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Secretary Robert F. Kennedy, Jr.
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1833-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1833-P - Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes; published at Vol. 90, No. 82 Federal Register 18002-18491 on April 30, 2025.

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

Dear Secretary Kennedy,

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 Policy Changes and Fiscal Year 2025 Rates. UnityPoint Health is one of the nation's most integrated healthcare systems. Through more than 29,000 employees and our relationships with 390+ physician clinics, 36 hospitals in urban and rural communities, five Inpatient Rehabilitation Facilities, and 12 home care areas of service across our eight regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin.

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 CMS Medicare Shared Savings Program (MSSP), and it contains providers that have participated in the Center for Medicare and Medicaid Innovation (CMMI) Global and Professional Direct Contracting Model, Next Generation ACO Model, and the Pioneer ACO Model.

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 Premier, Inc. and generally supports their formal comment letters. In addition, UnityPoint Health respectfully offers the following comments.**

INPATIENT PROSPECTIVE PAYMENT SYSTEM UPDATE (IPPS)

For FY 2026, CMS proposes to increase Medicare IPPS hospital rates by a net 2.4% (market basket update of 3.2% and -0.8% decrease for the productivity adjustment).

Comment: UnityPoint Health appreciates the increased Medicare payment rate, but this increase falls short of addressing inflationary pressures and the significant rise in healthcare labor and supply costs. For the sixth consecutive year, the CMS payment update has not aligned with actual hospital cost increases, resulting in strained hospital operating margins. UnityPoint Health IPPS hospitals have an average public payer mix of 68%. When Medicare and Medicaid reimburse services at rates below cost, commercial payers must subsidize these services, or hospitals must reconsider the scope and level of services provided to their communities. To ensure financial stability and effective planning, **we reiterate our recommendations: (1) implement a retrospective adjustment for FY 2026 to account for the discrepancy between the market basket update implemented for FY 2025 and the current projection for FY 2025; and (2) eliminate the productivity cut for FY 2026**.

LOW WAGE INDEX HOSPITAL POLICY

In October 2024, CMS issued an interim final rule in response to litigation announcing the termination and phase out of the low wage index hospital policy. For FY 2026, CMS proposes to continue a phase-out through a modified transitional policy.

Comment: We are frustrated with the litigation's outcome. **UnityPoint Health supports the intent of the low wage index hospital policy and CMS' transitional policy**. With hospital payment not keeping pace with labor and inflationary expenses, hospitals within the lowest quadrant are particularly hard hit. We encourage CMS to continue to evaluate policies to address wage index disparities that will promote the fiscal wellbeing of hospitals serving rural and underserved populations.

LOW-VOLUME HOSPITAL PAYMENT ADJUSTMENTS

For FY 2026 and in the absence of Congressional action, 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: Without Congressional action, UnityPoint Health is concerned about the changes to the low-volume adjustment criteria and how it will affect small rural hospitals and their communities. UnityPoint Health has two[1] "tweener" hospitals that qualify for the low-volume adjustment under both the 2011 and 2019 criteria. These hospitals have discharges between 200 and 1,600 annually. *If eligibility reverts to FY 2005 criteria, Medicare payment will drop by over $850,000 for each hospital*. These hospitals already have thin operating margins, and this loss from their largest payer will make it difficult to sustain current service offerings. **Retaining the 2019 criteria[2] is crucial to support healthcare access in rural areas.**

RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

This demonstration program began in 2004 and allows rural hospitals with fewer than 51 acute care beds

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

[2] Criteria 2019 through 2024 and 2025 discharges through December 31, 2024: (1) distance criteria of 15 miles and (2) total annual discharges of up to 3,800 with tiered adjustments.

to assess the feasibility of Part A cost-based reimbursement. This program is limited to 30 hospitals nationally. CMS proposes 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 healthcare access in rural areas.** We reiterate the following recommendations for program improvement from our 2023 IPPS comment letter:

- *Permanent Status*. Given its demonstration status, program participants are dependent upon program renewal every five years. This hampers long-term planning for healthcare access in rural areas. With a program duration of 20+ years, it is time for program permanency.
- *Sole Community Hospital Participant Financial Stability*. For Sole Community Hospital (SCH) participants, CMS should incorporate the "Safety Net" financial stability provisions pertaining to SCHs. Specifically, the demonstration should retain the financial SCH safeguard – "to provide a continued safety net for the SCH's 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 give up this safety net guardrail.
- *Assignment of Medicare Administrative Contractors (MACs)*. Medicare Administrative Contractor (MAC) audits should be assigned by geography. Under the demonstration, one MAC is assigned to audit all demonstration participants, which may vary from the MAC assigned to the demonstration hospital's state. Because perspectives/interpretations may differ between the regional MAC and the audit MAC, this creates administrative uncertainties and operational challenges on the back end.

MEDICARE QUALITY REPORTING PROGRAMS – OVERALL COMMENTS

For hospitals, CMS has established several quality programs – Hospital Inpatient Quality Reporting (IQR) Program; Hospital Value-Based Purchasing (HVBP) Program; Hospital-Acquired Conditions (HAC) Reduction Program; Hospital Readmissions Reduction Program; and the Medicare Promoting Interoperability Program. Each have different metrics, scoring, payment implementations, and public reporting features. For hospitals participating in value-based programs, additional requirements apply.

Comment: UnityPoint Health believes that quality is our best strategy. We welcome CMS' partnership to strengthen this strategy and actual outcomes. As CMS drives quality priorities across multiple programs, we request that CMS:

- Limit Annual Measure Changes and Provide Realistic Implementation Timeframes. **We urge CMS to examine the collective time and effort of hospitals across all Medicare quality programs prior to instituting new measures, revising current measures, and altering public reporting**. Each involves resources, time and costs, and several measures from last year are still undergoing resource-intensive training, testing, and implementation. **We appreciate CMS' exercise of restraint in minimizing overall changes in this proposed rule**.

- Continue to Streamline the Single All-Inclusive Tracking Report for Quality Data Submission. **UnityPoint Health applauds CMS' continuing efforts to streamline and improve quality tracking.** Although not all-inclusive, the recent addition of the HQR Submission Requirements Dashboard with the ability to include in a single report our submission and outcomes for objectives and eCQMs is phenomenal. The HQR Measure Detail View is another value add in that it shows facility performance and national averages. **We really appreciate that CMS is listening to and acting upon stakeholder input. As these tools and dashboards continue to evolve, we request that CMS embed download options for reports, including CSV and Excel file options.** In particular, it would be helpful for Overall Star Rating under the Measure Detail View to have download options outside PDF. While a PDF version is user friendly on the front end and easy to read, it is not ideal for analyses and side-by-side comparisons. Currently these analyses require a manual PDF conversion. The ability to download Overall Star Rating reports as CVS or Excel files would be a time saver in our efforts to improve patient care.

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS proposes to (1) refine readmission measures to add Medicare Advantage (MA) patient cohort data; (2) remove the COVID-19 diagnosed patients measure denominator exclusion from readmission measures; (3) reduce the applicable period from three years to two years; (4) modify the diagnosis-related group (DRG) payment ratios in the payment adjustment formula to include MA beneficiaries; and (5) update and codify the Extraordinary Circumstance Exception (ECE) policy.

Comment:

MA Data and Applicable Period: UnityPoint Health generally supports the addition of MA patient cohort data and the shorten performance period from three to two years. Since the advent of MA, quality programs for Medicare beneficiaries have been bifurcated making quality comparisons between fee-for-service (FFS) beneficiaries and MA beneficiaries challenging, if not impossible. CMS projects the inclusion of MA encounter data for these measures will double the cohort size, thereby improving measure reliability and more accurately reflecting the quality of care for all beneficiaries. **While we support goals of improving measure reliability and accuracy, we are optimistic but urge caution when incorporating MA encounter data due to longstanding questions about data collection. We encourage CMS to carefully monitor this data and impact on these measures, including the DRG payment ratio.** CMS could consider comparing measure results with and without MA encounter data to affirm reliability and accuracy improvements.

From an operational standpoint, it will be important for hospitals to receive baseline reports including the MA patient cohort data as soon as possible. In the past, CMS has released baseline reports in the August timeframe. The FY2026 IPPS Final Rule is not anticipated to be released until September. It is unclear whether the August reports will include the revised baseline or whether there will be a separate distribution. **We encourage CMS to clarify when revised baseline reports will be distributed**.

COVID-19 Diagnosis: Following the end of the public health emergency, COVID-19 diagnosis has been removed from exclusion lists and included in standard reporting. **We support** this standard reporting within performance and baseline periods. Because a COVID-19 diagnosis is often considered a secondary

diagnosis, **we also recommend that CMS include COVID-19 on the co-condition list for risk adjustment stratification**.

ECE Policy: **We support**.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

CMS proposes to (1) modify the COMP-HIP-KNEE (CMIT ID #1550) *measure; (2) remove the COVID-19 exclusion from six Clinical Outcomes domain measures; (3) update five NHSN Healthcare Associated Infection (HAI) measures; (4) update and codify the ECE policy; (5) eliminate the health equity adjustment; and (6) revise and establish performance standards.*

Comment: UnityPoint Health appreciates that CMS is not proposing new measures. The Hospital VBP measure modifications as proposed align with the Hospital IQR program modifications. As such, although specific Hospital VBP measures may vary, **UnityPoint Health's input is consistent with our Hospital IQR feedback** and we direct CMS to that narrative below.

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

CMS proposes to (1) update the NHSN HAI measures baseline; and (2) update and codify the ECE policy.

Comment: UnityPoint Health supports these changes.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

The Hospital IQR Program is a pay-for-reporting quality program. CMS proposes to (1) refine two claims-based mortality/complications measures; (2) modify submission requirements for two hybrid measures; (3) remove four measures; and (4) update and codify the ECE policy.

Comment: Thank you for limiting the number and breadth of proposed Hospital IQR Program revisions.

Claims-Based Mortality/Complications Measures: MORT-30-SKT (CMIT ID #4595) and COMP-HIP-KNEE (CMIT ID #1550) are being revised to add MA patient cohort data, shorten the performance period from three to two years, and change the risk adjustment methodology. As stated in our Hospital Readmissions Reduction Program feedback above, **we support goals of improving measure reliability and accuracy, but urge caution when incorporating MA encounter data due to longstanding questions about data collection, and we encourage CMS to carefully monitor this data and impact on these measures. We also see clarification when CMS will distribute revised baseline reports.** CMS could consider comparing measure results with and without MA encounter data to affirm reliability and accuracy improvements.

In other measurement revisions, **we support the two-year performance period as well as the use of ICD-10 codes**.

Hybrid (Claims and Electronic) Data Measures: Hybrid HWM (CMIT ID #3502e) and Hybrid HWR (CMIT ID #2879e) are being revised to lower the number of core clinical data elements (CCDEs) for laboratory results and vital signs, reduce the CCDEs submission threshold of discharges, and reduce the submission threshold of linking variables to discharges beginning July 1, 2025. **We support these revisions to facilitate measure submission – thank you!**

Measure Removal: CMS is removing measures for Hospital Commitment to Health Equity, COVID-19 Vaccination Coverage among Healthcare Personnel (HCP), as well as both Screening and Screen Positive

for Social Drivers of Health. Despite investing in infrastructure to capture and report the four standardized patient assessment data elements, **UnityPoint Health agrees that the CMS mandate to capture these data elements across multiple care settings is burdensome and duplicative for patients and staff**. In particular, the COVID-19 Vaccination Coverage among HCP measure definition has become challenging, inaccurate, and essentially meaningless. As vaccines developed and different versions were approved, version approval and administration did and do not fall neatly within one CMS data capture and reporting period. As a result, reporting and data capture tied to the administration of the most recent vaccine version created arbitrary time demarcations and failed to recognize/credit past efforts to administer former vaccine versions.

ECE Policy: **We support**.

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) SURVEY MEASURES IN THE HOSPITAL IQR PROGRAM, HOSPITAL VBP PROGRAM, AND PCHQR PROGRAM

CMS does not propose additional changes to the HCAHPS survey.

Comment: UnityPoint Health agrees that the patient perspective is extremely important to capture to enable a patient's experience to be improved within the hospital. **We continue to encourage CMS to shorten the survey, remove redundant questions, and consider authorizing real-time survey alternatives to HCAHPS.** Real-time alternatives to HCAPHS gather broader patient feedback and are timelier, more actionable, and less costly.

We also remain concerned about patient survey fatigue due to the sheer number of surveys being asked of patients during a stay. Patients are answering multiple questions as part of their general admission process under the CoP requirements, receiving post-care surveys for HCAHPS, as well as additional surveys based on procedures undergone during their hospitalization, such as survey requirements within the TKA/THA PRO-PM and Information Transfer PRO-PM. Additionally, private registries have developed. For hip and knee replacement data, the American Academy of Orthopedic Surgeons has the AAOS American Joint Replacement Registry (AJRR), which requires additional surveys at 30-, 60-, 90-, 150- and 300-day intervals. It is no surprise that HCAHPS survey response rates across the nation are trending downward.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

CMS proposes to (1) amend the definition of "EHR reporting period for a payment adjustment year"; (2) modify the Security Risk Analysis measure to require an attestation for security risk management; (3) modify the SAFER Guides measure to require an attestation for an annual self-assessment; and (4) add an optional bonus measure to the Public Health and Clinical Data Exchange objective for submission of health information to a public health agency (PHA) using the Trusted Exchange Framework and Common Agreement ™ (TEFCA).

Comment: UnityPoint Health supports maintaining the 180-day reporting period without expansion and modifying the Security Risk Analysis.

SAFER Guides: We support updates to the Safer Guides and likewise support the attestation. **We request that CMS clarify when the Safer Guides version subject to the attestation will change from 2016 to 2025**. For the 2025 performance year, CMS stated that the 2026 SAFER Guides were to be required to conduct

the self-assessments.[3] In the FY2025 IPPS Final Rule (CMS-1808-F), CMS indicated that while the SAFER Guides were last updated in 2016, "*We anticipate that updated versions of the SAFER Guides may become available as early as CY 2025, and we would consider proposing a change to the SAFER Guides measure for the EHR reporting period beginning in CY 2026 to permit use of an updated version of the SAFER Guides at that time.*"[4] The 2025 SAFER Guides are available on the ASTP website; however, the 2016 SAFER Guides are still listed as the measures for the Medicare Promoting Interoperability Program.[5]

TEFCA: UnityPoint Health participates in the Epic Nexus QHIN. This new optional attestation under the Public Health and Clinical Data Exchange objective appears to overlap with the *Enabling Exchange under TEFCA* measure under the Health Information Exchange objective. **We seek clarification as to whether hospitals can attest to both TEFCA measures or if only one TEFCA measure can be reported**.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

CMS proposes several eligibility, quality, financial and operational updates to TEAM. TEAM will continue to be a five-year mandatory model that will begin on January 1, 2026.

Comment: UnityPoint Health through our Accountable Care Organization, UnityPoint Accountable Care, is a member of *Accountable for Health* and the *National Association of ACOs (NAACOS)* and supports their formal comment letters on TEAM in addition to the separate comment letters on TEAM submitted by the AHA and Premier Inc. UnityPoint Accountable Care has a proven track record of improving quality of care and reducing costs for patients residing in urban and rural communities and across care settings for over a decade. ACOs are responsible for total cost of care, which may include episodic payment bundles. Our success relies on coordinating care between primary care physicians, hospitals, specialists, skilled nursing, and public or private health payers with a goal of providing higher quality of patient care while lowering costs. UnityPoint Health has hospitals in two markets (Cedar Rapids, IA; and Dubuque, IA) selected for TEAM participation.

UnityPoint Health offers general model feedback first before reacting to the specific proposed modifications to TEAM.

GENERAL FEEDBACK:

- Oppose Mandatory Subset Models – **As proposed, UnityPoint Health is opposed to the mandatory nature of TEAM**. This random selection of geographies forces a subset of vital community hospitals to test an alternative payment model. If CMS desires an uptake in provider participation (specifically, specialist engagement in value-based models), a better approach would be to incentivize participation within TEAM constructs as opposed to a mandate.
- Allow Hospital Participants to Select Individual Clinical Episodes – The episodes selected are dissimilar, require different workflows, processes and specialist engagement, and equate to not

[3] CMS Specifications Manual for Eligible Hospitals and Critical Access Hospitals Participating in the Medicare Promoting Interoperability Program, Electronic Health Record Reporting Period in Calendar Year 2025 accessed at https://www.cms.gov/files/document/cms-specifications-manual-ehr-period-cy-2025.pdf
[4] 89(167) Fed Reg 69625
[5] https://www.healthit.gov/topic/safety/safer-guides

one mandated program but at least five individual programs. **CMS should allow TEAM Participants to self-select one or more clinical episodes that make the most sense for their patient population and align with their clinical areas of focus**. Through TEAM, CMS has effectively stepped into hospital operations and mandated time, effort, and resources be devoted to specific care episodes without regard to participant capacity, patient need, or overall healthcare environment. This burden is then multiplied five-fold.

- Exclude Safety Net Hospitals, Rural Hospitals, and Special Designation Hospitals from TEAM – Many safety net, rural hospitals, and special designation hospitals do not have the experience or the infrastructure to be successful in risk-based models. Additionally, communities rely on these critical acute care settings to serve in low-volume geographic areas, but CMS mandating TEAM participation may further financially strain these critical organizations. **UnityPoint Health recommends excluding rural hospitals, safety net hospitals, and special designation hospitals from the TEAM proposal given existing financial constraints**.

- Allow Hospital Participants within Integrated Healthcare Systems to Voluntarily Add Affiliated Hospitals – Aside from randomly selected TEAM Participants, the TEAM model only permits BPCI-A Participants to opt into TEAM. If intended to create a comparison group, this methodology is flawed. For integrated healthcare systems comprised of multiple hospitals (often across multiple states), there is often efforts and investments to standardize clinical operations across the enterprise. For UnityPoint Health, we disseminate clinical best practices across our markets. When TEAM is being mandated in two of our eight markets, it is not practical or efficient to operate those markets differently. We would also posit that if TEAM is a preferred model, **CMS should encourage and permit voluntary opt in annually, particularly for other hospitals affiliated with TEAM Participants**.

- Include Benefit Enhancements for Post-Discharge Home Visits: UnityPoint Health encourages CMS to embed benefit enhancements within TEAM to promote operational flexibilities. TEAM includes episodes of care categories that target a reduction in post-acute care costs. Medicare ACO models housed in CMMI and dating back to the Next Generation ACO Model have tested Post-Discharge Home Visits. UnityPoint Accountable Care has tested and utilized this benefit enhancement to improve quality outcomes. **TEAM Participants should have the option to provide Post-Discharge Home Visits like those currently available to REACH ACO Participants**.

FEEDBACK ON PROPOSED TEAM MODIFICATIONS:

Patient Reported Outcome-Based Performance Measures (PRO-PM): CMS proposes to add the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) to the TEAM quality measure set. This measure would join the TKA/THA PRO-PM as the second TEAM PRO-PM.

(1) Information Transfer PRO–PM Measure (CMIT ID #1797). The purpose of this nine-question, three-domain survey is to assess a patient's understanding of clear and personalized recovery information after a facility-based outpatient procedure or surgery. It is proposed to be administered in days two through seven post-procedure.

Although this is currently within the Outpatient Quality Reporting (OQR) Program, UnityPoint Health believes the Information Transfer PRO-PM measure should be incorporated into the OAS CAHPS survey and not a separate measure/instrument. Information Transfer PRO-PM is duplicative and creates unnecessary administrative burden, including additional costs related to third-party vendor distribution. As CMS continues to push out patient surveys, this exacerbates "survey fatigue" that is commonplace within the patient experience. The Information Transfer PRO–PM is not just a separate survey, but it overlaps the OAS CAHPS survey. For some patients like those with a total hip or knee arthroplasty (THA/TKA) procedure, this is a third survey.[6] The duplication involves both content and timeframe. For content, the domains are covered in OAS CAHPS survey; and for timeframe, the post-procedure timeframe conflicts with the paper OAS CAHPS survey and a THA/TKA PRO-PM survey.

(2) THA/TKA PRO-PM Measure (CMIT ID #1618). The Risk-Standardized Patient Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty is also an existing measure within the OQR Program. **Our concerns remain as this measure presents operational challenges when surveying patients pre- and post-surgical events and is overly burdensome, is limited to a subset of patients, and lacks exclusions for small sample sizes**. Challenges include:

- Measure Definition: The denominator includes four sources of data – PRO-PM, claims data, enrollment data, and Census Bureau survey data. **Multiple data sources inherently create complexities and undue burdens** to avoid the potential for mismatched patient information.
- Multiple Surveys: **Patients are potentially surveyed multiple times** during a year under the PRO-PM, which presents challenges for administering the survey pre- and post-procedure. Post-acute surveys often fall outside the purview of the TEAM Participant. When surgeries are performed under the auspices of independent physicians with the TEAM Participant serving as the site of service, TEAM Participants become the reporting agent for locums. TEAM Participants become the de facto reporter for pre- and post-surgical outcomes that are not centrally located within one EHR or even be available across platforms. The measure also requires a follow-up care survey after a 300-day window. This long window from the reference point may create confusion and inaccurate responses and may also conflict with the distribution of CAHPS surveys.
- Data Collection and Tracking: Aside from TEAM Participants presently not collecting the proposed survey information, **the information regarding pre- and post-surgical outcomes for the PRO-PM is not centrally located**. Often this data may not be housed in the same electronic health record (EHR) or even be available across platforms. Given current state, TEAM Participants will also incur a cost to manage and report this data.
- Patient Experience: Like the Information Transfer PRO-PM, **the potential for survey fatigue and patient frustration is heightened with this measure**. First, while this measure targets inpatient

[6] For patients with providers participating in the AAOS American Joint Replacement Registry (AJRR), additional surveys at administered at 30-, 60-, 90-, 150- and 300-day intervals.

stays for survey reporting, patients may also receive various other surveys – CAHPS surveys mandated by CMS, pre-op surveys, and surveys from their specialist. Second, extremely long post-episode survey window creates issues of its own. Gaps exist within the PRO-PM around addressing patient dissatisfaction through follow-up care after the 300-day window. Additionally, a survey on surgical outcomes of care requested a year after the procedure may pose confusion and result in inaccurate responses from elderly patients as well as caregivers.

Target Price Methodology When Coding Changes: CMS proposes a standard, three-step approach to account for MS-DRG and HCPCS/APC changes by remapping and adjusting relevant MS-DRG/HCPCS episode types during the baseline period to estimate performance year costs. **UnityPoint Health supports this approach** to assist with financial sustainability.

Normalization Factor and Prospective Trend Factor: CMS proposes to calculate normalization factors at the MS-DRG/HCPCS region level – producing a total of 261 normalization factors (one per region and each MS-DRG/HCPCS episode type). The prospective trends factor will be calculated (1) using an annual percentage change based on a linear regression model; (2) including two years of additional episode spending prior to the three-year baseline period; and (3) using a blend of regional and national trend factors. **UnityPoint Health agrees with this approach that is intended to make trend adjustments more reliable**. As an early adopter of the Medicare ACO programming, UnityPoint Accountable Care continually evaluates a potential ratcheting effect (i.e., every year it gets harder to beat the trend). We appreciate that CMS has increased the number of baseline years as well as the size of the region.

Low Volume Hospital Policy: CMS proposes to maintain the current policy of having no low volume episode policy, but seeks further comment. UnityPoint Health is disappointed that CMS did not finalize a low-volume threshold last year. BPCI-A had a 41-episode threshold per clinical category, and it is unclear why CMMI would deviate from this threshold. **UnityPoint Health recommends that CMS utilize a low-volume threshold to ensure statistical significance, establish separate thresholds within each clinical episode category, and fully exclude hospitals not meeting those thresholds from participation**. CMS should exclude low-volume hospitals from TEAM to protect against large financial losses due to random variation as a result of assessing a small number of cases.

Beneficiary Risk Adjustment: CMS proposes to use a 180-day lookback period for beneficiary risk adjustment. **While UnityPoint Health prefers a 180-day lookback period over the current 90-day period, we recommend a 365-day period**. By expanding the lookback to one year, it enables Annual Wellness Visits to be consistently incorporated.

Date Range for Episode Attribution: CMS proposes that an episode with an anchor hospitalization beginning in a given baseline year and an anchor hospitalization discharge date in the subsequent baseline year would be attributed to the baseline year when the anchor hospitalization discharge date occurred. **We agree**.

Referral to Primary Care Services**:** CMS seeks comment on current policy that requires a TEAM Participant to refer a TEAM beneficiary to a supplier of primary care services on or prior to discharge from an anchor hospital or anchor procedure. This referral may differ from a beneficiary's existing primary care relationship. **UnityPoint Health supports the *Accountable For Health* recommendations to maintain a**

primary care referral requirement in TEAM, provide additional incentives to connect patients to a longitudinal primary care relationship, and adopt additional safeguards to ensure that patients who are already aligned to a provider be "tucked back in" to that provider.

Expanding the Skilled Nursing Facility (SNF) 3-Day Rule Waiver: To address stakeholder concerns surrounding post-acute care (PAC) access in rural and underserved areas, CMS proposes to allow TEAM Participants to use the TEAM SNF 3-Day Rule Waiver for TEAM beneficiaries discharged to hospitals and Critical Access Hospitals (CAHs) providing PAC under swing bed arrangements. **UnityPoint Health supports this PAC option for TEAM Participants and believes TEAM Participants should have contractual flexibility for its PAC network.** While CMS cited swing bed quality and their lack of Star Ratings as a potential network deterrent, our ACO has found that swing beds may not make financial sense as they often have costs similar to an acute readmission, which push total episode cost beyond the benchmark.

REQUEST FOR INFORMATION: TOWARD DIGITAL QUALITY MEASUREMENT IN CMS QUALITY PROGRAMS

CMS solicits comments on the use of the Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting in various quality reporting programs.

Comment: UnityPoint Health appreciates that CMS is seeking stakeholder input on this important program. We offer input on these select questions:

Approach to FHIR Patient Assessment Reporting in the IPFQR Program:

To what extent does your IPF use health IT systems to maintain and exchange patient records? 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 electronic patient records? Are these health IT systems certified under the ONC Health IT Certification Program? 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 HHS?305 Please specify.

UnityPoint Health utilizes EHR technology for patient documentation and care. We have a single instance of EHR for all patient care platforms within our health system. This software utilizes CERHT requirements for patient data exchange through various Health Information Exchange and EHR functionality. 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 electronic exchange of health information?

UnityPoint Health exchanges data with other healthcare systems and public health agencies across our multistate footprint, but faces challenges due to inconsistent state data sharing laws, regulations, and submission methods. In one state, providers pay a third-party vendor to submit CMS-required state-level public health data. That vendor created unique submission requirements utilizing USCDI standards, which are financially burdensome and resource intensive. Additionally, not all healthcare systems maintain direct addresses for data exchange, and the NPPES provider directory is often outdated. Lastly, some healthcare entities use third-party EHR support, which can complicate direct

address sharing.

Does limited internet or lack of internet connectivity impact your ability to exchange data with other healthcare providers, including community-based care services, or your ability to submit patient data to CMS?

Connectivity issues may hinder immediate data exchanges. Internet connectivity may be limited, especially in rural areas. UnityPoint Health has intentionally bult in network redundancies. We also employ workarounds like hotspots, network locations, and VPNs, but they are not available in all situations. While natural disasters and weather-related issues hamper connectivity, we have seen increasing incidents of breaks in underground utility lines due to construction or roadwork without 811 notices.

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 to ensure we are meeting protected Patient Health Information guidelines. 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?

Yes. The SAFER Guides are utilized in compliance with IPPS requirements.

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 provider burden. 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 EHR 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 the Health Information Exchange, FHIR technology needs to be standardized and consistent across EHR vendors, healthcare facilities, and those identified entities receiving the data, such as public health agencies and CMS.

General Solicitation of Comments:

Specific to FHIR-based quality reporting, are there any additional factors, or considerations to account for, that may help foster data harmonization and reduce reporting burden across entities?

Standardized requirements should extend beyond healthcare organizations to those entities receiving data--state and federal agencies, third party payers, various data warehouse registries, etc.

How could Trusted Exchange Framework and Common Agreement™ (TEFCA™) potentially support exchange of FHIR-based quality measures and patient assessment submissions consistent with the FHIR Roadmap? How might TEFCA enable the use of patient assessment data for secondary uses such as treatment and research?

UnityPoint Health is a member of TEFCA under the Epic Nexus contract. This ensures standardized FHIR API use and data sharing among QHIN organizations and facilitates sharing of patient assessment and EHR data. Not all entities need to participate in TEFCA or a QHIN to meet their data submission requirements therefore leaning on the use of TEFCA standards will not include all entities sending and receiving data. The FHIR API endpoint standardization is great, and if included in the TEFCA "rules of the roads" for standards of data points, this is also great; but CMS needs to account for numerous entities that require data submission or data sharing who are NOT included in the regulatory standards under the various rules.

REQUEST FOR INFORMATION: QUERY OF PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) MEASURE

CMS seeks public input to make improvements to the Medicare Promoting Interoperability Program that promote patient safety and encourage appropriate prescribing of controlled substances while minimizing provider burden.

Comment: UnityPoint Health offers input on select RFI questions below.

Changing the Query of PDMP Measure from an Attestation-Based Measure to a Performance-Based Measure:

Should CMS propose to adopt a performance-based (numerator/denominator) reporting requirement for the Query of PDMP measure? If so, how should the numerator and denominator be defined?

No, this is operationally difficult and overly burdensome.

What are potential barriers for eligible hospitals and CAHs meeting the Query of PDMP measure as a performance-based measure?

Not all PDMPs at a state level have the capability of being integrated completely within an EHR system. Although hospitals have the ability to link out and review PDMP data, hospitals cannot capture that the PDMP was reviewed (i.e., looked at) prior to prescribing a Schedule II drug. As a result, hospitals will not receive credit for using PDMP Query, as it is not trackable and linkable to a Schedule II prescription

How should CMS account for varying levels of readiness and capacity for performance-based reporting, particularly for small and rural providers, including eligible hospitals and CAHs?

Regardless of size or location, readiness does not exist for this reporting. Until ALL state PDMPs have standardized capabilities and integration functionality, AND CMS has created a mechanism to link PDMP queries at an order level within an EHR, the reporting of numerator denominator values is extremely burdensome.

What timeframe would allow for systems and process changes to account for a change of the Query of PDMP measure from an attestation measure to a performance-based measure while minimizing burden?

The timeline is contingent on the updating of state PDMP registries and their work with EHR developers to ensure this data can be accounted for within CEHRT technology.

Modification of the Query of PDMP Measure to Include All Schedule II Drugs:

What challenges exist, if any, around expanding the Query of PDMP measure to include all Schedule II drugs?

The same burdens apply at current state for the current requirement of PDMP query versus all Schedule II drugs.

REQUEST FOR INFORMATION: PERFORMANCE-BASED MEASURES

CMS seeks public input to both encourage and support eligible hospitals' and Critical Access Hospitals' use of modern technologies and standards to ensure data are usable, complete, accurate, timely, and consistent.

Comment: UnityPoint Health supports standardized, performance-based measures generally and applauds CMS for seeking to ensure data that is captured and reported is meaningful – namely, usable, complete, accurate, timely, and consistent. Until there is a standardized requirement for data submission across all state public health entities and clinical-based registries, measurement is premature, excessively burdensome, and difficult to capture accurately. UnityPoint Health offers input on select RFI questions below.

Measure concepts:

What data quality challenges does your health care organization experience (for example, discrepancies in data accuracy, completeness, reliability, and consistency)? How are you working to address data quality challenges? What data quality challenges persist longitudinally across your patient population(s)?

When measures are restructured, the value proposition needs to be clearly stated to ensure that benefits outweigh the costs, not only to the government but to the providers. Additionally, most of the HIT costs for providers are not borne by inhouse personnel revising software platforms and reports but by HIT vendors. HIT costs are costs that are diverted from direct patient care. Examples of challenges and considerations:

- Numerator Denominator Measures: The incorporation of numerator denominator values within existing measures requires rebuilds of data submission and information pulling processes as most public health registries capture actual patient volume numbers.
- Volume: Data capture can potentially be astronomical for some measures. For instance, electronic lab reporting or case reporting will have extremely large datasets with many variables.
- Syndromic Surveillance: This is just one example of instances where there are multiple reporting incidences per individual. For syndromic surveillance, this involves providing initial ADT information and then providing subsequent subset information. Identifying the appropriate numerator and denominator becomes convoluted and a resource-intensive

exercise.

For the Electronic Laboratory Reporting measure, should we require eligible hospitals and CAHs to report how many laboratory tests were ordered using Logical Observation Identifiers Names and Codes (LOINC) and how many results used Systematized Nomenclature of Medicine (SNOMED) codes?

This is operationally challenging. As each state has a different list of cases being accepted for state reporting, it would be difficult to determine case thresholds.

Scoring approach:
Should we score all public health measures for which we finalize a numerator and denominator based on performance? Or should we only score a subset of measures based on performance?

Performance-based scoring for public health measures is completely contingent on the capabilities of the receiving entity and is potentially problematic for entities in states that do not have expansive or updated submission processes. It can be financially burdensome for entities that must submit data to states with subcontracted third-party, for-profit vendors that collect and maintain data.

Opportunities to leverage FHIR-based capabilities:
What are the most promising uses of FHIR approaches to the public health reporting requirements under the Medicare Promoting Interoperability Program? What approaches have the most potential to reduce the burden of reporting on eligible hospitals and CAHs and increase the quality and timeliness of data submitted to PHAs?

Until all state and federal agencies are capable of utilizing FHIR technology and a standardized requirement is established for all states, the use of FHIR for data submission to state agencies is burdensome and complex.

REQUEST FOR INFORMATION: DATA QUALITY

CMS seeks public input on refinement and development of the Public Health and Clinical Data Exchange objective measures.

Comment: The federal government has incentivized meaningful use in some healthcare settings, but not all. As a result, organizations and care settings vary in their commitment and capacity to prioritize data exchange, and high-quality data collection is hampered by the rapid pace of reporting changes, inconsistent mapping, multiple coding systems, and varied state processes for collection.

What are the primary barriers to collecting high-quality data? What resources do you believe could help your organization address these challenges?

Simply, the primary barrier is the inconsistent mapping of data across organizations with multiple coding systems being used.

What steps should CMS consider to drive further improvement in the quality and usability of health information being exchanged? How can CMS partner with eligible hospitals, CAHs, industry, and Federal agencies to drive further improvements in the quality and usability of health information being exchanged? What methods should CMS and other partners explore to further rectify data quality issues in the health care community?

The answer is standardization, and there are foundational steps that are missing. 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 EHR 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. Some facilities utilize third-party resourcing for EHR support, which also makes contacting the appropriate resources to share these direct addresses difficult.

At the state level, there is wide variation in state data sharing laws and regulations and data submission methods to state agencies. Minimally requiring states to utilize USCDI standards for state exchanges and platforms is a good first step.

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 an acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis. In order to gather more data, Congress extended this waiver program in the short term.

Comment: UnityPoint Health encourages CMS to continue a platform to test the Acute Hospital Care at Home services beyond 2025. Such a platform would enable patients to be cared for at home and support efficiencies within the inpatient setting. Under the leadership of UnityPoint at Home (our Home Health arm), UnityPoint Health was one of the first six health systems with extensive experience providing acute hospital care at home approved for the hospital at home waiver. UnityPoint Health was the first to enroll a patient and to bill and be reimbursed under this Medicare waiver. As of April 1, 2025, 142 health systems with 398 CCNs in 39 states have applied and been approved to participate in this waiver[7]. Given the infrastructure investment needed to stand up this program and the uncertainty of its duration, UnityPoint Health only operates this model in two of our eight markets, and it is likely that more UnityPoint Health hospitals as well as other healthcare systems would participate under a program that has a longer duration and firm regulatory standing.

Additionally, UnityPoint Health urges CMS to authorize a full array of Medicare At Home services and permit patient admissions that originate from the home. While we recognize that CMS stood up the hospital at home waiver as a result of the COVID-19 public health emergency to avoid exposure to and spread of the COVID-19 infection, its efficacy beyond the public health emergency and an inpatient setting 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 (97%) 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 ACO waiver in which appropriate services were wrapped around the patient. Our bundles include hospital to home (two-hour response time), primary care at home (four-hour response time), palliative care at home, and skilled nursing facility at home. **Starting in 2023, UnityPoint Health**

[7] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

began offering At Home services in some of our commercial health plan contracts. We attribute our expansion to commercial plans as a direct result of being able to demonstrate proof of concept via the Medicare waiver program. **We welcome the opportunity to further engage with CMS and/or CMMI on this topic**.

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