

PointClickCare®

White Paper

The Future of Medicare Reimbursement: A Readiness Guide for Senior Care Practice Groups

Understanding the key factors shaping reimbursement and quality performance through 2028

Executive Summary

Between now and 2029, Medicare changes will bring evolving reporting, prescribing, and documentation expectations for senior care practice groups, alongside new opportunities in accountable care. Practice groups that act in 2027 and 2028 will be better positioned to protect revenue and strengthen their role with facility partners.

Key dates and proposed changes to monitor:

January 1, 2027: The Long-term Enhanced ACO Design (LEAD) Model begins, expanding accountable care for high-needs and dually eligible patients.
January 1, 2028: Prescriptions for long-term care residents begin counting toward Electronic Prescribing for Controlled Substances (EPCS) compliance.
2028: Under CMS's proposal, this is the last performance year for traditional MIPS. Under the proposal, MIPS Value Pathways (MVPs) becomes the main reporting path in 2029.
October 1, 2029: Skilled nursing facilities must submit Minimum Data Set (MDS) assessments for all covered skilled residents, regardless of payer.

Each change raises the stakes for physician documentation, care coordination, and risk visibility. This guide explains what's changing, why it matters to practice groups, and how to build a readiness plan around six practical steps. It also shows how PointClickCare's EHR for Practice Groups supports your work across every facility you serve.

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Introduction: Medicare Transformation Is Already Underway

Medicare reimbursement is evolving beyond traditional fee-for-service reporting. For years, many physician practices could treat quality reporting as a compliance exercise: submit the required measures, avoid a penalty, and move on. That approach is no longer enough. Value-based care, accountability, and care coordination are becoming central to how physicians are paid, and the practices that adapt early will be best positioned to protect their revenue and show the value of the care they deliver.

The Merit-based Incentive Payment System (MIPS) remains important today, but significant changes are ahead. CMS has proposed transitioning from traditional MIPS reporting toward MIPS Value Pathways (MVPs), a more focused framework organized around specialties, conditions, and episodes of care. At the same time, multiple Medicare initiatives are set to take effect between 2027 and 2028. Together, these changes will reshape what practices report, how performance is measured, and how payment adjustments are determined.

For practice groups serving skilled nursing facilities (SNFs) and senior living communities, the stakes are especially high. The clinicians who are part of these practice groups care for some of Medicare's most complex patients, and their work increasingly influences quality outcomes, reimbursement, and care transitions across the broader care continuum. That influence brings both opportunity and accountability. Documentation, care coordination, and performance management are no longer back-office concerns; they are strategic priorities.

Understanding the Shift from MIPS to MVPs

When MIPS was introduced in 2015, it was designed to encourage physicians to improve quality and value. Its four performance categories have been driving reimbursement for practice groups for more than a decade now: quality, resource use, clinical practice improvement, and advancing care information.

When all four categories are scored, the 2026 MIPS category weights are Quality 30%, Cost 30%, Promoting Interoperability 25%, and Improvement Activities 15%.[1] The 2026 performance threshold of 75 points remains in effect through 2028. CMS estimates the median 2026 final MIPS score at 89.47; the estimated median for solo practitioners is 75.[2]

In July of 2026, CMS released the 2027 Medicare Physician Fee Schedule with a proposal to sunset traditional MIPS after the 2028 performance period ends. This goal is designed to move MIPS away from fragmented reporting and toward more clinically meaningful measurement, with each MVP grouping a smaller set of measures and activities around a specific specialty or medical condition.

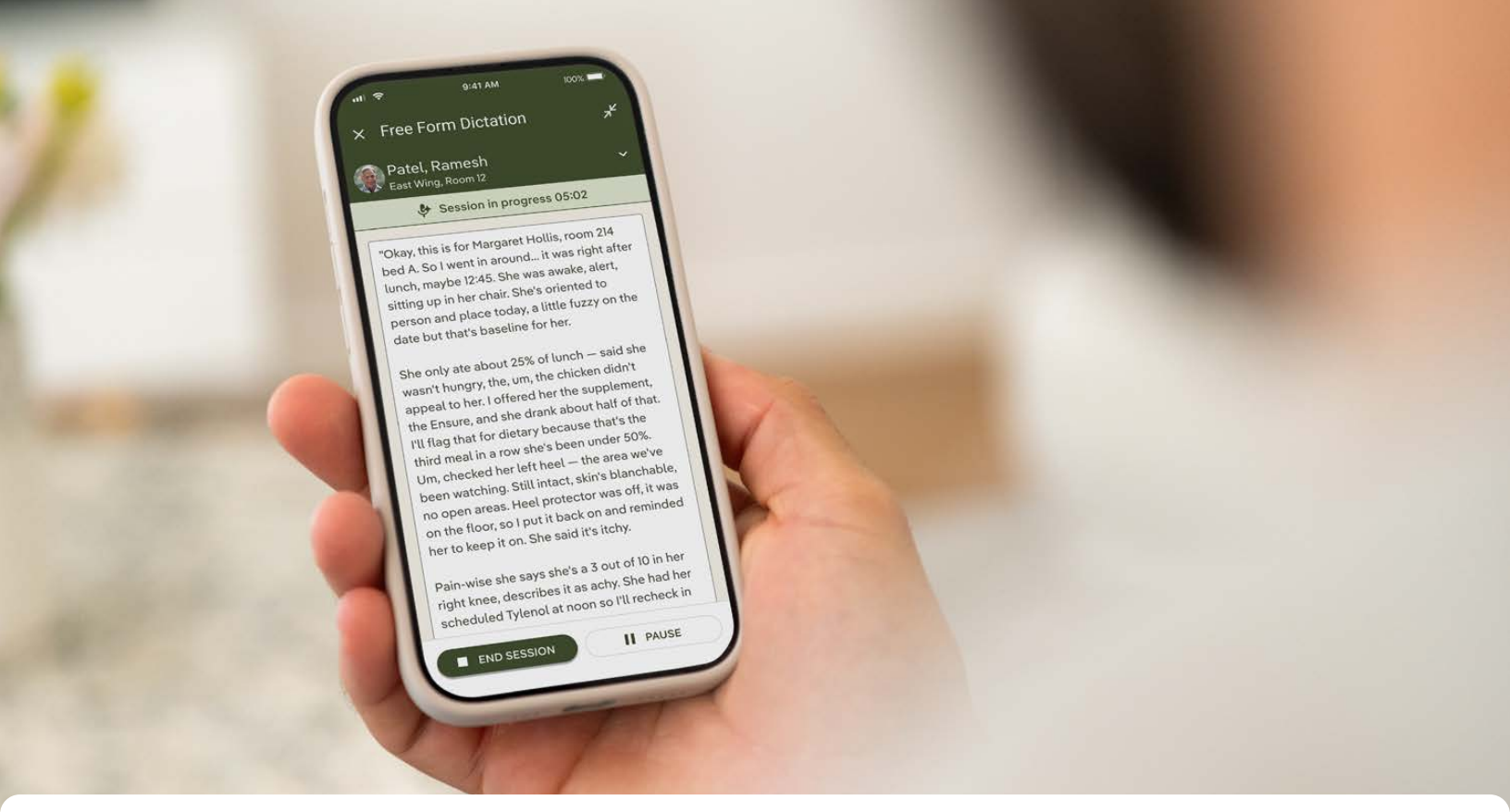
According to CMS, this approach is intended to reduce reporting burden, support team-based care, and give clinicians more relevant performance comparisons with peers who provide similar care.[3]

With CMS proposing to end traditional MIPS after 2028, practice groups have a runway to prepare for future reporting requirements. Two priorities are key. First, they should identify the MVPs that fit clinicians in the practice group and build workflows to support them. Second, they must track performance throughout the year, not just at submission time, so they have time to close gaps before they affect scoring.

How PointClickCare Helps



Your MIPS score depends on the gaps you catch before submission. With PointClickCare's EHR for Practice Groups, you can track quality measures and Promoting Interoperability performance through dashboards and reporting. That visibility helps you close gaps throughout the year, not just at submission time.



Preparing for a More Connected Senior Care Ecosystem

As demand for senior care grows, practice groups increasingly find themselves coordinating care across hospitals, skilled nursing facilities (SNFs), assisted living communities, and physician offices. That need will only grow, since 90% of adults aged 65 and older live with at least one chronic condition.[4]

In this context, physician documentation and clinical decision-making are crucial in influencing outcomes beyond a single encounter. For these efforts to drive outcomes effectively, timely access to facility-generated information and connected workflows are increasingly important, especially as CMS expands value-based care initiatives.

One example is the Long-term Enhanced ACO Design (LEAD) Model, a 10-year voluntary accountable care organization (ACO) model that begins January 1, 2027.5 LEAD focuses on coordinated care for high-needs patients, including people dually eligible for Medicare and Medicaid and those who are homebound.[5] Its quality measures include all-condition readmissions, unplanned admissions for older adults with multiple chronic conditions, and timely follow-up after acute events.[6]

How This Applies to Your Practice Group

As a voluntary ACO model LEAD is not a new requirement for every practice group. If your group participates in, partners with, or is evaluating an ACO, assess whether LEAD is relevant to that organization's plans and what participation could mean for your group's responsibilities.

Additionally, it's important to use conversations with SNF partners to identify how your encounter notes, medication changes, and follow-up plans support their care coordination priorities. Nearly one in four Medicare beneficiaries admitted to a SNF returns to the hospital within 30 days.[7] These readmissions also affect facility payment. The SNF Value-Based Purchasing (VBP) Program withholds 2% of Medicare fee-for-service SNF payments and ties incentive payments to multiple quality measures, including hospital readmission rates.[8]

How PointClickCare Helps

PointClickCare's EHR for Practice Groups helps your clinicians share information across the facilities they serve:

One login:

Access charts, manage orders, and view patient records across multiple senior care settings with a single login.

One patient record:

Review patient data in one record for informed care management and decision-making.

Cross-facility visibility:

Connect records across skilled nursing facilities in one system.



Documentation Is Becoming a Strategic Priority

In this new paradigm of increased care coordination and evolving senior care partnerships, how practice groups approach efficient, accurate documentation has significance on multiple fronts. Documentation now influences not just reimbursement, but also quality reporting, risk adjustment, and compliance. A complete diagnosis capture, for example, supports accurate representation of patient complexity, risk adjustment, and even care outcomes.

At the same time, physicians are tasked with balancing documentation burden with direct patient care without sacrificing quality. They spend approximately 13 hours per week on indirect patient care activities including documentation, referrals, and order entry, with the average physician workweek reaching 57.8 hours.[9] In 2024, 43.2% of physicians reported at least one symptom of burnout, further highlighting how a strategic approach to documentation is critical.[10]

How PointClickCare Helps

PointClickCare's EHR for Practice Groups helps reduce documentation burden so your clinicians can focus on patient care:

Accelerated documentation: Automated workflows and auto-populated patient data enable faster documentation.

Problem-oriented charting: Streamline problem-oriented charting with AI-powered scribe workflows through our Ambient Scribe (optional add-on).

Templates and macros: Simplify encounter documentation with templates, macros, smart actions, and auto-populated patient data.

Leveraging Technology to Reduce Administrative Burden

Burnout doesn't stay with the individual clinician. It limits how many patients a practice group can see and how quickly they can respond to facility needs. For groups that round across multiple facilities, that lost capacity affects every partner they serve.

Technology can help shift that balance. Automated workflows, auto-populated patient data, and AI-supported tools reduce the manual effort behind each note. Ambient AI scribes are one example. They capture the patient conversation and draft a note for the clinician to review and finalize.

Early research is promising. In a multicenter study of 263 clinicians across six health systems, burnout decreased from 51.9% to 38.8% after 30 days of ambient AI scribe use.[11] Clinicians also reported less after-hours documentation and more focused attention on patients.[11]

Less time spent documenting means more time for patient care and higher-value clinical work. Faster, more complete documentation also supports reporting requirements, so the practice group benefits on both fronts.

How PointClickCare Helps

Unlike standalone AI tools that sit outside clinical systems, Ambient Scribe is an optional, add-on tool (at an additional cost) built directly into practitioner workflows in PointClickCare's EHR for Practice Groups. It works alongside clinical risk insights to reduce documentation burden and help clinicians prioritize care. Your clinicians get the same workflow in both PointClickCare and non-PointClickCare facilities.

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minutes saved per note

"I save about 5 minutes per note, and across a 25-patient day, that adds up fast and makes a meaningful difference. Since starting with Ambient Scribe, my after-hours documentation has dropped significantly, and with ongoing enhancements, the impact continues to grow."

— Chief medical officer, physician provider group

Preparing for New Documentation and Reimbursement Requirements

The next major documentation change is already on the calendar. In July 2026, CMS finalized a rule requiring skilled nursing facilities to submit Minimum Data Set (MDS) assessments for all residents receiving covered skilled care, regardless of payer.[12] The requirement applies to residents admitted on or after October 1, 2029.[13] The date may seem distant, but facilities are building those workflows now, and accurate, timely practitioner documentation will be an important input.

Physician documentation sits at the center of the MDS. CMS defines active diagnoses as physician-documented diagnoses from the last 60 days that affect a resident's current condition or care. To be included in the MDS, supporting documentation must be completed within a short window of one to eight days. Federal regulations also require a baseline care plan, including diagnoses, within the first 48 hours of a resident's stay.[14]

Facilities can code only the diagnoses that the record supports. When physician documentation is late or incomplete, the result can be inaccurate payment, incomplete care plans, and quality data that understates resident complexity.[14] At the same time, CMS is watching for diagnoses the record doesn't support. For example, malnutrition was coded in 5% of stays before the Patient Driven Payment Model (PDPM) and 47% in FY 2024. That kind of jump draws closer review of whether the medical record supports each diagnosis.[15]

For practice groups, the challenge is twofold. Every active diagnosis needs to be captured promptly, and each one needs documentation specific enough to support the code. That depends on timely visits, clear notes, and fast communication with each facility's MDS team. As all-payer reporting expands the number of residents assessed, the volume of these requests will only grow.

How PointClickCare Helps

PointClickCare's EHR for Practice Groups helps your clinicians document diagnoses at the point of care and keep facility teams informed:



Physician-to-facility diagnosis workflow: Streamline problem-oriented charting and encounter documentation with templates, smart actions, and auto-populated patient data.



Facility integration: Work from one patient record that brings together practitioner and facility data, in both PointClickCare and non-PointClickCare facilities.



Mobile documentation: Use the Practitioner mobile app for chart access, order signing, and documentation while rounding.

Managing Risk and Performance in Value-Based Care

As of January 2026, about 14.3 million Medicare beneficiaries receive care coordinated by ACOs.[16] More of that care now carries financial risk. In 2026, 82.8% of Medicare Shared Savings Program ACOs are in tracks where they share in losses as well as savings.[16] The CMS Innovation Center has also said it will require all its models to include downside financial risk.[17]

Under these arrangements, payment depends on outcomes across a whole population, not just individual visits. That raises the stakes for practice groups serving senior care settings. More than half of Medicare beneficiaries live with four or more chronic conditions.[18] For these residents, a condition can change quickly, and a missed early sign can lead to an avoidable hospital transfer.

Managing that risk starts with knowing which residents need attention first. For practice groups rounding across many facilities, that picture is hard to see. Clinical information often sits in separate systems, and a change in condition may not reach the physician until the next scheduled visit. Practice groups need a way to spot rising risk early, prioritize their time across facilities, and track how their care affects quality performance.

Risk visibility serves two goals at once. It helps clinicians intervene before a patient's condition worsens. It also gives practice groups the data to show their value to facility partners and ACOs.

Supporting Clinical Visibility and Documentation

PointClickCare's EHR for Practice Groups helps your clinicians spot rising risk and act on it sooner:



pRTH risk stratification: Use AI-powered predictive return to hospital (pRTH) to see which patients need attention first and prioritize care across facilities.



Accelerated documentation: Automated workflows and auto-populated patient data help clinicians review a patient's status quickly and record changes in condition sooner.

"By embedding AI capabilities like Ambient Scribe and clinical risk insights directly into practitioner workflows, we're reducing documentation burden, improving clinical prioritization, and enabling faster, more informed decision-making."

— Dr. Steve Buslovich, chief medical officer of senior care at PointClickCare

Building Your 2027–2028 Readiness Plan

Federal deadlines set the timeline for this plan: beginning January 1, 2028, CMS will count prescriptions written for long-term care residents toward Electronic Prescribing for Controlled Substances (EPCS) compliance. Prescribers must e-prescribe at least 70% of qualifying Medicare Part D controlled substance prescriptions.[19] CMS has also proposed ending traditional MIPS after the 2028 performance period, which would make MVPs the reporting path for most clinicians starting in 2029.[3] Together with all-payer MDS reporting and the growth of accountable care, these changes make 2027 and 2028 the window to prepare.

Use the following steps to structure your plan:

1	**Assess MVP readiness**. Identify the MVPs that fit each clinician's specialty and patient population. Use 2027 and 2028 to test MVP reporting alongside traditional MIPS. CMS scores both and applies the higher score.[3]
2	**Strengthen documentation and diagnosis capture**. Measure how quickly active diagnoses reach the record after each visit. Set standards for documentation timing and specificity that support MDS coding and risk adjustment.
3	**Improve physician-facility collaboration**. Agree with each facility on how diagnosis questions, change-in-condition alerts, and visit notes move between teams. Name a point of contact in your practice group and at each facility.
4	**Close interoperability gaps**. Confirm that every prescriber can meet EPCS requirements for long-term care residents before January 1, 2028. Identify where clinical data still moves by fax, phone, or manual entry.
5	**Prepare for value-based care participation**. Evaluate your current and potential role in ACOs and models such as LEAD. Build the risk visibility and performance tracking needed to share in savings and losses.
6	**Build a long-term readiness strategy**. Assign ownership for regulatory monitoring, set annual goals, and review progress each quarter. CMS updates these programs through annual rulemaking, so your plan should evolve with them.

Turning Change Into Opportunity

Medicare transformation is about more than compliance and reporting. MVPs, all-payer MDS reporting, EPCS requirements, and the growth of accountable care all point in the same direction. Success will depend on documentation, quality performance, interoperability, risk management, and collaboration across care settings.

Practice groups serving senior care populations sit at the center of that shift. Their clinicians shape the diagnoses facilities code, the care transitions that drive readmissions, and the outcomes that value-based contracts reward. Groups that strengthen documentation, interoperability, and physician-facility collaboration now will be better positioned as Medicare payment models evolve.

One Platform for Senior Care Practice Groups

PointClickCare's EHR for Practice Groups connects records across skilled nursing facilities in one place. It automates workflows and delivers proactive insights so your practice group can reduce documentation burden, simplify post-acute coordination and improve efficiency.

Accelerate patient documentation: Automated workflows, auto-populated patient data, templates, and the optional Ambient Scribe help clinicians complete notes faster.

Support prescribing within existing workflows: EPCS through DrFirst enables practitioners to electronically prescribe controlled substances within EHR for Practice Groups, another investment in tools that fit naturally into how practitioners work.

Enhance collaboration across the care continuum: A single login and one patient record across senior care settings support better communication and decision-making with facility teams.

Streamline practice operations and recognize revenue faster: Reporting, billing export, tasking, and scheduling tools support day-to-day practice management.

Track performance: Dashboards for quality measures, practitioner productivity, RVUs, and Promoting Interoperability performance keep your readiness plan on track.

See EHR for Practice Groups in Action

Your 2027–2028 readiness plan starts with the right foundation. Request a demo to see how PointClickCare's EHR for Practice Groups supports documentation, collaboration, and more connected workflows across every facility you serve.

View Demo



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