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Secretary Robert F. Kennedy, Jr.
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1831-P
P.O. Box 8010
Baltimore, MD 21244–8010

RE: CMS–1831-P - Medicare Program; FY 2026 Inpatient Psychiatric Facilities Prospective Payment System Rate Update; published at Vol. 90, No. 82 Federal Register 18494-18531 on April 30, 2025.

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

Dear Secretary Kennedy,

UnityPoint Health appreciates this opportunity to provide comments on this proposed rule related to Inpatient Psychiatric Facilities (IPF) rates and quality reporting. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 29,000 employees and our relationships with 390+ physician clinics, 36 hospitals in urban and rural communities, 5 IPFs, and 12 home care areas of service across our 8 regions, UnityPoint Health provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UnityPoint Health provides a full range of coordinated care to patients and families through more than 8 million patient visits.

UnityPoint Health appreciates the time and effort of CMS in developing this proposed rule. We respectfully limit our input to the select quality measure issues outlined below.

INPATIENT PSYCHIATRIC FACILITIES QUALITY REPORTING (IPFQR) PROGRAM

CMS proposes to modify the reporting period for the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge. CMS proposes to remove four measures, all beginning with the CY 2024 reporting period/FY 2026 payment determination: Facility Commitment to Health Equity; COVID–19 Vaccination Coverage among Healthcare Personnel; Screening for Social Drivers of Health; and Screen Positive Rate for Social Drivers of Health. In addition, CMS proposes to update the Extraordinary Circumstances Exception (ECE) policy.

Comment: UnityPoint Health appreciates and supports the reporting period modification to align with the unplanned readmission measure. From a reporting standpoint, this is easier to maintain and less confusing.

CMS is consistently removing four quality measures across various Medicare prospective payment system

proposed rules. To comply with FY 2025 requirements, UnityPoint Health has invested resources and infrastructure to collect and report these measures, which will be maintained for the present year. **For FY 2026, we support removal of these measures with their associated reporting burdens**. Specifically, we applaud the elimination of the COVID–19 Vaccination Coverage Among Healthcare Personnel measure. With the end of the public health emergency, COVID-19 surveillance is being managed alongside other infectious diseases without special or added emphasis. But more importantly, this measure's definition, data collection, and public reporting do not accurately depict overall vaccination coverage, but rather a numerator snapshot of the most recent vaccine version administered. We appreciate the removal of this flawed measure. Additionally, CMS had mandated screening for social drivers of health across multiple care platforms. These screens were often duplicative, but required, and heavily contributed to survey fatigue from patients and created added burden for providers.

UnityPoint Health supports the revised ECE policy.

REQUEST FOR INFORMATION (RFI): STAR RATINGS FOR IPFs

CMS seeks input on the development of a five-star methodology for IPFs that can meaningfully describe the quality of care offered by IPFs.

Comment: Foremost, UnityPoint Health believes quality is our best strategy. **When instituting Star Ratings for IPFs, we urge caution and care so as not to inadvertently impact access to acute behavioral health services**. IPFs serve vulnerable patients in crisis situations and, with tightening inpatient operating margins, IPFs are often the first services to close. Should Star Ratings miss their mark, we are concerned for patient access.

Generally, Star Ratings help Medicare beneficiaries compare quality and performance to assist with care decisions. While beneficiaries have some degree of choice in seeking IPF services, patients admitted to IPFs often enter during times of crisis, limiting their ability to make informed choices or comparison shop. In that same vein, the underlying mental condition of IPF patients may also influence subjective assessments related to the quality of and satisfaction with their IPF services. Additionally, IPF populations are not homogeneous – for instance, some include more involuntary commitments, or some include more patients with conditions that are prone to outward manifestations of violence. These factors may skew ratings. While we recognize the importance of quality transparency, the audience and purpose of the IPF Star Ratings should be the primary focus when undertaking and developing this system.

Our feedback on select RFI questions are below.

Criteria for measure selection

Are there specific criteria CMS should use to select measures for an IPF star rating system, such as a measure's generalizability (degree to which a measure is applicable to a broad segment of patients)?

When developing a IPF Star Rating system, we recommend that CMS consider:

- **Established Data**: We encourage CMS to utilize data that has been publicly available for at least a year. This ensures reliability and consistency in the data used for Star Ratings.

- **Sufficient Sample Size**: We encourage CMS to use data with sufficient sample size to ensure the data is representative of the entire population.
- **Inclusion of Safety, Quality, and Care Coordination Measures**: We encourage CMS to include safety, quality, and care coordination categories to ensure Star Ratings are representative of overall patient care and have a quality focus.
- **Phased Implementation with Preview Periods**: Star Ratings, like the start of any new measurement program, should be phased in over time to ensure measures are accurately collected and reported. In particular, we encourage CMS to consider having a Star Rating preview year allowing for IPFs to review the ratings and provide feedback to CMS before publicly displaying.

Future use of additional data for a IPF Star Rating System

The PIX survey will become mandatory for the FY 2028 payment determination—that is, data collection occurring in CY 2026. Although PIX data may not be available for an initial version of an IPF star rating system, what considerations should CMS give these data, when they become available? For example, should they be included as part of an overall star rating, or used to derive a standalone patient experience star rating? See for example the Hospital patient experience star rating, which is derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS©) survey and displayed as "Patient survey rating" on the Compare tool.

Although UnityPoint Health supports the idea of gathering patient feedback, we recommend against including PIX data in the Star Ratings.

- IPF Nuances: The PIX survey focuses on capturing patients' perspectives of their inpatient stay, and given the patient makeup, survey results may be influenced by their medical condition and mental state and not by the conditions and quality of their stay. Different states have significantly different laws relating to involuntary civil commitment for mental health conditions. Within our footprint, Iowa and Wisconsin are examples of how involuntary commitments differ. Iowa has the fewest state inpatient psychiatric beds per capita in the country. As such, almost all court commitments are directed towards private hospitals, many of which are classified as IPFs. In Wisconsin, its State detention facilities provide immediate evaluation and treatment for most involuntary patients; however, private hospitals will occasionally treat a court committed patient in an IPF. This typically occurs when the patient arrives at the ED or is admitted to the IPF voluntarily, but then during the inpatient stay becomes involuntary usually due to their condition deteriorating or the patient wanting to leave against medical advice (AMA) and doing so would pose an imminent health and safety risk to the patient or others. When evaluating our internal patient satisfaction system, UnityPoint Health has seen a large variance in satisfaction results between voluntary patients versus involuntary patients – the latter generally have a lower level of patient satisfaction. We are concerned that a national Star Rating for IPFs would not be able to tease out these nuances within PIX Survey results.
- PIX Survey is Untested: It is premature to rely on the PIX survey results. Given this is a new survey, many organizations will need time to develop effective workflows and best practices for its

administration. Results in the first several years may not be reliable. Also, the PIX survey is to be distributed onsite in person (i.e., physically distributing a paper version of the survey to the patient while inpatient). This distribution method is extremely challenging. We not only anticipate that responses will be delayed, but overall response rates will likely suffer. And because surveys are de-identified, should they be returned with a complaint, there is no mechanism to follow up. The jury is still out on the efficacy of the PIX survey and data.

REQUEST FOR INFORMATION (RFI): DIGITAL QUALITY MEASUREMENT STRATEGY - APPROACH TO FHIR® PATIENT ASSESSMENT REPORTING

CMS seeks to gain an understanding of the current adoption and use of EHRs, other health IT, and data standards supporting interoperability (such as FHIR and USCDI) within IPFs.

Comment: As part of a larger integrated healthcare system, our responses incorporate the viewpoint of UnityPoint Health along with IPFs. Our feedback on select RFI questions are below.

To what extent does your facility use health IT systems to maintain and exchange patient records?

UnityPoint Health utilizes electronic medical record (EMR) technology for IPFQR patient documentation and care. We have standard EMR capabilities for patient data exchange through various health information exchanges (HIEs) and EMR functionality.

If your facility has transitioned to using electronic records in whole or in part, what types of health IT does your IPF use to maintain patient records? Are these health IT systems certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification program25? Does your facility use EHRs or other health IT products or systems that are not certified under the ONC Health IT Certification Program? If so, do these systems exchange data using standards and implementation specifications adopted by HHS26? Please specify.

Our IPFQR facilities utilize Epic as our EMR software. We maintain the most current CEHRT version of Epic, as defined by the ONC.

Does your IPF submit patient data to CMS directly from your health IT system, without the assistance of a third-party intermediary? If a third-party intermediary is used to report data, what type of intermediary service is used? How does your facility currently exchange health information with other healthcare providers or systems, specifically between IPFs and other provider types, or with public health agencies? What challenges do you face with the electronic exchange of health information?

UnityPoint Health uses a combination of manual submissions via reports created in our EMR or data warehouse tools to upload to hospital quality reporting (HQR) program as well as a third-party intermediary to submit IPFQR data to CMS. Our third-party intermediary aids in capturing data components and uploading data files on our behalf to meet requirements.

We utilize our EMR to exchange data with other healthcare systems and our public health agencies when possible. The connections to public health agencies vary, as we have a multistate footprint and the capacity of state health agencies to collect data is not standard.

The biggest challenges include lack of consistency in state data sharing laws and regulations and data submission methods to state agencies. In one state, we are also required to pay a third-party vendor to

submit CMS required state-level public health data. This is not only financially burdensome, but it is resource intensive as they have created their own submission requirements utilizing USCDI standards which are different than the general public health requirements.

When exchanging data with other healthcare systems, not all healthcare systems are consistent in supplying and maintaining their direct addresses for exchange. Many sites do not maintain CEHRT required EMR software, and therefore do not have this functionality available. The NPPES provider directory is not user friendly for collecting and updating direct addresses, and therefore is often outdated. Often IPFQR facilities utilize third-party resourcing for EMR support, which also makes contacting the appropriate resources to share these direct addresses difficult.

What steps does your IPF take to ensure compliance in using health IT with security and patient privacy requirements such as the requirements of the regulations promulgated under the Health Insurance Portability and accountability Act (HIPAA) and related regulations?

UnityPoint Health reviews HIPAA laws at a system level to ensure we are meeting protected Patient Health Information guidelines under HIPAA and the SAMHSA requirements. UnityPoint Health further investigates state guidelines to ensure we meet the most strict laws to maintain compliance.

Does your IPF refer to the SAFER Guides to self-assess EHR safety practices?

Because the IPFQR facilities are part of our inpatient facilities and utilize the same EMR as our inpatient care, we follow our standard Security Risk Assessments and SAFER Guides review to ensure EMR safety policies and procedures are up to date.

What types of technical assistance, guidance, workforce training resources, and other resources would help IPFs to successfully implement FHIR-based technologies for submitting the IPF-PAI to CMS? What strategies can CMS, HHS or other Federal partners take to ensure that technical assistance is both comprehensive and user-friendly? How could Quality Improvement Organizations (QIOs) or other entities enhance this support?

The adoption and standardization of FHIR technology across all state agencies would be beneficial. In many cases, state agencies do not require their EMR vendors to meet FHIR technology standards which in turn causes issues and difficulty with connections. We urge CMS to require third-party vendors who are supporting CMS reporting and public health agency data collection to meet FHIR standards and to not deviate from the definition for CEHRT requirements.

Is your facility using technology that utilizes APIs based on the FHIR standard to enable electronic data sharing? If so, with whom are you sharing data using the FHIR standard and for what purpose(s)? For example, have you used FHIR APIs to share data with public health agencies? Does your facility use any Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR applications? If so, are the SMART on FHIR applications integrated with your EHR or other health IT?

UnityPoint Health currently uses FHIR for some data sharing with the most success being with third-party payors under billing programs. Unfortunately, we cannot use FHIR API technology consistently due to the lack of consistent version requirements for all opportunities.

What benefits or challenges have you experienced with implementing technology that uses FHIR-based APIs? How can adopting technology that uses FHIR-based APIs to facilitate the reporting of patient

assessment data impact provider workflows? What impact, if any, does adopting this technology have on quality of care?

The largest challenge with FHIR implementation is the use of different standards/versions by various partners. On occasion we are unable to connect with some partners because we have adopted a "more updated version" than our partner.

Does your facility have any experience using technology that shares electronic health information using one or more versions of the USCDI standard?

While we support structured data elements to assist in standardized reporting, platforms to collect, warehouse, and ultimately report data vary, which adds burden for providers. In one of our states, a third-party vendor serves as an HIE and data warehouse for the State public health agency and is charged with supporting our state's public health data submission utilizing USCDI standards. This vendor created their own message system to submit USCDI data that does not utilize EMR software technology standards outlined under ONC's CEHRT standards. To submit USCDI data, providers must now "build" interface connections. Additionally, the vendor often exceeds base data submission guidelines for public health reporting standards under the USCDI. This nonstandard reporting also requires extra burden and expense for providers.

What other information should we consider, to facilitate successful adoption and integration of FHIR-based technologies and standardized data for patient assessment instruments like the IPF-PAI? We invite any feedback, suggestions, best practices, or success stories related to the implementation of these technologies.

For FHIR technology to be easily adaptable and capable of expanding health information exchange in the desired manner, FHIR technology needs to be standardized and consistent across EMR vendors, healthcare facilities, and those identified entities receiving the data, such as public health agencies and CMS.

We are pleased to provide input on this request for information and its impact on our IPFs, patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,

Cathy Simmons, JD, MPP
Executive Director, Government & External Affairs
UnityPoint Health