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August 31, 2026

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-1810

RE: CMS-1850-P – Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots, published at Vol. 91, No. 128 Federal Register 41734-42032 on July 7, 2026.

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

Dear Administrator Oz,

UnityPoint Health appreciates this opportunity to provide comments on the proposed rule related to the Outpatient Prospective Payment System (OPPS) for Calendar Year (CY) 2027. UnityPoint Health is one of the nation's most integrated healthcare systems. Through more than 31,000 employees and our relationships with 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, 340B Health, and Premier, Inc. and generally supports their formal comment letters.** In addition, UnityPoint Health respectfully offers the following comments on select topics.

PAYMENT SYSTEM UPDATE

CMS proposes to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.4%. Additionally, CMS proposes to continue applying a 7.1% payment adjustment for rural Sole Community Hospitals.

Comment: While UnityPoint Health generally supports increases to the OPPS base rate, a 2.4% increase is insufficient and not sustainable. **This is particularly problematic should CMS choose to accelerate its 340B offset – equating to a -0.6% net increase for the majority of hospitals after adjustments.** As costs in healthcare supply and labor continue to grow, we request that CMS continue to review rates to reflect the current healthcare financial landscape more accurately.

UnityPoint Health supports the proposed adjustment for rural Sole Community Hospitals.

340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program allows safety-net providers "to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." The program requires pharmaceutical manufacturers to provide front-end discounts on covered outpatient drugs purchased by specified government-supported facilities that serve the nation's most vulnerable patient populations.

Comment: As a large nonprofit, integrated healthcare system in the Midwest, the UnityPoint Health network of Disproportionate Share Hospitals, Sole Community Hospitals, Critical Access Hospitals, and Rural Health Clinics provide vital access to healthcare services. The 340B Drug Pricing Program has served as a critical federal resource for our safety-net providers and the patients we serve in Iowa, Illinois, and Wisconsin. *Not including our affiliated 17 critical access hospitals, we have 12 hospitals that participate as covered entities under the 340B Drug Pricing Program*. Savings from this program help to provide affordable medications and support medication therapy management clinics, behavioral health outreach, preventive screenings, and other team-based and wellness initiatives.

UnityPoint Health is troubled by the simultaneous efforts to weaken the 340B Program and its hospital covered entities through accelerated recoupment, reduced drug reimbursement, expanded manufacturer data requirements, and a rebate-based acquisition model. While each proposal is concerning independently, their cumulative effect threatens the ability of safety-net hospitals to stretch scarce federal resources and maintain patient access.

340B Remedy Proposed Accelerated Recoupment

The recoupment represents CMS' remedy to address budget neutrality for increased payment from CY 2018 through CY 2022 that CMS unlawfully redistributed. Effective January 1, 2027, CMS proposes to increase the annual reduction to the OPPS conversion factor for non-drug items and services from 0.5% to 3% and accelerate the period of reductions from 16 years to three years. Alternatively, CMS seeks comment on decreasing the annual percent reduction to 2%, instead of 3%.

Comment: UnityPoint Health urges CMS to withdraw this proposal altogether or minimally retain the existing 0.5% claw-back and timeline. We reiterate our position that a budget neutrality adjustment is not statutorily required and is in fact contrary to sound public policy.[1] Rather, CMS has both the legal obligation and legal flexibility, as well as the backing of sound public policy, to not seek a claw-back of funds that hospitals received as a result of a CMS mistake (i.e. illegal action) and that hospitals have long since spent on patient care. As CMS is now proposing to accelerate this illegal claw-back of funds under 42 CFR §419.32(b)(1)(iv)(B)(12), our position is the same, and **we again stand opposed to the illegal claw-back regardless of its duration.** For a thorough background and in-depth analysis of budget neutrality adjustments, we refer CMS to the Premier, Inc. comment letter narrative, "Additional Reduction to Recoup 340B Drug Payments," and its conclusion that:

> ***CMS has explicitly acknowledged that the budget neutrality is a prospective concept and it cannot revise payments prospectively to address later information that may have affected earlier estimates****. For this reason, Premier not only opposes CMS' prospective recoupment adjustment of -3.0 percentage points annually beginning in 2027 but Premier believes it is both inconsistent with the law and CMS' longstanding past precedent regarding application of budget neutrality adjustments.*

Under CMS' supersized adjustment proposal, **this accelerated recoupment (3%) equates to nearly $7.5 million annually in dollars diverted from UnityPoint Health hospitals.** Like any business, hospitals budgets for 2027 are set. Over the last two years, our hospitals have relied on this unlawful policy and have incorporated a 0.5% reduction into our budgets. Hospital reliance interests are not minimal. By exponentially increasing the claw-back on two months' notice, this does create an unforeseen expense with operational implications. It bears repeating that the purpose of the 340B Drug Pricing Program as enacted in 1992 was to help eligible safety net providers "stretch scarce Federal resources as far as possible reaching more eligible patients and providing more comprehensive services." Any reductions in this program divert resources from covered entities that care for underserved and vulnerable populations. With thin operating margins, UnityPoint Health hospitals thoughtfully use 340B funds to maintain vulnerable service lines (such as behavioral health, maternal and child health, and/or emergency services), enable preventive/outreach services (such as financial assistance for medications, medication therapy management, and/or meds-to-beds programs), and simply keep doors open (such as salaries for nurses and other frontline care staff).

CY 2027 OPPS Payment Methodology for 340B Purchased Drugs

CMS proposes to pay ASP minus 33.4% for 340B acquired drugs. CMS is implementing this proposal in a budget-neutral manner, which would increase OPPS payments for non-drug services by an equivalent amount estimated at an 8.44% increase to non-drug service payments. Additionally, CMS proposes to revise billing modifiers for separately payable OPPS drugs.

Comment: CMS proposes to cut reimbursement rates by almost 40% for drugs acquired under the 340B Program from the current rate of ASP plus 6%. The proposed reduction would represent one of the most

[1] UnityPoint Health comment letter to CMS-1793-P (Medicare Program: Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018–2022) on September 11, 2023, accessed at Regulations.gov tracking # lmf-2d7j-f5ns

significant reimbursement cuts ever imposed on 340B hospitals. Based on our analysis of 2025 claims experience, **UnityPoint Health estimates that our Disproportionate Share Hospitals alone would lose approximately $21.4 million in 2027 under the proposed payment reduction**. Cuts of this magnitude cannot be viewed as a simple technical payment adjustment. They would directly reduce resources available for patient care, community benefit programs, workforce support, medication access initiatives, and vulnerable service lines. The purpose of the 340B Drug Pricing Program is to enable safety-net providers to "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." A payment policy that removes tens of millions of dollars from providers serving vulnerable populations runs counter to that statutory purpose.

We are particularly concerned that CMS is proposing this reduction based on data that may not adequately support such a sweeping policy change. The American Hospital Association has conducted an analysis of the CMS Medicare Outpatient Drug Acquisition Cost Survey and found its methodology raises significant questions regarding representativeness, reliability, and statistical validity. **Given the magnitude of the proposed cuts and the substantial consequences for safety-net providers, we urge CMS' adoption of the AHA's recommendations.** At a minimum, CMS should conduct additional robust data collection and analysis before considering any future payment adjustment.

The rate reduction proposal is also troubling because it effectively transfers resources away from hospitals that disproportionately care for Medicaid beneficiaries, low-income Medicare beneficiaries, rural populations, and medically complex patients. **The budget neutrality redistribution is administratively burdensome and, as a whole, the redistribution amount for UnityPoint Health does not equate to current 340B savings.** CMS' own impact analysis demonstrates that hospitals with higher DSH percentages and major teaching hospitals are more likely to experience payment reductions, while hospitals serving comparatively fewer low-income patients are more likely to benefit from the redistribution. Likewise, CMS projects payment increases for many for-profit hospitals while safety-net providers bear the burden of the reductions. UnityPoint Health believes Medicare payment policy should support hospitals serving vulnerable populations rather than redistribute resources away from them.

In addition, CMS does not account for various costs that 340B hospitals incur to maintain compliance with 340B rules, such as the cost of implementing software, hiring additional staff, and buying drugs at their list price (wholesale acquisition cost) since the 340B Program prohibits our hospital from using our GPO for covered outpatient drugs. And hospitals are already facing growing administrative costs associated with manufacturer-imposed claims reporting requirements, contract pharmacy restrictions, new modifier requirements, and implementation of the 340B Rebate Pilot. The proposed reduction assumes that hospitals continue to realize the full value of the 340B benefit while ignoring the fact that the benefit is becoming increasingly expensive and administratively burdensome to access.

Most importantly, the proposal would have real consequences for patients and communities. UnityPoint Health uses 340B savings to support services that frequently operate on narrow margins, including behavioral health services, maternal and child health programs, emergency care, medication access assistance, medication therapy management, preventive health initiatives, and other community-based services. Any reduction in 340B resources ultimately reduces the ability of covered entities to invest in these activities. Particularly in rural and underserved communities, diminished 340B support can threaten

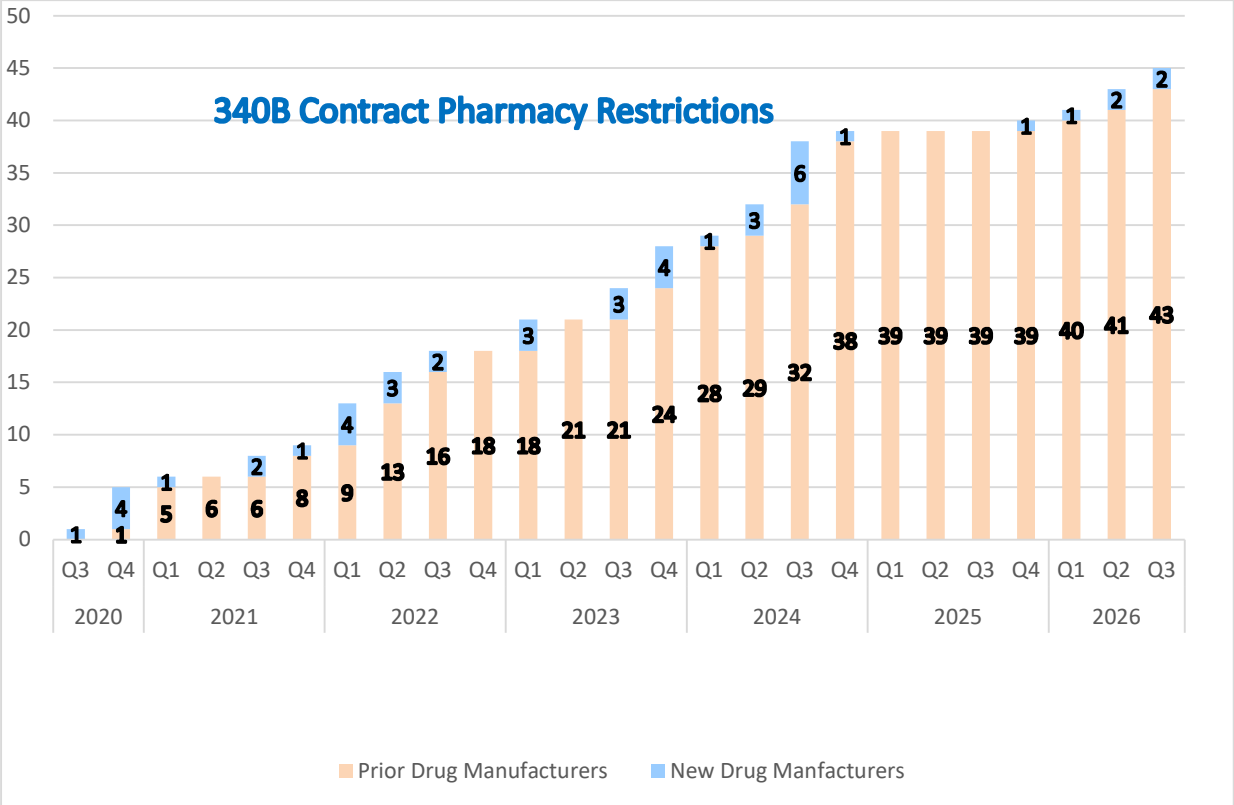
access to specialty services, outpatient infusion services, and programs designed to improve medication adherence and health outcomes.

Manufacturer Actions to Limit Access and Increase Administrative Burden

An important way covered entities are able to get 340B drugs to beneficiaries is through contract pharmacy arrangements. Under these arrangements, covered entities purchase drugs at 340B prices and contract with community pharmacies to dispense the drugs to covered entity patients on the covered entity's behalf. Since July 2020, 45 drug manufacturers have implemented policies refusing to provide or restricting 340B pricing to covered entities for drugs dispensed through contract pharmacies. In addition, drug manufacturers have started to require the submission of claims data and other information from covered entities through disparate data platforms in order to access 340B pricing.

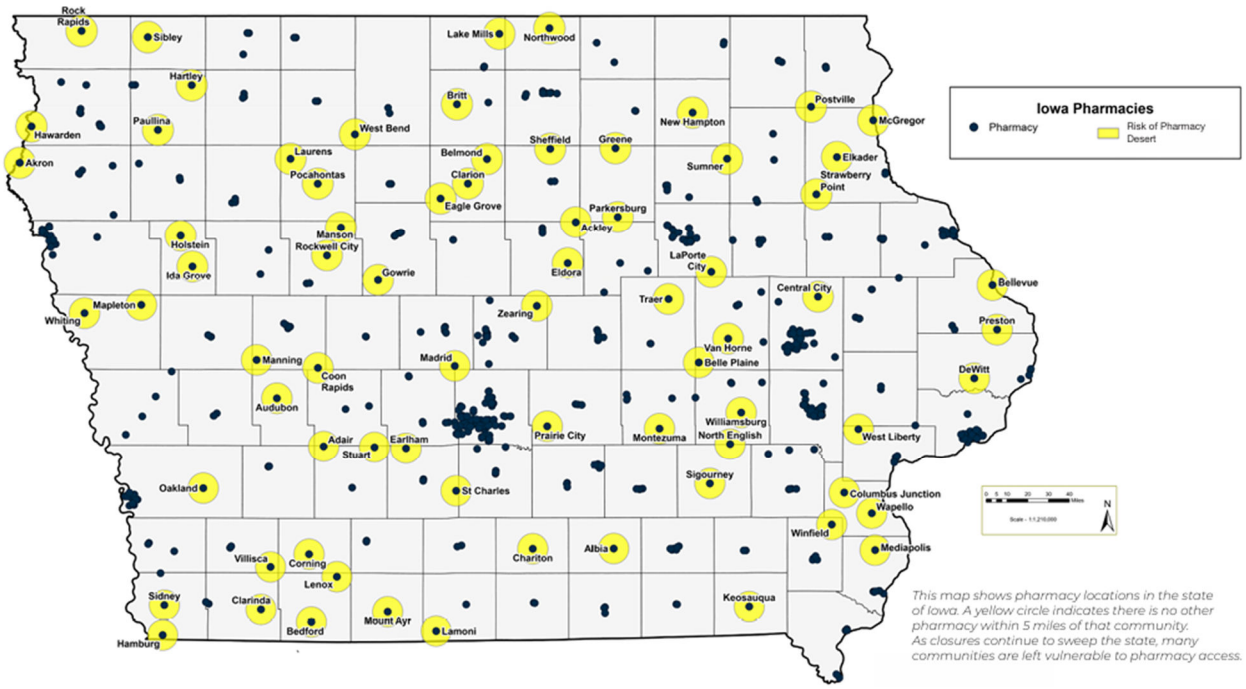
Comment: For UnityPoint Health hospitals, it is estimated that contract pharmacy restrictions and data submissions requirements will cost more than $8.5 million in 2026. Given the proposed 340B rate headwinds, there is renewed urgency for agency action to take back governance of the 340B Program from drug manufacturers. **UnityPoint Health strongly encourages Health Resources and Services Administration (HRSA) to enforce the 340B Program requirements to stop unilateral action by drug manufacturers to establish or alter conditions of program participation**.

Contract Pharmacy Restrictions: There are currently **45** drug manufacturers that have imposed contract pharmacy restrictions – AbbVie; Alkermes; Amgen; Amphastar Pharmaceutics; Astellas; AstraZeneca; Bausch & Lomb; Bausch Health; Bayer; Biogen; Boehringer Ingelheim; Bristol Myers Squibb; Eisai; Eli Lilly; EMD Serono; Exelixis; Genentech; Gilead; GlaxoSmithKline; Incyte Corp.; Jazz Pharmaceuticals; Johnson & Johnson; Karyopharm Therapeutics; Leo Pharma Inc.; Liquidia; Mallinckroft Pharmaceuticals; Merck;



Mitsubishi Tanabe Pharma America, Inc. (MTPA); Novartis; Novo Nordisk; Organon; Pfizer; Puma Biotechnology; Sandoz; Sanofi; Sobi; Stemline Therapeutics; Sumitomo; Takeda; Teva; UCB; United Therapeutics; Vertex Pharmaceuticals; and Viatris. *This number keeps growing (see timeline – 340B Contract Pharmacy Restrictions) as there is no government reprisal.*

Meanwhile, the impact of these restrictions is devastating. First, as manufacturers step into the shoes of regulators and impose new rules, this increases administrative workload for hospitals just to access the drugs at 340B-acquired drug pricing. Each manufacturer has imposed different restrictions, such as mandating submission of claims data using 340B ESP (a specific vendor) to access 340B pricing for drugs dispensed at contract pharmacies, refusing 340B pricing for drugs dispensed at contract pharmacies unless a limited exception applies, or both claims reporting and limited exceptions. **Effectively, hospitals now have 46 340B drug pricing programs to administer, including the one authorized by Congress and administered by the HRSA.** The 45 drug manufacturer programs are subject to frequent change with little notice, if any, and the frequency of changes is increasing. Many drug manufacturers no longer provide advanced notification of policy changes and simply post changes to their websites with simultaneous effective dates. This results in compliance chasing activities that distract 340B safety-net providers with extra administrative burdens and divert resources away from the program's intent to administrative tasks. Second, **this assault on the 340B Program from manufacturers impacts beneficiaries and access to medications**. These medications are needed to treat and manage chronic conditions and are not luxury items. This is especially apparent in the restrictions on specialty pharmacies. Contract pharmacies enable



outreach to beneficiaries at convenient locations and often with more extended hours. These restrictions also impact the growing landscape of pharmacy deserts. In 2024, 34 rural Iowa pharmacies closed.[2] In 2025, the Iowa Pharmacy Association identified another 73 (40%) rural pharmacies that risk closure and

[2] https://www.legis.iowa.gov/docs/publications/LGE/91/Attachments/SF383_GovLetter.pdf

the creation of a pharmacy desert.[3] In an era when CMS is doubling down on telehealth to facilitate healthcare access and beneficiary convenience, access to 340B-acquired drugs through community pharmacies seems similarly situated.

Data Submission Requirements: Historically, the 340B Program functioned as a straightforward upfront discount program. Covered entities maintained program integrity through HRSA oversight, audits, and compliance requirements. Increasingly, however, covered entities must submit detailed claims-level information to multiple manufacturer-designated platforms simply to access discounts that Congress already requires manufacturers to provide. **These reporting requirements have emerged without evidence of widespread diversion or duplicate discount concerns and effectively heightened administrative and compliance responsibilities for hospitals serving vulnerable populations**.

More concerning than the reporting obligation itself is the leverage attached to these requirements. **The practical consequence of these policies is that failure to submit claims data can result in loss of 340B pricing, loss of contract pharmacy eligibility, or both**. For covered entities, participation in vendor-operated systems is increasingly mandatory rather than voluntary. Hospitals are effectively forced to accept non-negotiable terms and conditions and provide sensitive operational information simply to access statutory discounts. Hospitals are providing this data to private entities, not the federal government.

Rather than submitting information through a standardized federal process, hospitals must comply with multiple independent reporting structures established by manufacturers and third-party vendors. Our 340B hospitals must master multiple overlapping reporting systems, including ESP, Beacon, and Truzo. Each platform has unique requirements, data fields, submission schedules, validation methodologies, and contractual terms. Rather than a single standardized federal process, covered entities must comply with numerous manufacturer-specific requirements that change frequently and often without meaningful advance notice. Collectively they require hospitals to devote significant resources toward data extraction, validation, reconciliation, submission, monitoring, dispute resolution, and audit response.

The administrative burden is compounded by the fact that the amount and type of information being requested continues to grow. As more manufacturers require data reporting, the scope of data requested continues to expand far beyond the 340B traditional reporting, which targeted drug information. Now information must be collected from a variety of sources, and some of the data fields required include:

- Medical claims data
- In-house pharmacy claims
- Health plan information
- Claim numbers
- Claim line numbers
- BIN and PCN routing identifiers
- Prescriber identifiers

[3]C. Tevis, "Pharmacy deserts threaten Iowa's picture of health, Iowa Capital Dispatch, March 27, 2024, accessed at https://iowacapitaldispatch.com/2024/03/27/pharmacy-deserts-threaten-iowas-picture-of-health/

- Service provider identifiers

Several of these data elements were not previously shared with manufacturers and have not historically been required to participate in the 340B Program. **As the scope of data collection continues to expand, we request agency oversight and guidance to establish clear guardrails, consistency, or demonstrated necessity.**

Manufacturer Rebate Reimbursement Actions

On August 3, 2026, HRSA announced a voluntary 340B Rebate Model Pilot Program to start January 1, 2027.

Comment: For more than three decades, the 340B Program has operated as an upfront discount program that allows safety-net providers to stretch scarce federal resources and reinvest savings into patient care, access, and community services. HRSA itself acknowledged that the Rebate Pilot would fundamentally change how the 340B Program operates. UnityPoint Health submitted comments to HHS Docket No. HRSA-2025-14998 outlining significant concerns regarding the absence of a compelling rationale for the pilot, the substantial operational and financial burdens it would create for covered entities, and the lack of adequate safeguards against delayed or denied rebates.

While we appreciate that HRSA has scaled back aspects of earlier manufacturer rebate proposals, the underlying concerns remain. The Rebate Pilot would require hospitals to purchase drugs at prices above the 340B ceiling price and subsequently seek reimbursement through a rebate process. As a result, financial risk and working capital obligations would shift from pharmaceutical manufacturers to safety-net providers. **UnityPoint Health previously estimated that, for piloted drugs alone, our hospitals could be required to advance $11 million dollars while awaiting rebate repayment**. Even temporary delays in reimbursement effectively transfer resources from hospitals serving vulnerable populations to pharmaceutical manufacturers.

Equally concerning, the Rebate Pilot would establish an entirely new administrative structure layered onto an already complex program. Covered entities would be required to devote significant resources to data collection, transaction validation, reconciliation, dispute resolution, denial management, audits, and compliance monitoring. These activities do not improve patient care, increase medication access, or enhance health outcomes. Instead, they divert personnel and financial resources away from patient-facing services and into administrative functions. UnityPoint Health remains concerned that covered entities would continue to bear responsibility for program compliance while having diminishing control over the systems, platforms, and processes governing rebate administration.

Above all, CMS should recognize the cumulative effect of these actions on Medicare providers and beneficiaries. The agency is simultaneously proposing policies that reduce OPPS reimbursement while other federal actions threaten to erode the value of the 340B benefit itself. Every delayed rebate, denied claim, administrative expense, compliance obligation, or financing cost reduces the resources available for hospitals to support medication access programs, behavioral health services, care management, preventive screenings, rural outreach, and other initiatives supported by 340B savings. In effect, providers are being asked to absorb lower reimbursement while also assuming new financial and administrative burdens associated with obtaining the same statutory benefit Congress intended them to receive.

OPPS PAYMENT FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS

Skin Substitutes

CMS continues its CY26 policy to unpackage skin substitutes and to reimburse skin substitutes separately as incident-to supplies. The proposed per unit payment rate is maintained at $127.14/cm^2.

Comment: UnityPoint Health supports this policy to address unsustainable spending growth and clinical inconsistency in the skin substitute product space.

ACOs are gatekeepers of total cost of care and are on the frontlines in identifying and reducing waste to deliver better care for beneficiaries. UnityPoint Accountable Care was one of the ACOs that identified fraudulent catheter claims and partnered with the Center for Medicare, the Center for Program Integrity, and the Center for Medicare and Medicaid Innovation (CMMI) to seek resolution. This was a win for beneficiaries, Medicare, and ACOs. We continue to encourage CMS to rethink how it could better leverage ACOs to identify potential fraud, waste, and abuse. CMS could streamline the process, build in transparency, and ensure that ACOs are not being held accountable for true fraud. **As a member of *Accountable for Health*, we reiterate their 2025 comment letter recommendations for ACOs**:

- **Suspend potentially fraudulent providers** if the circumstance meets certain conditions and communicate this claims suspension to ACOs.
- **Permit REACH and MSSP ACOs to re-open their settlements** for two or three years prior if criminal proceedings are initiated against potentially fraudulent providers and those providers rendered services to ACO-aligned beneficiaries.
- **Create a new stop loss policy** that applies to skin substitutes claims.

PARTIAL HOSPITALIZATION (PHP) AND INTENSIVE OUTPATIENT (IOP) SERVICES

CMS proposes to maintain the current payment rate methodology for calculating PHP and IOP payment rates for hospital-based providers. For Community Mental Health Centers (CMHCs), CMS proposes to multiply the CY 2027 rates for the hospital-based PHP and IOP APCs by 0.4 to calculate the payment rates for the CMHC PHP and IOP APCs.

Comment: UnityPoint Health is the largest provider of behavioral health services in Iowa. Aside from inpatient services, we operate 5 CMHCs in Iowa and 1 CMHC in Illinois. **We support continued federal payments for behavioral health services across the care continuum.**

DISTINCT NPI AND PROVIDER-BASED ATTESTATION REQUIREMENTS FOR OFF-CAMPUS HOPDs

Section 6225 of the Consolidates Appropriations Act, 2026, mandates that all off-campus hospital outpatient departments obtain distinct NPIs and submit provider-based attestations to maintain Medicare payment eligibility starting January 1, 2028. CMS proposes an attestation framework to operationalize this requirement.

Comment: UnityPoint Health appreciates CMS' efforts to implement Section 6225 of the Consolidated Appropriations Act, 2026, and supports the concept of a standardized attestation framework, particularly provisions intended to streamline provider-based attestations and minimize administrative burden. We agree that a standardized attestation process can improve oversight and transparency while supporting compliance with statutory requirements.

However, **UnityPoint Health has substantial concerns regarding the requirement that each off-campus hospital outpatient department (HOPD) obtain and bill under a separate National Provider Identifier (NPI) beginning January 1, 2028**. While we recognize this requirement is mandated by statute, its implementation will create considerable operational, financial, and administrative challenges for hospitals, physicians, payers, and patients.

- Operations: For integrated health systems, obtaining and maintaining separate NPIs for each off-campus HOPD would require substantial modifications to enrollment systems, billing workflows, contracting arrangements, revenue cycle operations, electronic health records, and payer interfaces. Health systems will need to establish new internal processes to manage multiple facility identifiers, monitor compliance requirements, update claims-editing logic, and coordinate information across numerous clinical sites. These changes will require extensive staff training, technology investments, and ongoing administrative oversight, diverting resources away from patient care.
- HIPAA: The separate NPI requirement could undermine the longstanding HIPAA objective of administrative simplification. A hospital organization currently relies on a consistent provider identifier across payers and care settings to support efficient claims adjudication and coordination of benefits. Requiring multiple facility-specific NPIs introduces additional complexity and increases the likelihood of claim denials, payment delays, data mismatches, and administrative rework.
- Benefit Coordination: The proposal may create significant challenges for physician and professional billing. Many physicians and other practitioners furnish services across multiple hospital outpatient locations as part of an integrated delivery system. The introduction of separate NPIs for individual HOPDs will increase claim submission complexity, create additional billing edits and reconciliations, and raise the risk of documentation and coding discrepancies between professional and facility claims.
- Care Coordination: Separate NPIs could adversely affect care coordination and patient access. Prior authorization processes are frequently linked to a facility's NPI. If services associated with a patient's episode of care span both a hospital's main campus and one or more off-campus HOPDs, providers may be required to secure multiple authorizations or revise existing approvals, creating unnecessary administrative burden and potentially delaying medically necessary care. Patients are unlikely to understand the distinction between NPIs assigned to locations within the same health system, increasing confusion regarding coverage determinations, billing, and cost-sharing responsibilities.
- Related Service Billing: The separate NPI requirement may disrupt established billing practices for integrated outpatient services and result in multiple claims instead of a single coordinated claim. Challenges associated with recognizing related services furnished across hospital locations could complicate claims processing, interfere with coordination of benefits, and potentially increase out-of-pocket costs for patients. These unintended consequences would undermine efforts to create a seamless patient experience across sites of care.

To mitigate these concerns and support a successful transition, we urge CMS to:

- Establish a phased, transparent implementation approach that allows adequate time for operational and systems changes.
- Provide sufficient lead time for provider enrollment updates, payer system modifications, testing, and stakeholder education.
- Issue comprehensive guidance for providers, Medicare contractors, and commercial payers to promote consistent implementation and minimize disruptions to patient care.
- Exercise reasonable enforcement discretion during the transition period to address unforeseen operational challenges.
- Develop a standardized crosswalk linking each off-campus HOPD NPI to the parent hospital's primary NPI and make this information available to Medicare Administrative Contractors (MACs) and other payers to facilitate claims processing and organizational recognition.
- Convene providers, health systems, physicians, health plans, and technology vendors to identify and resolve implementation challenges before the requirements take effect.

UnityPoint Health appreciates CMS' efforts to reduce burden through the proposed attestation framework and urges CMS to take additional steps to minimize the administrative complexity, billing disruption, and patient confusion that may result from the statutory separate NPI requirement. Careful implementation will be critical to ensuring compliance while preserving efficient operations and uninterrupted access to care.

INPATIENT ONLY (IPO) SERVICES

CMS proposes to eliminate the IPO list with a transitional period of three years. For CY 2027, CMS proposes to remove 637 services from the auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory and urinary clinical families.

Comment: We do not support this proposal. The IPO list contains mostly surgical procedures that are majorly invasive, complicated, and require the care and coordinated services provided in the inpatient setting of a hospital. With high-quality beneficiary outcome being paramount, we are concerned that IPO list elimination will result in more adverse safety and quality issues for beneficiaries outside an inpatient setting.

We continue to urge CMS to monitor beneficiary outcomes for procedures removed from the IPO list across settings, including quality measures (readmissions, avoidable ED visits, adverse events, etc.), beneficiary characteristics (age, comorbidities, etc.), and post-acute service utilization. To further support quality outcomes for all beneficiaries, we request CMS to continually evaluate baseline Fee-For-Service payments for potential readjustment to reflect heightened patient acuity for impacted inpatient procedures and assure access to inpatient services overall. As an early adopter of value-based arrangements, including ACO contracts, UnityPoint Health understands and supports transitioning care to lower acuity settings as dictated by each patient’s status and population health principles. From a policy

perspective, this highlights issues related to inequities perpetuated within the Fee-for-Service structure. Currently, lesser costs from "healthier" patients balance greater costs from more complex patients. As procedures are removed from the IPO list, "healthier" patients are transitioned to outpatient settings leaving more complex, costly patients within inpatient settings. These policies perpetuate a for-profit mentality and encourage more infrastructure builds to cater to younger, healthier, and less costly patients, divert resources from existing inpatient settings, and lead to greater healthcare costs overall. In the Midwest where access is determined by geography, this approach significantly impacts the sustainability of inpatient services, particularly in the nonprofit arena, and ultimately undermines access to care.

SITE NEUTRAL PAYMENTS FOR SERVICES FURNISHED AT OFF-CAMPUS PROVIDER-BASED DEPARTMENTS

CMS proposes to expand site neutral payments to imaging without contrast APCs furnished by excepted off-campus provider-based outpatient departments, with an exemption for rural sole community hospitals (SCHs). This proposal is intended to control unnecessary increases in volume for targeted outpatient services through payment policy – applying a rate reduction at the "PFS-equivalent" rate of 40% of the OPPS rate.

Comment: **UnityPoint Health opposes the proposed expansion of site-neutral payment policies for imaging services without contrast.** At its core, this proposal reflects a flawed assumption that reimbursement should be driven solely by the technical service being furnished rather than by the care setting, infrastructure, patient population, and clinical obligations required to safely provide that service.

Medicare's tiered payment structure was intentionally designed to recognize meaningful differences across sites of care. Hospital OPPS rates are based on hospital cost data and account for the personnel, supplies, standby capacity, regulatory compliance activities, and support services necessary to operate a HOPD. By contrast, Physician Fee Schedule (PFS) payments are designed to reimburse physician work, practice expense, and malpractice costs. These are fundamentally different payment systems serving different purposes and recognizing different resource requirements.

Site Neutral Policies Impose Unfunded Mandates on HOPDs: A fundamental flaw in the proposed site-neutral payment policy is that CMS seeks to equalize reimbursement while maintaining substantially different regulatory requirements across care settings. HOPDs remain subject to extensive Medicare Conditions of Participation (CoPs), accreditation standards, emergency preparedness requirements, quality oversight obligations, staffing requirements, infection prevention programs, medical staff governance requirements, and other hospital-wide regulatory expectations. These obligations exist regardless of the volume or reimbursement associated with any individual service.

The costs associated with complying with these requirements are largely fixed and unavoidable. Hospitals incur these expenses simply to maintain readiness and participate in Medicare. Hospital CoPs include specific radiology requirements under 42 C.F.R. §482.26 related to personnel qualifications, radiation safety programs, equipment inspections, oversight, reporting, and service availability. These requirements are supplemented by broader hospital-wide obligations related to quality assessment and performance improvement, emergency preparedness, patient rights, infection prevention, nursing

services, pharmaceutical services, and medical staff accountability. These requirements do not apply to physician offices.

While CMS may characterize site-neutral payment as a reimbursement reduction for a limited set of services, the practical effect is much broader. CMS is removing payment support for regulatory, operational, and infrastructure requirements that remain fully in place. In effect, site-neutral payment functions as an unfunded mandate: hospitals must continue meeting heightened federal requirements while increasingly receiving reimbursement that fails to recognize the costs of maintaining those capabilities.

This disconnect is particularly concerning because Medicare historically established separate payment systems precisely to recognize these differing obligations and resource needs. Preserving a tiered payment structure is therefore not about protecting a higher payment rate for an individual imaging service. It is about ensuring that Medicare payment policy continues to support the higher level of readiness, oversight, and clinical capability that beneficiaries expect from hospital-based settings.

HOPDs Serve Different and More Vulnerable Populations: CMS itself acknowledges that HOPDs serve unique patient populations and medically complex beneficiaries. We agree.

HOPDs routinely care for patients who are sicker, more clinically complex, and more economically vulnerable than those treated in independent physician offices. Our experience mirrors findings prepared for the American Hospital Association[4] demonstrating that Medicare beneficiaries primarily treated in HOPDs are:

- 54% more likely to qualify for Medicare due to disability, end-stage renal disease, or amyotrophic lateral sclerosis.
- 61% more likely to be dually eligible for Medicare and Medicaid.
- 60% more likely to reside in rural communities.

These beneficiaries are also more likely to have significant chronic disease burdens and recent histories of inpatient hospitalizations or emergency department utilization.

These differences matter. Higher-acuity patients frequently require greater clinical oversight, enhanced care coordination, immediate access to additional diagnostic and treatment resources, and the safety infrastructure available only in hospital-based settings. Yet CMS dismisses the significance of these distinctions and concludes that there is no evidence supporting higher payment for services that can also be furnished in lower-cost settings.

Again, CMS is missing the forest through the trees. The relevant question is not whether a single imaging study can technically be performed elsewhere. The relevant question is whether Medicare payment policy should continue to support sites of care equipped to serve medically complex beneficiaries and respond when patients require a higher level of care than anticipated.

[4] Prepared for AHA by KNG Health Consulting LLC, Comparison of Care in Hospital Outpatient Departments and Independent Physicians Offices: Updated Findings for 2019-2024 (September 2025)

Site Neutrality Erodes Support for Higher-Acuity Sites of Care: CMS evaluates these policies one service at a time. Hospitals, however, must maintain the infrastructure, staffing, regulatory compliance programs, and readiness capabilities necessary to care for patients across the continuum of outpatient services.

Incremental site-neutral reductions applied service by service gradually erode the financial support that sustains HOPDs even though the associated obligations remain unchanged. While any single reduction may appear modest in isolation, the cumulative effect is significant. Hospitals experience declining reimbursement while continuing to absorb the same fixed regulatory and operational costs required to maintain higher-acuity levels of care.

As a result, the debate should not focus narrowly on whether a particular imaging procedure uses the same equipment in a physician office and a HOPD. The broader policy question is whether Medicare can continue to impose higher standards and expectations on hospitals while systematically removing the payment mechanisms that were designed to support those obligations.

CMS Has Not Demonstrated That Payment Differences Drive Unnecessary Volume or Consolidation: We disagree with CMS's assertion that payment differences are a primary driver of physician practice acquisitions or increased utilization of imaging services without contrast. This has not been the experience of UnityPoint Health.

CMS's analysis overlooks the significant financial and operational pressures facing physician practices, including chronically inadequate Medicare and Medicaid reimbursement, workforce shortages, escalating labor and supply costs, prior authorization requirements, administrative burden, and increasing regulatory obligations. These factors have been far more influential in driving physician employment trends and market consolidation than payment differentials between sites of care. Reducing reimbursement to HOPDs will not address these underlying market dynamics.

Moreover, CMS' decision to exempt Sole Community Hospitals underscores a fundamental concern with site-neutral payment policies. We strongly support this exemption; however, it also serves as an acknowledgment that reimbursement reductions can destabilize providers that operate under unique market and access constraints. Rural hospitals face workforce shortages, geographic isolation, lower patient volumes, and limited opportunities to spread fixed costs. CMS appropriately recognizes that site-neutral payment cuts could threaten the viability of these providers and reduce access to care for Medicare beneficiaries.

The same principle extends beyond Sole Community Hospitals. Regardless of geography, many hospitals provide essential services, maintain compliance with CoPs, provide emergency readiness, support specialized staffing and equipment, and care for a disproportionate share of medically complex patients. If CMS acknowledges that site-neutral payment reductions can undermine access and financial stability in the rural setting, it should also recognize the broader reality that HOPDs nationwide incur significant obligations and costs that are not borne by other sites of care. The Sole Community Hospital exemption therefore highlights, rather than resolves, the central flaw in site-neutral policy: payment reductions risk eroding access to HOPD services precisely because hospitals serve a different role in the healthcare delivery system.

Hospitals Provide Essential Community Benefits Beyond Individual Services: Finally, CMS fails to adequately account for the broader role hospitals play in their communities. Hospitals and health systems invest substantial resources in services and activities that are inadequately reimbursed or entirely unreimbursed, including:

- Providing charity care and financial assistance.
- Maintaining emergency departments and trauma services.
- Supporting public health initiatives and community health programs.
- Investing in rural access and healthcare workforce development.
- Addressing social drivers of health and unmet community needs.

These investments are part of the broader value hospitals provide to Medicare beneficiaries and their communities. They depend upon payment policies that recognize the comprehensive responsibilities associated with operating acute care facilities.

For the reasons detailed above, Medicare payment policy should preserve, not erode, access to higher-acuity sites of care. Site-specific reimbursement exists because sites of care differ in meaningful ways. HOPDs face unique regulatory obligations, maintain critical community infrastructure, and serve more medically complex and vulnerable patient populations than physician offices. By carving out individual services for site-neutral payment treatment while leaving these obligations fully intact, CMS risks creating an unfunded mandate that gradually weakens the financial foundation supporting hospital outpatient care. Over time, such policies threaten access, increase wait times, reduce service availability, and undermine the very sites of care that Medicare beneficiaries depend upon when their needs exceed what can safely be provided in lower-acuity settings. Instead of pursuing additional piecemeal site-neutral payment reductions, CMS should preserve payment policies that recognize the resources, readiness, and clinical capabilities required to sustain access to higher levels of outpatient care.

TELEHEALTH AND REMOTE SERVICES

Telehealth and remote services have been transformative for healthcare delivery. In general, **UnityPoint Health urges coverage for comprehensive telehealth services on a permanent basis**, or care will continue to be inaccessible to beneficiaries who experience barriers to care. UnityPoint Health is committed to meeting patients at the right time, with the right care, and at the right place – and telehealth is vital to this commitment. **We appreciate Congressional and CMS efforts to take definitive action to expand telehealth services and billing providers**.

Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR) Services to Hospital Outpatients in Their Homes Via Audio and Video Real-Time Communications

CMS has issued sub-regulatory guidance to allow these services through December 31, 2027, in alignment with section 6211(b) of CCA, 2026.

Comment: UnityPoint Health supports this sub-regulatory guidance.

HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM

CMS proposes the following updates: (1) Removing the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure; and (2) revising validation and validation reconsideration procedures, including policies applicable to electronic clinical quality measures (eCQMs). CMS also seeks stakeholder input on a Request for Information on including an Advance Care Planning measure specified for the HOPD setting.

Measure Removal:

In a cross-program proposal, CMS is proposing to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure.

Comment: UnityPoint Health supports the removal of this measure. Follow-up surveillance intervals after colonoscopy are more appropriately managed by primary care providers and other longitudinal care clinicians. Eliminating this measure would better align accountability with clinical practice, reduce unnecessary administrative burden on HOPDs, and minimize the potential for inconsistent or conflicting follow-up recommendations. Additionally, we agree that the **OP-32 (Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy)** is a more appropriate quality measure for the hospital outpatient setting, as it directly reflects facility performance and meaningful patient care outcomes.

PRO–PM Measures:

There are two patient-reported outcomes-based performance measures within the Hospital OQR measure set.

Comment: Patient experience is important, and CMS has recently chosen to capture this through patient-reported outcome-based performance measures. UnityPoint Health reiterates our concerns with these measures as constructed.

(1) Information Transfer PRO–PM measure. The Patient Understanding of Key Information Related to Recovery After a Facility Based Outpatient Procedure or Surgery Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM) is a 9-question, 3-domain survey. Its purpose is to assess a patient's understanding of clear and personalized recovery information after a facility-based outpatient procedure or surgery. It is to be administered on days 2 through 7 post-procedure.

UnityPoint Health recommends that the Information Transfer PRO-PM measure be incorporated into the OAS CAHPS survey. This measure is duplicative and creates unnecessary administrative burden, including additional costs related to third-party vendor distribution. This survey 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. 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. While we appreciate that CMS delayed the administration timeframe so as not to conflict with the electronic survey timeframe, UnityPoint Health is actually reverting to a paper OAS CAHPS survey distribution to bolster response rates.

(2) THA/TKA PRO-PM measure. **OP-42** (Risk-Standardized Patient-Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty)

presents operational challenges when surveying patients pre- and post-surgical events and is overly burdensome. HOPD challenges include:

- 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 HOPD. When surgeries are performed under the auspices of independent physicians with the HOPD serving as the site of service, HOPDs become the reporting agent for locums. HOPDs become the de facto reporter for pre- and post-surgical outcomes that are not centrally located within one EHR 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 inaccurate responses and may also conflict with the distribution of CAHPS surveys.

- 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 potential mismatched patient information.

- Data Collection Responsibility: Due to the elective nature of these procedures and the data collection length, the party responsible for this measure should be the specialist/provider and perhaps their accreditation agencies, but not hospitals. While hospitals serve as the procedure site, it is the provider that manages pre- and post-procedure follow-up and care coordination. **This measure is a missed opportunity for CMS to engage specialists in the transition to value**. It is the providers/specialists, not hospitals, who will have the ability to use or act on the data for quality improvement. By having the providers engaged, this may also help to streamline patient surveys and reduce overall survey fatigue for THA/TKA procedures.

Refinement of Current Hospital OQR Measure Set:

While CMS has not solicited comment on prior finalized Hospital OQR measures, UnityPoint Health requests that CMS consider refinements to the following measure to address data collection challenges.

THA/TKA PRO–PM Death Exclusion: For OP-42 (Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO–PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting), patients are excluded who die within 300 days of the procedure date.[5] We support patient death as an index admissions excluded from this measure; however, **we request that the death exclusion period be extended to include the entire post-operative data collection period (300 to 425 days).** To state the obvious, hospitals cannot survey deceased patients. If a patient dies on day 301 post procedure, this is outside the exclusion window but within the post-operative survey window - hospitals are penalized for an impossibility.

Validation and Validation Reconsideration Procedures:

CMS proposes to incorporate and streamline the validation of eCQM data into the Hospital OQR Program's existing validation process. Revisions include: (1) change the validation selection pool from 500 to up to

[5] 2025 Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Hospital-Level Performance Measure Updates and Specifications Report — Version 2.0, p9.

400 hospitals; (2) clarify application of the targeting criteria to eCQMs; (3) update the number of cases for chart-abstracted and eCQM validation; (4) include eCQM validation in the timing and submission of medical record requests; (5) align the submission quarters for chart-abstracted and eCQM validation; (6) establish an eCQM validation scoring method based on data accuracy; and (7) update the educational review process for validation results.

Comment: UnityPoint Health generally supports CMS' proposal to integrate eCQM validation into the existing Hospital OQR Program validation framework and appreciates the agency's efforts to align validation processes across quality programs. Using consistent definitions, confidence intervals, sampling methodologies, and reconsideration procedures across inpatient and outpatient programs will help reduce administrative complexity, promote greater consistency in program oversight, and allow hospitals to focus resources on improving data quality and patient care rather than navigating differing validation requirements.

While we support the overall direction of the proposal, **we strongly encourage CMS to provide hospitals with a reporting-only year (i.e., learning year) before validation results trigger payment determinations or other program consequences**. Given the operational complexity associated with eCQM reporting, hospitals need adequate time to implement measure specifications, train clinicians and staff, refine documentation workflows, test electronic health record functionality, and address vendor-related challenges. An initial educational period would allow providers to gain experience with measure requirements and better ensure that validation results accurately reflect performance rather than implementation challenges.

During this learning year, CMS should conduct targeted validation activities and provide hospitals with educational feedback regarding identified issues. Such an approach would allow hospitals to identify documentation deficiencies, data abstraction concerns, measure logic inconsistencies, and submission errors before validation findings affect program compliance or reimbursement. Experience with eCQM implementation has demonstrated that many data quality issues are not fully apparent until validation activities are performed, making an educational review process particularly valuable during early implementation.

UnityPoint Health also supports the proposed validation reconsideration procedures and believes hospitals should have a meaningful opportunity to review and appeal validation findings. Clear communication regarding identified discrepancies, transparent validation methodologies, and sufficient time for hospitals to respond will help ensure fairness and improve confidence in the validation process.

Overall, we support CMS' efforts to harmonize validation requirements across quality programs but urge the agency to adopt a phased implementation approach that includes a reporting-only year and educational review process. Such safeguards would improve measure reliability, reduce unintended burden, and facilitate successful long-term adoption of eCQM validation within the OQR Program.

Request for Information: Advance Care Planning (ACP) eCQM:

CMS seeks feedback on potential inclusion of an ACP eCQM and other quality measure concepts related to ACP for the Hospital OQR Program.

Comment: UnityPoint Health appreciates CMS' interest in promoting patient-centered care and ensuring

that patients' treatment preferences and goals are documented and accessible across care settings. **We agree with the rationale for ACP and recognize the evidence-based benefits of facilitating discussions regarding patients' goals, values, and preferences**. ACP can improve care coordination, support informed decision-making, and help ensure that care provided aligns with patient wishes.

However, consistent with comments submitted by UnityPoint Health in response to the FY 2027 IPPS/LTCH PPS Proposed Rule, **we have significant concerns with the ACP eCQM as currently constructed.** When contemplating for the hospital outpatient setting, we strongly encourage CMS to further refine the measure.

First, CMS should carefully evaluate potential duplication across quality reporting programs. ACP concepts are already addressed through multiple federal quality initiatives, including inpatient quality programs and physician-focused quality programs under the Quality Payment Program. Expanding a similar measure into the OQR Program risks creating overlapping reporting requirements and duplicative documentation obligations while producing limited additional value for patients, providers, or policymakers.

Second, we question whether ACP is appropriate or feasible across all outpatient settings and encounters. HOPDs provide a diverse range of services, including diagnostic, procedural, and specialty care, many of which involve episodic interactions rather than longitudinal patient relationships. In these settings, clinicians may not be best positioned to initiate or update ACP discussions, which are often more appropriately conducted by primary care providers or other practitioners with ongoing longitudinal relationships and broader knowledge of the patient's health status and goals of care.

We are also concerned that broad adoption of an outpatient ACP measure could lead to patients being repeatedly asked the same ACP questions across inpatient, outpatient, physician office, and other care settings. Rather than improving care quality, repeated requests for the same information may create patient frustration, contribute to clinician burden, and result in inefficient workflows. CMS should prioritize interoperability and the availability of existing ACP documentation across care settings instead of incentivizing repetitive data collection.

In addition, significant operational concerns remain regarding the measure's design and implementation. As we noted in our IPPS comments, the ACP eCQM is a patient-based, true-or-false measure reported as the proportion of eligible patients with sufficiently documented ACP information in the medical record. Even in the inpatient setting, implementation of this measure requires substantial electronic medical record development, testing, clinician education, workflow redesign, and hospital validation efforts. Those challenges would be equally present, and potentially more complex, across the broad range of outpatient settings subject to the OQR Program. For this reason, we continue to believe hospitals and health IT developers require significant lead time prior to implementation.

The measure also raises important questions regarding measure intent, validation standards, workflow expectations, and accountability. CMS has not provided sufficient clarity regarding how organizations would determine whether ACP documentation is current, how performance would be assessed when patients already have existing ACP documentation in other care settings, or how hospitals would be evaluated when ACP discussions occur but patients choose not to make or document ACP decisions. As we previously noted in our IPPS comments, a measure that treats patient refusal or declination as a

negative outcome effectively disregards patient autonomy and could unfairly penalize hospitals for honoring patient choice. These concerns are particularly significant in the outpatient setting, where encounters are frequently brief and focused on a specific procedure, test, or specialty service.

Similar to our recommendations regarding short-stay inpatient encounters, we encourage CMS to carefully consider whether certain outpatient encounters should be excluded from the measure denominator and whether patients who decline ACP discussions or documentation should be excluded from performance calculations. Hospitals should not be disadvantaged when patients exercise their right not to participate in ACP.

Finally, we are concerned that the measure appears to broadly apply to all adults age 18 and older, regardless of clinical circumstance. While ACP can be valuable for many individuals, its relevance varies considerably based on age, health status, prognosis, and care needs. A universal approach risks encouraging documentation activities that are not clinically meaningful and may divert resources away from populations most likely to benefit from these conversations. CMS should consider a more targeted approach focused on individuals with serious illness, advanced age, multiple chronic conditions, or other characteristics that make ACP particularly relevant.

For these reasons, **UnityPoint Health encourages CMS to obtain additional stakeholder input and further refine the ACP eCQM before proposing adoption in the OQR Program. Any future measure should avoid duplication across federal programs, align with appropriate clinical workflows, respect patient autonomy, minimize administrative burden, clearly define accountability, and focus on patient populations most likely to benefit from ACP interventions.**

RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM

CMS does not propose any updates.

Comment: The Center for Healthcare Quality & Payment Reform recently reported that "700 rural hospitals – one-third of all rural hospitals in the country – are at risk of closing because of the serious financial problems they are experiencing. Over 260 of these rural hospitals are at immediate risk of closing because of the severity of their financial problems."[6] The REH designation could serve as a solution to avert some closures and retain local healthcare services for rural residents, and there are currently 53 hospitals with a REH designation. **We echo our OQR comments on the emergency care access and timeliness eCQM and request that CMS consider a two-year period for voluntary reporting (2027 and 2028) to enable a smooth transition from the chart-abstracted measures to the new eCQM**.

Aside from quality measures, UnityPoint Health requests that CMS continue dialogue with Congress to make recommendations related to REH program flexibility and financial viability. With oversight over REHs, Critical Access Hospitals, and small Prospective Payment System hospitals, CMS is well positioned to advise Congress on these facilities – successes and challenges. CMS holds data that could inform Congress on future REH revisions, including:

- 340B Drug Pricing Program Eligibility – REHs do not qualify as covered entities for the 340B Program.

[6] *Rural Hospitals At Risk of Closing* (July 2026) accessed at https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

Many Critical Access Hospitals (CAHs) and other small rural hospitals have greatly benefited from the 340B Program but would lose 340B eligibility upon REH conversion. **To inform Congressional decision-making, we encourage CMS to perform an analysis projecting the impact of the 340B Drug Pricing Program eligibility for REHs.** Similar to CAHs, we would recommend that CMS model REH status with automatic eligibility per this designation and, due to low patient volume, not tie status to disproportionate share hospital (DSH) percentages.

- Distinct Unit Authorization – The statute prohibits REHs from furnishing any inpatient services, except that skilled nursing services may be furnished in a separate and distinct unit of the REH. **To inform Congressional decision-making, we encourage CMS to analyze the impact of furnishing inpatient psychiatric and inpatient rehabilitative services in a separate and distinct unit.** This would enable rural communities with these needs to offer such services, and in the absence of inpatient services, REHs may be able to make these accommodations more readily.

- Transport as a Core REH Service – As REHs are charged with a focus on emergency treatment, the availability of timely Emergency Medical Services (EMS) is crucial. EMS is not only vital to getting patients to the REH timely but is necessary for timely transfers. Due to large geographic service areas and low population density, rural EMS providers often travel longer distances per run. The availability of rural EMS is often scarce and patchwork funding does not encourage stability in service providers. To assure access to EMS and inform Congressional decision-making, **we encourage CMS to analyze the impact of furnishing EMS within the list of core REH services that receive enhanced reimbursement**.

INPATIENT PROSPECTIVE PAYMENT SYSTEM: SEPARATE PAYMENT FOR DOMESTIC PROCUREMENT OF PERSONAL PROTECTIVE EQUIPMENT AND ESSENTIAL MEDICINES

CMS seeks input on potential policy approaches for a payment adjustment, a methodology to calculate the price differential between domestic and non-domestic PPE and essential medicines, information sources of those price differentials, a definition of domestic essential medicine and PPE, and a process for verifying that a given essential medicine or PPE is ''domestic.'' At this time, CMS is no longer exploring a new ''Secure American Medical Supplies'' friendly designation or a new structural quality measure as part of the Hospital IQR Program.

Comment: UnityPoint Health supports efforts to strengthen the domestic supply chain for critical medical products and essential medicines and believes federal policy can play a vital role where market forces alone are insufficient. We appreciate CMS' interest in exploring payment policies that encourage domestic manufacturing, beginning with the existing approach for NIOSH-approved N95 respirators. **As a member of Premier, Inc., UnityPoint Health contributed to and supports the recommendations outlined in Premier's comment letter**. Any expansion of this policy should prioritize domestic production of critical components and active pharmaceutical ingredients (APIs), be implemented in a non-budget-neutral manner, minimize administrative burden, and include ongoing stakeholder engagement and program evaluation.

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

Sincerely,

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Executive Director, Government & External Affairs
UnityPoint Health