September 9, 2026

Submitted electronically via Regulations.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Proposed Rule (CMS–1832–P; Federal Register document 2026–14327)

The Long Term and Post-Acute Care (LTPAC) Health IT Collaborative appreciates the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule. The Collaborative brings together national associations, providers, health information technology developers, researchers, policymakers, and subject-matter experts to advance meaningful, effective, and accessible health IT and interoperability policies for persons with chronic and complex needs. Our longstanding priorities include person-centered longitudinal records, interoperability and transitions of care, medication management, quality measurement, consumer and caregiver engagement, workforce support, and equitable investment across the LTPAC spectrum of care.

The proposed rule presents important opportunities to make Medicare Shared Savings Program (MSSP) participation more attractive and operationally feasible, expand value-based care (VBC), preserve access to remote monitoring and telehealth, and modernize health information exchange. These objectives will not be achieved unless CMS explicitly accounts for the health IT infrastructure, data standards, workforce, and workflow realities of skilled nursing facilities (SNFs), nursing facilities (NFs), assisted living, home health, PACE, hospice, senior housing, long-term services and supports (LTSS), and home- and community-based services (HCBS) providers.

LTPAC providers and the practitioners who care for their residents were largely excluded from the federal incentive investments that accelerated EHR adoption among hospitals and office-based practices. They nevertheless are expected to exchange actionable data, support care transitions, participate in value-based arrangements, and increasingly use certified health IT. CMS policy should close, not widen, this infrastructure gap by pairing interoperability expectations with practical, inclusive pathways and targeted implementation support.

Summary of Recommendations

- Finalize the proposed equalization of practice-expense payment for nursing-facility E/M visits furnished during a Part A SNF stay (POS 31) and a Part B nursing-facility stay (POS 32). In related future refinements, evaluate the practitioner's employment relationship and actual infrastructure costs, not merely the place of service, before applying facility-based practice-expense reductions.

- Finalize a more flexible MSSP CEHRT-use framework for performance year (PY) 2027, while ensuring that it advances meaningful, bidirectional exchange across the full spectrum of care, including LTPAC partners, rather than becoming a minimal TIN-level attestation endpoint.
- Improve timely visibility of a beneficiary's ACO attribution/alignment at the point of care and before transitions, using the Common Working File (CWF) or another existing Medicare eligibility mechanism.
- Recognize multiple standards-based interoperability pathways, including FHIR-based APIs, and avoid limiting LTPAC participation to CEHRT, QHIN, or other high-cost pathways when appropriately configured systems can enable the needed exchange.
- Provide targeted assistance and time-limited implementation exceptions for rural, small, and LTPAC-serving organizations that lack affordable broadband, interfaces, certified technology, exchange connectivity, or implementation capacity.
- Use accelerated pilots and demonstrations to test and rapidly scale LTPAC-inclusive FHIR-based exchange, digital quality reporting, and ACO/LTPAC collaborative-care models.
- Revise proposed RPM/RTM guardrails to address fraud, waste, abuse, fragmented care, and inappropriate marketing without restricting clinically appropriate access. Focus safeguards on the accountable clinical relationship and practitioner oversight—not a categorical employment relationship.
- Distinguish RPM from RTM in final policy, recognizing their different technologies, workflows, provider roles, and risk profiles, including RTM's relevance to physical therapy and rehabilitation.
- Preserve telehealth and technology-enabled care flexibilities that support access for persons with chronic and complex needs, especially in rural and underserved areas and across LTPAC settings.

I. Practice Expense and Nursing Facility POS 31/32 Differential

Rule section/title/code: II.B.2.d, "Updates to Practice Expense (PE) Methodology, Site of Service Payment Differential"; proposed payment refinement for CPT codes 99304–99310, 99315, and 99316. Proposed rule pp. 49–54.

CMS explains that its CY 2026 policy allocating half as much indirect PE per work RVU to facility services as to non-facility services created an unintended and significant payment difference for nursing-facility visits based solely on a beneficiary's Part A versus Part B status. CMS proposes to eliminate that anomaly by setting facility PE RVUs equal to non-facility PE RVUs for the specified nursing-facility E/M and discharge-management codes, so POS 31 and POS 32 services would be paid the same regardless of Part A status.

The Collaborative strongly supports this proposal. A practitioner's resources required to assess, manage, coordinate, document, and communicate about a resident's care do not inherently differ because the resident's stay is paid under Part A rather than Part B. The professional payment supports the technical and administrative infrastructure the practitioner needs to furnish the service. Unlike a hospital, an SNF generally cannot provide that infrastructure to an

independent practitioner without creating policy and legal concerns. Thus, independent physicians and other practitioners serving Part A SNF residents must retain the same office-based technical infrastructure, including clinical information access, communications, documentation, billing, scheduling, and care-coordination capabilities, that they require for Part B residents.

CMS is also seeking information on how PE costs vary by employment model and site of service, including whether its 50-percent facility indirect-PE allocation is accurate. The Collaborative urges CMS to avoid broad reductions or a physician-employment modifier approach until it has evaluated LTPAC-specific implications. The relevant question is not simply where a practitioner delivers services; it is whether the practitioner is employed by the facility or health system and whether the facility already bears the practitioner's indirect infrastructure costs.

The proposed POS 31/32 correction addresses the most significant nursing-facility anomaly, but similar access concerns may remain for independent practitioners who furnish services in other facility-based settings, including long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), particularly in small and rural communities where facilities may not employ the practitioners furnishing these services. A broad facility-based reduction that does not account for employment relationship and actual infrastructure costs may create a disincentive for independent practitioners to serve these settings.

Recommendation:

Finalize POS 31/POS 32 payment equalization for CPT codes 99304–99310 and 99315–99316. In future PE refinement, collect LTPAC-specific data and evaluate employment relationships and actual infrastructure costs before applying further facility-based reductions. Engage LTPAC providers, PALTC clinicians, independent practice organizations, LTCHs, IRFs, and rural providers in that work.

II. MSSP, ACO CEHRT Use, and Interoperability

Rule section/title/code: III.G.3.e, "Shared Savings Program Requirements for the Use of Certified Electronic Health Record Technology"; proposed 42 CFR §425.507(c) and related provisions. Proposed rule pp. 648–666.

CMS proposes to sunset the current requirement that all ACO participants report all MIPS Promoting Interoperability (PI) measures and activities at the APM Entity level. Beginning in PY 2027, an ACO could satisfy the Shared Savings Program CEHRT-use requirement through one of three paths: (1) complete reporting of at least one APP Plus measure through the eCQM or proposed Medicare eCQM collection type; (2) complete reporting of an APP Plus measure and attest to using certified FHIR-based API capability to support measure-data collection; or (3) attest to one proposed ACO CEHRT-use metric—electronic prescribing, HIE bidirectional exchange, or provider-to-patient exchange. CMS proposes that, for the third option, one provider or supplier from each participant TIN perform the selected action.

The Collaborative supports CMS's intent to reduce undue PI reporting burden and make MSSP participation more attractive. The current all-participant PI approach has been difficult for ACOs to operationalize where multiple EHR products, provider types, and special-status entities are involved. More feasible CEHRT pathways can help more clinicians and organizations enter or remain in VBC models.

At the same time, successful MSSP participation and meaningful VBC depend on sophisticated, interoperable health IT infrastructure, not merely a streamlined attestation. ACOs need reliable, timely, bidirectional exchange with LTPAC and community-based partners that receive beneficiaries after hospitalization and furnish much of their ongoing care. Without medication and problem information, functional and cognitive status, goals of care, advance directives, transition plans, social needs, and timely admission, discharge, and transfer information, ACOs cannot coordinate care effectively for beneficiaries with the most complex needs.

The Collaborative recommends that CMS finalize the three-path approach and take the following actions:

- Explicitly recognize exchange with SNFs, NFs, assisted living, home health, PACE, hospice, HCBS, LTSS, and senior housing partners as a core use case for the ACO HIE Bidirectional Exchange metric and related guidance. CMS should provide examples involving hospital-to-SNF, SNF-to-primary-care, and community-to-LTPAC transitions.
- Improve visibility of ACO attribution across the spectrum of care. CMS should make timely, reliable information identifying a beneficiary's ACO attribution/alignment and the applicable ACO readily available through the Common Working File (CWF) or another existing Medicare eligibility mechanism. Hospitals, physicians, SNFs, and other downstream providers should be able to identify the beneficiary's ACO at the point of care and before a care transition. This would prevent providers from coordinating a transition based on an assumed ACO relationship only to learn later that the beneficiary is attributed to a different ACO.
- Ensure that the HIE metric assesses meaningful capability to exchange actionable data with unaffiliated LTPAC partners using disparate systems, not merely exchange among acute, ambulatory, or affiliated ACO participants.
- Encourage FHIR-based exchange of LTPAC-relevant data, including PACIO-aligned functional status, cognitive status, advance directives, care-plan, transition-of-care, and medication-management profile data, as well as medication and social-needs information.
- Allow ACOs to document bona fide efforts to exchange with LTPAC partners where an organization lacks CEHRT, a certified module, QHIN connectivity, affordable interfaces, or broadband capacity. Recognize FHIR APIs and other standards-based exchange pathways that can operate independently of a QHIN or broad CEHRT adoption, where appropriate. CMS should avoid policy that confines interoperability to the most expensive or limited pathways.
- Monitor whether the "one provider or supplier per participant TIN" standard produces meaningful exchange at scale. It should remain an initial burden-reduction bridge, not the endpoint for interoperability and accountable care.

- Publish clear operational guidance well before PY 2027 on how ACOs should document CEHRT use, measure exclusions, participant-TIN exceptions, and standards-based exchange pathways, including how the framework applies to clinicians whose practice is primarily in LTPAC settings.

MSSP and PI concerns: The proposed MSSP CEHRT framework remains linked to the CEHRT definition at 42 CFR §414.1305 and to MIPS PI concepts and certification criteria. The Collaborative supports alignment where it reduces duplicate reporting but cautions that CEHRT-based requirements can still disadvantage ACO participants and care partners serving LTPAC populations. LTPAC providers and vendors did not receive the incentive funding that created the business case for hospital- and office-focused certification and quality-reporting functionality. CMS should not treat the presence of CEHRT as the only meaningful evidence of interoperable care coordination.

Recommendation:

CMS should establish an LTPAC-inclusive CEHRT/interoperability pathway for MSSP. This pathway should recognize standards-based exchange from appropriately configured non-CEHRT systems, including FHIR API-based exchange; permit time-limited implementation exceptions when an ACO or its LTPAC partners have documented technical barriers; and pair future requirements with technical assistance and targeted financial support.

III. CMS Interoperability Solicitation / Request for Information

Rule section/title/code: MSSP CEHRT-use proposals and related requests for comment, including proposed §425.507(c); FHIR-based digital quality reporting discussion. Proposed rule pp. 648–666.

The Collaborative appreciates CMS's focus on FHIR-based exchange and digital quality reporting. FHIR can reduce manual aggregation and provide a stronger foundation for coordinated care, but success depends on the availability of usable data, affordable interfaces, and implementation capacity across the full spectrum of care, including LTPAC.

The Collaborative's response to CMS's interoperability solicitation is that federal interoperability policy should advance a whole-person, longitudinal model rather than a hospital- and office-centric model. CMS should explicitly include LTPAC providers in policy design, technical assistance, model testing, and evaluation. The individuals most likely to experience preventable transitions, medication problems, functional decline, caregiver burden, and fragmented care are often served in these settings.

Recommendations for the interoperability solicitation:

- Develop a national implementation roadmap for bidirectional exchange among hospitals, physician practices, ACOs, and LTPAC/HCBS/LTSS partners, including transition-of-care workflows and a core set of actionable data elements.
- Prioritize interoperability capabilities that support person-centered care: functional status, cognition, advance directives, goals and preferences, caregiver information,

social needs, medication administration and medication-management information, and shared care plans.

- Invest in rural and small-provider readiness through broadband, implementation grants, shared services, HIE onboarding, API and interface subsidies, and practical technical assistance. Small and rural LTPAC providers should participate as valued VBC partners rather than be excluded because they cannot finance bespoke integrations.
- Coordinate across CMS, ONC, CMMI, HRSA, FCC, states, and other federal partners so health IT investment and connectivity support reach the full spectrum of care.
- Use accelerated pilots and demonstrations to test LTPAC-inclusive digital quality reporting, FHIR-based exchange, and ACO/LTPAC collaborative-care models in ways that support rapid scalability and use. Technology policy should not rely on multi-year demonstrations that outlast the technology under evaluation.

IV. Promoting Interoperability and Rural/Small-Provider Support

Rule section/title/code: MIPS Promoting Interoperability proposals in section IV.A.4.f.4; corresponding MSSP CEHRT-use proposals in §425.507(c).

CMS proposes PI-related changes that flow into the new MSSP CEHRT-use approach. The rule would permit an ACO to exclude certain participant TINs from an ACO CEHRT-use metric when the TIN is composed solely of providers or suppliers meeting specified special-status or hardship criteria, including insufficient internet access where insurmountable barriers prevent obtaining adequate access, extreme and uncontrollable circumstances, lack of control over CEHRT availability at practice locations, or CEHRT decertification with a good-faith replacement effort.

The Collaborative supports these exclusions but recommends that CMS strengthen them for rural and LTPAC-serving organizations. The rule states that small practices would not qualify as a special-status exclusion because joining an ACO should help them obtain care-coordination and quality-improvement assistance. That premise will not always hold for LTPAC providers and small rural practices. ACO membership does not itself provide broadband, certified modules, interfaces, trained staff, or the capital necessary to modernize legacy systems.

Recommendation:

Retain the proposed exceptions and add a time-limited rural/small/LTPAC implementation exception when an organization demonstrates that it lacks practical access to interoperable technology or exchange connectivity despite a good-faith effort. CMS should couple this with ACO-level technical assistance, shared services models, and financial support. The exception should prevent loss of access while CMS and ACOs build sustainable infrastructure; it should not become a permanent substitute for investment.

V. Remote Patient Monitoring and Remote Therapeutic Monitoring

Rule section/title/code: II.F.48, “Remote Monitoring”; CPT codes 98975–98981, 98984–98986, 99091, 99445, 99453–99458, and 99470–99474; proposed payment-policy refinements and comment solicitation. Proposed rule pp. 149–160.

CMS proposes several RPM/RTM refinements, including requiring RTM to be furnished only to established patients; requiring an initiating visit associated with the start of RPM or RTM; requiring initiation during an in-person or Medicare telehealth visit; limiting billable clinical-staff time for RPM/RTM to staff directly employed by the billing practitioner or practice; and exploring consolidated RPM/RTM HCPCS G-codes. CMS specifically seeks comment on how frequently third-party billing occurs and how the proposed employment restriction could affect access. CMS’s rationale responds to OIG findings concerning certain RPM billing practices, including incomplete service components and entities with insufficient clinical integration.

The Collaborative supports strong program-integrity safeguards. Beneficiaries should receive all required service elements; clinicians must retain clinical responsibility; and informed consent, medical necessity, documentation, data security, escalation protocols, and meaningful patient or caregiver communication are essential. CMS is right to address marketing practices that solicit beneficiaries for services they do not need and care models in which the billing practitioner lacks meaningful oversight.

The Collaborative is concerned that a categorical requirement that all clinical staff be direct employees of the practitioner or practice could unnecessarily limit access to RPM and RTM, especially for rural practices, small providers, LTPAC-serving clinicians, therapy practices, and organizations that rely on clinically integrated vendors or shared-service arrangements. The policy could prevent legitimate, high-quality models even when the billing practitioner retains clinical responsibility and the contracted entity is fully integrated into the care team.

The fundamental policy issue is the accountable clinical relationship, not the employment relationship. Specialized monitoring technology and related technical expertise frequently must be deployed across a region and across multiple providers to be viable. A small rural practice or nursing facility may have only one or two beneficiaries who would benefit from monitoring in a given month and cannot efficiently hire specialized personnel as direct W-2 employees. A regional vendor can provide devices, training, technical support, monitoring infrastructure, and clinically relevant information to the treating practitioner, who remains responsible for interpreting the information and making clinical decisions. A categorical employment restriction would impede this appropriate and scalable model.

The Collaborative also urges CMS not to apply RPM-focused OIG conclusions automatically to RTM. RTM involves distinct therapeutic-monitoring technologies and workflows, including respiratory, musculoskeletal, and cognitive behavioral therapy applications. RTM is particularly relevant to physical therapy and rehabilitation, where treatment adherence, therapy response, and functional progression are central. CMS should assess the technology, clinical workflow, provider type, patient population, and risk profile for RPM and RTM separately before finalizing uniform restrictions.

Recommendations:

- Do not finalize a categorical direct-employment requirement. Permit contracted clinical staff or vendors when the billing practitioner/practice remains accountable and can demonstrate formal clinical integration, practitioner oversight, access to monitoring data, documented care protocols, timely escalation pathways, patient/caregiver communication, privacy and security protections, and auditable records.
- Direct safeguards to clinical relationship and payment accountability. CMS should require that the ordering/billing practitioner establish or confirm the clinical need, retain responsibility for treatment management, and be able to demonstrate meaningful involvement in the service.
- Adopt targeted safeguards responsive to OIG concerns: prohibit or tightly regulate unsolicited beneficiary outreach; require a bona fide initiating clinical relationship and documented medical necessity; require documentation of all billed service components; require practitioner review and clinically meaningful treatment management; and use risk-based audit and program-integrity monitoring.
- ·Use claims edits and payment controls to ensure all required components are furnished and linked. For example, CMS should consider withholding payment for a vendor-supported technical component until the related practitioner professional/treatment-management component is submitted, as appropriate under the applicable code structure. This would reduce the risk that a vendor is paid for a service of which the clinician was unaware of or for which the beneficiary did not receive the complete service.
- Address SNF consolidated-billing implications before implementing any bundled RPM/RTM code structure. CMS should clarify how technical and professional components would be treated for beneficiaries in Part A SNF stays and avoid creating billing barriers that prevent appropriate monitoring services.
- Apply any final guardrails separately to RPM and RTM unless CMS has evidence that the same risk is present in both code families. Engage physical therapy, rehabilitation, LTPAC, and patient stakeholders before finalizing restrictions that affect RTM.
- If CMS creates consolidated G-codes, ensure their thresholds and all-component requirements accommodate clinically appropriate LTPAC and therapy workflows. Avoid an all-or-nothing monthly structure that denies payment when a beneficiary's clinical circumstances appropriately alter one component.
- Provide clear guidance on RPM/RTM for beneficiaries in LTPAC and congregate living settings, including roles for facility staff and caregivers, avoidance of duplicate billing, cons· Collect and consider implementation data on access, clinical outcomes, fraud/waste/abuse, and administrative burden, stratified by rurality, practice size, LTPAC setting, and RPM versus RTM, before adopting additional restrictive policies.

VI. Telehealth and Technology-Enabled Access

Rule section/title/code: Medicare telehealth services and related communications-technology policies; the rule reflects statutory telehealth flexibilities extended through December 31, 2027

and audio-only flexibilities through January 1, 2028. Proposed rule discussion of telehealth impacts, pp. 1152–1153.

The Collaborative supports the ongoing implementation of statutory telehealth flexibilities and urges CMS to apply them in ways that protect access for people with chronic and complex needs. Telehealth can help address transportation barriers, intermittent clinician presence, workforce shortages, and rural access challenges. This is especially important for LTPAC residents and home-based beneficiaries when telehealth is embedded in a coordinated care model and complements—not replaces—needed in-person care.

Recommendation:

CMS should issue clear guidance confirming how telehealth, remote supervision where authorized, and communications-technology services can support coordinated care in SNFs, NFs, assisted living, senior housing, and home-based LTPAC settings. Guidance should address caregiver participation, access for beneficiaries with cognitive, sensory, or functional limitations, and affordable broadband and technical support.

Final Summary of Recommendations

The Collaborative supports the CY 2027 PFS proposed rule's direction toward reduced reporting burden, more flexible MSSP CEHRT-use options, payment accuracy, and program integrity. CMS should finalize the proposed POS 31/POS 32 nursing-facility payment equalization and apply a more nuanced practice-expense methodology that recognizes the infrastructure costs borne by independent practitioners across the LTPAC spectrum of care.

CMS should pair MSSP reforms with an inclusive interoperability strategy. Making MSSP and VBC models more attractive requires more than changing attestations; it requires sophisticated, affordable health IT infrastructure that enables hospitals, physician practices, ACOs, and LTPAC/HCBS/LTSS partners to exchange actionable data. CMS should recognize LTPAC-relevant standards and workflows, support FHIR/API pathways that are not limited to CEHRT or QHIN participation, improve ACO-attribution visibility at care transitions, and direct targeted support to rural, small, and LTPAC-serving organizations.

Finally, CMS should address RPM/RTM program-integrity concerns with targeted, evidence-based safeguards that preserve access and support accountable, clinically integrated care. CMS should focus on the practitioner's clinical responsibility and the payment relationship, rather than categorically requiring direct employment of all supporting staff. CMS also should evaluate RPM and RTM separately and address SNF consolidated-billing implications before implementing new bundled codes.

In closing, the LTPAC Health IT Collaborative appreciates CMS's consideration of these comments and welcomes continued dialogue on how Medicare payment, interoperability, quality, telehealth, remote monitoring, and accountable-care policies can better support person-centered, longitudinal care across the LTPAC spectrum of care. The Collaborative stands ready

to work with CMS, ONC, CMMI, ACOs, providers, vendors, and other stakeholders to advance equitable, standards-based, and sustainable health IT-enabled care for Medicare beneficiaries. For questions regarding these comments, please contact the LTPAC Health IT Collaborative Convener, Michelle Dougherty, via the Collaborative's established channels at leaders@ltpachit.org or via our website at www.ltpachit.org.

Respectfully Submitted,

The LTPAC Health IT Collaborative

wwwltpachit.org