UnityPoint Health

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January 26, 2026

Administrator Mehmet Oz, MD
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-4212-P – Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program; published at Vol. 90, No. 227 Federal Register 54894-55030 on November 28, 2025.

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

Dear Administrator Oz,

UnityPoint Health appreciates this opportunity to provide comments on Contract Year CY 2027 Medicare Advantage (MA) Program Proposed Rule. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 29,000 employees and our relationships with 420+ physician clinics, 35 hospitals in urban and rural communities, 13 home care areas of service, and 5 affiliated community mental health centers throughout our 8 markets, UnityPoint Health provides care throughout Iowa, central Illinois, southeastern South Dakota, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics, and home health agencies provide a full range of coordinated care to patients and families through 8.5 million patient visits.

UnityPoint Health appreciates the time and effort of CMS in developing this proposed rule. We respectfully offer the following input.

STAR RATINGS

CMS proposes to remove the Excellent Health Outcomes for All Reward from the 2027 Star Ratings and continue applying the existing reward factor, which was set to sunset. CMS also proposes to remove 12 measures from the Star Ratings and Add Depression Screening and Follow-up (DSF) measure.

Comment: **UnityPoint Health supports CMS efforts to enhance the Star Ratings program** (as well as other quality programs) by simplifying measure sets and refocusing performance on clinical care, outcomes, and patient experience instead of operational and administrative functions. We agree with the proposed removal of 12 quality measures. We also wholeheartedly support the addition of the DSF measure, which aligns with HEDIS and national guidelines. Depression screening and follow-up in practice is important in managing a patient's health, and EHR vendors are incorporating tools to help providers manage these workflows.

REQUESTS FOR INFORMATION

RISK ADJUSTMENT*: CMS seeks input on (1) options, including near-term changes and entirely new approaches, (2) additional data sources and data elements, (3) approaches that do not rely on collection of diagnoses data, and (4) approaches that advance competition and foster a level playing field between different types of MA plans and MA organizations.*

Comment: **UnityPoint Health through our Accountable Care Organization (ACO), UnityPoint Accountable Care, is a member of NAACOS and encourages your strong consideration of the NAACOS comment letter**. UnityPoint Health is frustrated that current risk models encourage coding intensity resulting in variation that may not reflect patient status, lack sufficient adjustment for functional status and/or socioeconomic drivers of health, and perform poorly for low-cost beneficiaries. We support principals/goals for risk adjustment as laid out by NAACOS and its members:

- Support accountable care relationships, including for those at greater risk of adverse health outcomes.
- Support the shift of resources from traditional to 'higher value' service.
- Promote improved capture of reliable information on health status.
- Better reflect the relationship between social factors and health.

UnityPoint Health offers input on select CMS questions below.

> Which diagnoses are most essential for CMS to include in its MA risk adjustment model? In certain instances, should CMS limit the use of diagnoses in risk adjustment based on a minimum threshold of disease severity or to patient encounters within specific settings? Should CMS require diagnoses to be substantiated by follow-up encounters or treatments? Should CMS exclude diagnoses from plan-initiated encounters that do not lead to follow-up care, such as those resulting from in-home health risk assessments, or diagnoses not linked to specific services furnished to an enrollee?

For our patients, **diabetes is the most prevalent diagnosis, and it is crucial to accurately reflect the severity of the condition in the risk adjustment model.** In the existing v28 HCC model, we recommend resetting the values associated with diabetes with and without complications in the HCC model[1] because care needs and costs of care vary widely. Patients with known complications, such as chronic kidney disease, neuropathy, etc., require more care and incur more costs (more encounters, increased need for medication management, and more specialist referrals, including nephrology, neurology, endocrinology, etc.) than those without diabetic complications. Valuing all three HCCs related to diabetes similarly does not appropriately account for care and costs associated with managing these patients.

UnityPoint Health urges CMS to exclude diagnoses from plan-initiated encounters, particularly plans engaging in in-home risk assessments. Under the guise of care coordination and closing quality gaps, this practice is increasing among health plans, and providers are charged a medical expense within their shared savings agreements for these visits. This reduces providers' shared savings pools,

[1] HCC 17 (Diabetes with Acute Complications); HCC 18 (Diabetes with Chronic Complications); and HCC 19 (Diabetes without Complications)

and for UnityPoint Health, this equated to more than $1.5 million for one MA plan. UnityPoint Health has experienced issues with the validity of diagnoses made during these visits. In addition, it impacts provider workflows and is confusing to beneficiaries who equate this with an Annual Wellness Visit.

Over what timeframes should CMS incorporate diagnostic data for risk adjustment purposes? How can CMS account for certain illnesses and injuries that are likely to persist but may not be captured within a given data year by a patient encounter? How should CMS account for past conditions that are no longer active, but continue appearing as diagnoses?

We suggest that CMS increase the look-back period for diagnoses and documentation data beyond 1 year, which would better align with the 11+ month Annual Wellness Visit requirement. Medicare beneficiaries often have multiple chronic conditions, and it can be difficult to capture each within an annual timeframe due to the sheer number of conditions as well as beneficiary preferences to address exacerbating conditions over other conditions that are present but are considered routine. We encourage CMS to consider using a concurrent/prospective risk adjustment blend that incorporates current year diagnoses/disease state in consideration of performance year member health status.

A 2- or 3-year look-back period would be reasonable to better capture persistent illnesses and injuries. For example, Diabetic and Hypertensive complications, such as chronic kidney disease (CKD), are often missed in provider documentation because the focus is typically on the primary conditions (HTN/DM). We believe that reviewing diagnostic lab data every 2-3 years demonstrates the presence and management of CKD as a complication of the primary diagnosis.

As for inactive conditions, diagnostic or claims data review may be appropriate in some cases to determine that other diagnoses are no longer present or may have been eradicated through surgery or other treatment modalities. For example, some cancers with claims for surgical treatment or other treatments, such as chemotherapy, radiation, etc., diagnostic data could be reviewed to determine if ongoing submissions of an active cancer diagnosis is appropriate.

Although not specifically referenced, risk adjustment methodology fails miserably for 'New-to-Medicare' beneficiaries without a prior year (full 12 months) of Part B coverage. These beneficiaries are only credited with their demographic risk score, which is often half or less of the score attributed to their health status. This methodology significantly underfunds 'New-to-Medicare' beneficiaries, drives poor observed medical-loss-ratios, and results in payments owed from providers to health plans. **We recommend that CMS consider the current year's health encounters/diagnoses for ‘New-to-Medicare’ beneficiaries, similar to what many proprietary commercial ACO risk measurement methodologies use for benchmarking performance**.

When incorporating diagnostic data from particular encounters, should CMS account for the payment status of the services associated with that encounter? Should the risk adjustment model include diagnoses from encounters where a payment was denied, or approved and later found to be improper?

No, payment status of claims should not impact HCC capture. Denials occur for many reasons and may not be related to diagnoses at all. Diagnostic data are separate from and unrelated to coverage

determinations and/or claims processing based on Medicare LCD/NCD or other bundling or unbundling of service rules.

CMS has publicly discussed the prospect of moving towards a risk adjustment model calibrated based on encounter data. In addition to these efforts, should CMS consider testing new risk adjustment methods that replace the current Hierarchical Condition Category (HCC)-based risk adjustment model, such as an inferred risk adjustment model? How should CMS think about a model that is not primarily or solely based off medical diagnoses, but instead uses other types of information, such as utilization of medical services to infer both the presence and the severity of different conditions? What are alternative inputs that CMS should consider, which would be effective at predicting future health care spending by a patient, incentivizing appropriate care, while not being readily susceptible to gaming and manipulation? How can a next generation risk adjustment model be structured to minimize unnecessary administrative burden for plans and providers, and structured to minimize the sensitivity of risk scores to administrative effort or administrative skill? How should a model be structured to best support competition and to ensure a level playing field for all MA plans?

UnityPoint Health is open to CMS exploring other methods to capture disease burden. **We do support the use of encounter data for risk adjustment as this is a richer dataset that includes the entire chart with laboratory results and other testing like echocardiograms.** A methodology that includes encounter versus diagnosis data enables providers to continue a focus on seeing patients and managing their conditions as opposed to becoming skilled at coding capture. In the interim, we believe monitoring frequency of services through claims would be a good start. Beneficiaries with higher risk conditions are likely to seek care more often and possibly in more varied locations (provider office, surgery centers, inpatient stays, therapies, etc.). The frequency and variability of services may be indicators of greater need for care due to higher risk conditions. Beneficiaries may have a similar diagnosis but one may have one or two primary care visits versus another who may have multiple specialty visits, surgeries, and/or hospitalizations.

How might CMS utilize technological innovations, such as artificial intelligence (AI and machine learning, in calibrating current or future risk adjustment methodologies? What are the benefits and risks of shifting from the existing linear regression methodology to one that utilizes AI and/ or machine learning? Do plans have best practices when using AI? What types of protections need to be established to ensure the use of AI is fair? Can the efficiencies of AI be leveraged so as to reduce fraud, waste, and abuse?

There is exciting potential for AI tools in this area. AI can more efficiently collect voluminous information from multiple data sources. AI is a tool and cannot replace humans. Should AI be used to enhance risk adjustment methods, **we encourage transparency** and for humans to be kept in the loop to validate machine learning in this and all areas.

As part of either the existing HCC model or a next generation risk adjustment model, should CMS draw on additional elements within existing data sources, as well as entirely new sources of data? For example, should CMS incorporate prescription drug event data, beneficiary survey data, electronic medical record data, or lab data to infer an MA patient's expected health care spending and the severity of their medical conditions? What kinds of data elements should CMS draw on within existing data sources, specifically from medical claims and beneficiary characteristics files (for example,

procedure information)? Should CMS incorporate additional adjustments for a patient's place of residence to account for variation in costs within individual counties? How should CMS think about potential data sources that are not currently readily accessible or usable for the full population of Medicare beneficiaries, such as electronic medical record data? How should CMS go about making such novel data sources accessible and usable for risk adjustment, given that they would need to be accessible for every Medicare beneficiary?

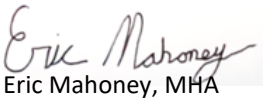
With the increasing availability of data, we agree that an enriched, comprehensive dataset has the potential to improve risk modeling. What is at issue is what data will be meaningful from a risk adjustment standpoint and whether that data is readily available from an interoperability standpoint. We do have concerns with how CMS (and health plans) will operationalize capture and access to these additional data sources, and we request that CMS carefully weigh provider burden and beneficiary privacy concerns when considering additional data sources. **We reiterate NAACOS input that "CMS should be transparent about how datasets are leveraged as significant inputs and provide ample transition time, as providers must be able to view, analyze, and validate how inputs impact risk scores."** We look forward to working with CMS and stakeholders to put patients first as AI innovations evolve.

What other policy approaches should CMS consider to ensure that risk adjustment maximizes incentives for offering high-quality coverage rather than investment in coding practices that may not improve enrollee health?

Current risk adjustment models do not value prevention. Instead, risk adjusted models pay providers more for sick care as beneficiaries progress through disease stages. **Providers should be incentivized as much for preventive screens and early-stage disease management.** For example, providers should be encouraged to discover and treat stage 0 or 1 cancers before the cancer advances to stage 4. Similarly, providers should be encouraged to identify and manage chronic kidney disease before it progresses to stage 5.

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

Sincerely,



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