

June 17, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1771-P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: CMS–1771-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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation; published at Vol. 87, No. 90 Federal Register 28108-28746 on May 10, 2022.

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 health care systems. Through more than 32,000 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 accountable care organization (ACO) affiliated with UnityPoint Health and has value-based contracts with multiple payers, including Medicare. UnityPoint Accountable Care currently participates in the Center for Medicare and Medicaid Innovation’s Global and Professional Direct Contracting Model, and it contains providers that have participated in the Next Generation ACO Model, the Medicare Shared Savings Program (MSSP), and the Pioneer ACO Model. UnityPoint Health also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health, which has a CMS five-star quality rating for the 2022 coverage year.

UnityPoint Health appreciates the time and effort of CMS in developing this proposed rule. UnityPoint Health is a member of the American Hospital Association and generally supports their formal comment letter to this proposed rule. UnityPoint Health respectfully offers the following comments:

INPATIENT PROSPECTIVE PAYMENT SYSTEM UPDATE (IPPS)

For FY 2023, CMS is proposing to increase Medicare IPPS rates by a net 3.2% (market basket update of 3.1%, -0.4 percentage points for total factor productivity, and +0.5 percentage points for documentation and coding).

Comment: While UnityPoint Health is appreciative of an increase in payment rates, this increase does not match inflationary pressures or exponential increases to health care labor and supply costs exacerbated by the COVID-19 pandemic. We echo the American Hospital Association's requests that CMS (1) implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022; and (2) eliminate the productivity cut for FY 2023.

AREA WAGE INDEX MODIFICATIONS

For FY 2023, CMS is proposing to adopt a permanent policy to place a 5% cap on all wage index decreases each year, regardless of the reason. In addition, CMS is proposing to continue a "rural floor" policy; however, the specific methodology is subject to recent court proceedings.

Comment: UnityPoint Health supports the permanent 5% cap on wage decreases and agrees that it will increase payment predictability for hospitals. As for the "rural floor," this policy is important to sustain acute care access for many smaller hospitals vital to regional care and serving a safety net function.

RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

This demonstration program allows rural hospitals with fewer than 51 acute care beds to test the feasibility of Part A cost-based reimbursement. For FY 2023, 26 hospitals are participating. For FY 2023, CMS is proposing to continue the budget neutrality offset.

Comment: 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 strongly support the continuation of this program but, given its demonstration status, this program does not offer long-term financial sustainability needed to maintain health care access in rural areas and **we urge CMS to consider a more permanent status for this rural designation**. In addition, we offer the following program improvement suggestions:

- Continuation of "Safety Net" Financial Stability Provisions for Sole Community Hospital Participants. Specifically, the demonstration should retain the financial SCH safeguard provided to all SCHs - "to provide a continued safety net for SCH's the first cost reporting period payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be 'the greater of' the reasonable cost of providing such services or the hospitals IPPS Payments." Presently, SCHs who are demonstration hospitals must waive this safeguard.

- Assignment of Medicare Administrative Contract (MAC) by Geography for Audits. Presently, one MAC is assigned to audit the demonstration, which may vary from the MAC assigned to the demonstration hospital's state. During the last audit, the MAC assigned to the demonstration had different perspectives/interpretations than our regional MAC. When audits are managed by a different MAC, it is very difficult to administer program rules that become subject to change in interpretation on the back end.
- Demonstration Participant Eligibility for the 340B Drug Pricing Program. Similar to CAHs, demonstration participants should be eligible for 340B drug rebates on inpatient services regardless of disproportionate share hospital (DSH) status.

LOW-VOLUME HOSPITALS

For FY 2023, CMS is proposing to revert to the 2005 eligibility criteria for low-volume hospital status, including a total discharge criteria of 200 or less and a distance criteria of 25 miles.

Comment: UnityPoint Health has two¹ "tweener" hospitals that are eligible for the low-volume adjustment using both the 2011 and 2019 eligibility criteria. Specifically, these hospitals currently have total annual discharges less than 1,600 but greater than 200. Should the low-volume adjustment revert to FY 2005 criteria, our financial analysis indicates Medicare reimbursement will dip -13.7% and -15.7% respectively. These significant reductions from their largest payer will likely hamper the ability of these hospitals to remain open in the rural communities that they serve. **We urge CMS to retain the 2019 eligibility criteria to support regional care models.**

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS is proposing continued suppression of the Pneumonia Readmission measure for FY 2023. Beginning in FY 2024, CMS has proposed this measure will no longer be suppressed under the Hospital Readmissions Reduction Program.

Comment: UnityPoint Health supports the continued suppression of the Pneumonia readmission measure for FY 2023.

HOSPITAL VALUE-BASED PURCHASING PROGRAM (VBPP)

CMS is proposing to suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and five Hospital Acquired Infection (HAI) measures, for the FY 2023 program year. CMS is also finalizing their proposal to suppress the Hospital 30-Day, All Cause, Risk Standardized Mortality Rate Following Pneumonia (PN) Hospitalization measure (MORT-30-PN) for the FY 2023 program year. CMS is also proposing several updates to the baseline periods in this proposed rule for the FY 2025 program year.

Comment: UnityPoint Health is supportive of suppressing these measures for FY 2023. CMS is proposing to revise the scoring and payment methodology for the FY 2023 program year such that hospitals will not receive Total Performance Scores (TPS). Instead, CMS is proposing to award each hospital a payment incentive multiplier that results in a value-based incentive payment that is equal to the amount withheld

¹ This number could potentially be four; however, UnityPoint Health has two hospitals participating the Rural Community Hospital Demonstration program.

for the fiscal year (2%). UnityPoint Health is supportive of the proposed payment methodology as long as the Hospital-Acquired Conditions (HAC) and Readmission Reduction program measures are also suppressed within the finalized rule, as currently proposed. Together, these programs help balance payment impacts.

UnityPoint Health is also supportive of data transparency and appreciates CMS providing confidential reports sharing individual data during program measure suppression. As far as determining new baselines and benchmarks for FY 2024 forward, **we recommend not risk adjusting for COVID-19 diagnosis within VBPP measures**, but rather adjusting the benchmarks for the achievement thresholds as well as reestablishing baselines inclusive of COVID-19 diagnosis. The COVID-19 virus has become part of normal infection prevention care, and therefore its inclusion would inherently risk adjust the 2022 baseline for 2024 outcome data, effectively and appropriately leveling the playing field to the new normal.

HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM

CMS is proposing to suppress the CMS PSI 90 measure and the five CDC NHSN HAI measures (CAUTI, CLABSI, Colon and Hysterectomy SSI, MRSA, and CDI) from the calculation of measure scores and the Total HAC Score, thereby not penalizing any hospital under the HAC Reduction Program FY 2023 program year. Furthermore, CMS plans to resume calculating measure scores in the FY 2024 program year.

Comment: UnityPoint Health supports the continued suppression of measures in the HAC Reduction Program for FY 2023. Suppression of measures across the pay-for-performance programs (HAC, Readmission, and VBPP) balances payment impacts to organizations.

INPATIENT QUALITY REPORTING PROGRAM

CMS is proposing the adoption of ten new measures and requesting comment on the potential future development and inclusion of two National Healthcare Safety Network (NHSN) measures. CMS is also proposing changes to current policies related to eCQM and hybrid measures.

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

Proposed New Measures:

- Health Equity Measures – **UnityPoint Health appreciates the ability to attest to the health equity measure sets.** Overall, these measure sets encompass four large elements including both internal and external partnerships. These expansive measures, while directionally correct, will pose barriers for hospitals just beginning their health equity journey. **UnityPoint Health recommends a longer glide path for payment determination on health equity measures**, allowing hospitals to build and deploy processes as well as ample time to collect information to aid understanding of health equity gaps within the current care delivery system. Additionally, we **recommend not publicly reporting data at this time** as it could be easily misinterpreted by consumers related to the organizational commitment of hospitals in the beginning stages of the health equity journey.
- Social Drivers of Health Measures – **UnityPoint Health is supportive of identifying social**

determinates of health (SDOH) and removing barriers to equitable care. Considerations around time for organizations to develop systems and processes for receiving and providing the required information is needed within these measures. Community services and partnerships will need to be established or reestablished to remove barriers and achieve positive outcomes on social drivers of health results. SDOH screenings often include sensitive subjects, and it will be important that these screenings are completed in an appropriate setting and where identified gaps can be effectively addressed. Given the time and response to implement this measure, **CMS needs to carefully direct which settings should prioritize implementation first.**

- **Severe Obstetric Complications Measure – UnityPoint Health agrees the continued rising rate of maternal mortality is alarming and supports inclusion of this measure.**
- **Cesarean Birth Measure – UnityPoint Health does not support the Cesarean Birth quality measure.** As proposed, this measure presents operational collection and reporting burdens as well as unintended consequences to low-volume, rural birthing centers. UnityPoint Health participates in the Iowa Maternal Quality Care Collaborative (IMQCC), “a multidisciplinary task force that serves as the principal oversight body responsible for improving communication and collaborations among groups addressing obstetrical care in Iowa.”² From state collaborative work completed over the past year, the measure for deliveries by nulliparous, term, or singleton vertex (NTSV) women is extremely difficult to accurately depict and it takes considerable time and resources to assure rates are truly reflecting what’s happening inside the hospital setting. UnityPoint Health has expended significant resources to compile and validate this data. This is especially demanding when tapping resources within rural hospitals, a geographical setting already experiencing workforce challenges.

According to HRSA, **Iowa ranks last, or 52nd in the nation (including the District of Columbia and Puerto Rico), for the number of OB/GYNs per 10,000³.** In Iowa, this lack of OB/GYNs is paired with the continued closure of facilities offering comprehensive maternity care services. Since 2000, 40 hospitals have closed labor and delivery units⁴ resulting in OB deserts in 52% of Iowa counties⁵. Adding the proposed measure could adversely affect our tertiary care centers who receive rural transfers for high acuity patients on a low volume but geographically critical basis.

² (<https://idph.iowa.gov/Bureau-of-Family-Health/Maternal-Health/Maternal-Health-Programs#:~:text=The%20Iowa%20Maternal%20Quality%20Care%20Collaborative%20%28IMQCC%29%20is,collaboration%20among%20groups%20addressing%20obstetrical%20care%20in%20Iowa>)

³<https://data.hrsa.gov/topics/health-workforce/ahrf>. Ranking is from the Area Health Resources Files release year 2020-2021 for the health profession “M.D.” with the subcategory “Obstetrics and Gynecology” and includes 2019 data.

⁴Iowa Department of Public Health, Division of Health Promotion & Chronic Disease Prevention – Bureau of Family Health, “Access to Obstetrical Care in Iowa: A Report to the Iowa State Legislature – Calendar year 2019”, January 2021 accessed at [https://www.idph.iowa.gov/Portals/1/userfiles/38/MaternalHealthDataReports/OBCareinIowa_2021LegislativeReport\(table 3 corrected\).pdf](https://www.idph.iowa.gov/Portals/1/userfiles/38/MaternalHealthDataReports/OBCareinIowa_2021LegislativeReport(table%203%20corrected).pdf)

⁵Iowa Department of Public Health, Bureau of Family Health, “2021 Maternal health Strategic Plan,” accessed at <https://idph.iowa.gov/Portals/1/userfiles/38/IowaMaternalHealthStrategicPlan2021.pdf>

Due to severe maternal morbidity and complications seen in these centers, the measure could inadvertently penalize tertiary care centers further limiting timely access to care and increasing disparities seen within rural communities.

- Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) – UnityPoint Health supports PRO-PMs generally; however as proposed, **this measure presents operational challenges when surveying patients pre- and post-surgical events.** First, the patient could potentially be surveyed multiple times, which presents challenges particularly ownership of the outcome survey pre and post. Second, ownership of this measure needs further definition. While proposed for hospital reporting, it is often the case that these surgeries are performed and under the auspices of independent physicians with hospitals serving as the site of service. Third, the information regarding pre- and post-surgical outcomes is not centrally located. Often this data may not be housed in the same electronic medical record or even be available across platforms. Organizations and providers would have to be extremely diligent in sharing information to ensure reporting occurs accurately and surveying is performed appropriately. Last, gaps exist within this measure around addressing patient dissatisfaction through follow up care after the 300-day window. Given TKA and THA patients generally tend to be elderly, a survey on surgical outcomes of care requested a year after the procedure may pose confusion and result in inaccurate responses from patients as well as caregivers. In some cases, patients also receive CAHPS surveys mandated by CMS. Multiple surveys could lead to survey fatigue and frustration for patients. As such, **UnityPoint Health encourages CMS to develop additional exclusion criteria to address these operational challenges.**

Additionally, the proposed measure includes four sources of data in the denominator: PRO-PM, claims data, enrollment data, and Census Bureau survey data. Multiple data sources inherently create complexities and undue burdens to avoid potential mismatched patient information. **UnityPoint Health recommends utilizing a single source of data, preferably claims data.**

Proposed Future Measure:

- Healthcare-Associated Clostridioides difficile (C. diff) Infection Outcome – **UnityPoint Health requests further clarification and review of the measure by CMS before deployment and payment determination.** While CMS has supplied some information on the proposed new measure, lack of measure specificity makes it difficult to provide recommendations and assess operational impact. For example, it is uncertain what diagnostics testing are being proposed. There are numerous diagnostic tests for C. diff and the ability to compare apples to apples becomes challenging when some facilities have very robust diagnostic testing while others do not. Also, in determining value sets, further clarification is needed on administered therapeutics. Often C. diff is caused by the administration of a therapeutic and data could include patients with C. diff infection based on use of a therapeutic that resulted in a false positive due to overproduction.

As for the proposed submission through FHIR, CMS is still developing and deploying the current FHIR program. With various versions and lack of standardization in use, FHIR is not ready to

support submission of any new measures. As such, **UnityPoint Health urges CMS to pause the submission of any new measures using FHIR until CMS has fully deployed and vetted the current FHIR program.**

- **Hospital-Onset Bacteremia (HOB) and Fungemia Outcome Measure** – As proposed, the HOB measure is very broad and, on its face, does not easily translate to causation or quality improvement. An in-depth chart review by an infection preventionist will still be needed to aid in data review and improved quality care initiatives. If CMS is to implement this measure, UnityPoint Health recommends replacing Methicillin-Resistant Staphylococcus aureus Bloodstream Infection (MRSA BSI), rather than requiring this as an additional measure. These measures exhibit very similar metrics, with the current representing only 1 pathogen. Other considerations for measure development would include a mechanism to determine HOB in patients with a central line as well as measure exclusions (e.g., HOBs as secondary to other infections, accounting for blood culturing differences, ensuring continued lab diagnostic stewardship, and incorporating new testing platforms other than culture (NAAT/PCR)). Generally, **UnityPoint Health recommends further research and review before deployment of this measure.**

Overall, UnityPoint Health encourages CMS to provide sufficient lead time for hospitals to adopt new measures and technologies. In this case, CMS has proposed 10 new measures; however, some are composite measures comprising multiple indicators for reporting. As a provider, UnityPoint Health presently has a backlog of EHR collection and reporting change requests pending with our developers and vendors. Some of these work orders are in response to the rapid succession and multitude of federal and state requirements, while others have been self-identified to improve workflows, efficiencies, and patient experience. The changes contemplated in this rule include fairly simple as well as complex coding. We urge CMS to consider implementing longer timeframes so that our vendors will be able to develop, test, train and go live for all changes to assure valid and reliable collection and reporting. While UnityPoint Health represents 40 hospitals in the Midwest, we are not unique, and this request should be considered and magnified in the context of backlogs created by nationwide mandates impacting hospitals across the country.

MATERNAL CARE DESIGNATION

CMS is proposing to establish a hospital designation related to maternity care to be publicly reported on a public-facing website beginning in Fall 2023 and is also seeking comments on other potentially associated activities regarding this designation.

Comment: There is an urgent need to support regional labor and delivery (L&D) facilities / hospitals. This is exacerbated in rural areas. In Iowa, approximately one-third of births occur in rural areas⁶, yet many rural communities struggle to keep the labor and delivery doors open. For hospitals, maternity care is more complex, comprehensive, and costly than primary care. It involves coordinated care with clinic, surgery, and L&D services and requires 24/7 emergency room coverage. “It takes a lot of staff and hospital

⁶ Iowa Medical Society (Marygrace Elson), “Maternity Workforce in Iowa” accessed at https://idph.iowa.gov/Portals/1/userfiles/38/OBSummit/Elson_MaternityWorkforceIDPH.pdf.

resources to be ready to deliver a baby at any time” and often times that results in hospitals “abandon(ing) OB to keep your hospital open.”⁷ **UnityPoint Health is pleased to see CMS place high priority on maternal care and supports a hospital designation related to maternity care.** While we appreciate the attestation opportunity in FY 2023, we do have concerns around the proposed measure: ‘Cesarean Birth’ used for this designation in future years. Those concerns have been outlined in the Inpatient Quality Reporting Program section above.

Although we support this hospital designation, such designation cannot be sustained without health care professionals trained in maternity care. This is especially true in rural communities. **We are pleased to note that the Health Resources and Services Administration (HRSA) has issued criteria for determining Maternity Care Health Professional Target Areas (MCTAs).** To start to impact maternal health care, a comprehensive strategy is needed and both facilities and providers must be incentivized to offer and coordinate services. An additional piece to the puzzle is tort reform and/or medical malpractice solutions for OB/GYN providers and L&D facilities. **We also encourage CMS to think creatively about offering tort reform and/or medical malpractice solutions to discourage further erosion of facility and provider networks offering maternal health care services.**

CONDITION OF PARTICIPATION (CoP) – REPORTING FUTURE PANDEMICS AND EPIDEMICS

CMS is proposing to revise the hospital infection prevention and control and antibiotic stewardship programs CoPs to extend the current COVID-19 and seasonal influenza reporting requirements, and to establish new reporting requirements for any future PHEs related to a specific infectious disease or pathogen.

Comment: UnityPoint Health is not supportive of revising CoPs to include specific infectious disease reporting. The precedence set here would be burdensome and is unnecessary. For the COVID-19 virus, this reporting is captured today as part of the public health emergency (PHE) for both CMS and the Occupational Safety and Health Administration (OSHA). It is unclear why this reporting requirement would be extended beyond the PHE. If CMS is anticipating that the COVID-19 virus will become a seasonal infection risk similar to influenza, we don’t disagree; however, we do not currently report influenza infections or deaths among health care personnel. As with all reporting requirements, it’s imperative to understand what the data will be used for to ensure efforts are resulting in meaningful outcomes. Capturing and submitting data takes time and resources and brings additional administrative burden. As proposed, **CMS has not made the case for continued collection and reporting of this data post-PHE, and we believe that the benefit of doing so does not outweigh the burden on hospitals.**

Aside from burden, we believe the measures themselves are flawed. The largest concern revolves around the word ‘staff’ within the data elements for both the COVID-19 and influenza measures. Specifically, challenges exist with the data element ‘total deaths among patients and staff’. For example, if a staff were to die outside the workplace, there are complexities to understanding why that employee died and if it was related to an infection acquired within the workplace. Even if the death was due to the workplace or occurred within the workplace, regulatory oversight already resides with OSHA. Today, only

⁷ Iowa Senate Democrats, “Rural Iowa’s Maternal Health Crisis: A Doctor’s Perspective,” accessed at <https://www.senate.iowa.gov/democrats/2020/02/rural-iowas-maternal-health-crisis-a-doctors-perspective>.

patient deaths are captured and reported by hospitals to CMS. Parsing additional subpopulations, such as staff / employees, would require a large lift as personnel records are kept outside of the hospital's EHR.

More importantly, **we do not believe CoPs should be the enforcement mechanism for these requirements.** If adopted, we are concerned that this will lead to a laundry list of infectious diseases or pathogens being included within the CoPs. This level of specificity within CoPs is unwarranted and ultimately can impact hospital certification if deficiencies are identified for these proposed specific infectious disease or pathogen requirements. *Should CMS desire continued collection and reporting of this data, we urge CMS to work closely with the Centers of Disease Control and Prevention (CDC) and OSHA to develop a streamlined and uniform process.*

REQUEST FOR INFORMATION – HEALTH EQUITY

CMS is requesting feedback on overarching goals and guiding principles for measuring social risks and disparities. Additionally, CMS is requesting feedback from stakeholders on the development and inclusion of health equity quality measures for the Inpatient Quality Reporting (IQR) Program.

Comment: As an integrated health system, UnityPoint Health is committed to diversity, equity, and inclusion (DEI) at all levels of the organization. UnityPoint Health's Chief Diversity Officer (CDO) is a Senior Vice President with a direct reporting relationship to both the UnityPoint Health Chief Executive Officer and UnityPoint Health Chief Human Resources Officer. The CDO leads a dedicated team charged with elevating and embedding DEI efforts and deploying resources across our system. Initiatives target internal education and development for team members as well as strategies to address health equity and health care disparities within the communities we serve. With this background, **UnityPoint Health applauds CMS for prioritizing health equity within each of its annual prospective payment system rules to assure alignment across settings of care and for soliciting input from stakeholders regarding implementation and measurement.** This sends a powerful message that the Administration and the Agency consider health equity to be ubiquitous and an area for continual improvement and vigilance. As an organization, we agree that health care providers should be encouraged to evaluate their structure and practices, from recruitment to access, to determine community impact and strive for excellence. In general, we strongly support the overall direction being proposed and welcome the opportunity to be transparent and accountable for health equity.

UnityPoint Health is an active member of The Academy Advisors⁸ and has signed on to The Academy Advisors' comment letter to this proposed rule, which provides detail input on the health equity topic. We have provided additional comments as it relates specifically to UnityPoint Health below:

- **Timeline** - UnityPoint Health is committed to ensuring that disparities are proactively identified and addressed in the workforce and our communities. This is intentional, embedded, and ongoing work but we are still refining goals and objectives. As many hospitals are likely at different stages of their health equity journey, a phased approach would allow hospitals to benchmark their

⁸ The Academy Advisors (TAA) is a group of clinically integrated delivery networks that are members of the Health Management Academy and pursue innovative care efforts throughout our communities. TAA health systems serve more than 36 million patients annually in 28 states across the country, including UnityPoint Health.

progress, independent of other hospitals, and to strategize how to advance into other levels of maturity. This approach would allow for workforce education and training on serving a diverse population, a critical component of health equity. As such, *UnityPoint Health respectfully suggests that CMS deploy a phased approach to measuring and implementing health equity strategies to enable development and deployment of operational infrastructure.*

- **Measurement and Reporting** – In terms of potential measures, UnityPoint Health supports the use of information already being collected as applicable. Hospitals already collect numerous data points, so leveraging existing resources would be appreciated and lessen administrative burden. Health equity should be about action (or planning if in initial stages) and not about reporting (particularly if administrative burdens are added). UnityPoint Health generally agrees with the proposed domains; however, further clarity is needed. As currently proposed, health equity measures lack standardization of data definition, collection methods and validation, making it difficult to equitably assess hospitals and likely resulting in unintentional program variation. *UnityPoint Health recommends providing detailed guidance on data collection and validation to ensure all hospitals uniformly collect and report data.* This upfront and detailed guidance will also assist with minimizing infrastructure costs required for building and operationalizing collection and reporting platforms. Additionally, it will be imperative for CMS to align health equity data requirements and overall program intentions with other federal and state agencies to limit redundant duties and more importantly to avoid additional duties stemming from non-uniform measurement requirements.
- **Referrals and Follow-up** – As stated in our comments above to the social drivers of health measures under the Inpatient Quality Reporting Program, community services and partnerships will need to be established or reestablished to remove barriers and achieve positive outcomes on social drivers of health results. *While UnityPoint Health believes that hospitals have a role in reporting health equity indicators, hospitals are not single-handedly responsible for ensuring appropriate and adequate community resource availability.* We urge CMS to clarify community roles for health equity outcomes.

UnityPoint Health wholeheartedly agrees that implementing viable and sustainable health equity solutions will allow communities to see real change in their health and well-being. When hospitals are required to screen, there may be the misperception that hospitals also own the solutions. This is particularly problematic in communities where services are under resourced (i.e. resources are non-existent, underfunded or lack capacity to service those with identified risks). For example, if a patient is assessed for transportation needs in a small rural community and barriers are identified, the likelihood of adequate transportation solutions in this geographic setting is unlikely.

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” through incentives,**

not a “stick approach” with punitive performance measures. We suggest that CMS evaluate the large variation in health equity definitions as well as explore additional ways, including pre-existing data sources and platforms, 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.

REQUEST FOR INFORMATION - FHIR

CMS is seeking feedback on refined future definitions of digital quality measures (dQMs) for the Inpatient Quality Reporting Program (IQRP). CMS is also seeking feedback on data standardization activities to leverage and advance standards for digital data and approaches to achieve FHIR eCQM reporting.

Comment: Similar to our comments submitted on FY2022 IPPS proposal⁹, **UnityPoint Health urges CMS to require standardization with all health care systems and vendors before fully implementing measures.** With hospitals historically being the first to implement electronic health records (EHRs) and FHIR, our major concerns lie within the variation of FHIR versions, lack of version requirements, and variation in industry timelines. With multiple 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.

Additionally, expanded measures will require extra time to build out functionality and reporting. The more data required to be sent through FHIR, the more timelines will need to be extended for organizational readiness, including validation of processes for each measure. **UnityPoint Health recommends that CMS take organizational readiness into consideration when determining final timelines for FHIR.**

ADDITIONAL INPUT – AT HOME CARE DELIVERY AND PAYMENTS

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: With the inevitable end of the Public Health Emergency (PHE), CMS should consider facilitating a demonstration program to test and create case uses beyond the limited diagnoses currently recognized under the Acute Hospital Care at Home waiver. 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 hospital waiver. UnityPoint Health was the first to enroll a patient and to bill and be reimbursed under this waiver. As of June 8, 2022, 105 health systems with 239 hospitals in 36 states have applied and been approved to participate in this waiver. Given the infrastructure investment needed to stand up this program and the uncertainty of its duration being tied to the PHE, it is likely that more hospitals would participate under a program that has a longer duration and regulatory standing. **UnityPoint Health encourages CMS to continue a platform to test the Acute**

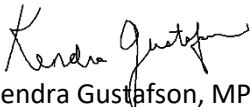
⁹ UnityPoint Health submitted a formal comment letter on June 28, 2021 (tracking number - kqh-962o-fxpi).

Hospital Care at Home services upon the termination of the PHE.

Additionally, UnityPoint Health would welcome the opportunity to further discuss the potential for operationalizing a full array of Medicare At Home services with CMS. While we recognize that CMS stood up the hospital at home waiver as a result of the COVID-19 pandemic to avoid exposure to and spread of the COVID-19 infection, its efficacy beyond the pandemic is undeniable. Best practices and lessons learned from shifting care delivery to patients' homes should be built upon, with the purpose of expanding At Home services from other care settings. UnityPoint Health has implemented an At Home care model that is a safe, high quality and cost-saving alternative for patients. By shifting care to home with the proper supports, UnityPoint Health has maintained high patient satisfaction rates (99+%) and achieved outstanding clinical outcomes, including markedly reduced readmission and preventable ED visit rates. This was accomplished through a post-acute care bundling strategy under an accountable care organization waiver 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), palliative care at home, and skilled nursing facility at home. In 2023, UnityPoint Health will offer At Home services in some of our commercial health plan contracts.

We are pleased to provide input on this proposed rule and its impact on our 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,



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