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June 9, 2026

Administrator Mehmet Oz, MD
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1849-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1849-P - Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Requirements for Quality Programs; and Other Policy Changes; published at Vol. 91, No. 71 Federal Register 19312-19887 on April 14, 2026.

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

Dear Administrator Oz,

UnityPoint Health appreciates this opportunity to provide comments on this proposed rule related to Hospital IPPS and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates. UnityPoint Health is one of the nation's most integrated healthcare systems. Through more than 31,000 employees and our relationships with more than 420+ physician clinics, 35 hospitals in urban and rural communities, 13 home care areas of service, and 5 community mental health centers across our 8 regions, UnityPoint Health provides care throughout Iowa, central Illinois, southeast South Dakota, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics, and home health agencies provide a full range of coordinated care to patients and families through more than 8 million patient visits.

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 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 on select topics.

INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) UPDATE

For FY 2027, CMS proposes to increase Medicare IPPS hospital rates by a net 2.4% (market basket update of 3.2% less a -0.8 percentage-point productivity adjustment).

<u>Comment</u>: **UnityPoint Health appreciates the increased Medicare payment rate, but this increase falls short of addressing inflationary pressures and the significant rise in healthcare labor and supply costs**. For the seventh consecutive year, the CMS payment update has not aligned with actual hospital cost increases, resulting in strained hospital operating margins. UnityPoint Health IPPS hospitals have an average public payer mix of 63%. When Medicare and Medicaid reimburse services at rates below cost, commercial payers must subsidize these services, or hospitals must reconsider the scope and level of services provided to their communities. To ensure financial stability and effective planning, **we reiterate our long-standing recommendations: (1) implement a retrospective adjustment for FY 2027 to account for the discrepancy between the market basket update implemented for FY 2026 and the current projection for FY 2026; and (2) eliminate the productivity cut for FY 2027**.

LOW WAGE INDEX HOSPITAL POLICY

In October 2024, CMS issued an interim final rule in response to litigation announcing the termination and phase out of the low wage index hospital policy. For FY 2027, CMS proposes to continue a phase-out through a narrow transitional exception for low wage index hospitals significantly impacted by the discontinuation of the low wage index hospital policy.

<u>Comment</u>: **UnityPoint Health supports the intent of the low wage index hospital policy, is disappointed in the litigation's outcome, and agrees with CMS' transitional policy**. With hospital payment not keeping pace with labor and inflationary expenses, hospitals within the lowest quadrant are particularly hard hit. We encourage CMS to continue to evaluate policies to address wage index disparities that will promote the fiscal wellbeing of hospitals serving rural and underserved populations. We question whether these policies should be applied in a budget-neutral manner, which limits potential solutions and relies on a false assumption that other hospitals are overpaid.

LOW-VOLUME HOSPITAL PAYMENT ADJUSTMENT

In the absence of Congressional action, the low-volume hospital payment adjustment sunsets after December 21, 2026. 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 more than 25 road miles.

<u>Comment</u>: **Without Congressional action, UnityPoint Health is concerned about the changes to the low-volume adjustment criteria and how it will affect small rural hospitals and their communities**. UnityPoint Health has two[1] "tweener" hospitals that qualify for the low-volume adjustment under both the 2011 and 2019 criteria. These hospitals have discharges between 200 and 1,600 annually. *If eligibility reverts to FY 2005 criteria, Medicare payment will drop by over $850,000 for each hospital*. These hospitals already have thin operating margins, and this loss from their largest payer will make it difficult to sustain current

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

service offerings. **Retaining the 2019 criteria[2] is crucial to support healthcare access in rural areas.**

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. Unless Congress reauthorizes this demonstration, participating hospitals will term out of the program in a tiered fashion through June 2028.

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. This program has expired; however, the Iowa Congressional delegation is championing its reauthorization – Senator Chuck Grassley (IA) along with 15 cosponsors led passage of the bipartisan Rural Community Hospital Demonstration Reauthorization Act (S. 4460); and Congressman Randy Feenstra (IA-04) introduced the bipartisan companion reauthorization bill (H.R. 8967) with 16 cosponsors, including Congresswoman Mariannette Miller-Meeks (IA-01), Congresswoman Ashley Hinson (IA-02), and Congressman Zach Nunn (IA-03). **UnityPoint Health strongly supports the continuation of this program.**

Assuming the program is reauthorized, we offer the following recommendations for improvement:

- *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. In its advisory role, we encourage the agency to recommend permanence. It is our understanding that there were more applicants than slots during the last application round demonstrating an interest and need for this program.
- *Sole Community Hospital Participant Financial Stability*. For Sole Community Hospital (SCH) participants, CMS should incorporate 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)*. 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)

[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.

Reduction Program; Hospital Readmissions Reduction Program (HRRP); and the Medicare Promoting Interoperability (PI) Program. Each has 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. For HVBP, HAC, and HRRP, CMS is proposing to add Medicare Advantage (MA) patients and shorten the performance period from 3 years to 2 years. **UnityPoint Health applauds CMS for this holistic approach across quality programs. It is easier to track and monitor programs when consistent framework is used**. In particular, we appreciate that CMS is aligning the patient scope to include all Medicare patients and lessening the performance period as a reduction in burden; however, **UnityPoint Health urges CMS to stratify and monitor MA versus FFS beneficiaries in impacted measures** as MAO coverage and reliability of MA encounter data will now influence FFS quality penalties and payment adjustments.

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

- Limit Annual Measure Changes and Provide Realistic Implementation Timeframes. **UnityPoint Health urges 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, and several measures from last year are still undergoing resource-intensive training, testing, and implementation. We appreciate the exercise of restraint in minimizing overall changes.
- Continue to Streamline the Single All-Inclusive Tracking Report for Quality Data Submission. UnityPoint Health applauds CMS' efforts to streamline and improve quality tracking with recent tools, including dashboards and detail view. **For Overall Star Ratings, UnityPoint Health requests that CMS consider providing quarterly Preview reports in CVS and Excel formats and Overall Star Ratings under the Measure Detail View in Excel formats**. While a PDF version is user friendly on the front end and easy to read, it is not ideal for analyses and side-by-side comparisons as we seek to improve patient care.
- Involve EMR and software developers in pre-rulemaking measurement development. Providers are frequently at the mercy of EMR vendors and software developers to timely implement CMS quality program changes. In certain instances, workarounds and manual abstraction must occur as data cannot be captured as envisioned by CMS. Whether through internal hiring or external consults, **UnityPoint Health requests that CMS embed health information technology expertise within the rulemaking process for quality measurement.**

Specific Measure and Reporting Suggestions: Our clinical excellence team has also identified other quality reporting issues that, while not referenced in this proposed rule, add to administrative burden or do not support clinical best practices.

- Healthcare-Associated Infection (HAI) measure exception submissions: As of January 1, 2026, acute care hospitals are required to report CAUTI Standardized Infection Ratio Stratified for Oncology Locations (CAUTI-Onc) and CLABSI Standardized Infection Ratio Stratified for Oncology Locations

(CLABSI-Onc) data on patients being treated in locations mapped as NHSN "oncology wards." For hospitals without specific oncology units, CMS requires annual submission of a measure exception form signed by the hospital CEO for HAI data submission for these measures. This annual exception filing triggers a reporting exception for CAUTI-Onc and CLABSI-Onc and any data reported from non-required units in CDC's NHSN will not be submitted to CMS. Oncology hospital unit designations rarely change, and this annual filing is an unnecessary administrative task for most hospitals. **As a reduction in regulatory burden, UnityPoint Health encourages CMS to consider a measure exemption form for CAUTI-Onc and CLABSI-Onc to be evergreen unless the NHSN mapping changes**.

- SEP-1 (Severe Sepsis and Septic Shock Early Management Bundle) abstraction guidance (version 5.18): For documentation of the presence of severe sepsis, there must be documentation of an infection, two or more manifestations of systematic infection according to the Systemic Inflammatory Response Syndrome (SIRS) criteria, and organ dysfunction. For infection documentation, **UnityPoint Health is concerned and opposes the inclusion of "documentation of an infection is within a radiology report (e.g., Xray report, CT report, etc.)," without considering other clinical or physician documentation**. The use of imaging findings as time zero in the sepsis bundle is ill-conceived for several reasons:
    - *Radiology Reports Do Not Constitute Clinical Diagnosis* - Radiology interpretations are inherently limited to imaging findings and are typically framed as differential considerations (e.g., "possible pneumonia," "cannot exclude infection"). Radiologists do not directly evaluate the patient, integrate bedside findings, or assess clinical trajectory. As such, their reports are appropriately qualified and routinely recommend clinical correlation. Equating these reports with definitive documentation of infection elevates hypothetical or provisional impressions to the level of clinical diagnosis, which is inconsistent with standard medical practice.
    - *High Risk of False Positives and Sepsis Over-Identification* - Allowing radiology findings alone to establish infection introduces systematic risk of overdiagnosis, particularly in common inpatient scenarios such as:
        - Pulmonary edema from heart failure misinterpreted as possible pneumonia
        - Atelectasis is described as "early consolidation"
        - Chronic or inflammatory lung changes labeled as "cannot exclude infection"

      These findings are frequently nonspecific and non-diagnostic, yet under the current guidance, may inappropriately trigger inclusion in the sepsis measure.
    - *Misalignment with Accepted Sepsis Definitions* - Current clinical standards (Sepsis-3) require a clinician's suspicion of infection in conjunction with organ dysfunction. Imaging findings alone does not meet this threshold without integration of clinical examination, laboratory data, and overall patient context. This guidance substitutes imaging suggestion for clinical judgment, which risks undermining the validity of the measure.
    - *Inaccurate and Artificial "Time Zero" Assignment* - The recommendation to use the radiology report time to establish infection timing introduces potential inaccuracies. Of concern, these

reports may (1) precede clinician awareness or suspicion; (2) create artificially early "time zero" points; and (3) lead to false SEP-1 failures despite timely and appropriate care. This disconnect reflects a documentation artifact rather than true clinical delay.

- *Lack of Clinical Accountability* - Radiologists do not initiate sepsis management, reassess patients longitudinally, or make treatment decisions. Assigning diagnostic weight to radiology interpretations without corresponding clinical responsibility is inconsistent with how sepsis is recognized and managed at the bedside.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

The Hospital IQR Program is a pay-for-reporting quality program. CMS proposes to (1) adopt three new measures in FY2027; (2) adopt five modified mortality rate measures in the FY2028 payment determination in which MA patients will be included and the performance period will be reduced to 2 years; (3) modify three excess dates in acute care after hospitalization measures in the FY2028 payment determination in which MA patients will be included and the performance period will be reduced to 2 years; and (4) remove three measures in the FY2030 payment determination. Additionally, CMS proposes changes to the data reporting and submission requirements for certain electronic clinical quality measures (eCQMs) *and structural measures.*

Comment: The sheer number of proposed changes for this program alone is administratively burdensome and includes significant changes to EMR reports with associated software vendor resources. We support the removal of measures. We also offer specific measure input as follows:

- Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes measure beginning with the FY 2029 payment determination. **UnityPoint Health believes adoption of this EDAC measure is premature**. This measure has not been reviewed by a Measure Applications Partnership (MAP) workgroup or endorsed by a Consensus-Based Entity (CBE). In its current form, there were concerns expressed by Blue Cross Blue Shield of America, Aspirus Health, Vizient Inc., American Medical Association, Society for Hospital Medicine, and Kansas Hospital Association – many of which appear unanswered in this measure.[3] In comparison to other EDAC measures, we believe this diabetes measure will be more challenging given the range of patient complexities and co-morbidities, the variety of complications and specialists that may be associated, and a hospital's lack of control over post-acute care. This also has the potential to disproportionately impact areas with provider shortages, particularly rural areas where travel barriers thwart even the best discharge plans.

- Hospital Harm-Postoperative Venous Thromboembolism eCQM beginning with the FY 2030 payment determination. We appreciate that this measure replaces two eCQMs; however, it lacks support from the pre-rulemaking committee. **UnityPoint Health is also not convinced that this measure will be adequately captured in the eCQM framework**, as this condition may be treated at different hospitals and by different, independent providers.

- Advance Care Planning eCQM beginning with the FY 2030 payment determination. **UnityPoint**

[3] https://p4qm.org/prmr-measures/muc2025-053

Health agrees with the measure rationale and the evidence-based benefits of Advance Care Planning (ACP). From an operational standpoint, this patient-based eCQM is a true/false measure and is reported by a hospital as the proportion of eligible patients who have ACP sufficiently documented in the medical record. As proposed, it is a complex measure that will take time for EMR developers to create and test logic, clinicians to be trained, and hospitals to perform validity testing. We appreciate the implementation delay. This measure omits criteria for determining whether ACP documents are current, creates challenges for short-stay patient documentation, and for situations in which an ACP discussion occurred but the patient declined ACP decisions, disregards patient choice and punishes hospitals. **UnityPoint Health recommends that short-stay or declining patients be removed from the measure denominator**.

- Hospital Harm eCQMs mandatory reporting after two years of self-selected reporting status. The intent is to replace claims-based measures, like Patient Safety and Adverse Events Composite (PSI 90), with eCQMs. This is an aggressive timeline for transitioning all Hospital Harm eCQMs. Although CMS cites 12 years of progressive reporting experience for hospital with eCQMs, not all hospitals have reported similarly. Additionally, it should be noted that eCQM reporting relies on accurate mapping and documented workflows which cannot be posthumously fixed, unlike fixes to PSI measures. **UnityPoint Health encourages CMS to consider an extended timeline** for mandatory reporting to enable technical changes and accurate data capture for eCQM reporting.
- Maternal Morbidity Structural measure. CMS proposes an additional “yes” attestation requirement – submission of the identity of the perinatal quality collaborative program the hospital participates in. **UnityPoint Health supports** this submission requirement.

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS proposes to adopt the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure beginning with an applicable period of July 1, 2025, to June 30, 2027, for the FY 2029 program year.

Comment: Most hospitals, including at UnityPoint Health, have clinical initiatives aimed at preventing and curbing sepsis and it is an ongoing priority. UnityPoint Health appreciates that the measure’s scoring methodology is unchanged, which helps with predictability. That said, **UnityPoint Health believes the use of national benchmarks for sepsis is a flawed approach.** Low-volume hospitals can be overly disadvantaged from a single sepsis case. Instead of a national benchmark, CMS should consider using a standard low threshold percentage or shift to an improvement framework in which hospitals are compared to their own performance – either showing improvement, or in cases of high performance, maintaining excellence. CMS has proposed “early look” reports for FY2028 with pay-for-performance occurring in FY2029. **UnityPoint Health supports the “early look” reports but requests that CMS consider extending this for 2 years** to enable a runway to analyze the data and implement improvements from the first report.

In the PI Program[4], CMS requests stakeholder input on the inclusion of drugs administered during a

[4] See our response narrative under “MEDICARE PROMOTING INTEROPERABILITY (PI) PROGRAM” on page 10

hospitalization within the electronic prior authorization measure. In the treatment of sepsis, time is of the essence and requiring a prior authorization before administering medication during a hospitalization is nonsensical. We raise this issue here as an example of the siloed approaches taken within the various quality programs. While we value CMS ongoing efforts to streamline measurement and reporting, we question how this expanded PI measure would further advance the reduction of hospital readmissions.

QUALITY PROGRAM REQUESTS FOR INFORMATION

CMS solicits comments on (1) potential use of the Emergency Care Access and Timeliness eCQM in the inpatient setting; (2) potential use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure; and (3) updating the scoring methodology associated with the Birthing Friendly Hospital designation.

Comment: Thank you for soliciting stakeholder input.

Emergency Care Access and Timeliness measure: CMS seeks input for potential inclusion of a measure on occupancy and boarding rates in emergency departments within both the Hospital IQR and HVBP programs. While we believe this eCQM measure is conceptually sound in the Hospital Outpatient Quality Reporting (OQR), we have already indicated that the measure needs a two-year implementation runway to assure smooth transition from a chart-abstracted measure and to conform workflows with arbitrary CMS timeframes.[5] **As proposed, it is duplicative with the Hospital IQR**, and UnityPoint Health does not support making this measure more complex by bifurcating this measure between patients admitted during their stay and those who were not admitted. There are numerous root causes for ED boarding but simply recording the amount of wait time does not identify or address those causes. It also does not account for whether those delays are systemic or cyclical. It is too early to be implementing an inpatient measure before the outpatient measure has been evaluated or even started.

Adult Community-Onset Sepsis Standardized Mortality Ratio measure: CMS seeks input for potential inclusion in the Hospital IQR Program. While CMS has requested input on operational and policy considerations, **UnityPoint Health believes the proposed measure has substantive validity issues**. We encourage CMS to consider revising the nominator and denominator definitions and the risk adjustment model.

- *Inclusion of Hospice Discharge in the Outcome Measure* - The inclusion of observed/predicted discharge to hospice in the numerator/denominator alongside in-hospital mortality is problematic and may misrepresent quality of care. In routine clinical practice, discharge to hospice frequently reflects appropriate, goal-concordant care decisions for patients with advanced or terminal illness, rather than a treatment failure. Many patients discharged to hospice have underlying, end-stage conditions (e.g., advanced malignancy, severe neurodegenerative disease), where sepsis may represent a terminal event but not the primary driver of prognosis. By categorizing hospice discharge equivalently to mortality, hospitals that appropriately engage in early goals-of-care discussions may be inadvertently penalized, and this measure may disincentivize patient-centered decision making, including timely transition to palliative care.

[5] See UnityPoint Health response to CMS-1834-P, page 11 – Regulations.gov tracking number, mfl-l2we-d1b6

- *Insufficient Consideration of Socioeconomic Determinants of Health* - The current risk-adjustment model includes important clinical variables (e.g., comorbidities, vital signs, laboratory values) but does not appear to adequately account for socioeconomic status or social determinants of health. Extensive evidence demonstrates that socioeconomic status significantly influences:
  - Timeliness of presentation (e.g., delayed care due to access barriers);
  - Baseline health status and comorbidity burden;
  - Health literacy and adherence to treatment recommendations; and
  - Post-discharge resources and support systems.

  Hospitals serving underserved or economically disadvantaged populations may therefore exhibit higher observed mortality rates that are not reflective of care quality, but rather of structural inequities. Failure to incorporate socioeconomic status into risk adjustment risks penalizing safety-net hospitals, undermines the goal of fair and equitable performance comparisons, and may exacerbate healthcare disparities if used in payment programs.

Birthing-Friendly Hospital Designation: **UnityPoint Health supports this designation but has concerns with the proposed modifications**. We understand the desire to expand the designation to include outcomes measures in addition to a structural measure. At this point in time, CMS PC-02 (Cesarean Birth) and CMS PC-07 (Severe Obstetric Complications Electronic Clinical Quality Measure) are not ready for prime time. The data on these measures has been suppressed and not publicly reported. It would be premature to support any measures without being able to evaluate the national data and performance trends. As for the scoring methodology, CMS proposes four large peer groups. Although we generally support a peer-group approach, the use of delivery volume alone may not be a true differentiator of hospital maternal health resources and outcomes. In addition, we believe this tiered grouping combined with aggregated and weighted measures will make “predicting” outcomes and consistent public reporting difficult. This has implications for an icon rating system. Should CMS choose to move forward with a rating system, public outreach and education on the rating system will be necessary.

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

CMS does not propose additional changes to the HCAHPS survey.

Comment: UnityPoint Health agrees that the patient’s perspective is extremely important to capture to enable a patient's experience to be improved within the hospital. **UnityPoint Health continues to encourage CMS to shorten 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.

UnityPoint Health also remains concerned about patient survey fatigue due to the sheer number of surveys being asked of patients about their inpatient stay. Patients are answering multiple questions as part of their general admission process under the CoP requirements, 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 and Information Transfer PRO-PM. Additionally, private registries have developed. For hip and knee replacement data, the American Academy of Orthopedic Surgeons has the AAOS American Joint Replacement Registry (AJRR), which requires additional surveys at 30-, 60-, 90-, 150- and 300-day intervals. It is no surprise that HCAHPS survey response rates across the nation are trending downward.

MEDICARE PROMOTING INTEROPERABILITY (PI) PROGRAM

CMS proposes to (1) Update the definition of CEHRT; (2) remove ONC Direct Review and ONC-Authorized Certification Body (ONCACB) Surveillance attestations; (3) remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures; (4) modify the Electronic Prior Authorization measure; (5) modify the reporting requirements for the Public Health and Clinical Data Exchange objective; (6) adopt two new eCQMs beginning with the FY 2030 payment determination to align with the Hospital IQR program; and (7) remove three eCQMs beginning with the FY 2030 payment determination to align with the Hospital IQR program.

Comment: Overall, **UnityPoint Health recognizes and supports CMS efforts to standardize and streamline health information technology requirements**. The ONC Health IT Certification Program should align with the PI program and we applaud these changes. CMS does streamline reporting by eliminating the ONC Direct Review and ONCACB Surveillance attestations. Similarly, the removal of the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures is duplicative of Trusted Exchange and Common Framework (TEFCA) as well as portability and access CoP requirements. When CMS eliminates duplicative measures, stakeholder messaging is important to reinforce that requirements still exist and overall operational expectations remain unchanged – i.e., the need to update, send, and reconcile clinical information still exists. Additionally, we understand the agency's desire to transition receipt of Fast Healthcare Interoperability Resources® (FHIR®)-formatted data; however, this should not be done prematurely and until it is a standard across all healthcare. While hospitals may be early adopters of advanced technology, other providers that hospitals share discharge data with, such as nursing facilities and physical therapy groups, may not have EMRs with FHIR-formatted data capabilities.

In terms of the updates to the Electronic Prior Authorization measure, we appreciate the clarifications, support revisions to the definitions, and are pleased that CMS is aligning requirements with Health IT certification requirements. We also support its status as a bonus measure for the CY 2027 EHR reporting period. CMS requested input on expanding this measure to include prior authorization for drugs administered during the hospitalization. **UnityPoint Health vehemently opposes adding prior authorizations for medications administered during an inpatient stay**. This becomes problematic during urgent emergent treatment and will (not "may") slow down and/or impede care in all cases. This interjects potential liability risks for delayed treatment and alternatively administrative penalties and/or reimbursement consequences when a medication was not authorized but was lifesaving or clinically impactful. From an operational perspective, many hospitals/providers use a third-party verification process for the Prescription Drug Monitoring Program, and prior authorizations would introduce additional complexity and third-party liability risks, especially when numerator-denominator values must

be reported. For supplies used to administer medications, it is unclear how prior authorizations may impact those. Overall, CMS should not require additional administrative steps prior to delivering direct inpatient care and bedside clinical judgment.

REQUEST FOR INFORMATION: MEDICARE PI PROGRAM

Should CMS choose to adopt the Unique Device Identifiers (UDI) for Implantable Devices Measure, CMS seeks further information on future measure modifications.

Comment: We support the concept that when "valuable data are captured at the point of care and available for subsequent exchange and use by health care providers," health care safety and quality can be advanced. Likewise, it would seem a reasonable goal to promote the routine, electronic capture and discrete storage of UDIs for implantable medical devices. As proposed, the measure is meaningless – allowing both a "yes" and "no" attestation to "allow eligible hospitals and CAHs to become familiar with the concept of UDI and highlight its importance while avoiding undue burden." In the future, CMS intends to modify the measure's UDI definition as well as the attestation requirement. **UnityPoint Health suggests that CMS delay this "placeholder" measure until it can define a more specific phased-in approach to implementation**.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

CMS proposes several updates to the TEAM model, including: (1) adding a Medicare Severity Diagnosis Related Groups (MS-DRGs) that would initiate a spinal fusion anchor hospitalization; (2) clarifying quality measure performance periods for certain quality measures; (3) using a rolling historical Composite Quality Score (CQS) baseline period for certain quality measures; (4) adding an Ambulatory Payment Classification (APC) and MS-DRG update factor to target prices; and (5) using the full baseline period to construct the prospective normalization factor.

Comment: UnityPoint Health has two Iowa hospitals participating in TEAM – Finley Hospital in Dubuque and St. Luke's Hospital in Cedar Rapids. From 2022 to 2024, Finley Hospital performed an average of 6,163 surgeries, 85.6% of which were outpatient; and St. Luke's Hospital performed an average of 12,154 surgeries, 78.4% of which were outpatient. Finley Hospital participates in TEAM Track 1, and St. Luke's Hospital participates in TEAM Track 3.

UnityPoint Health offers general model feedback first before reacting to the specific modifications proposed to TEAM.

GENERAL FEEDBACK: **TEAM participation has been a heavy operational and resource lift for our hospitals.** TEAM requires mandated participation in five diverse episodic payment bundles. The hospitals selected for TEAM participation have varied experience with value-based payments and arrangements and differ widely in the number of identified episode procedures performed. TEAM requirements involve detailed financial modeling, workflow revisions, and specialist and post-acute care outreach, which are not consistent across TEAM episodes. While the CMMI overview materials and webinars produced in 2024 and 2025 were helpful in our overall understanding of the program's intent, UnityPoint Health still needed to hire external consultants to assist in our timely implementation.

As CMMI and CMS consider future mandatory models, UnityPoint Health recommends:

- EMR vendor pre-work: Prior to launching new models, **CMS/CMMI should engage with an EMR vendor workgroup to determine IT build framework and analyze work effort**. Detailed financial white papers and attribution / overlap framework for new models have historically been released without sufficient time to build workflows and accurately capture data for mapping and reporting.
- Precursory data sharing agreements and exchanges: **CMS/CMMI should enter into DUA agreements at least three full months prior to the model start date and engage in interactive data exchange.** This would familiarize Model Participants with data feeds and reports prior to model go live. We are well within the second quarter of TEAM and Participants are still experiencing data integrity issues (e.g., late, inaccurate, and changing formats of files and reports), which make it difficult to manage operations and monitor performance.
- Broad public notice outside annual payment rules: **UnityPoint Health suggests that CMS publish new mandatory payment models outside annual calendar year or fiscal year payment rules**. For TEAM (as well as CJR-X), CMS chose to embed a new mandatory model within the annual IPPS payment rule. Although it is the hospital who is the TEAM Participant and is ultimately responsible for model performance, the duration of this episodic payment model extends beyond the inpatient and/or outpatient stay. For TEAM, the 30-day episodes also involve providers, specialists, and post-acute providers and facilities. These other healthcare providers/entities are not necessarily put on notice of new mandated requirements when it is not published in their siloed annual payment rule. Rather by placing a new mandatory model within IPPS, the hospital is not only CMS' de facto agent responsible for managing all patient outcomes, costs, and experience for 30 days, but hospitals also become responsible for CMS provider outreach and coordination. As TEAM Participants were attempting to learn a new model, they were also charged with aligning and educating other providers.
- Participant benefits vs. burden: In TEAM, the random selection of geographies forces a subset of vital community hospitals to test an alternative payment model. When CMS announces a new mandatory model, Participants generally do not view this as a "win" or the coveted "golden ticket." **While UnityPoint Health has been an early adopter of value-based arrangements, we generally oppose mandatory models that "randomly" select Participants.** The resources diverted to mandatory models are significant and may not align with community needs, clinical priorities, or financial capabilities. 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 mandate. Additionally, benefits can and should include regulatory waivers and programmatic flexibilities for mandated participation and for taking on risk. CMS must strive to create a clinical and payment framework that fosters excitement from providers, not saddle them with burdens that place them in disadvantaged positions compared to similarly situated but non-selected providers.

For TEAM specifically, UnityPoint Health suggests that CMS consider:

- Model website and portal functionality: **CMS should implement user-friendly tools** that enable easy navigation and content retrieval across its website and portal. This includes features such as

a searchable interface, clear status tracking for user requests (e.g., inquiries submitted through a shared mailbox), and transparent versioning by dating updates to posted materials, such as FAQ documents.

- Voluntary participation by hospitals affiliated with mandated Participants from integrated healthcare systems: Aside from randomly selected TEAM Participants, the TEAM model only permitted BPCI-A Participants to opt into TEAM. If intended to create a comparison group, this methodology is flawed. For integrated healthcare systems comprised of multiple hospitals (often across multiple states), there are often enterprise-wide efforts and investments to standardize clinical operations. For UnityPoint Health, we disseminate clinical best practices across our markets. When TEAM is being mandated in two of our eight markets, it is not practical or efficient to operate those markets differently. We would posit that if TEAM is a preferred model, **CMS should encourage and permit voluntary opt in annually, particularly for other hospitals affiliated with TEAM Participants**.
- Self-selection of individual clinical episodes: TEAM episodes are dissimilar, require different workflows, processes and specialist engagement, and equate not to just one mandated program but to five individual programs. **CMS should allow TEAM 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**. Or at least allow these episodes to be phased in as pay-for-performance over a course of years. For instance, CMS could allow Participants to self-select three episodes for pay for performance starting in PY 2 and expanding to all five episodes not later than PY 4. 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. A phased-in approach would reduce this burden.
- Staged knee replacement surgeries: Lower Extremity Joint Replacement category does not allow for a staged knee replacement surgery within the initial 30-day episode. **The timing for staged knee surgeries should not be dependent upon agency regulation** but rather upon the patient's health status and circumstances and the provider's clinical judgment and discretion. A shorter time between surgeries can facilitate shorter down time and better coordination of post-surgical services. For patients wanting a short turnaround, waiting for a CMS payment episode to conclude is a dissatisfier and we have had to change our workflow to accommodate this.
- Include benefit enhancements for post-discharge home visits: UnityPoint Health encourages CMS to embed benefit enhancements within TEAM to promote operational flexibilities. TEAM includes episodes of care categories that target a reduction in post-acute care costs. Medicare ACO models housed in CMMI and dating back to the Next Generation ACO Model have tested Post-Discharge Home Visits. UnityPoint Accountable Care has tested and utilized this benefit enhancement to improve quality outcomes. **TEAM Participants should have the option to provide Post-Discharge Home Visits like those currently available to REACH ACO Participants and proposed for LEAD and CJR-X Model Participants**.
- Minimum volume threshold: TEAM has a minimum baseline threshold of at least 31 episodes in a

given episode category. BPCI-Advanced had a 41-episode threshold per clinical category. **UnityPoint Health does not understand why CMMI lowered the BPCI-Advanced threshold, and in fact, we would recommend that CMS consider a higher threshold** to ensure statistical significance as well as savings from economies of scale. Currently the minimum threshold does not even equate to one procedure per month. In addition, low-volume Participants are more susceptible to adverse quality outcomes from just one outlier case (such as a readmission).

- Beneficiary risk adjustment: **UnityPoint Health recommends that CMS expand the TEAM 180-day lookback period for beneficiary risk adjustment to at least 12 months to ensure accurate capture of beneficiary clinical complexity.** The lookback period should also include the anchor procedure itself. While the 180-day approach represents an improvement over shorter windows, it remains insufficient to capture chronic conditions for beneficiaries with low or intermittent utilization. This limitation results in systematic understatement of true clinical risk and, consequently, inaccurate benchmarking.

  The current approach also relies heavily on pre-operative and episodic encounters to capture comorbidities, which is misaligned with clinical practice. Primary care and specialty visits immediately preceding surgery are not designed to comprehensively document all chronic conditions, nor is it appropriate to expect procedural specialists to code non-relevant conditions for risk adjustment purposes. In addition, the 180-day window is inconsistent with the cadence of annual wellness visits, where diagnoses are typically comprehensively captured once per year. As a result, beneficiaries receiving procedures later in the year may have relevant conditions fall outside the lookback period, leading to artificially lower risk scores driven by timing rather than true health status.

  Expanding the lookback period to at least 12 months would better align with real-world coding practices, improve capture of persistent, outcome-relevant conditions, and produce more stable and predictable benchmarks. Concerns that a longer lookback could reduce the eligible population should not outweigh the need for methodological validity. Other payers routinely apply varying eligibility and lookback windows (e.g., 6 vs. 12 months) based on clinical appropriateness. CMS should similarly adopt a more flexible framework rather than constrain the model in a way that jeopardizes accuracy.

FEEDBACK ON PROPOSED TEAM MODIFICATIONS:

Spinal Fusion: *Starting on October 1, 2026, MS-DRGs 523, 524, and 525 would be added to the spinal fusion episode category.*

CMS seeks to add three MS-DRGs on extensive or complex spinal fusion procedures in order to initiate a spinal fusion anchor hospitalization. **UnityPoint Health recommends that CMS refrain from adding new codes in the midst of a performance year** and instead add at the start of Performance Year 2 – January 1, 2027.

CJR-X overlap and attribution: *CMS proposes that TEAM Participants will be excluded from CJR-X. However, in situations where a TEAM episode begins during the CJR-X 90-day post-discharge period, those procedures would be included in the CJR-X episode and not trigger a TEAM episode.*

UnityPoint Health supports allowing TEAM to supersede CJR-X when the models overlap, with the exception CMS identifies where a TEAM episode occurs during a CJR-X episode.

Composite Quality Score (CQS): *CMS proposes to switch of a sliding historical CQS baseline methodology and aligning CQS baselines periods with CMS hospital reporting timeframes. In addition, Hospital Harms measures are transitioned from claims-based PSI-90 reporting to eCQMs in advance of the Hospital IQR Program timeline.*

CQS represents a combination of seven potential measures. There are three measures in Performance Year (PY) 1, five measures in PY2, and six measures in PY3 through PY5. **UnityPoint Health appreciates having advanced notice of these measures but would have preferred a static measure set for the duration of the model**.

Hospital Harm (HH) measures: Starting in PY 2, the measure set includes HH—Falls with Injury (CMIT ID #1518) and HH—Postoperative Respiratory Failure (CMIT ID #1788). In PY1, both HH measures were included in the PSI-90.[6] The TEAM introduction of HH measures in 2027 contradicts the IPPS "two-year bridge" from self-selected measure status to mandatory reporting in 2028 for these same measures. **The early mandated adoption of untested eCQMs places additional resource burdens on TEAM Participants.**

Patient Reported Outcome-Based Performance Measures (PRO-PM): CMS proposes to add the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) to the TEAM quality measure set. This measure would join the TKA/THA PRO-PM as the second TEAM PRO-PM.

(1) THA/TKA PRO-PM measure (CMIT ID #1618). The Risk-Standardized Patient Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty is required in all five PYs of TEAM, is also an existing measure within the Hospital OQR and ASC Quality Reporting programs and is proposed for the CJR-X Model. **UnityPoint Health has consistently provided input on the operational challenges when surveying patients pre- and post-surgical events. This measure is overly burdensome, is limited to a subset of patients, and lacks exclusions for small sample sizes**. Challenges include:

- Measure definition: The denominator includes four sources of data – PRO-PM, claims data, enrollment data, and Census Bureau survey data. **Multiple data sources inherently create complexities and undue burdens** to avoid the potential for mismatched patient information.
- Multiple surveys: **Patients are potentially surveyed multiple times** during a year under the PRO-PM, which presents challenges for administering the survey pre- and post-procedure. Post-acute surveys often fall outside the purview of the TEAM Participant. When surgeries are performed under the auspices of independent physicians with the TEAM Participant serving as the site of service, TEAM Participants become the reporting agent for locums. TEAM Participants become the de facto reporter for pre- and post-surgical outcomes that are not centrally located within one EMR or even be available across platforms. The measure also requires a follow-up care survey after a 300-day window. This long window from the reference point may create confusion and

[6] Hospital Harm—Falls with Injury (PSI 08) and Hospital Harm—Post-Respiratory Failure (PSI 11)

inaccurate responses and may also conflict with the distribution of CAHPS surveys.

- Data collection and tracking: Aside from TEAM Participants 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 EMR or even be available across platforms. Given current state, TEAM Participants will also incur a cost to manage and report this data.

- Patient experience: Like the Information Transfer PRO-PM, **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. 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.

(2) Information Transfer PRO–PM measure (CMIT ID #1797). The purpose of this nine-question, three-domain survey is to assess a patient's understanding of clear and personalized recovery information after a facility-based outpatient procedure or surgery. It is proposed to be administered in days two through seven post-procedure.

Although this is currently within the Hospital Outpatient Quality Reporting (OQR) Program, UnityPoint Health believes the Information Transfer PRO-PM measure should be incorporated into the OAS CAHPS survey and not be a separate measure/instrument. Information Transfer PRO-PM is duplicative and creates unnecessary administrative burden, including additional costs related to third-party vendor distribution. As CMS continues to push out patient surveys, this exacerbates "survey fatigue" that is commonplace within the patient experience. The Information Transfer PRO–PM is not just a separate survey, but it overlaps the OAS CAHPS survey. For some patients like those with a total hip or knee arthroplasty (THA/TKA) procedure, this is a third survey.[7] The duplication involves both content and timeframe. For content, the domains are covered in OAS CAHPS survey; and for timeframe, the post-procedure timeframe conflicts with the paper OAS CAHPS survey and a THA/TKA PRO-PM survey.

REQUEST FOR INFORMATION: TEAM

CMS solicits comments on (1) future inclusion of Ambulatory Surgical Center (ASC) episodes; and (2) potential voluntary participation of physician-owned hospitals.

Comment: UnityPoint Health limits our input to the future inclusion of ASC episodes. **CMS will need to carefully consider implications for a shared savings model in this setting of care.** One challenge is that while the procedures may be the same, the patient population is not. ASC patients are generally younger, less complex, healthier, lower-risk beneficiaries. Another challenge may be that ASCs lack episodic volume

[7] For patients with providers participating in the AAOS American Joint Replacement Registry (AJRR), additional surveys at administered at 30-, 60-, 90-, 150- and 300-day intervals.

for several selected TEAM categories. And finally, the CMS ASC Quality Reporting Program is pay for reporting. The readiness of ASCs to accept downside risk and to successfully report outcomes given the measure set disparities between the TEAM and ASC Quality Reporting programs may present obstacles to model performance.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT EXPANDED (CJR-X) MODEL

CMS proposes to expand CJR nationally in FY 2028. CJR-X would be a mandatory 90-day episode-based payment model for hospitals performing lower extremity joint replacement (LEJR) as an inpatient or outpatient surgery and in all states and U.S. territories, except for Maryland and TEAM participants. CJR-X would include five quality measures, a regional risk-adjusted target price that includes capped normalization and trend factors, policies for low-volume or dual-eligible hospitals, and beneficiary-identifiable and regional aggregated data sharing. Additionally, CJR-X would be considered an Advanced Alternative Payment Model (A-APM) via a CEHRT attestation process..

Comment: Except for limiting ankle replacement to inpatient in the CJR-X Model, TEAM and CJR-X have the same LEJR episode definition but diverge in terms of episode length (30 days vs. 90 days). While there are other subtle model differences, most model attributes are similar and the rationale for testing dual tracks in different models is confusing – particularly when these models will apply to different hospitals within one integrated health system. **As the newest mandatory model, UnityPoint Health respectfully suggests that much of the input under the TEAM GENERAL FEEDBACK narrative is also relevant to the CJR-X Model**. As proposed, UnityPoint Health may have nine IPPS hospital TINs participating in this model.

Ratchet effect and price stabilization: *CMS acknowledges that episodic-based payment models have a "ratchet effect" over time – achieving lower spending penalizes Participants by resulting in lower target prices in subsequent years. CMS proposes to mitigate the "ratchet effect" through more frequent rebasing and setting regional target prices. Prices may be stabilized through trend adjustments*.

UnityPoint Accountable Care (UAC) has participated in Medicare ACO programs since their inception in 2012. Over time, UAC has experienced the "ratchet effect" in a Total Cost of Care shared savings program firsthand. As a mandatory episodic payment program with no end date relying on regional benchmarks and a discount, CJR-X will be a race to the bottom. CMS recognizing the "ratchet effect" is not akin to CMS fixing the "ratchet effect." The MSSP experiment with protective trends (ACPT) has been a disaster. UAC is a regionally efficient ACO with consistent high-quality rankings. Yet, in the absence of agency action, the flawed ACPT formula has provided no price stability and has completely eroded any shared savings that are driven back into beneficiary care. For CJR-X, we have seen the future and attempting to forecast trends will not work, will drive hospital Participants away from offering LEJR procedures, and ultimately will limit access and choice for beneficiaries.

When regionally efficient LEJR procedures are also high quality, CMS and the CRJ-X Model have succeeded. We endorse Premier's observation that these CRJ-X Participants should no longer be held to an achievement-based model but be transitioned to a spending containment model. And the recommendation – "Rather than relying on complicated prospective and retrospective trend adjustments to arrive at a regionally efficient price target, **CMS should consider a simple methodology such as setting the efficient price target at the 20th percentile of a regional benchmark**. Such a methodology is intuitively easier to understand and thus defensible."

<u>Model start date</u>: *CMS is proposing to begin the CJR-X Model on October 1, 2027.*

To conform with most hospital fiscal years that operate on a calendar year basis, **we request that CMS start this model at the beginning of the calendar year** – January 1, 2028, at the earliest. We also suggest that CMS institute a risk glidepath to allow pay-for-reporting in the first year, unless a hospital elects to take on down-side risk.

<u>Quality measures set</u>: *The proposed measure set is comprised of five quality measures. The complications domain is weighted at 50 percent, the patient experience domain is weighted at 40 percent, and the patient reported outcomes domain is weighted at 10 percent.*

The measure set includes two Hospital IQR measures - Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CMIT ID #350) and Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (CMIT ID #338). It also includes two Hospital OQR measures – Hospital Visits Within 7 days of Hospital Outpatient Department (HOPD) Surgery (CMIT ID #344, OP-36) and Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS) (CMIT ID #162). The fifth is a PRO-PM measure – Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome (PRO)-Based Performance Measure (CMIT ID #1618) – and is included in measure sets for Hospital IQR, Hospital OQR, ASC Quality Reporting, and TEAM programs. While derived from existing measure sets and a partial artifact of the CJR Model, **CJR-X measures differ significantly from TEAM and create confusion about how CMS defines quality for LEJR procedures**.

Similar to the financial benchmark "ratcheting effect," proposed scoring for the CJR-X measure set pits hospitals against each other – forcing winners and losers rather than seeking to improve overall quality outcomes for all beneficiaries. **This scoring construct is not meaningful or sustainable** when topped-out measures are included and may not represent the actual experience of the CXR-X episodes. We do appreciate that high quality performance may be rewarded through a discount factor reduction.

<u>Discount factor</u>: *CMS proposes a 2 percent discount, which may be adjusted downward through quality performance.*

UnityPoint Health appreciates lower discount factors for models in which participation is not voluntary. **UnityPoint Health also supports the approach of permitting quality performance to further lower the discount factor** and urges CMS to consider this framework for other value-based models.

<u>Low-volume threshold</u>: *CMS is proposing to define "low-volume hospital" as a hospital with fewer than 31 LEJR episodes performed during the baseline period.*

Reiterating from our TEAM narrative, BPCI-Advanced had a 41-episode threshold per clinical category. **UnityPoint Health does not understand why CMMI lowered the BPCI-Advanced threshold, and in fact, we would recommend that CMS consider a higher threshold** to ensure statistical significance as well as savings from economies of scale. Currently the minimum threshold does not even equate to one procedure per month. In addition, low-volume Participants are more susceptible to adverse quality outcomes from just one outlier case (such as a readmission).

<u>Risk adjustment</u>: *CMS proposes to use an 180-day lookback period for beneficiary risk adjustment.*

UnityPoint Health encourages CMS to consider a 365-day lookback period. Our rationale is provided in the TEAM narrative.

Model overlap: *CMS proposes that TEAM Participants will be excluded from CJR-X. However, in situations where a TEAM episode begins during the CJR-X 90-day post-discharge period, those procedures would be included in the CJR-X episode and not trigger a TEAM episode.*

UnityPoint Health supports allowing TEAM to supersede CJR-X when the models overlap, with the exception CMS identifies where a TEAM episode occurs during a CJR-X episode.

Beneficiary notifications: *CMS proposes that every beneficiary must receive written notification of their inclusion in the model prior to discharge. Moreover, CMS proposes that participants provide beneficiaries with written notifications about any sharing arrangements with CRJ-X collaborators.*

UnityPoint Accountable Care echoes the sentiments contained in the Premier comment letter – "Experience with beneficiary notification requirements in the Medicare Shared Savings Program (MSSP) shows us that these notifications only confuse beneficiaries and serve little value, while taking up tremendous hospital resources to comply."

UnityPoint Health wholeheartedly joins Premier in its strong opposition to these proposed beneficiary notifications. As a mandatory model, the duty to notify beneficiaries should fall on CMS. Minimally, CMS should supply hospitals with standard templates, language, and protocols related to beneficiary notification. Preferably, CMS should distribute these notifications to ensure uniform communication. This is a significant Medicare change and informing beneficiaries should not be delegated to hospital Participants.

NURSING AND ALLIED HEALTH EDUCATION PROGRAMS

CMS proposes to continue the existing capped Medicare Advantage nursing and allied health education payment pool. Additionally, CMS proposes the addition of numerous compliance and cost-reporting requirements.

Comment: Allen College is a degree-granting institution affiliated with UnityPoint Health, located in Waterloo, Iowa, and dedicated to preparing the next generation of nursing and allied health professionals. Established in 1925 as the Allen College of Nursing, the institution began as a diploma-based nursing program and has since evolved into a comprehensive academic provider. Today, Allen College offers a wide range of programs, including associate and bachelor's degrees in nursing, public health, and allied health disciplines (such as medical laboratory science, radiography, and therapy-related fields), as well as graduate and doctoral-level education across nursing and allied health professions.

Allen College is a member of the National Alliance for Nursing Education and supports its comment letter. As a provider-based nursing and allied health education program, Allen College plays a critical role in strengthening the nation's healthcare workforce infrastructure. However, as proposed, **this rule would introduce additional administrative burden, diminish appropriate recognition of legitimate educational costs, and create uncertainty regarding the status of approved programs**—potentially undermining the stability and effectiveness of provider-based education models.

Allen College and UnityPoint Health reiterate the National Alliance for Nursing Education

recommendations and respectfully urge CMS to:

1. Withdraw or substantially revise the proposed nursing and allied health net-cost calculation methodology.
2. Avoid mandatory componentization of "Administrative and General" and other overhead cost centers.
3. Preserve recognition of reasonable, properly documented indirect costs.
4. Reconsider the treatment of related-party educational and clinical training costs.
5. Narrow and clarify any new approval-related nondiscrimination or accreditation requirements.
6. Provide clear contractor guidance and practical documentation standards.
7. Delay implementation and apply any final changes prospectively only.

ORGAN ACQUISITION AND REASONABLE COST PAYMENT POLICIES

CMS proposes to codify Medicare's reconciliation of organ acquisition costs for non-renal organs for Independent Organ Procurement Organizations (IOPO) and Histocompatibility Laboratories. CMS clarifies and proposes to codify instructions on allowable costs under Medicare's reasonable cost principles for all provider types as well as Medicare's rules for allocating overhead costs across all provider types.

Comment: Iowa Methodist Medical Center, a senior affiliate of UnityPoint Health, is located in Des Moines, Iowa, has performed more than 1430 kidney-only transplants over the course of 30+ years, and is an Increasing Organ Transplant Access (IOTA) Model participant. As a kidney-only transplant center, the Iowa Methodist Transplant Center is a recipient of reconciled IOPO kidney costs. **UnityPoint Health and Iowa Methodist Transplant Center support CMS in its endeavor to prevent inflated non-renal organ procurement costs, implement standardized and reasonable cost principles for all organ procurement, and provide greater oversight of IOPO spending**. Transplant centers are cost takers – IOPO organ procurements costs are passed through to transplant centers. Overall procurement cost transparency and standardization will remove any incentives to shift non-renal organ acquisition costs to kidney acquisition cost centers on the Medicare cost report. Currently, organ procurement costs for cadaver kidneys vary widely among IOPOs[8] and have experienced exponential cost increases averaging more than $5,600 annually over the past 4 years (the prior 4 years averaged a $600 increase annually). We encourage CMS and OIG to:

- Monitor future cost growth and any cost center shifts that may occur as this proposal is implemented; and
- Examine any relationship between the OPTN Modernization Initiative with its performance standards and increased organ procurement costs.

[8] The procurement cost range has consistently been roughly double the lowest rate and trending upward. For December 1, 2018, procurement costs ranged from $28,000 to $55,000 – a 1.96% rate range; and in December 1, 2025, procurements costs ranged from $40,000 and $92,000 – a 2.31% rate range. Rates as reported by Palmetto GBA - https://palmettogba.com/jja/did/avzmal6447?cat=jja-facilities-and-organizations

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. The Consolidated Appropriations Act, 2026, extended this waiver program through September 30, 2030.

Comment: UnityPoint Health enthusiastically thanks Congress and CMS for their continued support of the Acute Hospital Care at Home waiver. We are pleased that this waiver program has been extended for 5 years. 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.

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 public health emergency to avoid exposure to and spread of the COVID-19 infection, its efficacy beyond the public health emergency 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 ACO 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
Executive Director, Government & External Affairs