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September 14, 2026

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

Subject: 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

Dear Administrator Oz:

LeadingAge represents more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, 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, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. 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) 2027 proposed rule concerning payment policies under the physician fee schedule (PFS) and other changes to Part B payment and coverage policies.

Section II.B.4.d. Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

The Centers for Medicare & Medicaid Services (CMS) proposes to equalize the rate for nursing facility visits without regard to the beneficiary's status by setting the facility PE

relative value units (RVU) equal to the non-facility PE RVU for CPT codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, and 99316. We support this proposal, since practice expenses do not differ when it comes to furnishing services provided in facility and non-facility settings. As we stated in our comments to the proposed CY2026 Physician Fee Schedule rule last year, 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; coordination of federally mandated visits and telemedicine visits; and gathering laboratory and radiologic studies. It is important to underscore that these practice expenses do not change between skilled nursning facility (SNF) patients and nursing facility patients.

Section II.D. Valuation of Specific Codes Including Potentially Misvalued Services Under the PFS

(48) Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

(D) Supervision Requirements

CMS proposes to only allow payment for remote patient monitoring (RPM) or remote therapeutic monitoring (RTM) services when they are furnished by clinical staff directly employed by the practice. As a result, the RPM and RTM codes could not be billed where the services are contracted out to third-party companies. CMS cites concerns about adequate oversight by the billing practitioner and lack of clinical integration between the third-party providing RPM/RTM and the billing practitioner as a basis for this change.

LeadingAge opposes CMS' proposal to limit payment for RPM services to clinical staff of the billing practitioners. This limitation could reduce providers' willingness and ability to offer RPM, even when it would be especially valuable in rural and under-resourced communities. Requiring the clinical staff supporting these services to be employed directly by the practice would create an additional barrier for aging services providers that may not have sufficient staff or resources to continuously monitor data and respond to abnormal readings. Allowing qualified third-party contractors to support these functions can make RPM more practical and sustainable. LeadingAge believes that CMS' concerns about oversight should not come at the cost of reducing access to care, particularly for populations and providers that already are facing challenges in accessing and providing care. Accordingly, LeadingAge requests that CMS continue to allow third party contractors to bill for RPM services.

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Section II.E. Request for Information (RFI) on Redesigning Primary Care to Make America Healthy Again

3. Care Management Code 'Family'

CMS is seeking input on "how to reconfigure the care management code 'family' to establish effective payment for between visit care management services and how supervision requirement may need to change in technology-enabled care models where patients may initially engage with digital tools or receive care entirely in a digital environment." LeadingAge has been supportive of these care management codes for longitudinal care management and have encouraged their use for older adults who live in our senior living communities. However, we have heard of primary care practitioners (PCPs) not willing to engage in longitudinal care management of senior living residents. Our members serve older adults through a variety of senior living communities including assisted living (AL), life plan communities (LPCs, a.k.a continuing care retirement communities) and affordable seniors housing, and we would like to see more opportunities for the codes to be used for older adults in these residential care settings.

Senior living residents often have multiple chronic conditions, cognitive and functional limitations, behavioral health needs, and frequent transitions between care settings. Thus, their care management needs can be substantially different from those of patients receiving care in a traditional primary care practice in a clinic setting. PCPs may appropriately bill chronic care management (CCM) for eligible patients in their traditional practice setting, but some do not bill CCM for patients residing in senior living because senior living staff already perform significant portions of the coordination work. This does not mean the resident does not need longitudinal care management. Instead, it suggests that PCPs in a community clinic may not be the best entity to undertake this work.

- Senior living staff already bear much of the responsibility for assisting families and residents with healthcare navigation and coordination with physicians, specialists and pharmacies. **LeadingAge would recommend CMS not make access to longitudinal care management contingent upon physician employment or primary care practitioner ownership of the workforce.** Successful care management models involve an interdisciplinary team (IDT) of providers, and much of the work does not require physician-level medical decision-making. In fact, longitudinal care management could likely be provided more cost effectively by engaging qualified nurses, care managers, social workers, navigators, and other appropriately trained personnel to perform substantial portions of the service each working to the top of their license or training. In turn, the physician is engaged when their clinical judgment, treatment decisions, orders, and escalation are required as part of the IDT but should not be required to personally perform a predetermined portion of the care management work.

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- Realistically, PCPs may not have the staffing, infrastructure, or physical access to manage these needs effectively, while senior living staff already perform substantial coordination work but cannot absorb unlimited care management responsibilities. Therefore, we would recommend qualified longitudinal care management organizations be permitted to share in the care management duties and operate as an extension of the PCP—providing outreach, navigation, follow-up, coordination, monitoring, family communication, escalation, and care-plan support.

- Further, CMS should permit qualified providers—not only PCP practices—to furnish and bill care management when clinically appropriate, based on beneficiary need, practitioner qualifications, documented care plans, patient consent, and coordination with the treating practitioner.

Program integrity: We agree it is important to be vigilant in preventing fraudulent actors from billing for services they are not providing to older adults. Therefore, we think requiring an office visit solely for the purpose of initiating longitudinal care management incurs an unneccessary cost. While an office visit could be one way to initiate longitudinal care management, we urge CMS to allow clinically meaningful triggers such as a diagnosis, hospital or emergency department discharge, significant change in condition, functional decline, medication concern, new chronic condition, or documented referral—to also be used to initiate these codes. Further, CMS should address fraud, waste, and abuse through meaningful documentation, claims analytics, targeted audits, evidence of eligibility and consent, care plans, substantive interventions, communication with treating practitioners, escalation records, and follow-up—not overly burdensome minute-by-minute documentation.

CMS should modernize the care management code family without assuming that the PCP practice must directly furnish all care management. We think it is important to recognize that care management is not the same as physician management. In fact, we believe TANDEM 365 program in Michigan has demonstrated successful care management of high needs populations for many years using an interdisciplinary team. If we are sincere in the goal of redesigning care to achieve better outcomes and lower costs, then we must be open to that care being coordinated from a different centralized location than just a PCP office. Further, we must use existing staff resources more wisely whether they be in the PCP clinic or a senior living community. It is nonsensical to require a PCP practice to duplicate the efforts of staff in the senior living community but also requires those PCPs to engage when their clinical expertise is needed.

Therefore, CMS should define supervision through clinical integration and accountability, not through physician employment status or a required percentage of physician-performed time. The physician should remain responsible for clinical judgment, treatment decisions, orders, escalation, and care-plan input, while qualified auxiliary personnel

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perform coordination and follow-up within the scope of their license or other professional credentials.

To make such an approach work and ensure these care management codes are used more often and as appropriate, CMS should establish clear attribution so one entity is responsible for a beneficiary's care management during a defined period, while allowing multiple clinicians to participate in the care plan and prohibiting duplicative billing. Perhaps there could be a database where a PCP could look up a patient to determine if another PCP has claimed the care management code.

Older adults in senior living settings often need real-time, longitudinal care management where they live. For this reason, these codes should permit senior living staff and qualified longitudinal care management organizations to serve as an extension of the PCP to deliver the needed care management for these populations.

6.B. Primary Care Capitated Payment Arrangements Considerations for the Shared Savings Program.

With respect to participant eligibility, CMS posed the question of whether prior experience with risk-bearing should be an explicit prerequisite for capitated payment eligibility or whether risk-bearing Accountable Care Organizations (ACOs) in their first agreement period should also be eligible to participate in capitated payment arrangements. LeadingAge agrees that it is wise to limit capitated payments to those organizations with prior risk bearing experience. However, to achieve this, CMS must also create opportunities within and outside of the ACO structure, for providers to gain such experience. Therefore, we continue to recommend that CMS develop pathways for providers to participate in value-based arrangements (VBAs) that start with lower risk and graduate over time to higher risk arrangements. CMS support could include VBA templates for ACOs to use with all providers participating in the work of managing beneficiary needs like we imagine will be possible with the CMS-Administered Risk Arrangements within the LEAD ACO. This approach should be tested but quickly extended to SSP ACOs to engage more providers in the risks and rewards of accountable care delivery. Currently, these opportunities are typically limited to physicians.

As CMS evaluates capitated payments for primary care, we encourage it to think beyond the traditional view of primary care services as those provided in a clinic and consider primary care provided in an older adult's home such as a nursing home or AL. Older adults in these residential care settings benefit from nursing home and AL staff seeing them daily, delivering medications, assisting with activities of daily living and interacting with them during meals. These daily interactions often provide a more comprehensive view of the evolving needs of the individual than a brief office visit.

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Section II.G. — Advance Care Planning (ACP) Services and RFI on Community-Based Palliative Care

LeadingAge's membership encompasses the entire continuum of aging services, including skilled nursing, AL, memory care, affordable housing, life plan communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. Many of our members already deliver palliative care to Medicare beneficiaries. Far more would do so if a sustainable billing pathway existed. That is the core of these comments. The barrier is not clinical capability or evidence of value.

Our members already employ interdisciplinary teams and already meet detailed documentation requirements under Conditions of Participation and coverage determinations. What they lack is a code set that pays for what the team actually does. Under the current Part B inventory, the disciplines at the center of palliative care — nurses, social workers, and chaplains — either cannot bill at all or are captured only through care management codes valued well below the time and skill involved. Programs cross-subsidize from other lines of business until they cannot, and then they close.

We ask CMS to do two things: create a distinct code that identifies specialty palliative care, and pay for it through a monthly bundle that sustains the non-billing members of the interdisciplinary team. Both are already operating in Medicaid. Hawai'i and New Jersey have each built a community palliative care benefit on three codes — an initial assessment, a periodic reassessment, and a monthly interdisciplinary bundle — using HCPCS S0280, S0281, and S0311. These are approved State Plan Amendments with published clinical criteria, provider qualification standards, and rate floors. CMS should build on them rather than start over.

II.G.1 — Advance Care Planning (HCPCS Codes GACP1 and GACP2)

LeadingAge supports establishing GACP1 and GACP2 to recognize advance care planning furnished by clinical staff, and supports adding them to the Medicare Telehealth Services List. In many of the palliative care programs our members operate, goals-of-care conversations are led by a nurse or social worker who then coordinates with the medical provider to adapt the plan of care. Today that work is invisible on the claim. We offer four recommendations.

Recognize social work explicitly. CMS should state affirmatively that licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, and registered nurses qualify as clinical staff whose time counts toward these codes. CMS should also permit clinical social workers to bill CPT codes 99497 and 99498 directly when they personally furnish the service within their scope of practice. Confining social workers to an incident-to pathway is impractical in the inpatient and hospital-based clinic settings where much palliative social work occurs, and it makes the participation of the discipline

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most likely to lead the conversation contingent on a supervising practitioner's location and schedule.

Address beneficiary cost-sharing. This is the reason the ACP codes remain underused a decade after they were established, and the rule is silent on it. Cost-sharing relief is currently available only when ACP is furnished alongside the Annual Wellness Visit and reported with the -33 modifier — a pathway that, as a practical matter, belongs to primary care. When an oncologist, cardiologist, or nephrologist conducts a goals-of-care conversation, the beneficiary incurs specialty cost-sharing, and clinicians report that this deters them from either having the conversation or billing for it. The same problem will follow any new code CMS attaches to an E/M visit, including the proposed complexity add-on. We ask CMS to decouple cost-sharing relief from the Annual Wellness Visit, and to address the preventive services question discussed below.

Offer a combined code as an option, not a replacement. CMS asks whether a single code capturing combined practitioner and clinical staff time would better reflect practice. It would reduce documentation burden where both work within the same encounter, and we support offering it. But CMS should retain GACP1 and GACP2 as standalone codes, because longitudinal palliative care routinely involves clinical staff time furnished on a different day than the practitioner visit. A combined-only structure would foreclose reporting it. We also ask CMS to confirm that documentation within a standardized care plan satisfies the documentation requirement; a wholly separate note is burden without integrity benefit.

Confirm settings, and specify documentation for shared appointments. CMS should confirm that GACP1 and GACP2 may be reported for beneficiaries in skilled nursing facilities, nursing facilities, and under a home health plan of care, and clarify the interaction with SNF consolidated billing. Separately, we support payment for shared medical appointments under HCPCS code GSMAS, but note that providers today have no structured way to document that a non-billing clinician shared an appointment with a billing clinician. A joint visit by a nurse practitioner and a social worker appears in most electronic health records as a nurse practitioner visit, with the social worker's role in unstructured narrative. CMS should specify the required documentation elements — each participating clinician by discipline, the role each played, and duration of participation — or it will have no way to distinguish a shared appointment from a routine one.

II.G.2 — RFI on Community-Based Palliative Care

Establish a distinct code for specialty palliative care

Medicare cannot currently identify, from claims, that a beneficiary received specialty palliative care. This limits CMS in every direction: it cannot measure utilization, evaluate outcomes, risk-adjust, or target program integrity efforts. ACOs that have made community-based palliative care a cornerstone of their strategy cannot verify that their

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investment is being delivered. The Z51.5 diagnosis code does not solve this — it indicates an encounter for palliative care, but not who furnished it, at what intensity, over what period, or whether interdisciplinary requirements were met.

LeadingAge supports CMS's proposed restructuring of the inherent complexity add-on. An add-on recognizing the work of assessing and managing medical complexity is overdue and maps well to the comprehensive palliative care assessment. But it is not a substitute for a specialty palliative care code. An add-on identifies that a visit was complex; it does not identify that specialty palliative care was delivered, or who is qualified to deliver it. It carries every limitation of the E/M visit it attaches to, including cost-sharing. And it pays for the assessment, not for what happens between assessments — which is where the savings in palliative care come from. If CMS pays for the assessment and not the follow-through, it will have purchased a document rather than a service.

We therefore recommend CMS establish a standalone, monthly, bundled specialty palliative care management code alongside any complexity add-on, together with separately payable assessment and reassessment codes. CMS should look directly at the S0280 / S0281 / S0311 framework. Because S-codes are not valid for Medicare, CMS would need to establish corresponding G-codes or work through the CPT process; the mechanism matters less than the existence of an adequately valued standalone code.

Do not tie eligibility to prognosis

LeadingAge strongly opposes restricting eligibility to a certified life expectancy. An individual's need for palliative care fluctuates over the years. A newly enrolled beneficiary may face a sudden cancer diagnosis, need substantial support during treatment, then enter remission and live another decade before ever needing hospice. A prognostic standard would exclude that beneficiary. It would also reimport the single feature of the hospice benefit that most reliably deters people from accepting care: requiring a clinician to certify limited life expectancy converts a conversation about symptom relief into a conversation about dying, which for many beneficiaries — including for cultural and religious reasons — is precisely why they decline hospice.

Prognostication at a twelve-month horizon is also unreliable for the non-cancer trajectories where much of this population sits. Heart failure, COPD, end-stage renal disease, and dementia decline in patterns punctuated by exacerbation and partial recovery. Making payment contingent on an attestation the evidence does not support is itself a program integrity risk.

Relatedly, palliative care should not be framed as a bridge to hospice. Many beneficiaries need it for a discrete period before remission or subsiding symptoms, and that trajectory does not always lead to hospice. CMS should not tie improved palliative access under Part B or home health to eventual hospice transition. We do recommend that assessment of

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hospice appropriateness be a required element of the interdisciplinary team meeting, as Hawai'i requires — that is good practice, and different from making hospice the objective. We recommend instead a two-part standard used by both states: a qualifying serious illness diagnosis, plus objective evidence of reduced quality of life demonstrated through any one of several alternative pathways:

- **Functional decline on a validated instrument** — for example, the Palliative Performance Scale or the Karnofsky Performance Status. Published instruments with published thresholds remove subjectivity and produce analyzable data.

- **Acute care utilization** — two or more emergency department visits in six months, or one acute hospitalization in twelve. This pathway is claims-identifiable, so CMS can verify it without any provider attestation, addressing burden and integrity simultaneously.

- **Device dependency or clinical biomarkers** — Examples could include durable medical equipment utilization (e.g., oxygen) or certain clinical biomarkers.

- **Documented clinical judgment** — both states preserve a pathway for individual determinations where a beneficiary does not meet an enumerated threshold but the assessor documents why the service is appropriate. Any framework should retain this.

Caregiver strain should be a required assessment domain rather than a standalone eligibility gate. New Jersey requires caregiver burden to be assessed. It drives the care plan, and our members report that unaddressed caregiver strain is a significant contributor to avoidable hospitalization — but as an independent criterion it would invite subjectivity without adding much. We also urge CMS not to require homebound status, which excludes beneficiaries who are ambulatory but seriously ill and those whose function fluctuates. Additionally, those who are homebound and otherwise meet home health eligibility criteria can access palliative care through a home health pathway, as discussed in the CY 2027 Home Health PPS proposed rule, which CMS has indicated will be further developed through sub-regulatory guidance following publication of the final rule.

To keep eligibility administratively light, CMS should allow any qualified clinician to conduct the assessment (New Jersey permits any Medicaid-enrolled MD, DO, PA, APN, or LCSW, who need not be part of a palliative team), prohibit prior authorization as a prerequisite to the assessment, pay for the assessment regardless of outcome, and use a single standardized assessment tool. If CMS takes the leads on that standardization, other payers are likely to follow.

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Sustain social work and spiritual care

The largest revenue gaps in community-based palliative care are social services and spiritual care. Nearly every program relies on social workers to address barriers to care — financial resources, transportation, housing, caregiving capacity — yet the work RVUs assigned to the care management codes are not aligned with the skill applied or the time involved, and incident-to requirements do not fit the settings where much of this work occurs.

Spiritual care is the starker gap. Spiritual and existential needs intensify in serious illness, and as many as 79% of patients report unmet spiritual needs. Yet National Palliative Care Registry data indicate that 46% of adult palliative care programs have no access to chaplains or other spiritual support, and only about one in four programs provide spiritual care in the ambulatory setting. When program leaders are asked why, they cite the absence of any revenue to support an employed chaplain. Our members describe this as the service they most want to offer and are least able to sustain.

The structural fix is the monthly bundle

Rather than requiring each discipline to generate a billable encounter, a bundle pays for the team's work as a whole, subject to documented minimum activity. New Jersey conditions the monthly claim on at least one documented team-member interaction with the beneficiary and one documented internal team meeting. Hawai'i requires 24/7 access, a quarterly in-person prescribing-clinician visit, a monthly team visit, and biweekly interdisciplinary team meetings. These requirements are meaningful and auditable, and none of them require the participating discipline to hold billing privileges.

CMS should also apply the auxiliary personnel standard it has already established

The Principal Illness Navigation and Community Health Integration codes permit auxiliary personnel to furnish services under the billing practitioner's supervision, with the expectation that staff hold credentials appropriate to competent care. CMS can use that same construct to incorporate chaplaincy and social work into the interdisciplinary team.

Palliative care should be treated as a preventive service

CMS has already accepted this characterization. On May 7, 2024, CMS approved Hawai'i State Plan Amendment 22-0013, effective retroactive to January 1, 2023, adding "Community Palliative Care" to the list of covered services under the Preventive Services benefit. The approved plan language states that palliative care "is based on the needs of the patient, not on the patient's prognosis," that it is appropriate at any age and stage, and

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that it may be provided alongside curative treatment — a preventive designation that expressly disclaims a prognostic standard. Attachment 4.19-B establishes a monthly bundled rate with assessments and reassessments billed separately. Supplement 4 designates the physician, registered nurse, licensed clinical social worker, and grief counselor as required team members. CMS approved a preventive service whose required team includes disciplines that cannot bill Medicare directly. New Jersey followed the same route under 42 C.F.R. § 440.130(c).

The characterization is correct on the merits. Community palliative care prevents progression of symptom burden, functional decline, and caregiver collapse; the evidence consistently associates palliative care with improved quality of life, reduced symptom burden, and lower health care utilization; and the mechanism by which it generates savings is inherently preventive, in that the team looks ahead, builds a plan, and acts on it to avert the emergency department visit and admission that would otherwise occur. This is squarely consistent with the Administration's stated objective of shifting Medicare from sick care to health care.

We acknowledge that Medicare's framework for preventive care is narrower than Medicaid's. Section 1861(ddd)(1) of the Social Security Act, implemented at 42 C.F.R. § 410.64, permits the Secretary to add "additional preventive services" through the national coverage determination process where the service identifies medical conditions or risk factors, is reasonable and necessary for prevention or early detection, is recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF), and is appropriate for beneficiaries. That designation carries the cost-sharing waiver added by section 4104 of the Affordable Care Act. The USPSTF grade requirement is a real obstacle: the Task Force has not issued a recommendation on community-based palliative care. We ask CMS to state its position in the final rule on whether section 1861(ddd) or any other authority could support designating longitudinal palliative care management or advance care planning as preventive; to say plainly if the statute forecloses it and, if so, to support a targeted legislative fix. In the interim, CMS should confirm that advance care planning, care management, and any future palliative care management services are eligible for the Part B cost-sharing support arrangements CMS proposes elsewhere in this rule to permit for Shared Savings Program ACOs. That last step would remove the barrier immediately for attributed beneficiaries, with no change in preventive services authority.

Provider qualifications, program integrity, and 24/7 access

From a payment integrity standpoint, it matters that the appropriate specialty can bill for and track this service — not simply anyone. But the field should not build a barrier that excludes the oncologists, cardiologists, nephrologists, and pulmonologists now integrating palliative care into their service lines, whose participation is necessary if access is to scale. CMS should examine the existing accreditation frameworks, existing palliative care

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education options, and what state Medicaid programs have done in considering provider standards. CMS should also give interested entities a runway to complete the education. CMS should permit a broad range of provider entities. New Jersey limits participation to hospices, home health agencies, physician groups, and independent clinics, and expressly bars entities licensed as a hospital or skilled nursing facility. Hawai'i's participation is broader, expressly contemplating hospitals, long-term care facilities, clinics, hospice and home health agencies, and other community-based providers with trained licensed clinical staff. We urge CMS to adopt the broader approach. Our membership includes nursing homes, life plan communities, and multi-service organizations well positioned to serve residents and the surrounding community, and already employing most of the required team.

On program integrity, the core safeguard is that payment is contingent on a documented, standardized assessment and on documented minimum monthly activity. A qualified assessment on a standard tool, signed by the assessing clinician, should be a prerequisite to authorization and to any monthly payment. Reassessment every six months confirms continued eligibility. If CMS chooses to include requirements like encounter documentation, it should set the expectation at the outset with a reasonable implementation runway rather than retrofit it.

Finally, both the clinical guidelines and emerging program standards require 24/7 access to a knowledgeable clinician with access to the medical record. Crises among unstable, high-need patients occur at all hours, and families must be able to reach someone who can avert an unnecessary emergency visit or admission. The resulting visit may be reimbursable under Part B; the on-call infrastructure that makes it possible is not. That cost cannot be sustained on fee-for-service billing. Both states require a 24/7 line as a condition of participation and fund it through the monthly bundle. CMS should do the same. LeadingAge thanks CMS for its focus on palliative care across the continuum during this rulemaking cycle and looks forward to working with CMS and our members to expand access to this vital service.

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

LeadingAge appreciates CMS's continued efforts to strengthen the SSP by improving financial incentives that encourage ACOs to remain in the program over time. A stronger risk-adjusted benchmark cap could make higher-risk populations, including long-stay nursing home residents, more attractive for ACO alignment and help expand participation in accountable care. Growth incentives may also encourage ACOs to partner with aging services providers to better coordinate care through value-based arrangements. However, CMS should pair these financial incentives with practical steps that make it easier to assign long-stay nursing home residents to appropriate ACOs based on the onsite primary care they receive.

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We believe ACOs provide an important counterbalance to Medicare Advantage by giving beneficiaries another option for coordinated, accountable care. Allowing SSP ACOs to reduce or eliminate Part B cost sharing is another meaningful step toward greater parity between ACOs and Medicare Advantage.

Beneficiary assignment methodology changes

LeadingAge supports the proposed changes to the beneficiary assignment methodology to capture more Medicare Fee for Service (FFS) beneficiaries in the pool of those eligible for ACO assignment. We particularly appreciate the proposed changes permitting ACO assignment for Medicare beneficiaries returning to original Medicare after leaving a Medicare Advantage plan. This step eliminates an unintentional penalty that currently delays these beneficiaries' ability to benefit from the care accountability offered from an ACO more quickly.

CMS notes in reference to these changes that they are seeking approaches to further expand ACO assignment. With this in mind, we reiterate recommendations we've made in previous years to 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 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 their residents being assigned to an ACO.

Recommendations: 1) To avoid misalignment, we would recommend CMS remove the long-term care nursing home population from the SSP and other shared savings models' assignment and 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 short-stay SNF patients. 2) Another possible approach may be to allow nursing homes to exclusively align their CMS Certification Number (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 category for nursing homes

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whose FFS population is attributed in full to an ACO that is different than existing ACO SNF roles such as SNF Affiliate or preferred provider.

By creating a role for nursing homes and possibly other aging service 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 AL communities. See "Considerations for Long Term Care Providers Participating in Value-Based Care Models" white paper for additional ideas and details.

Growth Adjustment to the Historical Benchmark

While CMS appropriately proposes policies to recruit additional clinicians and beneficiaries into accountable care arrangements, the agency should also encourage ACOs to develop formal value-based relationships with non-physician providers that manage Medicare's highest-need populations. Skilled nursing facilities, home health agencies, AL providers, and other aging services organizations frequently provide the longitudinal care management, care transitions, medication oversight, and functional supports that drive successful performance under accountable care models. CMS should explore opportunities to incorporate these providers more directly into SSP accountability structures, beneficiary alignment methodologies, benchmark incentives, and shared savings arrangements.

We think one way to do this may be to include the CMS-Administered Risk Arrangement (CARA) structure from the LEAD ACO into the SSP ACO. We recognize that CMS likely would prefer to test and refine CARA first within the LEAD ACO model before expanding it to SSP. We hope that with its success, CMS will look to expand this offering to the Shared Savings Program ACOs. We believe such an approach could 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 Considerations for Long-Term Care Providers Participating in Value-Based Care Models white paper, we outline considerations for developing a nested bundle approach for a SNF or LTSS nursing home. 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.

RFI on Applying Electronic Prior Authorization Measures to Shared Savings Program ACOs

LeadingAge is unaware of how many SSP ACOs currently utilize prior authorization in their program. This information could be useful in developing prevalence and then if prevalent,

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we would encourage CMS to require e-prior authorization (e-PA) requirements for ACOs similar to the regulations that Medicare Advantage plans must meet in January 1, 2027, as part of the Interoperability and Prior Authorization rule finalized in 2024.

Prior authorization should never be a barrier to needed care nor should it pose a significant administrative burden on providers that outweighs its value. Therefore, utilizing an electronic format to process and share information for these determinations is essential to minimize the administrative burden of the process and speed up the decision-making process. Having said that, implementing e-PA in an ACO could prove much more challenging given that an ACO is not a single provider organization with a shared information technology system but instead an amalgamation of providers working toward a shared goal. We think it would be important for CMS to begin by quantifying how many ACOs currently are using prior authorizations and what IT systems they are using. Then, if there is prevalent use, CMS should engage ACO stakeholders to obtain input on the timeline and process for rolling out an e-PA requirement and provide ample time to prepare. Given that ACOs operate within the Medicare FFS infrastructure, it could make sense for CMS to develop a single portal or Applicable Programming Interface (API) with a standardized process to be used by all ACOs and their providers for e-PA submissions and information exchange across all ACOs.

RFI on Specialty Care in the Shared Savings Program

Financially, all providers that contribute to the beneficiary's care outcomes should share in the financial rewards. For aging service providers, CMS should consider creating episodic payment options that are embedded within the existing ACO structures that allow ACOs to more effectively partner with nursing homes and AL communities to deliver accountable, patient-centered care.

Some aging service providers have previously participated in various risk-based models including the original bundled payments for care improvement and/or are currently participating in risk arrangements or leading Medicare Advantage, Special Needs Plans, or Programs of All Inclusive Care for the Elderly (PACE). These experienced aging service provider organizations are ready for a population-based or total cost of care payment to provide accountable care to residents in nursing homes, AL communities, and their home care clients. While other aging services providers, such as nursing homes, could benefit from the opportunity to participate in an embedded episodic payment for their residential population allowing them to take on a greater accountability for those they already care for and to be rewarded financially for changes in care delivery to improve care outcomes and lower costs. For more details on the idea of an embedded episodic payment within an ACO for long term care providers, see this white paper.

Structurally, current SSP laws prevent a nursing home, for example, from leading a SSP for their residents because they are not a hospital, health system or physician. CMS should

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consider testing accountable care models in residential care settings such as nursing homes, AL and life plan communities. Nursing homes already coordinate care for those that live in their setting with primary and specialty care providers, pharmacies, and families but are typically paid a per diem under Medicare and Medicaid. A population-based or episodic payment could provide critical financial incentives to change current care delivery patterns while providing needed funding to support the required infrastructure needed for these changes. Nursing homes and aging services providers are longitudinal care coordinators for high-need beneficiaries but need to be recognized both financially and with a greater role within an ACO.

We encourage CMS to think beyond the traditional view of primary care services as those provided in a clinic and consider primary care provided in an older adult's home such as a nursing home or AL. Older adults in these residential care settings benefit from nursing home and AL staff seeing them daily, delivering medications, assisting with activities of daily living and interacting with them during meals. These daily interactions often provide a more comprehensive view of the evolving needs of the individual than a brief office visit. In many cases, these residential care settings either employ their own or contract with primary care practitioners and practices to deliver primary care where the older adult lives instead of a community-based clinic.

With all of this in mind, we ask CMS to consider how to create a variety of value-based arrangements that can be used with specialty providers within an ACO for residential-based care such as is provided in long-stay nursing homes and AL communities. If these settings were eligible for a sub-capitated payment for their resident population, it could help expand the population enrolled and benefitting from accountable care. It would create new financial incentives to avoid hospitalizations and help further care coordination. Such an approach would not exclude primary care practitioners but instead make the hub of accountability the residential setting providers who then coordinate with outside professionals. In this case, primary care comes to the beneficiary, rather than the other way around. In addition, within residential care settings information on the beneficiaries is regularly updated and contained within the nursing home or AL electronic health record, including observations about gait, food intake, any cognitive concerns, independence, chronic condition management, etc., enabling earlier detection of changes in condition and timely intervention to prevent higher-cost care, such as hospitalizations.

Section IV.A.4.c. RFI on Fast Healthcare Interoperability Resources (FHIR)

(2) Transition to FHIR-Based Quality Measurement in the Quality Payment Program and Other CMS Clinician and Hospital Quality Programs

In its RFI, CMS requests public comment on the timeline for transitioning to FHIR-based quality reporting in CMS quality reporting programs. In particular, CMS seeks input on a transition timeline, key milestones, and implementation considerations for FHIR-based

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quality reporting in the Quality Payment Program and other CMS clinician and hospital quality programs. LeadingAge generally supports CMS's proposed transition timeline and its acknowledgment that implementation of FHIR-based quality measurement and reporting will vary across programs based on feasibility, complexity, and organizational readiness.

In considering how readiness to adopt FHIR-based quality measurement and reporting varies by practice type and organizational setting, CMS should recognize that aging services providers did not receive the same HITECH Act "meaningful use" incentives for health information technology adoption as acute care providers. As a result, many LeadingAge members begin this transition with fewer resources, less developed digital infrastructure, and more limited interoperability capabilities. CMS should account for these differences by providing aging services providers with appropriate flexibility and support as they implement FHIR-based quality measurement and reporting.

CONCLUSION

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

Sincerely,

Clarette Yen
Vice President, Legal Affairs

About LeadingAge: We represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, 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, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. 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.

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