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June 10, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1808-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1808-P - Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes; published at Vol. 89, No. 86 Federal Register 35934-36649 on May 2, 2024.

*Submitted electronically via* https://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 2025 Rates. UnityPoint Health is one of the nation's most integrated healthcare systems. Through more than 29,000 employees and our relationships with 375+ physician clinics, 36 hospitals in urban and rural communities, 5 Inpatient Rehabilitation Facilities, and 13 home health agencies across 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 2025, CMS proposes to increase Medicare inpatient prospective payment system hospital rates by a net 2.6% (market basket update of 3.0% and -0.4% decrease for the productivity adjustment).*

**Comment: While UnityPoint Health is appreciative of an increase in Medicare payment rates, this increase does not match inflationary pressures or exponential increases to healthcare labor and supply costs.** This is the fifth straight year in which the CMS payment update is misaligned to actual hospital cost increases. In the meantime, hospital operating margins have to languish. 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. To promote financial stability and planning, we reiterate and update recommendations from last year to (1) implement a retrospective adjustment for FY 2025 to account for the difference between the market basket update that was implemented for FY 2024 and what the market basket is currently projected to be for FY 2024; and (2) eliminate the productivity cut for FY 2025.

## LOW WAGE INDEX HOSPITAL POLICY

*CMS proposes to continue its "low wage index hospital policy" and related budget neutrality adjustments.*

**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. Overall, 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.

## 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 of 200 or less and a distance criteria of 25 miles.*

**Comment: Without Congressional action, UnityPoint Health is extremely concerned about the changes to the low-volume adjustment criteria and the impact this will have small rural hospitals and the communities that they serve**. UnityPoint Health has two[1] "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 $850,000 for each of these community hospitals*. These hospitals have thin operating margins, and these significant reductions from their largest payer will likely hamper their ability to provide the current level of services in their rural communities. **Retaining the 2019 eligibility criteria[2] is vital to support regional care models**

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

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

**in rural areas.**

## GRADUATE MEDICAL EDUCATION (GME) RESIDENCY SLOTS

*Section 4122 of the CAA, 2023, requires the distribution of an additional 200 Medicare-funded residency positions to train physicians. CMS proposes an application and award process to dedicate at least one-half of the total number of positions to psychiatry or psychiatry subspecialty residencies. CMS also proposes, to the extent slots are available, to focus positions on health professional shortage areas.*

**Comment:** In 2020, Congress added 1,000 additional Medicare-funded GME residency positions to help meet the needs of the healthcare workforce – particularly in rural and underserved communities. This was the largest increase in Medicare-funded residency slots in over 25 years. In Round 1, UnityPoint Health (Iowa Methodist Medical Center) was awarded 2.92 slots. These slots helped to address critical physician shortages in Iowa and to ensure Iowans continue to have access to high quality healthcare in their local community. As a rural state, our program most importantly and consistently produces physicians and surgeons that remain in Iowa to serve Iowans. For this next round, **we again extend our appreciation to Congress for Medicare-funded residency positions that may be used by existing or new programs. The stated emphasis on psychiatry or psychiatry subspecialties is laudable, but we urge caution in becoming too prescriptive related to positions**. Rather CMS should allow program flexibility to enable applicants to tailor programs to support positions needed most in rural and underserved communities. We encourage CMS to consider the following:

- *Pro-rated vs FTE position support*: As proposed, every qualified applicant will receive funding if the application is submitted within the deadline – and the deadline is generous. If more than 200 applicants apply, this will necessitate awarding pro-rated FTEs. If applicants exceed 400, this may make the award virtually unworkable at many programs. **From a sustainability standpoint, it is operationally preferrable to have CMS guarantee an award of at least 1.0 FTE, and ideally to fund entirely in 1.0 FTE increments**. With limited positions and the desire to spread to as many applicants as possible, we understand that this may not be feasible without an increase in overall positions.
- *Practice and specialty needs*: UnityPoint Health commends the emphasis on behavioral health. That stated, the dedication of at least one-half of the total number of positions to psychiatry or psychiatry subspecialty residencies may result in some slots going unused, which will not help physician training or access in rural and underserved areas. In Iowa and nationally, there are additional and significant specialty needs in Family Medicine, particularly in rural areas (but urban as well); OBGYN; and Geriatrics, among others. While we agree that behavioral health may warrant an application preference, **we discourage CMS from establishing a set-aside percentage for behavioral health and defer to local needs**.

With physician shortages, any flexibilities to GME overall are welcome. **In concert with training support, GME should not be viewed in a silo and UnityPoint Health urges any additional support for educational expenses, flexibilities to recruit and retain foreign-born providers, and thoughtful increases to provider reimbursement (both fee-for-service and value-based services)**. As workforce challenges are pervasive across healthcare, developing comprehensive and innovative solutions are a must and we appreciate efforts to work in concert with CMS to address.

## ACCESS TO ESSENTIAL MEDICINES PAYMENT

*CMS proposes a separate payment for small, independent hospitals to establish and maintain a buffer stock of essential medicines for use during future drug shortages.*

**Comment:** As stated in our comment letter[3] to the Request for Information within the FY 2024 OPPS proposed rule, UnityPoint Health supports incentivizing the creation of private sector reserves of essential medicines not adequately provided in the Strategic National Stockpile. **We support the concept of a 6-month inventory and that CMS has not limited support in a budget neutral fashion, but we are disappointed that CMS has chosen to limit this payment to small, independent hospitals**. At a high level, CMS should consider the following:

1. Establish a buffer inventory that sits upstream of individual hospitals to improve efficiency in allocation and inventory management.
2. Allow companies to provide data on the cost of buffer stock using accepted financial calculations.
3. To reduce reliance on companies likely to have quality failures, exclude drugs from manufacturers with a recent history of FDA warning letters.

**We encourage CMS to continue to work with stakeholders, including the American Society of Health-System Pharmacists, in crafting a solution to assure access to essential medicines for all hospitals**.

## RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

*This demonstration program began in 2004 and allows rural hospitals with fewer than 51 acute care beds to assess the feasibility of Part A cost-based reimbursement. This program is limited to 30 hospitals nationally. 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 healthcare access in rural areas.** We reiterate the following recommendations for program improvement from our 2023 IPPS comment letter:

- *Permanent Status*. Given its demonstration status, program participants are dependent upon program renewal every five years. This hampers long-term planning for healthcare access in rural areas. With a program duration of 20 years, it is time for program permanency.
- *Program Capacity*. While the program website lists 28 participants for 2025[4], this number is likely lower based on public reports of hospitals that have converted to Critical Access Hospital status and and/or designations. 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 for the remainder of those terms.

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[3] Letter submitted by UnityPoint Health to https://www.regulations.gov on September 11, 2023. Tracking number lmf-8kdo-qktu

[4] https://www.cms.gov/priorities/innovation/where-innovation-happening#model=rural-community-hospital-demonstration

- *Sole Community Hospital Participant Financial Stability*. For Sole Community Hospital (SCH) 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 the SCH's first cost reporting period payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be 'the greater of' the reasonable cost of providing such services or the hospitals IPPS payments." Presently, SCHs who are demonstration hospitals must give up this safety net 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.

## MEDICARE QUALITY REPORTING PROGRAMS – OVERALL COMMENTS

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

**Comment:** UnityPoint Health believes that quality is our best strategy. We welcome CMS' partnership to strengthen this strategy and actual outcomes. Being on the frontline, we also appreciate that the state of healthcare is evolving daily and that the learning curve is steep. As CMS annual payment rules have been proposed over the last several years, CMS continues to add complexity and ratchet up the burden placed on hospitals to comply. This takes the form of total number of measures collected and reported as well as revisions to those existing measures, inadequate timeframes for implementation of changes, and heightened submission requirements. Often administrative requirements overlap reporting that is occurring within various other aspects of multiple program requirements. **The constant need to upgrade software technologies, improve cybersecurity protections, and increased redundancy across reporting programs while reducing funding is causing a financial strain on healthcare entities.** This volume and speed of regulatory change has also caused operational fatigue from providers and administrative staff. Given limited resources, an unintended consequence is that hospitals are forced to shift resources to chase submission compliance which in some cases may be diverted from resources underlying quality improvement activities.

As CMS drives quality priorities across multiple programs, we request that CMS:

- Limit annual measure changes and provide realistic implementation timeframes. **We urge CMS to examine the collective time and effort of hospitals across all Medicare quality programs prior to instituting new measures, revising current measures, and altering public reporting**. Each involves resources, time and costs. For instance, the expansion of the patient population for the global malnutrition measure may be perceived by CMS as a simple/minimal change with negligible burden; however, this change requires the CEHRT software vendor to update the reporting logic, that new

logic to be implemented into the client's software, and data collection to be validated. The software update does not include the development, implementation, and education of new hospital workflows associated with new or revised measures. It is a struggle to "go live" with software and workflow updates from the date of the IPPS Final Rule release to the beginning of the calendar year for just one "simple" measure. When viewed across all quality programs, the timeline and capabilities of vendors and implementation for multiple measures is unrealistic, the financial cost is burdensome, and development and implementation is resource intensive.

- Develop a single all-inclusive tracking report for quality data submission. **As CMS increases submission requirements and provides multiple reporting websites/portals, the development of a single all-inclusive tracking report for submission of data requested, starting with the IQR program**. Currently multiple reports are used to track submission of various components of the IQR dataset, and these reports are updated inconsistently. A single source for submission tracking, using a consistent timeline for updates across all program components, would reduce hospital burden to assure all data submission has occurred as required.

## HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

*The Hospital IQR Program is a pay-for-reporting quality program. CMS proposes to adopt seven new quality measures, remove five existing quality measures, and modify one current electronic clinical quality measures (eCQMs). CMS also proposes two changes to current policies related to data validation: an increase over two years in the total number of mandatory eCQMs reported by hospitals and cross-program modifications to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure.*

**Comment:** UnityPoint Health is frustrated by the sheer number of changes being proposed as well as the timeline of Value Set Authority Center (VSAC) releases.

- **Timeframe for VSAC Releases**: With each reporting year, CMS via the VSAC releases a new value set associated with each electronic measure required to be submitted. These value sets are not released until May of the performance year. For 2024, these were released May 24, 2024. While in general, value set changes are minimal, there are occurrences where the value set changes can and do impact measure outcomes. When value set changes occur, new logic must be established, measures must be revalidated back to January 1, and education must occur for end users. This process takes June and July – effectively, hospitals have less than half a year to identify any gaps and engage in performance improvement. **UnityPoint Health respectfully requests that VSAC release the value set in December proceeding the effective performance/calendar year to allow hospitals to update, validate and educate early within the data collection process**. This earlier release timeline aligns with the proposed eCQM validation process changes, will enable more efficient clinical workflows and will potentially result in improved outcomes given longer runways for process improvement.
- **Patient Safety Structural Measure**: This attestation measure assesses whether hospitals are implementing 25 separate policies and practices across five "all-or-nothing" domains identified by CMS as leading to safer care in hospitals. At first blush, it would appear that attestations of structural measures would entail less burden; however, the idea of structural measures means organizations

have policies and procedures in place to meet each sub-measure within each domain. Although we support the intent of this measure (patient safety should be a primary focus for healthcare organizations), **this measure is too prescriptive and contains redundancies**. Our specific recommendations follow.

- *Prescriptive sub-measures*: The prescriptive nature of many sub-measures substitutes CMS in the place of hospital operations and leadership in determining the appropriate means to accomplish a quality domain. **UnityPoint Health requests that CMS revisit the details within sub-measures to be less prescriptive and more flexible to allow hospitals themselves to determine the best approach to meet measure goals**. This approach enables hospitals to tailor strategies that reflect community need and available resources. For example, *Domain 3: Culture of Safety & Learning Health Systems* requires as a high-reliability practice that "hospital leaders participate in monthly rounding for safety on all units, with C-suite executives rounding at least quarterly, with a method in place for follow-up on issues identified." UnityPoint Health has a robust rounding mechanism in place that has been intentionally and thoughtfully designed to institute timely improvements and disseminate best practices across the system. As written, this sub-measure does not account for current practices that are in place and may be more effective. For a health system that has centralized quality leadership, it would be unrealistic to believe that a safety counsel leader could individually round with each unit each month across a multi-hospital system and it would be perceived as a step backwards to require individual hospital leaders to perform monthly rounding specific to quality – potentially leading to blind spots due to the nature of self-assessments and creating workflows outside current practices.
- *Duplicative reporting*: **UnityPoint Health requests that CMS revisit sub-measures for duplication with other CMS programs or CoP requirements audited through accreditation organizations**. Reporting twice is a waste of hospital resources, and we encourage CMS to remove these requirements. For instance in *Domain 3: Culture of Safety & Learning Health Systems*, the sub-measure on high-reliability practices includes technologies including bar medication administration and computerized physician order entry systems. These technologies are required for utilization of CEHRT technology under the Medicare Promoting Interoperability Program. A hospital required to participate in IQR is also required to participate in the Medicare Promoting Interoperability Program. If CMS believes that these activities merit additional programming emphasis, instead of requiring across quality programs, we request for simplicity that CMS address in one program through added incentives for compliance (or penalties for noncompliance).
- *Patient Safety Organizations (PSOs) relationship*: Again within *Domain 3: Culture of Safety & Learning Health Systems*, hospitals are mandated to participate in PSOs. This is a resource intensive and costly proposition. **UnityPoint Health requests that CMS remove this sub-measure**. To attest yes, hospitals will need to engage in multiple processes, procedures and contracts as the attestation requires participation, specific data sharing obligations, and completion of an implementation best practice. Without a pre-existing PSO relationship, this will be nearly impossible for hospitals to achieve within year one and requires expenses that may

challenge operating margins for some hospitals.

- *All-or-nothing scoring*: This scoring methodology does not accurately reflect current state and organizational time and effort, and its public reporting as proposed may cause reputational harm to hospitals. Hospitals meeting four of five sub-measures should not receive a zero score. **UnityPoint Health recommends the following alternatives:**
  - **Utilize a phased scoring approach.** For instance, if there are five submeasures, CMS could allow hospitals to score full credit for implementing one sub-measure in the first year, three sub-measures in the second year, and five submeasures in the third year.
  - **Provide partial credit for meeting each domain sub-measure.** This scoring would indicate time and effort set forth for each domain and indicate progress over time.
  - **Refrain from public reporting of scores altogether for at least the first year and preferably two years.** This pause would enable hospitals to restructure their processes and/or chains of communication accordingly.
- *Public reporting*: As proposed, public reporting would begin in the first performance year. This is setting hospitals up for failure. Aside from the sheer number of sub-measures and related time and effort as well as the proposed all-or-nothing scoring, first-year public reporting does not align with the general public reporting approach for new measures introduced into the IQR program. **UnityPoint Health requests that public reporting of scores not occur for at least the first performance year**.
- *Submission portal*: The proposal to complete attestations within the CDC's National Healthcare Safety Network (NHSN) portal does not align with the attestation of other structural measures within the CMS Hospital Quality Reporting (HQR) portal. Currently the HQR portal houses attestations for the Social Drivers of Health Structural Measure, Maternal Morbidity Structural Measure, and Health Equity Structural Measure. The use of multiple portals across agencies only increases confusion and the potential for failed data submission. There are also logistics issues with this proposal. Presently only infection control personnel have access to the NHSN portal and these personnel are not responsible for quality reporting. Submission via the NHSN would mean either granting additional access to quality personnel and engaging in relevant training or retaining infection control personnel on these attestations. Neither solution is ideal. **UnityPoint Health requests CMS use the HQR portal for these attestations to promote consistency and lessen reporting burden**.

- **Age Friendly Hospital Measure**: This attestation measure assesses whether hospitals implement certain policies and practices that CMS believes are linked to better care and outcomes for a subset of adults, age 65 and over. Although UnityPoint Health understands the drive to ensure the aging population is receiving care that meets high standards, **this structural measure is simply an age-stratified subset of already reported measures within other CMS programs**. Duplicative reporting in a piece-meal, age-specific fashion not only requires additional time and effort, but it increases the opportunities for errors in data pulls and submissions The duplicative elements are set forth below:

- *Domain 1 (Eliciting Patient Healthcare Goals)*: This domain contains protocols required by CoPs and must be reported as part of our accreditation process. UnityPoint Health is accredited by Det Norske Veritas (DNV).
- *Domain 2 (Responsible Medication Management)*: The domain requiring medication review and identification of potentially inappropriate medications is already captured within:
  - HCAHPS under medication review questions,
  - Accreditation requirements regarding intake and patient history collection, and
  - Medicare Promoting Interoperability Program in a sub-component of the health information exchange measure.
- *Domain 3 (Frailty Screening and Intervention)*: This domain requires an attestation for screening, follow up, data collection and protocols reported under various CMS programs and include patient safety indicators (PSIs). It also appears that this measure is being used to drive new eCQM implementation, which is costly and burdensome.
- *Domain 4 (Social Vulnerability)*: This domain is already collected within the Social Determinants of Health and Health Equity structural measures applied to hospital settings. Additionally, it is required by CMS 1557 non-discrimination policies.
- *Domain 5 (Age-Friendly Care Leadership)*: This domain is intended to ensure a point person or leadership is addressing identified concerns within the other four domains. Each of the four previous age-friendly domains requires engagement and oversight, so this domain is also duplicative.

**UnityPoint Health requests that this measure be reconsidered for adoption.**

- **TKA/THA Pro-PM Measure (CMIT ID #1618)**: While this measure remains unchanged from the FY2024 IPPS Final Rule, **UnityPoint Health reiterates our concerns with this measure and urges CMS to remove this measure from the IQR (as well as from the TEAM proposal)**. Although patient reported outcomes can be extremely insightful for medical procedures, the TKA/THA Pro-PM measure presents operational challenges when surveying patients pre- and post-surgical events, is overly burdensome, is limited to a subset of patients, and lacks exclusions for small sample sizes. Specifically,
  - *Patient relationship*: For this surgical procedure, the patient is only admitted to the hospital for a relatively small period and the ongoing patient relationship lies generally with the specialists – in this case, the orthopedist. This measure does not acknowledge that most hospitals do not own/employ orthopedic providers. When hospitals allow surgical rights to independent orthopedic groups, these hospitals do not have all data leading up to the surgery or post operative care within their electronic medical records (EMR). Despite this, hospitals are responsible for submission of the TKA/THA Pro-PM measure data – so hospitals must rely on external orthopedic groups to capture this data and relay it to the hospital, or hospitals in which the surgery occurs would need to start collecting this data.

- *Data collection and tracking*: Aside from hospitals presently not collecting the proposed survey information, the information regarding pre- and post-surgical outcomes for the PRO-PM is not centrally located. Often this data may not be housed in the same EMR or even be available across platforms. Given current state, hospitals will also incur a cost to manage and report this data.
- *Inpatient survey only*: This measure targets only inpatient admissions, despite the fact that CMS removed TKA/THA procedures from the Inpatient Only List and many are now performed on an outpatient basis. Using only an inpatient population, outcomes will be skewed as inpatient admissions tend to have comorbidities, be older, and have poorer health status overall.
- *Minimum procedure threshold*: There appears to be no minimum case threshold for this measure, whereas most procedure measures have a minimal case threshold that must be met for reporting requirements. Without a minimum threshold, low-volume hospitals may be disadvantaged in obtaining the required 50% response rate. For example, a hospital with 2 inpatient TKA/THA patients would fail this measure without 100% compliance – both (2) patient surveys must be returned and their data submitted timely.
- *Patient experience*: The potential for survey fatigue and patient frustration is heightened with this measure. First, while this measure targets inpatient stays for survey reporting, patients may also receive various other surveys – CAHPS surveys mandated by CMS, pre-op surveys, and surveys from their specialist. For TKA/THA procedures particularly, all TKA/THA patients (even outpatients) receive an inpatient pre-op survey. This process was necessitated from a Medicare payment change that reimburses initial scheduling of all TKA/THA procedures as outpatient unless a known risk exists. Pre-op surveys are therefore conducted with the entire population on the off chance that something happens during the outpatient stay requiring inpatient admission. Second, extremely long post-episode survey window creates issues of its own. Gaps exist within the PRO-PM around addressing patient dissatisfaction through follow-up care after the 300-day window. Additionally, a survey on surgical outcomes of care requested a year after the procedure may pose confusion and result in inaccurate responses from elderly patients as well as caregivers.

Aside from our general process concerns with the TKA/THA Pro-PM measure, **UnityPoint Health recommends that CMS reconsider requiring physicians to ask the chronic narcotic question**. Within the orthopedic care space, the workflow regarding surveying patients will fall heavily on ancillary support staff. Having a single question required to be documented by providers interrupts the workflow during the day of the procedure and adds reporting burden due to training components and software builds to appropriately capture the question.

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

*For the Hospital IQR and PHCQR Programs, beginning with the 2025 Reporting Period/FY 2027 Payment Determination or Program Year (as applicable), CMS proposes eight new questions and removes five current questions, so that the survey has 32 questions that span 11 sub-measures. For the Hospital VBP,*

*the questions would comprise nine dimensions. For Hospital VBP, CMS proposes to change HCAHPS scoring methodology for the FY 2027 through FY 2029 program years to score only survey dimensions that remain unchanged from the current version.*

Comment: UnityPoint Health acknowledges and agrees that the patient perspective is extremely important to capture to enable a patient's experience to be improved within the hospital. **We generally agree with the HCAPHS domain restructure.** As restructured, we want to thank CMS for the changes to the Care Coordination dimension – particularly, the question regarding staff and doctors working together, as we recognize a team approach improves patient care outcomes and experiences. **We also appreciate that CMS will pause scoring of new domains during the transition to new measures until FY 2030.** Although these are positive steps in capturing the voice of patients, **we encourage CMS to shorten (not lengthen) the survey, remove redundant questions, and consider authorizing real-time survey alternatives to HCAHPS.** Real-time alternatives to HCAPHS gather broader patient feedback and are timelier, more actionable, and less costly.

The expansion of the survey by increasing the number of questions could be deemed burdensome by patients. We believe there is a risk of patients having survey fatigue due to the sheer number of surveys being asked of patients during a stay. Patients are answering multiple questions as part of their general admission process under the CoP requirements, multiple questions under Social Drivers of Health assessments, and receiving post-care surveys for HCAHPS, as well as additional surveys based on procedures undergone during their hospitalization, such as survey requirements within the TKA/THA Pro-PM measure. HCAHPS survey response rates across the nation are trending downward and becoming more expensive to administer due to language requirements without a solid return of investment due to lower response rates. Lengthening the HCAHPS survey to 32 questions increases the potential for reduced response rates even more.

Upon review of the proposed changes, some questions appear redundant and could be removed to shorten survey length. For example, under the *Restfulness of Hospital Environment* dimension, the questions pertaining to "how often did you able to get the rest you needed?" and "how often was the area around your room quiet at night?" seem redundant. Within the *Responsiveness of Hospital Staff* dimension, the questions pertaining to "how often did you get help in getting to the bathroom or using a bedpans as soon as you wanted?" and "when you asked for help right away, how often did you get help as soon as you needed?" seem redundant. For each of the above, we would recommend keeping only one question to help reduce overall survey length.

## MEDICARE PROMOTING INTEROPERABILITY PROGRAM

*CMS proposes to divide one existing measure into two distinct measures, adopt two new eCQMs, modify one current eCQM, increase the performance-based scoring threshold, and over two years increase the total number of mandatory eCQMs reported. CMS provides notification of definitional changes.*

**Comment:** Under the *Public Health and Clinical Data Exchange* objective, **UnityPoint Health applauds the division of the Antimicrobial Use and Resistance (AUR) Surveillance measure into distinct measures on Antimicrobial Use (AU) and Antimicrobial Resistance (AR)**. These measures rely on different data sources, and separation will ease reporting burden. We also support the timeline extension for the Option

1 and Option 2 requirements, the exclusion criteria, and maintenance of the 25-point scoring value relative to the AUR change.

CMS proposes updates to the definition of CEHRT beginning with the EHR reporting period in CY 2024. **We request that the CEHRT definitional changes be paused**. While we support the ongoing improvement with technology, the proposed timeline for hospitals to implement changes in software versions to meet new ONC CEHRT requirements is extremely short and very costly. This proposal fails to recognize the interplay of this proposal with ongoing USCDI expansion and challenges with interoperability transmissions given various state-level limitations.

CMS proposes to increase the performance-based scoring threshold from 60 points to 80 points. We agree that this threshold should be raised, but the timeframe should be extended to support success in reaching this threshold. The increase is significant and will be challenging to improve under short turnaround, especially given the multitude of other changes such as eCQMs. **We urge CMS to consider a three-year phased approached to operationalize this threshold** – remaining at 60 in year one, jumping to 70 in year two, and finally jumping to 80 in year three.

In terms of quality measures and reporting requirements, CMS proposes to align the Medicare Promoting Interoperability program with the Hospital IQR program[5]. **We appreciate the alignment of clinical quality measures, but reiterate our concerns with the continued expansion and overly burdensome reporting requirements of the Hospital IQR**.

*Electronic Clinical Quality Measures (eCQMs)*: **UnityPoint Health remains concerned with the rapid adoption of eCQMs.** CMS proposes an increase in overall eCQM reporting from four measures to nine measures in CY 2026. This is a dramatic jump over two years and is very resource heavy. While we support the goal of obtaining real-time data on a digital platform, eCQM adoption is a laudable goal but it 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 year in the Hospital IQR Program (no incentive-based outcome) prior to moving to any incentivized quality program.

How eCQMs relate to other quality measures must also be carefully considered to avoid provider and public confusion. Challenges include:

- 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.

[5] Detailed in Table IX.F.-05: *Previously finalized eCQMs for eligible hospitals and CAHs for the reporting period* and Table IX.F.-06: *Previously finalized eCQMs for eligible hospitals and CAHs for the CY 2025 reporting period*

- 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.

*SAFER Guides*: **UnityPoint Health agrees the assessment of cybersecurity is extremely important, appreciates CMS' recognition that SAFER guides are outdated, and supports the work underway with ONC to update. Until CMS and ONC complete their work, we respectfully request a pause in further SAFER guide updates, so that healthcare resources can be appropriately preserved**. Ultimately, we recommend incorporating the use of SAFER guide components of assessment as part of existing Security Risk Assessment requirements, instead of adding duplicative attestations to the Medicare Promoting Interoperability Program. Incorporating in existing requirements outside the Medicare Promoting Interoperability Program would ensure security assessments at a department level meet SAFER guidelines while ensuring that ongoing mitigation of safety risks continues. By requiring SAFER guides and self-risk assessments separately, this risks duplication in confirming actions, documenting the process, and identifying completed items. Furthermore, components of SAFER guides are duplicative of EHR cybersecurity requirements falling under the latest HIPAA revisions as well as requirements for CEHRT standards, CoP, and various other programs. For example, with the high priority practices for SAFER guides, 2.5 calls out "the EHR is used for ordering medications, diagnostic tests, and procedures." Computer Provider Order Entry is a topped-out measure under EH PI, yet it is included as an attestable component of the Hospital IQR patient safety structural proposed measure and it is a mandated functionality to meet CEHRT requirements. We suggest that CMS retract this requirement to work with ONC to update the SAFER guide components, review and merge the Security Risk Assessment requirement with SAFER Guides implementation, and then allow time for hospitals to implement the new standards prior to requiring mandatory attestation.

*Fast Healthcare Interoperability Resources® (FHIR)*: While we appreciate CMS' drive to move forward with FHIR technology, its implementation and updates are costly and resource intensive. As CMS considers making available new capabilities for exchanging data with public health agencies using the FHIR standard, we urge caution. Although we recognize the ongoing need for public health reporting, huge variability exists nationally as states are at various levels of accepting public health reportable data. For healthcare systems with footprints in multiple states, this becomes extremely burdensome and costly as connections to state agencies cannot be duplicated and copied. **We request that CMS delay the adoption of FHIR technology to ensure that all states are capable of receiving the same data, in the same file structure, and in the same file format prior to mandating FHIR for data submission**. Consistent data requests and file structures across states will yield a better national view of data and more accurate depiction of public health information – lesson learned from COVID-19 public health emergency reporting discrepancies.

## REQUEST FOR INFORMATION: MEDICARE PROMOTING INTEROPERABILITY PROGRAM

*CMS describes the goals and principles for the Medicare Promoting Interoperability Program's Public Health and Clinical Data Reporting objective and solicits feedback in response to a series of questions related to that objective and related topic.*

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

- *Goal #1: Quality, Timeliness, and Completeness of Public Health Reporting - How can CMS incentivize more complete electronic case reporting to Public Health Agencies (PHAs)? For example, should CMS update the measure to require healthcare providers to meet a certain threshold for conditions reported?*

  Comment: This question seems to focus on the role of hospitals without consideration that this is a two-way street. **Reporting to PHAs is not only contingent on the capabilities of the healthcare organization to submit, but also continent on the capabilities of PHAs to receive the submission**. It becomes increasingly difficult for hospitals to report when a large variation in file formatting and data structure exists across various states and state agencies. Furthermore some state agencies are utilizing third-party vendors to support public health reporting. These third-party vendors (1) can collect data outside the scope of the required submission for public health needs due to loopholes in the USCDI data sharing clauses; (2) are not required to follow a specific file structure guideline; and (3) are charging healthcare organizations to submit the CMS-required public health reporting data to them. This process has proved to be quite costly and administratively burdensome as CMS-reporting requirements across programs expands and third-party vendors institute a multitude of inconsistencies within the data submission process. For health systems spanning multiple states and jurisdictions, like UnityPoint Health, these burdens are increased.

- *Goal #4: Eliminating Reporting Burden for Healthcare Providers - Under the current Public Health and Clinical Data Exchange objective, which measures, or other requirements result in the most administrative burden for eligible hospitals and CAHs?*

  Comment: The largest administrative burden is the lack of guidelines and requirements for data file structure for submission of public health information. Third-party vendors in contractual agreements with state agencies are not required to follow standard protocols for submission and this inconsistency entails additional money and resourcing for hospitals to tailor reporting submissions. For example, our software vendor supports and provides the required feed to meet syndromic surveillance guidelines; however, a state-contracted third-party vendor that collects the CMS-required syndromic surveillance data requires a different feed for reporting with an expanded dataset to meet their needs. Third-party vendors are also charging healthcare organizations a fee to submit this data through them and disallow direct submission to the state agency. **CMS oversight regarding state-level contracts and requirements for submission of the required CMS datasets under the public health measure would be extremely beneficial to help eliminate inflated costs by third-party vendors working with states for data collection**.

## TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

*CMS proposes a 5-year mandatory model beginning on January 1, 2026, and ending on December 31, 2030. The proposed 30-day bundled payment would cover five episodes of care: Lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure. Hospitals including CAHs are participants and will be randomly selected by core-based statistical area tiers.*

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

**As proposed, UnityPoint Health is opposed to the mandatory nature of TEAM**. If CMS desires an uptake in provider participation (specifically, specialist engagement in value-based models), a better approach would be to incentivize participation within TEAM constructs as opposed to a blanket mandate. In this spirit, UnityPoint Health urges CMS to consider the following:

- **<u>Reduce the 3% Discount</u>** – TEAM's proposed discount is significant, making it incredibly challenging for participants to achieve shared savings. Since the DRG payment from the anchor stay is fixed, hospitals will have to generate all the savings from the Part B procedure payment and the 30-day post-acute care spending. With a 3% discount, analyses from both NAACOS and the healthcare actuarial consulting firm Wakely estimate a 5-13% reduction on Part B and post-acute care components (depending on the bundle) to breakeven across the entire bundle. For hospitals with a history of managing population health spend through participating in CMS ACOs, a 3% discount is significant given that shared savings over time yields diminishing returns. UnityPoint Accountable Care has been participating in CMS value-based models since 2012.
- **<u>Allow Hospital Participants to Select Individual Clinical Episodes</u>** – The episodes selected are dissimilar, require different workflows, processes and specialist engagement, and equates to not one mandated program but at least five individual programs. If CMS is to proceed with a mandated episode of care model, CMS should allow participants to self-select one or more clinical episodes that make the most sense for their patient population and align with their clinical areas of focus. Through TEAM, CMS has effectively stepped into hospital operations and mandated time, effort and resources be devoted to specific care episodes without regard to participant capacity, patient need, or overall healthcare environment. This burden is then multiplied five-fold.
- **<u>Exclude Safety Net Hospitals, Rural Hospitals and Special Designation Hospitals from TEAM</u>** – Many safety net, rural hospitals and special designation hospitals do not have the experience or the infrastructure to be successful in risk-based models. Additionally, communities rely on these critical acute care settings to serve in low-volume geographic areas, but CMS mandating TEAM participation may further financially strain these critical organizations. UnityPoint Health recommends excluding rural hospitals, safety net hospitals and special designation hospitals from the TEAM proposal given existing financial constraints.
- **<u>Revise the Low-Volume Threshold</u>** – CMS proposes a low-volume threshold of 31 cases across all five-episode categories and all three baseline years. Hospitals not meeting the threshold must still participate in TEAM with slightly lower risk metrics. Low-volume hospitals will be challenged to meet

the proposed threshold across all episode categories and, under proposed rules, there is no exclusion from participation. *UnityPoint Health suggests that CMS increase the low-volume threshold to ensure statistical significance, establish separate thresholds within each clinical episode category, and fully exclude hospitals not meeting those thresholds from participation*. CMS should exclude low-volume hospitals from TEAM to protect against large financial losses due to random variation as a result of assessing a small number of cases. The low-volume threshold should be increased, and hospital participation should be evaluated for each of the five episodes individually.

- **Delay Implementation Pending Release of Detailed Model Requirements and Participants** – Although we appreciate that CMS does not intend TEAM to begin until January 1, 2026, the lead time required for hospitals to stand-up episode of care models for five disparate clinical episodes is no small task. Given the degree of variables that are still uncertain and for which CMS is seeking input, hospitals cannot begin to operationalize until a Final Rule is published and hospital participants are announced. Even for hospitals with experience in value-based arrangements, implementing TEAM requirements will require time for hospitals and partners to develop policies, workflows, processes and additional plans to meet model requirements.
- **Release Future Models in a Separate Payment Rule** – Including stand-alone, value-based clinical models within an annual payment rule obscures notice and provisions of new models for stakeholders historically outside the jurisdiction of specific annual payment rules. UnityPoint Health recommends that CMS release future models in their own public notice and rulemaking process versus including them in an existing annual payment rule. Given the scope of the model, at least one more round of public comment on this model as revised would be appreciated.
- **Quality Measures** – We appreciate that CMS has tried to reduce reporting burden through proposing claims-based measures. We do have concerns related to the TKA/THA PRO-PM measure and have detailed those above in the Hospital IQR narrative.

## REQUEST FOR INFORMATION: OBSTETRICAL SERVICES STANDARDS

*CMS seeks public comment on potential solutions that can be implemented through the hospital CoPs to address well-documented concerns regarding maternal morbidity, mortality, disparities, and maternity care access in the United States without exacerbating access to care issues.*

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

- *What types of facilities and care settings should such a CoP apply to (that is, all hospitals, hospitals with/without OB units, hospitals with/without emergency services, CAHs, REHs, outpatient settings, which may include inpatient and outpatient prenatal, postpartum, emergency, and birthing care services)? Options include optional services CoP specific to obstetrical services; Modelling an OB services CoP after infection prevention and control stewardship program CoPs; or Requiring hospitals to develop standard processes for managing pregnant, birthing, and postpartum patients with or at risk for: (1) obstetric hemorrhage (a leading cause of maternal mortality); and (2) severe hypertension (a common pregnancy complication).*

Comment: **UnityPoint Health supports requiring hospitals to develop standard processes for managing pregnant, birthing, and postpartum patients with or at risk for: (1) obstetric hemorrhage (a**

**leading cause of maternal mortality); (2) severe hypertension (a common pregnancy complication); as well as (3) maternal sepsis.** Maternal sepsis is characterized as an obstetric emergency and a leading cause of severe maternal morbidity and maternal mortality. In the United States, maternal sepsis is estimated to complicate 10 cases per 10,000 live births,[6] and 13.9% of all pregnancy-related deaths are related to sepsis.[7] Approximately 63% of maternal deaths from sepsis result from delays in care.[8] Early recognition and prompt treatment are crucial in managing this condition. Standard processes could aid early detection and treatment, consistent care, risk reduction, and emergency response. UnityPoint Health has protocols for maternal sepsis, supports widespread adoption of standards, and encourages CMS to consider including maternal sepsis alongside obstetric hemorrhage and severe hypertension as conditions warranting standard processes .

- *What are existing acceptable standards of practice, organization, and staffing for obstetrical services (including staff qualifications and scope of practice considerations) in hospital obstetrical wards, emergency departments, CAHs, and REHs?*

Comment: Several professional organizations of providers and nursing have developed these standards, and **UnityPoint Health urges CMS to rely upon these organizational stakeholders**, such as the American College of Obstetrics and Gynecology (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).

- *How could CMS better understand patients' experience of maternity care? What tools or instruments exist to understand individuals' experience of maternity care? How might CMS incorporate these tools or instruments into an obstetrical CoP?*

Comment: **Patient experience is an important topic, but we believe it is premature to incorporate specific tools/instruments into an obstetrical CoP without further analyses, CMS planning, and corresponding stakeholder input**. Like CMS, UnityPoint Health is working to better understand patients' experience in maternity care. Presently UnityPoint Health uses NRC Health patient satisfaction surveys, which have specific but standardized questions for obstetrics services; however, despite best efforts, response rates for obstetrics units have been traditionally low and lag time does not promote timely, actionable performance improvement. Conversely when rounding with patients while hospitalized, it is sometimes challenging to gauge veracity and completeness as patients may mask concerns/complaints for fear of adverse impact on services. As CMS gathers information from this RFI, it would be helpful if CMS would share best practices or lessons learned from stakeholders on improving survey response rates.

Additionally, UnityPoint Health supports diversity, equity and inclusion for our workforce, patients and communities. As CMS reviews RFI response, UnityPoint Health would appreciate it if CMS would

[6] Acosta CD, Knight M, Lee, HC, Kurinczuk, JJ, Gould, JB, & Lyndon, A. The continuum of maternal sepsis severity: incidence and risk factors in a population-based cohort study. PloS one. 2013. 8(7). Accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3699572/

[7] Society for Maternal-Fetal Medicine (SMFM); Andrea D. Shields, MD, MS; Lauren A. Plante, MD, MPH; Luis D. Pacheco, MD; and Judette M. Louis, MD, MPH; SMFM Publications Committee. AJOG. 2023. B2-B19. Accessed at https://doi.org/10.1016/j.ajog.2023.05.019

[8] California Maternal Quality Cre Collaborative, https://www.cmqcc.org/content/sepsis

disseminate any stakeholder or agency insights (tools/instruments/techniques) related to gaining actionable information from patients based on their race and ethnicity. Patient experience surveys do not presently solicit this race and ethnicity information, so these instruments are not only backward-looking but they tend not to be as helpful in understanding how patients of color perceive whether their race and/or ethnicity impacted the care they received.

- *What should be required with respect to credentialling of health professionals to provide obstetrical services within a specific facility?*

Comment: **Credentialing should require certification, or eligibility for certification, from respected national organizations**. For example, obstetricians should be required to hold board certification from the American College of Obstetrics and Gynecology. Likewise, nurse midwives should hold board certification through the American College of Nurse-Midwives. In addition, providers should demonstrate competence annually, by numbers of completed procedures and through participation in drills and simulations.

- *Should obstetrical units be required to maintain a minimum set of obstetrical care equipment and supplies? Should hospitals and CAHs without obstetrical units, emergency departments, and REHs have similar requirements?*

Comment: **Yes, all hospitals, including non-OB hospitals, should have the supplies and equipment necessary to deliver a patient at any time**. Supplies should also include medications for hypertension, post-partum hemorrhage, and maternal sepsis, which is consistent with our recommendation for standard protocols.

- *Beyond what is already required for emergency department (ED) patients under EMTALA, should a hospital obstetrical services CoP include a requirement for transfer protocols for when a non-ED patient needs care that exceed the capability of the hospital (that is, inpatient to inpatient transfers)? Should a similar requirement apply to hospitals and CAHs without emergency services and/or obstetrical services?*

Comment: **Yes, all hospitals should be required to develop a protocol for when patient care needs exceed the capability of the hospital and a transfer to a higher level of care is needed**. Some states have statewide transfer centers that are invaluable to ensure OB patients are transported to the appropriate level of care, closest to where they live.

**Data**

- *Are there common critical data elements that would be most important and appropriate to collect through a CoP aimed at improving maternal health data? Are there data standards currently available or under development that can support standardized reporting? How do we ensure data collection encompasses all demographics?*

Comment: **CMS could consider the following measures: (1) PC-06 Neonatal Complications; and (2) PC-07 Severe Maternal Complications**. In addition, we encourage CMS to avoid mandating a minimum number of deliveries at a hospital, as such a requirement will prompt additional closures and undoubtedly exacerbate labor and delivery deserts. UnityPoint Health recommends that CMS adopt the approach used by the Iowa Department of Health and Human Services. In Iowa, the perinatal guidelines require every Level I hospital to receive outreach education and support from higher level hospitals.

This support for both nursing and providers encourages providers to continue practicing in rural settings.

## CONDITIONS OF PARTICIPATION TO REPORT ACUTE RESPIRATORY ILLNESSES

*Beginning on October 1, 2024, CMS proposes to replace the COVID-19 and Seasonal Influenza reporting standards for hospitals and CAHs with a new standard to electronically report certain data elements about COVID-19, influenza, and respiratory syncytial virus (RSV). Reporting is proposed weekly; however, during a public health emergency both reporting frequency and items are subject to change.*

**Comment: UnityPoint Health agrees that a more comprehensive dataset for respiratory illnesses would include confirmed COVID-19, influenza, and respiratory syncytial virus (RSV) infections.** Similar data is currently collected and available through the CDC's RESP-NET Interactive Dashboard for most states. As such, hospitals have developed efficient processes to support current reporting requirements and UnityPoint Health generally supports this national reporting requirement for hospitals, health systems and communities (public health entities).

We do, however, have a concern with potential administrative burden. While we understand that CMS may be reluctant to name a specific reporting tool for these "weekly totals or snapshots of key indicators," this creates uncertainty related to reporting time and effort as well as associated costs. **To reduce administrative burden, we urge CMS to refrain from changes to the reporting format (file layouts), definitions, and frequency that will require new processes and collection tools. Instead we respectfully request that CMS use the existing RESP-NET dashboard**. Similarly, CMS proposes to grant itself reporting authority flexibility in the event of a future public health emergency (PHE), but these agency flexibilities described as increases in reporting frequency and/or additions or modifications to data elements will likely result in significant increases in hospital reporting burden. During the COVID-19 PHE, hospitals experienced tremendous burden to ensure the safe provision of care. We request that CMS reporting flexibilities in the event of a future PHE consider the potential increased burden of additional and/or modified reporting on hospitals and healthcare providers for the new/different data.

## 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: UnityPoint Health encourages CMS to continue a platform to test the Acute Hospital Care at Home services beyond 2024.** This platform enables patients to be cared for at home and supports efficiencies within the inpatient setting. Under the leadership of UnityPoint at Home (our Home Health arm), UnityPoint Health was one of the first six health systems with extensive experience providing acute hospital care at home approved for the hospital at home waiver. UnityPoint Health was the first to enroll a patient and to bill and be reimbursed under this Medicare waiver. As of May 30, 2024, 136 health systems with 330 hospitals in 37 states have applied and been approved to participate in this waiver[9].

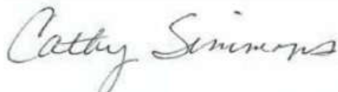
[9] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

Given the infrastructure investment needed to stand up this program and the uncertainty of its duration, UnityPoint Health only operates this model in two of our eight markets, and it is likely that more UnityPoint Health hospitals as well as other healthcare systems would participate under a program that has a longer duration and regulatory standing.

**Additionally, UnityPoint Health urges CMS to authorize a full array of Medicare At Home services and permit patient admissions that originate from the home.** While we recognize that CMS stood up the hospital at home waiver as a result of the COVID-19 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 (97%) and achieved outstanding clinical outcomes, including markedly reduced readmission and preventable ED visit rates. This was accomplished through a post-acute care bundling strategy under an accountable care organization waiver in which appropriate services were wrapped around the patient. Our bundles include hospital to home (two-hour response time), primary care at home (four-hour response time), palliative care at home, and skilled nursing facility at home. **Starting in 2023, UnityPoint Health began offering At Home services in some of our commercial health plan contracts**. We attribute our expansion to commercial plans as a direct result of being able to demonstrate proof of concept via the Medicare waiver program. We welcome the opportunity to further engage with CMS and/or CMMI on this topic.

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

Sincerely,



Cathy Simmons, JD, MPP
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