PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

9891 Broken Land Parkway, Suite 101
Columbia, MD 21046
www.paltmed.org

September 12, 2025

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

Re: 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; Medicare Prescription Drug Inflation Rebate Program; [CMS-1832-P]

Dear Administrator Oz:

The Post-Acute and Long-Term Care Medical Association (PALTmed) (formerly known as AMDA-The Society for Post-Acute and Long-Term Care Medicine) appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) on the 2026 Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies proposed rule, published in the *Federal Register* on July 14, 2025.

PALTmed is the only medical association representing the community of medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. PALTmed's members work in skilled nursing facilities (SNFs), long-term care and assisted living communities, continuing care retirement communities, home care, hospice, PACE programs, and other settings. In serving this population, these clinicians care for the most high-risk and costly group of beneficiaries covered by Medicare and Medicaid programs. Medicare beneficiaries in both Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) deserve and need equitable access to high-quality physician care. Our comments are grounded in a deep understanding of the complex medical needs of these vulnerable patients, as well as the resources and support physicians and other healthcare providers require to deliver optimal, efficient care.

We would like to offer the following specific comments and recommendations in response to the CMS proposals:

CY 2026 PFS Rate Setting and Medicare Conversion Factors

The CY 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule introduces updated conversion factors (CFs) that will directly affect payment rates for clinicians across all specialties. CMS proposes a CF of $33.4209 for clinicians not participating in a qualifying Advanced Alternative Payment Model (APM) and a slightly higher CF of $33.5875 for those who are Qualifying APM Participants (QPs). While these rates reflect a modest adjustment from previous years, they continue a pattern of flat or declining base payments for Medicare services when adjusted for inflation and rising operational costs.

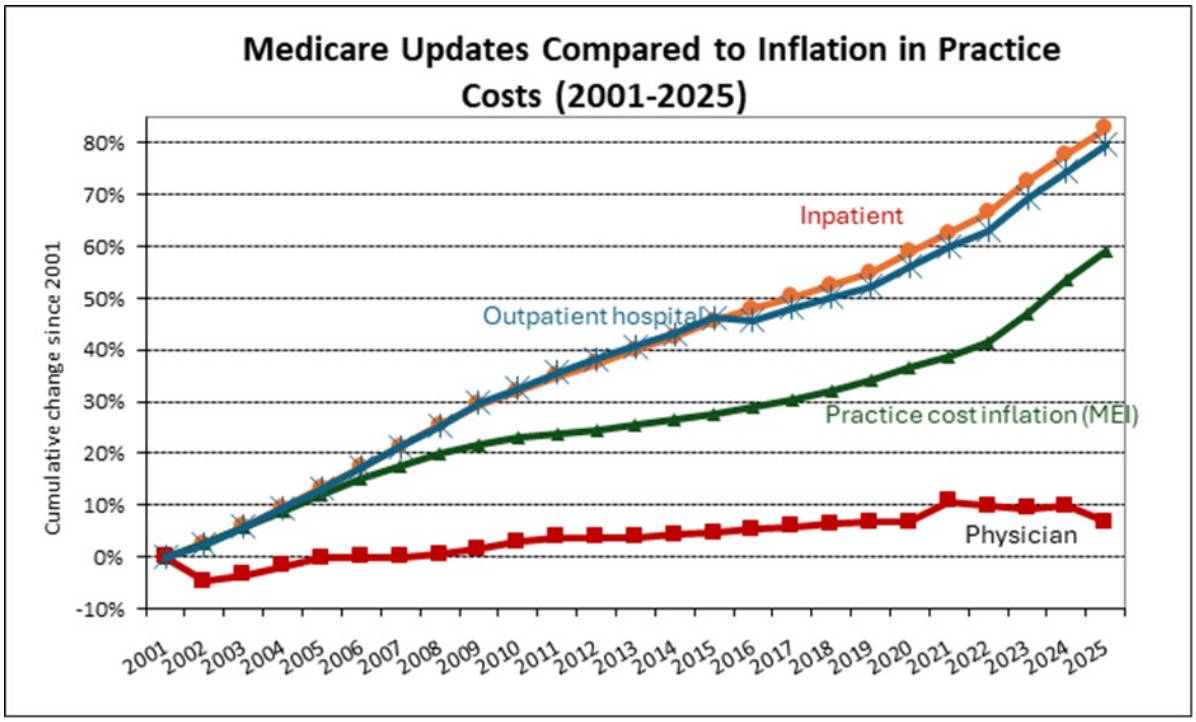
For clinicians working in post-acute and long-term care (PALTC) settings, including nursing homes, assisted living communities, and home-based care, these conversion factors play a critical role in determining the final reimbursement for Evaluation and Management (E/M) services, advance care planning, and chronic care management. These clinicians often operate with thin margins and face high administrative burdens, staffing constraints, and the need to travel between care sites. Even a small reduction in the CF can compound financial pressure and affect service availability, particularly in underserved or rural areas where access is already fragile. Eventually small reductions will add up over time and inevitably lead to less physicians practicing in this space. This will only harm the frail older adults we care for in these settings when they need thoughtful and value-based healthcare the most.

Importantly, many PALTC clinicians do not participate in qualifying APMs, meaning they will be paid using the lower $33.4209 CF. Currently, few APMs are designed to include PALTC clinicians. This further widens the gap between those in value-based arrangements and those still in traditional fee-for-service models. For smaller practices or independent clinicians who lack the infrastructure to join APMs, this creates additional strain and could influence provider decisions about where and whether to continue offering care in long-term settings.

PALTmed stands ready to work with CMS and the Centers for Medicare and Medicaid Innovation (CMMI) to develop models tailored to the PALTC population. To date, models have been designed with a more acute focus and many quality metrics used in value-based care models are not appropriate for the population we serve. A recent article in *the Journal of the American Geriatrics Society* highlighted issues with the current diabetes measures widely used for performance measurement in value-based care models (https://www.fau.edu/newsdesk/articles/diabetes-hypertension-treatment-older-adults.php). Likewise, the current ACO REACH high needs demonstration is scheduled to sunset in 2026 with no indication of continuation. Without models of care focused on the frail, older population, clinicians who treat patients in PALTC will not be able to meaningfully participate in value-based care models and therefore be subject to lower reimbursement under this proposal. CMS must take immediate steps to develop models of care that benefit this population and ensure these models are inclusive and tailored to the unique PALTC care environment.

While the CF is only one part of the payment equation, when combined with other proposed changes like the redistribution of practice expense (PE) RVUs from facility to non-facility settings, the financial outlook for PALTC clinicians remains unoptimistic. CMS must carefully consider the cumulative impact of these shifts to avoid inadvertently reducing access to complex care for the frail, elderly, and medically vulnerable populations that PALTC clinicians serve.

We are pleased that CMS acknowledges private physician practices require additional support to stay afloat and compete with hospitals and health systems. One major source of the problem is that settings of care like hospitals receive annual, inflation-based updates while physician practices do not. As shown in the chart below, Medicare updates to hospitals totaled roughly 80 percent (or 2.5 percent per year on average) since 2001, while physician payments remained essentially flat. As mentioned above, we would greatly appreciate support from the Trump Administration for congressional efforts to provide annual, inflation-based updates for physicians consistent with hospitals and nearly all other Medicare providers.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Practice Expense (PE) Adjustment

We appreciate CMS for its efforts to ensure a proper and just physician fee schedule. However, PALTmed is deeply concerned about CMS's new proposal to differentiate and reduce practice

expense (PE) RVUs based on facility and non-facility settings. According to the proposed rule, CMS plans to, "change to the methodology so that when work RVUs are used to allocate indirect PE to the facility RVUs, they are assigned at one-half the amount allocated to the non-facility PE RVUs for that same service."

The CMS Medicare Claims Processing Manual defines two places of service for nursing homes. Skilled nursing facilities (POS 31) are categorized as facility settings. Nursing Facilities (POS 32) are categorized as non-facility settings. In the SNF (POS 31) setting, Medicare does not make a separate payment to the SNF for physician services under Part A. Instead, these services are billed directly by the clinician and are reimbursed under Medicare Part B, just as they would be in an office or other non-facility setting. SNFs are not financially responsible for furnishing or supporting these professional physician services, nor are they paid by Medicare to do so. The clinician remains solely responsible for providing all necessary practice expenses to deliver care, including clinical staff time and other indirect and direct costs.

Regardless of funding source, clinicians typically bill Medicare Part B for these visits using CPT codes 99304–99316. At one point historically, the practice expense RVUs differed between POS 31 and POS 32 due to a perceived unique facility versus non-facility base practice expense. This was corrected around 2006, equalizing practice expenses for both POS 31 and 32.

Clinicians practicing in the nursing home will agree that the practice expense is not in reality different between skilled nursing facility and nursing facility. In fact, the same patient, in the same bed, 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. It can change quite rapidly although the care is very similar.

Physicians and advance practice practitioners that practice in this setting need to typically maintain staff, an office, examination equipment, and separate electronic medical record and services for communication with the nursing home 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 office staff typically are involved in phone calls from nursing homes, patients/families and other health care providers 24 hours per day, 7 days per week; requests for durable medical equipment, therapy and pharmacy reviews; helping coordinate timing of federally mandated visits; coordinate telemedicine visits; and help gather laboratory and radiologic studies. These practice expenses do not differ between POS 31 and POS 32 patients.

PALTmed believes 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 clinicians to care for vulnerable residents. Reducing payment for POS 31 services will only worsen this problem, making patients in non-skilled nursing facility more profitable to treat than those in skilled nursing facilities. For these reasons, **practice expense values should not be cut; they should remain equivalent between POS 31 and POS 32.**

It's important to understand that in both POS 31 and POS 32:

- Physicians furnish face-to-face, Part B-billable services directly to patients in nursing home settings.
- Physicians are not supported by facility-furnished staff or infrastructure related to their professional services. SNFs and NFs do not provide exam rooms, documentation tools, or billing support, nor do they receive separate Medicare payment for any component of the physician's services.
- The patient populations are equally medically complex and require high levels of care coordination, documentation, and administrative oversight, resulting in similarly high indirect costs for the practitioner.
- A patient could enter a facility as a SNF patient, be in the same bed and room, and then be considered a NF patient while still receiving the same level of care.

CMS justifies the lower facility PE RVUs on the assumption that having the same indirect PE per work RVU for services furnished in the facility setting as the non-facility setting may "no longer reflect contemporary physician practice trends." However, this rationale does not accurately reflect clinician practice and reimbursement in nursing home settings.

Clinicians furnishing services in nursing home settings are often independent practitioners or small groups operating outside of institutional employment structures. As such, they continue to bear substantial indirect costs, even when the care is delivered in a facility, because the facility does not furnish or support the technical or administrative components of the physician's work. These costs are comparable to, and in many cases greater than, those incurred in office-based care due to the complexity of the patient population and regulatory environment.

Key Categories of Indirect PE Costs Incurred:

1. Administrative Staff Time
    - Scheduling, patient intake, credentialing, order coordination, quality reporting, and claims processing are all handled by the physician's practice, not the facility.
    - Staff are often needed to coordinate with facility personnel, follow up on lab results, arrange care transitions, and manage communication with families and pharmacies.
2. Health IT and EMR Infrastructure
    - Clinicians must document in their own EMR systems (required for billing, compliance, and MIPS reporting), even if the facility uses a separate record system.
    - Data must often be duplicated or transferred manually from the facility chart into the clinician's EMR, and from the clinician's EMR back to the facility's, increasing both labor and software costs.
3. Compliance, Risk Management, and Reporting

- Long-term care is highly regulated, and clinicians must maintain internal protocols, staff training, HIPAA compliance systems, and documentation standards that mirror or exceed those in office-based settings.
- Quality programs (e.g., MIPS or APMs) require the same infrastructure investment, regardless of site of care.

4. Telecommunications, Equipment, and Supplies
    - Practices must provide their own laptops, tablets, mobile devices, secure messaging systems, and communication tools used within the facility, none of which are provided by SNFs/NFs.
    - Stethoscopes, otoscopes, reflex hammers, wound destruction equipment, and other examination supplies are typically purchased and used by physicians and APPs rather than by skilled nursing or nursing facilities.
    - Many practices invest in mobile tech infrastructure to support documentation and patient monitoring on-site.
5. Care Coordination and Non-Face-to-Face Time
    - Clinicians in SNFs and NFs often manage patients across multiple transitions of care (hospital to SNF to home), necessitating frequent communication with other providers and caregivers.
    - Clinicians often manage patients across multiple SNFs and NFs, necessitating travel and remote clinical management for acute changes in condition.
    - This indirect clinical work, often not billable, represents a major time and cost burden.

Recommendations

Given the clinical and operational equivalence of physician work in these settings, we urge CMS to:

1. **Exempt nursing homes codes from the PE RVUs redistribution,** these codes should maintain the non-facility PF RVUs independent of their place of service.
2. **Align PE RVU policy with practitioner responsibility**, not facility certification status, since neither the SNF (POS 31) nor the NF (POS 32) incurs or is reimbursed for the indirect costs of the physician's work.
3. **Avoid payment cuts and payment differentials that are based on administrative distinctions** between SNF and NF certification status, when the actual service and setting are otherwise indistinguishable from a resource use standpoint.

By carving out these services from the redistribution framework, CMS can better align PE RVUs with actual resource use and avoid unintended payment distortions for clinicians serving high-need, medically complex populations in nursing homes and similar care settings. We believe this policy adjustment would serve as a practical and equitable step toward modernizing the PE system without undermining access to care in long-term care environments. Costs will only increase throughout the healthcare system if access to care is negatively impacted by the PE adjustment.

Medicare beneficiaries in both SNFs and NFs deserve equitable access to clinician care, and clinicians should be paid fairly based on the work performed and costs incurred, not based on arbitrary distinctions between POS codes. A differential in PE RVUs between POS 31 and POS 32 would introduce a misalignment that undermines the integrity of the physician fee schedule and disproportionately impacts providers serving high-need populations in long-term care.

Now is the time to invest in the clinician workforce, not reduce it. Ensuring access to high-quality care in nursing homes is essential not only for improving outcomes for some of Medicare's most vulnerable beneficiaries, but also for strengthening the program's financial sustainability. When skilled clinicians are available to care for this complex population, avoidable hospitalizations, emergency department visits, and costly complications are significantly reduced, resulting in substantial savings for Medicare. Providing adequate reimbursement is key to maintaining access to quality care for residents and ensuring stability within the PALTC workforce.

We urge CMS to ensure that payment policy reflects the realities of care delivery in these settings and does not penalize clinicians based on the facility's Medicare certification status.

Expand Use of G2211 Add-On Code to Home and Residence E/M Visits

PALTmed appreciates the opportunity to comment on the proposal to extend the applicability of HCPCS code G2211 to home and residence-based evaluation and management (E/M) visits. We support this proposed expansion, which appropriately recognizes the longitudinal, relationship-based care provided in these settings. However, we remain concerned that CMS continues to exclude the use of G2211 in the nursing home setting, despite strikingly similar care delivery characteristics.

We commend CMS for acknowledging that home/residence E/M visits often involve ongoing, complex care planning and frequent touchpoints, often monthly or weekly, for patients with serious or multiple chronic conditions. These services inherently require trust-building, care coordination, and clinical follow-through over time, all of which are resource-intensive. As CMS rightly noted, the complexity captured by G2211 is not determined solely by a patient's diagnosis or acuity, but by the depth and continuity of the practitioner-patient relationship.

However, we urge CMS to recognize that the same elements are present in nursing home care, particularly in POS 31 (skilled nursing facility) and POS 32 (nursing facility) settings. Clinicians

practicing in these environments, such as attending physicians, nurse practitioners, and physician assistants, often provide care to patients with chronic or serious conditions over extended periods. These practitioners are responsible for coordinating complex care plans, preventing hospitalizations, and managing patients across transitions in care, just as they do in home or residence-based settings. The nature of these relationships and the clinical responsibilities they entail mirror care dynamics CMS is now recognizing in the home/residence setting.

This differential treatment for place of service risks creating artificial disparities in reimbursement for the same type of work, depending on where the patient happens to reside. It may also discourage continuity of care across settings and inadvertently disincentivize practitioner involvement in facility-based care for chronically ill populations.

We believe **there is a compelling case for extending HCPCS code G2211 to nursing facility E/M codes, including CPT codes 99304–99310 and 99315–99316.** Doing so would align with CMS's intent to value the time and effort involved in providing whole-person, relationship-centered care and would bring equity to practitioners serving vulnerable populations in all residential care environments.

PALTmed urges CMS to expand eligibility for HCPCS code G2211 to include nursing facility E/M visits in future rulemaking, recognizing the resource costs and clinical complexity of longitudinal care provided in these settings.

Telehealth

Removing Frequency Limitations for Subsequent Nursing Facility Visits

PALTmed strongly supports CMS's proposal to permanently remove the frequency limitations for subsequent nursing facility visit codes (CPT codes 99307–99310) via telehealth.

This proposal is an important and evidence-based step toward modernizing care delivery for patients in nursing facilities. During the COVID-19 public health emergency, the temporary removal of frequency limitations enabled practitioners to use telehealth to provide more timely and effective follow-up care, which, in many cases, contributed to reduced hospitalizations and improved care coordination.

Telehealth has become a critical tool in many value-based care models and is especially valuable in skilled nursing and long-term care settings where patients often have complex medical conditions and limited mobility. Telehealth has significantly improved the ability to deliver timely, high-quality clinician care in SNFs, particularly during changes in condition when no physician or other medical personnel are present on site. It has also created access to specialists who would otherwise be unavailable to our largely home- and facility-bound patient population. Beyond improved access, telehealth has contributed to better clinical outcomes by enabling earlier intervention, reducing unnecessary hospital transfers, and supporting care coordination. These improvements not only enhance patient quality of life but also lower overall healthcare costs. Arbitrary frequency caps on subsequent visits create unnecessary administrative burdens and may

delay needed care. Removing these limits permanently will allow clinicians to exercise their judgment in determining the appropriate cadence of follow-up based on each patient's clinical needs.

Moreover, this change supports broader CMS goals to expand access, improve quality, and advance health equity, particularly for populations who face barriers to frequent in-person care due to geography, staffing constraints, or frailty. Access to both primary and specialty care increases with telehealth.

For these reasons, we urge CMS to finalize this proposal and continue to support policies that expand access to high-quality, clinically appropriate telehealth services in the nursing facility setting.

Changes to the Medicare Telehealth List

PALTmed supports the CMS proposal to simplify the telehealth list review process and remove the use of "permanent" or "provisional" designation on the Medicare Telehealth list. We commend CMS for recognizing that the current framework, anchored in temporary or permanent labels, has introduced unnecessary confusion and complexity for both providers and stakeholders. As the landscape of care delivery continues to evolve, especially following the rapid telehealth expansion during the COVID-19 public health emergency, it is critical that the process for evaluating and maintaining telehealth services remains flexible, clinically driven, and administratively efficient.

By removing the "permanent" and "provisional" designations, CMS can shift toward a more streamlined, evidence-based review process that focuses on whether services are safe, effective, and appropriate for delivery via telehealth, rather than on arbitrary categorizations tied to outdated timelines or emergency authorities. This approach also provides greater clarity to practitioners, who often face uncertainty about whether specific services will continue to be reimbursed via telehealth beyond temporary extensions.

PALTmed particularly appreciates CMS's intent to maintain transparency in how services are evaluated for inclusion and to continue to use a public process for stakeholder input. We support CMS's plan to assess services under a consistent clinical framework, using clear criteria and regularly published updates to the Medicare Telehealth Services List. A simplified process will help ensure that innovation in virtual care can proceed without being hindered by administrative hurdles that may no longer reflect current clinical practice or beneficiary needs.

We urge CMS to finalize this proposal and to continue supporting a modernized, patient-centered telehealth infrastructure that prioritizes clinical appropriateness, equitable access, and the reduction of unnecessary regulatory burden.

COVID Era Flexibilities

PALTmed urges CMS and the Department of Health and Human Services to support a legislative or regulatory pathway to extend the originating site and geographic restrictions waivers for Medicare telehealth services beyond their current expiration date on September 30, 2025.

During the COVID-19 public health emergency, statutory waivers allowed Medicare beneficiaries to receive telehealth services regardless of geographic location and without the requirement to be physically present at a traditional originating site, such as a rural clinic or hospital. This flexibility enabled care to reach patients in their homes, nursing facilities, and other community-based settings, many of whom would have otherwise faced significant barriers to access. It also allowed clinicians, particularly those serving vulnerable populations such as the frail elderly and residents of long-term care facilities, to maintain continuity of care in a safe, timely, and efficient manner.

These changes were not only essential during the pandemic but have since proven their long-term value. Numerous studies and provider experiences have demonstrated that telehealth delivered in non-traditional sites, especially the home, can improve access, support chronic disease management, reduce hospitalizations, and increase patient satisfaction. These flexibilities are especially critical for:

- Patients in skilled nursing, assisted living, or group home settings where transportation is burdensome or disruptive.
- Medically complex patients with mobility limitations, who require visits with medical specialists that are office-based, or those requiring frequent monitoring.
- Underserved populations in urban or suburban areas who do not meet the historical “rural” geographic restrictions.
- Practices participating in value-based care models, which rely on real-time, flexible modes of communication to manage patient outcomes efficiently.

Allowing these flexibilities to expire would be a significant setback to the progress made in modernizing care delivery, expanding access, and advancing equity. It would disproportionately affect those who have come to rely on telehealth as a lifeline, particularly in the home and long-term care settings.

PALTmed recommends that CMS work with Congress to permanently remove the outdated statutory requirements for originating site and geographic restrictions, or, at minimum, to support legislation that would extend these waivers beyond 2025. In the interim, we encourage CMS to use all available regulatory discretion to ensure continuity and predictability for providers and beneficiaries who have integrated telehealth into their standard care workflows.

We also encourage CMS to collect data and stakeholder feedback over the next year to further document the ongoing clinical appropriateness, cost-effectiveness, and patient-centered value of maintaining flexible site of service rules.

Skin Substitutes

Beginning in CY 2026, CMS proposes that skin substitute products not licensed by the Food and Drug Administration (FDA) through the Biologic Licensure Application (BLA) process be paid as "incident to supplies." Under this approach, which is common for other supplies and medical devices used as part of broader clinical services, the payment amount would be determined based on the volume-weighted average of Average Sales Prices (ASPs), using OPPS volume to calculate the weighting. This represents a significant shift away from the current methodology, which has allowed manufacturers to obtain unique HCPCS codes and payment rates for each product based on self-reported pricing information.

PALTmed appreciates CMS's ongoing efforts to refine payment policies under the Physician Fee Schedule and recognizes the agency's attention to the rapid growth in Medicare expenditures for skin substitutes. We acknowledge that aligning payment more closely with clinical value and actual resource use is an important goal. We support CMS's approach to establishing a uniform payment rate for skin substitutes in CY 2026 while allowing for the possibility of future differentiation based on FDA regulatory pathways. This step provides a pragmatic interim solution that balances simplicity in implementation with the potential for more nuanced reimbursement in the future.

At the same time, we urge CMS to continue considering the diverse clinical contexts in which skin substitutes are used, particularly for medically complex patients and in settings where these products may be essential to achieving optimal outcomes. We encourage CMS to ensure that any final policy preserves flexibility for clinicians to select the most appropriate products for their patients while advancing cost-effective care and protecting program integrity. PALTmed looks forward to ongoing collaboration with CMS to ensure that payment reform achieves both fiscal responsibility and high-quality patient outcomes.

Calendar Year 2026 Updates to the Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

On January 31, 2025, President Trump issued an Executive Order, titled, "Unleashing Prosperity through Deregulation," to promote prudent financial management and alleviate unnecessary regulatory burden. There is no better way to fulfill this directive than by reducing the morass of complicated rules and requirements that define the ineffective MIPS program. Despite being implemented in 2017, MIPS has yet to demonstrate better health outcomes for Americans or lower avoidable spending. Nevertheless, the program imposes steep compliance costs on physicians. Even worse, the program disproportionately hurts small and rural practices as well as those that treat the most complex and high-cost patients.

We appreciate that CMS has continued to make changes to the MIPS program and proposes the following improvements to MIPS:

- Maintaining the performance threshold at 75 points for the next three performance periods (until the CY 2028 performance period/2030 payment year) to provide continuity and stability to physicians.
- Updating the benchmarking methodology used for calculating administrative claims-based quality measures to align with the benchmarking methodology used for cost measures. PALTmed urges CMS to consider applying it to ALL quality measures, not just administrative claims measures.
- Refining the Total Per Capita Cost (TPCC) measure attribution methodology.
- Creating a two-year informational-only period for new cost measures to allow physicians to improve their performance on new measures before being held accountable for them.
- Aligning with the PALTmed and other society recommendations on an alternative framework for structuring MIPS Value Pathways (MVP) by proposing "Clinical Groupings" within MVPs. Instead of the current approach of having a long list of quality measures in the MVP ordered by Measure ID, we suggested that CMS organize the quality and cost measures into categories, each of which is relevant to a particular patient condition or an episode of a particular type of treatment.
- PALTmed continues to request that CMS consider setting of care in addition to specialty of care when developing MVPs and cost measures. Many clinicians who practice in PALTC are disproportionately impacted by programs that are designed for an internal/family medicine-based practice and do not consider the reality of taking care of patients in PALTC settings like the nursing home. Currently, there is no MVP under development for this patient population, and the cost measures continue to hurt physicians who take care of this high-cost population when compared to office-based internal/family medicine practice.

While CMS put forward several positive changes in the 2026 MPFS proposed rule, there is more red tape to be cut. PALTmed makes the following key recommendations:

- While there is no one-size-fits all approach to MVPs that will work for every medical specialty, we believe that MVP clinical groupings MUST prioritize alignment of quality and cost measures and be clinically relevant. We continue to have concerns that even with the clinical groupings, MVPs still ignore the variation in care provided by subspecialists, differences among patient populations, and the relevancy of the cost measures.
- We urge CMS to incentivize the reporting of MVPs, rather than mandate it, **and do not support sunsetting traditional MIPS.** In 2023, which is the most recent data CMS has shared, only 1.26 percent of MIPS eligible clinicians were scored via MVPs.
- **CMS must maintain a robust portfolio of MVPs and quality measures, including accepting new measures.** Measurement burden is increased when there are too few measures in the program and physicians are forced to report for the sake of reporting and compliance.
- We are concerned that requiring group practices to form multiple subgroups to report MVPs will add significantly to the burden of compliance and reduce the reliability of their scores. At

a minimum, to reduce the burden on multispecialty practices of forming subgroups and reporting multiple MVPs, we recommend CMS establish a maximum number of MVPs for multi-specialty groups and develop guidelines for choosing MVPs for multi-specialty groups, such as MVPs based on the highest volume of service and/or largest number of clinicians.

- CMS should provide the option to apply facility-based scoring to MVP participants that otherwise qualify for this scoring option in traditional MIPS to encourage alignment of quality improvement efforts between physicians and the facilities where they provide care.
- CMS should reduce unnecessary quality measure reporting burden and eliminate arbitrary scoring rules that drive up the cost of compliance with MIPS and disincentivize reporting on new and substantially revised measures.
- Although CMS proposes changing the most egregious attribution problems with TPCC, these changes do not address its fundamental flaw of holding physicians accountable for care outside of their control. PALTmed continues to urge CMS to remove TPCC from MIPS or, at a minimum, from any MVP that also includes an episode-based cost measure.
- We urge CMS to maximize usage of electronic health records (EHRs) and other emerging technologies while minimizing wasteful "check the box" reporting exercises. PALTmed supports CMS' efforts to transition to digital quality measures (dQMs). Transitioning to dQMs makes the Promoting Interoperability (PI) requirements duplicative and obsolete because the use of technology is inherently built into the quality measures. Therefore, we recommend CMS sunset PI.

We are also disappointed that the 2026 MPFS does not address MIPS data access issues. PALTC clinicians join others in a united agreement about the need for timely data to improve care for patients and reduce avoidable costs. Unfortunately, CMS provides physicians with an annual Medicare MIPS Feedback Report that includes information about performance on quality and cost measures six to 18 months after services have been provided to a Medicare patient. Without this information at any point during the actual performance year, physicians have no way to understand gaps in care and identify opportunities to improve health outcomes, reduce variations in care delivery, or eliminate avoidable services—all steps that can improve quality and lower costs for patients and the Medicare program. CMS must fulfill the requirements in the Medicare Access and CHIP Reauthorization Act (MACRA) statute to provide timely (e.g., quarterly) feedback reports and Medicare claims data to physicians.

Conclusion

We appreciate the opportunity to comment on these proposals. Should you have any questions please reach out to our Senior Director of Advocacy and Strategic Partnerships, Alex Bardakh at abardakh@paltmed.org or 410-332-3132.

Sincerely,

Sabine von Preyss-Friedman, MD, CMD, FACP

President