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June 24, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1716-P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: **CMS–1716-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 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals; published at Vol. 84, No. 86 Federal Register 19158-19677 on May 3, 2019.

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

Dear Administrator Verma,

UnityPoint Health ("UPH") appreciates the opportunity to provide comment on this proposed rule related to hospital inpatient rates. UPH is one of the nation's most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

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

UPH appreciates the time and effort of CMS in developing this proposed Inpatient Prospective Payment System (IPPS) rule and respectfully offers the following comments.

HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS

This rule proposes to reduce disparities in the Wage Index values by correcting for the downward spiral and changing the rural floor calculation to exclude reclassified hospital labor costs. As proposed, the Wage Index values for hospitals in Quartile 1 and Quartile 4 are offset in a budget neutral fashion over the course of four years. For hospitals in the high-wage quartile, there is a cap to avoid Wage Index reductions in excess of 5%.

Comment: UnityPoint Health is a largely rural integrated healthcare system that includes 17 acute care hospitals. As a rural provider, we believe that this Wage Index proposal has been mischaracterized as a rural provision. With the exception of one IPPS hospital, all our acute care hospitals have Wage Index values of less than 1.0, and five fall within the lowest wage quartile. While you might think that the proposed correction for wage disparities would represent an overall benefit to our system, its proposed methodology actually results in a negative impact of approximately $500,000 for this year. The culprit is the stop loss pool, which allocates a rate reduction to all IPPS hospitals to fund a pool to limit the loss of top quartile hospitals to no more than 5%. This one-time adjustment dilutes the benefit for our hospitals in the lowest quartile targeted for a Wage Index increase. In particular, our rural Sole Community Hospitals, Medicare Dependent Hospitals, and others receiving Low Volume Adjustments are negatively impacted and required to contribute to this shortfall fund. It also impacts our hospitals in the middle quartiles, essentially penalizing their "average" status, to support hospitals with Wage Index values that have been proportionally too high. ***This short-term redistribution scheme is not equitable and prioritizes the Wage Index disparity above other rate adjustments. We do not support the stop-loss pool as proposed.***

Additionally, we are concerned that CMS will similarly propose this Wage Index disparity solution in the Outpatient Prospective Payment System proposed rule. As such, we anticipate that the negative financial impact on rural nonprofit hospitals will only be magnified.

OTHER DECISIONS AND PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS

The proposed market basket rate increase for FY2020 is 3.2 percent. Other select provisions include methodology changes for determining the distribution of Disproportionate Share Hospital (DSH) uncompensated care payments, changes related to CAHs as non-providers for direct GME and IME payment purposes and implementation of the Rural Community Hospital Demonstration Program in FY2020.

Comment:

DSH Factor 3 Calculations: We are extremely concerned with the proposed changes for determining the distribution of DSH uncompensated care payments. This year's calculation uses cost report Worksheet S-10 data alone, instead of a blended rate that included the proxy measures. Although this change was anticipated, CMS is now proposing to replace the use of a rolling three-year period with data from a single year's cost report. This transition to a one-year period results in an overall impact of -$2.9 million for our system as a whole. ***We do not support the calculation alternatives suggested in this rule as both rely on one year of data and eliminate use of the three-year average, which aids in normalizing fluctuations. We would request that CMS reinstate the three-year average and only use years that have audited data***,

regardless of whether underlying worksheet instructions have changed. In terms of the proposed alternatives:

- Use of FY2015 Cost Reports: We would recommend that CMS use a three-year average. We agree that the instructions during the time period of filing were vague and that subsequent instructions and guidance were provided after the fact and did not allow for sufficient time for hospitals to prepare adequate data to support all of the requested amounts. For this reason, there is a potential that all FY2015 hospital cost reports may be incorrect and the use of the FY2015 cost report would benefit from a three-year trending to flatten these results. Despite the instructions controversy, we prefer this cost report period because it is audited.
- Use of FY2017 Cost Reports: We would recommend that CMS use a three-year average. This alternative proposes the use of unaudited 2017 data. We do not recommend using unaudited data as there is too much potential uncertainty regarding the validity of the initial filings. We prefer the use of audited data to encourage standardization in reporting among providers.

Critical Access Hospital (CAH) as a Non-Provider Setting: For direct graduate medical education (GME) and indirect medical education (IME) payment purposes, ***we support the proposed changes*** that recognize CAHs as a non-provider setting to enable a hospital to include full-time equivalent (FTE) residents training at a CAH in its FTE count. With the shortage of physicians in rural areas, we believe that this will encourage more CAH rotations and expose more residents to the benefits of rural practice, which may ultimately increase rural physician recruitment and retention.

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

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

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

MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS

This proposal includes changes to MS–DRG classifications, adjustment to the standardized amounts and recalibration of the MS–DRG relative weights. Recommendations are included for technology add-on payments and an alternative pathway for certain transformative new devices is proposed. Input is sought on the substantial clinical improvement criterion used to evaluate new IPPS technology add-on payments and the Outpatient Prospective Payment System (OPPS) transitional pass-through payments.

Comment: We are limiting our comments to the proposed revisions to the Complications and Comorbidities / Major Complications and Comorbidities (CC/MCC) list. After undertaking a comprehensive CC/MCC analysis, CMS clinical advisors recommended a change in the severity level designation for 1,492 ICD–10–CM diagnosis codes. The analysis involved a review of the data as well as consideration of the clinical nature of each of the secondary diagnoses and the severity level of clinically similar diagnoses. As a result, there is a net change of -145 codes designated as an MCC, -838 codes designated as a CC and 983 codes designated as a non-CC. Given the sheer number of impacted codes, UPH was not able to perform a thorough analysis of impact to our organization within the rulemaking comment period. ***In the future, we would request that CMS consider extending the comment period for portions of the IPPS rule when a significant number of MS-DRGs are impacted*** to enable organizations to provide vetted feedback. Greater opportunity for stakeholder input into this review process would be appreciated.

CHANGES FOR HOSPITALS EXCLUDED FROM THE IPPS

This proposal includes payment based on 101 percent of the reasonable costs of the Critical Access Hospital (CAH) or the CAH-owned and operated entity in furnishing ambulance services, in a situation where there is another provider or supplier of ambulance services located within a 35-mile drive of the CAH that is not legally authorized to transport individuals either to or from the CAH.

Comment: ***We support this change related to CAH ambulance services.*** Generally, we are concerned with the adequacy of access to health care in rural areas and this is a small step to support this vital rural service. As a health care provider with a presence on state borders, we also appreciate any efforts by CMS to remove artificial reimbursement barriers to regional health care delivery.

QUALITY DATA REPORTING REQUIREMENTS

Included in this proposal are updates to requirements for the Medicare hospital Promoting Interoperability (previously Meaningful Use) and Inpatient Quality Reporting (IQR) programs. The EHR reporting period remains a minimum of any continuous 90-day period for 2020 and 2021, and CMS proposes changes to the optional measures within the Electronic Prescribing objective. While reporting of 4 eCQMs remain for 2020 through 2022, the overall number of eCQMs is reduced and, beginning in 2022, the Safe Use of Opioids-Concurrent Prescribing measure becomes a mandated eCQM. Under IQR, the existing hospital-wide readmissions measure is proposed to transition in 2026 to a hybrid hospital-wide all-cause readmission measure comprised of both claims and EHR data. Also, in this rule, CMS announced plans to issue confidential reports to hospitals on differential 30-day readmission outcomes for dual eligibles as part of the Hospital Readmissions Reduction Program.

Comment:

Promoting Interoperability: ***Generally, we support the continued use of the 2015 Edition CEHRT and the 90-day Promoting Interoperability (PI) reporting period for 2020 and 2021; however, we oppose changes that inconsistently apply reporting timeframes for "actions within the calendar year" between Medicare and Medicaid.*** As proposed for CY2020, both the numerators and denominators of measures in the Medicare PI Program would only increment based on actions that have occurred during the EHR reporting period that was selected by the hospital. This contradicts the Medicare Eligibility and Participation FAQ 8231[1] and Medicaid PI Program. Under present requirements, unless the numerator of a measure is specifically restricted to the EHR reporting period in the measure specifications, health care providers are permitted to include actions taken before, during or after the EHR reporting period if the period is less than one full year; however, these actions must be taken no earlier than the start of the same year as the EHR reporting period and no later than the date of attestation. Inconsistent reporting requirements requires two different reporting logics for the same data, which relates to additional software costs for providers and potentially two separate incentives for providing care. We support a numerator timeframe that encompasses the entire year to promote patient convenience and provider workflow. The current guidance allows more flexibility for providers (as opposed to upfront attestations within the proposed rule) and EHR reports have been developed and are in use that restricted numerator actions to the reporting period, based on the original measure descriptions.

Opioid-Related Measures: Beginning with the reporting period in CY2021, two new opioid-related eCQMs (Safe Use of Opioids—Concurrent Prescribing eCQM (NQF #3316e) and Hospital Harm—Opioid-Related Adverse Events eCQM) are proposed. ***We support the optional reporting status for both new measures in 2021, removing the opioid treatment agreement verification for 2020 and maintaining the PDMP query as optional with Yes/No Attestation status in 2020.*** Upon initial review, we believe the new opioid-related measures may be readily collected, are meaningful and could be incorporated in decision support tools via flags or drug warnings. We do request CMS consider the following:

- ***Exclude emergency department (ED) and observation-status patients from the Hospital Harm-Opioid-Related Adverse Events eCQM***. This measure does not distinguish the administration of naloxone to treat emergent cases. Without the suggested exclusion, the treatment of an emergent patient presenting in the ED and later admitted will be included as an opioid-related adverse event resulting from care while in the hospital. We do not believe this is the intent. We would recommend that CMS further clarify its logic and definitional requirements for this measure.
- ***Add/align the new opioid measures to IQR, so they may count for IQR reporting.*** This will reduce burden by requiring IQR to report four eCQMs and clarify that CMS requires three self-reported eCQMs plus the mandated opioid measure.

Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure: CMS is proposing to retire the claims-based HWR measure in July 1, 2023, from the IQR to be replaced by the new Hybrid HWR. The new

[1] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQs.pdf

measure would combine claims and EHR data. While reporting of the Hybrid HWR measure would be voluntary for FY2021 and FY2022, reporting becomes mandatory in FY2023. ***Although we support the concept, we have substantive and process concerns with this measure as proposed and encourage CMS to delay mandatory reporting until the measure has been certified as valid and reliable.*** We believe that a FY2023 mandatory reporting deadline is too aggressive for this unproven measure. We oppose establishing a timeframe for mandatory reporting until the Hybrid HWR measure is further defined, tested and proven, and we likewise disagree with the removal of the current HWR metric until a reliable replacement measure is established. Our hospitals have invested significant time, capital and infrastructure into readmissions initiatives and need to be assured that efforts are accurately measured.

As the Hybrid HWR is described, we believe that CMS would have the responsibility of matching patient records for the IQR program and, if hospitals wanted to monitor their performance, they would do the same. As a Next Generation ACO Participant, we have experience trying to match EHR and claims data for aligned beneficiaries, and our confidence level relating to our ability to accurately match patient records is low. This measure raises many issues, including the following:

- What is the impact on our readmission rate if a patient in the claims data doesn't match the EHR data? In our experience, this results in patients being assigned inappropriate risk scores because we can't match the patient, or patients are included twice (one with claims data and one with EHR data). From the rule, it is unclear how this will be reconciled.

- Is there the potential that this measure will incentivize service volume over value? As proposed, the Hybrid HWR measure includes 13 data elements. We request that CMS provide a detailed description of how these elements would impact the patient's risk adjustment. For instance, we question whether this measure may incentivize unnecessary laboratory tests in order to complete the risk adjustment and meet the 90% threshold proposed.

- Should medication data be included in risk adjustment? In our experience, a combination of laboratory results, vitals/biometrics, and medication utilization tends to be most useful in predicting readmissions. The absence of medications data will hamper our predictive analytics.

Aside from substantive issues of measurement, we are also concerned that this creates yet another dependency on our EHR vendor to be able to build or map this metric with associated costs and timeframes. Among our process concerns are reporting timeframe variances and the interplay of IQR and PI submissions. We would recommend that mandatory reporting start at the beginning of a calendar year, and not a July start date. We would also request that CMS verify that a single submission for the Hybrid HWR measure would count towards both IQR and PI programs, akin to how a single submission of eCQM data is treated today.

Dual Eligible Readmission Reports: Under the Hospital Readmissions Reduction Program (HRRP), CMS will distribute confidential data stratified reports beginning in the Spring of 2020. The reports will feature disparities within hospitals and in comparison to all hospitals. The purpose of the reports is to provide a "more meaningful comparison and comprehensive assessment of the quality of care for patients with social risk factors and the identification of providers where disparities in health care may exist. . . [as well

as] additional perspectives on health care equity." ***We support receiving these reports***, understanding that they are for informational purposes and not be used as HRRP payment adjustment factors nor publicly reported on *Hospital Compare*. Assuming they are released in advance of the next IPPS comment period, we would appreciate the opportunity to comment on the format and usefulness of these reports at that time.

Timeframes: We would be remiss if we didn't ***encourage CMS to provide sufficient lead time for hospitals to adopt new technology and measures***. As a provider, we presently have a backlog of changes to our developers and vendors. Some of these are in response to the rapid succession of other federal and state requirements, while others are being requested to improve workflows, efficiencies and satisfaction that we have self-identified. The changes contemplated in this rule include fairly simple as well as complex coding. We urge CMS to consider implementation timeframes of 18 months to 2 years so that our vendors will be able develop, test, train and go live for all changes. This request should be multiplied in the context of backlogs created by nationwide mandates. In addition, we fear that overly aggressive and tight timeframes will only increase the price tag for providing these technology solutions. Generally, we do not believe that CMS adequately adjusts its cost estimates to reflect national demand for these changes and taking into effect the cumulative demand for software changes from the other CMS fee schedules and quality initiatives.

FUTURE DIRECTION OF THE PROMOTING INTEROPERABILITY (PI) PROGRAM

In this rule, CMS has included several requests for information (RFI) from stakeholders and the public on a variety of issues regarding the future direction of the Medicare and Medicaid Promoting Interoperability Programs.

Comment:

RFI: Potential Opioid Measures for PI: We would reiterate our support of the two new opioid-related eCQMs proposed for CY2021 as well as our suggestions for their improvement in the *Quality Data Reporting Requirements* narrative above. ***This RFI begs the question of how many opioid-related eCQMs are optimal.*** When considering additional opioid measures:

- Measures should be clearly defined for standardization;
- Long-term measures should not be established for acute care settings;
- Preference should be given for existing data fields within the EHR to avoid additional data entry burden; and
- Whether the new measure adds value to existing measures.

RFI: Metric to Improve Efficiency of Providers within EHR: Overall, as an integrated healthcare system participating in numerous value-based arrangements, efficiency is already being tackled on a daily basis. Instead of having an efficiency measurement mandated by CMS, we would prefer that health care organizations be allowed flexibility to target activities that are most beneficial to our patients and organizational goals.

We seek clarification regarding the input being sought by CMS. This RFI describes efficiency related to health care processes as well as efficiency related to resource utilization. The questions combine these

concepts; however, we view them as distinct – redundant and/or unnecessary paperwork is vastly different than avoidable utilization. We caution CMS to carefully review responses to this RFI and distinguish between these efficiency categories. ***As described, UnityPoint Health is not convinced that PI measurement is needed for either efficiency category.***

Related to efficient health care processes, we believe the addition of a PI measure would just muddy the waters. Because there is no single definition of efficiency, we are concerned that any measure will have unintended consequences dependent upon a provider's scope of practice, clinical responsibilities and organizational structure. There is also the potential for adverse incentives. For instance, PI efficiency may prioritize speed over time spent with patients, including those with complex needs. Patient care should be dictated by an individual's health care needs and the provider's scope of practice. Lastly, we fear that a PI measure may prioritize EHR improvements over larger systematic issues. The EHR is a tool and should not be the focus on efficiency, although it can be part of a solution.

In terms of measuring efficiency through cost reduction and resource utilization, there are other programs and measures that address these concerns. Medicare ACO programs encourage cost reduction. Appropriate Use Criteria is already in place and requires consultation of qualified clinical decision support to reduce avoidable advanced imaging services. The Hospital Value-Based Purchasing program incentivizes improving the quality of care for hospital patients while reducing costs.

RFI: Posting Medicare PI Program Data on the Hospital Compare Website: ***UnityPoint Health does not support posting of specific PI measures to meet the requirements of section 1886(n)(4)(B).*** We believe that posting more specific measures will result in information overload, contain content that is not easily understood or intuitive and will not further aid consumers in making informed decisions regarding their health care team. We are concerned that posting these measures may result in some consumers viewing interoperability and health information exchange capacity as potential HIPAA violations. Should CMS decide to post any or all of these PI measures, we urge CMS to engage consumer focus groups to determine whether these concepts are easily understood and, more importantly, whether this information actually informs health care decisions. For any posting, we encourage CMS to include a detailed explanation of each measure, including its purpose/intent, so as to avoid misunderstanding related to this program and its measures. We would also recommend that this posting not impact quality and payment incentives until it is further studied.

RFI: Provider to Patient Exchange Objective: This objective is noble but doesn't sufficiently recognize that EHRs are still struggling to share data with each other due to variance in set up and configuration. To be successful, ***we believe that CMS should first focus on better national standards for data exchange and facilitating engagement in data exchanges by various care settings and community-based services.*** We support the inclusion of ambulatory providers, post-acute care providers, pharmacies, dental providers and community-based services. We know that health IT adoption rates are depressed in care settings that were not subject to the EHR Incentive Programs. We also know that, as providers try to maintain patients within community settings, it is important that patient records are comprehensive and follow the patient across care settings. The need for further standardize interoperability and to increase participation cannot be understated. ***We would also suggest that CMS include payers within these efforts.***

We should also highlight the importance of timing of access to information and the need for reasonable and targeted standards in the area. Immediate electronic access to information, such as laboratory results, without provider review or consult has consequences and has the potential to add stress and confusion for patients and providers. Information regarding pathology and cytology can be detrimental to a patient if they have not heard this news from a provider first. While patients can see test results, providers may need to explain that not all abnormal results are bad or that not all normal results are good. When establishing timeframes between result finalization and release to the patient, this process needs to be targeted. While we believe it may be possible to further condense these timeframes, we would not support further reductions for pathology and cytology due to the highly complex and sensitive nature of results. In addition to patient concerns, health plans and payers often demand immediate access to information to start processing. Often providers wait for various laboratory tests and results to be returned prior to completing documentation. Health plans and payers often want documentation to support charges, and such documentation may not be done due to this workflow regarding the wait for results. For payers, we believe that access should be defined by standards of when documentation should be completed in a patient chart. Again, clear standards related to information access are needed.

To promote record accuracy, standards that promote patient matching should be prioritized. Among initiatives that could be undertaken include:

- Standardize processes and/or formats for data collection, such as the use of standardizing conventions for naming newborns (e.g. use of legal name);
- Additional data elements, such as patient email addresses; and
- Standardize patient addresses into USPS format that includes a verification process.

We would also suggest that CMS engage a stakeholder group to seek feedback and build consensus on data elements to be collected and the preferred format.

RFI: Integration of Patient-Generated Health Data into EHRs using CEHRT: Although we support initiatives to empower patients to be engaged in their health care, ***we have concerns with the role that providers should have in this area and whether it is an appropriate PI measure***. In the initial definition of Meaningful Use Stage 3, a patient-generated health data (PGHD) measure was included but subsequently removed when the program transitioned to an interoperability focus. We question what has changed to warrant its inclusion now. As for the role of the provider, incorporating PGHD requires action on the part of patients. Providers cannot force patients to take steps to improve their generated data. We are opposed to any such measures that would penalize providers if their patients choose to not engage in applications or portals that allow submission of data. Should CMS develop a PGHD measure, it would need to be well defined and allow adequate time for implementation and training of patients to complete.

RFI: Engaging In Activities that Promote EHR Safety: This topic is not new. Our health care system is heavily engaged in security risk analysis and mitigation plans related to our EHR and technology implementation and, given that CMS has deemed additional clinical decisions support tools for safety to be "topped out," we assume that this is true of most hospitals. ***We do believe that increased standardization for interoperability and requiring agencies, such as state departments of health, to meet the same security requirements will enhance EHR safety.*** As CMS explores this issue, ***we would suggest additional work***

surrounding HIPAA and cybersecurity definitions for where patient accountability begins and health care organizations accountability ends.

While attesting to security measures, such as those within SAFER Guides, could be beneficial, we do not have enough information to provide a judgment at this point. We are uncertain about overall reporting burden, whether these attestations represent more topped out activities and whether additional infrastructure costs are associated. As this is developed, we would suggest any proposal undergo another round of rulemaking to solicit specific feedback.

NEW DATA COLLECTION CATEGORY WITHIN THE LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM (LTCH QRP)

Under the auspices of the IMPACT Act, this rule proposes a new data collection category: social determinants of health (SDOH). Social determinants of health, also known as social risk factors, or health-related social needs, are the socioeconomic, cultural and environmental circumstances in which individuals live that impact their health. CMS is proposing to collect information on seven proposed SDOH standardized patient assessment data elements (SPADE) relating to race, ethnicity, preferred language, interpreter services, health literacy, transportation and social isolation. To collect these data starting in 2022, CMS is proposing to use the resident assessment instrument minimum data set (MDS), the current version being MDS 3.0.

Comment: As background, the SPADEs collect function (e.g., self-care and mobility); cognitive function (e.g., express and understand ideas; mental status, such as depression and dementia); special services, treatments and interventions (e.g., need for ventilator, dialysis, chemotherapy and total parenteral nutrition); medical conditions and co-morbidities (e.g., diabetes, heart failure and pressure ulcers); impairments (e.g., incontinence; impaired ability to hear, see or swallow); and other categories. This rule proposes to begin SDOH data collection in 2022. The purpose of the SDOH domain is to "inform provider understanding of individual patient risk factors and treatment preferences, facilitate coordinated care and care planning, and improve patient outcomes."

It is widely accepted that SDOH greatly impact an individual's health and quality of life. UnityPoint Health believes that SDOH significantly impact health outcomes and must be considered in the delivery of health care services. As an integrated healthcare system, we strive to collaborate with community partner organizations to provide the right care, at the right time, without defect or duplication for our patients and their families, and this includes strengthening the reliability of care coordination across the care continuum. We also recognize that SDOH are largely absent from CMS and other payer quality measures and value-based arrangements. We agree that this gap must be addressed.

The challenge with requiring healthcare providers to collect additional SDOH data is that we don't know the most useful social risk data to collect and collecting a very comprehensive record comes with significant administrative burden. ***We do support an approach based on current collection tools that transforms select general data categories into more discrete data points*** that can be aggregated and analyzed for programmatic strategies/policy. For example, a "Housing" category could have options for "Own Home, Rent Home, Homeless, Other." While we support the incorporation of SDOH to promote access and assure high-quality care for all beneficiaries, we encourage CMS to be mindful of meaningful collection and the potential for data overload as well as the ability to leverage existing data sources from

across care settings. ***Since SDOH have impacts far beyond the post-acute care (PAC) setting, we caution data collection that cannot be readily gathered, shared or replicated beyond the PAC setting. For healthcare settings that have more established electronic health records, the collection of SDOH should be aligned and associated costs for gathering, sharing or replicating considered.***

As an integrated healthcare system, we would encourage CMS to consider leveraging data points from primary care visits. In terms of collecting these data points, ***we would offer that an initial capture of a small set of social risk information could be extracted from the EHR as the result of the annual wellness visit or social history within the E/M documentation.*** Per guidance of the American Academy of Family Physicians[2], the Past, Family, Social History component of the CPT code for E/M visits creates an opportunity to record these data. Below is a table of social risk factors that may already be contained within the EHR and could serve as a starting point, albeit not currently formatted in discrete data points. Administrative burden can be reduced when we use current data sources and collection tools.

Data Points	When Collected	Notes
Employment	At registration if insurance is on employer plan	
Insurance status	At registration	
Transportation	E/M	"who brought you today?"; "do you have a way to get back home and to pick up the medications I've prescribed?"
Nutrition	Required as part of the BMI discussion	Noted on After Visit Summary
Personal Safety / falls prevention	In falls protocol	
Ability to afford medications		Quality indicator in the CG-CAHPS "stewardship of patient resources"
Housing	Triggered if home safety concerns	Addressed as home safety falls
Physical activity	E/M	
Substance abuse	E/M	Includes tobacco
Mental health	Separate depression screening at visits	
Disabilities	HCC and updated problem list	
Family and community support	Updates if care navigator or coordinator	

In theory, the ability to have a hospital's or physician's EHR also collect, capture and exchange segments of this information is powerful. This assumes that the underlying assessment is accurate and properly documented and that the information is a value-added item – clinically meaningful and not cost prohibitive. ***We urge CMS to take a holistic view of SDOH across the care continuum so that all care***

[2] https://www.aafp.org/practice-management/payment/coding/evaluation-management.html

settings may gather, collect or leverage this data efficiently and the collection will yield the utmost impact.

We are pleased to provide input on this proposed rule and its impact on our integrated health system and the individuals and communities we serve. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs