

GEORGIA POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION • August 29, 2026

Policy & Advocacy Update

Alex Bardakh, MPP, CAE, PLC
VP Government Affairs and Policy
CareConnectMD
abardakh@careconnectmd.com
<https://www.linkedin.com/in/alex-bardakh/>



The Washington Landscape

POLITICAL ENVIRONMENT

- Unified Republican government
- Narrow congressional margins
- Midterm election cycle approaching
- Continued focus on deficit reduction and government efficiency

HEALTHCARE POLICY ENVIRONMENT

- Least productive Congress; more regulatory
- Focus on waste, fraud, and abuse
- Continued transition toward value-based care
- Emphasis on reducing administrative burden



What's Driving Healthcare Policy?

Affordability

- Medicare spending
- Medicaid
- Drug pricing



Value

- Value-based care
- Quality
- Accountable care



Access

- Workforce
- Rural health
- Behavioral health



Modernization

- Administrative burden
- Digital quality
- Interoperability



Federal Healthcare Activity

Congress



- Physician payment
- Budget
- PBM reform
- Telehealth
- Oversight

CMS



- CY 2027 Physician Fee Schedule
- SNF PPS
- OPPS/ASC
- Medicare Advantage
- Quality programs

CMMI



- LEAD
- AHEAD
- ACCESS
- Innovation models
- Value-based care

Congressional Developments: Physician Payment and Accountable Care

Patients First Act of 2026

H.R. 9693

Status: Bipartisan bill introduced July 15, 2026

- Replaces the current fixed physician fee schedule updates with an MEI-based update and provides an additional 0.5 percentage-point update for the qualifying APM participant conversion factor.
- Replaces MIPS with the new POINTS program after a transition period and freezes current Advanced APM qualifying thresholds for three years.
- Introduced by Reps. Greg Murphy, John Joyce, Kim Shrier (Dem and Congressional Doc Caucuses)

Health Care Efficiency Through Flexibility Act

H.R. 5347

Status: Passed the House unanimously June 29, 2026; awaiting Senate action

- Preserves multiple MSSP quality-reporting options through 2029 and clarifies data-completeness requirements.
- Establishes a digital quality-measure reporting pilot for 2028–2032.
- Introduced by Rep. Vern Buchanan

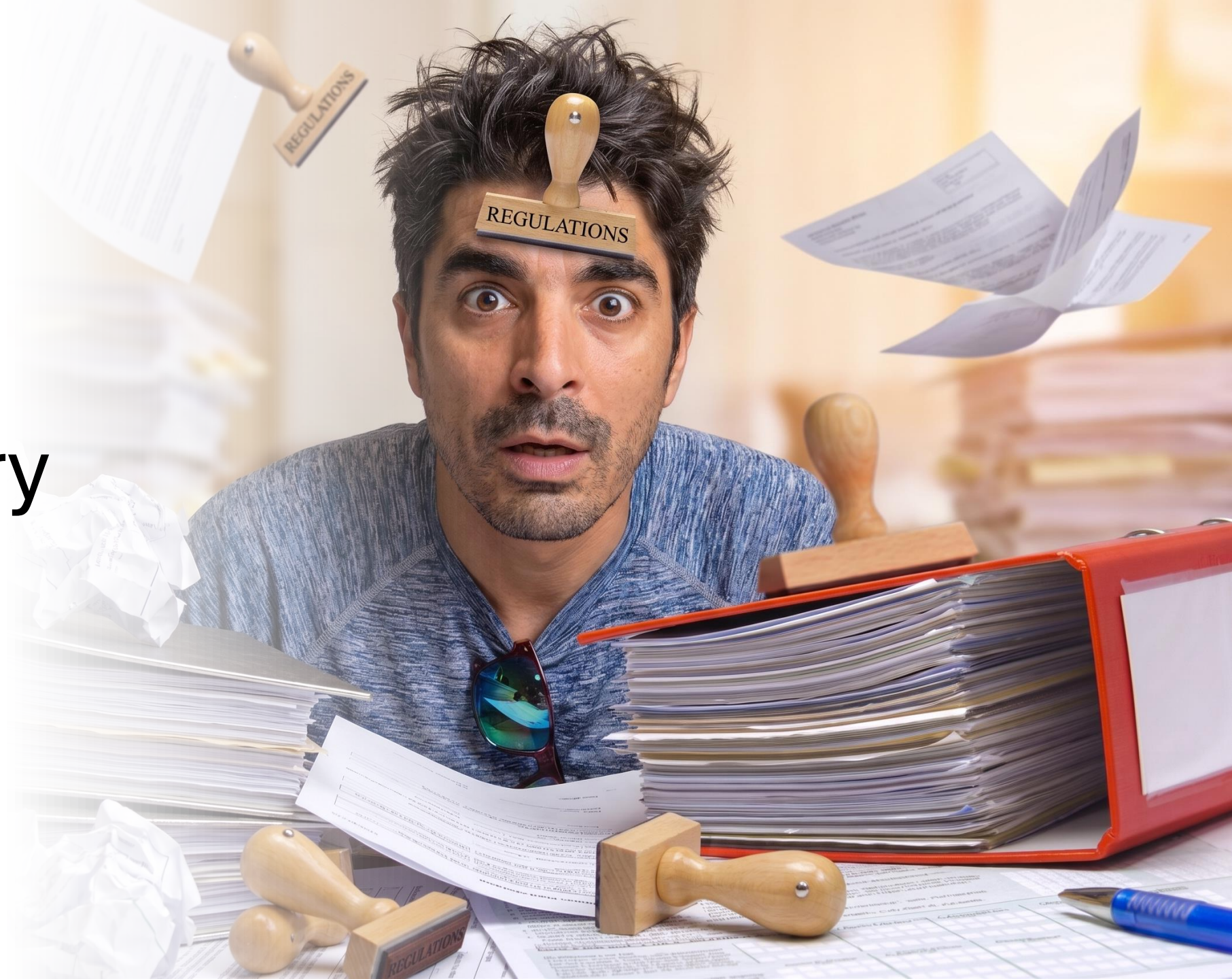
Permanent Full-Risk ACO Program

H.R. 8129

Status: Bipartisan bill introduced March 26, 2026

- Creates a permanent statutory full-risk ACO program in Traditional Medicare with Standard and Complex Care tracks.
- Provides a permanent pathway for capitated payment and full-risk accountable care similar to the approach tested through ACO REACH and LEAD.
- Introduced by Rep. Claudia Tenney and Brad Schneider

Regulatory Update



Key Themes of Physician Fee Schedule Proposed Rule

01

Traditional Medicare physician payment remains under pressure

02

CMS is creating additional financial advantages for accountable care participation

03

Changes in MSSP ACO

04

CMS continues moving away from traditional MIPS

05

Several proposals directly affect PALTC and high-needs care models

Two Conversion Factors: CY 2027 Physician Payment

Participant type	CY 2027 conversion factor	Net Update (due to expiration of 2.5% update)
Qualifying APM participant (QP)	~\$33.17	-1.19%
Non-qualifying participant	~\$32.84	-1.68%

- Expiration of the temporary CY 2026 payment increase results in a net reduction versus CY 2026
- Practice-expense methodology changes will produce different effects by specialty and site of service

Major Win: Correcting SNF Payment (CMS Overturns Bad Policy)

- CY 2026 policy created different practice-expense payments based on Part A status
- CMS acknowledges the professional's practice costs do not change based on the resident's Medicare coverage status
- CMS proposes equal facility and non-facility PE RVUs for nursing-facility E/M services
- A significant proposed correction for nursing-facility practices

APPLIES TO CPT CODES

99304 – 99310

Nursing-facility E/M — initial & subsequent care

99315 – 99316

Nursing-facility discharge services

Code	Proposed Non-APM rate for 2027	POS 31 Part A stay		POS 32 Part B stay	
		2026 rate	Change	2026 rate	Change
99304	\$79.80	\$71.14	+12.2%	\$81.16	-1.7%
99305	\$135.63	\$119.58	+13.4%	\$140.95	-3.8%
99306	\$186.54	\$163.33	+14.2%	\$193.06	-3.4%
99307	\$41.71	\$37.07	+12.5%	\$42.09	-0.9%
99308	\$75.86	\$67.80	+11.9%	\$78.83	-3.8%
99309	\$110.67	\$98.53	+12.3%	\$114.57	-3.4%
99310	\$157.31	\$140.28	+12.1%	\$163.33	-3.7%
99315	\$82.76	\$73.15	+13.1%	\$85.84	-3.6%
99316	\$133.33	\$117.57	+13.4%	\$138.28	-3.6%
G0317	\$32.84	\$27.05	+21.4%	\$33.73	-2.6%

Code	Proposed APM rate for 2027	POS 31 Part A stay		POS 32 Part B stay	
		2026 rate	Change	2026 rate	Change
99304	\$80.60	\$71.16	+13.3%	\$80.90	-0.4%
99305	\$136.99	\$120.51	+13.7%	\$141.65	-3.3%
99306	\$188.40	\$164.48	+14.5%	\$194.36	-3.1%
99307	\$42.13	\$37.26	+13.1%	\$41.96	+0.4%
99308	\$76.62	\$68.14	+12.4%	\$79.22	-3.3%
99309	\$111.78	\$98.69	+13.3%	\$114.80	-2.6%
99310	\$158.88	\$140.65	+13.0%	\$163.81	-3.0%
99315	\$83.59	\$72.84	+14.8%	\$85.60	-2.3%
99316	\$134.67	\$118.49	+13.7%	\$139.31	-3.3%
G0317	\$33.17	\$26.85	+23.5%	\$33.23	-0.2%

Changes to GG2211 Complexity Add-On Code

Modifier	Proposed effect	Eligibility
MOD1	+16% to the associated E/M payment	Broad application
MOD2	+32% to qualifying E/M payments	Eligible MSSP & LEAD ACO practitioners

- G2211 would be replaced by percentage-based modifiers
- MOD2 could apply to assigned and non-assigned beneficiaries
- Additional payments would flow through ACO expenditure calculations
- Not eligible in SNF/NF

MSSP Benchmark and Financial Changes

Provision	Current	Proposed
BASIC Track Level E sharing rate	50%	60%
Prior-savings adjustment scaling factor	50%	75%
5% benchmark-adjustment cap	Flat cap	Risk-adjusted

- New benchmark growth incentive would support adding providers and beneficiaries new to accountable care
- ACPT guardrails would reduce extreme forecasting variation

Fee Schedule Misc...

OTHER PROPOSALS

- Remote monitoring requirements and potential bundled payment changes
- New advance care planning codes for clinical staff work
- Separate coding and payment for shared medical appointments
- RFIs on interoperability and duplicate testing

CMMI Update

- New Models
 - TEAM – Transforming Episode Accountability Model
 - Based on surgical bundles
 - Post-acute care networks
 - Meant to reduce fragmentation in care (previous CJR)
 - <https://www.cms.gov/priorities/innovation/innovation-models/team-model>
 - ACCESS – Advancing Chronic Care With Effective Scalable Solutions
 - Technology supported care options
 - Four tracks including Behavioral Health Integration (BHI)
 - <https://www.cms.gov/priorities/innovation/innovation-models/access> (new)
 - LEAD – Long-Term Enhanced ACO Design
 - <https://www.cms.gov/priorities/innovation/innovation-models/lead>



"When does the improvement phase
of this home improvement project begin?"

Why ACOs?



MSSP ACO

- The [CMS Shared Savings Program](#) reported its eighth consecutive year of positive savings
- **Net Savings to Medicare: \$2.5 billion** returned directly to the Medicare Trust Funds.
- **Shared Savings Earned by Providers: \$4.1 billion** paid out as performance bonuses to successful ACOs.
- **Success Rate: 75%** of the 476 participating ACOs managed to successfully reduce costs below their benchmarks while maintaining high-quality care standards.

ACO REACH

- **Net Savings to Medicare: \$988 million** returned to the program.
- **Gross Savings: \$2.5 billion** in total cost reductions.
- **Success Rate: 83%** (96 out of 115 participating ACOs) earned net savings under this mode

LEAD Model Update

- Succeeds ACO REACH
- Applications submitted by May 17, 2026
- 300 ACOs have provisionally been accepted



Biggest Changes

Dedicated high-needs population focus
Concurrent risk adjustment
10-year model duration
Expanded alignment opportunities
Prospective payment structure

Key Areas Under Consideration

Voluntary Alignment Benchmarking
Risk Score Growth Cap

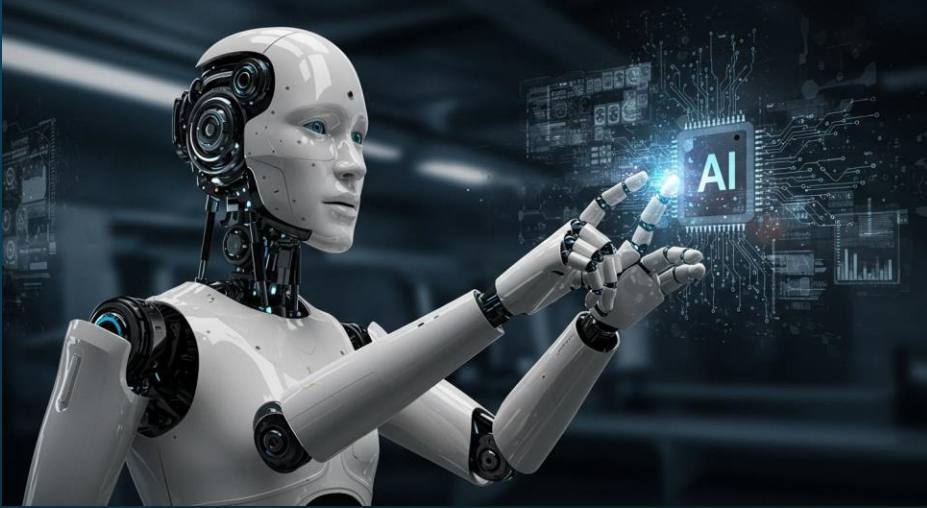
Quality measurement
Implementation guidance

What Do You Need to Participate in an ACO (or any value-based care)?

- **Access to actionable data** to identify high-risk patients and care gaps
- **Care coordination resources** to support patients across care settings
- **Clinical workflows** that support quality measurement and reporting
- **Provider engagement** and commitment to value-based care principles
- **Infrastructure and support** to manage population health and performance

You don't have to build all of this yourself—but these capabilities must exist somewhere within the ACO structure.





AI

- **Clinical decision support:** AI tools increasingly used for readmission risk stratification, discharge planning, and predicting PAC needs.
- **Documentation & coding:** Natural language processing (NLP) supports CCM/TCM/APCM documentation, easing provider burden and improving billing accuracy.
- **Prior authorization automation:** Emerging AI-driven tools help MA plans and providers streamline prior auth requests, a major barrier in care transitions.
- **Equity & bias concerns:** Policymakers and regulators (e.g., ONC, FDA) raising oversight on algorithmic bias, especially in LTC populations where data may underrepresent minorities.
- **Operational efficiency:** AI used in staffing, scheduling, and resource allocation in SNFs and HHAs — indirectly improving transition capacity.

Questions?

