June 9, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1785-P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: CMS–1785-P - Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; published at Vol. 88, No. 83 Federal Register 26658-27309 on May 1, 2023.

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 Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates. 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 400 physician clinics, 36 hospitals in urban and rural communities and 14 home health agencies throughout our 8 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 also participates in a Medicare Advantage provider-sponsored health plan through HealthPartners UnityPoint Health.

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 2024, CMS proposes to increase Medicare inpatient prospective payment system rates by a net 2.8% (market basket update of 3.0% and -0.2% decrease for total factor productivity).

**Comment:** UnityPoint Health IPPS hospitals have an average 68% public payer mix. When Medicare and Medicaid continue to reimburse for services at less than cost, services must be subsidized by commercial payers and/or hospitals must revisit the number and level of services provided to the community. **While UnityPoint Health is appreciative of an increase in Medicare payment rates, this increase does not match inflationary pressures or exponential increases to health care labor and supply costs exacerbated by the COVID-19 pandemic and current economic conditions.** We noted these concerns in our comments to the FY 2023 proposed rule, and this is the fourth straight year in which the CMS payment update is misaligned to actual hospital cost increases. In the meantime, hospital operating margins have continued to decline. In October 2022, Iowa had a Medicare Dependent Hospital shutter. Given the fragile financial situation facing the majority of hospitals, now is not the time to underpay hospitals. To promote financial stability and planning, we reiterate and update recommendations from last year to (1) implement a retrospective adjustment for FY 2024 to account for the difference between the market basket update that was implemented for FY 2023 and what the market basket is currently projected to be for FY 2023; and (2) eliminate the productivity cut for FY 2024.

LOW WAGE INDEX HOSPITAL POLICY AND RURAL RECLASSIFICATION

For FY 2024, CMS proposes to continue its “low wage index hospital policy” and related budget neutrality adjustments to allow more time to collect data and to evaluate the policy. For the rural floor calculation, CMS proposes to treat an urban to rural reclassified hospital like a hospital physically located in a rural area.

**Comment:** UnityPoint Health supports the intent of the low wage index hospital policy and supports its continuance pending additional data. With hospital payment not keeping pace with labor and inflationary expenses, hospitals within the lowest quadrant are particularly hard hit. As operationalized, the low wage index hospital policy was intended to provide immediate relief in the short-term; however, this policy does not address depressed wage reimbursement overall. In the long run, the wage index needs to be revisited as staffing shortages persist across the nation and public payer shortfalls continue to disproportionately challenge the fiscal wellbeing of hospitals serving rural and underserved populations.

As for the “rural floor” policy, this policy is important for many smaller reclassified hospitals to sustain acute care access vital to regional care and serving a safety net function. **UnityPoint Health supports the proposal to include all hospitals within the calculation of the rural floor.**

DISPROPORTIONATE SHARE HOSPITAL PAYMENT & UNCOMPENSATED CARE PAYMENT

The aggregate pool of uncompensated care payments to hospitals are calculated based on three factors. For FY 2024, CMS estimates a 2.3% decrease in uncompensated care payments based primarily on changes in actuarial assumption related to hospital discharges and changes in the uninsured population.

**Comment:** Foremost, we applaud CMS for using a 3-year approach using audited amounts for Factor 3. We have consistently advocated for this approach and are pleased to see its adoption. As we reviewed
Factor 1 and Factor 2 and the proposed decrease, we found that the narrative lacks specificity related to CMS underlying assumptions, including significant anticipated changes in patient population/acuity from COVID-19, the impact of the Public Health Emergency (PHE) ending, higher inflation, and Medicaid/payer enrollment and coverage shifts. While it appears that CMS is attempting to be thoughtful in its efforts to adjust for what “normal” will look like for FY 2024, the assumptions lack transparency. We request CMS provide more specificity related to how these changes are incorporated into the calculation. As an example, when using the audited data for FY 2018, 2019, and 2020, it is difficult to forecast the positive/negative impact on our hospitals without understanding an adjustment for COVID-19. Further assumption details from CMS on Factors 1 and 2 would be helpful for planning and to enable more reflective commentary.

**LOW-VOLUME HOSPITALS**

For FY 2025, CMS is proposing to revert to the 2005 eligibility criteria for low-volume hospital status, including a total discharge criteria or 200 or less and a distance criteria of 25 miles.

**Comment:** UnityPoint Health has two1 “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. 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. **We urge CMS to retain the 2019 eligibility criteria to support regional care models.**

**RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM**

This demonstration program began in 2004 and allows rural hospitals with fewer than 51 acute care beds to test the feasibility of Part A cost-based reimbursement. For FY 2024, 26 hospitals are participating. CMS proposed 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 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.

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1 This number could potentially be four; however, UnityPoint Health has two hospitals participating the Rural Community Hospital Demonstration program.
• **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 disproportionate share hospital (DSH) status.

**PHYSICIAN-OWNED HOSPITALS**

*CMS clarifies its authority to reject or approve expansion exception requests for physician-owned hospitals and provides further guidance on the process for expansion requests. CMS also reinstates program integrity restrictions for physician-owned hospitals approved as “high Medicaid facilities.”*

**Comment:** In 2010, Congress closed the “whole hospital” exception loophole to the Stark law. Expansion exceptions have been approved since then but at a far reduced rate. Like CMS, UnityPoint Health has interpreted current law to give CMS authority to consider and ultimately approve or deny requests for expansion exceptions. As such, we support CMS efforts to provide clarity on this process and to reinstate program integrity restrictions for high Medicaid facilities to protect access and quality of care for vulnerable populations.

**GRADUATE MEDICAL EDUCATION (GME)**

*CMS proposes to make several modifications to GME that would affect Medicare direct GME and IME payments to teaching hospitals. For rural training, CMS proposes to treat Rural Emergency Hospitals (REHs) in a manner similar to Critical Access Hospitals (CAHs) for purposes of determining GME payments. Additionally, this rule provides the implementation details for Section 4143 of the Consolidated Appropriations Act 2023 related to recalculating and reconciling Medicare Advantage payments to applicable hospital’s for their total nursing and allied health (NAH) programs.*

**Comment:** With physician shortages, any flexibilities to GME are welcome. In concert with training support, GME should not be viewed in a silo and any additional support for educational expenses, flexibilities to recruit and retain foreign-board providers, and thoughtful increases to provider reimbursement (both fee-for-service and value-based services) are also encouraged.
UnityPoint Health supports the new Medicare REH designation as an alternative for rural communities to retain health care access for residents. The REH designation is available to both CAHs as well as small prospective payment system hospitals with less than 51 beds. As proposed in this rule, REHs have the option to (1) be treated as a “Non-Provider” site, such that another hospital could report the FTEs of residents training at the REH for Medicare payment purposes, or (2) incur the costs of the resident training and be reimbursed by Medicare at 100% of the allowable costs. **We anticipate this REH policy will be favorable to rural communities and REHs** as it would provide for continued training of residents in rural areas for converting CAHs and offer the opportunity for additional rural training of residents that might not otherwise be viable in the absence of this proposal.

In 2010 to 2019, UnityPoint Health had four affiliated hospital-based nursing and allied schools and greatly appreciates the Congressional relief provided in Section 4143. Nurses and other allied health professionals who are educated and receive their training at hospital-based programs provide high-quality care to communities across the country, including areas facing nursing shortages. **We are pleased that CMS has detailed how payments will be recalculated and reconciled to return past and avoid future recoupments.**

**HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM**

The Hospital IQR Program is a pay-for-reporting quality program. CMS proposes to adopt three new electronic clinical quality measures (pressure injury, acute kidney injury, and excessive radiation dose/inadequate image quality for diagnostic computed tomography); remove three existing quality measures (risk-standardized complication rate total hip/knee arthroplasty measure, Medicare spending per beneficiary measure, elective delivery measure); and modify three current quality measures (hybrid hospital wide all cause readmission/risk standardized mortality measures, COVID-19 Vaccination among Health Care Personnel).

**Comment:**

**eCQMs:** For the proposed electronic clinical quality measures (eCQMs), **UnityPoint Health agrees that eCQM adoption is a laudable goal but may not be operationally feasible in all cases due to interoperability concerns.** It should also be noted that not all measure definitions lend themselves to an eCQM data capture. To help hospitals with successful eCQM reporting, CMS should be thoughtful of implementation timeframes taking into account voluntary versus mandatory reporting, software development, and organizational readiness to operationalize workflows and tracking. Ideally, we suggest at least three years post introduction of a new measure, with at least one mandatory reporting year in the Hospital IQR Program (no incentive-based outcome) prior to moving to any incentivized quality program.

- **Hospital Harm – Pressure Injury eCQM.** **UnityPoint Health does not support adoption of this eCQM.** First, this new measure is duplicative as PSI-3 Pressure Ulcer is part of the Composite PSI-90 measure, which is publicly reported. Duplicative measures muddy CMS priorities for quality programs and measures, and duplication may inadvertently over-emphasize certain activities. By prematurely converting to an eCQM, this measure may in fact penalize some providers on interoperability issues rather than the underlying quality measure. Second, this measure has
fundamental issues with data capture based on present on admission (POA) identification, the measure’s robust exclusion list, and the timeframe for data submission. We believe that the data collection requirements do not reflect the quality of the care provided, and while measure scores may be depressed (i.e. there are opportunities for improvement), measure complexity is a compounding factor to these scores.

- **Hospital Harm – Acute Kidney Injury (AKI) eCQM.** Compared to the other proposed eCQMs, this measure is easier to implement, and we thank CMS for not embedding stringent data collection timeframes in this measure. Our major concern is eCQM readiness – penalizing those based on interoperability issues rather than the underlying measure itself.

- **Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM (Excessive Radiation eCQM).** UnityPoint Health opposes the mandatory adoption of this measure as it is not ready for prime time. We urge CMS to consult with hospitals for additional input and testing prior to implementation. At its core, this measure requires patient information to be integrated into electronic medical records (EMRs) to create a single patient eCQM file per encounter for all measures. While UnityPoint Health has an expert and experienced quality reporting team, we question how measure stewards envisioned measure implementation without the need for a sophisticated third-party tool to create a separate file from an external configuration system. Data capture challenges (i.e. the functionality of third-party software vendors) include:

  - **Multiple Data Source Capture:** A solution limited to merging CT data for multiple hospitalizations from external sources would not allow for adequate tracking and control of patient exposure throughout the year.
  - **Patient Complexity Capture:** A solution must consider the multiple and varied health issues that could arise during a single calendar year or for single treatment due to traumatic injury/illness monitoring.
  - **Picture Archiving and Communication System (PACS) Integration Capture:** A solution cannot assume that all EMR systems use PACS as an integrated point of EMR software. For some, data capture will require data pulls from PACS system and a solution that matches these pulls with EMR encounter data. For example, data related to dosing or body habitus information may not be captured from PACS into EMRs.

**Measure Revisions:** CMS also proposes to refine three current Hospital IQR Program measures.

- **COVID-19 Vaccination Coverage among Healthcare Personnel (HCP).** UnityPoint Health supports alignment of this vaccination measure across all quality reporting programs and agrees that it should conform with up-to-date National Healthcare Safety Network (NHSN) standards. This proposal recognizes one source of truth and enables science to dictate standards for infectious disease management, which can change and should change related to an evolving disease state. To reduce duplicative reporting burden, we strongly encourage CMS to further recognize that NHSN data submission by hospitals for this measure meets all Hospital IQR Program requirements. Additionally, due to reporting lag, the recent roll-back of the federal mandate for vaccination of
health care personnel, and the variance of state and local law governing vaccination requirements, we request that CMS continue to review this measure to determine whether to require public display by facility one-year in arrears.

- **Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM).** CMS proposes to expand the measure cohort to include Medicare Advantage (MA) patients, beginning with the FY 2027 payment determinations. **UnityPoint Health recommends that CMS continue to evaluate and monitor the quality of MA encounter data prior to incorporating the data into the Hybrid HWM measure.** MA plans are already requiring this reporting as part of the payer contracts, which places duplicative reporting burdens on hospitals. CMS should seek measure reporting from MA plans, instead of hospitals.

- **Hybrid Hospital-Wide All-Cause Readmission (HWR).** CMS proposes to expand the measure cohort to include MA patients, beginning with the FY 2027 payment determinations. **UnityPoint Health recommends that CMS continue to evaluate and monitor the quality of MA encounter data prior to incorporating the data into the Hybrid HWR measure.** MA plans are already requiring this reporting as part of the payer contracts, which places duplicative reporting burdens on hospitals. CMS should seek this data from MA plans, instead of hospitals.

**Measure Removal:** CMS proposes to remove three Hospital IQR Program measures. We have feedback on one removed measure as well as a future PRO-PM that is also proposed for this surgical event.

- **Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure (THA/TKA Complication Measure).** This claims-based measure is being transitioned to the HVBP Program, with slightly different specifications. There will be overlap in public display measures during the transition, which risks public confusion as well as result in increased hospital time and effort to monitor and validate each similar but different measure. **We provide further input on this measure later in this comment letter under the HVBP Program section.**

While this claims-based THA/TKA Complication Measure is being removed, CMS intends to begin a new voluntary PRO-PM in FY2025 for THA/TKA. We reaffirm our general support for PRO-PMs; however, **the Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure presents operational challenges when surveying patients pre- and post-surgical events and is overly burdensome.** First, the patient could potentially be surveyed multiple times over the course of a year under the PRO-PM, which presents challenges for administering the survey pre- and post-procedure. In particular, who is responsible for documenting the post-acute survey? It does not seem appropriate to fall within the purview of the hospital. Second, ownership of the PRO-PM measure needs further definition. While proposed for hospital reporting, it is often the case that these surgeries are performed and under the auspices of independent physicians with hospitals serving as the site of service. Should hospitals be the reporting agent for locums? Third, 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 EMR or even be available across platforms. Last,
gaps exist within the PRO-PM around addressing patient dissatisfaction through follow up care after the 300-day window. Given TKA and THA patients generally tend to be elderly, a survey on surgical outcomes of care requested a year after the procedure may pose confusion and result in inaccurate responses from patients as well as caregivers. In some cases, patients also receive CAHPS surveys mandated by CMS. Multiple surveys may lead to survey fatigue and frustration for patients. As such, UnityPoint Health encourages CMS to develop additional exclusion criteria to address these operational challenges.

Additionally, the PRO-PM measure includes four sources of data in the denominator: PRO-PM, claims data, enrollment data, and Census Bureau survey data. This includes some reporting overlap with measures being retired (or transitioned to the HVBP). Multiple data sources inherently create complexities and undue burdens to avoid potential mismatched patient information.

**Future Measures:** In support of the proposed Geriatric Hospital Designation, which includes both hospital and surgical structure components, CMS sets forth two potential composite measures involving a combined 25 questions across 15 domains as well as a proposal for public reporting. **UnityPoint Health does not support adoption of these two attestation-based geriatric care measures, which neither measure patient outcomes nor evaluate patient care. UnityPoint Health also has concerns with the public reporting proposal.** By instituting overly complex composite quality measures, we are extremely concerned that rural hospitals, who may be providing a disproportionate share of geriatric health care services based on their aging population, will not be able to receive this designation even if appropriate. Measure collection and reporting would further stretch limited inhouse quality reporting personnel or require additional investments in external contractors to perform these functions. For indicators that may rely on information from community partners and post-acute providers, many partner entities simply lack CEHRT technology or cannot uphold requirements for bi-directional data share, and health information exchange (HIE) cost and additional expenses requirements are prohibitive.

The first proposed measure, geriatric hospital structural measure, assesses hospital commitment to improving outcomes for patients 65 years or older through patient-centered competencies aimed at achieving quality of care and safety for all older patients. The measure includes 14 attestation-based questions across eight domains related to inpatient or emergency department services. There is a burden associated with information collection and re-education efforts to be undertaken related to process and validity of attestations covering eight domains for a single measure. **UnityPoint Health does not support this quality measure.** As proposed, this measure presents operational collection and reporting burdens as well as unintended consequences that may result in excluding low-volume, rural hospitals.

The second measure, geriatric hospital surgical measure, assesses hospital commitment to improving surgical outcomes for patients 65 years or older through patient-centered competencies aimed at achieving quality of care and safety for all older patients. The measure includes 11 attestation-based questions across seven domains related to surgical procedures. There is a burden associated with information collection and re-education efforts to be undertaken related to process and validity of attestations covering seven domains for a single measure. **UnityPoint Health does not support this quality measure.** As proposed, this measure presents operational collection and reporting burdens as well
as unintended consequences that may result in excluding low-volume, rural hospitals.

In alignment with the geriatric hospital and geriatric surgical structural measures, CMS is considering a geriatric care hospital designation to be publicly reported on a CMS website. Initially CMS envisions this designation to be based on data from hospitals reporting on both geriatric hospital and geriatric surgical structural measures if finalized. While supportive of additional support for hospitals serving geriatric patients prone to higher medical acuity and complexity, we are not convinced that the proposed measures capture this nor what content should be included in a public facing webpage. We urge CMS to establish an advisory group, including stakeholders and hospitals providing geriatric health care, to assist with the further development of these measures and webpage development. Input on the proposed designation itself is addressed later in this comment letter under the Geriatric Hospital Designation section.

**Social Drivers of Health (SDOH) Screening Measures:** SDOH-1 (Screening for Social Drivers of Health) and SDOH-2 (Screen Positive Rate for Social Drivers of Health) were finalized in the FY 2023 IPPS Final Rule. SDOH-1 targeted the number of patients screened, while SDOH-2 targets the number of patients with SDOH indicators. These measures are voluntary in 2023 and required by 2024. UnityPoint Health would suggest that CMS consider a one-year delay for mandatory reporting. We have many outstanding questions related to how to implement these measures, especially related to screening frequency, timeframes, and recapturing information upon transitions. We encourage CMS to develop a shared resource on these measures. Some frequent questions are listed below.

- **Inpatient screenings:** Is there a limit on the number of hospital SDOH screens per calendar year? Are there limits on frequency of SDOH screens for multiple hospitalizations/ED visits in a short timeframe? Is there a preferred time for SDOH screen administration during a hospitalization? For Medicare patients with 3-day or 10-day post-acute follow up contacts, do SDOH screens need to be readministered?

- **Ambulatory care screenings:** As a Hospital IQR Program measure, is a SDOH screen required if a patient has not been hospitalized but receives clinic services? Is there a limit on the number of ambulatory SDOH screenings per calendar year per setting or location?

- **Transfers:** Is a separate SDOH screen required for every patient with each transfer? Are there allowances/exceptions on administering SDOH screens when medical records are shared across care settings?
  - **Transfer/Admission from clinic to hospital:** If a clinic administers a SDOH screen and then directly admits the patient to the hospital, does the hospital need to readminister the SDOH screen?
  - **Transfer/Admission to LTCF, SNF, Home Health, Hospice, etc. from hospital:** If hospital administers a SDOH screen and subsequently transfers the patient to another care setting, does the SDOH screen need to be readministered upon transfer?

**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.** CMS proposes several updates to the HCAHPS survey, beginning with January 2025 discharges. UnityPoint Health is generally pleased and supportive of the CMS proposed changes – new modes for administration and
removal of antiquated modes; proxy responders; and limit on supplemental questions. Our experience with the survey would suggest that these will improve response rates. While we are also supportive of an extended period for data collection (from 42 to 49 days), we are concerned about potential downstream impact on the preview of outcomes and release/publication of stars data. Current process results in a 9-month lag, which is already “stale” and may not reflect current state of care for consumers.

CMS also seeks comment on the potential inclusion in the HCAHPS Survey of patients with a primary psychiatric diagnosis who are admitted to short-term, acute care hospitals. Currently, only patients with a secondary psychiatric diagnosis are eligible for inclusion in the survey. **UnityPoint Health supports exploration of a HCAHPS survey for patients with a primary psychiatric diagnosis, as appropriately captured feedback may be helpful.** CMS should work with stakeholders to consider:

1. **Targeted population** (all patients with a primary psychiatric diagnosis versus a segmented population). While CMS calls out particular diagnoses or MS-DRGs for consideration, other considerations could include voluntary admissions, whether to distinguish Inpatient Psychiatric Facility admissions from acute versus acute admissions, etc.;

2. **Survey composition.** Questions should capture effective feedback of the health care experience of psychiatric patients and overall survey length should be restricted. We do not endorse the use of the current HCAPHS for this population. As suggested by Premier, Inc., CMS could evaluate the current list of patient-reported experience measures and consider which metrics would be most appropriate, which could include interpersonal relationships, respect and dignity, access and care coordination, drug therapy, communication/information, psychological care, and the care environment.

3. **Survey timing and administration.** CMS should also evaluate whether real-time surveys at discharge should be conducted, instead of post-discharge surveys with extended timeframes.

We also recommend that CMS first pilot a revised HCAHPS survey to assess the impact and integrity of responses prior to broader adoption in quality reporting programs.

### HOSPITAL VALUE-BASED PURCHASING (HVBP) PROGRAM

CMS proposes to modify two existing measures (hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA); and Medicare spending per beneficiary (MSPB)); change HCAHPS scoring; adopt a Severe Sepsis and Septic Shock: Management bundle measure; include a health equity scoring change; and codify policies for measure removal, modification and continuation. There is also request for information on health equity.

**Comment:** UnityPoint Health reviewed the measure changes and offers select input on the following:

- **Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure (THA/TKA Complication Measure).** This is a claims-based measure under the Clinical Outcomes Domain and targets surgical complications and readmissions. This measure has different specifications than the THA/TKA Complication Measure within the Hospital IQR Program. Due to measure differences, **UnityPoint Health believes this risks public confusion as well as will result in increased hospital time and effort to monitor and validate each similar but different measure.**
• **Severe Sepsis and Septic Shock: Management Bundle.** Managing and controlling sepsis is a national priority; however to date, measure sets have not adequately captured this in a fashion that is reliable, actionable, and not administratively burdensome. **UnityPoint Health has overall concerns with this proposed measure and opposes its inclusion in an incentive-based quality program.** Sepsis management, like other infectious disease management, would appear to be fundamentally misaligned with value-based purchasing but should be encouraged in other quality programs. In addition, converting to an eCQM targeting present on admission (POA) status raises additional issues. POA status is difficult for software developers to capture, as presently we capture with manual extraction due to time sensitivity and measure complexity. We recommend more measure testing to assure reliability and validity.

Despite our opposition, we do support CMS efforts to align definitions/exclusions and require consistency across health care programs. In particular, UnityPoint Health supports removing the exclusion of COVID-19 from this measure, similar to its treatment in the measurement and reporting of other respiratory diseases.

**Domain threshold discrepancies.** UnityPoint Health also requests clarification related to domain threshold discrepancies. Recently, we noted significant differences in the 2025 HVBP Safety Domain Thresholds for HAI Measures from the F2023 IPPS Final Rule versus the QualityNet website for performance standards. The misaligned thresholds are listed in Table 1. When we reached out via the QualityNet service center portal, our ticket was closed as “resolved” with the comment that “CMS is researching the issue and will make an announcement of their findings once they have concluded their research.” We respectfully suggest that this issue is not resolved and request that CMS provide a response to aid our implementation efforts.

**Request for information – health equity.** Beginning with the FY 2026 program year, CMS is considering revisions to the Hospital VBP Program scoring methodology to address health equity by rewarding excellent care in underserved populations. **UnityPoint Health supports the use of dual eligibles as a proxy for now.** It is recognized and already captured, although Medicaid eligibility does vary by state (outside of those on SSI/SSDI).

**HOSPITAL-ACQUIRED CONDITIONS (HAC) REDUCTION PROGRAM**

*The HAC Reduction program is a pay-for-performance program that links Medicare payments to health care quality in the inpatient hospital setting. CMS proposes a validation reconsideration process for this*
program. In addition, CMS requests comments on future measures to advance patient safety and reduce health disparities as well as on potentially adopting several of the patient safety related eCQMs currently used in the Hospital IQR Program.

**Comment:** UnityPoint Health will reiterate our concerns with eCQMs, particularly in the advancing patient safety space. **We support the goal of obtaining real-time data on a digital platform - eCQM adoption is a laudable goal but may not be operationally feasible.** It should also be noted that not all measure definitions lend themselves to an eCQM data capture. To help hospitals with successful eCQM reporting, CMS should be thoughtful of implementation timeframes taking into account voluntary versus mandatory reporting, software development, and organizational readiness to operationalize workflows and tracking. Ideally, we suggest at least three years post introduction of a new measure, with at least one mandatory reporting period in the Hospital IQR Program (no incentive-based outcome) prior to moving to any incentivized quality program. Aside from these general principles, **patient safety measures collected as eCQMs should be further vetted to assure that discrete data can be captured and will provide an indicator of the underlying measure.** Patient care is fluid and eCQM data capture presents these challenges:

- As a pay-for-reporting program, the Hospital IQR Program lacks performance thresholds for eCQM outcomes. When eCQMs are transitioned to other quality programs like the HAC Reduction Program, thresholds will need to be established with adequate notice to hospitals.

- Measures included in the Hospital IQR Program as voluntary or self-selected optional measures should require a 1-year minimum mandatory reporting period within the Hospital IQR Program before transitioning to a pay-for-performance program, such as the HAC Reduction Program.

- eCQMs require very specific and defined workflows for accurate data capture, which do not necessarily reflect patient safety protocols. Current HAC Reduction Program definitions look at time variables (present on admission (POA) versus non-POA status), which can be difficult to capture with eCQM data. As a rule, eCQMs should not prioritize documentation within discrete timeframes over capturing overall patient care and/or status.

- Utilizing the Hospital IQR Program as a de facto testing ground for measures does create some measure overlap and confusion among quality programs when measures are transitioned to pay-for-performance programs. CMS should minimize duplicative public display of measures across programs and recognize that hospitals still have time and effort to monitor and validate measures appearing across multiple quality programs.

- Some proposed eCQMs within the Hospital IQR Program and other CMS pay-for-performance programs appear to align more closely with AHRQ Patient Safety Indicators (PSIs). Clarification as to how measures align and are being collected and reported across HHS agencies would be a helpful resource for hospitals to understand how to prioritize quality resources.

**UnityPoint Health also supports the adoption of the HAC Reduction Program validation reconsideration process.** As CMS revisits processes for approvals, denials, reconsiderations, and other determinations, we encourage CMS to streamline processes and adopt the same process across quality programs.
MEDICARE PROMOTING INTEROPERABILITY PROGRAM

CMS proposes to adopt three new eCQMs beginning with the CY 2025 reporting period (pressure injury, acute kidney injury, and excessive radiation dose/inadequate image quality for diagnostic computed tomography) and to maintain the definition of “EHR reporting period”. CMS also proposes to modify the Safety Assurances Factors for EHR Resilience Guides (SAFER Guides) measure.

Comment: UnityPoint Health limits our comments to the SAFER guides measure and the CMS proposal to require annual SAFER Guides self-assessments and attestations for each of the nine guides. As proposed, an attestation of “no” disqualifies hospitals from meeting the definition of a meaningful EHR user and results in a downward payment adjustment. UnityPoint Health opposes mandating the SAFER guides measure. First, while we agree that organizations should develop a “culture of safety,” we are perplexed why CMS has endorsed a specific framework from a specific vendor instead of providing general standards. For UnityPoint Health, this measure is a step backwards for our rigorous standards and requires additional time and effort without corresponding benefit. Second, SAFER guide self-assessments employs a training and reporting structure that is confusing and burdensome. SAFER guides require individual provider/entity level access; however, multiple components of SAFER guides involve items outside the knowledge base of providers/entities and instead are within the purview of the organization and/or software vendor. We urge CMS to reconsider making this measure mandatory.

GERIATRIC HOSPITAL DESIGNATION

CMS requests input on the potential future inclusion of geriatric measures and a potential public-facing geriatric hospital designation. The designation is intended to inform patients and consumers when choosing a hospital and will be based on new quality measures adopted in the Hospital IQR Program. This designation could be similar to the Birthing-Friendly designation that was finalized in the FY 2023 IPPS/LTCH PPS final rule but using geriatric structural measures.

Comment: The footprint of UnityPoint Health overwhelmingly represents aging communities and service areas, many of them rural. We are intrigued by this designation and would be willing to participate in stakeholder discussions with CMS to refine and make this a workable and attractive designation for hospitals and consumers alike. As proposed, the geriatric hospital designation raises more questions than answers.

Medicare provides health care coverage for patients, 65 years and older, which is basically equivalent to the geriatric population being defined under this proposed designation. While UnityPoint Health would support extra incentives or advantages for hospitals that provide high quality care for geriatric patients, it would seem that star measures and Medicare Compare already include geriatric friendly information for consumers. Also the case use for a geriatric hospital designation would appear to be much different than a birthing friendly hospital designation. Whereas it may be the case that consumers of labor and delivery services would seek out a birthing-friendly hospital, we are uncertain that patients would seek out a geriatric hospital for inpatient or surgical services, and furthermore, whether designation may have an adverse impact of dissuading non-geriatric patients (patients covered by commercial health plans outside MA) from seeking care at these hospitals. With the chronic underfunding of Medicare hospital services, this also assumes that hospitals want to increase their Medicare payer mix as well as undertake
additional quality measure reporting to obtain this designation. Aside from these foundational questions, additional concerns with the mechanics of the proposed measures have been outlined in the Hospital IQR Program section of this comment letter. **UnityPoint Health requests that CMS further develop this concept and clearly delineate designation advantages prior to implementation.**

**REQUEST FOR INFORMATION – SAFETY NET HOSPITALS**

*CMS seeks public feedback on determining an appropriate basis for identifying safety-net hospitals for Medicare purposes. Specifically, CMS would like input on the possibility of using the Safety-Net Index (SNI), which was developed by MedPAC, or the Area Deprivation Index (ADI).*

**Comment:** **UnityPoint Health appreciates that CMS is exploring safety net hospitals for Medicare purposes,** and we are a stakeholder in this area and happy to provide input as this discussion progresses. However, at this point and without further context regarding how CMS intends to apply the definition to Medicare, it is difficult to fully vet potential approaches to a safety net hospital definition. **UnityPoint Health will monitor CMS communications and more formal rule making processes for opportunities to weigh in on this topic.**

**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 beyond the PHE through 2024.*

**Comment:** CMS should consider facilitating a demonstration program to test and create case uses beyond the limited diagnoses currently recognized under the Acute Hospital Care at Home waiver. **UnityPoint Health, under the leadership of UnityPoint at Home (our Home Health arm), 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 waiver. As of May 30, 2023, 125 health systems with 281 hospitals in 37 states have applied and been approved to participate in this waiver. Given the infrastructure investment needed to stand up this program and the uncertainty of its duration, it is likely that more hospitals would participate under a program that has a longer duration and regulatory standing. **UnityPoint Health encourages CMS to continue a platform to test the Acute Hospital Care at Home services beyond 2024.**

Additionally, **UnityPoint Health would welcome the opportunity to further discuss the potential for operationalizing a full array of Medicare At Home services with CMS.** While we recognize that CMS stood up the hospital at home waiver as a result of the COVID-19 pandemic to avoid exposure to and spread of the COVID-19 infection, its efficacy beyond the pandemic 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**
(99+%)) 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 accountable care organization waiver in which appropriate services are wrapped around the patient. Our bundles include a hospital to home (2-hour response time), primary care at home (4-hour response time), palliative care at home, and skilled nursing facility at home. **Starting in 2023, UnityPoint Health 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 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