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September 13, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1772-P
P.O. Box 8010
Baltimore, MD 21244-1810

RE: CMS-1772-P – Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; published at Vol. 87, No. 142 Federal Register 44502-44843 on July 26, 2022.

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

Dear Administrator Brooks-LaSure,

UnityPoint Health appreciates this opportunity to provide comments on this proposed rule related to the Outpatient Prospective Payment Systems (OPPS) for Calendar Year (CY) 2023. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 32,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health agencies provide a full range of coordinated care to patients and families through more than 8.4 million patient visits.

UnityPoint Health appreciates the time and effort of CMS in developing this proposed rule and respectfully offers the following comments.

PAYMENT SYSTEM UPDATE

CMS proposes to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.7%. Additionally, CMS proposes to use CY 2021 claims data with cost reports and cost reporting periods prior to the Public Health Emergency (PHE).

Comment: UnityPoint Health generally supports increases to the OPPS base rate; however, a 2.7% increase is grossly insufficient when compared to the current consumer price index (CPI) rate of 9.67%. As cost in health care supply and labor continues to grow, we recommend CMS continue to review and deploy rates that more accurately reflect the current health care financial landscape. **UnityPoint Health**

supports the proposed pre-pandemic timeframe for data collection, as it reflects a more normal service/severity mix.

340B DRUG PRICING PROGRAM

For CY 2023, CMS formally proposes to continue the payment rate of Average Sales Price (ASP) minus 22.5% for drugs and biologicals acquired through the 340B Drug Pricing Program, which aligns with policies prior to the Supreme Court decision, American Hospital Association v. Becerra. Based on this ruling, CMS intends to apply a payment rate of ASP plus 6% to such drugs and biologicals instead. CMS also seeks comments on potential remedies for payment reductions impacting CY 2018 through CY 2022.

Comment: As a large nonprofit, integrated health care system in the Midwest, the UnityPoint Health network of Disproportionate Share Hospitals, Sole Community Hospitals, Critical Access Hospitals, and Rural Health Clinics provide vital access to health care services. The 340B Drug Pricing Program has served as a critical federal resource for our safety-net providers and the patients we serve in Iowa, Illinois, and Wisconsin. *Not including our affiliated 20 critical access hospitals, we have 12 hospitals that participate as covered entities under the 340B Drug Pricing Program.*

340B Payment Rate – UnityPoint Health fully supports reverting the 340B payment rate back to Average Sales Price (ASP) + 6%. Our hospitals are eligible to participate in the 340B Drug Pricing Program by virtue of high volume of Medicaid and low-income Medicare patients as well as rural locations. We rely on our 340B savings to meet the needs of low-income patients and rural patients in our communities. **UnityPoint Health urges CMS to swiftly repay 340B hospitals the difference between ASP + 6% and the amount paid to hospitals for 340B drugs during the years in which CMS varied reimbursement rates for 340B drugs, including interest.** The health care financial landscape is dire as hospitals across the nation are faced with labor shortages, high-cost supplies, and a looming recession. The ability to reinvest 340B savings is more critical than ever as our nation continues to face unprecedented health care challenges. Furthermore, **UnityPoint Health adamantly opposes the recoument of funds from hospitals** who received subsidy during the years in which CMS varied reimbursement rates for 340B drugs. It is irrational to penalize hospitals through budget neutral restrictions to rectify errors made by CMS. Clawing back funds would only further impact hospitals' ability to provide needed access, outreach, and services in their communities.

Acquisition Cost Survey – Congress created the 340B Drug Pricing Program to allow covered entities to purchase outpatient drugs at a discount from drug manufacturers and to provide additional health care services to vulnerable populations. This program has been critical in helping covered entities expand access to lifesaving prescription drugs and health care services to low-income, underinsured, and uninsured individuals in communities across the country. In 2020, CMS elected to distribute the acquisition cost survey for completion in the middle of the COVID-19 national pandemic when hospitals were focused on mitigating outbreaks within their walls and within communities. The data was collected under a methodology that required significant calculations and manipulation by individual hospitals. This resulted in inconsistent information across hospitals, ultimately leading to unreliable data. **This flawed method to calculate 340B payments, is at odds with the congressional intent of the 340B Drug Pricing Program** and creates another hoop that diverts, rather than facilitates, the allocation of scarce resources to vulnerable populations.

Claims Modifiers – **UnityPoint Health is pleased to see CMS end differential pricing based on the ‘JG’ and ‘TB’ claims modifier.** Ensuring regulatory compliance of these claims modifiers has proven burdensome and of little value to hospitals. UnityPoint Health estimates 20–40 hours of monthly burden spent on administrative tasks from clinical staff documentation to supportive services for claims review. Ending the pricing differential will allow our hospitals the ability to provide additional outreach and services to underserved patients and communities.

Medicare Advantage – While the Supreme Court decision, *American Hospital Association v. Becerra*, focused on CMS imposing unlawful reductions in 340B drug payments in Medicare fee for service, Medicare Advantage and other commercial payors followed suit, benefiting as well. For UnityPoint Health, Medicare Advantage plans comprise approximately 40 percent of the underpayments associated with the 340B payment rate reductions. **We recommend that CMS hold Medicare Advantage plans to the same standards and general rate structure as Medicare fee for services so that hospitals are made whole based on the full impact of unlawful cuts.**

Contract Pharmacies – UnityPoint Health strongly encourages the enforcement of the 340B program requirements to stop unilateral action by drug manufacturers to establish or alter conditions of participation. During last year’s OPPS public notice and comment period, there were eight major drug manufacturers engaging in actions to limit the distribution of certain 340B drugs by hospitals; this year there are eighteen. **UnityPoint Health urges HHS and the Office of the Inspector General (OIG) to use current statutory authority in imposing civil monetary penalties against all drug manufacturers who have unlawfully overcharged safety net health care providers.** These companies’ unlawful actions have undermined 340B hospitals’ ability to serve vulnerable communities, particularly in rural areas, where contract pharmacies are vital to providing access to more affordable medications.

INPATIENT ONLY (IPO) SERVICES

CMS proposes to remove ten codes starting in CY 2023 based on established removal criteria. Additionally, upon clinical review, CMS proposes to add eight codes to the IPO list for CY 2023.

Comment: UnityPoint Health appreciates CMS’ measured approach and use of criteria to remove and add services to the IPO list. The IPO list contains mostly surgical procedures that are majorly invasive, complicated, and require the care and coordinated services provided in the inpatient setting of a hospital. Until CMS can reference an ample evidence basis from the Medicare population to support a change in setting, we encourage procedures to remain on the IPO list. In tandem, UnityPoint Health also urges CMS to monitor procedures that are removed from the IPO list to determine if baseline Fee-For-Service payments should be readjusted to reflect heightened patient acuity and assure access to inpatient services. As procedures are removed from the IPO list, “healthier” patients are transitioned to outpatient settings leaving more complex, costly patients within inpatient settings. An unintended consequence of these policies is the perpetuation of a for-profit mentality and incentive for more infrastructure builds to cater to younger, healthier, and less costly patients. Ultimately these policies divert resources from existing inpatient settings threatening their financial stability and beneficiary access to high-acuity settings.

REMOTE MENTAL HEALTH SERVICES

CMS proposes to designate mental health services furnished remotely by hospital staff using communications technology to beneficiaries in their homes as covered outpatient department services as covered outpatient services. Remote services are contingent upon the provision of in-person services at identified intervals (with exceptions). CMS also proposes limited use of audio-only services.

Comment: UnityPoint Health is pleased to see CMS designate remote mental health services to a beneficiary's home as a covered outpatient service. By providing access to beneficiaries through virtual visits, beneficiaries may avoid seeking services at unnecessarily heightened levels of care, such as an emergency department. This also enables workforce efficiencies in areas where behavioral health providers are in short supply. UnityPoint Health agrees with the exceptions to the in-person visit requirements based on case-by case clinical need as we strongly believe care is beneficiary specific and should be directed by a provider's medical judgment.

SUPERVISION BY NONPHYSICIAN PRACTITIONERS OF DIAGNOSTIC SERVICES

CMS proposes to clarify that certain nonphysician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law.

Comment: UnityPoint Health supports this proposal.

SITE NEUTRALITY

CMS proposes to exempt off-campus provider-based departments of rural sole community hospitals (SCHs) from CMS' volume control method policy as well as pay the full OPPTS payment rate, rather than the physician fee schedule equivalent rate. CMS seeks input regarding other rural hospitals for similar exemptions.

Comment: UnityPoint Health supports this exemption to preserve access at excepted off-campus, provider-based departments for SCHs. As CMS considers other rural hospitals for a similar exception, we support the expansion of this exemption to serve rural communities. In particular, we request that off-campus, provider-based department of hospitals in the Rural Community Hospital Demonstration Program receive similar treatment.

OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

CMS proposes reporting updates for the OP-31 Cataracts and OP-40 eCQM (STEMI) measures. CMS proposes to align patient encounter quarters for chart-abstracted measures to the calendar year for annual payment update (APU) determinations and add a targeting criterion for data validation of certain hospitals. CMS is seeking comment on the future reimplementation of the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP-26) measure or the future adoption of another volume indicator as a quality measure.

Comment: UnityPoint Health supports the ongoing development and improvement of quality measures within the OQR program and appreciates that CMS has signaled some areas of interest so hospitals can be engaged in this process.

Measure Updates:

- OP-31 Cataracts- UnityPoint Health supports maintaining voluntary reporting status for OP-31 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

- **OP-40 eCQM (STEMI)**- As mentioned in our comments to CY 2022 OPPTS proposal (CMS-1753-P), this measure will replace two very similar chart abstracted measures (i.e. OP-2: Fibrinolytic Therapy Received within 30 Minutes of ED Arrival; and OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention) that are currently collected. **UnityPoint Health generally supports this measure, which transitions from chart-abstracted data collection to an electronic auto-reporting modality.** While we appreciate the reporting burden reduction, there are costs associated with eCQM reporting – namely, software vendors must build logic, which entails an 18- to 24-month implementation period. This period is needed for development, validation, and certification, for rolling out to the hospital, and for adopting any new workflows and training.

Chart-Abstracted Measures: CMS is proposing to align the patient encounter quarters for chart-abstracted measures with the calendar year beginning with CY 2024 (CY 2026 payment determination). **UnityPoint Health is supportive of this proposal and encourages overall alignment across quality programs.**

Future Measure Considerations: CMS is looking to re-implement the OP-26 Hospital Outpatient Volume on Selected Outpatient Surgical Procedures measure or include another volume-based measure. **We have general concerns with volume-based measures and request that CMS address these concerns prior to mandating such measures.** First, while we agree that volume indicators may show quality of care for procedures within larger facilities, results may vary for smaller facilities. This is particularly true in rural facilities, where patient access to certain procedures in the outpatient setting becomes challenging. Second, CMS only has access to Medicare/Medicaid claims populations, which will likely result in skewed data for surgical procedure volumes and outcomes. For example, some outpatient surgical procedures are more prevalent with advanced age, such as cataracts. Third, as with any measure utilizing claims data, reporting is delayed making it challenging for hospitals to identify gaps and improve performance.

Participation Report: Hospitals have been challenged in efficiently confirming submission of quality program requirements for both Outpatient and Inpatient Quality Reporting programs. Historically, QualityNet, a CMS approved website for secure health care quality data exchange, has published a participation report that was easy to navigate and effectively displayed reporting requirements a hospital had met in both quality programs. About a year ago, QualityNet discontinued the participation report and transitioned to an excel file format. While users are able to download the document, it is very difficult to navigate when trying to manage what requirements have been submitted. For example, there are some requirements that only need to be submitted annually. In the past, the participation report clearly displayed the annual requirements, however, within the new document users have to know what quarter the annual requirement was submitted within in order to review submission status. With various requirement deadlines, this becomes problematic in monitoring program adherence efficiently. **UnityPoint Health strongly encourages CMS to provide a participation report for each program year that clearly indicates if the program requirements have been met.**

Outpatient and Ambulatory Surgery (OAS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – CMS has proposed no changes to OAS CAHPS survey this year, however, UnityPoint Health still has concerns with:

- Survey length. This lengthy survey is in itself a patient dissatisfier. **We encourage CMS to revisit this survey and reduce its length.**
- Use of CPT codes to trigger survey distribution. The exclusion list is relatively short, and the CPT code list is extensive. As a result, coding is onerous and time-consuming, and this often delays survey distribution. In some cases, the timeframe around submission of claims and coding information simply does not match – meaning that coding may not be completed to accommodate the 21- to 60-day survey timeframe. **We encourage CMS to eliminate the use of CPT codes to trigger survey distribution.**
- Administrative burden. While CMS opines that web-based distribution reduces burden, there is still a cost associated with processing. In addition, the proposal is not limited to web-based distribution, so hospitals still need to have the capacity to distribute via web+phone or web+mail, an overall increase in burden. **We encourage CMS to permit web-based distribution as a stand-alone option without pairing web-based distribution with phone and/or mail.**

Overall, UnityPoint Health does not believe that OAS CAHPS is ready for prime time and should not be mandated for services provided to Medicare beneficiaries.

RURAL EMERGENCY HOSPITALS (REHs)

Congress enacted the Rural Emergency Hospital designation in the Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116–260), which was signed into law on December 27, 2020. CMS proposes to include within the statutorily mandated +5 payment rate emergency services, observation care, and OPPTS covered outpatient services, while other outpatient services are proposed to receive flat reimbursement under other fee schedules. An additional monthly facility fee is also proposed. CMS outlines provider enrollment requirements for REHs including compliance with all applicable Medicare provider enrollment provisions in 42 CFR part 424, subpart P. In relation to the Physician Self-Referral Law, CMS proposes (1) a new exception for ownership or investment interests in an REH; and (2) revisions to certain existing exceptions to make them applicable to compensation arrangements to which an REH is a party.

Comment: UnityPoint Health appreciates the efforts of Congress to recognize this new rural hospital designation. From 2010 to 2021, 136 rural hospitals closed with 19 closures occurring in 2020¹. This designation preserves essential health care services in rural communities as an alternative to shuttering facilities and requiring rural residents to travel further for emergency and outpatient services. This decision to right size health care in rural communities is retained at the local level. In general, we envision that a REH will retain standing in rural communities as the hub of health care services, despite the lack of inpatient services. While the UnityPoint Health system footprint includes 3 tweener hospitals and 20 critical access hospitals, none are considering conversion to REH at this point, but we believe this rural option is needed and may have prevented prior as well as avoid future hospital closures. **As CMS issues rules and guidance to operationalize this designation, we request that CMS defer to operational**

¹ American Hospital Association, Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities, 2022, assessed at https://www.aha.org/2022-09-07-rural-hospital-closures-threaten-access?utm_source=newsletter&utm_medium=email&utm_campaign=aha-today&mkt_tok=NzEwLVpMTC02NTEAAAGGvfvygq42_svRQkPNTY1Z9BmmJVdJJaDE0seaifi0WTYIHthQdHQbN91t3d34CZqPyGI5KApxFs6psDYl6dMiwepqy8iWcoaOON76sodX_kTX

flexibility and the elimination or reduction of regulatory barriers and administrative burdens to assure rural health care access.

Prior to addressing specific regulatory proposals, UnityPoint Health expresses our disappointment that CMS has taken more than 18 months to release the proposed REH payment structure and other implementing regulations. This delay has not afforded interested hospitals and communities sufficient time to evaluate conversion and hold crucial community conversations, nor has it facilitated a robust adoption of enacting legislation at the state level. In Iowa, a small rural hospital announced its intent to close on October 1, 2022. **UnityPoint Health urges CMS to place REH within the established annual proposed rule making process** so that stakeholders can have assurances of rulemaking timing and the commitment of CMS to entertain future rule refinement.

Payment of REH Services: The payment scheme proposed by CMS is unduly complex and does not necessarily comport with legislative intent. We agree that “all services that are paid under the OPSS when furnished in an OPSS hospital, with the exception of acute inpatient services, would be REH services when furnished in a REH.”² Additionally we agree that “payments for REH services would be calculated using existing OPSS payment policies and rules” with the addition of five percent. **We deviate from CMS in that we do not believe CMS should be seeking comment on how to narrow the scope of REH services or that the statute itself precludes CMS from including other medical and health services outside OPSS as specified by the Secretary from receiving a 105 percent rate.** Instead of requesting stakeholders to suggest how to narrow the definition of REH services, CMS should be soliciting comment to understand what other medical and health services are vital for REHs to maintain patient access and promote overall safety and quality. As for the additional five percent reimbursement, this reimbursement uptick recognizes in part the elevated cost of access to health care in rural areas. CMS is the Medicare rate-setting institute and Congress should not be required or expected to legislate in statute particular “other medical and health services” that encompass REH services. It is also nonsensical that Congress would desire to saddle REHs with a patchwork of reimbursement levels for hospitals intentionally closing inpatient services and with limited staffing and resources. As such, **we encourage CMS to revisit and expand the scope of medical and health services.** For example, services such as clinical laboratory services are vital to REH operations and should be reimbursed at 105 percent of their fee schedule in support of rural access, safety and quality. The harm caused by overly restricting REH services and their reimbursement is to create financial disincentives and administratively remove this health care alternative from community consideration.

Further, we request that CMS support and/or clarify the following:

- **Provider-based rural health clinics (RHCs) – REHs should be able to seamlessly transition provider-based RHCs associated with their predecessor hospital.** Specifically, these RHCs should receive the all-inclusive rate and be entitled to grandfather status as applicable under the

² See Social Security Act section 1833(t)(1)(B) defines covered OPD services to mean hospital outpatient services designated by the Secretary, including certain implantable items, but excluding “any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include screening mammography (as defined in section 1861(jj)), diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hh)(1)).”

predecessor hospital.

- Federally-facilitated marketplaces – **REHs should be included as essential community providers for qualified health plans.**
- Medicare Advantage plans – **CMS should encourage Medicare Advantage plans to use Medicare services and the proposed Medicare rate structure as the Medicare Advantage floor.** We encourage CMS to monitor REH payments and REH-specific policies issued by Medicare Advantage plans.
- Medicaid programs – If REH licensure is recognized in their respective state, **CMS should encourage Medicaid plans to use Medicare services and the proposed Medicare rate structure as the Medicaid floor.**

REH Facility Payment: **UnityPoint Health generally supports the concept of a facility payment to assure health care access to rural communities but has concerns related to the actual facility payment amount.**

As this payment is not subject to judicial review once finalized, we urge CMS to be transparent by providing the underlying data used to populate the formula. Without this information, it is unclear whether the proposed amount is accurate, and the narrative appears to reference inconsistent underlying figures. In future years, this facility payment is proposed to be increased by the hospital market basket percentage. While we support an annual adjustment, the hospital market basket has not kept up with cost of living – labor and supplies – or inflation. The trend for CMS to underpay for Medicare services is an area of increasing concern for hospitals.

Enrollment and Accountable Care Organization (ACO) Participation: **UnityPoint Health appreciates that CMS will permit new REHs to enroll in Medicare through the 855A “change of information” process.** To assure seamless payment during the conversion process, we urge CMS to clarify its intent to provide continuous payment to critical access hospitals (CAHs) or small acute care hospitals under existing Medicare payment regulations until the REH billing privileges become effective. Any gap in the receipt of Medicare payment during this conversion may not only undermine the converting hospital’s fragile financial state, but it will reflect poorly on the program as a whole and may dissuade further participation. **We will also reiterate our request for CMS to implement a seamless process for continued participation of REHs in the Medicare Shared Savings Program** so conversions are recognized in real time and ACO Participants in an Advanced Alternative Payment Model do not lose Qualified Participant (QP) status.

Statutory Barriers: UnityPoint Health requests that CMS continue dialogue with Congress to further model and make recommendations related to the financial viability of REHs. Areas of significant financial impact include:

- 340B Drug Pricing Program – REHs do not qualify as covered entities for the 340B Drug Discount Program. Many CAHs and small rural hospitals have greatly benefited from the 340B program and would lose much needed funding with the conversion to a REH. **We strongly urge CMS to work with Congress to modify statute to ensure that REHs are eligible for 340B Drug Discount Program.** Similar to CAHs, we would recommend that that REH status is automatic per this designation and, due to low patient volume, not tied to disproportionate share hospital

percentages.

- Distinct Unit Authorization – The statute prohibits REHs from furnishing any inpatient services, except that skilling nursing services may be furnished in a separate and distinct unit of the REH. **We encourage CMS to work with Congress to expand the statute to allow REHs to furnish inpatient psychiatric and inpatient rehabilitative services if furnished in a separate and distinct unit.** This would enable rural communities with these needs to offer such services, and in the absence of inpatient services, facilities may be able to make these accommodations more readily.
- Transport as a Core REH Service – As REHs are charged with a focus on emergency treatment, the availability of timely Emergency Medical Services (EMS) is crucial. EMS is not only vital to getting patients to the REH timely but is necessary for timely transfers. Due to large geographic service areas and low population density, rural EMS providers often travel longer distances per run. The availability of rural EMS is often scarce and patchwork funding does not encourage stability in service providers. To assure access to EMS, **UnityPoint Health urges CMS to work with Congress to include EMS within the list of core REH services that receive enhanced reimbursement.**
- OPD Services – Subdivision (iii) of 1833(t)(1)(B) lists exclusions from the definition of “covered OPD services.” **CMS should work with Congress to enable REHs to provide outpatient therapy services as well as screening and diagnostic mammography services.** These are vital services for rural residents and should be available for REHs to offer.

Other REH Public Notice and Rulemaking: CMS has proposed REH regulations across three separate rulemaking vehicles. As these rules are interdependent, it is our hope that CMS program officials charged with REH subjects/issues are coordinating efforts. UnityPoint Health also submitted formal comments on REH proposals within both the 2023 Physician Fee Schedule proposed rule (CMS-1770-P) and the REH Conditions of Participation proposed rule (CMS-3419-P). Should CMS desire further stakeholder input on opportunities for improvement outside the rulemaking process, UnityPoint Health is an interested stakeholder and would be pleased to participate.

RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM

CMS proposes to require a QualityNet account and Security Official (SO) requirement in line with other quality programs for purposes of data submission and access of facility level reports. In terms of the quality program itself, CMS requests input on: (1) measures recommended by the National Advisory Committee on Rural Health and Human Services and additional suggested measures for the REHQR Program, and (2) and potential inclusion of measures on rural telehealth, behavioral and mental health, and maternal health services.

Comment: UnityPoint Health believes that health care facilities and providers should be accountable for performance and meeting quality standards. Rural residents should not be the subject of lesser quality expectations for health care services than urban residents. No quality measures are proposed to be implemented for REHs in CY 2023, rather CMS solicits comments on appropriate measures for this new designation. **We generally support CMS’ intent to “adopt a concise set of important, impactful, reliable, accurate, and clinically relevant measures for REHs that would inform consumer decision-making regarding care and further quality improvement efforts in the REH setting.”**

Phased reporting approach: **By statutory definition, REH core services are emergency department services and observation services. We urge CMS to target measures to these services first** as these are the only services that will be consistently provided by all REHs. From the current core measures in the Medicare Beneficiary Quality Improvement Project (MBQIP) focused on the emergency department services, these include the Emergency Department Transfer Communications (EDTC) composite measure, OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients, and OP-22: Patient Left Without Being Seen. From the optional MBQIP measure set, OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional targets the emergency department setting. While we support the EDTC composite measure for inclusion in the REHQR, the remainder are chart-abstracted, influenced by external factors potentially unrelated to quality, and if reported should be limited to pay-for-reporting.

As a second phase in measure set development, we encourage CMS to review other outpatient service measures for inclusion within the REH measure. Outpatient services are not core services but rather may be offered at the discretion of the hospital and in alignment with community needs. By definition, the provision of outpatient services will vary. Without understanding what services REHs will typically be maintaining, it is difficult at best to opine which measures may be most appropriate. We would suggest that CMS delay reporting quality measures for these services until their scope is better defined. Additionally, these measures should begin as pay-for-reporting measures.

Quality performance impact: It is unclear how CMS intends to tie quality reporting and performance to reimbursement. **UnityPoint Health recommends that CMS make reporting mandatory starting in 2024 and that REHs be paid a quality bonus for reporting only.** This approach will not penalize hospitals that lack reporting infrastructure, but will incentivize such reporting. Over time, as a baseline is established and compared with other hospitals, REHs could gradually shift to pay-for-performance quality measures.

Reporting burden: **We applaud CMS for considering the reduction of reporting burden** through the use of claims-based measures, preference for digital quality measures over chart-abstracted measures, and use of multi-payer measures when feasible. First, we wholeheartedly agree that measures should avoid or minimize manual chart abstraction, especially for rural facilities with lean staffing. Although CMS references an 81.5 percent success rate by CAHs reporting eQMs under the Hospital Promoting Interoperability Program, this should not imply that all eQMs can be reported by CAHs, or even other hospitals. Second, we support the streamlining of measures and agree that multi-payer measures would be ideal. We do urge caution in this area as often measures across payers are not identical and add confusion when publicly reported data varies.

HOSPITAL OUTPATIENT PRIOR AUTHORIZATION

CMS proposes to add Facet Joint Interventions as a new service category subject to the Hospital Outpatient Prior Authorization Process on or after March 1, 2023.

Comment: UnityPoint Health opposes instituting the Facet Joint Interventions as a new service category subject to the prior authorization process. We believe this addition will result in unnecessary administrative burden for both providers and CMS as well as superfluous delays in providing patient care. There are preliminary costs associated with operationalizing a new service category for prior authorizations which entails an implementation period for development, validation, and certification, for

rolling out to the hospital, and for adopting any new workflows and training. UnityPoint Health would recommend CMS consider a year runway for implementation post final requirements on prior authorization of facet joint interventions. Additionally, we believe that CMS has underestimated the administrative burden within the proposal. Based on UnityPoint Health's annual volume for facet joint injections, we anticipate a cost burden of \$21,000+ to cover over 2300 procedures as well as additional cost for infrastructure within our electronic health record (EHR).

HOSPITAL QUALITY STARS RATING

CMS proposes to use publicly available measure results on Hospital Compare from a quarter within the prior twelve months instead of the "prior year". While CMS intends to publish Overall Hospital Quality Star Ratings in 2023, data may be suppressed if analyses demonstrate substantial impacts resulting from the COVID-19 PHE.

Comment: UnityPoint Health supports accountability and transparency in quality programs, and we believe that the health care industry should emphasize value from all providers, regardless of practice setting. **UnityPoint Health supports the current scoring methodology used for the 'Overall Hospital Quality Star Ratings' program;** however, we do have concerns as it relates to timing of Stars rating releases. Historically, no consistent cadence for Stars rating release dates has been established and there have been significant cyclical release date fluctuations. In the last 5 years, Star rating release dates have occurred in July, April, January, February, and July, respectively. Overall Hospital Star Quality Ratings are used by hospitals for internal quality review (trending, successes, and improvement opportunities) and national comparison. Although CMS distributes quarterly data that is utilized to configure the Overall Hospital Quality Stars Rating at set intervals, inconsistent Star rating release dates do not allow transparency into which underlying preview report will be used for the Star ratings, making trend projections difficult to manage. **UnityPoint Health recommends a consistent annual release date of the Overall Hospital Quality Stars Ratings,** such as every April.

REQUEST FOR INFORMATION – HEALTH EQUITY

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

Comment: As part of an integrated health system, UnityPoint Health is committed to diversity, equity, and inclusion (DEI) at all levels of the organization. We applaud CMS for prioritizing health equity within each of its annual prospective payment system rules to assure alignment across settings of care and for soliciting input from stakeholders regarding implementation and measurement. As many hospitals are likely at different stages of their health equity journey, we respectfully suggest that CMS deploy a phased approach to measuring and implementing health equity strategies, to carefully evaluate underlying data collection burden and accuracy, and to begin with a rewards or incentive program instead of a punitive system for performance. UnityPoint Health has submitted more detailed feedback on this request for information within our formal comment letter to *CMS-1771-P: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates* proposed rule. CMS should consider:

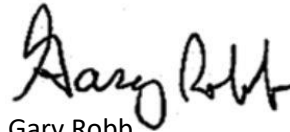
- Timeline - Many hospitals are likely at different stages of their health equity journey and a **phased approach to measuring and implementing health equity strategies**, enabling development, and deploying operational infrastructure will be necessary.
- Measurement and Reporting – Measure **stratification must be robust to highlight variations in local market populations**, including imbalanced race/ethnicity distributions or other identified equity attributes.
- Referrals and Follow-up – Community services and partnerships will need to be established or reestablished to remove barriers and achieve positive outcomes on social drivers of health results. **Additional clarification is needed around community roles for health equity outcomes.**

We are pleased to provide input on this proposed rule and its impact on our hospitals and health system, our beneficiaries, and communities served. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director, Government & External Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



Sue Erickson
Senior Vice President & Chief Operating Officer



Gary Robb
Vice President, Chief Pharmacy Officer



Cathy Simmons
Executive Director Government & External Affairs