POST-ACUTE AND LONG-TERM CARE
MEDICAL ASSOCIATION

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August 21, 2026

The Honorable John Joyce, M.D.
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

Submitted electronically via email

Re: Request for Information on the Patients First Act of 2026 (H.R. 9693)

Dear Representative Joyce:

The Post-Acute and Long-Term Care Medical Association (PALTmed) appreciates the opportunity to respond to the request for information on the Patients First Act of 2026. PALTmed represents the physicians, nurse practitioners, physician associates, and other clinicians who care for patients in nursing facilities, assisted living, and other post-acute and long-term care (PALTC) settings. Physicians and clinicians working in nursing facilities, assisted living, and home care settings deliver the primary care and serve as the central anchor for our nation's most vulnerable elders. This complex, frail population is made up almost entirely of Medicare beneficiaries who depend on these clinicians for the continuous, coordinated care they need to manage chronic conditions right where they live. Delivering that care directly in the places these individuals call home is what keeps them stable, well cared for, and out of the hospital when hospitalization can be avoided.

We support the core goals of the bill. Tying physician payment to a measure of inflation, reducing the administrative burden of quality reporting, and building a physician-led framework for developing quality measures are all steps that would strengthen the Medicare program and the workforce that serves PALTC patients. Throughout these comments, our guiding concern is a simple one: Medicare payment and program eligibility should follow the clinical work and the patient, not the site of service or the structure of the practice. For the residents PALTC clinicians serve, these clinicians provide their primary care. PALTC care is primary care, delivered in the nursing facility rather than the office. That fact is central to the comments below. We offer the following comments on provisions that, as drafted, would not fully reach the clinicians who care for this population. Our comments are provided under the request's invitation for additional relevant information.

1. The hybrid primary care demonstration should count nursing facility E&M services toward eligibility

Section 1866H names geriatric medicine and internal medicine among the specialties eligible to participate in the hybrid primary care demonstration. We support their inclusion. As drafted, however, the eligibility test may exclude the very clinicians the provision is intended to reach.

The difficulty is that the eligibility test defines primary care by its setting rather than its substance. To qualify as a participating supplier, a practitioner must have at least 60 percent of their prior-year Medicare payments come from designated primary care services. That term includes office-based evaluation and management (E&M) services, but it does not mention the E&M services that PALTC clinicians furnish when they deliver primary care to nursing facility residents, assisted living, and home care settings. These visits are primary care. They are simply billed under the nursing facility E&M codes (CPT 99304 through 99310 and 99315 through 99316) and Assisted Living/Home (99341-99345, 99347-99350) rather than the office-based codes, because of where the care is delivered. Because these visits make up the majority of a PALTC clinician's billing, a clinician who delivers primary care full time in a nursing facility could fall below the 60 percent threshold and be excluded, even though geriatric and internal medicine are named as eligible specialties.

The care these clinicians provide is squarely within the intent of the demonstration. PALTC clinicians manage exactly the population the hybrid model is designed to serve, beneficiaries with multiple chronic conditions who need continuous, coordinated primary care. They already furnish qualifying care management services for these patients. The gap is one of setting, not substance. The definition of designated primary care services is built around the office, and it does not account for primary care delivered in the nursing facility.

We recommend that the definition of designated primary care services in Section 1866H(f) be amended to include evaluation and management services furnished in nursing facility and other PALTC settings (i.e. assisted living, home health, etc.). This change would align the eligibility test with the full scope of primary care these clinicians deliver and would ensure the demonstration reaches the geriatric and internal medicine clinicians the bill already identifies as eligible.

2. POINTS metric development should include PALTC representation and account for the PALTC practice setting

The new care efficiency performance category under POINTS measures reductions in avoidable hospitalizations, reductions in medication burden where clinically appropriate, reductions in complications from chronic disease, and referral patterns to the lowest-cost clinically appropriate setting. These are core functions of PALTC practice. PALTC clinicians work to keep medically complex residents stable in place, to avoid unnecessary hospital transfers, and to reduce unnecessary medication use for this population.

Because this category aligns so closely with PALTC practice, we ask that the Quality Reform Task Force established under Section 203 include representation from clinicians who practice in PALTC settings when it considers measures that apply to this population. This is consistent with the bill's requirement that each relevant specialty and subspecialty be represented when a measure affecting that field is under consideration.

We also ask that measures be developed with careful attention to attribution. PALTC clinicians practice in facilities where many of the factors that affect measured outcomes, including staffing levels and facility-level protocols, are outside the individual clinician's control. Section 203 already directs the Task Force to take into account the circumstances of practitioners whose services differ from typical office-based practice. We ask that this consideration expressly extend to attribution methods, so that PALTC clinicians are assessed on the outcomes they can reasonably influence.

3. The excluded practice test should not cut off PALTC patients from the demonstration or disadvantage them under POINTS

PALTC clinicians practice differently from office-based ones. They serve as the primary care clinicians for residents within nursing facilities and other PALTC settings, rather than seeing patients in a physician office. The excluded practice test in the bill turns on ownership and control, and it was written with corporate consolidation of office-based practice in mind. It does not map cleanly onto the range of arrangements through which PALTC care is delivered to these patients.

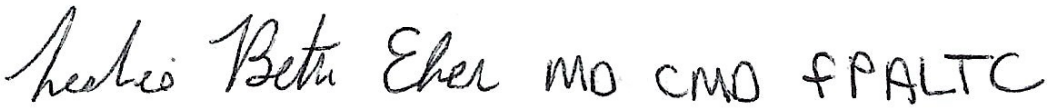
As a result, several provisions could disadvantage PALTC patients based on how their clinician's practice is structured rather than the care that clinician delivers. The hybrid primary care demonstration is limited to practices that are not excluded practices. Under POINTS, positive payment adjustments for clinicians in excluded practices are reduced by 50 percent, and the exceptional performance bonus is not available to them. A nursing facility resident could lose access to demonstration-supported primary care or be cared for by a clinician who is penalized under POINTS, because of a practice-structure test that was not designed with the PALTC setting in view.

We support the bill's goal of strengthening independent physician practice and share the concern about consolidation that motivates these provisions. We ask only that the demonstration and the POINTS adjustments be structured so that PALTC patients are not cut off from participation, or their clinicians penalized, because the excluded practice test does not fit the way PALTC care is delivered. At a minimum, we ask that the sponsors consider a pathway for PALTC clinicians who serve nursing facility residents to participate in the demonstration and to be assessed under POINTS based on the care they provide.

Conclusion

PALTmed appreciates the sponsors' leadership on physician payment reform and the opportunity to provide these comments. The clinicians who care for nursing facility residents provide those residents' primary care, and the bill's primary care and quality provisions should reach them as such. The changes described above would help ensure that the bill's primary care and quality provisions reach the clinicians who care for the nation's most medically complex long-term care patients. We welcome the opportunity to serve as a resource as the bill advances.

Respectfully submitted,



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