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Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: 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

Dear Administrator Oz:

LeadingAge represents more than 5,400 nonprofit aging services providers and other mission-driven organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care including Medicare home health agencies. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

On behalf of these members and partners, we appreciate the opportunity to offer the following comments in response to the Calendar Year (CY) 2026 proposed rule concerning payment policies under the physician fee schedule (PFS) and other changes to Part B payment and coverage policies.

Section II.B. Determination of Practice Expense Relative Value Units – Site of Service Payment Differential

Section II.B.5.c. would significantly change current Practice Expense (PE) methodology: for each service valued in the "facility" setting under the PFS, CMS is proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to "non-facility" PE RVUs beginning in CY 2026.

We oppose this proposal, which will create a significant and unwarranted payment differential between physician services in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs). As the Post-Acute and Long-Term Care Medical Association (PALTmed) has noted, substantial evidence shows that consistent clinician presence in these settings reduces avoidable hospitalizations and costly health outcomes, and we are concerned that any reduction in payment for nursing home services, whether in SNFs or NFs, will jeopardize access to care and undermine efforts to improve quality and generate savings within the Medicare program.

There are two Place of Service (POS) codes used in nursing homes: POS 31 for a SNF and POS 32 for a NF.[1] POS 31 applies when a patient is on a Medicare Part A/rehabilitation stay, while POS 32 is used

[1] See https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets (accessed Sept. 9, 2025)

once the patient is no longer on Part A and the stay is funded either privately or by Medicaid. According to CMS, POS 31 is considered a facility-based practice expense, whereas POS 32 is treated as non-facility-based. Regardless of funding source, physicians typically bill Medicare Part B for these visits using CPT codes 99304–99316, and currently there is equalized practice expense for POS 31 and 32 under the current PFS.

CMS states that its proposed change will better recognize the relative resources involved in furnishing services provided in facility and non-facility settings. In fact, however, practice expenses do not differ in the case of service to an individual in a nursing home.

Physicians typically need to maintain staff, office space, and separate electronic medical record (EMR) and services for communication with the nursing home in order to maintain a nursing home practice (nursing home EMRs do not currently interface with physician EMRs, in addition to having separate portals for radiologic and laboratory services). The nursing home physician's office staff typically are involved in communications from nursing homes, patients/families and other health care providers; requests for durable medical equipment, therapy and pharmacy reviews; coordinate timing of federally mandated visits and telemedicine visits; and help gather laboratory and radiologic studies. These practice expenses do not change between SNF patients and NF patients. In fact, a service provided to the same person, in the same room, in the same nursing home, with the same physician will be billed using both POS codes in a short period of time if the patient is recovering from an illness resulting in hospitalization.

We share PALTmed's concern that altering practice expense values without fully examining the realities of care delivery in these settings will create distortions in incentives and threaten access. Nursing homes already struggle to maintain enough physicians to care for their residents, and reducing payment for POS 31 services will only worsen this problem.

For these reasons, we urge CMS to ensure that services furnished using the same CPT codes in POS 31 and 32 are not subject to any reduction in the final payment methodology.

Section II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

LeadingAge supports CMS's proposal in Section II.D.1.d to permanently remove the Medicare telehealth frequency limitations for certain inpatient visits, nursing facility visits, and critical care consultation services. We supported the previous one-year suspensions of these frequency limitations for 2024 and 2025, and we agree that physicians and other practitioners, who have the greatest familiarity and insight into the needs of individual beneficiaries, can use their professional judgment to determine whether they can safely furnish a service via telehealth, given the clinical profile and needs of the person being served in a given circumstance.

We also support the proposal in Section II.D.2 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 an expanded set of services. Our members, as well as many healthcare practitioners with which our members partner or coordinate in the delivery of care, face significant workforce shortages, and allowing physicians and other approved practitioners to virtually supervise telehealth visits allows for better coordination between teams and provides more flexibility to beneficiaries in scheduling virtual visits with their care team. We endorsed CMS's extending (in the CY 2025 PFS Final Rule) the definition of direct supervision to permit virtual presence for an additional year, and we support the current proposal to build on that position.

Finally, however, we question a telehealth-related omission that arises in the context of CMS's proposed Ambulatory Specialty Model (ASM), which would test whether adjusting payment based on performance measures specific to Medicare beneficiaries with heart failure and low back pain results in higher quality and lower costs through more effective management of these chronic conditions.

As one of many items within this detailed section of the proposed rule, CMS notes its expectation that the proposed ASM design features would lead to greater interest on the part of ASM participants caring for ASM beneficiaries in furnishing services to beneficiaries in their home or place of residence.

In keeping with that expectation, CMS proposes a new regulatory subsection that would waive certain statutory telehealth requirements, but with a limitation relating to home health: Specifically, CMS proposes at § 512.775(b)(1) and (2) to waive the geographic site requirements that limit telehealth payment to services furnished within specific types of geographic areas and originating site requirements that specify the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system – ***except for the geographic site and originating site requirements for a face-to-face encounter for a home health certification***.

While this language is consistent with what was proposed for the Transforming Episode Accountability Model (TEAM) that was finalized last year, that model was specific to patients who were admitted to inpatient stays. Unlike the TEAM model, ASM seeks to engage primary care and specialty physicians who may not be practicing in an inpatient setting and can help with the prevention of more expensive care for patients with heart failure and back pain. The exclusion of telehealth flexibility for face-to-face encounters for home health certification has the possibility of eliminating an essential tool in these providers' toolkit, community admission home health.

We believe home health agencies would be in a strong position to partner with ASM-participating clinicians and beneficiaries and support them in achieving the goals of the new demonstration model if it is finalized, especially with home health agencies' expertise in physical therapy and rehabilitation along with pain management and supporting individuals with heart failure. We therefore urge CMS not to carve home health certifications out of the proposed telehealth waivers. If CMS chooses to keep the carve out, we ask that CMS explain its rationale when it publishes the final rule.

Section III.G. Medicare Shared Savings Program (MSSP)

After reviewing the intended changes and updates to the MSSP for CY 2026, we offer just one comment, which is a note of support for the proposal to allow modifications to an ACO's SNF affiliate list – at any time during the performance year – for SNF affiliate changes of ownership (CHOW) resulting in a change to the tax identification number (TIN). Historically, SNFs that undergo a CHOW that result in a change to the TIN have been unable to continue participation in the SNF 3-day rule waiver until the next change request cycle. We agree with CMS that this proposal, if finalized, would ensure more timely access to skilled nursing as well as consistency of care coordination during a transition to that setting, and would benefit CMS, ACOs and their SNF affiliates, and beneficiaries.

More broadly, however, we wish to offer ideas for refining the MSSP and other accountable care models, that we believe CMS should explore and pursue in future years.

If ACOs are going to be one of the primary accountable care models in traditional Medicare, then we must begin to consider how these ACOs engage non-physician providers in the care of older adults. Some Medicare beneficiaries reside in the community in single family homes and apartments, while others require more assistance with their activities of daily living and chronic condition management.

This high-needs population often receives the bulk of their care from nursing staff and aides in residential settings such as long-stay nursing homes and assisted living. Therefore, we think CMS should refine MSSP and other similar accountable care models in three ways, many of which are outlined in a white paper titled *Considerations for Long-Term Care Providers Participating in Value-Based Care Models* (Value Based Models White Paper),[2] produced by a group of provider and ACO stakeholders, including LeadingAge.

Pursue Statutory Change to Permit Other Provider Types to Be the Accountable Entity and Coordinator of Care in an ACO. Under the current statutory limitations of the MSSP, primary care physicians, hospitals and health systems are the only permitted leaders of this model. While primary care and specialty care physicians play an integral part in a Medicare beneficiaries care, we think the law should be revisited to permit a broader array of providers to be accountable for the total cost of beneficiaries' care as leaders of these models. Nursing homes often provide both post-acute care (skilled, short-stay), and long-stay custodial care where the nursing home is the beneficiary's residence. Long-stay nursing home residents are also Medicare beneficiaries even though the bulk of their care is funded through other payor sources. We encourage CMS to explore a residential-based ACO model where the nursing home is at risk for total cost of care and coordination with physicians, hospitals, health systems and other providers. CMS has yet to test such a residential-based hub of accountable care. We believe that economies of scale could be achieved through such an approach, especially where the hub of care is where the person resides. In these cases, the individual beneficiary often has daily interaction with their care providers instead of a 20-minute office visit. Assisted living and other senior living communities should be considered for this model in addition to nursing homes. Hospice providers are also engaging in MSSP through the formation of physician practices but are essentially using their core skillsets to manage serious illness – forming a new entity to do so should not be a requirement for entry into the accountable care space.

Develop Value-Based Arrangements That Are Embedded Within the ACO For Non-Physician Participating Providers or Organizations (Nursing Homes, Assisted Living, Home Care, etc.). As the ACO model expands to more beneficiaries, it is critical that the model evolves and engages other providers in the work for managing total cost of care and improving outcomes. Most importantly, every provider who is involved in this work should share in the financial rewards of those labors. Accountable care is a team sport and, as such, there is less success when all providers involved in a beneficiary's care don't work together. This means all team members must be accountable and appropriately rewarded for their actions. The ACO model as it stands lauds that it reduces Post-Acute Care (PAC) spend to generate its savings. However, another way to look at this is taking from one provider type to pay another. It is unsustainable and may ultimately create access issues as the current financing model for these PAC providers is no longer sustainable. CMS could help ensure ACOs adopt more value-based arrangements with PAC and other providers by offering a menu of value-based payments embedded within the ACO, such as a nested bundle for SNF, home health, or palliative care/serious illness management services. In the Value Based Models White Paper, we outline considerations for developing a nested bundle approach for a SNF or nursing home.

Consider New Avenues for Beneficiary Assignment to ACOs. As CMS seeks to improve beneficiary assignment and ensure all Medicare beneficiaries are part of an accountable care relationship by 2030, we encourage CMS to explore better ways for assigning Medicare beneficiaries who reside in nursing homes for long-stay custodial care (100 days or more) to an ACO. Long-stay nursing home residents who

[2] Considerations for Long-Term Care Providers Participating in Value-Based Care Models (https://leadingage.org/wp-content/uploads/2024/04/NAACOS-White-Paper_Final.pdf)

were admitted to a nursing home within the past two years are at risk of being prospectively misaligned to an ACO in which their prior community-based care provider participates. Once in the nursing home, these individuals are typically no longer treated by these community-based providers, making it difficult for them to achieve desired ACO results and prevent these nursing home residents from benefitting from an accountable care relationship. In contrast, other long-stay nursing home residents, in many cases, are not enrolled in an ACO because they don't receive the plurality of their primary care in the community but instead via the nursing home and/or an affiliated physician practice. We agree that these Medicare beneficiaries could benefit from ACOs and would encourage CMS to explore ways for the nursing home to meaningfully participate in an ACO that would result in its residents being assigned to an ACO. To avoid misalignment, we would recommend CMS remove the long-term care NF population from the MSSP and other shared savings models attribution based upon visit history, to prevent inappropriate overlap and misalignment to community-based providers that no longer provide primary care to these beneficiaries. This is already done for SNF patients. Another possible approach may be to allow nursing homes to exclusively align their CCN to a particular ACO and this would assign their Medicare FFS beneficiaries to a single ACO. This is similar to an approach CMS takes with Federally Qualified Health Centers. This may require CMS to establish an additional role for nursing homes where this could occur, versus SNF Affiliate roles or preferred providers.

By creating a role for nursing homes and possibly other aging services providers in beneficiary assignment, it also elevates their position within an ACO as a whole, including the possibility of having a seat at the decision-making table for distribution of shared savings and care delivery redesign. This engagement could lead to even greater success at managing Medicare beneficiaries who receive long-term services and supports (LTSS) within nursing homes and assisted living communities. We cannot leave these providers out of the financial rewards of improving outcomes or these services/providers will cease to exist as their payments and units of services continue to be reduced by ACOs and Medicare Advantage plans.

We would welcome an opportunity to discuss these and other options for meaningful participation in the MSSP and other models by PAC and LTSS providers.

CONCLUSION

We thank you for your consideration of our comments on the issues highlighted above. Please contact me (jlips@leadingage.org) if I can answer any questions or provide additional information.

Sincerely,

Jonathan Lips

Jonathan Lips, Vice President, Legal Affairs

***About LeadingAge**: We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.*