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September 14, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1848–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS-1848-P: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program, published in Vol. 91, No. 135 Federal Register 43842-44557 on July 16, 2026.

Submitted electronically via www.regulations.gov

Dear Administrator Oz:

UnityPoint Clinic appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services (CMS) proposed rule for the 2027 Physician Fee Schedule (PFS). UnityPoint Clinic is comprised of 1,180+ physicians and advanced practice providers in 400+ physician clinics located in Iowa, Illinois, South Dakota, and Wisconsin and provided more than 4.8 million clinic visits in 2024. UnityPoint Clinic offers services in family medicine, internal medicine, obstetrics/gynecology, pediatrics, and a wide variety of specialty services, and is the ambulatory arm of UnityPoint Health. UnityPoint Health is one of the nation's most integrated healthcare systems. UnityPoint Health has more than 31,000 employees and, aside from UnityPoint Clinic, offers services through 34 hospitals in urban and rural communities and 13 home health areas of service throughout our eight Midwest markets.

In addition, UnityPoint Health and UnityPoint Clinic are committed to payment reform and are actively engaged in numerous initiatives that support population health and value-based care. UnityPoint Accountable Care is an accountable care organization (ACO) affiliated with UnityPoint Health and UnityPoint Clinic 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. In total, UnityPoint Accountable Care covered over 400,000 lives in 2025.

UnityPoint Clinic respectfully offers the following comments to the proposed regulatory framework.

REVISIONS TO PAYMENT POLICIES

Conversion Factor

CMS proposes calendar year (CY) 2027 physician conversion factors (CF) of $33.17 for qualifying Alternative Payment Model (APM) participants (QPs) and $32.84 for all other clinicians. The QP CF is a projected decrease of -1.19% over the CY 2026 CF and the non-QP CF is a projected -1.68% decrease over CY 2026 CF.

Comment: According to the Medicare Trustees[1], Medicare physician payment updates set under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) "*are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range*." The consistent erosion of the physician CF devalues providers who are the most educated and skilled within the healthcare workforce. Notably the actuarial statement in the Medicare Trustee report cautions "*There remains continued uncertainty regarding adherence to current law payment updates, particularly in the long range. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report."*[2] Insufficient updates coexist in a challenging financial backdrop of inflationary pressures, exponential increases to healthcare labor and supply costs, and an escalation in regulatory burdens (e.g., prior authorization, interoperability requirements, and participating in Medicare quality programs such as Merit-based Incentive Payment System (MIPS)). These cuts ultimately threaten access to vital services provided to Medicare beneficiaries

Medicare Physician Conversion Factor (2017–2027)				
Year	CF for QPs	CF for non-QPs	Actual Update QPs (%)	Actual Update non-QPs (%)
Jan 1, 2017	35.8887		0.24	
Jan 1, 2018	35.9996		0.31	
Jan 1, 2019	36.0391		0.11	
Jan 1, 2020	36.0896		0.14	
Jan 1, 2021	34.8931		-3.32	
Jan 1, 2022	34.6062		-0.82	
Jan 1, 2023	33.8872		-2.08	
Jan 1, 2024	33.2875		-1.77	
Jan 1, 2025	32.3465		-2.83	
Jan 1, 2026	33.5875	33.4009	3.84	3.32
Jan 1, 2027	33.17*	32.84*	-0.40*	-0.56*

**Proposed*

[1] *2026 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 2 and 5, accessed at https://www.cms.gov/oact/tr/2026 - "Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large."

[2] Id, page 265.

and Medicaid members. **UnityPoint Clinic strongly requests CMS to adequately increase the physician CF to reflect the current financial landscape of healthcare.**

Overlap Between Stand-Alone E/M Visits and Global Periods

To address overvaluation, CMS proposes to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same physician or practice on the same day as a 0-, 10-, or 90-day global procedure. The most expensive service would be paid at 100% and all other services furnished on the same day would be paid at 50%.

Comment: UnityPoint Clinic supports full reimbursement for separate and clinically distinct services furnished on the same date of service. CMS already limits same-day payment. An office visit is paid separately on the day of a procedure only when it is reported with modifier -25, which identifies work that is significant and separately identifiable from the usual work of the procedure. We are concerned that policies reducing payment based on presumed duplication (whether common organizational ownership, shared tax identification numbers, or the timing of service delivery), rather than demonstrated overlap, may inappropriately penalize multispecialty practices and undermine beneficiary access to comprehensive, coordinated care.

We additionally believe that this policy will disproportionately impact rural residents. To reduce travel burdens, time away from work, lodging costs, and delays in care, rural providers often coordinate E/M visits on the same day for patients traveling long distances. Payment policies should not penalize providers for improving convenience and access through efficient, patient-centered scheduling.

Modification to the E/M Visit Complexity Add-On

CMS proposes to transition HCPCS code G2211 to a two-tiered modifier – MOD1 would increase associated payment by 16%, while MOD2 would increase associated payment by 32% for certain ACOs.

Comment: Year to date (e.g., through mid-August), HCPCS code G2211 has been associated with more than 46,000 claims at our clinics. Given the acuity and multiple underlying conditions of an aging and largely rural population, this add-on code reflects what we already knew about the increasing complexity of Medicare beneficiaries.

We support the proposal to replace G2211 with percentage-based E/M modifiers, including a 16% modifier for longitudinal care and a 32% modifier for MSSP and LEAD ACO clinicians. UnityPoint Accountable Care has experienced firsthand that accountable care providers incur additional care coordination and population health management costs that warrant additional reimbursement. However, **we encourage CMS to adjust ACO benchmarks and fee-for-service trends to reflect the new payments**, so that this recognition of effort and its value to beneficiaries does not ultimately act as a penalty for ACOs.

Advanced Care Planning (ACP)

CMS proposes to create two new HCPCS codes to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner.

Comment: UnityPoint Clinic supports this proposal to establish separate coding and payment for ACP services furnished by clinical staff under the direct supervision of a physician or other practitioner. ACP

is inherently a team-based process that often requires education, documentation support, identification of healthcare agents, collection and validation of advance directive documents, caregiver engagement, and reinforcement of patient preferences over time. While physicians and other practitioners maintain ultimate responsibility for a patient's plan of care, appropriately trained clinical staff play a critical role in facilitating these conversations and ensuring ACP information is accurately documented and readily available across care settings.

UnityPoint Clinic's operational experience demonstrates that ACP is rarely confined to a single physician encounter and instead functions as a multidisciplinary process that unfolds over time. Clinical staff routinely support ACP by educating patients and caregivers, documenting healthcare directives and healthcare agents, facilitating structured conversations regarding patient values and treatment preferences, and ensuring ACP information is accurately recorded and accessible across care settings. These activities require time, training, and coordination, yet they are not consistently recognized under current payment policies. CMS' proposal to allow clinical staff to furnish ACP services under direct practitioner supervision aligns with our clinical practice. This approach appropriately recognizes the team-based nature of ACP, helps integrate ACP into routine care management workflows, and expands patient access to these important conversations while preserving practitioner oversight and accountability.

Additional Stakeholder Feedback: Annual Wellness Visits (AWVs)

For subsequent AWVs, 42 CFR 410.15(c)(2) specifies a time lag of at least 11 full months between AWVs.[3] This rolling deadline does not align with an "annual" or calendar year benefit and, in fact, creates clinic workflow issues for beneficiaries who schedule their AWV in the fall and early winter. For instance, in an agricultural state, it is usual for farmers and agricultural workers to schedule AWVs and non-emergent care after harvest – November to December timeframe. Since 2011, dates for these appointments have slipped making December an extremely busy month on top of respiratory season. In some cases, we have had to schedule into the next year meaning that the AWV did not occur in the calendar year and beneficiaries did not get their "annual" benefit. **To enable flexibility for beneficiaries and providers, we urge CMS to consider a policy implemented by the majority of MA plans to allow for subsequent AWVs to occur any time in the calendar year.** This would eliminate the date slippage issue.

TELEHEALTH

Annually, 191,841 UnityPoint Clinic patient visits use telehealth[4], which represents 6% of total patient visits, and 33,916 telehealth visits involve new patients. In general, **UnityPoint Clinic urges coverage for comprehensive telehealth services on a permanent basis**, or alternatively care will continue to be inaccessible to beneficiaries who experience barriers to care. UnityPoint Clinic 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 CMS efforts to take definitive action and expand telehealth services and

[3] 42 CFR 410.15(c)(2) – "*An eligible beneficiary as described in this section and who has had either an initial preventive physical examination as specified in § 410.16 of this subpart or either a first or a subsequent annual wellness visit providing personalized prevention plan services performed within the past 12 months.*"
[4] This represents outpatient visits only during the 12-month period from July 1, 2025, to June 30, 2026.

billing providers when authorized on a permanent basis.

Telehealth Authority to Sunset in the Absence of Congressional Action

In CAA (2026), Congress extended the following telehealth flexibilities through either December 31, 2027, or January 1, 2028:

- *Waiving originating and geographic sites;*
- *Audio-only coverage;*
- *Expansion of eligible telehealth providers;*
- *Allowing Rural Health Clinics and Federally Qualified Health Centers to serve as distant sites;*
- *Temporary waiver of behavioral health in-person requirement.*

To track the provision of certain telehealth services, CAA (2026) also requires CMS to establish claim modifiers. CMS proposes to establish modifiers BB and BS in sub-regulatory guidance.

Comment: Telehealth is no longer an optional adjunct to care delivery. For many patients, it has become an expected access point to the healthcare system, offering convenience, reduced travel burdens, and timely access to providers. This expectation is reinforced by strong patient experience data, with 76.7% of patients reporting that telehealth is an easy and effective way to connect with a clinician. **UnityPoint Clinic requests CMS to work alongside Congress to make these flexibilities permanent.** Cyclical extensions beget coverage confusion for beneficiaries and discourage providers from making long-term telehealth investments.

Updates to the Telehealth Services List

Five new codes are proposed to be added to the list – Advanced care planning (GACP1 and GACP2); Group-based medical sessions (GSMAS); pediatric speech, language, or communication treatment (GSLPP); and E/M visit for vaccine adverse effects (GADV1).

Comment: We support.

Frequency Limitations

CMS proposes to clarify time parameters for "initial" and "subsequent" critical care consultations.

Comment: UnityPoint Clinic appreciates this clarification.

Teaching Physician Billing Clarifications

CMS proposes to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary.

Comment: We support.

Telehealth Originating Site Facility Fee Payment

CMS updates the originating site facility fee schedule by the percentage increase in the Medicare Economic Index (MEI). For CY 2027, the projected increase is 2.5% and HCPCS code Q3014 is projected at $32.65.

Comment: UnityPoint Clinic supports this fee update.

REMOTE MONITORING

Recently, CMS established payment for two code families that describe certain remote monitoring services: remote physiologic monitoring (RPM) and remote therapy monitoring (RTM). For CY 2027, CMS proposes

to limit RTM services to established patients, to require a separately reportable initiating visit in association with the onset of RPM or RTM services, and to restrict payment to services performed by clinical staff employed by the practice and not those delivered by contractors.

Comment: UnityPoint Clinic opposes this proposal and requests that CMS withdraw the proposed remote monitoring restrictions in their entirety. We agree with the Alliance for Connected Care[5] that these proposals will cause "immediate and significant disruption for Medicare beneficiaries who rely on remote monitoring to manage chronic conditions, avoid preventable complications, and remain connected to their care teams." We currently use RPM to support chronic disease management, care management, post-discharge monitoring, and early intervention for beneficiaries with conditions such as diabetes, hypertension, heart failure, and COPD. These services enable real-time monitoring, targeted clinical outreach, and treatment adjustments that help keep patients connected to their care teams between visits. RTM serves a complementary role by monitoring non-physiologic treatment response, symptoms, and functional status.

We caution CMS against equating increased billing volume with inappropriate utilization. Many physicians were performing elements of remote monitoring before Medicare established payment for RPM and RTM services, often without reimbursement because the services were clinically beneficial to patients. The growth in claims following creation of these codes may therefore reflect long-overdue recognition of existing care management activities and broader adoption of proven monitoring tools rather than a sudden increase in service intensity. Restrictive payment policies based solely on utilization trends risk reducing access to services that help prevent complications, improve adherence, and avoid more costly downstream utilization.

If CMS believes that there are instances of fraud, waste, or abuse, we urge a targeted response instead of a wholesale industry disruption that will impact access to meaningful services that promote well-being and maintain beneficiaries in the community. Given workforce shortages in healthcare, partnerships with vendors to delivery these services should not be considered unwelcome but rather viewed as an extension of the care team. CMS should be promoting RTM and RPM instead of dissuading their use and we urge CMS to work with stakeholders to address any concerns.

ACCESS TO BEHAVIORAL HEALTH SERVICES

UnityPoint Health is the largest provider of behavioral health services in Iowa.

Integrating Behavioral Health into Advanced Primary Care Management (APCM)

In the final year of a four-year transition for timed behavioral health codes, CMS proposes to include smoking and tobacco use cessation and screening, brief intervention, and referral to treatment (SBIRT) services.

Comment: We offer these services and support this proposal.

Psychiatric Collaborative Care Model (CoCM)

[5] Alliance for Connected Care, Letter to Administrator Oz – *Proposed Remote Monitoring Policy Would Disrupt Patient Access to Care* – dated August 14, 2026

CMS proposes increasing work RVUs and behavioral healthcare manager labor valuations for psychiatric CoCM services to better reflect the work involved and comparable clinical labor rates. The proposed changes would result in increases of up to 46.3 percent for certain CoCM codes.

Comment: We support the proposed increases in reimbursement for Psychiatric CoCM services. CoCM is a proven, measurement-based, team-oriented approach that integrates behavioral health into primary care, improves access to mental health services, supports proactive intervention, and aligns with CMS' goal of advancing preventive, patient-centered care. The proposed payment increases more appropriately reflect the significant clinical coordination, psychiatric consultation, care management, and treatment optimization required to successfully implement the model and improve patient outcomes.

RURAL HEALTH CLINICS (RHCs)

UnityPoint Clinic has 35 RHCs in Iowa, which are vital to providing access to healthcare for our rural residents. UnityPoint Clinic appreciates and supports the operational flexibilities proposed in the rule. In addition, we request that RHC telehealth services be reimbursed at the full all-inclusive rate (AIR), instead of the fee-for-service physician office rate. AIR is a cost-based payment put in place to help address the inadequate supply of providers who serve Medicare beneficiaries and Medicaid enrollees in rural areas.

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)

CMS proposes to recognize DSMT and MNT services as qualified preventive services that are covered and paid the AIR as stand-alone billable visits under the RHC benefit.

Comment: UnityPoint Clinic supports the proposal to recognize DSMT and MNT services as qualified preventive services under the RHC benefit. Diabetes remains one of the most prevalent and costly chronic conditions affecting Medicare beneficiaries, particularly in rural communities. DSMT and MNT are evidence-based interventions that improve self-management, support healthy lifestyle changes, enhance treatment adherence, and help prevent avoidable complications, hospitalizations, and emergency department utilization. Recognizing these services as stand-alone billable visits paid at the AIR will improve beneficiary access to preventive care while supporting RHC financial sustainability.

Telehealth Services

To align with CAA (2026), CMS proposes to enable RHCs to eliminate the in-person visit requirements for mental health visits and extend payment for non-behavioral health visits furnished via telecommunication technology through December 21, 2027.

Comment: We appreciate Congress' extension of these important telehealth flexibilities and support CMS' efforts to preserve access to care for rural Medicare beneficiaries. However, extending telehealth authority without addressing the underlying reimbursement disparity does not provide a sustainable pathway for rural healthcare access.

Under current policy, RHCs bill HCPCS code G2025 for more than 280 telehealth services, receiving a single payment rate of $97.53 in 2026 regardless of the service furnished. This reimbursement is substantially lower than both the Medicare PFS payment for comparable telehealth services and the RHC AIR paid for in-person visits. As a result, the current payment structure creates a financial disincentive for RHCs to

invest in and expand telehealth services despite significant patient demand.

Telehealth has proven to be an effective strategy for extending specialty care into rural communities. In one of our rural markets, RHC telehealth currently supports approximately 36 pulmonology visits, 12 gastroenterology visits, and 320 neurology visits each month, services that would otherwise require lengthy travel or may be unavailable altogether. Demand for similar specialty access exists in additional rural communities across our system, yet current reimbursement levels limit our ability to expand these services.

If CMS and Congress seek to improve rural access to specialty care, telehealth should be incentivized, not disadvantaged. **We therefore urge CMS and Congress to work with the National Association of Rural Health Clinics to establish payment parity for RHC telehealth services and ultimately align telehealth reimbursement with the RHC AIR**. Doing so would strengthen rural healthcare infrastructure, expand specialty access, and ensure that Medicare beneficiaries can receive care closer to home.

CLINICAL LABORATORY FEE SCHEDULE (CLFS) PAYMENT AND REPORTING REQUIREMENTS

To align with CAA (2026), CMS proposes to update the requirements for data collection and data reporting as well as the phase-in of payment reductions for clinical diagnostic laboratory tests (CDLTs) paid under the CLFS.

Comment: As background, UnityPoint Health laboratories provide comprehensive laboratory and pathology services to patients in our hospitals, clinics, and home health settings. Laboratory services are also provided to nursing home residents, assisted living facilities, physician offices, and other hospitals in many regions. Our laboratories perform thousands of tests daily and over 14 million tests annually. Testing is offered in all general laboratory disciplines and certain specialty services for clinical and anatomical pathology.

We appreciate efforts to implement the statutory requirements contained in CAA (2026). However, we continue to have concerns regarding the resumption of CLFS payment reductions based on private payer rate reporting. Clinical laboratories continue to face significant inflationary pressures, labor shortages, supply chain challenges, and increasing regulatory requirements that were not reflected in the market data used to establish current payment rates. Further reductions are likely to disproportionately impact laboratories serving rural and underserved communities, where access to local laboratory services is already fragile.

The repeated Congressional delays to CLFS payment reductions reflect a longstanding bipartisan recognition that additional evaluation is necessary before fully resuming PAMA-related cuts. Given the continued questions regarding the representativeness of the underlying private payer data and the potential impact on beneficiary access, **we urge Congress and CMS to further delay payment reductions while evaluating alternative approaches to data collection and rate setting**. Any future payment updates should be based on transparent, representative market data that accurately reflects the costs of furnishing laboratory services across diverse provider settings, including rural hospitals and health systems.

Clinical laboratory testing is foundational to timely diagnosis, chronic disease management, preventive care, and population health initiatives. Policies that undermine the financial viability of local laboratory services risk increased turnaround times, reduced access, and greater dependence on distant reference laboratories.

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

CMS proposes to expand 340B reporting by covered entities to the Medicare Part D Claims Data 340B Repository beginning with claims with a date of service on or after January 1, 2027.

Comment: UnityPoint Health supports efforts to develop a retrospective mechanism for identifying Part D claims associated with 340B-acquired drugs for purposes of implementing the Medicare Prescription Drug Inflation Rebate Program. We continue to believe that a retrospective claims-based methodology similar to the Oregon Medicaid model is preferable to prospective claim modifiers and better reflects the operational realities of the 340B program.

At the same time, we have concerns regarding the proposal to transition from voluntary to mandatory reporting beginning January 1, 2027. Covered entities, contract pharmacies, third-party administrators, and health systems will require substantial time and resources to establish, validate, and maintain the processes necessary to collect and transmit claims-level data accurately and consistently. CMS should ensure that covered entities have sufficient implementation time, clear technical specifications, and a robust testing period before mandatory reporting requirements become effective.

We also encourage CMS to minimize duplicative reporting obligations and provide strong safeguards governing the use, disclosure, and retention of repository data. Claims information submitted by covered entities should be used solely for purposes authorized by statute and should not be made available for unrelated commercial activities or program oversight functions outside CMS' stated objectives.

Lastly, we believe the loss of Medicare enrollment would be an extreme response to routine reporting errors or implementation difficulties, particularly while the repository remains in a testing phase. We encourage CMS to provide notice and reasonable time to correct problems, set thresholds separating significant failures from minor errors, protect good-faith submissions and reasonable efforts to resolve errors outside providers' control, and use progressively stronger enforcement measures before any enrollment action.

REQUESTS FOR INFORMATION

Redesigning Primary Care to Make America Healthy Again

CMS seeks input on reconsidering primary care service valuation to better support our objectives of shifting the U.S. healthcare system toward a focus on preventive rather than reactive medicine. Comments are sought on: 1) reconsidering relative primary care payment; 2) understanding the payment implication of including technology in primary care; and 3) establishing prospective primary care payment in MSSP and Original Medicare.

Comment: UnityPoint Clinic appreciates CMS' willingness to consider broader reforms to primary care

payment and shares the agency's goal of strengthening longitudinal, relationship-based primary care. **We encourage CMS to ensure that future payment reforms are operationally simple and scalable. While innovation in primary care payment is important, increasingly complex coding structures, documentation requirements, and reporting expectations can undermine the intended benefits of reform and create additional burden for physicians and care teams.** Any technology-enabled payment policies should prioritize simplicity, interoperability, and measurable improvements in patient outcomes rather than requiring providers to navigate multiple new billing codes, administrative processes, or documentation frameworks. As CMS evaluates prospective payment, capitated arrangements, artificial intelligence, digital tools, and technology-enabled care models, we encourage the agency to focus on payment approaches that reward outcomes, support team-based care, and reduce administrative complexity while preserving physician time for direct patient care. This will better position primary care practices to manage chronic disease, improve prevention, and advance the goals of value-based care.

We also support the continued exploration of prospective and hybrid payment models that provide greater predictability and flexibility than traditional fee-for-service reimbursement and better recognize the value of care management, prevention, care coordination, and population health activities that occur outside of face-to-face visits. As CMS considers future payment models, we encourage the agency to build upon lessons learned from MSSP, ACO Primary Care Flex, APCM services, and other accountable care initiatives, while ensuring that incentives remain aligned with total cost of care accountability. As a longstanding participant in accountable care models through UnityPoint Accountable Care, UnityPoint Clinic has firsthand experience with the opportunities and operational challenges associated with transitioning from volume-based to value-based payment. **Prospective payment approaches should support primary care investment, reduce unnecessary administrative burden, and create flexibility for providers to deliver services in the manner most appropriate for patients. We encourage CMS to continue developing these concepts in close collaboration with accountable care stakeholders, including organizations such as the *National Association of ACOs (NAACOS)* and *Accountable For Health (A4H)***, whose members have extensive experience implementing population-based payment models and can provide valuable operational insight regarding model design, beneficiary engagement, risk accountability, and primary care transformation.

Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

CMS is soliciting stakeholder input to inform potential actions aimed at addressing these interoperability and duplicate testing concerns.

Comment: Diagnostic testing should be informed by complete and timely access to prior results rather than arbitrary frequency limits. **CMS should prioritize interoperability, real-time result sharing, and provider access to longitudinal patient records before considering payment restrictions related to duplicate testing**. ACOs and other value-based care entities are well positioned to identify clinically unnecessary duplication while preserving appropriate repeat testing when a patient's condition changes, additional information is required, or prior results are unavailable.

PAYMENT FOR SKIN SUBSTITUTES

CMS proposes to nationally price the nonsheet form skin substitutes consistent with the payment rates associated with the sheet form skin substitutes. The proposed per unit rate is maintained at $127.14/cm^2.

Comment: UnityPoint Clinic 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 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 *A4H*, 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 LEAD 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.

AMBULATORY SPECIALTY MODEL (ASM)

CMMI plans to launch a new mandatory, 5-year alternative payment model for heart failure and low back pain beginning January 1, 2027. The two-sided risk model aims to improve beneficiary and provider engagement, incentivize preventive care, and increase financial accountability for specialists.

***Comment*:** While we understand CMS' motivation to rein in specialist low-value care and transition to value-based care, **ASM competes with and limits specialists' participation in Advanced APMs and particularly ACOs who are charged with total cost of care**. The ASM financial adjustment schedule incentivizes specialists to remain in fee-for-service instead of moving to two-sided accountable care models – detracting from ACO uptake and financial standing. For specialists participating in ACOs, ASM layers more metrics and benchmarks for episodic care. CMS should exempt specialists from mandatory participation in ASM when they elect to participate in ACOs with Advanced APM QP status.

Although we believe ASM adds unnecessary complexity, we appreciate that CMS lists ASM participants on a public-facing webpage.[6] While the webpage's data fields include individual NPIs, the data fields do not include organizational TINs but rather the Organization Legal Name. As some providers practice under multiple TINs, **we request that CMS consider including a TIN field on the ASM participant webpage for**

[6] https://data.cms.gov/cms-innovation-center-programs/disease-episode-based-payment-models/ambulatory-specialty-model-participants/data

clarity and ease of cross-referencing.

In the ASM low back pain quality measure set, CMS proposes a new measure as well as a replacement measure for a total of five measures. The new measure – Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain (modified for ASM) – is a modified version of a measure removed from the Hospital Outpatient Quality Reporting Program in 2017. This measure raises concern because although CMS touts its virtue as an administrative, claims-based quality measure, CMS only commits to providing detailed measure information "before the start of the 2027 ASM performance year." Even with administrative claims, the timing of this notice does not facilitate sufficient time for Participants to review and understand measure implications.

The replacement measure – Functional Outcome Assessment (MIPS Q182) – is proposed in exchange for Functional Status Change for Patients with Low Back Impairments (MIPS Q220) that is being removed from the MIPS measure inventory because the measure steward does not intend to maintain it. Our concerns with this replacement measure are two-fold: first, the measure (like the one being replaced) is a MIPS CQM, when CMS is encouraging a transition to eCQMs; and second, the measure is not supported by our EMR vendor and there is insufficient time to develop a reporting construct. As a result, we request that CMS provide alternative reporting options for a fifth ASM low back pain quality measure. Finally, UnityPoint Accountable Care supports the use of a standardized tool such as Patient-Reported Outcomes Measurement Information System (PROMIS)s for consistency across platforms and specialists.

Overall, as CMS continues to evolve its specialty engagement strategy, we believe that total cost of care models should be prioritized over episodic care models, and that CMS should revisit how to better leverage ACOs. CMS should create incentives for specialists to engage with total cost of care entities, such as allowing QP eligibility to account for downstream risk arrangements, exempting specialists in ACOs from other mandatory models, and addressing program rules that necessitate the removal of specialists from ACOs. CMS should also facilitate more robust data sharing with ACOs to empower innovation. Data to ACOs should include robust, detailed local market data on cost and quality of specialists, rather than data limited solely to attributed ACO populations.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

UnityPoint Accountable Care is currently participating in the ENHANCED Track of the MSSP. In addition to the following comments, **UnityPoint Accountable Care is a member of the NAACOS and A4H. Both organizations have also submitted comment letters to this proposed rule, and we encourage CMS to consider their input**.

Financial Incentives for Two-Sided Risk

CMS proposes to increase the shared savings rate for Level E of the BASIC Track from 50% to 60%; reduce the maximum weight used in calculating the positive regional adjustment for ACOs participating under the ENHANCED Track from 50% to 35%; increase the prior savings adjustment's scaling factor from 50% to 75%; and risk adjust the 5% cap on upward adjustments to the historical benchmark.

Comment: UnityPoint Accountable Care appreciates the intent to develop policies to increase the number of healthcare providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Fund while improving the quality of care for beneficiaries. **We support both the sharing rate and risk-adjusted 5% cap proposals as is. As for the scaling factor, we believe this is directionally correct but its magnitude will do little to reduce the ratchet effect.** We support the recommendation of A4H and urge CMS to increase the scaling factor to 95%.

CMS should not reduce the maximum positive regional adjustment for ENHANCED Track ACOs from 50% to 35%. The current adjustment appropriately rewards ACOs that have achieved sustained efficiency relative to regional peers while voluntarily accepting the highest level of downside risk under MSSP. Reducing the adjustment would weaken a critical incentive for ACOs to advance to and remain in the ENHANCED Track, diminish the return on years of investment in care transformation, and increase benchmark ratcheting for the program's most efficient participants.

Insufficient evidence has been offered to justify this change. CMS suggests that positive regional adjustments may contribute to stronger ACO performance, but this outcome is consistent with the policy's intended purpose. The Regional Efficiency Adjustment was specifically designed to reward ACOs that deliver care more efficiently than their regional peers. The fact that efficient, long-standing ACOs benefit from the adjustment demonstrates that the policy is working as intended, not that it has failed. Before weakening a foundational benchmark policy, CMS should conduct rigorous analyses demonstrating that the current approach creates unintended consequences that outweigh its benefits.

We also disagree with CMS' assertion that a larger prior savings adjustment can offset a reduction in the Regional Efficiency Adjustment. These policies serve distinct purposes. The prior savings adjustment mitigates benchmark ratcheting between agreement periods, while the Regional Efficiency Adjustment recognizes sustained efficiency relative to market performance. CMS' own analysis shows that many ACOs would still experience net benchmark reductions under the proposal. As a result, reducing the positive Regional Efficiency Adjustment would effectively intensify the benchmark ratchet effect for ACOs that have already delivered significant savings to Medicare.

If CMS is concerned that newly formed ACOs or newly participating providers may receive favorable regional adjustments before demonstrating long-term performance, CMS should pursue a targeted solution rather than reducing incentives for all ENHANCED Track participants. Finally, the proposal would create an unnecessary inconsistency with the LEAD Model, where CMS recently adopted the 50% positive Regional Efficiency Adjustment based on MSSP experience. Maintaining the current policy across CMS ACO programs/models would provide greater stability, consistency, and certainty for ACOs pursuing advanced value-based care arrangements.

To encourage longitudinal preventive services, CMS could consider excluding preventive services from MSSP total cost of care calculations. For instance, the current use of APCM services in ACOs is limited because ACOs have historically used shared savings to offer similar approaches and billing for this service would impact our benchmark. To increase uptake by ACOs and enable investments in other care innovations, **we request that CMS consider eliminating the costs associated with billing preventative**

services (such as APCM) from the total cost of care when calculating an ACO's shared savings/losses. This approach would increase the adoption of more value-based care improvement options (like preventative and chronic care management) and alleviate some of the ratchet effect.

Benchmark and Financial Data and Reporting

Growth Adjustment to the Historical Benchmark – *This adjustment is intended to reward ACOs for recruiting ACO professionals who are inexperienced with value-based care arrangements and serving beneficiaries new to value-based care. This growth adjustment would be applied on top of the highest existing benchmark adjustments, not exceed the proposed risk adjusted 5% cap, and be included in a subsequent agreement period's prior savings adjustment (if applicable).*

Comment: As an early adopter of Medicare ACO models/programs, UnityPoint Accountable Care understands CMS' desire to encourage greater uptick in value arrangements and we support a Growth Adjustment that expands participation in accountable care and increases the number of beneficiaries receiving care through value-based arrangements. **We agree with NAACOS that this policy is a positive step toward encouraging growth in accountable care but may have limited impact as currently structured.** Specifically, we recommend CMS remove the requirement that qualifying beneficiary growth be attributable only to newly added ACO professionals, as ACOs may successfully expand beneficiary participation through a variety of mechanisms beyond recruiting new providers. We also agree with NAACOS that the current five percent cap on positive benchmark adjustments will substantially limit the effectiveness of this incentive for many ACOs and encourage CMS to increase the cap so organizations can fully benefit from growth-related benchmark adjustments. Together, these modifications would better support program expansion, reward successful beneficiary engagement efforts, and strengthen incentives for continued participation in accountable care.

Accountable Care Prospective Trend (ACPT) – *CMS proposes to implement a guardrail policy that limits the effect of under-projection or over-projection as compared to observed growth in expenditures for the national assignable FFS population such that the ACPT is no more than 1 percentage point below (or no more than 1.5 percentage points above) national growth. The lower guardrail would be implemented retroactively for ACOs within existing agreement periods with 2024, 2025, and 2026 start dates. Also, CMS proposed to calculate annualized growth rates for each performance year.*

Comment: **Thank you!!** UnityPoint Accountable Care has been a vocal proponent for ACPT reform – guardrails, releasing rate in advance of PY start, and annual ACPT update across all start years. We appreciate the willingness of CMS to participate in multiple stakeholder forums and listening sessions to hear input on this issue. You listened and incorporated feedback in this rule. **UnityPoint Accountable Care supports these ACPT reforms. In addition, we agree with NAACOS and request that in the future CMS consider issuing provisional reconciliations while it completes the final reconciliation,** including issuing 2025 provisional settlement reports for ACOs awaiting final reconciliations.

Additional Stakeholder Feedback: CMS Reporting Packages – As a healthcare business, ACOs must engage in budgeting and financial planning. For 2025 performance year, ACOs finalized provider lists in September 2024, and CMS issued settlement reports in August 2026. The lag time between provider list submission and settlement reports is 23 months. Even for ACOs with a staff actuary, this nearly 2-year lag

stimies operations and clinical innovation. If MSSP ACOs could obtain reasonable estimates by September/October 2025 (12-13 months instead of 23 months), the investment decision cycle would be cut in half. **We request that CMS equip MSSP ACOs with more frequent and transparent data and reporting packages**. **As a starting point, CMS could utilize data and reports supplied to REACH ACO Participants – Monthly Expenditure Reports, Quarterly Benchmark Reports, Quarterly Risk Score Reports, and monthly trend updates.** Consistent data sharing and reporting packages would also aid ACOs and/or providers choosing to transition between CMS and CMMI models. To enable quicker MSSP ACO investments and hasten innovation, UnityPoint Accountable Care urges CMS to share the following (using 2025 performance year as a reference point):

- 2025 risk scores starting in the Q2 reporting package.
- 2025 re-normalization factor estimate starting in the Q2 reporting package.
- SAHS billing for the region in the quarterly reporting package.
- BM3 regional expenditures for prospective ACOs.
- BM3 and PY regional risk scores.
- Reporting packages with formulas!

Please note that formula transparency is particularly helpful as ACOs audit our performance and engage in continual improvement projects to replicate results.

Related to report timing, we request that CMS:

- **Provide more specificity on report release windows**. Specifically, notice of timeframes could provide approximate months or a more specific anticipated release window (rather than broader seasonal references such as "Fall 2026") to reduce ambiguity and create clearer expectations. Broader seasonal references span roughly three months and may be interpreted differently by readers. For example, a recent ACO Spotlight stated, "A final annual Chronic Conditions Report will be released in Fall 2026."
- **Release preliminary impact reports when MSSP rulemaking timelines are delayed.** When final regulations or sub-regulatory guidance are delayed and released near or after the start of a performance year, ACOs are often required to make operational, financial, and care delivery decisions without fully understanding the impact of pending policy changes. At a minimum, CMS should provide scenario-based analyses showing estimated performance and benchmark impacts under both the current policy and the proposed policy assumptions. Similar to the expectations placed on participants in value-based payment models to operate within established reporting timelines despite delays in final results, CMS should provide ACOs with timely preliminary information to support planning, forecasting, and investment decisions.

In addition, MSSP ACOs must monitor and evaluate not only changes to the MSSP itself, but also modifications to other CMS and CMMI value-based payment models that may overlap with MSSP. New

models and policy changes can have significant implications for ACO benchmarks, beneficiary attribution, participant composition, and care delivery opportunities, often requiring ACOs to engage external actuarial and analytic support to assess potential financial and operational impacts. To improve transparency while reducing the need for costly independent analyses, **we request that CMS and CMMI consider providing ACO-specific impact analyses when proposing or implementing new models and major policy changes that affect MSSP performance**. **For instance, we request that CMS include the proposed E/M complexity modifiers (MOD1 and MOD2) within the expenditure report.** At a minimum, CMS should furnish ACOs with estimates illustrating how proposed changes would have affected the ACO's historical performance and how they are expected to influence current and future benchmark calculations, attribution, and financial outcomes. Providing this information directly would enable ACOs to make more informed participation and investment decisions while reducing the need for costly independent analyses.

Additional Stakeholder Feedback: Modernizing MSSP Risk Adjustment

MSSP continues to rely exclusively on prospective risk scores when determining risk-adjusted expenditures.

Comment: UnityPoint Accountable Care appreciates CMS' continued efforts to refine MSSP benchmark methodology and encourages the agency to explore a blended risk adjustment approach that incorporates both prospective and concurrent risk factors. While prospective risk adjustment appropriately protects against incentives to increase coding intensity, it may not fully capture meaningful changes in beneficiary health status that occur during the performance year, particularly among populations with complex chronic conditions, significant acute events, or rapidly evolving clinical needs. A blended methodology would better align benchmark adjustments with the actual health status of beneficiaries for whom ACOs are accountable and could improve the accuracy of expenditure projections and financial reconciliation.

Research and operational experience across value-based payment models demonstrate that concurrent risk information inclusion is often a stronger predictor of current-year cost and utilization than prospective risk scores alone. By incorporating diagnoses and clinical information from the performance year, concurrent methodologies can more accurately reflect changes in disease burden, newly emerging conditions, and acute health events that materially affect spending. CMS itself has acknowledged the importance of accurate risk adjustment in population-based payment models, and several CMMI models, including ACO REACH and Kidney Care Choices, employ sophisticated risk-adjustment methodologies that continue to evolve to better align payments with beneficiary acuity. While LEAD applies concurrent evidence into its calculation of high-needs membership risk profiles, this is an important feature for Medicare (aged) beneficiaries generally and should not be restricted to “high-needs” populations.

Importantly, blended approaches are already common in value-based care. Medicare Advantage utilizes a prospective CMS-HCC model for payment, while plans routinely use concurrent risk analytics to manage populations, forecast expenditures, and identify changes in member acuity. Likewise, many commercial payers and accountable care arrangements incorporate both historical and current-year clinical information when establishing financial targets and evaluating performance. Although safeguards against coding-driven risk score growth remain important, CMS should evaluate whether a limited, carefully

designed concurrent component could improve benchmark accuracy without undermining program integrity.

We encourage CMS to test alternatives through modeling and stakeholder engagement, including approaches that blend prospective and concurrent risk factors, apply condition-specific adjustments for newly emergent high-cost conditions, or limit concurrent adjustments to beneficiaries experiencing significant changes in health status. Such policies may better account for the complexity of today's Medicare population while reducing situations in which ACOs are financially disadvantaged for appropriately caring for beneficiaries whose health status deteriorates during the performance year. Ultimately, more accurate risk adjustment would improve benchmark precision, strengthen confidence in MSSP financial results, and better align accountability with the clinical realities facing providers participating in total cost of care models.

Beneficiary Assignment

Among the changes, CMS proposes to exclude from assignment primary care services billed through a non-ACO Taxpayer Identification Number (TIN) by an ACO professional; and include for assignment updates to the definition of primary care proposed in the CY2027 PFS rule.

Comment: UnityPoint Accountable Care supports CMS' proposal to align beneficiary assignment more precisely with participating ACO providers. Beneficiary assignment should reflect the clinicians and organizations that are actually accountable for the beneficiary's cost and quality outcomes under the MSSP. Excluding primary care services billed under a non-ACO TIN by an ACO professional is a reasonable and necessary refinement that will improve assignment accuracy and reduce unintended attribution.

We also support updating the assignment methodology to reflect any finalized changes to the CY 2027 PFS definition of primary care services. Beneficiary assignment should continue to prioritize clinicians and care settings that serve as the focal point for ongoing, comprehensive care management. Collectively, these changes will help ensure that beneficiaries are assigned to the providers and organizations most responsible for managing their overall health and healthcare utilization.

Lastly, **we request that CMS continue this focus on primary care attribution and disallow attribution from Advanced Practice Providers practicing in specialty settings**. UnityPoint Accountable Care has observed instances where patients are attributed through Advanced Practice Providers practicing in specialty settings, even though those clinicians are not serving as the beneficiary's longitudinal source of primary care. CMS has already recognized in models such as Making Care Primary that beneficiary attribution should be centered on primary care relationships rather than specialty care encounters. LEAD also has a design feature that allows exclusion of Advanced Practice Providers identified as specialists from attribution. We encourage CMS to incorporate similar attribution rules in MSSP.

Beneficiary Engagement

CMS proposes to allow ACOs to reduce or eliminate Part B cost sharing for beneficiaries in accordance with an approved implementation plan starting April 1, 2027. Additionally, CMS proposes to change beneficiary notification to once during the agreement period by May 30th or later if specified by CMS.

Comment: UnityPoint Accountable Care supports CMS' proposals to strengthen beneficiary engagement

and reduce unnecessary administrative burden. **We support the proposal to require beneficiary notification only once during an agreement period**, unless otherwise directed by CMS. Once beneficiaries have been informed of their participation in an ACO and their rights, repeated notifications provide limited additional value and may contribute to beneficiary confusion. Streamlining these requirements preserves transparency while allowing ACOs to focus resources on direct patient engagement and care coordination.

We also strongly support the proposal to allow eligible ACOs to reduce or eliminate Medicare Part B cost sharing through an approved implementation plan. We agree that the current Beneficiary Incentive Program is often too restrictive and administratively burdensome to serve as an effective beneficiary engagement tool. Cost sharing remains a meaningful barrier to accessing primary care, preventive services, chronic disease management, and other high-value care. Allowing ACOs to reduce financial barriers is consistent with the goals of accountable care and provides organizations with an important tool to encourage beneficiary engagement, improve adherence to recommended care, and support better health outcomes. ACOs are uniquely positioned to identify populations that would benefit from targeted cost-sharing assistance and evaluate the impact of these interventions on utilization, outcomes, and total cost of care. We believe these proposals will improve beneficiary access to care, support population health management, and further the principles of value-based care.

As CMS explores additional beneficiary engagement strategies, **we encourage the agency to evaluate whether differential beneficiary cost-sharing could be used to promote informed site-of-care decision-making when clinically appropriate alternatives are available**. Medicare cost-sharing obligations generally do not reflect the substantial variation in Medicare expenditures that may occur across post-acute care settings providing comparable skilled nursing services. For example, skilled nursing care furnished in hospital-based swing-bed settings, particularly within Critical Access Hospitals, can be several times more expensive to the Medicare program than care provided in freestanding skilled nursing facilities.

When clinically appropriate and consistent with beneficiary preferences, aligning beneficiary cost-sharing more closely with the relative cost of care could encourage consideration of lower-cost settings while preserving beneficiary choice and access to services. Such an approach would not restrict care options or deny coverage, but rather provide beneficiaries with greater transparency regarding the cost implications of available care settings. We encourage CMS to explore demonstrations or future policy options that promote value-based beneficiary decision-making, support more efficient use of Medicare resources, and advance the goals of accountable care and total cost of care management.

Additional Stakeholder Feedback: Care Delivery Flexibilities

For total cost of care programs/models, two-sided ACOs by definition are incentivized to provide holistic, value-based care. UnityPoint Accountable Care urges CMS to consider additional care delivery flexibilities to remove regulatory burdens that limit beneficiary choice as guided by ACO professionals.

- Anytime Calendar Year Annual Wellness Visits (AWV): While we have already suggested earlier in our letter that CMS should allow this flexibility for ALL Medicare beneficiaries, we firmly believe that at minimum this flexibility should be extended to MSSP beneficiaries to be consistent with

the flexibility available to many Medicare Advantage and Innovation Center model beneficiaries. The current requirement to wait a full 11+ months between AWVs can create unnecessary delays in preventive care, risk assessment, care planning, and quality-gap closure. Allowing calendar-year AWVs would improve beneficiary access to timely preventive services, simplify scheduling and outreach efforts, align incentives across Medicare programs, and support CMS' goals of prevention, chronic disease management, and value-based care

- Post Discharge Home Visits – We encourage CMS to extend post-discharge home visit flexibilities to MSSP Enhanced Track ACOs, similar to those available in other risk-bearing models such as LEAD and CJR-X. ACOs participating in two-sided risk arrangements are accountable for the cost and quality of care following hospitalization, yet beneficiaries often do not qualify for traditional home health services despite remaining at elevated risk for complications, medication issues, falls, and avoidable readmissions. Allowing targeted post-discharge home visits would enable ACOs to perform medication reconciliation, assess home safety, provide caregiver education, identify emerging clinical concerns, and improve care coordination during the highest-risk period following discharge.

  As CMS increasingly holds providers accountable for total cost of care and patient outcomes, Medicare policies should provide corresponding flexibility to deploy evidence-based interventions in the home. Post-discharge home visits are a low-cost, targeted tool that can support recovery, reduce avoidable utilization, improve patient experience, and help ACOs succeed under value-based payment arrangements. Extending this flexibility to MSSP Enhanced Track participants would better align Medicare policy with the goals of accountable care and population health management.

- Three-Day Waiver Skilled Nursing Facility (SNF) Star Rating Exception – We support CMS' continued emphasis on high-quality post-acute care and recognize the role that the Skilled Nursing Facility Five-Star Quality Rating System can play in helping beneficiaries and providers evaluate facility performance. However, we are concerned that the immediate loss of three-day SNF waiver eligibility when a participating SNF's rating falls from three stars to two stars may create unintended access challenges for beneficiaries and operational disruptions for ACOs, particularly in rural and underserved communities.

  Post-acute care capacity remains constrained in many markets due to workforce shortages, facility closures, and limited provider availability. In these environments, ACOs often develop longstanding care coordination relationships with local SNFs that may experience temporary rating fluctuations despite continued investments in quality improvement and strong clinical collaboration. Immediate removal from the waiver-approved SNF list can disrupt established referral patterns, delay beneficiary placement, complicate discharge planning, and reduce patient choice at a time when timely access to post-acute care is increasingly challenging.

  As organizations bearing accountability for total cost of care and patient outcomes, Enhanced Track ACOs are well positioned to evaluate and balance quality, access, beneficiary preferences,

and local market realities. Specifically, **CMS should permit Enhanced Track MSSP ACOs to continue utilizing the three-day SNF waiver with participating SNFs for up to 12 months following a decline from three stars to two stars, provided the facility remains Medicare-certified and is actively engaged in quality improvement activities**. This policy would preserve beneficiary access and care continuity while still incentivizing facilities to restore higher performance ratings.

Quality Performance Standards and Other Reporting Requirements

Relevant comments are contained within the *Quality Payment Program (QPP)* narrative below, and particularly under the *Alternative Payment Model (APM) Performance Pathway (APP)* section. In addition, we offer the following recommendations to improve the quality program.

Quality Performance: CMS should consider developing quality and outcome measures that place greater emphasis on preventing avoidable hospitalizations, particularly for patients with chronic and complex conditions. While reducing readmissions remains important, an initial hospitalization often marks a significant decline in health status and is associated with increased costs, morbidity, and mortality. **Expanding measures that reward effective care management, proactive care coordination, and other interventions that help patients remain healthy and avoid hospitalization would better align incentives with the goals of prevention and population health management**.

CMS should also consider expanding measures related to palliative care and primary-care-focused advance care planning, including documentation of goals of care and advance directives. Earlier engagement in palliative care can help ensure treatment aligns with patient preferences, improve patient and family experience, and reduce unnecessary utilization. Together, these measures would support a more proactive, patient-centered approach that emphasizes prevention, goal-concordant care, and better outcomes.

Shift Emphasis from Thresholds to Incentives: CMS should strengthen the role of quality performance in MSSP shared savings by allowing exceptional quality performance to increase shared savings, rather than using quality primarily as a mechanism to reduce them. Iowa Health Accountable Care has consistently been among the highest-performing ACOs in MSSP. In Performance Year 2024, Iowa Health (UnityPoint Accountable Care) achieved a QualScore of 95.11, ranking 14th among 477 ACOs nationally. Despite this level of performance, the current methodology provides limited additional financial recognition for organizations that achieve exceptional quality outcomes.

Under the current design, quality functions largely as a minimum participation standard. ACOs with average quality performance may earn substantial shared savings, while organizations that invest heavily in care management, prevention, and quality improvement receive little additional benefit for top-tier performance. **CMS should consider establishing a quality bonus or shared savings multiplier for high-performing ACOs, particularly those achieving exceptional quality scores.** Like a Medicare Advantage quality bonus structure, CMS should allow quality excellence to increase, rather than simply protect, shared savings. This would better align program incentives with CMS' goals of improving patient outcomes, rewarding high-value care, and advancing accountable care.

QUALITY PAYMENT PROGRAM (QPP)

Merit-based Incentive Payment System (MIPS)

CMS proposes to sunset the traditional MIPS reporting option after the CY 2028 performance period.

Comment: **We support and applaud the sunset of MIPS**.

Quality Category – *CMS proposes a total of 180 quality measures for the CY 2027 performance period, which is 10 fewer than in 2026. The designation of high priority is being replaced with the concept of core measures, and 78 measures are designated as core measures. MIPS eligible clinicians will be required to report at least one core measure, replacing the requirement to report an outcome measure, and topped out core measures will have a 10-point maximum score.*

Comment: **We support the adoption of core measures**, instead of high priority measures.

Improvement Activities (IAs) – *CMS proposes six new IAs, five modified IAs, and 11 removed IAs.*

Comment: IAs are essentially an additional workflow without discrete numerator denominator values. These workflows must be integrated into provider systems, and they can be cumbersome to implement. **We support the removal of topped-out IAs**; however, we reiterate that modifications to existing IAs can be just as burdensome as implementing a new IA and require time, effort, and cost.

CEHRT Requirements – *CMS proposes revisions to conform with the decertification proposals for the ONC Health IT Certification Criteria as outlined in the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule.*

***Comment*: We support the use of updated requirements, which align with other CMS programs.**

Promoting Interoperability (PI) Performance – *CMS proposes to remove the required ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation as well as the Security Risk Analysis measure. CMS also proposes to (1) modify the Electronic Prior Authorization measure and change its status to optional reporting and (2) establish a new measure, Electronic Prior Authorization for Prescription Drugs measure.*

***Comment*:** In the spirit of reducing administrative burden, **UnityPoint Clinic supports removal of the two ONC attestations and the Security Risk Analysis measure**. With the inclusion of electronic prior authorizations in MIPS, we are pleased that clinicians are provided an opportunity to test drive FHIR-based workflows.

MIPS Value Pathways (MVPs)

In general, we believe that instead of continually expanding MVPs (many populated with MIPS CQM measures and/or incomplete TBD measures), CMS should concentrate on digital reporting with a focus on population health constructs. MVPs further fracture the premise of population health and promote siloed care through voluminous quality measures that promote episodic care and volume to the detriment of healthcare value. **It is a disservice to Medicare beneficiaries to promote that specialist engagement can only occur through extremely specific measure sets that largely target process-based and topped-out measures. Rather, providers should be encouraged to work together on behalf of beneficiaries under holistic quality constructs.** To lessen reporting burden, we encourage CMS to leverage existing quality reporting and consider excluding any MSSP TIN participant from any mandated MVP reporting for

specialists.

MVP Measure Sets – C*MS proposes three new MVPs – Diabetic Disease, Hospitalist, and Hypertension. Additionally, CMS proposes to modify all 27 previously finalized MVPs.*

Comment: **CMS has changed every MVP proposed for 2027, and every MVP was changed in 2026.** For CY 2027, modifications to measures include MIPS core measure selections, additional measures that expand upon a clinical concept or capture additional specialties, maintenance requests from the public, and measure or activity removal or replacement. **Regardless of whether changes are well-intended, every modification relates to time, effort, and costs for providers.** This sheer volume of changes adds to provider reluctance to transition to MVPs. This magnitude also seems to suggest that MVPs are being implemented prematurely and that this construct is not ready for mandatory status.

We are also concerned about the challenges associated with advancing two significant Quality Payment Program modernization efforts simultaneously: the transition from Traditional MIPS to MVPs and the transition from eCQMs to digital quality measures (dQMs) supported by FHIR-based standards. While we support both objectives, the current approach may create unintended barriers to broader adoption of digital quality reporting. Many MVPs continue to rely heavily on MIPS CQMs, including as required core measures with limited or no alternative reporting options. As a result, providers and health systems that have invested substantially in electronic and digital quality reporting may be unable to fully leverage those investments within the MVP framework.[7] Additionally, specialists participating in MVPs may face continued reliance on more resource-intensive reporting approaches rather than benefiting from CMS' long-term vision for digital measurement.

Of the 27 currently available MVPs, 26 contain at least one core measure that is available only through the MIPS CQM collection type, and numerous MVPs rely exclusively on CQM-only core measures. The Value in Primary Care MVP remains the notable exception, offering more robust reporting flexibility.[8] As CMS continues its transition toward digital quality measurement, **we encourage the agency to prioritize the availability of adequate dQMs across specialties before requiring broad MVP participation**. Epic echoes this request to "ensure the success of these transitions."[9] Aligning the MVP transition with completion of the dQM/FHIR transition would help maximize prior investments, reduce reporting burden, and support successful long-term adoption of both initiatives.

In review of the Hospitalist MVP measure set, the inclusion of Q047: Advance Care Plan (a CQM) as a core measure creates reporting overlap and supplicative administrative burden. Q047 is collected during an inpatient hospital encounter that is also billed as an allowable Part B charge. CMS1317v1 (Advance Care Planning) is an eCQM in the Hospital Inpatient Quality Reporting Program, and CMS is the measure

[7] Epic sign-on letter in response to CMS-1848-P – "*To date, the adoption of MVPs has been limited in part because providers are not able to participate in my MVPs with their current quality reporting investments in eCQMs. Currently, seventeen MVPs contains insufficient eCQMs. In CMS' proposed rule, 21 MVPs contain insufficient eCQMs.*"

[8] The only MVP with robust reporting options for core measures is the Value in Primary Care MVP.

[9] Epic sign-on letter in response to CMS-1848-P.

steward. It is unclear why CMS would maintain two different measures eliciting the same content in the same setting by requiring a cumbersome collection process for a subset of providers. **CMS should align advance care planning measures across clinician and hospital reporting programs** to minimize duplicative workflow development, reduce documentation burden, and support consistent digital quality measurement strategies.

MVP Care Compare Reporting – *There is currently a 1-year delay to publicly report new improvement activities and the Promoting Interoperability measure and attestation information for MVP Participants on Compare Tools. CMS proposes to publicly report MVP data during the initial period.*

Comment: **We support CMS' proposal to publicly report MVP data during the initial reporting period, provided clinicians and groups retain access to a robust preview and correction process before information is made publicly available**. The original one-year delay was intended to function as a learning period, allowing participants to gain experience with new measure specifications, reporting requirements, and submission processes before results were publicly displayed. As MVP participation becomes more mature and stakeholders gain familiarity with the reporting framework, earlier public reporting is appropriate. However, CMS should continue to provide participants with sufficient opportunity to review, validate, and, when necessary, correct reported information to ensure publicly displayed results accurately reflect clinician performance rather than reporting, attribution, or implementation issues.

Alternative Payment Model (APM) Performance Pathway (APP)

MSSP ACOs are required to report the APP Plus quality measure set.

APP Plus Measure Set – *For PY 2027, this measure set includes eight measures assuming the removal of Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493) as proposed by CMS.*

Comment: **UnityPoint Accountable Care supports the removal of measures** to reduce reporting burden and streamline the APP Plus measure set to target a smaller, impactful group of measures.

Measure Collection Types – *For PY 2027 and subsequent PYs, CMS proposes to extend the CQM collection type for ACOs reporting the APP Plus quality measure set. CMS also proposes a new collection type, Medicare eCQMs. "Beneficiary eligible for Medicare CQMs" is revised to align with ACO assignment changes.*

Comment: This proposal to maintain multiple quality reporting pathways, including extending the Medicare CQM collection type while introducing the new Medicare eCQM collection type, offers options to ACOs reporting on the journey to digital quality measurement. Over the past several years, ACOs have made substantial investments in eCQM infrastructure, data mapping, workflow design, validation processes, and reporting capabilities in response to CMS' longstanding push toward electronic and digital quality measurement. While we support aligning quality measurement with assigned beneficiary populations in accountable care models, the proposed Medicare eCQM approach represents a significant departure from the all-payer/all-patient eCQM methodology that organizations have spent years implementing. As a result, ACOs will need time to redesign data extraction processes, quality monitoring workflows, and reporting strategies to accommodate this new assigned-beneficiary construct. The

proposal to extend the availability of MIPS CQMs and establish Medicare eCQMs as an additional reporting option appropriately recognizes these operational realities and provides needed flexibility during the transition.

We encourage CMS to maintain both Medicare CQMs and Medicare eCQMs for a meaningful transition period while continuing to align eCQMs, dQMs, and FHIR-based reporting standards across MSSP and QPP. A phased approach will allow ACOs to evaluate measure performance, benchmark reliability, and operational feasibility while adapting to a fundamentally different reporting population. Consistent with stakeholder concerns regarding implementation timelines for broader FHIR-based quality measurement, CMS should provide sufficient time for testing, refinement, and workflow redesign before making Medicare eCQMs the predominant reporting pathway. **We recommend maintaining reporting flexibility and preserving the Medicare CQM option for at least three PYs following Medicare eCQM implementation to ensure a successful and sustainable transition to digital quality measurement**.

MIPS Data Completeness – *For PYs beginning on or after January 1, 2026, CMS proposes to allow ACOs to exclude one or more ACO participant TINs from an ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data upon certain circumstances.*

Comment: **UnityPoint Accountable Care appreciates this flexibility**.

Quality Scoring – *For CY 2027 and beyond, CMS proposes to use flat benchmarks for Medicare CQMs and Medicare eCQMs. For CY 2026, a retroactive flat benchmark will be applied to three Medicare CQMs related to diabetes, depression screening, and high blood pressure.*

Comment: **UnityPoint Accountable Care supports the proposal to extend the use of flat benchmarks for all Medicare CQMs and to apply flat benchmarks to Medicare eCQMs beginning in PY 2027**. As ACOs continue to navigate significant changes to MSSP quality reporting, including APP Plus implementation, the introduction of Medicare eCQMs, and the broader transition to digital quality measurement, flat benchmarks provide a predictable and transparent scoring methodology that reduces uncertainty and allows organizations to focus resources on quality improvement rather than benchmarking variability. CMS has previously acknowledged stakeholder support for flat benchmarks because they improve scoring predictability and help ensure high-performing ACOs are not disadvantaged by benchmark fluctuations unrelated to actual performance.

We believe applying the same flat benchmark approach to both Medicare CQMs and Medicare eCQMs will promote consistency across collection types and create a smoother transition to digital quality reporting. Stable benchmarking policies will allow ACOs to focus on investments in data capture, clinical workflows, and FHIR-enabled reporting while CMS gains experience with the new Medicare eCQM collection type.

ACO CEHRT Use Requirements – *CMS proposes to sunset the current MSSP CEHRT use requirement and for PY 2027 require ACOs to complete one of three activities.*

Comment: **We support this change**, which lessens administrative burden.

Advanced Alternative Payment Model (APM)

CMS proposes to apply Qualifying APM Participant (QP) and Partial QP determinations at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs. For PY 2027 and beyond, the QP payment threshold will increase to 75% and the QP patient count threshold will increase to 50%.

Comment: **UnityPoint Accountable Care opposes the proposal to apply QP and Partial QP determinations at the TIN/NPI level and encourages CMS to retain NPI-level determinations**. While we understand the intent to target Advanced APM incentives to participating organizations, the proposal would weaken one of the most important incentives for physician participation in accountable care. Many physicians furnish services under multiple TINs, including ACO participant organizations, hospitals, rural outreach clinics, and other practice settings. Under the proposal, the same clinician could qualify as a QP under one TIN while simultaneously being subject to MIPS requirements and lower payment updates under another. This fragmentation reduces the value of the Advanced APM incentive, increases administrative complexity, and may discourage participation in accountable care arrangements at a time when CMS is seeking to expand value-based care participation. Consistent with the goals of accountable care, CMS should preserve a simple and predictable NPI-level approach that rewards clinicians for engaging in Advanced APMs regardless of the practice setting in which services are furnished.

While we understand that Congressional action is needed for statutory change, it is within the discretion of the Secretary to establish the MACRA patient count threshold. **We respectfully request that CMS maintain the patient count threshold at the current 35% threshold**. In your role in advising Congress, we also implore you to detail the projected impact of the threshold increases as well as bonus expiration on provider participation in CMS' transition to value and ultimately on the health of the Medicare Trust Fund.

QUALITY PERFORMANCE REQUESTS FOR INFORMATION (RFI)

Fast Healthcare Interoperability Resources (FHIR) Timeline RFI

CMS seeks information on the future transition to FHIR-based digital quality reporting for QPP, including the overall transition timeline, key milestones, and implementation considerations.

Comment: UnityPoint Accountable Care supports the long-term vision for FHIR-based digital quality measurement and appreciates CMS' efforts to provide a transition pathway toward dQMs. However, we believe the proposed timeline is aggressive given the scope of work required across CMS, measure stewards, EHR vendors, registries, ACOs, and clinicians. Successful implementation will require measure specification updates, vendor development and certification, testing environments, workflow redesign, data validation, and extensive provider education. **Stakeholders have indicated that implementation of FHIR-based quality reporting may require closer to three years rather than the proposed two-year transition period**, particularly for ACOs operating across multiple EHRs and reporting programs.

We encourage CMS to maintain existing reporting pathways during the transition, provide robust testing opportunities and implementation guidance, and avoid mandatory FHIR-based reporting until stakeholders have demonstrated operational readiness. Our support of the transition to standardized digital quality measurement is tempered by our recommendation to use a phased approach that

prioritizes successful implementation over accelerated adoption timelines. CMS should also ensure alignment of FHIR requirements across MSSP, QPP, and other quality reporting programs to maximize provider investments and reduce unnecessary burden.

MVP Scoring Methodology RFI

CMS seeks input on feedback on a scoring methodology that would allow CMS to fairly compare performance of clinicians within the same MVP, with each MVP focusing on measures and activities that are relevant to a given specialty or medical condition.

Comment: UnityPoint Clinic appreciates efforts to improve the fairness and transparency of MVP scoring and supports further evaluation of score normalization methodologies. **Any future scoring approach should prioritize predictability, transparency, and ease of implementation for clinicians and organizations**. Before adopting MVP-specific normalization, CMS should provide participants with meaningful opportunities to understand and model expected performance under the methodology. Large multispecialty organizations may participate in numerous MVPs simultaneously, making it difficult to estimate overall quality performance and financial implications without greater transparency into scoring calculations. We encourage CMS to develop projection tools, educational resources, and preview reports that allow organizations to understand how individual MVP performance translates into final scores and payment adjustments. Consistent with our suggestions for the CMS' proposed implementation timeline, any new methodology should be piloted and validated before being tied to mandatory MVP participation or payment consequences.

Star Rating Assignment Methodology RFI

CMS seeks feedback on improvements and alternative options to the current Star rating assignment methodology for quality measure scores collected under the administrative claims collection type.

Comment: MACRA requires the continuous public display of individual MIPS eligible clinician and groups performance information, in an easily understandable format, on the CMS Compare tool on Medicare.gov. **UnityPoint Clinic questions whether this exercise is meaningful given the structure of MIPS itself.** First, there are a significant number of Medicare clinicians excluded from MIPS because they qualify as Advanced APM participants, fall below the low-volume threshold, or meet other statutory exemptions, leaving many clinicians without a rating. Second, the vast majority of MIPS-eligible clinicians report as a group, making Star ratings attributable to individual clinicians dubious. Third, the MIPS measure universe contains nearly 200 measures, making direct comparisons across clinicians difficult. With this foundation, CMS seeks to assign Star ratings to administrative claims, like cost measures. We believe that applying simplified Star rating for administrative claims and cost measures runs the risk of misleading consumers instead of educating them or providing clarity.

In general, we encourage CMS to prioritize stability, transparency, and statistical reliability when evaluating alternative Star rating assignment methodologies. Any future methodology should avoid creating inconsistent benchmarks for identical measures across programs, account for the increased volatility associated with small patient populations and specialty practices, and ensure that differences in Star ratings reflect meaningful performance variation rather than methodological artifacts. CMS should

also provide clinicians with greater visibility into how ratings are calculated and the impact of performance changes on final scores. We believe these principles would promote confidence in public reporting while reducing unnecessary complexity and unintended consequences.

As CMS proceeds, we highly recommend that CMS work outside the annual payment public notice and comment period to engage stakeholders and the public. We urge CMS to establish a stakeholder workgroup, hold hearings and/or informational sessions to include both testing and technical experts, and conduct consumer focus groups before piloting a Star rating for administrative claims data.

DEREGULATION AND FRAUD, WASTE AND ABUSE

CMS seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other stakeholders participating in the Medicare program.

Comment: We suggest the following:

- Anytime Calendar Year Annual Wellness Visits (AWV): CMS should allow all Medicare beneficiaries, including MSSP beneficiaries, to receive an AWV at any time during a calendar year, consistent with the flexibility available to many Medicare Advantage and CMMI model beneficiaries. The current requirement to wait a full 11+ months between AWVs can create unnecessary delays in preventive care, risk assessment, care planning, and quality-gap closure.
- Expansion of Hold Harmless Policy for ACOs. NAACOS has previously urged CMS to hold ACOs harmless from fraudulent DMEPOS and other suspect spending by excluding such claims not only from the current performance year but also from historical benchmark calculations used in future agreement periods.[10] We respectfully request that CMS expand its SAHS policy to encompass claims associated with ANY provider under investigation by the state or federal government and their escrowed claims so that ACOs are not financially penalized for fraud, waste, and abuse beyond their control.

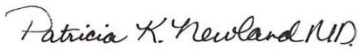
  Additionally, CMS proposed a significant overhaul of Medicare provider enrollment regulations in *CMS-1844-P, Calendar Year 2027 Home Health Prospective Payment System Rate Update*. Under the auspices of fighting fraud, waste and abuse and protection of the Medicare Trust Fund, many revisions were proposed to "prevent payments to a provider while it is out of compliance." As CMS continues this work, we recommend that ACOs (or generally providers in capitated and two-sided risk arrangements) also be held harmless for claims from non-compliant providers in the context of provider enrollment. This would include situations of retroactive revocation, and any claims from non-compliance providers should be removed from the current PY and historical benchmark calculations used in future agreement periods.

UnityPoint Clinic is pleased to provide comments on this proposed rule. To discuss our comments or for

[10] NAACOS comment letter to CMS–1832–P, CY2026 Physician Fee Schedule, dated September 12, 2025.

additional information, please contact Cathy Simmons, Government and External Affairs, at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



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