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June 17, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1710-P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS–1710-P - Medicare Program; Inpatient Rehabilitation Facility (IRF) Prospective Payment System for Federal Fiscal Year 2020 and Updates to the IRF Quality Reporting Program; published at Vol. 84, No. 79 Federal Register 17244-17335 on April 24, 2019.

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

Dear Administrator Verma,

UnityPoint Health ("UPH") appreciates this opportunity to provide comments on this proposed rule related to Inpatient Rehabilitation Facility (IRF) payment system and quality reporting. 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 rule and is ***limiting our comments to the proposed social determinants of health data collection proposal***.

IRF QUALITY REPORTING PROGRAM (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[1], 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

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

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

We are pleased to provide input on the SDOH proposal 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