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October 5, 2023

Honorable Jason Smith, Chairman
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, D.C. 20515

RE: Request for Information: Improving Access to Health Care in Rural and Underserved Areas; dated September 7, 2023.

Submitted electronically via WMAccessRFI@mail.house.gov

Dear Chairman Smith,

UnityPoint Health appreciates this opportunity to provide comments on this RFI on improving access to health care in rural and underserved areas. 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 370+ physician clinics, 36 hospitals in urban and rural communities and 13 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 the Ways and Means Committee in developing this RFI and respectfully offers the following comments.

GEOGRAPHIC PAYMENT DIFFERENCES

The Committee is requesting comments on policies to improve existing payment methodologies to end the perpetuation of historical payment inequities and to reduce opportunities for abuse. This includes a review of the area wage index and the geographic practice cost index. Comments should address proposals that ensure adequate payments to health care facilities while avoiding harmful cliffs and perverse incentives. Feedback is also requested on how best to ensure adequate payments to providers without creating unjustified disparities.

Comment:

Home Health Implications: While this topic appears to target facilities, UnityPoint Health has a robust home health division, UnityPoint at Home. Geographic payment differentials for rural areas are absolutely essential to maintain care that is being pushed increasingly to community, especially rural communities. Home Health previously had a rural add-on payment for all Medicare claims provided to beneficiaries

living in a county identified as rural[1]. This 3% add-on payment has since been essentially eliminated[2]. For one home health agency in rural northwest Iowa, this 3% decrease was equivalent to the annual salary and benefit cost of one registered nurse. As a result of the cuts, the thin operating margins of this home health agency forced a tough decision to not hire an open registered nurse position and decrease the number of Iowa counties served.

Congress should consider reinstating the rural add-on without regard to additional rural classifications – a 3% add-on payment for all rural core-based statistical areas. Rural home health providers depended on this 3% add on to help offset the increased expenses of operating in a rural area. Nurses and therapists providing home health in rural areas see fewer patients per day because of the amount of time spent driving from patient to patient. The efficiency of these clinicians is often 20% less than clinicians seeing home health patients in more urban/population-dense areas. Additionally, these clinicians drive over 1000 miles a month and home health agencies reimburse them for this mileage without any agency reimbursement from Medicare to do so. As the IRS raises federal mileage reimbursement rates to keep up with inflation, home health agencies pay those same rates to their staff without any reimbursement increase directly adding to the financial strain on rural home health providers.

Definition of Rural: Also within the geographic payment differences, UnityPoint Health would suggest that Congress **streamline the definition of rural**. Presently three federal agencies define rural differently – Office of Management and Budget, US Department of Agriculture, and the Census. HHS subagencies pick and choose from these definitions for programs and grant funding, often placing additional arbitrary restrictions on what is considered rural or urban. This is extremely confusing for providers to navigate what regulations and potential funding is applicable.

In some instances, subagencies rely on these definitions by inference and are greatly impacted when definitions change. For instance, CMS relies in part upon the U.S. Census Bureau (Census) definitions for Rural Health Clinic eligibility. Since the inception of the RHC program in 1977, the rurality requirement for an RHC's location relied on the Census definition of "urbanized area" (e.g. a facility . . . located in an area that is not an urbanized area (as defined by the Bureau of the Census)). Likewise the CMS Medicare State Operations Manual Chapter 2, 2242A1 - Location of Clinic references Census definitions. Specifically, a rural area is defined as an area that is not delineated as an "urbanized area" by the Census, and an "urban cluster" is not considered an urbanized area.

Beginning with the 1950 Census, the term "urbanized area" has been defined as an area of 50,000 or more population. For RHCs, that meant that RHCs could be certified in areas with less than 50,000 population. Definitions changed for the 2020 Census (see table below). Now the Census no longer defines the terms

	2010 Census	**2020 Census (Federal Register 3.24.22)**

[1] For calendar years 2019 through 2022, rural add-ons were subject to varying amounts depending on the rural county (or equivalent area) classification by classifying each rural county (or equivalent area) into one of three distinct categories: (1) High utilization; (2) low population density; and (3) all other.

[2] Section 4137 of the Consolidated Appropriations Act, 2023 extends the 1% rural add-on payment for home health periods and visits that end in CY 2023 for counties classified as ''low population density.''

Rural	0 – 2,499	**4,999**
Urban Clusters	2,500 to 49,999	Retired- No longer Defined
Urbanized Areas	50,000 or >	Retired- No longer Defined
Urban Area	Term was not defined prior to 2020 Census Bureau change	**5,000**

of "urban clusters" and "urbanized areas." This definitional change leaves the RHC program without a clear and explicit location standard. On March 31, 2023, CMS issued a memorandum on Interim CMS RHC Rural Location Determinations due to Census Bureau Regulatory Changes. This memo states "*During this time, an RHC applicant or a relocating RHC would be considered as meeting the rural location requirement at 42 CFR §491.5 if its physical address is identified as either "non-urbanized" or in an "urban cluster" under the 2010 CB data, or if its physical address is not identified as in an urban area under the 2020 CB data.*" B. Since these requirements do not align and guidance is not clear, there are risks to relocating to a non-qualifying area, which will result in a termination of RHC status.

UnityPoint Health supports the *Rural Health Clinic Burden Reduction Act* (S. 198, Barrasso, T. Smith, Blackburn and Bennet, and H.R. 3730, A. Smith, Blumenauer, Tokuda, K. Armstrong), which is part allows RHCs to be located in an area that is not in an urban area of 50,000 or more.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

The Committee is requesting comments on policies that support the long-term health of medical providers and facilities to ensure access to care for patients in rural and underserved areas. This includes proposals to simplify and streamline Medicare's outdated patchwork of rural hospital adjustments and designations while ensuring adequate payments for safety net hospitals. Comments should describe improvements needed to Medicare payment systems and structure to incentivize providers to operate in rural and underserved areas. Feedback is also requested on regulatory or financing changes needed to ensure facilities in rural areas maintain critical inpatient services while promoting access to specialized services, such as maternity care.

Comment: UnityPoint Health urges Congress to carefully consider efforts to simplify and streamline adjustments and designations for safety net hospitals. Many of these designations are a lifeline to maintain hospital access within rural and underserved communities. Hospitals not only provide 24/7 access to higher acuity and urgent health care services, but hospitals are often an economic engine for rural communities being among the largest employers with competitive wages.

Rural Community Hospital Demonstration Program: UnityPoint Health has two Iowa hospitals participating in the Rural Community Hospital Demonstration Program. **We strongly support the continuation of this program but, given its demonstration status, this program does not offer long-term financial sustainability needed to maintain health care access in rural areas**. We offer the following recommendations for program improvement:

- *Permanent Status*. Given its demonstration status, program participants are dependent upon program renewal every five years. This hampers long-term planning for health care access in rural areas. With a program duration of approaching 20 years, it is time for program permanency.

- *Program Capacity*. When hospital participants exit the demonstration (whether mid-term or at the conclusion of the five-year term), CMS should institute an annual application process when openings exist.
- *Sole Community Hospital Participant Financial Stability*. For Sole Community Hospitals (SCHs) participants, CMS should recognize 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 SCH's the first cost reporting period payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be 'the greater of' the reasonable cost of providing such services or the hospitals IPPS Payments". Presently, SCHs who are demonstration hospitals must give up this safety net safeguard.
- *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.
- *Demonstration Participant Eligibility for the 340B Drug Pricing Program*. Similar to CAHs, demonstration participants should be eligible for 340B program drug rebates on inpatient services regardless of disproportion share hospital (DSH) status.

Low-Volume Hospitals: UnityPoint Health has two[3] "tweener" hospitals that are eligible for the low-volume adjustment using both the 2011 and 2019 eligibility criteria. Specifically, these hospitals currently have total annual discharges less than 1,600 but greater than 200. Despite being in communities with larger percentages women of child-bearing age, both hospitals have recently closed their labor and delivery units due to difficulty with recruitment and retention of OB/GYNs and, with those closures, their DSH percentages fell below 340B drug pricing program eligibility. **The low-volume adjustment is needed to support regional care models. Should the low-volume adjustment revert to FY 2005 criteria, Medicare reimbursement will decrease by more than $800,000 for each of these community hospitals**. These significant reductions from their largest payer will likely hamper the ability of these hospitals to provide the level of services in the rural communities that they serve.

Critical Access Hospitals: A rural, Medicare-dependent Iowa hospital closed October 1, 2022. This joins of the ranks of more than 100 hospitals that have closed in the last decade. **We encourage Congress to permit the deemed necessary provider designation to be reopened**. The designation process could be based on the former process in place prior to January 1, 2006. Alternatively, as critical access hospitals close or convert to another designation, Congress could direct that new critical access hospitals slots would be limited to the number that are closed.

Rural Emergency Hospitals (REH): We appreciate the leadership and advocacy of Senator Chuck Grassley

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

to establish this designation for rural stand-alone emergency department hospitals. As is the case with all hospitals, care is local. This translates to each hospital being responsible for different community health needs and offering different services. This is particularly true in rural communities. As rural hospitals consider a conversion to REH status, there are programs / services outside of inpatient services that are needed in the community but are not contemplated in the REH model as it stands. UnityPoint Health requests that Congress consider the following REH program revisions to support flexibility and financial viability:

- *340B Drug Pricing Program*. REHs do not qualify as covered entities for the 340B program. Many critical access hospitals (CAHs) and other 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 Congress to modify the statute to ensure that REHs are eligible for 340B Drug Pricing 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 skilled nursing services may be furnished in a separate and distinct unit of the REH. **We encourage 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 Congress to include EMS within the list of core REH services that receive enhanced reimbursement**.
- *OPD Services*. Subdivision (iv) of 1833(t)(1)(B) lists exclusions from the definition of "covered OPD services." **We urge 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.

Rural Health Clinic (RHC): UnityPoint Health's ambulatory clinic division, UnityPoint Clinic, ambulatory clinic division) has 35 RHCs in Iowa, which are vital to providing access to health care for our rural residents. In terms of general care management, our patients are elderly, and many have several comorbidities. **Remote Physiologic Monitoring, Remote Therapeutical Monitoring, and Chronic Care Management services have been well received and reduce travel barriers for beneficiaries**. When considering this from a health equity lens, patients cared for by a RHC provider are not able to receive the same services as their urban counterparts without allowing for this payment methodology for this care delivery modality. We are concerned about the potential reduction in payment for these services due to the addition of other more specialized care navigation services – Chronic Pain Management, general

Behavioral Health Integration, Community Health Integration, and Principal Illness Navigation services. We anticipate that these latter services will not be utilized as greatly in the RHC setting, yet these services will negatively impact reimbursement for existing services. **We respectfully request that Congress monitor utilization to help identify any geographic disparities impacting care coordination for rural residents.**

In terms of RHC operations, **UnityPoint Health applauds the continuation of direct supervision via the use of two-way audio/video communications technology**. This has been a game changer. While initiated during the PHE, this flexibility has allowed our providers to deliver quality care efficiently to rural Iowans. As workforce challenges exist and are pronounced in some of our rural communities, this enables our RHCs to have a larger community presence, including longer hours or more days. We simply did not and do not have the bodies to maintain these schedules if a physical presence for direct supervision is required. **UnityPoint Health wholeheartedly supports the permanency of this flexibility beyond 2024**.

Behavioral Health Initiatives: UnityPoint Health offers the following suggestions to further expand access to behavioral health services in rural areas.

- *Certified Community Behavioral Health Centers (CCBHCs) should be Federally Qualified*. Once behavioral health models or services are authorized, there is a need for stable funding to assure that these models and services can be offered and maintained. Case in point is the CCBHCs. UnityPoint Health drank the Kool-Aid – four of our five affiliated Community Mental Health Centers have received one or more rounds of Substance Abuse and Mental Health Services Administration (SAMHSA) funding. These models enable crisis and mobile services that are well received, but require consistent funding to maintain. Touted as a one-stop shop providing a comprehensive range of mental health and substance use services, this model has been the subject of inconsistent federal funding and aims to have States manage and fund these programs moving forward. It seems ironic that this model would be pushed to States whose poor Medicaid rates dissuade many mental health providers from accepting Medicaid patients altogether. To be successful, **we recommend that CCBHCs should be federally funded and managed like Federally Qualified Health Centers, with a core 3-year federal grant and periodic opportunities for supplemental federal funding**. Presently, we have former CCBHC grant recipients who are struggling to maintain services under this model once federal funding lapsed.
- *Behavioral Health Patients Awaiting Placement are being Boarded in Emergency Departments (EDs) and Inpatient Units for Lengthy Stays*. The number of behavioral health patients presenting at our EDs is troubling. At one of our small rural hospitals with 40 staffed beds, 3,500+ annual hospital discharges, and 19,500+ annual ED visits, they have noted that:
    - Behavioral health ED visits have grown over time – reaching almost 6% of total ED visits in the last 12 months;
    - Both total behavioral health patients and visits are trending upwards – 9% increase since 2019;
    - Behavioral health patients with longer stays are increasing – while an average of 3 behavioral health patients present daily at this small hospital this year, 34% (average of

one per day) stay for more than 12 hours;
  - For behavioral health patients with extended ED stays in excess of 24 hours this year:
    - Average length of stay in the ED is 55 hours;
    - 19% of extended stay patients stayed at least 2 days;
    - The longest ED stay was 15 days.

We have similar trends for behavioral health patients housed in inpatient acute beds without medical need but who are awaiting community or post-acute placement. Some have been housed for months, far exceeding any DRG payment.

Ideally, these patients need step-down placement. In the meantime, **Congress could consider reimbursing hospitals for days awaiting placement for inpatient stays. For ED stays, Congress could consider the provision of add-on behavioral health services during this visit**.

- Behavioral Health Urgent Care Clinic Models are Clinically Effective but Lack Sustainable Funding Mechanisms. During the advent of the COVID-19 pandemic in April 2020, UnityPoint Clinic established a behavioral health urgent care clinic in nine days at a location across the street from one of our hospitals. Not only did this better protect behavioral health patients from the COVID-19 virus as well as free up ED beds for medical patients, but this clinic also provided immediate access to step-down services for patients whose behavioral health concerns did not require an ED visit. In the first two years of operation, 5,580+ visits were provided avoiding ED visits and 95% of patients avoided admissions to an inpatient unit. Roughly 22 patients continue to be seen per day with average appointments lasting 60 minutes. Co-located in the clinic are care coordinators as well as representatives from Community Mental Health Centers serving both adults and children. Despite positive clinical outcomes, this clinic has significant financial losses. **When we replicated this clinic in a rural market, it closed within a year due to financial losses.** To bolster financial sustainability, **Congress should examine reimbursement for team-based care as visits are lengthy and involve multiple team members and disparate funding streams** – traditional fee-for-service reimbursement is insufficient forcing the clinic administrators to chase grant-like mechanisms for funding that are often short-term and in small amounts. In this market, 340B savings have been vital to keep these doors open.

HEALTH CARE WORKFORCE

The Committee is requesting comments on policies to revitalize the health care workforce across the country to improve patient access to care, especially in rural and underserved areas. This includes policies that develop new providers and specialties in areas of the country where shortages are most acute, encourage providers to spend more time on patient care than paperwork, and ensure independent practice remains a viable option in a highly consolidated health marketplace. Comments should address existing barriers that prevent health care professionals at all levels from best providing health care services for patients. Feedback is also requested on how policies like nursing home staffing mandates at the state or federal level impact the health care workforce availability in other settings of care and the adequacy of how graduate medical education (GME) slots are being distributed in rural America.

Comment: UnityPoint Health .

Conrad 30: It is extremely difficult to recruit physicians to rural areas. The best way to retain physicians in rural areas is to recruit them as residents. The "Conrad 30" law has accomplished just that. Since its enactment in 1994, this law has authorized an essential waiver to physicians who come to the U.S. on J-1 work-study visas for residency training in underserved areas, many of which are rural. With the prevalence of health professional shortage areas in Iowa, this program (and its 30 slots per state for foreign medical graduates in J-1 status) has been a lifeline for maintaining physician access in our communities. Specifically:

- Conrad State 30 J-1 waiver slots should be re-apportioned so that states with unused allotments can be shifted to states with waiting lists. **UnityPoint Health supports S. 2719 (DOCTORS Act), as introduced by Sens. Ernst and Klobuchar**.
- Conrad State 30 J-1 waiver should allow participating physicians who transition to an HB-1 visa to remain practicing in the community where their residency took place.

Rural Hospital GME Funding: UnityPoint Health wholeheartedly supports further support in this area. There is a need for more rural physicians, especially more primary care/OBGYN/psychiatry providers in rural areas. **The effectiveness of this funding is dependent upon how "rural status" is defined. Fundamentally, financial support should target strategic re-commitment and deployment of physicians into high-need areas in underserved and rural regions, AND the level of financial support must reflect 2023, not mid-1990s, costs of educating residents**.

INNOVATIVE MODELS AND TECHNOLOGY

The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas. Comments should address proposals that can be replicated at the federal level while ensuring providers with limited resources can participate. Feedback is also requested on how recent Medicare flexibilities may have bolstered access to care. Thought should be given to addressing how these policies can maintain and not diminish quality of care or increase overall costs to taxpayers.

Comment:

Maternal Health Center of Excellence: In Iowa, UnityPoint Health delivers more babies than any other health system. While we have 13 Iowa facilities that offer labor and delivery services, eight of which provide Neonatal Intensive Care Unit (NICU) services, we also have had two hospitals recently close their labor and delivery services. UnityPoint Health is pleased to house a regional rural maternal health Center of Excellence, one of the initial centers funded in part through State of Iowa funds. Located in Grinnell, Iowa, this Center serves four rural counties, three of which are maternal health deserts. Through trialing ShareCare and Hub and Spoke models along with innovations in pre-natal and post-partum care, we are pleased to report positive outcomes as well as the preservation and expansion of labor and delivery services. This Center of Excellence has also contributed to the recruitment of an OB/GYN.

Telehealth Reimbursement: UnityPoint Health encourages Congress to adopt reimbursement parity across the board. The location of the patient does not change the investment of provider time/expenses that goes into providing the service. As provider shortages grow and disproportionately impact rural

geographies, telehealth is critical to maintain access in rural areas, especially to specialty care. Reimbursement levels definitely impact where care is provided. CMS should continue to evaluate reimbursement data and seek additional feedback to ensure reimbursement rate changes do not have a negative impact on health care access as technology advances.

Other opportunities that would benefit from reimbursement equality include:

1) **Reimbursement parity for inpatient encounters via telehealth equal to in-person encounters**. These codes should be reimbursed to reduce duplicative work, improve provider efficiency, and enhance patient experience. In the absence of a change to enable billing through a telehealth provider, patient histories and physicals must be performed twice by providers on the same team.

2) **Additional eligibility categories for the FCC Rural Health Care Program**. Home Health Agencies serving rural areas should be eligible to participate to promote maintaining rural residents in their homes when possible.

Extension of Certain Medicare Telehealth Flexibilities: **UnityPoint Health appreciates that Congress extended telehealth flexibilities through CY 2024.** Like most providers, we heavily increased adoption of telehealth during the COVID-19 pandemic to safely provide care to vulnerable populations and communities. **UnityPoint Health supports a permanent status for these telehealth flexibilities** and shares some outcomes data:

- The federal PHE telehealth waiver of originating site requirements has been transformational in providing access via telehealth services in patient homes and in urban/Metropolitan Statistical Areas. By simply waiving originating site restrictions for the same billable services, *outreach to a more geographically disperse population resulted – from patients residing in 41% of all rural Iowa zip codes in 2019 to patients residing in 90% of all rural Iowa zip codes in 2020 and 2021*.
- Any reinstatement of in-person requirements for mental health visits should include flexibility. The need for behavioral health services has increased over time and behavioral health providers are in short supply. Telehealth is used to manage behavioral health needs in both ED (to reduce boarding times and admissions) and outpatient settings. *For outpatient visits, telehealth correlated to an increase in appointments kept – 75% when telehealth is available, compared to 58% for in-person visits.*

With 35 Rural Health Clinics (RHCs) across Iowa, rural residents have benefited from RHCs serving as a distant site and qualifying for a distant site payment. Annually we provide over 5,000 distant sites visits with 25% of these visits to patients age 70+. For patients surveyed after receiving care through telehealth, 94% rated their overall care experience as "very good." While RHCs are permanently recognized as distant sites for behavioral health services, this is not the case for general medical telehealth provided after December 31, 2024. **We urge Congress to (1) permanently extend distant site status to RHCs for all telehealth services; (2) reimburse RHCs at their full AIR payment for distant site visits; and (3) treat telehealth visits the same as in-person visits for cost reporting purposes.**

Remote Monitoring: UnityPoint Health supports remote monitoring as a means to provide the right care

at the right time in the right setting. This has been extremely beneficial for Chronic Care Management (CCM) to our rising-risk and high-risk Medicare beneficiaries to keep them connected with a care team between regular visits. **We request that Congress institute further flexibilities, such as monitoring thresholds, cost-sharing requirements, and concurrent billing for remote physiologic monitoring (RPM) and remote therapeutical monitoring (RTM).** In terms of the latter, while both services aim to lower the overall cost of health care for these patients, they are in fact two separate services that patients with complex medical conditions may benefit from independently. RPM targets physiologic metrics, while RTM targets therapeutic monitoring, such as adherence to a medication regimen, a physical therapy program, or a cognitive behavioral therapy program. For a diabetic patient, RPM can monitor A1c levels and RTM can monitor medication adherence.

Remote Monitoring and Home Health: Remote patient monitoring has proven to increase access and improve outcomes for home health patients living in rural areas. During the public health emergency, Home Health Agencies were able to complete some visits using audiovisual technology but were not allowed to submit those visits as billable. Medicare has made this flexibility permanent and is now requiring these visits to be submitted on the home health claim even though they are still not a billable service. Additionally, Medicare has asked for Home Health Agencies to count for these expenses in our cost report even though home health agencies are not cost-based reimbursed.

Home Health Agencies would be able to further expand remote patient monitoring services and audiovisual visits if Medicare recognized these visits as billable (i.e., counted toward visit thresholds within current PDGM methodology). To prevent abuse and/or inappropriate utilization, **UnityPoint Health would support piloting the billing of home health remote monitoring in rural areas and/or limiting to a percentage of total visits as a guideline**.

We are pleased to provide input on this RFI and the importance of maintaining and strengthening rural and underserved health care access for 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,

Cathy Simmons, JD, MPP
Executive Director, Government & External Affairs