Health rules for calendar year 2022. UnityPoint at Home is the Home Health Agency (HHA) affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment, pharmacy, palliative care, hospice care, and (in certain locales) public health. In 2020, UnityPoint at Home provided more than 318,000 visits to consumers in Iowa and Illinois. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMMI Next Generation ACO Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa and is a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. We respectfully offer the following comments to the proposed regulatory framework.

PAYMENT UNDER THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

For CY 2022, CMS is proposing that the 30-day episode rate increase by the 3.1% market basket, offset by a 0.4% productivity factor. In addition, the rate would be subject to a case-mix weight recalibration budget neutrality factor of 1.0390 and a wage index budget neutrality factor of 1.0013. CMS notes that to calculate the wage index budget neutrality factor, it compared the use of CY 2019 versus CY 2020 data to assess the potential impact of the COVID-19 public health emergency (PHE) and found a small difference, thus proposing to use the most recent CY 2020 claims data.

Comment: **UnityPoint at Home appreciates the proposed rate increase**. That said, payment adjustments over time have not kept pace with increased costs attributable to labor, technology, and mileage. This is due in part to CMS's overly broad application of behavioral assumptions beginning in CY 2020. As a nonprofit with small operating margins, we struggle with embedded assumptions that are in reaction to bad actors and penalize an entire industry that is meeting patients at their preferred point of care – their homes. **We would reiterate our request that CMS employ a targeted approach to behavioral assumptions based on data from the PEPPER reports which should be continually monitored and tied to value-based outcomes**. CMS has the data to make informed enforcement decisions, yet we are perplexed at the continued use of behavioral assumptions that are adversely impacting small and nonprofit HHAs.

We also question CMS's decision to use CY 2020 claims data to calculate the wage index budget neutrality factor. CMS represents that in comparison to CY 2019 there was only a small difference; however, when determining a baseline year for new HHAs (certified in 2019), CMS proposes to use CY 2021 quality data instead of CY 2020 quality data "due to the potentially destabilizing effects of the PHE on quality measure data in CY 2020." Based on this statement, **we believe CMS should consistently forego using "potentially destabilizing" data from CY 2020 for use in quality and financial measures**.

HOME HEALTH VALUE-BASED PURCHASING (HH VBP) MODEL

CMS proposes to expand the HH VBP model nationwide, with mandatory participation for all Medicare-certified HHAs in all 50 states, the District of Columbia, and territories beginning January 1, 2022, (i.e., performance in CY 2022 would inform the preliminary payment adjustment on CY 2024 payments). CMS proposing a number of provision changes in the area of cohorts, measures, payment adjustments, timing, and reporting.

Comment: UnityPoint at Home has had Iowa HHAs participating in the HH VBP since its inception. As a pilot participant, we had hoped that CMS would have correctly some fundamental model principles prior to a nationwide release. First, because performance is modeled on a bell curve, a large percentage of HHAs crowd the top of the curve and skew results. It is extremely difficult and sometimes arbitrary to score within the top decile (or the lowest decile), which is where monetary rewards live. For the remainder of the HHAs, most HHAs fall in the middle of the curve, receive a neutral impact for implementing program requirements, and are not truly incentivized to make significant or even incremental change. **CMS should re-evaluate whether the current structure adequately incentivizes HHAs to change behavior**.

Generally, **UnityPoint at Home supports CMS's continued emphasis and transition to measures that are not self-reported**. We applaud the progress thus far with 65% are non-OASIS measures

based on claims and patient experience. As the model expands nationally, **we would encourage CMS to reconsider how HHAs stack up in terms of population served and patient acuity**. While we understand that risk adjustment is intended to alleviate some of these concerns, we also urge CMS to consider creative methods by which to peer group cohorts by population characteristics as well as recognizing access to home health services (e.g., the number of HHAs) within a service area.

HOME HEALTH QUALITY REPORTING PROGRAMS (HH QRP)

VACCINATION FOR HHA HEALTH CARE PERSONNEL

CMS is proposing to publicly report the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure.

Comment: UnityPoint at Home, in alignment with UnityPoint Health, opposes measuring COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) as a quality measure. While our organization has instituted a COVID-19 vaccination requirement for employees, we are concerned with the precedent that a CMS pandemic quality measure will establish. First, CMS proposed this measure while COVID-19 vaccines are currently under an emergency use authorization (EUA). As vaccines are approved and protocols changes, this is not reflected in the measure. Second, if quality measures are developed and required for each disease-specific pandemic, this runs counter to principles of meaningful measures that target outcomes rather than outputs. Third, we question CMS's intent is best served through a quality measure or a vaccination requirement. The proposal to measure, and potentially tie, COVID-19 vaccination adherence to reimbursement gives the appearance that CMS is indirectly mandating vaccines for health care workers. If CMS is going to mandate vaccines, it should do so directly and clearly rather than through an indirect reimbursement incentive. Fourth, 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. Lastly, our HHAs as well as other sites of service 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 at Home appreciates CMS's attempt to curb the devastating impact of the COVID-19 pandemic; however, we have concerns with operationalizing an indirect mandate through a proposed quality measure.**

QUALITY REPORTING PROGRAM

CMS proposes to remove dug education on all medications provided to patient/caregiver during all episodes of care measure beginning with the CY 2023 HH QRP. CMS also proposes to replace the acute Care Hospitalization during the first 60 days of home health measure and emergency department use without hospitalization during the first 60 days of home health measure with the home health within stay potentially preventable hospitalization measure beginning with the CY 2023 HH QRP. CMS proposes to publicly reporting quality measures beginning with the CY 2022 HH QRP, specifically, publicly report the percent of residents experiencing one or more major falls with injury measure and application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function measure beginning in April 2022. Finally, CMS also proposes to collect the transfer of health Information to provider-PAC

measure, the transfer of health information to patient-PAC measure, and certain standardized patient assessment data elements beginning January 1, 2023.

Comment: UnityPoint at Home supports the proposed measure set revision. In general, we agree that measures should shift from those that are self-reported and subjective to claims-based and patient experience measures. If measure collection and reporting duties can be minimized for HHAs, this will enable more resources to be diverted from administrative duties to patient care. Overall, we support clinicians being enabled to perform at top of licensure and to concentrate time and effort on direct patient care.

CONDITIONS OF PARTICIPATION

CMS is seeking comment on proposed changes to allow virtual supervisory assessments of home health aides for patients receiving skilled care and for the proposed changes to supervision, competency assessment, and retraining for aides providing care to patients receiving all levels of HHA care.

Comment: UnityPoint at Home applauds CMS for facilitating supervisory assessment of home health aides via telehealth. As nursing shortages continue to be a barrier, this flexibility theoretically frees up nurses to visit patients with skilled needs instead of tagging along for supervisory assessment of home health aides.

That said, the proposal contains limitations that if removed could further improve access to care through the efficient use of skilled clinicians.

- We encourage CMS to remove arbitrary restrictions - "2 virtual assessments in a 60-day period" per HHA or to "rare circumstances." Tracking and documentation of these timeframes/circumstances pose challenges for large organizations and will not be cost effective.
- We request CMS to reconsider limiting the visit to two-way, audio/visual communications. This will artificially limit this method of assessment due to patient technology capabilities and/or patient condition.
- We seek clarification on the addition of "and all related skills" in 484.80(h)(3). Specifically, we urge CMS to clarify "related skills" to avoid an interpretation that all skills are required to be reassessed. For example, an infection control related deficiency could technically be related to anything being done in the home.
- We recommend that home health CoP revisions in this area mirror, or be as similar to, hospice CoP requirements. There are a large number of agencies that use aides for both programs, and there are efficiencies gained when aide training requirements are consistent.

PERMANENCY OF COVID-19 PANDEMIC FLEXIBLITIES FOR HOME HEALTH SERVICES

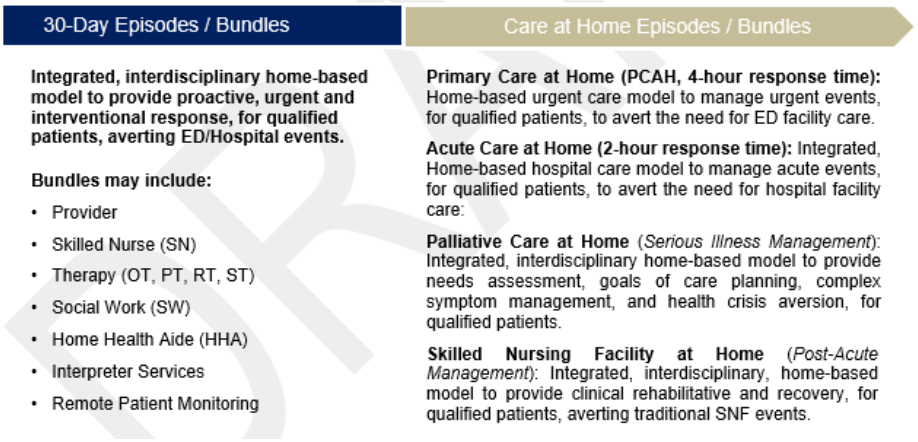
ACUTE HOSPITAL CARE AT HOME WAIVER AND AMBULATORY BUNDLES

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, 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 waiver program 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. While we recognize that this waiver came into being as a result of the COVID-19 pandemic, its efficacy beyond the pandemic is undeniable. **UnityPoint at Home is a national leader and would welcome being included in CMS conversations about the future of the Acute Hospital Care at Home program.**

In addition to participating in the Acute Hospital at Home program, program outcomes were heightened through a post-acute care bundling strategy in which appropriate services are wrapped around the patient. Through Care at Home services, UnityPoint at Home has delivered a suite of home-based medically necessary services, with the objective to both optimize quality and enhance economic outcomes, introducing an innovative ambulatory care bundle in October 2019. Within the ambulatory space, Acute Care at Home episodes can then lead to 30-day bundle episodes at home to manage unplanned acute events and reduce patients' risk of avoidable Emergency Department or hospitalization events. These ambulatory bundles feature service delivery flexibilities and a seamless approach to patients that avoids hospital conditions of participation and policies, inpatient electronic medical record barriers, and unnecessary Emergency Department visits and hospitalizations and are described below:



This program is a difference maker. Since the introduction of the Primary Care at Home 30-Ambulatory Care bundle model, UnityPoint at Home has treated 151 patients. The intervention led to a significant decrease in ED escalation rate and hospital admit escalation rate (Table below).

ED and Hospitalization Rates

	Outcome Target	ACAH Baseline*	ACAH w. PCAH 30-Day Bundle**
Number of patients served		59	151
7-Day ED Escalation Rate	≤ 10%	8.5%	1.4%
7-Day Hospital Admit Escalation Rate	≤ 10%	6.8%	6.8%
30-Day ED Escalation Rate	≤ 15%	27.1%	5.8%
30-Day Hospital Admit Escalation Rate	≤ 13%	22.0%	13.1%
30-Day ED Escalation Rate		30.5%	10.2%
30-Day Hospital Admit Escalation Rate		25.4%	18.0%

Source: UnityPoint at Home Analytics Report

ACAH – Acute Care at Home; **PCAH** – Primary Care at Home
* Between 09/2018-09/2019; ** Between 10/19-07/2021

Additionally, patient overall rating of care received exceeds 99%. **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.**

TELEHEALTH SERVICES

During the PHE, CMS has indicated that the use of technology may not substitute for an in-person home visit that is ordered on the plan of care and cannot be considered a visit for the purpose of patient eligibility or payment; however, the use of technology may result in changes to the frequencies and types of in-person visits as ordered on the plan of care.

Comment: The pandemic has also been the impetus to lift existing restrictions on Medicare coverage and payment for telehealth services furnished to Medicare beneficiaries. **UnityPoint at Home has been an early adopter of telehealth infrastructure and supports the use of telehealth beyond the PHE, including remote patient monitoring, telephone calls (audio only and TTY); and 2-way audio-video technology.** These are valuable tools not just for safely providing access to needed care during the pandemic but generally to manage the health of individuals with chronic conditions in the least restrictive and most convenient setting. As an example, during a significant COVID-19 surge in a rural part of Iowa, the hospital was overwhelmed by patient volume. Our HHA was able to increase census capacity via the use of remote patient monitoring. Generally, RN case managers are able to manage more patients when they are able to monitor and connect remotely. During the pandemic, remote monitoring was also crucial to our strategy to conserve Personal Protective Equipment (PPE). While CMS is proposing to permit telehealth service delivery as a home health benefit beyond the PHE, **this proposal stops short of authorizing reimbursement and/or allowing for an audiovisual connection to count toward visit frequency, which improves the ability of HHAs to serve more patients, especially in rural areas. We urge CMS to expand this proposal**. As CMS considers potential reimbursement framework for HHA telecommunication encounters, **we would recommend reimbursement be tied to those encounters identified within the Home Health plan of care and that the rate be commensurate**

with the various evaluation and management visit codes as set forth in the Medicare physician fee schedule.

HOME INFUSION THERAPY SERVICES

CMS proposes to continue to apply the geographic adjustment factor (GAF) with a budget neutrality factor whenever there are changes to the GAF in order to eliminate large-scale variation. CMS also proposes an increase the payment amount for the first home infusion therapy (HIT) visit to take the more time- and resource-intensive nature of these preliminary visits into account and proposes to reduce the payment amounts for subsequent visits accordingly.

Comment: As this benefit has been operationalized, UnityPoint at Home continues to be concerned with its overall structure. As predicted, CMS has established a complex, costly, and inefficient process for a very limited benefit. **The HIT benefit disadvantages beneficiaries in comparison to services formally provided under the Medicare home health benefit**. In particular, the Part B HIT benefit requires a 20% beneficiary copay for professional services that were otherwise covered in full under the home health benefit, offers a more limited benefit in that skilled services are provided but not other support services, and may result in fragmented care because the HIT benefit and home health benefit can operate concurrently under separate plans of care.

PROVIDER AND SUPPLIER ENROLLMENT

CMS proposes multiple changes to provider and supplier enrollment including effective dates, rejection and returns, as well as deactivation.

Comment: CMS appears to be codifying current policy, and UnityPoint at Home supports this. In terms of process, we would request that CMS update the paper enrollment forms to mirror the PECOS system as some revision dates are very old and the information requested differs. If not already in guidance, CMS should state when paper forms are required instead of submission via the PECOS system (e.g., paper applications, and not PECOS, are required to add a branch office located in a different state from the parent organization).

HOSPICE SURVEY AND ENFORCEMENT REQUIREMENTS

CMS proposes a comprehensive strategy to enhance the hospice program survey process, increase accountability for hospice programs, and provide increased transparency to the public.

Comment: UnityPoint at Home has long recognized the importance of hospice services for our patients. UnityPoint Hospice is affiliated with 5 Medicare certified agencies in Iowa and Illinois and provides high quality care in those service areas. In addition, we are committed to payment reform and are actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMMI Next Generation ACO Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa and is a CMMI Medicare Care Choices Model awardee in three Iowa regions. ***As a member of the National Association for Home Care and Hospice (NAHC), UnityPoint at Home is generally supportive of their comments on the proposed revisions to the survey process.*** We offer additional thoughts below.

Surveyor qualifications and conflicts of interest: CMS is proposing to disqualify a surveyor for a State survey agency (SA) or Accrediting Organization (AO) from surveying a particular hospice if that

surveyor worked for the hospice program within the last two years or has a financial interest in the hospice program. UnityPoint at Home not only supports this requirement but would suggest imposing a longer conflict of interest period of time (or even an outright prohibition) for a surveyor who was terminated by the hospice program being surveyed.

Hospice Program Hotline: CMS is proposing that the State or local agency maintain a toll-free hotline. UnityPoint at Home respectfully suggests that States house this hotline and responsibility. Currently States have an established Home Health hotline, and we would recommend that hospice programs utilize this same process and hotline as an efficiency measure.

Public Display of Form CMS-2567: UnityPoint at Home supports being accountable and transparent to our patients and the public. When deficiencies are noted, it is extremely important for the public to understand that deficiencies have been corrected. That said, the deficiency report (CMS-2567) is not consumer friendly and easily digestible for public reporting/posting as is. We highly encourage CMS to work with hospice programs outside a formal notice and comment mechanism to develop appropriate and timely public reporting. Accurate and easily understood reporting is not only important for the public but also for the integrity of hospice programs. For instance, the presence of an action plan could be reported to show that noted issues/discrepancies have been or are being addressed.

Standardized Training for AO and SA Surveyors: UnityPoint at Home supports this. Because we operate hospice programs in multiple states, we also encourage CMS to promote standardization of training and ultimately enforcement among states as well. Our preference is for objective measures. For instance, when a sample is surveyed, surveyors have defined discrepancies differently – equating similarly one or ten discrepancies within a sample as a deficiency with similar enforcement.

Validation Surveys: While UnityPoint at Home understands the need to assure consistent survey results, we have concerns with the current process. Generally, the current validation survey process to be disruptive to hospice operations. Having a separate survey to validate a work of a survey contractor is time consuming for hospice programs and distracts resources from providing direct patient care. We strongly urge CMS to consider a process whereby (1) a SA is present at the time of the initial AO survey to validate the underlying survey or (2) a SA performs a desk review validation using AO paperwork/information collected during the underlying survey. Additionally, if there are findings in the validation survey, these findings should apply to the AO and not the hospice program. UnityPoint Health supports an accurate and consistent survey process, but not at the expense of hospice operations.

Special Focus Program (SFP): UnityPoint at Home supports the NAHC comments, including the use of a technical expert panel to enhance the SFP in terms of selection, enforcement, and technical assistance criteria.

REQUEST FOR INFORMATION: 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 the first to implement electronic health records (EHRs) and FHIR, the 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. 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 organizations are at v4.1.0 yet because vendors and providers are not required to meet ONC CURES Edition CEHRT.

While UnityPoint at Home 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 providers and smaller organizations. **Overall, UnityPoint at Home 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.

REQUEST FOR INFORMATION: 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: With UnityPoint at Home 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 at Home appreciate CMS's commitment to addressing health

equity and looks forward to partnering with CMS in advancing this important focus. UnityPoint at Home, through 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 at Home 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 at Home 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 at Home 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 at Home 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 at Home 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 HHAs 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 at Home urges CMS to consider offering HHAs 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 at Home is supportive of health equity and developing a framework for measuring so that HHAs 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 at Home 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 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 at Home 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 at Home 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 at Home 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 at Home appreciates the Administration's pervasive emphasis on health equity

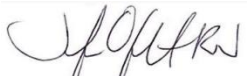
[1] (https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/)

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 at Home looks forward to partnering closely with CMS in future efforts driving health equity.

UnityPoint at Home appreciates the opportunity to provide comments to the proposed Home Health rules and their impact on our HHAs and beneficiaries. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director of Government & External Affairs, at (319) 361-2336 or cathy.simmons@unitypoint.org.

Sincerely,

Margaret VanOosten, RN, BSN
President and Chief Clinical Officer
UnityPoint at Home



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