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September 12, 2025

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1832–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: CMS-1832-P: Medicare and Medicaid Programs; CY 2026 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. 90, No. 134 Federal Register 32352-33261 on July 16, 2025.

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 2026 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 health care 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 8 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 provided services to 453,990 covered lives in 2024.

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

REVISIONS TO PAYMENT POLICIES

Conversion Factor

CMS proposes calendar year (CY) 2026 physician conversion factors (CF) of 33.5875 for qualifying APM participants (QPs) and 33.4209 for all other clinicians. The QP CF is an increase of 3.8% over the CY 2025 CF and the non-QP CF is a 3.3% increase over CY 2025 CF.

Comment: UnityPoint Clinic appreciates the positive proposed rate increase, largely driven by a one-year 2.5% patch from Congress. According to the Medicare Trustees[1], Medicare physician payment updates set under 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 health care 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 health care labor and supply costs, and an escalation in regulatory burdens (e.g., prior authorization, interoperability requirements, and participating in Medicare quality programs such as MIPS). Although the CY 2026 rate increases are positive as the result of a one-time Congressional fix, the negative to low-margin rate trends with no inflationary factor ultimately threaten access to vital services provided to Medicare beneficiaries and Medicaid members. **UnityPoint Clinic supports the inclusion of an inflationary index for PFS rates to reflect the current financial landscape of health care.**

Medicare Physician Conversion Factor (2017–2026)				
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	33.4209	3.84	3.32

[1] *2024 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 4, accessed at https://www.cms.gov/oact/tr/2024 - "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 267.

Modification to the New Add-On Code for Complexity

In CY 2024, CMS finalized a new E/M visit complexity add-on code, G2211. In CY 2026, CMS proposes to allow G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family.

Comment: UnityPoint Clinic supports this proposal, which better recognizes care delivery by providers serving an aging population. As patients are being pushed to the community, we believe it was an oversight to limit G2211 to the office/outpatient (O/O) space.

TELEHEALTH AND REMOTE SERVICES

Annually, 153,000 UnityPoint Clinic patient visits use telehealth[3], which represents 3% of total patient visits, and 28,000 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 billing providers when authorized on a permanent basis.

Telehealth Authority to Sunset in the Absence of Congressional Action

In March, Congress extended the following telehealth flexibilities through September 30, 2025:

- *Waiving originating and geographic sites;*
- *Audio-only coverage;*
- *Expansion of Medicare telehealth list to include therapists;*
- *Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant sites;*
- *Temporary waiver of elemental health in-person requirement; and*
- *Continuation of Acute Hospital Care at Home Program.*

Comment: UnityPoint Clinic requests CMS to work alongside Congress to make permanent or extend these flexibilities for as long as possible before the end of September. Following an extension, it is critical that CMS release aligning regulatory guidance as soon as possible to reduce confusion amongst the industry.

Updates to the Telehealth Services List

CMS makes significant changes to the Medicare Telehealth Services List. Specifically, CMS is proposing to remove steps four and five from the list review process, eliminating the need for a provisional list. All codes currently on the provisional list would be added to the permanent list. Four new codes are proposed to be added to the list, while dialysis, home INR monitoring, and telemedicine E/M services are not being added at this time.

Comment: We support the elimination of the provisional list and associated review steps**.**

Frequency Limitations

CMS proposes permanent changes to frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.

[3] This represents outpatient visits only during the 12-month period from July 1, 2024, to June 30, 2025.

Comment: UnityPoint Clinic supports permanent changes. Providers should be able to determine frequency for each case and underlying needs. This modality respects patient choice and convenience.

Provider Home Address

CMS does not propose to extend distant site practitioners to use their currently enrolled practice location, instead of their home address, when providing telehealth services.

Comment: It is not practical, workable, or safe to require a provider to publicly report their home address as their practice location. Medicare providers should not be compelled to share their personal information, especially when it relates to their home addresses. This enrollment structure is outdated and does not support providers new operational and privacy concerns faced in a digital age. **We urge CMS to support the continued use of a provider's currently enrolled practice location**.

Direct Supervision

CMS proposes permanent changes to allow more flexibility in virtual presence. CMS seeks to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for most services described as incident-to a physician's professional services. CMS is also proposing to limit to rural settings when teaching physicians are permitted to have a virtual presence for reimbursement of services provided through audio/video real-time communications technology.

Comment: Given workforce shortages, UnityPoint Clinic applauds this proposal to support health care access and efficient workflows. If "immediate availability" no longer includes a remote option, there may simply not be enough physicians for an onsite presence at each rural or underserved location. Presently, this flexibility enables a physician to virtually supervise multiple locations giving precedence to the convenience of beneficiaries. This also helps with provider recruitment and retention knowing that they are able to practice top of licensure more efficiently with less windshield time.

As for the supervision of residents by teaching physicians, we defer to the Accreditation Council for Graduate Medical Education (ACGME).

Telehealth Originating Site Facility Fee Payment

CMS updates the originating site facility fee schedule by the percentage increase in the Medicare Economic Index (MEI).

Comment: UnityPoint Clinic supports this fee update.

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)

CMS proposes to create optional add-on codes for APCM services that would facilitate the delivery of behavioral health integration services.

Comment: UnityPoint Clinic supports the proposed changes to aid primary care providers and auxiliary personnel in their roles in delivering collaborative and integrated psychiatric care with enhanced compensation.

Digital Mental Health Treatment

CMS clarifies that, for patients with a mental health condition diagnosis, the billing practitioner does not need to be the same practitioner who made the initial patient mental health condition diagnosis. Additionally, CMS proposes to expand DMHT coverage for attention deficit hyperactivity disorder (ADHD) diagnoses.

Comment: UnityPoint Clinic supports this payment update.

Upstream Drivers of Health, Community Health Integration (CHI) Services, and Principal Illness Navigation (PIN) Services

CMS proposes to delete Social Determinants of Health code G0136 due to overlapping resource costs with existing services and to reference "upstream drivers" for factors impacting the health of Medicare beneficiaries. CMS also clarifies "certified or trained auxiliary personnel" for CHI and PIN codes.

Comment: UnityPoint Clinic supports authorizing marriage and family therapists (MFTs) and mental health counselors (MHCs) to bill Medicare directly for CHI and PIN services. We also support the recognition of "upstream drivers."

REQUESTS FOR INFORMATION

Advanced Primary Care Management (APCM) and Prevention

CMS seeks input on cost sharing for preventive services, APCM services and potential revisions, and interaction with ACOs.

Comment: APCM services recognize the resources required to deliver advanced primary care and the need to reduce administrative burdens associated with time-based billing. To further recognize the work of advanced primary care practices in preventing and managing chronic disease, CMS should consider implementing these flexibilities:

- Concurrent billing. **We encourage CMS to revise this policy such that the *same practitioner* could not bill duplicative services, rather than an *entire practice*.** As a backdrop, multispecialty practices are becoming more prevalent. Under the umbrella of one tax identification number (TIN), multispecialty practices may be comprised of hundreds of providers at multiple locations and often employ primary care providers as well as specialists. As proposed, a TIN cannot currently bill for APCM services and certain other care management and CTBS, including chronic care management (CCM), transitional care management (TCM), remote evaluation of patient images/videos, and virtual check-ins. There are instances in which specialty services should be reimbursed outside the constructs of enhanced care management for primary care services (such as a virtual check-in). Additionally, this proposal arbitrarily restricts billing for specialty services on the basis of how a physician practice is organized for taxation, as a specialist under a separate TIN could bill for these services.
- Patient complexity in coding. **We encourage CMS to revisit patient complexity to reflect the additive impact of multiple chronic conditions.** There is a significant number of Medicare beneficiaries with more than 2 conditions and, as the number of chronic condition increases, the types of support and time needed to manage these patients increases. We do not believe that the current codes

appropriately resource care for beneficiaries with multiple complex conditions. CMS could consider additional tiers and/or increases in RVU assumptions to include all possible services.

- Cost sharing. As with other care management services, cost sharing is often a deterrent to obtaining beneficiary consent. We support options for reducing or waiving cost-sharing for beneficiaries.
- APCM service elements and practice-level capabilities. CMS delineates 10 APCM elements and capabilities that billing practitioners must have the ability to furnish monthly as appropriate for a beneficiary. **The documentation requirements remain unclear and the potential burden may counteract the benefits of these codes**. For MSSP ACO providers, CMS will assume three of these elements (initiating visit for new patients; patient population-level management; and performance measurement) without documentation. We support; however, we believe that CMS has missed other elements that ACOs provide intrinsically – comprehensive care management; patient-centered comprehensive care plan; and enhanced communication opportunities – and that CMS should also assume those elements as well.
- Exclusion of preventive services from MSSP total cost of care calculations. 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 the ratchet effect.

Prevention and Management of Chronic Disease

CMS is broadly soliciting feedback to enhance support for prevention and management of chronic disease.

Comment: Chronic disease is pervasive and UnityPoint Clinic supports CMS' priority to reverse this trend. This will take a village, and in health care, this equates to team-based care. We encourage CMS to support models of care and reimbursement for team-based care. And as CMS has noted, four in ten Americans have multiple chronic diseases. Reimbursement structures should consider the complexity of treating beneficiaries with more than one chronic disease – whether it is additional time during an encounter or greater frequency of visits (by one or more providers).

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.[4] 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

[4] 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.*"

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.

PAYMENT FOR SKIN SUBSTITUTES

CMS proposes to unpackage skin substitutes and pay for them separately as incident-to supplies. The proposed per unit payment rate is $125.38, based on a volume-weighted average sales price (ASP) for products used in the hospital outpatient setting in Q4 2024.

Comment: CMS is reconsidering its payment policy for skin substitutes due to a nearly 40-fold rise in Part B spending over five years. **We wholeheartedly support the proposed change** in reimbursement of skin substitutes to address unsustainable spending growth and clinical inconsistency in the skin substitute product space. Current payment models incentivize the use of high-cost—rather than high-quality—solutions for patients. *UnityPoint Accountable Care has one patient that has received more than $4.6 million in skin substitutes over the course of 3.5 years.* While the patient is attributed to our ACO through primary care services, the specialist billing for these skin substitutes is not an ACO provider.

As a member of *Accountable for Health*, we echo its general recommendations:

- **Support treating skin substitute products that are not drugs and biologicals as incident-to supplies** in accordance with section 1861(s)(2)(A) of the Act.
- Agnostic on the proposal to subdivide the products into three different payment categories based on their FDA regulatory pathway – PMA, 510(k), 361 H/CTP. Instead, CMS should consider greater aggregation within payment categories, including CMS' recommended "synthetic" vs "non synthetic" option, given the lack of differences (i.e., clinical outcomes, supporting evidence, and resource costs) across products.
- **Support the development of a single payment rate across all non-biologic products** regardless of their classification.
- **Support the use of hospital outpatient utilization data** to inform the development of Physician Fee Schedule practice expense RVUs. While the CY 2026 proposal uses the highest volume weighted average to establish the initial payment rate of $125 per sq cm, we **recommend that CMS use the "pooled" payment rate that reflects an average across all products** and would establish a rate of $65 per sq cm. We believe a pooled payment rate will more accurately reflect resource costs and further discourage the "profiteering" and extreme growth in Medicare spending.

ACOs are a gatekeeper of total cost of care and are on the frontlines in identifying and reducing waste to deliver better care for beneficiaries. UnityPoint Accountable Care (affiliated with UnityPoint Health and UnityPoint Clinic) 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. As result, CMS acted to address the fraud and created a process to remove "suspect and anomalous" billing from the Medicare Shared Savings Program (MSSP) and ACO REACH. This was a win for beneficiaries, Medicare, and ACOs. Unlike the fraudulent catheter scam, skin substitutes more appropriately fall within a "dark grey" area of waste – e.g., services that are clinically inappropriate and incentivized as a result of payment policy and lax coverage policy. CMMI has stated that skin substitutes do not fit squarely within the significant anomalous and high suspect (SAHS) billing policy, and we agree but that does not excuse inaction. We 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. We reiterate the *Accountable for Health* 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.

RURAL HEALTH CLINICS (RHC)

CMS proposes optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services. Additional proposals include redesignating care management services as care coordination services; permanently adopting a definition of direct supervision for real-time audio and visual interactive telecommunications; and extending through December 31, 2026, the use of HCPCS code G2025 for billing non-behavioral health visits furnished via telecommunication technology.

Comment: UnityPoint Clinic has 35 RHCs in Iowa, which are vital to providing access to health care 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.

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 is structured using the MIPS Value Pathway (MVP) framework and increases risk adoption from 9% in 2027 to 12% in in 2031. ASM 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, we believe that ASM misses the mark. 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.

As for ASM model constructs, NAACOS reviewed the ASM, identified some design challenges, and recommended the following changes for CMS' consideration.

- reconsider the use of redistribution percentage;
- collectively pool participant results;
- change the model from individual reporting to team/TIN-based reporting;
- increase volume thresholds to account for statistical variations; and
- create safeguards to account for data fluctuations and ensure timely data sharing needed for clinical interventions.

We agree with NAACOS' suggestions and additionally urge CMS to release specific model requirements as soon as possible to enable providers to prepare for implementation. Finalizing provider lists in Q3 of 2026 does not allow sufficient time to prepare specialists and institute documentation workflows.

As CMS continues to evolve its specialty 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 detailed local market data on cost and quality of specialists, rather than data limited to ACO populations.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

As a reminder, UnityPoint Accountable Care is currently participating in the ENHANCED track of the Medicare Shared Savings Program. In addition to the following comments, **UnityPoint Accountable Care is a member of the National Association of Accountable Care Organizations (NAACOS) and the Accountable For Health (A4H) Coalition. Both organizations have also submitted comment letters to this proposed rule, and we encourage CMS to consider their input**.

Benchmark and Financial Data and Reporting

Accountable Care Prospective Trend (ACPT): *ACO financial benchmarks are based on its assigned patients' historic spending and trended forward using a blend of national and regional growth rates. In 2024, CMS introduced ACPT in combination with national and regional growth rates to provide ACOs with more predictability in their targets and reduce the benchmark ratchet effect. ACPT was weighted at 33.3%. For 2024, the ACPT inaccurately projected spending at 4.9% against an 8% increase in national expenditures, which arbitrarily lowered benchmarks for ACOs.*

Comment: UnityPoint Accountable Care signed an agreement in 2024 to participate in MSSP based in part

upon the financial predictability from the introduction of ACPT. **UnityPoint Accountable Care supported and still supports the inclusion of the ACPT in the benchmark formula. UnityPoint Accountable Care does not support being held financially responsible for CMS actuarial errors resulting in significant and unexpected variations in projected versus actual costs**. For 2024 and 2025, UnityPoint Accountable Care urged CMS to mitigate the immediate benchmark impact and reset the ACPT to zero for relevant agreement periods. We sincerely appreciate that CMS has revisited the significant discrepancy between projected and actual growth rates and made two corrections – the first in March 2025 to correct for errors in accounting for COVID-19 PHE inpatient expenditures, and the second in June 2025 to reweight ACPT from 1/3 to 1/6. These adjustments did improve potential shared savings, but did not make ACOs whole. **We reiterate our request that CMS use its existing authority to reduce the ACPT to zero for agreement periods beginning in 2024 and 2025**.

To support future ACO financial planning and benchmark predictability, we encourage CMS to consider further revising the ACPT process:

- Guardrails: **CMS should apply the "better of" benchmark blend or a recalibration trigger symmetrically, protecting ACOs from losses and allowing upward adjustments when savings are understated** (see Example Scenarios only table). We prefer the "better of 2-way or 3-way blend" approach. This would allow a second chance protection for all ACOs. When CMS selectively applies protective adjustments (only for losses), it signals that benchmark integrity is secondary to risk mitigation. The alternative recalibration trigger approach is borrowed from a recent commercial ACO contract. Using this alternative, the ACPT weight or rate would be adjusted at year end if the ACPT exceeds X.X%.

Example scenarios only - not based on actual rates.
Example: ACPT (4%) underestimated actual trend (7%) by 3%

Scenario	Benchmark Factor	Weight	Rate	Wt. x Rt.
Starting Point	National/Regional	67%	7.00%	4.67%
	ACPT	33%	4.00%	1.33%
no reclibration	Total Benchmark	100%		6.00%
Better of	National/Regional	100%	7.00%	7.00%
2-way or	ACPT	0%	4.00%	0.00%
3-way blend	Total Benchmark	100%		7.00%
Recalib. [1]	National/Regional	83%	7.00%	5.83%
ACPT weight	ACPT	17%	4.00%	0.67%
(keep rate)	Total Benchmark	100%		6.50%
Recalib. [2]	National/Regional	67%	7.00%	4.67%
ACPT rate	ACPT	33%	5.50%	1.83%
(keep wt.)	Total Benchmark	100%		6.50%

[1] ACPT rate is off by more than X.X%, decrease its weight
[2] ACPT rate is off by more than X.X%n adjust rate towards actual.
Example: ACPT = 4%, Actual = 7%, Δ = 3%, 4.0% +(3%/2) = 5.5% adj ACPT.

- Timing: **CMS should commit to a fixed release schedule of ACPT prospectively, prior to the start of the performance year, like Medicare Advantage** (see Timing Disparity table).

Timing Disparity: MSSP ACPT vs. Medicare Advantage Rate Announcements

Program	Announcement Timing	Applies to Year	Planning Implications
MSSP ACPT	Nov-24	2024	Released mid-year; limits prospective planning
	Jun-25	2025	
Medicare Advantage Rates	Apr-24	2025	Released 9 months prior; enables strategic bidding

ACPT is set for five years at the start of a new agreement. When ACPT is underestimated, ACOs have the option to Early Renew; however, the release date of the new ACPT has not supported informed decision-making for the Early Renewal deadline (2025 ACPT was released 6 months after deadline).

Timely Reporting Packages: As a health care business, ACOs must engage in budgeting and financial planning. For 2024 performance year, ACOs finalized provider lists in September 2023, and CMS issued settlement reports in August 2025. 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 2024 (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 2024 performance year as a reference point):

- 2024 risk scores starting in the Q2 reporting package.
- 2024 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.

Significant, Anomalous and Highly Suspected (SAHS) Billing Policy: In the 2024 Physician Fee Schedule, CMS finalized a policy to exclude all payments associated with CMS-identified SAHS billings from ACOs' financial calculations in a relevant calendar year, as well as historic benchmarks for affected future agreement periods. **We continue to support this policy, but request that CMS consider expanding this policy to more comprehensively address fraud, waste, and abuse. We reiterate NAACOS' recommendations** that CMS:

- Apply the policy at the ACO or county level, not just rare/extreme, national cases
- Modify the criteria to identify SAHS to include:
    - Significant increase in a particular billing code compared to historical data;
    - Claims for which CMS payment is paid into escrow;
    - Claims submitted by a provider under indictment or investigation by a Federal agency;

- Claims from any DMEPOS provider for which CMS has reversed a threshold of the claims for a Performance Year;
- Claims for billing codes previously deemed SAHS in prior years.

- Include a materiality threshold of 0.5% of ACOs benchmark and services not provided by ACO participants.

ACO Participation and Eligibility Requirements

CMS proposes to limit one-sided risk participation in the BASIC track's glide path to an ACO's first agreement period only, to permit limited mid-year modifications to an ACO's Participant List and SNF Affiliate List due to Change of Ownership (CHOW), and to enable participation by ACOs with less than 5,000 assigned beneficiaries.

Comment: **UnityPoint Accountable Care supports these revisions**. CHOW is a frequent occurrence with ACO Participants, and especially Skilled Nursing Facilities, so the ability to modify lists mid-year is important for beneficiary continuity of care and provider engagement.

Beneficiary Assignment

Beneficiary "assignment" is the process CMS uses to determine whether a beneficiary receives a sufficient level of specified primary care services from participants in an ACO, indicating that the ACO qualifies as responsible for that beneficiary's care. CMS proposes to revise the definition of "primary care services" and to retroactively revise the definition of "beneficiary eligible for Medicare CQMs."

Comment: **UnityPoint Accountable Care supports** the expanded definition of primary care services and the revised retroactive definition of "beneficiary eligible for Medicare CQMs."

Quality Performance Standards and Other Reporting Requirements

Aside from the quality performance topics immediately following, other relevant comments are contained within the *Quality Payment Program (QPP)* responses.

Quality Payment Program Reporting Mechanisms – *CMS proposes to sunset the Web Interface and MIPS CQM reporting options for MSSP ACOS in PY 2026.*

Comment: **UnityPoint Accountable Care opposes this sunset and encourages CMS to extend the transition of reporting options. Specifically, we request that Web Interface reporting be maintained for another three years** while ACOs continue to make investments to support and pilot the eCQM reporting approach. Transitioning to new eCQMs and Medicare CQMs is challenging for ACOs with independent providers on disparate EMRs, and these challenges are multiplied when faced with the rapid expansion of metrics (i.e., APM APP Plus quality measure set) and new MVPs.

Extreme and Uncontrollable Circumstances (EUC) Policy – *CMS proposes to revise the EUC policies to explicitly include cyberattacks as qualifying events.*

Comment: **UnityPoint Accountable Care supports this change, but recommends that CMS modify the loss forgiveness amount**. As proposed, loss forgiveness is limited to a percentage of the loss based on the percentage of the year impacted by the EUC event. Particularly for a cyberattack event, losses in a one- to two-month period could greatly exceed savings generated in the other months. We encourage CMS to consider the full amount of the loss attributed to the EUC event.

Health Equity Benchmark Adjustment (HEBA)

CMS proposes renaming the HEBA to the "population adjustment." This does not alter how the adjustment is calculated and is applied to agreement periods beginning on or after January 1, 2025.

Comment: **UnityPoint Accountable Care supports**.

QUALITY PAYMENT PROGRAM (QPP)

Merit-based Incentive Payment System (MIPS)

CMS proposes to maintain the program threshold required to avoid a MIPS penalty and receive a positive payment adjustment through the 2028 performance period. CMS estimates that its proposed changes will result in 84.04% of eligible clinicians receiving a positive MIPS adjustment in the CY 2026 performance period. The median payment adjustment is estimated to be 1.3%.

Comment: Providers participating in Advanced APMs should be disproportionately incentivized for their commitment to value. **CMS should continue to monitor MIPS payment adjustments to ensure that MIPS providers are not earning more on average than Advanced APM providers**.

Quality Category – *CMS proposes to add 5 quality measures, including 2 eCQMs, remove 10 quality measures, and modify 32 existing quality measures. CMS revises the definition of high priority measure to remove health equity. CMS permits 19 topped-out quality measures to be included in the specialty measures sets. CMS updates the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures.*

Comment: We appreciate that CMS is attempting to align measures across programs. MIPS has 195 measures, which will be reduced to 190 under this proposal. That said, 47 measures or approximately 25% are being changed through removal, addition, or revision. Regardless of whether changes are well-intended, every modification relates to time, effort, and costs for providers.

We are particularly concerned that CMS would choose to "engage" select specialists by permitting them to earn quality points through reporting topped-out measures. This runs counter to CMS policy and sends a bifurcated message to select specialists versus other providers about the importance of meeting rigorous quality standards. It is also difficult to fathom that the entire MIPS dataset does not contain other measures, including population health measures, which could apply to specialists. Giving providers the choice of selecting MIPS measures would be a much better method to promote engagement.

Cost Performance Category – *CMS proposes a two-year informational-only feedback period for new cost measures and to update candidate event and attribution rules for the Total Per Capita Cost (TPCC) measure.*

Comment: **We support inclusion of a two-year informational-only feedback period**. The cost category can be a black hole in that CMS configures and provides results after the conclusion of the performance period. We are hopeful this feedback loop will result in more accurate measures and can enable timely process improvement by providers. Using this rationale, **we also encourage that CMS include, within "new" cost measures, existing cost measures when modified**. Additionally, we request that CMS share cost data during the performance period.

Improvement Activities (IAs) – *CMS proposes to replace the Achieving Health Equity subcategory with an Advancing Health and Wellness subcategory. In addition, 3 new IAs are added, 7 existing IAs are modified,*

and 8 IAs are removed.

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 will reiterate that modifications to existing IAs can be just as burdensome as implementing a new IA and require time, effort, and cost.

Promoting Interoperability (PI) Performance – *CMS proposes to limit automatic reweighting and adopt a measure suppression policy. Measure proposals include a Public Health Reporting Using the TEFCA bonus measure, a second attestation to the Security Risk Analysis measure, and revision to use the newest SAFER Guides in the High Priority Practices SAFER Guide measure.*

Comment: UnityPoint Clinic supports maintaining the 180-day reporting period without expansion, and modifying the Security Risk Analysis.

- SAFER Guides: We support updates to the Safer Guides and likewise support the attestation. **We request that CMS clarify when the Safer Guides version subject to the attestation will change from 2016 to 2025.**[5]
- TEFCA: UnityPoint Clinic participates in the Epic Nexus QHIN. This new optional attestation under the Public Health and Clinical Data Exchange objective appears to overlap with the *Enabling Exchange under TEFCA* measure under the Health Information Exchange objective. **We seek clarification as to whether providers can attest to both TEFCA measures or if only one TEFCA measure can be reported**.

QP Determination – *CMS proposes an overhaul to the QP determination process to increase APM participation, particularly among specialists. CMS proposes to perform individual-level QP calculations and to expand the definition of "attribution-eligible beneficiary" beyond e/m services.*

Comment: **UnityPoint Clinic opposes this expansion** of the definition of attribution-eligible beneficiaries. Presently attribution targets primary care services. Shifting from E/M services to all professional services will shift the QP determination methodology to include both primary and specialty care. This will result in more clinicians and services that account for an ACO's QP determination and a larger increase in the attribution-eligible patient population without an increase in the overall number of attributed beneficiaries. Some existing and experienced ACOs will not meet QP thresholds. Should CMS make this change, CMS should also consider lowering QP thresholds.

MIPS Value Pathways (MVPs)

Instead of continually expanding MVPs and exponentially developing new measures, CMS should concentrate on population health constructs and pivot away from MVPs and MIPS. 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 health care 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**

[5] See UnityPoint Health's FY2026 IPPS comment letter - Regulations.gov tracking #mbq-zeac-szc5

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.

UnityPoint Health has 54 organizational TINS across our enterprise. Due to reporting complexity and expense, we do not submit MVPs for any of our TINS or providers. As structured, **MVP requirements often overlap eCQMs, MIPS CQMs, and CAHPS for MIPS requirements and requires exponentially more resources and costs than reporting traditional MIPS**. Specifically, factors that dissuade our participation in MVP include:

- MVPs are extremely complex measure groups that involve multiple methods of data collection, including MIPS CQMs and eCQMs as well as cost measures.
- The drive to utilize MVPs does not reduce burden for organizations with a multispecialty practice.
- Each specialty has its own set of measures (including up to 6 separate measures), which must be updated, mapped, and reviewed annually. CMS has proposed changes to all MVPs this year.
- MIPS CQMs require report writing within our EMR and are not supported directly, like eCQM reporting. For MIPS CQMs, staff need to map, validate, and build measures in another form for reporting.
- A single file must be utilized for submission, and therefore MIPS CQMs and eCQMs would need to be combined into a single reporting method (QRDA III) file or manually attested per measure per specialty increasing the burden of reporting submission. In the absence of a third-party vendor at additional cost, group reporting also requires subgroup validation and individual reporting requires manual submission of their measures subset.

As an operational example, one of our TINs is a multispecialty practice with roughly 1200 providers across 45 specialties. Of these providers, about two-thirds are in an Advanced APM and the remaining 400 are MIPS eligible clinicians representing 35-40 specialties. If we assume MVP reporting for half or 20 specialties, we would be reporting for 120 different measures, not including the collective blanket measures used for the remainder. MVP measures cross multiple collection methods (eCQM, MIPS CQM) and require large resource teams for upkeep and maintenance in an ever-changing system. To reiterate, each of the 120 measures requires map data points, design workflow, data capture tools and audits as well as clinical workflow design and training for providers and staff. It is a challenge to maintain and perform well on 100+ measures aside from targeted accountable care quality initiatives.

MVP Measures**:** *CMS proposes 6 new MVPs, includes a specialty attestation requirement during MVP registration, and includes three separate requests for information. The new MVPs focus on the following areas: Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, and Vascular Surgery. Additionally, CMS proposes to modify all 21 previously finalized MVPs.*

Comment: **CMS has changed every MVP proposed for 2026. 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 for mandatory status.

MVP Reporting: *CMS redefines single specialty group, subgroup, multispecialty group as well as MVP Participant. CMS proposes to allow small practices to report under the MVP.*

Comment: **We believe that mandated specialty and subgroup reporting is a flawed approach**. Subgrouping practitioners is innately complex, as organizations must determine how to classify eligible clinicians by subgroup along with their CMS designation (rural, hospital-based, non-patient facing, etc.). This information is not easy to obtain, and changes occur from year-to-year based on claims. For multispecialty TINs, this is challenging as a single practice could contain 40+ specialties/subspecialties. Even a specialty practice like cardiology is often comprised of physicians with different focus areas. For example, the measures in the Cardiology MVP may not be appropriate for both interventional cardiologists and electrophysiologists. The Cardiology MVP includes both the Screening for and Controlling Hypertension measures, Tobacco cessation, and use of Meds such as ACE, ARB and Beta Blockers for various conditions. These measures do not align with the scope of work for an electrophysiologist. While there is an MVP measure set for electrophysiologists, there are only two measures which would not be appropriate for those practicing interventional cardiology. Additional Measure sets for subspecialists adds an extra layer of complexity, tracking, resource allocation, measure build, validation, and report configuration, as well as potential confusion within clinics with numerous subspecialty cardiology clinicians.

Core Elements MVP Reporting Request for Information: *CMS seeks input to potentially implement core elements for MVP groups to provide patients with comparative clinician performance data.*

Comment: The APP Plus measure set could be considered as common elements, instead of expanding and further individualizing MVP groups, and this could encourage transition to value-based care. **We are generally opposed to CMS' approach of mandating specific specialty measures and rather advocate that providers should be able to choose QPP measures aligned with their organization's quality and safety priorities**. This would allow flexibility for multispecialty groups and small practices alike. It would also avoid the selective inclusion of topped-out measures just to fill MVP measure sets.

Alternative Payment Model (APM) Performance Pathway (APP) Plus

CMS proposes removing Quality ID: 487 (Screening for Social Drivers of Health) from the APP Plus quality measure set, reducing it to 10 required measures starting in performance year 2028 (or one year after the eCQM for Quality ID: 493 becomes available).

Comment: **We appreciate the delayed stair-stepping approach for new measures**.

Requests for Information

Well-being and Nutrition

CMS seeks information on well-being and nutrition measures for consideration in future rulemaking.

Comment: UnityPoint Clinic appreciates the Administration's interest in preventive care and encouraging healthy lifestyles. These upstream supports are welcome to avoid health care interventions when possible. Currently UnityPoint Clinic collects, tracks, and reports numerous quality measures, and similar to our feedback on all new measures, **we encourage CMS to thoughtfully design measures / tools that**

are meaningful, actionable, and avoid duplication. From the patient perspective, CMS should also consider reducing survey fatigue by avoiding lengthy screening tools with repeated and duplicative administration across settings of care. Until we understand CMS definitions, goals, and objectives in these areas, it is difficult to opine as to how to appropriately identify these concepts in constructs that are meaningful and capture improvement / outcomes. We look forward to partnering with CMS as details are released and are happy to participate in stakeholder groups that develop and review such measures / tools.

Fast Healthcare Interoperability Resources (FHIR)

CMS seeks information on challenges providers and health information technology vendors anticipate during the transition.

Comment: **For FHIR technology to be easily adaptable and capable of expanding the Health Information Exchange, FHIR technology needs to be standardized and consistent across EHR vendors, health care facilities, and those identified entities receiving the data, such as public health agencies, states, and CMS**. UnityPoint Clinic exchanges data with other health care systems and public health agencies across our multistate footprint, but faces challenges due to inconsistent state data sharing laws, regulations, and submission methods. In one state, providers pay a third-party vendor to submit CMS-required state-level public health data. That vendor created unique submission requirements utilizing USCDI standards, which are financially burdensome and resource intensive. Additionally, not all health care systems maintain direct addresses for data exchange, and the NPPES provider directory is often outdated. Lastly, some health care entities use third-party EHR support, which can complicate direct address sharing.

Additionally, connectivity issues may hinder immediate data exchanges. Internet connectivity may be limited, especially in rural areas. UnityPoint Clinic has intentionally bult in network redundancies. We also employ workarounds like hotspots, network locations, and VPNs, but they are not available in all situations. While natural disasters and weather-related issues hamper connectivity, we have seen increasing incidents of breaks in underground utility lines due to construction or roadwork without 811 notices.

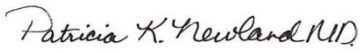
Query of Prescription Drug Monitoring Program (PDMP) Measure

CMS seeks input on adopting a performance-based (numerator/ denominator) reporting requirement for the Query of PDMP measure.

Comment: **We urge CMS to keep this as an attestation measure** and not adopt a numerator/denominator reporting requirement. Quite simply, it would be extremely burdensome, particularly for providers with multistate practices. First, we are challenged in that our software does not have the capacity to pull numerator and denominator data. Second, because each state PDMP database varies, state functionality differs and would require obtaining and combining state reports.

UnityPoint Clinic is pleased to provide comments on this proposed rule. To discuss our comments or for additional information, please contact Cathy Simmons, Government and External Affairs, at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



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