American Academy of Physician Associates

September 14, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), on behalf of the more than 200,000 PAs (physician associates/physician assistants) throughout the United States, would like to provide comments to the 2027 Physician Fee Schedule (PFS) proposed rule. PAs provide hundreds of millions of patient visits each year, many with Medicare beneficiaries. As such, PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies proposed in the rule. Due to the essential role PAs play in meeting many of the challenges faced by the healthcare system, AAPA hopes that the Centers for Medicare and Medicaid Services (CMS) continues to advance policies that allow PAs to meet the care needs of Medicare beneficiaries.

Several themes conveyed by CMS throughout the proposed rule align with AAPA's goals of increased efficiency and transparency, prioritization of patient experience and access, a renewed focus on wellness and prevention, reduced burden of care provision, simplification of processes, and rigorous standards to improve care quality. However, while several of the policies contained in the rule make progress toward these goals, AAPA finds further opportunities to advance these objectives through revised proposals and modified policies. In these comments, AAPA provides constructive feedback where appropriate and seeks to work in concert with CMS going forward to continue to advance these common values.

Proposed Update to the Conversion Factor

As a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), starting in 2026, CMS established two separate conversion factors: an elevated one for qualifying participants under Advanced Alternative Payment Models (APMs), or "QPs," and one for all those who are not considered QPs. Unfortunately, after the first conversion factor increase in six years, occurring in 2026, CMS has again proposed reducing the Medicare conversion factor for 2027.

In dollar terms, CMS has proposed a 40-cent reduction for QPs from $33.5675 in 2026 to $33.1693 in 2027 (-1.19%), and a 56-cent reduction for non-QPs from $33.4009 in 2026 to $32.8409 in 2027 (-1.68%). These reductions come despite positive payment adjustments of 0.75 percent for the qualifying APM conversion factor, 0.25 percent for the non-qualifying APM conversion factor, and a positive budget neutrality adjustment of 0.53 percent. Instead, the reductions result from a 2.5% one-year payment increase, included in previous budget reconciliation legislation, expiring on December 31, 2026.

AAPA hoped last year's positive adjustment would reflect a commitment to appropriate payment levels for medical services going forward. Unfortunately, the 2027 Physician Fee Schedule proposed rule has confirmed our longstanding concern that, absent Congressional intervention, CMS may be unable to make adjustments that would reflect the actual costs of care. AAPA reaffirms that Congress providing temporary fixes to boost the conversion factor to an acceptable level is not a sustainable strategy. With medical practice costs affected by rising inflation and the effects compounding each year there is a decrease, AAPA remains concerned that financial losses incurred by health professionals may cause practice adaptations that could negatively affect the ability of patients to access care.

Health professionals deserve a reliable payment method that sufficiently compensates them for their work. Amid rising demand for care, AAPA continues to urge CMS to work with Congress to finalize a long-term fix by designing and passing a more equitable system of provider reimbursement. Congress must consider the feasibility of alternative, long-term options, such as addressing budget neutrality requirements and the possibility of automatic annual inflation adjustments. The Medicare Payment Advisory Commission (MedPAC) agrees with this necessity. On April 10, 2025, MedPAC voted affirmatively that Congress should replace the current statutory updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index. This recommendation was formalized in its June 2025 report[1] to Congress.

[1] Medicare Payment Advisory Commission. 2025. June 2025 Report to the Congress: Medicare and the Health Care Delivery System. https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-thehealth-care-delivery-system/

AAPA Positions and Recommendations on this Topic

- **AAPA again requests that CMS prioritize working with Congress and affected stakeholders to both produce immediate relief for health professionals in 2027, as well as design and pass a more equitable long-term system of provider reimbursement.**

Update to HCPCS Add-On Code G2211

In the 2024 Physician Fee Schedule, CMS finalized separate payment for an office/outpatient (O/O) Evaluation and Management (E/M) add-on code (G2211) for ongoing care for a patient's single, serious, or complex condition and/or services that are a part of the ongoing focal point for all needed healthcare services. Specifically, the code descriptor reads:

> *G2211: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*

AAPA supported CMS's activation of Healthcare Common Procedure Coding System (HCPCS) add-on code G2211, noting the benefit of additional payment to properly compensate for the intangible but necessary actions of tracking, monitoring, and reviewing that go into providing the longitudinal care patients with complex conditions deserve. We also supported the code activation because it would likely benefit primary care amid serious challenges in maintaining a robust primary care delivery model, and because the code could help health professionals build effective, trusted long-term relationships with patients.

In the 2026 Physician Fee Schedule, CMS clarified that the application of G2211 should be based on the relationship between provider and patient, not the patient's characteristics. CMS also finalized an expanded applicability of G2211 to be billed as an add-on code to the home and residence E/M codes, noting that the intent of G2211 is to recognize resource costs inherent in building long-term relationships that are not included in the valuation of code sets; and the same resource costs not captured in the valuation of the O/O E/M code set are also not captured by the home and residence E/M code sets. AAPA supported this expansion, noting that health professionals who provide home and residence E/M services meet patients where they are, as these patients are frequently unable to leave their residence to receive primary care, and should not be treated differently because

of a site of service beyond their control. AAPA appreciated that the policy change would expand the number of people who would benefit from G2211.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes major modifications to further broaden use of this incentive by making the process less complex and more financially appealing. Specifically, CMS proposes replacing HCPCS code G2211 with two modifiers, MOD1 and MOD2 (placeholders to be finalized with a two-digit code if finalized). CMS indicates that because the resource costs of furnishing longitudinal care are an inherent part of the visit, it does not make sense to treat it as a separate service requiring a separate code; rather, it would be more accurately reflected by a modifier. CMS notes that the reporting of a modifier may also reduce operational burden as there's no requirement to complete a separate claim line.

MOD1 would be billed under the same circumstances as G2211 is currently billed (to account for the complexity of visits that would otherwise go unaccounted for when a practitioner who serves as the continuing focal point for all needed health care services, or with medical care that is part of ongoing care related to a patient's single, serious, or complex condition). As a result, the code descriptor for modifier MOD1 would be very similar to G2211, with some technical changes:

> *MOD1: Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.*

Instead of the flat-rate reimbursement that HCPCS code G2211 provided, MOD1 would reimburse a percentage of the base code to which it is affixed. This would allow for a payment increase for the base code that is proportional across E/M visits. MOD1 would be valued at 16% of the base E/M code.

MOD2 seeks to provide payment for circumstances similar to MOD1, but for those practitioners providing care through an Accountable Care Organization (ACO) – ACO participants, ACO professionals, ACO providers/suppliers, and LEAD Participant Providers. Under the ACO program, health professionals are responsible for managing overall health and patient goals, coordinating care, and assuming responsibility for the quality and cost of care provided. CMS indicates the complexity of acting as the focal point of all necessary care within an accountable care relationship is inherently more complex than providing this service outside such a relationship. As such, CMS proposes valuing MOD2 at 32% of the base E/M code to account for the anticipated additional resource costs.

The code descriptor for MOD2 would be:

> *MOD2: Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services furnished by a participant or practitioner participating in a Medicare accountable care organization. Services must serve as the continuing focal point for all needed health care services and/or be part of ongoing care related to a patient's single, serious condition or complex condition.*

These modifiers would be voluntary, with health professionals determining their appropriateness on a case-by-case basis. In addition, CMS proposes that ACO professionals may use the MOD2 modifier for all beneficiaries to whom they provide care, whether they are an ACO-assigned beneficiary or not.

CMS will allow payment for MOD1 and MOD2 with modifier -25 when the O/O E/M code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventative service when furnished in the office or outpatient setting. This authorization mirrors the policy established for G2211 in the 2025 Physician Fee Schedule final rule.

AAPA appreciates CMS's willingness to refine policies when appropriate. We support the proposed transformation of G2211 into two modifier codes, as this method is both more intuitive and potentially more effective in encouraging utilization, especially for more complex services. However, AAPA requests further examination and clarification of how this transformation will affect the allocation of relative value units (RVUs) to health professionals for these additional services. Because G2211 is a separately billed code, it is assigned a set value for work RVUs that can be attributed to a health professional. When G2211 is transitioned to modifiers, those separate work RVUs are no longer assigned to the health professional, but rather the RVUs of the base code will be increased by the stated percentage. As many health professionals are now paid through a compensation arrangement that factors in their work RVUs, AAPA requests that CMS provide an analysis as to whether the proportional increase in RVUs by the modifiers are sufficient to counteract the loss of RVUs from the elimination of G2211 as a separate code.

Additionally, AAPA approves of the policy that ACOs may use MOD2 for all patients, not just those assigned to their ACO. ACO professionals provide care to many patients: some assigned to their ACO, some assigned to a separate ACO, and some not assigned to any ACO at the time. Allowing ACO professionals to use MOD2 across these patient types encourages consistent care without requiring them to determine a patient's ACO assignment prior to delivering care. Instead of allowing two standards of care, we believe the ability to bill MOD2, regardless of assignment status, will elevate the level of care and coordination offered to all patients.

AAPA supports CMS's intention that certain policies that were applicable for G2211 be carried over to these successor modifiers, such as authorizing the use of MOD1 and MOD2 on any O/O E/M code when the base code is reported by the same practitioner on the same day as an Annual Wellness Visit, vaccine administration, or other Part B preventive service in an office or outpatient setting. Not authorizing modifiers in certain clinical scenarios may disrupt care delivery, as preventive services are often provided on the same day as a separately identifiable O/O E/M visit, and modifier -25 is used. Before the change was made two years ago to allow for HCPCS code G2211 to be used concurrently with modifier -25, AAPA had expressed concern that such a restriction may have caused a modification in the way care is typically provided by avoiding the provision of the preventive service, or else cause the code not to be utilized to minimize negative effects on the provision of efficient care and may have led to an underutilization of the code. We believe applying the same policies to MOD1 and MOD2 will help avoid the same potential pitfalls G2211 initially faced.

Regarding valuation, preliminary estimates suggest MOD2 will generate greater financial benefits. AAPA supports the increased payment percentage for ACO professionals using this code, as ACOs are intended to hold professionals to a higher standard while providing a higher reward. ACO professionals are expected to provide increased care coordination and corresponding care efficiency. The higher MOD2 payment percentage may ideally increase participation in ACOs and expedite the transition to a more value-based payment system. However, some concern remains about whether MOD1 successfully increases payment over the current flat rate. AAPA agrees that MOD1 is likely to increase payment for more complex codes that were underpaid under the flat-rate system of G2211, but suggests that CMS further analyze the effects on lower-level E/M codes to ensure there is no resulting decrease. If a potential decrease is found, we recommend modifying the percentage associated with MOD1 to properly incentivize continued and expanded use.

AAPA Positions and Recommendations on this Topic

- **AAPA supports CMS's proposed transformation of G2211 into two modifier codes, MOD1 and MOD2.**
- **AAPA requests that CMS provide an analysis as to whether the proportional increase in RVUs by the modifiers is sufficient to counteract the loss of RVUs from the elimination of G2211 as a separate code.**
- **AAPA approves of CMS authorizing ACO professionals to use MOD2 for all beneficiaries to whom they provide care, regardless of assignment status.**
- **AAPA appreciates that CMS made explicit certain policy consistencies between MOD1, MOD2 and G2211, specifically the ability to use the modifiers on any O/O E/M when the base code is reported by the same practitioner on the same day as an Annual Wellness Visit, vaccine administration, or other Part B preventive service in an office or outpatient setting.**
- **AAPA urges CMS to further analyze whether certain E/M codes will see a decrease in payment under the MOD1 percentage compared to the G2211 flat rate, and for the sake of proper incentivization of these modifiers, adjust the MOD1 payment percentage if necessary.**

Global Surgical Payment Valuation

CMS pays for surgical services under "global surgical packages," which provide one payment for the surgery, pre-, and post-operative care. There are three types of global surgical packages that are defined by their expected post-operative care coverage periods: 0-day, 10-day, and 90-day. When billed, payment for the global surgical package is made to the primary surgeon's practice, and anyone outside the practice who provides post-operative care can bill for those services separately.

For over a decade, CMS has expressed concern about the accuracy of global surgical package valuations and whether payments match the type and number of post-operative services provided. The Office of Inspector General and CMS analyses suggest that practitioners are providing fewer post-operative services than Medicare assumed when it previously valued global surgical packages. This was relevant for the 10- and 90-day global packages, which comprise approximately 4,200 of the 5,500 global surgical packages for which CMS reimburses.

CMS's initial policy to address the perceived overvaluation of global surgical packages, finalized through the 2015 Physician Fee Schedule, was to change all 10- and 90-day global surgical packages to 0-day global surgical packages so that postoperative services would be billed separately. While AAPA appreciated the intended increase in transparency and accuracy of payments, we were concerned with the potential unintended effects of the policy, such as post-operative visits that were formerly provided without separate fees for the beneficiary, because they were under the global bundle, would be subject to deductibles and/or co-payments for each visit. These new payments would have burdened beneficiaries financially and may have caused some to avoid needed follow-up care after surgery.

However, Congress prevented this policy from being implemented through MACRA, which required CMS to collect data on the number of post-operative visits and use it for future revaluations of global surgical packages. CMS began collecting data, producing reports, and soliciting further stakeholder feedback on post-operative services to improve the accuracy of global surgical package valuations. Working with RAND since 2017, CMS has collected data from health professionals and practices on the number and intensity of post-operative visits performed within the global surgical package.

In its 2017 Physician Fee Schedule final rule, CMS reduced its proposed reporting requirements from what was perceived as an overly burdensome mandate requiring all health professionals to submit a series of G codes to demonstrate ten-minute increments of post-operative global surgical E/M services to a more manageable data-collection method. Specifically, the new reporting requirements targeted primarily surgical practices in nine states with ten or more health professionals. CMS asked for information on certain high-volume surgical services, with a HCPCS code as the method of reporting.

In the 2019 Physician Fee Schedule proposed rule, CMS explained that it had not yet received a robust data submission. However, after additional research and data collection activities by RAND, including an updated report published in 2021, CMS's internal analyses were reaffirmed: only a portion of the post-operative services CMS expected when it valued global surgical packages were being provided.

When one health professional performs the surgery, and a separate health professional in a different practice provides post-operative care, CMS relies on transfer-of-care modifiers to split the valuation between the two parties. In its 2025 Physician Fee Schedule rule, CMS expanded the use of these modifiers, requiring their use for all cases when the surgeon does not intend to provide postoperative care.

Complimentary policy in the 2025 Physician Fee Schedule rule created a new add-on code, G0559, to identify post-operative services provided by practitioners outside the same practice as the surgeon who performed the surgery. CMS expects this add-on code to account for the increased complexity and the added resources a practitioner providing post-operative care would incur in this situation. AAPA approved of this add-on code because we believed it would more adequately reimburse health professionals who were not involved in the surgical aspect of care and who would require greater resources to obtain and assess appropriate information to provide the level of care patients deserve. This add-on code also supports patient flexibility in allowing them to see a different health professional for their follow-up care than the practice that provided the original surgery. For example, if the patient had to travel a long distance for the original surgery, it would potentially be more convenient to seek subsequent care closer to the patient's residence.

In its 2026 Physician Fee Schedule proposed rule, CMS again solicited additional strategies to improve payment accuracy for global surgical packages. The agency also identified three alternatives for how shares of the payment are determined for the procedure versus post-operative care when the transfer of care modifier 54 is reported.

In the 2027 Physician Fee Schedule proposed rule, CMS indicates that it still thinks global surgical packages are overvalued. CMS indicates that, after several years of data collection through its partnership with RAND, it now has significant corroborating data suggesting that postoperative care paid for under the global surgical period is not being provided and is resulting in overvaluation. Despite these findings, CMS is not presently making any changes to payment and billing policies surrounding global surgical packages. Instead, the agency says it is laying the groundwork for future rulemaking to "right-size" global surgical package payments over time and keep them aligned with current clinical practice. CMS also hopes future rulemaking may establish a method to update resource costs for global surgical packages more readily based on empirical data.

While section 523(a) of MACRA prevents changing all 10- and 90-day global surgical packages to 0-day global periods, CMS may revalue these codes to reflect actual costs if evidence shows overvaluation. Section 523(a) also authorizes CMS to reassess the need for data collection on global surgical package valuations every four years.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes pausing the data collection with RAND. The agency acknowledges that this data collection, conducted solely by surgical practices in nine states with ten or more health professionals, likely caused an undue burden on reporting providers. However, while pausing the current data collection, CMS is soliciting feedback on whether broader data collection is warranted. Specifically, CMS is requesting input as to whether, in the future, all practitioners who provide surgeries with 10- and 90-day global surgical periods should be required to report CPT code 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*) for follow-up visits.

AAPA understands and appreciates the goals of determining both the appropriate value of services, as well as the levels of reimbursement for the respective procedure and post-operative components of surgical services. We note that in a budget-neutral environment, CMS payment for overvalued global surgical packages may lower the valuation of other important services.

While AAPA hesitates to support policies that increase the burden on already overstretched health professionals, we see value in CMS requiring the reporting of 99024 for all 10- and 90-day global surgical post-operative visits for a limited time. Although in the 2027 Physician Fee Schedule proposed rule, CMS indicates the data suggest a clear outcome, in previous iterations of the fee schedule, CMS stated that the data collected are insufficient. AAPA suggests that the added burden of requiring more widespread submission of 99024 may be outweighed by the need for CMS to make an informed decision regarding code valuations. Otherwise, if CMS reduces the valuations of 10- and 90-day global surgical packages based on data that, by its own admission, was insufficient, or, as proposed in other sections of the rule, by an arbitrary percentage reduction, the results could be drastic and detrimental. Therefore, AAPA believes that when CMS modifies the valuation of global surgical packages, the data it uses must be representative and comprehensive.

If CMS proceeds with requiring broader reporting of 99024, AAPA suggests that the agency mitigate burden in any way possible. First, CMS should set a predetermined timeline for data collection, complete with an anticipated sunset date and expected revaluation timeline. Second, CMS should explore other data sources that could supplement 99024 data and, by their inclusion, shorten the data-collection timeline. This would include both empirical estimates, as well as feedback from affected stakeholders. CMS has, by its own admission, received little feedback thus far through the comment process regarding appropriate levels of revaluation, but it should continue to solicit information through this venue, especially as the data takes shape and CMS can issue more specific

requests than a general call for feedback. CMS should also convene an in-person discussion with affected stakeholders (e.g., PAs and other health professionals, patient groups, medical societies and associations, and payers). While we anticipate any subsequent revaluations will rely most heavily on the agency's collected data on post-operative visit utilization codes, we believe comment responses and stakeholder groups can provide supplementary unforeseen context or data validation. Additionally, CMS should be transparent in its findings, provide regular updates, and adjust the collection timeline if the data allow.

When CMS chooses to use the collected data to modify global surgical packages, AAPA recommends that the agency avoid a one-size-fits-all approach to adjusting the valuation of these packages. The data will likely show that the number of post-operative visits varies by procedure and location. As such, valuation adjustments should account for these variables and be made on a procedure-by-procedure basis.

AAPA continues to remind CMS that any future modifications to the current global surgical payment for 90-day global procedures should not inadvertently penalize health professionals who serve as surgical assistants. Payment for surgical assistant services is calculated as a percentage of the global surgical fee in its entirety. If the post-operative payment is reimbursed separately from the procedure, or if the overall valuation of a global surgical package is reduced, this should not result in a corresponding lowering of payment for surgical assisting services, as the valuation change would be based solely on the post-operative assessments, while the professional work and intensity of the surgical assistant services have not changed.

Finally, AAPA requests that patients not be penalized in the pursuit of increased transparency. We request CMS pursue modifications to global surgical packages that keep the existing structure in place and ensure that patients will not be charged extra for post-operative care, even when such care has been transferred to another health professional.

AAPA Positions and Recommendations on this Topic

- **AAPA supports efforts for increased transparency regarding global surgical package valuations and conditionally supports a broad data collection effort regarding CPT code 99024. Conditions would include CMS setting a predetermined timeline that could be shortened by using other data sources, soliciting supplementary information from comment letters and a convening of stakeholders, and being transparent in its findings and subsequent calculations.**
- **AAPA recommends that any modifications to global surgical package valuations not use a one-size-fits-all approach of adjusting the valuation of these packages but rather make code updates on a case-by-case basis using collected information that varies by procedure.**

- **AAPA reaffirms that, consistent with the current policy regarding surgical assistant payment being a percentage of the total global package, when updates are made to global surgical package valuations, payment to the surgical assistant should not be reduced.**
- **AAPA requests that CMS pursue modifications to global surgical packages that keep the existing structure in place and ensure that patients will not incur increased costs for post-operative care, even when such care has been transferred to another health professional.**

Surgical Procedures on the Same Day as E/M Codes

In the 2027 Physician Fee Schedule proposed rule, CMS proposes that when separately identifiable O/O E/M services appended with a modifier -25 are furnished on the same date as a 0-, 10-, or 90-day surgical procedure, the agency would discount the total payment for these services. Specifically, under the proposal, CMS would reimburse the most expensive service at 100 percent but discount the other service by 50 percent. This policy would also apply to other E/M services or surgeries provided on the same day, allowing the most expensive service to be reimbursed at 100 percent and discounting payment for all other surgical procedures or E/M visits by 50 percent. CMS justifies this proposed policy by stating that resources used for the E/M service are already accounted for in the global surgical valuation, which covers pre-operative visits, intra-operative services, post-operative visits, supplies, and removal of items used during or after surgery. CMS is further considering whether to extend this to all E/M visits, including inpatient E/M visits.

CMS proposed a similar policy change in its 2019 Physician Fee Schedule proposed rule. In comments to the proposed rule, AAPA expressed concerns regarding the effects on patient access. AAPA also postulated that the proposal may be rooted in a misunderstanding in that any duplication of resources that occurs when a procedure follows an E/M visit on the same date of service has already been incorporated into the valuation of the procedure that is reimbursed in this scenario by the American Medical Association's Relative Value Scale Update Committee (RUC). We suggested that a 50 percent cut may cause practices to lose money for these services. In the final rule of the 2019 Physician Fee Schedule, CMS elected not to finalize this provision due to significant opposition.

AAPA remains opposed to this change and urges CMS not to finalize the policy. We are particularly concerned about the unintended consequences that may result in reduced patient access. While AAPA does not support scheduling medical services to maximize reimbursement, we are concerned that this practice would occur. To receive 100 percent reimbursement for all services, a provider may require patients to return on separate days for care they could have received on the initial day services were provided. This scheduling method would be an inefficient use of provider and patient time. Patients may be forced to take additional time off work to receive

services on a separate day, and if they face transportation challenges, they will face them more than once. Delayed care that could be provided the same day, if not for a disincentive, may also worsen patient conditions if the wait increases severity. In addition to the direct health effects on the patient, a more acute condition may ultimately make care more expensive for the patient and the Medicare program.

While we applaud that CMS notes its ability to monitor patient returns after procedures to see if this is occurring, we note that it would need to create a monitoring window large enough to capture patient returns that may not be as obvious as occurring the next day. Services may be put off until a week, weeks, or months later, which would make it difficult to assign causation to a scheduling policy. The burdens, costs, and risks of returning for additional services do not lessen and may even increase if a subsequent service is scheduled for the next week rather than provided the same day. We also expect that widespread use of this practice will make monitoring difficult, as these instances may not be identifiable as outliers. Finally, while CMS notes the existence of monitoring capabilities, it makes no commitment to using them, stating instead that they may be used if necessary, and not tying conditions for payment to the absence of this practice. For these reasons, our concerns regarding the effect of this proposal on patient care remain.

In addition, AAPA is concerned that the proposal continues to address a problem that may not even be an issue. As noted in the proposed rule, because global surgical periods cover all resource costs for associated visits, O/O E/M visits provided on the same day (identified by modifier -25) are billable only if they are significant and separately identifiable from the procedure. As such, modifier -25 indicates that a visit is separately identifiable and has distinct resource costs. We also reiterate that the RUC review process includes adjustments to account for duplicative costs and CMS's proposed adjustment would be in addition to those already made. CMS did not directly address this concern.

Finally, AAPA has further reservations regarding the extent of the proposed adjustment. CMS has selected a discount rate of 50 percent to match the multiple procedure payment reduction (MPPR) implemented elsewhere. However, in support of CMS's recent increased focus on data-based valuations, AAPA requests that, should CMS move forward with a reduction, it provide a rate supported by empirical data to justify the extent of the discount.

AAPA Positions and Recommendations on this Topic

- **AAPA requests that CMS withdraw its proposal to reduce all but the most expensive service by 50% when one or more surgical procedures are performed on the same day as one or more O/O E/M visits.**
- **Should CMS proceed with a proposal to discount all but the most expensive service, AAPA requests that the rate of the reduction be based on empirical data.**

Remote Monitoring

Remote monitoring consists of two code families: remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM). Established in the 2018 PFS, the RPM code family pays for the collection, analysis, and interpretation of physiologic data (e.g., weight, blood pressure, pulse oximetry, etc.), followed by the development and management of a treatment plan. Meanwhile, the RTM code set pays for monitoring adherence to at-home therapeutic interventions. Both RPM and RTM services consist of three components: education and setup, device supply, and treatment management. Both can be billed concurrently with Chronic Care Management (CCM), Transitional Care Management (TCM), Principal Care Management (PCM), Chronic Pain Management (CPM), or Behavioral Health Integration (BHI). Several updates to the codes have been made in the various fee schedule final rules over the years.

In the 2027 Physician Fee Schedule proposed rule, CMS is proposing further updates in response to recommendations from the Office of Inspector General (OIG). Two OIG reports, "Additional Oversight of Remote Patient Monitoring in Medicare is Needed" and "Billing for Remote Patient Monitoring," identified the need to make further refinements to RPM and RTM policies to better protect against fraud.

Proposal to Require RTM to be Provided Only to Established Patients

During the COVID-19 pandemic public health emergency (PHE), CMS instituted a temporary flexibility that allowed RPM services to be provided to patients with whom a practitioner did not have an established medical relationship. When the PHE ended, CMS again required that RPM services be provided only to established patients. In the 2027 Physician Fee Schedule proposed rule, CMS is proposing to likewise require that RTM services be provided only to established patients. This is both in response to a direct OIG finding that some practices did not have a prior relationship with patients for whom they billed remote monitoring services, and to ensure health professionals providing RTM services better understand the patient's current medical status and needs. AAPA supports this proposal. We recognize the value of providing remote therapeutic monitoring, which seeks to detect adherence to already authorized at-home interventions, to established patients.

Proposal to Require an Initiating Visit for Both RPM and RTM Services

In the 2027 Physician Fee Schedule proposed rule, CMS proposes requiring that, for both RPM and RTM services, a separately reportable initiating visit occur first. CMS indicates that this initiating visit may be performed either in-person or by telehealth but must be face-to-face. During this visit, the provider must explicitly discuss the use of remote patient monitoring, evaluate the patient, confirm the clinical appropriateness of patient monitoring, and obtain the patient's consent. AAPA supports this requirement when no prior visit meets these standards. We

believe an initiating visit would allow a billing professional to personally establish a baseline regarding patient needs for remote monitoring while also improving program integrity to ensure the service is used as intended. However, if an E/M visit occurred within the past twelve months and the requirements for initiating the services were met, then this E/M visit should suffice as an initiating visit. Requiring a separate initiating visit when these qualifications are already met would be unnecessarily duplicative of provider and patient time, as well as likely increase patient costs and burden.

Proposal to Restrict the Provision of Remote Monitoring Services to Employed Clinical Staff

A third policy revision proposed by CMS in the 2027 Physician Fee Schedule proposed rule is that all remote patient monitoring must be directly furnished by clinical staff employed by a practice, and not by any third-party company or contractor. CMS is concerned that these companies may provide services exclusively by telephone and online contact. CMS notes that the OIG found that certain companies were "cold calling" beneficiaries to solicit them for unnecessary remote monitoring services. While AAPA agrees that "cold calling" beneficiaries to solicit monitoring services is inappropriate because it neglects a conditional determination of medical necessity, we caution CMS against a wholesale restriction on using third-party companies and contractors to conduct this monitoring.

AAPA is aware of instances where it is both medically appropriate and a more efficient way to provide care to use a third-party vendor (a fairly regular practice) to provide remote monitoring, such as when employed clinical staff have limited capacity or training to personally perform these services. AAPA is concerned that a blanket restriction may reduce beneficiary access to these services if practices choose to limit or forgo remote monitoring altogether because of limitations. This is especially true for small, independent, or rural practices that may lack the infrastructure, resources, or staff to provide remote monitoring services. If a practice lacks the capacity to provide consistent remote monitoring services, several negative effects may result. A beneficiary may instead be required to regularly visit a health professional's practice for clinical assessments or adherence checks, creating unnecessary transportation burdens for at-risk patients and requiring health professionals to spend time on direct patient visits that could be used for other clinical services. A reduction in remote monitoring may also require patients to receive continuous in-person monitoring in a more expensive care setting, thereby increasing care costs for both patients and the Medicare program. For patients whose remote monitoring helps assess a condition that could worsen through an acute incident or could alert to pending death, the loss of monitoring could have catastrophic consequences. Finally, remote monitoring is often used preventively to enable early detection and intervention for potential issues. Without this opportunity, patients may return to a care setting only after conditions have progressed far enough that the cost and nature of treatment may have escalated.

AAPA supports CMS efforts to identify and eliminate fraud. We have long supported past CMS efforts to protect the integrity of the Medicare program through enhanced payment accuracy and have championed causes like data transparency. As such, AAPA would support increased required oversight of third-party companies/contractors and a required greater involvement of the billing provider. For example, more frequent reporting by third-party companies/contractors to billing providers, and requirements for billing provider oversight of monitoring, could ensure greater integration of monitoring data into longitudinal care decisions. AAPA encourages CMS to review feedback to this proposed rule directly from practices that offer these remote monitoring services regarding feasibility of offering these services under the proposed requirements and, if necessary, modify the proposal to enhance oversight of third-party companies/contractors rather than restrict their use.

Proposal to Revalue Remote Monitoring Services

CMS, believing RPM and RTM codes are overvalued, proposes reducing reimbursement for RPM and RTM services. CMS indicates this is linked to a revised assessment of device costs, believing this number has decreased as the technology has progressed. AAPA is concerned that CMS's estimation of overvaluation is not based on empirical data. AAPA requests that CMS revisit its revaluation of RPM and RTM services after receiving data in response to this proposed rule, and after additional data can be gathered from upcoming RUC surveys and empirical sources.

AAPA Positions and Recommendations on this Topic

- **AAPA supports CMS's proposal to require that remote therapeutic monitoring be provided only to established patients.**
- **AAPA approves of CMS's proposed requirement for an initiating visit prior to RPM and RTM services in the absence of a previously occurring visit that already meets these standards. We believe an initiating visit would allow a billing professional to personally establish a baseline regarding patient needs for remote monitoring while also improving program integrity to ensure the service is used as intended. However, if an E/M visit occurred within the past twelve months and the requirements for initiating the services were met, then this E/M visit should suffice as an initiating visit to prevent duplication of services and minimize patient costs and burden.**
- **AAPA is concerned regarding the potential negative impact of CMS's proposed policy preventing the use of third-party companies or contractors in remote monitoring. We encourage CMS to first review feedback on the proposed rule regarding the feasibility of providing remote monitoring when third-party companies are restricted from providing these services and, if necessary, modify the proposal to enhance oversight of third-party companies/contractors rather than restrict their use.**
- **AAPA believes that CMS should make it explicit that these G-codes are available to bill in settings with different billing requirements, such as RHCs and FQHCs.**

- **AAPA requests that CMS revisit its reevaluation of RPM and RTM services after data is received in response to this proposed rule, and additional data can be gathered from upcoming RUC surveys and empirical sources.**

Ambulance Services

In the 2027 Physician Fee Schedule proposed rule, CMS proposes several revisions to the Ambulance Fee Schedule. These revisions include implementing provisions in the Consolidated Appropriations Act of 2026 to extend payment add-ons, as well as the Super Rural Bonus, for transports that originate in a "qualified rural area" through 2027. These changes reflect Congress's and CMS's continued commitment to increase pay for ambulance services in rural areas where transportation may be most difficult. AAPA supports such efforts. However, AAPA notes that CMS's acknowledgment of access challenges in these settings should prompt a renewed examination of other superfluous regulatory requirements related to certifying the need for certain ambulance services. Certain physician-centric language in the CFR reflects outdated ways of providing care and should be updated to reflect modern practice and encourage maximum efficiency for beneficiaries who require ambulance services.

Some patients cannot travel for services such as preventive screenings, management of chronic conditions (e.g., dialysis), or required regular maintenance of a condition (e.g., wound care) because of a contraindication to certain modes of transportation. However, if certified by a physician, these individuals can receive nonemergency, scheduled, repetitive ambulance services.[2] Requiring a physician to provide this certification, instead of a qualified health professional already familiar with the patient, is inefficient and a barrier to care for chronic conditions. The effect may be more troublesome in rural or underserved areas where transportation is already challenging. Inability to receive timely authorization for transportation may also delay or prevent necessary services, potentially worsening illness, and the added burden of finding a physician to provide authorization may lead patients to forgo widely accepted preventive practices like routine screenings. As such, these restrictions risk increasing costs both to patients and the Medicare system.

CMS previously extended the ability of PAs and nurse practitioners (NPs) to sign a certification statement for other types of ambulance transfers (i.e., for unscheduled transfers or scheduled but not repetitive transfers). AAPA requests that CMS similarly modify § 410.40(e)(2) to authorize PAs who provide care to patients who require nonemergency, scheduled, repetitive ambulance care to provide the required certifications to ensure these patients have access to needed services. This modification would align with CMS's recent prioritization of chronic

[2] Palmetto GBA. 2021. Physician Certification Statement for Ambulance Services. https://www.palmettogba.com/palmetto/jmb.nsf/DID/8T4MAF7511

care management and removal of unnecessary regulations, and it would support provisions in the proposed rule that similarly enhance rural access to care.

CMS's willingness to modify regulations pertaining to the ambulance fee schedule signals a willingness to reexamine incentives to ensure the availability of ambulance services, particularly in rural or underserved communities. AAPA emphasizes that such incentives do not need to take the form of higher compensation, but removing these unnecessary restrictions may similarly incentivize sufficient availability of ambulance transfers in these settings.

AAPA Positions and Recommendations on this Topic

- **AAPA supports CMS efforts to incentivize the availability of ambulance transfers in rural and underserved areas.**
- **AAPA requests that, in addition to financial compensation, CMS consider that a complementary way to ensure sufficient availability of ambulance transfers is to remove unnecessary burdensome restrictions. As such, AAPA requests that CMS modify § 410.40(e)(2) to authorize PAs who provide care to patients who require nonemergency, scheduled, repetitive ambulance care to provide the required certifications to ensure these patients have access to needed services.**

Shared Medical Appointments

Shared medical appointments are voluntary group-based sessions in which beneficiaries receive clinical guidance and interact with other beneficiaries confronting similar health challenges or conditions. These visits are often provided by multiple (two to four) care providers with various expertise, from clinical to education. CMS suggests that shared medical appointments encourage sustainable lifestyle and behavioral changes and foster beneficiary engagement.

Currently, there is no CPT or HCPCS code for shared medical appointments, but rather these appointments, when held, are often billed under E/M codes. In the 2027 Physician Fee Schedule proposed rule, CMS proposes to authorize payment for shared medical appointments.

> *HCPCS code GSMAS: Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the*

supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session.

CMS further elaborates that shared medical appointments would last 60 minutes with a maximum of ten beneficiaries per session. The visits could occur in person or via telehealth. The shared medical appointments would include a combination of individual and group interaction with health professionals, and group interactions would sometimes allow discussion among fellow patients. Each session would require E/M elements, education, and discussion of positive lifestyle change. Finally, CMS would require beneficiaries to consent both to participation in shared medical appointments, as well as to established confidentiality terms to protect other participants.

AAPA approves of CMS establishing a code and payment for shared medical appointments. We concur with CMS that there is value in beneficiaries hearing from others in the same situation and discussing success stories related to condition management strategies. AAPA further postulates that shared medical appointments may improve access to care by allowing several patients to receive care simultaneously, potentially reducing wait times. In addition, the format of a shared medical appointment may allow health professionals to provide clinical education and guidance to more individuals by disseminating information to a broader audience simultaneously.

AAPA was also pleased that CMS acknowledged in the proposed rule the potential of shared medical appointments to help some beneficiaries address social isolation. In comments to the 2026 Physician Fee Schedule, AAPA emphasized the need to mitigate social isolation. We praised previous actions taken by CMS, such as the agency finalizing payment for safety planning interventions for high-risk patients in crisis (those at risk of suicide or overdose) that included using social contacts, social settings, family members, caregivers, and significant others in a way that may help resolve crises. In the same rule, CMS finalized payment for post-discharge telephonic follow-up contact interventions, which seek to incentivize regular provider check-ins with at-risk patients. In response, AAPA noted that, while these policies represented excellent initial steps to help address social isolation, there may be more the agency could do, including expanding interventions such as social plans and periodic check-ins for those at moderate risk for depression (instead of just high risk) or those determined at risk for social isolation due to an intake survey. AAPA concurs that shared medical appointments are another promising tool to address social isolation. We urge CMS to encourage health professionals to make ongoing assessments to determine risk for social isolation, and to consider shared medical appointments as one intervention if risk is identified.

CMS assigns certain stipulations to the billing of shared medical appointments. AAPA wishes to address these stipulations below.

Requirements to Establish an Existing Medical Relationship with a Provider of the Same Specialty

In the 2027 Physician Fee Schedule proposed rule, CMS proposes that shared medical appointments would be limited to beneficiaries who have received care "from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months." AAPA is concerned with the language as written, specifically the requirement that the initial visit and shared medical appointment be provided by health professionals in the same specialty and subspecialty. We support CMS's intent to ensure an existing clinical relationship with a health professional before integration into a group care setting. However, the language as written is overly restrictive, particularly in team-based practice. This is especially relevant given how Medicare identifies the PA "specialty." Specifically, Medicare recognizes PAs as the specialty "physician assistant," which identifies the profession without further elucidation of the clinical specialty in which the PA practices. As such, we are concerned that the proposed language would only allow a beneficiary to participate in a shared medical appointment by a PA if the patient had seen a PA previously, when we believe the intent was to merely ensure someone within the same practice with the same clinical focus has first established a relationship with the patient.

AAPA recommends that CMS revise the language regarding initial visits for shared medical appointments to account for the limited way PA specialty is identified under Medicare. The language should instead be broadened to allow PAs who practice in the same group and specialty of medicine as physicians and NPs to meet the initial visit and subsequent provision of shared medical appointment interchangeability qualifications. If necessary, PA specialty focus can be attested to validate alignment with other providers with the same specialty focus.

Requirements for Patient Conditions to be Modifiable with Lifestyle Changes

In the proposed rule, CMS suggests establishing coding and payment for shared medical appointments only for conditions that are modifiable with lifestyle changes (e.g., diet, physical activity, and self-management). Examples could include diabetes mellitus, obesity, hypertension, and others. However, AAPA cautions that conditions one could consider modifiable with lifestyle changes may vary by interpretation. The Department of Health and Human Services (HHS) Make America Healthy Again initiative suggests a broad perspective on conditions that could be remedied, or at least improved, through lifestyle changes. As such, to mitigate denials we recommend that CMS make a list of specific conditions the agency would deem "modifiable" and for which it would allow shared medical appointments. AAPA concurs with HHS's perspective on the beneficial effects of healthy living for nearly all chronic conditions and therefore requests that CMS take a broad view when defining which conditions may be considered modifiable. AAPA also believes CMS should provide explicit guidance on whether shared medical appointments apply to behavioral health services.

Requirements if a Beneficiary Requires a Separate E/M Service

In the 2027 Physician Fee Schedule proposed rule, CMS proposes that if another E/M visit is required by someone of the same specialty in the same group practice, that time and effort cannot be counted twice, but otherwise CMS will not treat this as two E/M same-day visits. AAPA seeks explicit clarification from CMS regarding the interpretation of this statement. We interpret this to mean that a separate E/M in addition to the shared medical appointment may be warranted and if so, billed for as long as there is no double counting of time. If this inference is correct, AAPA would approve of this policy. We foresee several situations in which an E/M visit may be required that is not even related to the condition for which someone is participating in a shared medical appointment, or the discovery of a factor while participating in a shared medical appointment that necessitates a separate, private E/M service.

Further, AAPA has repeatedly conveyed to CMS the pitfalls of restrictions on same-day services by individuals in the same specialty when they involve health professionals like PAs, who are identified by profession rather than specialty. CMS allows one E/M service per beneficiary, per day, per provider specialty type. Because PAs are enrolled in Medicare under a single specialty taxonomy code (i.e., CMS specialty code '97') rather than the specialty in which they practice, when services are provided by two PAs (e.g., primary care and orthopaedics) on the same day, one of the visits is often not paid due to the assumption that practitioners of the same specialty performed both visits. This is particularly burdensome in multispecialty groups, which by design can coordinate care across the specialties represented. Chronic illnesses are seldom one-dimensional and may frequently require treatment from multiple health professionals to manage the illness. This restriction impedes any efficiencies that may benefit a patient from visiting a multispecialty group. This has led to a high number of claim denials and overturns on appeal, resulting in several Medicare Administrative Contractors (including NGS)[3] creating a workaround of including a secondary specialty on the claims form to reduce otherwise unnecessary and costly appeals that result in significant administrative burden and unnecessary documentation and reporting. Patients with chronic illnesses should be allowed to see two PAs working in different specialties during a visit. Consequently, Medicare should authorize a PA to use a secondary code on claim forms.

AAPA Positions and Recommendations on this Topic

- **AAPA approves of CMS establishing a code and payment for shared medical appointments.**
- **AAPA urges CMS to encourage health professionals to make ongoing assessments to determine risk for social isolation, and to consider shared medical appointments as one intervention if risk is identified.**

[3] National Government Services. Evaluation and Management Services. Published September 30, 2024. Accessed June 26, 2025. https://www.ngsmedicare.com/web/ngs/evaluationandmanagement?selectedArticleId=768586&artfid=2072831&lob=96664&state=97118&region=93623

- **AAPA recommends that CMS revise the language regarding initial visits for shared medical appointments to account for the limited way in which PAs are identified under Medicare. The language should instead be broadened to allow PAs who practice in the same group and specialty of medicine as physicians and NPs to meet initial visit and subsequent provision of shared medical appointment interchangeability qualifications. If necessary, PA specialty focus can be attested to validate alignment with other providers possessing the same specialty focus.**
- **AAPA recommends that, to reduce the number of denials, CMS make a list of specific conditions the agency would deem "modifiable" and for which it would allow shared medical appointments. AAPA requests that CMS take a broad view when defining which conditions may be considered modifiable.**
- **AAPA believes that CMS should provide explicit guidance regarding whether shared medical appointments are applicable to behavioral health services.**
- **AAPA seeks explicit clarification from CMS regarding its statement pertaining to separate E/M visits on the same day as a shared medical appointment.**
- **AAPA requests that CMS authorize PAs to use a secondary code on claim forms so that a patient does not encounter care coordination obstacles due to needing to see PAs who work in two different specialties on the same day.**

Caregiver Training Services

In the 2024 Physician Fee Schedule, CMS finalized payment for the process of properly training caregivers when a treating practitioner identifies that one or more caregivers are necessary to carry out a prescribed treatment plan. To bill for caregiver training services, a health professional must first establish a treatment plan, previously identify and document the need for caregiver training, obtain consent from the patient or representative to provide the training to the caregiver or caregivers, and document that consent in the medical record. This new reimbursement replaced CMS's previously stated position that it would not reimburse for services not directly administered to a patient.

In comments to the 2024 Physician Fee Schedule, AAPA approved of CMS's payment for caregiver training, recognizing that individuals other than patients are often essential to successfully implementing treatment plans. Proper training allows caregivers to improve patient function and alleviate symptoms.

In the 2025 Physician Fee Schedule, CMS proposed two major updates. First, CMS proposed adding caregiver training services codes to the Medicare Telehealth Services List, authorizing caregiver training services to be provided via telecommunications, as appropriate. AAPA approved of this proposal. While we concur with CMS that

these services would largely be provided through in-person interactions, if the billing practitioner can effectively provide the required knowledge and skills electronically, this would provide flexibility in when and how such training can be offered. Often, patients and caregivers may not be aware of certain considerations until after they leave the immediate care of health professionals, and returning in person to get questions answered or receive necessary skills may be burdensome and make them less likely to receive such training.

Second, CMS expanded covered caregiver training services to include direct care services and support. Specifically, CMS would pay for health professionals to provide caregivers with specific clinical skills to monitor and provide hands-on treatment to the patient, such as infection control and wound dressing.

The three HCPCS codes CMS established for direct care caregiver training services were:

- G0541 *(Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes)*
- G0542 *(Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use g0542 in conjunction with g0541))*
- G0543 *(Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers)*

In comments to the 2025 Physician Fee Schedule, AAPA approved of the expansion of authorized caregiver training services as caregivers will be the ones providing routine care for patients. Properly equipping caregivers with certain skills can reduce reliance on the healthcare system for either routine care or readmissions due to worsening symptoms.

In the 2027 Physician Fee Schedule proposed rule, CMS is seeking comment on whether the resource costs associated with the three direct care caregiver training services codes are best reflected in their current coding format, or whether the resource costs are instead reflected in the valuation of other codes paid under the physician fee schedule, such as E/M visits.

AAPA supports maintaining separate coding for direct care caregiver training services. Having separately identifiable codes pertaining to caregiver training for direct care allows for targeted incentivization of these services, assuming sufficient valuation. Separate coding also allows for adequate tracking of direct care caregiver training services uptake. Replacing the current G codes with E/M services may also result in unintended confusion and misuse as E/M services are structured for direct care of patients, whereas caregiver training services are intended to provide a service to a third party (the caregiver).

AAPA Positions and Recommendations on this Topic

- **AAPA recommends maintaining the coding structure for caregiver training services in its current form.**

Health Coaching

In the 2026 Physician Fee Schedule proposed rule, CMS included a Request for Information (RFI) requesting feedback on motivational interviewing and health coaching. AAPA expressed interest in CMS establishing payment in future rulemaking for these services, as we saw the benefit to CMS supporting collaborative, goal-oriented discussions with a focus on change.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to create three new HCPCS G codes that would allow health professionals to bill for health coaching services. These G-codes include:

- 0591T (*Health and well-being coaching face-to- face; individual, initial assessment, 60-90 minutes*)
- 0592T (*Individual, follow-up session, at least 30 minutes*)
- 0593T (*Health and well-being coaching, group [2 or more individuals], at least 30 minutes*)

CMS also includes the following prefatory language for all three codes:

> *"Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The health and well-being coach is qualified to perform health and well-being coaching by education, training, national examination and, when applicable, licensure/regulation, and has completed a training program in health and well-being coaching whose content meets standards established by an applicable national credentialing organization. The training includes behavioral change theory, motivational strategies,*

communication techniques, health education and promotion theories, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being."

AAPA supports CMS implementing payment for health coaching. We believe that this service aligns with current CMS initiatives, including a focus on disease prevention and management, and the "Make America Healthy Again" focus on positive lifestyle changes relating to physical activity, nutrition, technology, environmental impacts, and more. Health coaching services may empower patients to make changes that could produce positive long-term effects on their health and wellness.

Many health professionals already provide some form of this assistance to patients in implementing lifestyle changes, often without direct compensation. Developing and paying for codes that compensate for health coaching may formalize and proliferate this practice.

In the proposed rule, CMS elaborates on additional requirements regarding health coaching. One area in which CMS provides greater detail is regarding qualifications for those providing health coaching services. CMS notes that individuals providing health coaching must do so under the direct supervision of the billing practitioner, unless the individual is employed by certain community-based organizations, in which case the requirement can be met with general supervision.

CMS is requiring that all health professionals providing care, even those auxiliary providers under direct supervision, must meet certain certification requirements to include, at minimum, fulfilling the National Board for Health and Wellness Coaching National Standards, the National Commission for Health Education Credentialing eligibility for Certified Health Education Specialists, or the American Holistic Nurses Credentialing national standards for Certified Nurse Coaches. Otherwise, auxiliary personnel can also meet appropriate certification requirements by receiving training through evidence-based health promotion and disease prevention programs funded under the Older Americans Act and overseen by the Administration for Community Living (ACL). AAPA supports clearly identifying training requirements and familiarity with health coaching.

In the proposed rule, CMS does not propose frequency limitations on these codes if the visits are reasonable and necessary. AAPA approves of the agency's decision not to implement frequency limitations. We note that the breadth of information to be covered, and the range of issues on which a health coach may provide input and feedback, may require several follow-up sessions. While we expect health coaching needs to vary in frequency, we anticipate times when a beneficiary's health status necessitates multiple sessions within the same calendar month. We appreciate that CMS will continue to monitor billing patterns for abuse, but we suggest reaching out to billing providers, on an individual basis, regarding whether the frequency of sessions was reasonable and necessary.

Finally, CMS is requesting feedback on whether these services should be captured as Category III CPT codes or instead established as G-codes for 2027. Category III codes are temporary codes used to gather information (such as utilization) in preparation for eventual consideration as a Category I code, whereas G-codes are permanent codes established by CMS. One major difference is that G-codes have assigned RVUs, whereas Category III codes do not. We note that health coaching is not new, and CMS has indicated its potential to improve health outcomes. If CMS anticipates health coaching as a foundational service in disease prevention and management, it suggests the agency would want to incentivize use beyond direct payment by allowing health professionals who provide these services to claim RVUs as well. This may provide additional incentives for providers whose compensation arrangements factor in RVUs when assessing productivity. As such, AAPA suggests that CMS should consider establishing health coaching as G-codes for 2027 instead of Category III CPT codes.

AAPA Positions and Recommendations on this Topic

- **AAPA approves of CMS establishing codes and payment for health coaching.**
- **AAPA agrees with CMS regarding its choice not to enforce frequency limitations on health coaching at this time. We appreciate that CMS will continue to monitor billing patterns for abuse, but suggest reaching out to billing providers, on an individual basis, regarding whether the frequency of sessions was reasonable and necessary.**
- **AAPA suggests CMS consider establishing health coaching as G-codes for 2027 instead of Category III CPT codes.**

Advance Care Planning Services

Advance Care Planning services help patients define and refine future healthcare goals and priorities. This practice helps involve patients in their own care decision-making and prioritizes patient preferences and experience. CMS recognizes the value of Advance Care Planning services, as shown by the agency's proposed inclusion of it as a measure under the skilled nursing facilities and inpatient rehabilitation facilities quality reporting programs.

In calendar year 2016, CMS activated two codes for Advance Care Planning: 99497, which would account for the first 30 minutes, and 99498, which would account for each subsequent 30 minutes. When Advance Care Planning services are provided by the same health professional on the same day as an annual wellness visit, modifier 33 is reported to indicate the services are preventive and not subject to cost sharing. Advance Care Planning services are also available in conjunction with an E/M visit so discussions regarding long-term planning can occur alongside short-term, focused treatment options. CMS also, in support of team-based care, finalized a provision that allowed

the time of clinical staff to be counted if the billing practitioner managed, participated, and meaningfully contributed to the provision of services.

In the 2027 Physician Fee Schedule proposed rule, CMS notes that, while Advance Care Planning services use is growing, interested parties have communicated to CMS that utilization is still not commensurate with the need. CMS notes that underutilization of Advance Care Planning services may result from health professionals' belief that only the time they personally spend counts. As such, in the proposed rule, CMS is seeking to add new codes to the Advance Care Planning code family that allow for separate identification of clinical staff providing these services.

Currently, CMS policy authorizes clinical staff to provide Advance Care Planning services to patients, and these services are billed "incident to" the billing provider. In the 2027 Physician Fee Schedule proposed rule, CMS is proposing two new HCPCS codes to distinguish Advance Care Planning services provided by clinical staff currently billed "incident to" the billing provider from services provided by the billing practitioner. If finalized, 99497 and 99498 would continue to be used to identify Advance Care Planning services provided directly by the billing practitioner.

The two newly proposed codes would be:

- GACP1 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), surrogate directed by a treating physician or other treating qualified health care professional*)
- GACP2 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), surrogate directed by a treating physician or other treating qualified health care professional (List separately in addition to code for primary procedure*))

Along with finalizing these codes, CMS proposes adding both GACP1 and GACP2 to the telehealth services list.

CMS is soliciting feedback on whether the new G-codes should instead reflect the combined time of the billing practitioner and their clinical staff when the time spent by the billing practitioner and the clinical staff meets the time thresholds only when considered together.

AAPA requests that CMS modify its proposal to allow for time thresholds to be met by a combination of services provided by the billing practitioner and their clinical staff. With services as important as Advance Care Planning, the focus should be on ensuring an appropriate amount of care is provided to the patient to prepare them for future medical considerations, without requiring the additional consideration of ensuring all participating

providers meet discrete time thresholds. The decision of who can provide these services should be based on assessments of workforce capacity and clinical appropriateness, not on encouraging billing practitioners to assume more Advance Care Planning services to receive higher reimbursement. Meanwhile, AAPA approves of CMS's proposed policy to allow Advance Care Planning services to be conducted via telehealth when appropriate as this has the potential to reduce travel burdens for beneficiaries.

Meanwhile, we appreciate CMS's broader intention to bring greater transparency to the actual provider of services and request that CMS take action to mitigate the harmful effects of "incident to" billing.

Further Opportunity to Increase Transparency Regarding the Provider of Services: "Incident to" Billing

"Incident to" is a Medicare billing provision that allows medical services performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of another health professional. Of particular interest to AAPA is "incident to" billing for services performed by PAs and NPs that are attributed to physicians.

Due to how services billed "incident to" are reported through Medicare's claims process, with the claims being indistinguishable as being performed by the actual rendering provider, a substantial percentage of medical services performed by PAs and NPs may be attributed to physicians with whom they work. When this occurs, it is nearly impossible to accurately identify the type, volume, or quality of medical services provided by PAs and NPs. Accurate data collection and appropriate analysis of workforce utilization are lost.

The transparency concerns regarding "incident to" billing are well documented. The Medicare Payment Advisory Commission, in its report released on June 14, 2019, noted the increasing role of PAs and NPs in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and NPs were billed "incident to," and identified many of the adverse consequences of "incident to" billing stemming from compromised data quality.[4] This lack of transparency under "incident to" and the resulting threat to data accuracy negatively affect patients, health policy researchers, PAs and NPs, and the Medicare program.

Under "incident to" billing, claims data collected and used by the Medicare program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This has financial implications, as "incident to" billing allows services provided by PAs and NPs, typically reimbursed at 85%, to be reimbursed at the physician rate of 100%. The financial incentive to receive higher reimbursement when services are billed "incident to" may lead to improper billing practices to bolster revenue, including practitioners claiming an increased rate

[4] Medicare Payment Advisory Commission. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. 2019. https://www.medpac.gov/document-type/report/

without meeting all required conditions. Improper payments and the association of services to a different health professional have downstream financial consequences to the Medicare program, biasing programmatic assessments of quality of care and resulting value incentives.
The possibility of fraudulent claims being submitted compounds other threats of "incident to" to the Medicare program, including hindering CMS's ability to make accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, and resource use allocation. For example, in CMS's 2019 Physician Fee Schedule final rule, the agency acknowledged limitations in data use and burden-reduction estimates because services could be reported using "incident to" billing.[5]

In addition to the direct negative financial effects "incident to" may have on the Medicare program, the possibility of fraud also affects patients. A key element in ensuring healthcare is consumer-centric is providing patients with relevant, accurate information about their health status, the care they receive, and the health professionals delivering it. After receiving care, each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB). The MSN/EOB identifies the service the patient received and who delivered the care, along with other visit details. "Incident to" billing often confuses patients because the name of the health professional who provided care does not appear on the MSN/EOB notice. When PA or NP services are billed "incident to," the MSN/EOB lists the service as having been performed by a physician who did not see the patient, which can cause patients to question the accuracy of the MSN/EOB and whether they need to correct what appears to be erroneous information regarding their visit.

One way to significantly reduce the threat of bad actors using "incident to" for either claims that do not meet the billing requirements or for nonexistent services would be to repeal "incident to" billing. However, this would require an act of Congress, as the billing provision is rooted in the US Code. Another way to eliminate inappropriate billing to capture a higher reimbursement rate would be to remove the incentive by reimbursing PAs and NPs at the same rate as physicians for equivalent services. However, this too would require an act of Congress. AAPA encourages CMS to support these efforts to help reduce fraud in the Medicare system.

While AAPA is aware CMS cannot eliminate the statutorily established "incident to" billing, we believe there are policies the agency can modify to minimize its use and/or the effect of insufficient transparency brought on by

[5] The Department of Health and Human Services. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.
https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-topayment-policies-under-the-physician-fee-schedule-and-other-revisions

"incident to" billing. First, CMS should require that the name and NPI of the health professional who rendered patient care be included on all claims, including those billed "incident to." This could be accomplished by requiring claims to list an additional provider (e.g., a "performing" provider) to the "billing" or "rendering" provider. At a minimum, a modifier code should be used to identify a claim as "incident to." This additional detail, alerting Medicare for the first time to the volume of services billed "incident to," may indicate potential overuse or improper use. Identifying who uses "incident to" billing may deter bad actors from submitting fraudulent claims, while also helping Medicare target audits toward heavy "incident to" users to ensure compliance with the billing provision's requirements. Identifying PAs and NPs on claims for all services they provide will allow proper attribution when Medicare makes subsequent determinations of provider quality and resource utilization that lead to financial adjustments. Proper attribution would also improve the accuracy of provider ratings that patients rely on for care selection.

Second, CMS should remove regulatory policies that perpetuate and may even expand the use of "incident to" billing. One example is the agency's recently finalized policy allowing direct supervision by electronic means for PAs and NPs. This policy could exacerbate existing transparency problems around accurately attributing services to the appropriate health professional by making it easier to provide direct supervision, a requirement for "incident to" billing. Instead, AAPA recommends that CMS revise this policy to allow for direct supervision by audio/visual communication only for the supervision of health professionals who are not authorized to bill Medicare for their services. AAPA is concerned that CMS's policy to broadly redefine direct supervision to include audio/visual communication for all health professionals in nearly all circumstances under §410.26 will continue to make it easier for practices to use "incident to" billing when it comes to services provided by PAs and NPs. As "incident to" use increases, the potential for fraudulent claims to go undetected also rises. Contrary to registered nurses, medical assistants, and technicians, PAs and NPs can provide and bill for services under their own names instead of a physician's name, and at a lower cost of care (reimbursement rate) to the Medicare program.

Further Opportunity to Increase Transparency Regarding the Provider of Services: Provider Enrollment

Some private payers, such as those that work with CMS through Medicare Advantage plans, Medicaid Managed Care plans, and plans on the Federally Facilitated Exchange, have policies that do not allow enrollment of PAs under a plan. When this occurs, PAs, who are authorized to provide services under the plan, submit their services under a physician with whom they work. This has a similar effect to Medicare's "incident to" billing because it does not allow services to be attributed to the health professionals who provided them. It also typically results in reimbursement at the physician rate.

These flawed enrollment practices can result in negative financial implications in several ways. First, when health professionals bill for the services of other health professionals who can bill themselves, payers are less likely to

identify fraudulent claims, as the higher volume of services a health professional provides is assumed to reflect the services of multiple health professionals. Second, obscuring the health professional who provided care biases data based on such services. As payers increasingly use data to make decisions on network adequacy and provider value, payers that do not separately identify PAs within their systems will have inaccurate information to perform these analyses. Several of the determinations that stem from these analyses are financial in nature. Because Medicare has a financial relationship with these payers, it has a vested interest in reducing costs that result from inaccurate data.

To improve transparency about which health professionals provide which services, AAPA requests that CMS require all private payers with whom it contracts under the Federally Facilitated Exchanges, Medicare Advantage, and Medicaid Managed Care to enroll PAs as rendering providers and appropriately identify them on a claim.

Identifying professional work is important for clinical quality assessment, practice improvement, productivity measurement, care contribution, and population health management. Accurate recognition of PAs will not change state or federal laws regarding the range of services PAs are authorized to perform and will not increase the amount of reimbursement paid. In fact, it is likely to reduce overall expenditure and help ensure Medicare program integrity. For improved accuracy and accountability, and to reduce opportunities for fraud, AAPA advocates submitting claims under the name of the health care professional who performed the service.

AAPA Positions and Recommendations on this Topic

- **AAPA approves of CMS's proposed policy to allow Advance Care Planning services to be conducted via telehealth when appropriate.**
- **AAPA requests that CMS modify its proposal and not create separately identifiable codes for clinical staff performing Advance Care Planning to allow for time thresholds to be met by a combination of services provided by the billing practitioner and their clinical staff.**
- **In the spirit of CMS's commitment to properly identify the actual provider of care, AAPA recommends the agency pursue changes to other policies that obscure this information.**
    - **Work with Congress to repeal "incident to" billing and increase the rate of reimbursement for services provided by nonphysician health professionals such as PAs and NPs.**
    - **Require that the name and NPI of the health professional who rendered patient care be included on all claims, including those billed "incident to."**
    - **Remove regulatory policies that perpetuate and potentially proliferate the use of "incident to" billing, such as allowing for direct supervision by electronic means for PAs and NPs.**
    - **Require all private payers with whom the agency contracts under the Federally Facilitated Exchanges, Medicare Advantage, and Medicaid Managed Care to enroll PAs as rendering providers and authorize PAs to be appropriately identified on a claim.**

Telehealth Services

Updates to the Medicare Telehealth Services List

In the 2026 Physician Fee Schedule proposed rule, CMS simplified the process of determining which services should and should not be on the Medicare Telehealth Services List, consisting primarily of a process in which the agency reviews elements of a service as described in its HCPCPS code to determine whether each element is capable of being furnished using an interactive telecommunications system. CMS finalizes updates to the Medicare Telehealth Services List annually through the Physician Fee Schedule.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to add the following HCPCS codes to the Medicare Telehealth Services List:

- GACP1 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), directed by a treating physician or other treating qualified health care professional)*
- GACP2 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), directed by a treating physician or other treating qualified health care professional (List separately in addition to code for primary procedure)*)
- GSMAS (*Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session.*)
- GSLPP (*Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; for the pediatric population up to age 18 or 21*)
- GADV1 (*Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350*)

Elsewhere in AAPA's comments to the proposed rule, we expressed support for adding Advance Care Planning services and Shared Medical Appointments to this list. AAPA generally prefers a broad interpretation of which

services can be provided using telehealth, trusting the professional judgment of health professionals best able to assess the context and clinical appropriateness of telehealth services in each situation. As such, AAPA supports adding these services to the Medicare Telehealth Services List.

Continuation of Telehealth Flexibilities

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to implement statutory requirements that would renew certain flexibilities surrounding the provision of telehealth services. As a result of the COVID-19 pandemic, regulatory waivers and temporary, Congress-authorized flexibilities have allowed many services to be provided via telehealth with a patient's home serving as an originating site, and no need to be in a rural area. CMS also authorized certain telehealth services to be furnished via audio-only communication technology. Congress has extended these flexibilities several times since, most recently under the Consolidated Appropriations Act of 2026, which delays their expiration from January 30, 2026, to December 31, 2027.

AAPA notes that during the period these flexibilities have been in place, there have been no widespread reports of detrimental effects. Rather, their continued renewal suggests the widely acknowledged value of these flexibilities in allowing telehealth services to be provided to a broader range of beneficiaries, decreasing access burdens in multiple settings and contexts. AAPA believes repeated renewal of these flexibilities has become inefficient, perpetuates uncertainty, and is no longer necessary. We urge CMS to work with Congress to make telehealth flexibilities regarding geographic areas, originating sites, and audio-only services permanent.

In-person Visit Requirement Prior to Mental Health Services

A statutory requirement obligates a beneficiary to have an in-person visit with a physician or practitioner within six months before initiating mental health telehealth services. However, repeated Congressional action has delayed this requirement for several years. In the 2027 Physician Fee Schedule proposed rule, CMS implements section 6209(d) of the Consolidated Appropriations Act of 2026 to again delay in-person visit requirements for mental health services furnished through telehealth. While AAPA recognizes the value of an in-person visit before initiating mental health telehealth visits, we support continued flexibility to waive these rules as long as the agency deems it appropriate.

AAPA notes that § 410.78 (b)(3)(xiv) implements this policy, but language contained in subsection C of this section contains language that is unduly restrictive. Specifically, subsection C indicates that these requirements for in-person visits may be "met by another physician or practitioner of the same specialty and subspecialty in the same group as the physician or practitioner who furnishes the telehealth service, if the physician or practitioner who furnishes the telehealth service described under this paragraph is not available."

Requiring the health professional who provided the in-person visit to be the same specialty and sub-specialty as the health professional who provides the telehealth services is unnecessarily limiting. Health professionals in the same practice who are qualified to provide these services should be interchangeable for these purposes, as efficient workflows often require a division of labor. Similarly, if a patient receives team-based care from multiple health professionals with different taxonomies (e.g., physicians and PAs), this policy could be interpreted to require more than one in-person visit to meet the requirement for each specialty. We encourage CMS not to impose any additional requirements beyond those required by law, as it may harm access to needed behavioral health services.

New Required Modifiers

In the 2027 Physician Fee Schedule proposed rule, CMS proposes implementing Section 6209(g) of the Consolidated Appropriations Act of 2026, which requires creating new modifiers starting January 1, 2027. These modifiers do not affect payment but are for information gathering. The first modifier would identify telehealth services that are furnished through a virtual telehealth platform by a physician or practitioner that contracts with an entity that owns such virtual platform; or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform. The second modifier would identify claims for telehealth services that are furnished incident to a physician's or practitioner's professional service.

In the rule, CMS indicates it is creating modifiers BB and BC for these purposes but provides no further detail. Instead, CMS intends to provide guidance on these modifiers through the CMS website and provide updates through sub-regulatory guidance. AAPA encourages CMS to provide more information regarding these modifiers as expeditiously as possible. We are particularly interested in the details surrounding the modifier to identify claims that are furnished "incident to" another health professional's service. AAPA has long advocated for transparency, particularly regarding which health professional is providing services to a patient. However, we question why the modifier to identify "incident to" services should be restricted to telehealth services. We encourage CMS to consider extending this modifier beyond telehealth services. Similarly, we urge CMS to review our position and recommendations regarding "incident to" billing under the Advance Care Planning section of these comments.

AAPA Positions and Recommendations on this Topic

- **AAPA supports the addition of the proposed services to the Medicare Telehealth Services List.**
- **AAPA advises CMS to work with Congress to make telehealth flexibilities regarding geographic areas, originating sites, and audio-only services permanent.**
- **AAPA suggests that CMS revise § 410.78 (b)(3)(xiv), subsection C, to remove the suggestion that the other practitioner within the same group must be of the same specialty and sub-specialty.**

- **AAPA encourages CMS to provide more information regarding the BB and BC modifiers as expeditiously as possible.**
- **We encourage CMS to consider extending the modifier tracking "incident to" beyond telehealth services and urge CMS to review our position and recommendations regarding "incident to" billing under the Advance Care Planning section of these comments.**

Ambulatory Specialty Model

In the 2027 Physician Fee Schedule proposed rule, CMS makes several updates and policy modifications to its new Ambulatory Specialty Model (ASM), first proposed in the 2026 Physician Fee Schedule and now set to begin its first performance year on January 1, 2027. The ASM is a mandatory payment model focused on specialty care for beneficiaries with either lower back pain or heart failure. These two conditions represent major areas of Medicare spending. CMS proposes the model would last for five years, extending through 2031. The model aims to reward and hold certain specialists accountable for improving upstream chronic disease management, adhering to best practices, and practicing effective care communication and coordination.

Broadly, AAPA supports developing new models that emphasize public health priorities and incentivize innovative practice methods. We believe these models have significant potential to test flexibilities that may hinder access to care. Information gathered from observing these models may also provide valuable data to inform policymakers about making such flexibilities permanent. For example, CMMI's ACO Reach currently trials several flexibilities pertaining to PA practice, such as authorizing PAs to order therapeutic shoes for people with diabetes and Medical Nutrition Therapy. If data are produced from this model that demonstrate no harm, then this data may inform Congress to make these policies permanent, thereby expanding access to these services. However, models that exclude health professionals limit their potential in promoting desired policies and testing potential innovative practices.

The 2027 Physician Fee Schedule proposed rule continues to use restrictive language regarding who may participate in the ASM. Specifically, CMS prohibits the participation of non-physician health professionals such as PAs and NPs who may provide regular care to patients with the targeted conditions. CMS indicates that non-physician health professionals were excluded due to their inability to meet the proposed eligibility criteria, which require ASM participants to be assigned one of several enumerated specialty codes. However, PAs and NPs are enrolled in Medicare under a single specialty taxonomy code (i.e., CMS specialty code '97' for PAs) that reflects their profession, rather than the specialty in which they practice.

AAPA continues to caution that excluding PAs and NPs because their specialty cannot be determined will exclude health professionals who serve a prominent role, and will increasingly do so, in meeting the care needs of Medicare beneficiaries. Of the estimated 1.5 million practitioners in the U.S. in 2033, about 50% will be physicians and 50% will be PAs and other non-physician practitioners.[6] Further, a report stated, "This growth is not arbitrary but stems from the pivotal contributions these professionals make to our healthcare system."[7] Excluding PAs and NPs may bias any data collected through the ASM and may also limit the reach of the intended incentives.

Mirroring our comments to the 2026 Physician Fee Schedule, AAPA continues to recommend that CMS not exclude PAs and NPs from participating in the ASM and, instead, make participation voluntary for these practitioners. To meet the proposed eligibility requirements, CMS could establish methods to collect data regarding the specialties in which PAs and NPs practice. To accomplish this, we recommend two potential solutions. First, CMS could allow PAs and NPs to attest to the specialty in which they practice. Second, CMS could authorize PAs and NPs to provide, through PECOS, secondary or tertiary specialty designations that could be used in cases like this. We believe that health professionals are incentivized to choose the most appropriate specialty since, if they do not, their ability to score well on specialty-specific measures will be compromised and will negatively affect their reimbursement. This is especially true in the case of ASM, which CMS proposes as a mandatory model.

AAPA Positions and Recommendations on this Topic

- **AAPA recommends that CMS authorize voluntary participation for PAs and NPs and establish attestation methods to collect data regarding the specialties in which they practice, or authorize PAs and NPs to provide, through PECOS, secondary or tertiary specialty designations that could be used in instances such as this.**

Request for Information on Community-based Palliative Care

In the 2027 Physician Fee Schedule proposed rule, CMS is requesting feedback as to whether to establish payment for "community-based palliative care," and what that might look like in practice. An initial solicitation of this information was included in the 2027 Hospice Wage Index rule. CMS is looking to establish a community-based

[6] The 50/50 statistic comes from comparison of the estimated total number of providers to the BLS estimates of total number of PAs combined with: Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. https://www.bls.gov/ooh/healthcare/nurseanesthetists-nurse-midwives-and-nurse-practitioners.htm

[7] Singh, L, & Gurjar, R, Insight Brief: The Increasingly Important Role of NPs and PAs in Healthcare Sales Targeting, IQVIA. April 26, 2024. https://www.iqvia.com/locations/united-states/library/insight-brief/theincreasinglyimportant-role-of-nps-and-pas-in-healthcare-sales-targeting

palliative care benefit that would be distinct from the hospice benefit and would provide palliative services outside of a hospital setting.

In the 2027 Physician Fee Schedule proposed rule, while trying to determine eligibility requirements, CMS inquires whether eligibility should be conditional on a likely life expectancy duration. AAPA would oppose such a requirement as this may further confuse stakeholders regarding the distinction between hospice and palliative care, a distinction this proposal is seeking to establish. Palliative care seeks to offer management of pain or other symptoms that result from an illness, whereas hospice seeks to provide similar services to those with a certified terminal illness (less than six months to live). If a terminal prognosis were required for community-based palliative care, the result would effectively be the same as a hospice code that expands to a larger life expectancy window. We note that palliative care can be provided to individuals who require maintenance of symptom burden at all stages of life and should not be narrowed to those with a defined life expectancy.

In the proposed rule, CMS also inquires whether eligibility should be dependent on a patient possessing a certain number of chronic conditions as a stipulation to receive community-based palliative care. AAPA would not support this requirement. Diseases are multi-faceted and complex, with the existence of one serious illness often meeting the circumstances in which palliative care would be appropriate.

Instead, AAPA would recommend eligibility be based on an assessment of impact of a serious illness on a person's daily function, with additional consideration on the degree of potential burden placed on caregivers. Determinations of functional status should be assessed through initiating comprehensive examinations by qualified health professionals like physicians and PAs, a subsequent documentation of degree of burden, and certification regarding qualifications for palliative care services.

AAPA would support delivery of community-based palliative care in a similar manner in which hospice care is provided in that there would be an attending professional chosen by the beneficiary to ensure care continuity, with an interdisciplinary team providing palliative care services in conjunction with the chosen professional. Of the suggested service elements CMS supplied as examples for inclusion in the proposed rule (access to timely clinical support, comprehensive symptom and caregiver assessment, electronic care plans, coordination with treating physicians, patient/caregiver education, timely follow up after ED/discharge) we would support the inclusion of all of these, but would request the change in physician-centric language from "treating physician" to "treating provider."

AAPA requests that, when drafting specific policies regarding community-based palliative care, CMS make a deliberate effort to not replicate restrictive policies that exist under the Hospice benefit. Certain policies under Hospice have rightfully evolved to become more inclusive of health professionals like PAs, but other policies persist

that are vestiges of a practice model that does not exist anymore. Examples of this include statutory requirements that a physician must certify and recertify terminal illness and that a PA cannot conduct the face-to-face encounter prior to recertification. Other examples that are regulatory place certain restrictions on PAs who are employed by a hospice. As CMS is developing the community-based palliative care benefit without statutory source language, CMS can avoid these unnecessary restrictions. AAPA recommends that CMS structure any explanatory language as inclusive of PAs, physicians, and NPs, in terms of who may certify and recertify eligibility, authorization to order these services, authorization to provide these services without restrictions, and authorization to be a required member of a patient's interdisciplinary team.

AAPA Positions and Recommendations on this Topic

- **AAPA would oppose conditioning eligibility for community-based palliative care services on a likely life expectancy duration.**
- **AAPA would oppose conditioning eligibility for community-based palliative care services on the existence of more than one serious illness.**
- **AAPA would support determining eligibility for community-based palliative care based on an assessment of impact of a serious illness on a person's daily function, with additional consideration on the degree of potential burden placed on caregivers.**
- **AAPA would support delivery of community-based palliative care in a similar manner in which hospice care is provided in that there would be an attending professional chosen by the beneficiary to ensure care continuity, with an interdisciplinary team providing palliative care services in conjunction with the chosen professional.**
- **AAPA would support the inclusion of all service elements CMS suggested for community-based palliative care, but with modifications to the language to not be physician-centric.**
- **AAPA recommends that CMS structure any explanatory language as inclusive of PAs, physicians, and NPs, in terms of who may certify and recertify eligibility, authorization to order these services, authorization to provide these services without restrictions, and authorization to be a required member of a patient's interdisciplinary team.**

Updates in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Recognition of Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) in Rural Health Clinics

Section 4105 of the Balanced Budget Act of 1997 authorized Medicare coverage of DSMT when the services are provided by a certified provider who meets certain quality standards. The program is designed to educate beneficiaries in the successful management of diabetes, including instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin dependent; and motivation for patients to use self-management skills. PAs and other qualified Medicare practitioners managing a beneficiary's diabetes must certify the need for the services and maintain the plan of care, along with any changes to the plan of care, in the beneficiary's medical record.

Section 1861(s)(2)(V) of the Social Security Act authorizes coverage of MNT for certain beneficiaries who have diabetes or a renal disease. MNT services are nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional to manage diabetes or a renal disease under a physician referral.

Historically, RHCs did not receive separate payment for DSMT or MNT. Rather, the service was considered included in the all-inclusive rate. However, both DSMT and MNT may be provided and billed for in FQHCs.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to authorize separate payment for DSMT and MNT in RHCs. Stakeholders have informed CMS that low utilization for these services in RHCs may result from the inability for RHCs to be separately compensated. In addition, CMS notes that studies have shown rising rates of diabetes and significant disparities in rural areas, and while separate payment is not the sole reason for this, expanding access to these services, which CMS indicates are clinically essential, in rural areas may mitigate these trends.

AAPA approves of CMS's proposed authorization to separately pay for DSMT and MNT in RHCs. A commitment to preventive care and chronic condition management must properly incentivize improved behavior, regardless of setting. However, the expansion of MNT to RHCs suggests CMS would likely agree that beneficiaries would benefit from fewer restrictions on receipt of these services generally.

MNT is a preventive service CMS previously identified as a high-value, potentially underutilized service. One explanation for this underutilization is the narrow definition of MNT, which indicates that only physicians are authorized to order MNT services. PAs are professional medical providers for patients with diabetes, cancer, kidney disease and other conditions in which MNT may be a necessary part of the treatment plan. However, language in the US Code, section 42 U.S.C. 1395x (vv)(1) reads as follows: "The term "medical nutrition therapy services" means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1))." This physician-only requirement results in administrative burden and delay in care for patients in need of these services, as patients must wait for a physician order. While the restriction

is statutory, if CMS seeks to expand therapeutic nutrition options for Medicare beneficiaries, the agency should work with Congress to modify 42 U.S.C. 1395x (vv)(1) to add "or a PA (as defined in subsection (aa)(5))" after (r)(1), which would authorize PAs to order Medical Nutrition Therapy.

Telehealth In RHCs and FQHCs

Section 3704 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) directed HHS to establish payment for telehealth services when RHCs and FQHCs are the distant site provider, to last for the duration of the public health emergency. This payment authorization has been extended by Congress several times since, most recently under Section 6209(c) Consolidated Appropriations Act of 2026, which would extend the ability for RHCs and FQHCs to provide non-behavioral health services via telehealth through December 31, 2027. The rule also implements section 6209(d), which delays RHC and FQHC requirements for an in-person visit prior to telehealth mental health visits (through December 31, 2027). This is similar to a flexibility implemented elsewhere in the rule regarding this same requirement outside of RHCs and FQHCs, discussed under the telehealth section of our comments. Meanwhile, the authorization for RHCs and FQHCs to provide mental health services via telehealth has been made permanent elsewhere.

AAPA approves of CMS implementing these statutory flexibilities and appreciates CMS efforts to minimize access burdens for patients who receive care through RHCs and FQHCs. These telehealth services have become a regular method of care provision since the COVID-19 pandemic. In line with our comments submitted to the 2026 Physician Fee Schedule, we continue to urge CMS to work with Congress to establish a more permanent solution to expiring telehealth flexibilities within RHCs and FQHCs.

Other Opportunities to Advance Diabetic Care Under Medicare: Therapeutic Shoes for People with Diabetes

AAPA approves of the policies included in this section regarding the coverage of diabetes-related services (such as DSMT and MNT). We believe this, in concert with other policy changes made in the 2027 Physician Fee Schedule proposed rule, such as Shared Medical Appointments, health coaching, and a new diabetes-focused MVP, shows a commitment by the agency to improve diabetic care. This would align with CMS priorities to improve care for manageable and modifiable health conditions to improve prevention and overall health outcomes.

As CMS has shown interest in improving and expanding diabetes services under the Medicare program, AAPA would like to propose an additional policy change for CMS to work with Congress to implement that could greatly enhance patient access to necessary diabetes treatment: authorizing PAs to prescribe diabetic/therapeutic shoes. PAs and NPs are authorized to order durable medical equipment. The exclusion of therapeutic shoes for patients with diabetes is a rare exception to this authority. PAs and NPs also commonly manage the care of patients with

diabetes. Currently, however, only a physician is authorized to certify the need for, and order, therapeutic shoes for people with diabetes.

Language in the US Code, section 42 U.S.C. 1395x (s)(12) reads as follows: "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if— (A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition."

These requirements require a PA's or NP's patient with diabetes to make an additional visit with a physician, solely to meet Medicare's physician certification and order requirements. This may cause additional access burdens or decrease patient satisfaction with the care experience. It may also increase costs to the patient and the Medicare system. AAPA requests that CMS support Congress in changing 42 U.S.C. 1395x(s)(12), subsections (A) and (C), to authorize PAs and NPs to certify the need for, and order, diabetic shoes. This will improve access to care and eliminate unnecessary physician visits and the cost associated with those additional visits.

AAPA Positions and Recommendations on this Topic

- **AAPA approves of CMS's proposed authorization to separately pay for DSMT and MNT in RHCs.**
- **AAPA implores CMS to work with Congress to modify 42 U.S.C. 1395x (vv)(1) to authorize PAs to order MNT generally.**
- **AAPA approves of CMS implementing statutory flexibilities that allow the agency to continue to pay for RHC and FQHC non-behavioral health telehealth services and urges CMS to work with Congress to establish a more permanent solution to the problem of regularly expiring telehealth flexibilities within RHCs and FQHCs.**
- **AAPA requests that CMS support Congress changing 42 U.S.C. 1395x (s)(12), subsections (A) and (C), to authorize PAs and NPs to certify the need for, and order, therapeutic shoes for patients with diabetes.**

Redesigning Primary Care Request for Information

In the 2027 Physician Fee Schedule proposed rule, CMS includes a lengthy RFI regarding the future of primary care. CMS calls primary care the cornerstone of the healthcare system and notes that it is essential to the administration's Make America Healthy Again initiative by providing preventive care over reactive medicine.

In the RFI, CMS issues a broad call for information on the future of primary care. Noting initial steps taken by the agency, such as Advance Primary Care Management services, CMS signals an intention to eventually move primary care payment from fee-for-service to outcomes-based payments or prospective primary care payments. CMS groups its RFI into three broad topics:

1) How to address the relative undervaluation of primary care services
2) Payment implications on technology-enabled primary care
3) Establishing Prospective Primary Care Payment under the Medicare Shared Savings Program (MSSP)

AAPA appreciates CMS's solicitation on various potential solutions to bolster primary care. Among our recommendations to the agency over the years, AAPA has consistently requested bold payment reforms, including reducing fee-for-service payments and adding a modified, risk-adjusted monthly payment. Accordingly, we welcome the broad request for information on several concepts to improve primary care and will address each topic in turn.

The Valuation of Primary Care Services

Under fee-for-service, primary care services are overwhelmingly paid for by O/O E/M visit codes that do not distinguish between one-time visits and those that are part of more resource-intensive longitudinal care. CMS indicates this has led to payment discrepancies that disadvantage primary care relative to specialties that frequently provide procedures or diagnostic tests. In response, CMS has increased the work RVUs for E/M services and created HCPCS code G2211 to provide extra compensation for longitudinal primary care services. However, CMS notes that E/M codes still fail to reflect differences in care provided and required intensity. To address this, CMS is considering establishing differing categories of O/O E/M codes that would distinguish between 1) longitudinal care, 2) acute care, and 3) consultative care (which is not currently paid by Medicare).

AAPA agrees with CMS that primary care services remain undervalued, given the agency's recognition of their role as the "cornerstone of healthcare." Proper incentivization of primary care services will require appropriate payment. While AAPA appreciates the intention of CMS to identify and incentivize longitudinal care, we are concerned regarding the potential burden of adding new families of codes that may increase reporting burden and confusion. AAPA suggests that the division of E/M codes into sub-categories would be a significant change in the longstanding practice of reporting E/M codes that would require re-education and training of most health professionals to report properly. For these reasons, AAPA would oppose separating E/M codes according to the proposal in the near term.

AAPA suggests that, should CMS plan to move forward with this concept, CMS pilot these codes under a voluntary model that would allow health professionals to opt in to usage of the new E/M code families sets. Initiating this concept as voluntary would allow CMS to collect feedback on implementation challenges and additional burdens associated with reporting more codes, and to assess scalability. Under a voluntary method, CMS would still need to provide clear answers on process details, such as varying valuations for different E/M code sets, time parameters for longitudinal E/Ms, and a method to clearly distinguish between longitudinal and acute care, to name a few. Such decisions should be made with public input if CMS progresses with this concept through a more formal process. CMS would also be required to undertake extensive public education of provider and billing professionals regarding appropriate scenarios for when each may be used, complete with clinical scenarios.

In the RFI, CMS also indicates that it is open to modifications to its care management codes (Transitional Care Management (TCM), Chronic Care Management (CCM), Principal Care Management (PCM), and Advanced Primary Care Management (APCM). CMS explains that uptake of these care management codes has been limited. In response to concerns that this was due to cost sharing and documentation requirements, CMS previously updated APCM, but uptake still has not reached anticipated levels. AAPA is open to a new, streamlined structure for care management services, as long as two principles can be adhered to: 1) any beneficiaries once eligible for care management services remain covered under a new system, and 2) there should not be a reduction in valuation for care management services. We note that the number of care management options, with varying requirements, may seem overwhelming and difficult for some providers to distinguish; therefore, simplification and consolidation/regrouping may help reduce the complexity of using these codes. The primary difference between CCM and PCM is management for one versus two or more serious chronic conditions. AAPA has noted that the severity of one chronic condition may require as much or more management than two or more chronic conditions. CMS could consider consolidating these two codes and removing the requirement for a certain number of serious chronic conditions. Further, like CCM and PCM, APCM seeks to provide management for all patient care. However, unlike CCM and PCM, this applies to patients with or without chronic conditions and does not contain a time requirement. CMS could consider simplifying the code set into one code for managing all care for patients without chronic conditions and one for managing all care for patients with one or more chronic conditions, and further consider whether these should align with a time component requirement. CMS should also review corresponding requirements for each type of care management service and assess feasibility of further simplifying associated stipulations where possible, as CMS has already done for APCM services documentation requirements. Regarding whether CMS should create a technology-enabled care management, AAPA recognizes the potential for technology to provide enhanced coordination but would need to hear more about the distinction between this form of care management and established care management options to ensure that the addition of such services is not simply exacerbating the increased complexity CMS is hoping to counter with consolidation of care management codes elsewhere.

Technology and Primary Care

AAPA believes modern technology has increasingly removed barriers to care and enabled patients to make more informed care decisions. Precision surgeries with less chance of human error, detection of conditions through advanced diagnostic tests, more durable retention of medical information through electronic health records, electronic prescribing, and simplified documentation and billing processes are just some of the positive recent technological developments that benefit patients. Other technologies that offer great benefits for patients, such as patient portals, artificial intelligence, and interoperability, continue to evolve and be implemented. AAPA supports CMS efforts to further empower patients through technology.

In the RFI, CMS requests feedback on the role of technology in care provision, both generally and specifically regarding artificial intelligence. CMS indicates that current uses of artificial intelligence are predominantly to reduce administrative burden (such as automating documentation) and to support clinical decision-making. CMS indicates that while artificial intelligence could support direct care delivery, this application is still in its infancy. CMS expects more data-driven, personalized care to lower the cost of care while increasing quality. However, CMS notes that valuing technology services is difficult because they evolve so quickly.

AAPA agrees with CMS's concerns about properly valuing specific technology services. We believe the solution may be to focus payment on improved outcomes, both clinical outcomes (such as reduced readmissions) and patient-reported outcomes (such as receiving care and monitoring virtually, patient satisfaction, etc.). In addition to focusing on outcomes, CMS may wish to continue making separate payments for select technology-related services to encourage adoption and use of specific emerging or promising technologies.

In the RFI, CMS asks about the role of technology in both increasing uptake of Annual Wellness Visit services and enhancing their effectiveness. AAPA believes technology offers significant opportunities to achieve these goals. Technology can remind beneficiaries of their eligibility for Annual Wellness Visits and alert them when it has been a year since their previous Annual Wellness Visit appointment. Technology may also extend the benefits of an Annual Wellness Visit by synthesizing historical and clinical data to identify potential warning signs that warrant further care and suggest clinical options. It may also develop customized treatment plans and communicate them to patients through simplified, understandable messages. Technology can enable instant communication regardless of location, such as transferring a patient's medical information at will and issuing prescriptions immediately. Wearable technology may also monitor patient status and send updates to primary care providers responsible for longitudinal care between Annual Wellness Visits. Technology may even use data from monitoring services to update treatment plans as needed and alert patients when in-person follow-up care is advised. Finally, technology may help synthesize federal and state health policy changes that are often difficult to understand and explain in plain language what they will mean for affected beneficiaries when necessary. For these promising reasons, AAPA

supports broad use of technology in the provision of patient-centered primary care, especially to encourage uptake and enhance the quality of Annual Wellness Visits.

AAPA notes that, despite technology's promise, CMS must continue to set privacy standards for authorized technology. In addition, if CMS chooses to develop codes that pay for various technologies, the agency should avoid physician-centric language when identifying which health professionals may order, use, and interpret data from these technologies. Finally, CMS must formally acknowledge that technology may have limits that require proper oversight, such as provider oversight of technology-generated clinical assessments or payer oversight of automated prior authorization eligibility authorizations/denials.

AAPA believes that CMS could support increased use of technology to benefit patients in several additional ways. First, because a significant barrier to using emerging technologies is often the burden of initial adoption, the agency could offer direct technical assistance to practitioners using certain technologies to support adoption and optimization, as CMS has done in the past with various required technologies. Second, because many beneficial technologies may have limited awareness of their potential benefits and risks, CMS should widely report on promising or innovative technologies and best practices for technology implementation and use. Third, because data reporting requirements may vary by request, CMS should offer multiple methods for providers and payers to submit data and clearly identify submission requirements for each. Finally, because extensive data submission can often feel more like a burden than an important process, CMS may alleviate data reporting fatigue by clearly justifying the requested data and showing how it will be used to improve care accountability and the beneficiary experience.

Additional Recommendations to Improve Primary Care

As noted earlier in our comments to the RFI, AAPA supports CMS doing more to bolster primary care. According to a report from the Health Resources and Services Administration, the US health system is experiencing a clinician shortage, particularly in primary care.[8] A shortage in the primary care workforce may lead to insufficient patient access to needed healthcare services and to more intensive, high-cost interventions such as hospitalization or emergency care.[9] AAPA appreciates that some of our previous policy recommendations, such as reducing fee-for-service payments with the addition of a modified risk-adjusted monthly payment, have made their way, in some form, into the request for information. However, in addition to those discussed above, AAPA recommends

[8] Westat. 2015. Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4. https://aspe.hhs.gov/reports/impact-state-scope-practicelawsother-factorspractice-supplyprimary-care-nurse-practitioners
[9] Shi, Leiyu. 2012. The impact of primary care: a focused review. https://pubmed.ncbi.nlm.nih.gov/24278694/

exploring additional types of payment approaches and methodologies to boost primary care participation and solvency, such as:

- Enhancing scholarship and loan repayment assistance programs for PAs in exchange for a certain number of years practiced in primary care.
- Testing through the Center for Medicare and Medicaid Innovation the concept of 100% reimbursement for PAs when providing primary care.
- Promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA practice in federal health programs.
- Encouraging states to eliminate state-level legislative and regulatory barriers that either hinder PAs from practicing to the highest level of their education and expertise, or hinder their ability to autonomously practice, like requirements for physician co-signatures or stringent oversight.
- Eliminating patient cost sharing for preventive APCM services to make participation more attractive.
- Evaluating APCM and other care management utilization and determining whether health professionals may be abstaining from participating due to the existing payment structure not aligning with the realities of modern primary care delivery, and if beneficial, to boost care management payment, with an additional financial incentive for ACO participants.

AAPA also suggests modifications to increase uptake of Annual Wellness Visits. Annual Wellness Visits allow beneficiaries to have regular discussions with their health professionals about care concerns and provide benchmarks to identify trends that may portend chronic disease. We suggest that CMS seek further information through surveys of beneficiaries regarding the primary reason those who choose not to take part in an Annual Wellness Visit made that decision. There may be educational opportunities, as some beneficiaries may not know about the option or that it can be done free of charge. CMS may also want to share best practices with health professionals on outreach to beneficiaries about Annual Wellness Visits, including incentive campaigns shown to work, reminder methods, and more. In addition, while PAs and NPs are authorized to perform the annual wellness visit, they are statutorily prohibited (42 U.S.C. 1395x (hhh)(3)(C)) from supervising other medical professionals/staff performing these services. Instead, the direct supervision of a physician is required. This may limit the number of Annual Wellness Visits that can be performed, as some settings may not have a physician available to provide such supervision. As such, AAPA requests that CMS work with Congress to revise 42 U.S.C. 1395x (hhh)(3)(C) to allow PAs to supervise other medical professionals and staff performing Annual Wellness Visit services. In the meantime, CMS could authorize physicians to provide general supervision of staff performing the Annual Wellness Visit.

AAPA Positions and Recommendations on this Topic

- **AAPA agrees with CMS that primary care services continue to be undervalued and require sufficient valuations to encourage prioritization.**
- **AAPA is concerned about the potential burden of adding new families of codes that may increase reporting burden and confusion and would oppose separating E/M codes according to the proposal in the near term.**
- **AAPA suggests that if CMS plans to move forward with the concept of separating E/M codes into three categories, CMS pilot these codes under a voluntary model that would allow health professionals to opt in to the use of the new E/M code families.**
- **AAPA is open to a new, streamlined structure for care management services, as long as two principles can be adhered to: 1) any beneficiaries once eligible for these care management services remain covered under a new system, and 2) there should not be a reduction in valuation for care management services.**
- **AAPA suggests that CMS could look to CCM and PCM for possible consolidation with removal of a requirement for a certain number of serious chronic conditions.**
- **AAPA encourages CMS to review corresponding requirements for each of the care management service codes and assess feasibility of further simplifying associated stipulations where possible.**
- **Regarding whether CMS should create a technology-enabled care management code, AAPA recognizes the potential for technology to provide enhanced coordination but would need to hear more about the distinction between this form of care management and established care management options to ensure that the addition of such services is not simply exacerbating the increased complexity CMS is hoping to counter with consolidation of care management codes elsewhere.**
- **AAPA agrees with CMS concerns regarding identifying the proper valuation of specific technology services. We believe the solution may be to focus payment on improved outcomes while making separate payment for select technology-related services to encourage the use of specific emerging or promising technologies.**
- **AAPA recommends that, if CMS chooses to develop codes that make payment for various technologies, the agency should refrain from using physician-centric language when identifying which health professionals may order, utilize, and interpret data from these technologies.**
- **AAPA supports broad use of technology in the provision of patient-centered primary care, especially in encouraging uptake and enhancing quality of the Annual Wellness Visit.**
- **AAPA believes that CMS must formally acknowledge that technology may have limits that require proper oversight, such as provider oversight of technology-generated clinical assessments or payer oversight of automated prior authorization eligibility authorizations/denials.**
- **AAPA suggests that CMS offer direct technical assistance to those practitioners utilizing certain technologies to help in their adoption and optimization.**

- **AAPA notes that, as there may be limited awareness of many beneficial technologies available and their potential benefits and risks, CMS should widely report on promising or innovative technologies and best practices for technology implementation and use.**
- **AAPA recommends that CMS offer multiple methods through which providers and payers may submit data to CMS and provide clearly identified submission requirements for each.**
- **AAPA proposes that CMS may alleviate data reporting fatigue by providing clear justification for requested data, illustrating how the data will be used to improve care accountability and beneficiary experience.**
- **AAPA identifies various opportunities to boost primary care, including additional scholarship and loan repayment assistance programs in exchange for a certain number of years practiced in primary care, testing through the Center for Medicare and Medicaid Innovation the concept of 100% reimbursement for PAs when providing primary care, promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA practice in federal health programs, encouraging states to eliminate legislative and regulatory barriers that hinder PAs from practicing to the highest level of their education and expertise, increasing the autonomy of health professionals practicing in primary care, working with states to encourage the elimination of burdensome practice requirements, such as requirements for physician co-signatures or direct oversight, eliminating patient cost sharing for preventive APCM services to make participation more attractive, and evaluating APCM and other care management utilization and determine whether health professionals may be abstaining from participating due to the existing payment structure not aligning with the realities of modern primary care delivery, and if beneficial, to boost care management payment, with an additional financial incentive for ACO participants.**
- **AAPA recommends that, to further incentivize beneficiary utilization of the Annul Wellness Visit, CMS work with Congress to revise 42 U.S.C. 1395x (hhh)(3)(C) to allow PAs to supervise other medical professionals and staff performing Annual Wellness Visit services. In the meantime, CMS could authorize physicians to provide general supervision of staff performing the Annual Wellness Visit.**

Practice Expense Updates

Practice Expense (PE) RVUs reflect the relative resources required to furnish services. In the 2026 Physician Fee Schedule, CMS made significant changes to practice expense by reducing the portion of the facility practice expense RVUs allocated based on work RVUs to half the amount allocated to non-facility practice expense RVUs. In the 2027 Physician Fee Schedule proposed rule, CMS seeks to make further changes to the way in which it calculates Practice Expense.

One proposed policy change is to phase out the Indirect Practice Cost Index (IPCI) over the next two years. The IPCI currently adjusts PE RVUs based on specialty-level practice cost data collected in a 2007 survey conducted by the American Medical Association. CMS indicates that this data, nearly two decades old, is now likely outdated and unrepresentative, and that the conclusions are based on "small, selective samples based on pre-determined assumptions about where costs are likely to differ." CMS further notes that the IPCI favors aggregate specialty-level data instead of more preferable code-level inputs. Some stakeholders have advocated for eliminating the IPCI, arguing that certain specialties were disadvantaged because the data relied on averages of indirect costs.

While CMS expects removing the IPCI will improve the stability of expense determinations over time, the agency acknowledges that the IPCI has stabilized year-to-year changes in PE RVUs. To mitigate volatility from the transition from the IPCI to more objective data, CMS is also proposing to limit annual increases or decreases in PE RVUs to +/- 5 percent through a "stabilization adjustment." This cap on PE RVU changes does not apply to services that are new, revalued, or revised, as it depends on a comparison with the previous year's RVUs.

AAPA shares CMS's goal of replacing the IPCI with accurate data based on objective assessments of specialty indirect costs while provoking minimal disruption. However, while AAPA supports more accurate valuations and the importance of using recent, granular, empirical data over averages determined by outdated surveys, we do not believe CMS has provided sufficient analysis of the impact of this change. AAPA requests that CMS provide additional information and analyses regarding the effect of this change on code valuations and whether this transition will have a dramatic effect that disadvantages certain types of providers or providers in certain care settings. CMS should also provide longer-term impact estimates that extend beyond the expiration of the stabilization adjustment. If CMS proceeds with this policy, AAPA requests that CMS collect data on the practical effects of PE RVU valuation changes and, for transparency, provide updates in future fee schedule rules, leaving open the possibility of modifying the policy further if unintended effects result. Meanwhile, AAPA appreciates CMS's proposal for the stabilization adjustment to mitigate large short-term swings in PE RVUs.

AAPA Positions and Recommendations on this Topic

- **AAPA recommends that CMS provide additional information and analyses regarding the effect of this change on code valuations and whether this transition will have a dramatic effect that disadvantages certain types of providers or providers in certain care settings.**
- **AAPA suggests that CMS should provide longer-term impact estimates that extend beyond the expiration of the stabilization adjustment.**
- **Should CMS proceed with this policy, AAPA requests that CMS collect data on the practical effects on PE RVU valuation changes, and, for the sake of transparency, provide updates in future fee schedule rules**

- **AAPA appreciates CMS's proposal for the stabilization adjustment in an effort to mitigate large short-term swings of PE RVUs.**

The Role of the CPT and the RUC

In a Request for Information, CMS asks about the American Medical Association's (AMA) role in developing and maintaining codes through the CPT Advisory Group and CPT Editorial Panel and in informing code valuation through the Relative Value Scale Update Committee (RUC), noting that the AMA owns and holds the copyright to CPT codes. CMS also provides historical background regarding its longstanding collaboration with the AMA in establishing and valuing codes for services under Medicare. CMS indicates that regulations that interpret the Health Insurance Portability and Accountability Act of 1996 (HIPAA), rather than the statute itself, require CMS to use CPT-4 in combination with HCPCS codes. As a result, CMS notes that it retains regulatory discretion regarding the coding standards used for Medicare claims and is seeking input on whether additional flexibility or alternative approaches may be warranted.

While CMS has long relied on CPT Editorial Panel recommendations and RUC data, the agency notes "longstanding concern" with federal reliance on these processes. MedPAC has similarly noted concern regarding "overreliance" on the RUC, suggesting CMS should establish a separate group of experts to make payment recommendations. In the 2027 Physician Fee Schedule, CMS asks for input regarding potential modifications to, or alternatives within, the current coding framework.

AAPA shares the concerns about the CPT and RUC processes. Both should be informed by objective data, conflicts of interest should be minimized, and no entity should financially benefit from the development and maintenance of the codes. Additionally, the processes should fully reflect the different types of medical professionals and stakeholders who use the codes. AAPA recognizes that the process needs improvement but given the healthcare industry's longstanding reliance on CPT codes, developing an alternative system would take considerable time and resources. To avoid potential administrative burden to providers, health systems, and payers, AAPA recommends specific modifications to the current system that would increase objectivity and representation.

The code valuation process utilized by the RUC relies on survey methodology that CMS has sought stakeholder input regarding potential improvements. In the 2026 Physician Fee Schedule proposed rule, CMS noted that new methods to identify this same information have been developed. AAPA agrees that, to the extent possible, the valuation of services should be based on objective, timely data and with input from all practitioners, including PAs.

As such, AAPA encourages CMS to supplement the RUC recommendations with empirical evidence or input from an independent advisory group that is representative of practitioners, including PAs, and other stakeholders.

The current CPT Editorial Panel, despite assertions that it is "representative of all medical professionals," is comprised of 19 allopathic and osteopathic physicians, a podiatrist, and a chiropractor.[10] It includes no PAs, APRNs, therapists, or other clinicians, who also use these codes. Also, while these latter practitioners can participate in the CPT Advisory Group, which provides recommendations to the voting members of the CPT Editorial Panel, they are considered a subgroup of participants in the Health Care Professionals Advisory Committee (HCPAC) and do not individually have voting rights.

Similarly, most participants in the CPT Advisory Group and RUC are also physicians. This is because, aside from HCPAC members, the AMA requires that advisors represent medical specialty organizations in which physicians comprise the majority of the voting members of the organization. In addition, the AMA requires those specialty organizations to have AMA-member physicians to participate. For example, the AMA requires:

> "(a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA."[11]

These requirements promote an AMA membership holding physician majority in the CPT Advisory Group and CPT Editorial Panel and mandate AMA membership for a significant number of physicians.

Physicians are not the sole users of CPT codes, and they will soon not be the primary users. Even now, looking only at physicians, PAs, and APRNs, physicians account for about 60 percent of CPT users (1 million physicians versus 700,000 PAs and APRNs). That estimate is expected to drop to 50 percent within the next ten years and does not account for the numerous other clinicians (e.g., counselors, pharmacists, podiatrists, chiropractors, and others) who also use these codes. The RUC similarly over-relies on physicians, with 31 of its 32 committee members being allopathic and osteopathic physicians.[12] Therefore, AAPA recommends that the CPT Editorial Panel, CPT Advisory Group, and RUC, and any successor entities, include all practitioners who use CPT codes equally and to the same extent as physicians. If a coding system like the current process is maintained, PAs should have permanent PA

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[10] American Medical Associations. *The purpose of the CPT® coding system & the CPT® Editorial Panel.* Updated April 24, 2026. https://www.ama-assn.org/about/cpt-editorial-panel/purpose-cpt-coding-system-cpt-editorial-panel

[11] American Medical Association. *Governance: Admission of specialty organizations to our AMA House G-600.020.* Updated 2019. https://policysearch.ama-assn.org/policyfinder/detail/600.020?uri=%2FAMADoc%2FHODGOV.xml-0-8.xml

[12] American Medical Association. *Composition of the RVS Update Committee (RUC*). Updated Feb 19, 2026. https://www.ama-assn.org/about/rvs-update-committee-ruc/composition-rvs-update-committee-ruc

voting members to promote meaningful representation in decisions about the codes that describe and support the payment for the care they provide.

AAPA Positions and Recommendations on this Topic

- **AAPA shares concerns regarding the CPT Editorial Panel and the RUC.**
- **AAPA believes a thoughtful, measured approach to change is warranted, including equal representation of all provider groups and, if possible, dispersed oversight among various healthcare professional organizations.**
- **AAPA suggests complementing the current valuation process with empirical evidence and/or an independent advisory group.**
- **AAPA believes that voting members of the CPT Editorial Panel should represent the professionals who use CPT codes.**
- **AAPA believes that if any independent advisory group or alternative to the CPT Editorial Panel and RUC is developed, it should be inclusive of all practitioners who use the codes, including PAs.**

Behavioral Health

AAPA continues to commend CMS for its years-long commitment to improving behavioral health care. In the 2027 Physician Fee Schedule proposed rule, CMS again speaks directly regarding the importance of accessible behavioral health services. In the rule, CMS also makes policy changes to support this claim, including proposals to increase the work RVUs and, thus, payment for Psychiatric Collaborative Care Model (CoCM) and Advanced Primary Care Management Behavioral Health Integration (APCM BHI) add-on codes. CMS is also proposing to include smoking and tobacco use cessation services and Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in this final year of the transition for timed behavioral health codes, which would increase the payment (work RVUs) for several services to support chronic care and behavioral health condition management.

AAPA approves of CMS's proposed increases in payment for several behavioral health services. Elsewhere in our comments, AAPA has expressed approval for other policies contained in CMS's 2027 Physician Fee Schedule proposed rule that seek to further address behavioral health concerns (such as addressing social isolation through shared medical appointments) and expand access to behavioral health (Extension of the flexibility to not require an in-person visit prior to providing mental health services via telehealth). AAPA notes these are positive steps toward expanding access to, coverage of, and the types of behavioral care available, but also notes additional opportunities within CMS's purview to further advance these goals.

Untreated mental and behavioral health conditions can result in disability, isolation, substance abuse, family discord, and death.[13] Unfortunately, while demand for mental health services is increasing, this increase is causing patient access to decrease.[14] Several factors contribute to these access obstacles, including workforce shortages.

Mental and behavioral health, like healthcare more broadly, is facing worsening provider shortages, compounding existing access issues. 122 million people reside in communities with limited access to mental health services.[15] As many as 65% of non-metropolitan counties have no practicing psychiatrists and limited numbers of psychologists or social workers, significantly limiting access to needed behavioral health treatment and contributing to inadequate care and unsafe conditions.[16] The Association of American Medical Colleges found that while half of U.S. counties lack a single psychiatrist, roughly 60% of current physician psychiatrists are aged 55 or older.[17] The National Center for Health Workforce Analysis projects that by 2030, 44 states will have fewer psychiatrists than needed to meet the demand for services.[18] Even now, fewer than 20% of psychiatrists are available to see new patients, and the median wait time for telehealth and in-person behavioral health visits is 43 days and 67 days, respectively.[19] Additionally, the American Psychiatric Association found that the supply of adult psychiatrists is expected to decrease by 20% by 2030 and emphasized that efforts to increase the supply of mental health and addiction professionals should be a "central component of legislation intended to enhance access to mental health or substance use disorder treatment."[20] An inadequate supply of providers of behavioral/mental health services may lead to delays in diagnosis and care, rationing of resources, ineffective care, and increased negative consequences of mental illness and substance use.[21] These problems will be even more severe in rural and underserved areas.

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[13] Mayo Clinic. Mental Illness. https://www.mayoclinic.org/diseases-conditions/mental-illness/symptomscauses/syc20374968. Dec 13, 2022
[14] American Psychological Association. Increased need for mental health care strains capacity. https://www.apa.org/news/press/releases/2022/11/mental-health-care-strains. Nov, 2022
[15] Health Resources and Services Administration, Department of Health and Human Services. Health Workforce Shortage Areas. January 9, 2025. https://data.hrsa.gov/topics/health-workforce/shortage-areas
[16] Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. J Clin Transl Sci. 2020;4(5):463-467. May 4 2020. doi:10.1017/cts.2020.42 https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/#r6
[17] Weiner, S. A growing psychiatrist shortage and an enormous demand for mental health services. AAMC. 9 Aug 2022. https://www.aamc.org/news/growing-psychiatrist-shortage-enormous-demand-mental-health-services
[18] National Center for Health Workforce Analysis, Bureau of Health Workforce, Health Resources and Services Administration, Department of Health and Human Services. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. September 2018. https://bhw.hrsa.gov/sites/default/files/bureauhealthworkforce/data-research/state-level-estimates-report-2018.pdf
[19] Sun CF, Correll CU, Trestman RL, et al. Low availability, long wait times, and high geographic disparity of psychiatric outpatient care in the US. General Hospital Psychiatry. 2023;84:12-17. doi:10.1016/j.genhosppsych.2023.05.012
[20] Workforce Development. www.psychiatry.org. https://www.psychiatry.org/psychiatrists/advocacy/federalaffairs/workforce-development
[21] National Council for Mental Wellbeing. The psychiatric shortage: Causes and solutions. https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/. March 2018.

As qualified behavioral and mental health service providers, PAs are crucial to increasing beneficiary access to essential care. PAs are trained and qualified to treat behavioral and mental health conditions through their medical education,[22] including didactic instruction and clinical practice experience in psychiatry, behavioral and mental health conditions, substance use disorders, and other relevant disciplines, and have national certification, state licensure, and authority to prescribe controlled and noncontrolled medications. Based on their graduate-level medical education, PAs graduate with more than 2,000 hours of clinical practice experience, including in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan, from pediatrics to geriatrics.[23] This provides a foundation for addressing the diverse medical needs of people with mental illness or substance use issues. PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral and mental health services.

PAs perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans; and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists.[24] In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral/mental health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs have been shown to improve access to high-quality care and increase patient satisfaction similar to physicians.[25] PAs work to ensure the best possible care and outcomes for patients in every specialty and setting, interacting with patients with mental and behavioral conditions in psychiatry, family medicine, internal medicine, emergency medicine, and other specialties. Payers authorizing PAs to deliver high-quality behavioral and mental health care, as allowed under Traditional Medicare, can help address ongoing and worsening trends in access to behavioral and mental health services.

PAs are a growing profession that can help meet demand. The National Commission on Certification of Physician Assistants, the only certifying organization for PAs in the United States, published a statistical profile of PAs in the

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[22] ARC-PA. Accreditation Standards for PA Education. 6th Ed. 2025. https://www.arc-pa.org/wpcontent/uploads/2025/10/Standards-6e-10-03-25-Pub-10-09-25.pdf
[23] American Academy of Physician Associates. Accessed January 2, 2026. What is a PA? https://www.aapa.org/what-is-apa/
[24] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. Am J Prev Med. 2018. https://pubmed.ncbi.nlm.nih.gov/29779543/
[25] Medicare Payment Advisory Commission. 2019. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. https://www.medpac.gov/document-type/report/

U.S. in 2025 showing there are over 200,000 PAs, with a marked growth of 26.9% from 2021 to 2025.[26] The PA profession is one of the fastest-growing occupations per the Bureau of Labor Statistics,[27] with a projected 21% increase in PAs from 2025 to 2035. Furthermore, national trends[28] show an increase in non-physician practitioners with nearly 40% of all clinical encounters now being provided by non-physicians. This growth will maintain the high quality of care received by patients. The Medicare Payment Advisory Commission has noted[29] that based on a "large body of research, including both randomized clinical trials and retrospective studies using claims and surveys" the quality of PA-provided care "produces health outcomes that are equivalent to physician-provided care."

The number of PAs practicing in psychiatry has remained low due to restrictions placed on PAs by some payers. However, the recognition of PAs as qualified providers of mental and behavioral health services can increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st Century Cures Act,[30] CMS's inclusion of PAs as authorized providers in community mental health centers,[31] and the establishment of PAs as mental and behavioral health providers at the state level.

This growth projection, along with PAs' qualifications, suggests that increased PA utilization will be an effective way to enhance behavioral health care delivery and efficiency. However, to sufficiently address access challenges, all qualified health professionals should be authorized to practice to the full extent of their education, training, experience, and license. As such, we encourage CMS to implement additional access-enhancing policies.

Private Payers and Coverage of Behavioral Health Services Provided by PAs

While Traditional Medicare, many state Medicaid programs, and some commercial payers cover behavioral and mental health services provided by PAs, some private payers, many of which interact with Medicare and its

[26] National Commission on Certification of Physician Assistants. Statistical Profile of Board Certified Physician Assistants: Annual Report. 2025. https://www.nccpa.net/wp-content/uploads/documents/2025-Statistical-Profile-ofBoard-Certified-PAs.pdf
[27] US Bureau of Labor Statistics, US Department of Labor. Occupational Outlook Handbook. Physician Assistants. August 28, 2025. https://www.bls.gov/ooh/healthcare/physician-assistants.htm
[28] Shryock, T. Nonphysician clinicians make up 40% of U.S. health care workforce, report finds. Medical Economics. May 7, 2025. https://www.medicaleconomics.com/view/non-physician-clinicians-make-up-40-of-u-s-health-careworkforce-report-finds
[29] Medicare Payment Advisory Commission. 2019. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reportsjun19_medpac_reporttocongress_sec-pdf/
[30] 21st Century Cures Act. Public Law No: 114-255 2016. https://www.congress.gov/bill/114th-congress/housebill/34
[31] Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. https://www.law.cornell.edu/cfr/text/42/485.904

beneficiaries through the provision of MA plans, do not. Private payers should authorize payment for all behavioral and mental health services provided by PAs that are performed in compliance with state law.

Private payers removing policies that may act as barriers to behavioral and mental healthcare will allow greater utilization of the PAs that currently practice in behavioral and mental health, as well as encourage more PAs to practice in psychiatry and related specialties. The increased demand for behavioral and mental health services requires contributions from all qualified health professionals, without restrictions that constrain access to care.

AAPA requests that CMS require all payers who offer a plan under the purview of the agency, such as MA plans, Medicaid fee-for-service and managed care plans, CHIP fee-for-service and managed care plans, and plans offered on the Federally Facilitated Exchange, to eliminate prohibitive policies and authorize PAs to provide behavioral and mental health services based on alignment with their education, training, and experience. This would align the behavioral and mental health policies under these plans with those of Traditional Medicare and ensure that beneficiaries covered by these plans have the same qualified care options.

Community Mental Health Centers

Regulatory language regarding Community Mental Health Centers continues to be phrased in a manner that can be interpreted as restricting non-physician health professionals from providing certain services. Specifically, 42 CFR §485.914(e)(3)(iii) and §485.916(a)(3) use physician-centric language regarding Community Mental Health Centers, including a requirement for the inclusion of only physician orders on a discharge summary and the lack of explicit inclusion of PAs on the interdisciplinary treatment team. Physician-centric language regarding "physician orders" on a discharge summary may be strictly interpreted in a manner that would result in only a subset of orders related to a patient's care (i.e., those issued by a physician) being included in the summary, and omit orders made by non-physician health professionals. This may then provide patients with incomplete information regarding the care they received. Meanwhile, the omission of PAs by name in the list of those who may participate on an interdisciplinary team starkly conflicts with §485.916(a)(1), which authorizes PAs to lead such teams. AAPA recommends that CMS revise §485.914(e)(3)(iii) and §485.916(a)(3) to be inclusive of PAs.

Restrictive Local Coverage Determinations

Some restrictions remain on PAs helping formulate treatment plans and providing certain services that are occasionally used in behavioral health treatment and management. Specifically, Local Coverage Determination (LCD) L34353 regarding Outpatient Psychiatry and Psychology Services indicates that only physicians may prescribe and establish an individualized treatment plan for outpatient psychiatry and psychology services and bill for electroconvulsive therapy. Removing these limitations would improve access to behavioral and mental health

services and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain services and treatment plans that their PA could otherwise provide. AAPA recommends that CMS work with Medicare Administrative Contractors to standardize LCD policies regarding the provision of behavioral health care and, in the case of LCD L34353, authorize PAs to prescribe and establish individualized treatment plans for outpatient psychiatry and psychology services and bill for electroconvulsive therapy. CMS may wish to consider issuing an NCD to make policy within various localities consistent.

Inpatient Psychiatric Services

PAs are trained and qualified to diagnose and manage behavioral and mental health conditions, including determining medical necessity for psychiatric hospitalization. They perform psychiatric evaluations, manage medications, and develop treatment plans in collaboration with psychiatrists and other clinicians. However, current statutory language (42 USC § 1395f) and federal regulation (42 CFR § 424.14) unnecessarily restrict PAs from certifying and recertifying the necessity for inpatient psychiatric services. Similarly, statutory language (42 USC § 1395(ff)) restricts PAs from prescribing or supervising partial hospitalization services. These restrictions present a significant barrier to timely access and coordination of care, especially in rural and underserved areas where psychiatrists are in short supply. Restrictions on the ability of PAs to prescribe or supervise services or certify care that they are already delivering undermine both patient access and the efficiency of psychiatric facilities.

AAPA encourages CMS to take concurrent actions to ease and eventually eliminate the burden of these restrictions. For immediate burden relief, we recommend regulatory action to provide additional flexibility that the agency has already provided in similar situations. Specifically, AAPA suggests modifying the language regarding certification of need for inpatient psychiatric hospital services to align with requirements for certification for general inpatient hospital services. Language regarding general inpatient hospital services, found at 42 § 424.13, indicates a requirement for physician certification only if a) the inpatient stay is expected to last at least 20 days, or b) the need for inpatient status is an outlier case. AAPA recommends that CMS apply the same standard to inpatient psychiatric hospital services, removing the certification requirement for stays expected to last less than 20 days and for non-outlier cases. This would cover most inpatient psychiatry visits, as the average length of stay is 5-6 days.[32] In cases where certification remains required, AAPA recommends authorizing PAs to provide this certification with a physician co-signature. This would be similar to the Medicare policy to authorize a physician to co-sign a PA's documentation for therapeutic shoes for persons with diabetes, which otherwise has a statutory requirement of physician certification.[33] These regulatory flexibilities would immediately remove barriers to

[32] Hyuntaek Oh, Jaehoon Lee, Seungman Kim, Katrina A. Rufino, Peter Fonagy, John M. Oldham, Bella Schanzer, Michelle A. Patriquin, Time in treatment: Examining mental illness trajectories across inpatient psychiatric treatment. Journal of Psychiatric Research. 2020;130:22-30. https://doi.org/10.1016/j.jpsychires.2020.07.001
[33] Centers for Medicare and Medicaid Services. Therapeutic Shoes for Persons with Diabetes - Policy Article. December 5, 2024. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52501

patients accessing needed psychiatric services in a timely manner while still meeting statutory physician certification requirements when certification is needed.

Concurrently, CMS should also provide guidance to Congress to remove the ongoing statutory restrictions (e.g., explicitly authorize PAs to certify and recertify inpatient psychiatric services). Congress looks to the agency for its expertise on the intricacies of health policy and significant dialogue and cooperation occur between CMS and legislative bodies. As such, AAPA believes CMS can increase patient access to care in Inpatient Psychiatric Facilities (IPFs) by communicating certain recommendations to Congress for future consideration.

Additionally, sections B106, B107, B109, and B110 of the State Operations Manual: Appendix AA[34] contain ambiguous language in outlining requirements and guidance for admissions to psychiatric hospitals, psychiatric and neurological evaluations, and documentation of patient care in IPFs. While regulations do not prohibit PAs and other non-physician practitioners from conducting these assessments, the guidance implies that such services and evaluations must be performed exclusively by physicians. This ambiguity has led to inconsistent interpretations across facilities and surveyors, creating confusion and sometimes delaying patient admission or care transitions. AAPA recommends updating the language in the identified sections to include "physicians or other licensed practitioners" where appropriate to ensure patient care is not disrupted by barriers created by varying interpretations. While helpful modifications were made to the September 5, 2025, transmittal,[35] the manual for Psychiatric Hospitals[36] and others[37] contain inconsistent and confusing physician-centric language that should be addressed. As such, AAPA requests updating these manuals with the transmittal language to avoid conflicting language and confusion.

AAPA has recently met with CMS IPF staff to convey these concerns. After the meeting, AAPA provided stepwise recommendations for immediate and long-term actions that mirror those made here. If CMS pursues these actions, we believe they could improve patient access to care in IPF settings.

AAPA Positions and Recommendations on this Topic

- **AAPA approves of CMS's proposed increases in payment for several behavioral health services.**

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[34] State Operations Manual Appendix AA - Psychiatric Hospitals – Interpretive Guidelines and Survey Procedures. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_aa_psyc_hospitals.pdf
[35] Revisions to Hospital – Appendix A of the State Operations Manual. September 5, 2025. https://www.cms.gov/files/document/qso-25-24-hospitals-original-release-date-2025-09-05.pdf
[36] State Operations Manual Appendix AA - Psychiatric Hospitals – Interpretive Guidelines and Survey Procedures. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_aa_psyc_hospitals.pdf
[37] State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

- **AAPA has expressed approval for other behavioral health services policy changes noted elsewhere in our comments such as shared medical appointments and the extension of the flexibility to not require an in-person visit prior to providing mental health services via telehealth.**
- **AAPA requests that CMS require all payers who provide a plan under the purview of the agency, such as Medicare Advantage Plans, Medicaid fee-for-service and managed care plans, CHIP fee-for-service and managed care plans, and plans offered on the Federally Facilitated Exchange, to eliminate prohibitive policies and authorize PAs to provide behavioral and mental health services.**
- **AAPA recommends that CMS revise §485.914(e)(3)(iii) and §485.916(a)(3) to include PA orders on discharge summaries and explicitly include PAs on interdisciplinary teams in Community Mental Health Centers.**
- **AAPA suggests that CMS work with Medicare Administrative Contractors to standardize LCD policies regarding the provision of behavioral health care and, in the case of LCD L34353, authorize PAs to prescribe and establish individualized treatment plans for outpatient psychiatry and psychology services and bill for electroconvulsive therapy.**
- **AAPA requests that CMS take regulatory action as outlined above to ease the burden of these existing statutory restrictions and associated regulations regarding certifying inpatient psychiatric services (42 CFR § 424.14 and 42 CFR § 424.24) by advancing flexibilities within your authority to remove barriers to patients accessing needed psychiatric services in a timely manner. These regulatory flexibilities would mirror existing flexibilities CMS has implemented elsewhere in similar contexts.**
- **AAPA requests that CMS work with Congress to amend 42 USC § 1395f(a)(2) to explicitly authorize PAs to certify and recertify inpatient psychiatric services and amend 42 USC § 1395x(ff) to authorize PAs to order and supervise partial hospitalization services.**
- **AAPA requests that CMS update its subregulatory language contained in Sections B106, B107, B109, and B110 of the State Operations Manual: Appendix AA to remove ambiguous language that could be interpreted as a restriction on PAs performing psychiatric evaluations, neurological evaluations, or documenting in the medical record.**

CMS Efforts Regarding Efficiency and Transparency

Throughout the 2027 Physician Fee Schedule proposed rule, CMS makes clear its commitment to policies that favor efficiency and transparency. For example, in the proposed rule, CMS discusses increasing efficiency by consolidating care management codes, incentivizing the use of artificial intelligence, improving the efficiency of the Welcome to Medicare Visit and Annual Wellness Visit, and promising efficiency through the shared savings program and electronic prescribing. CMS mentions that one of the five strategic goals of the Rural Health

Transformation program is to "Improve the efficiency and long-term sustainability of rural health care providers as enduring access points for care." CMS even goes so far as to say, "Central to CMS's strategic goals is protecting the taxpayer by improving program efficiency and integrity and reducing administrative burden." AAPA supports CMS's commitment to policies that increase efficiency, and we seek to identify and support such policies when possible. However, AAPA is aware of several additional opportunities within CMS's purview to further enhance the efficiency of care provided to beneficiaries. We have briefly detailed each of these opportunities below.

Select Hospice Services

Current regulations prohibit PAs who work for a hospice from ordering medications for patients (42 CFR § 418.106(b)(1)(iii)). This restriction prevents PAs from providing needed treatments to hospice patients, which may delay care and reduce quality of life. This contrasts with PAs not employed by a hospice, who, when acting as a patient's attending physician, are authorized to order medications on the patient's behalf.

In addition, Medicare policy contained within the Medicare Benefits Policy Manual states that if a beneficiary does not have a physician, NP, or PA who provided primary care to them prior to, or at the time of, terminal illness, the beneficiary is given the choice of having either a physician or NP who works for the hospice as an attending physician (Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.3). This policy unnecessarily limits the number of PAs who can fill the important role of an attending physician under specific circumstances, contrary to Section 1861(dd)(3)(B) of the SSA, which authorizes PAs to serve as "attending physicians" for hospice.

The Medicare hospice population should not face additional unnecessary inconveniences to care delivery that may cost time and money, exacerbate medical conditions, and impose additional burdens on select providers. CMS should augment the efficiency of care provided to hospice beneficiaries by removing arbitrary restrictions on PAs who work in hospice settings. As such, AAPA recommends that CMS rescind §418.106(b)(1)(iii)(A) and (B) and revise the language in §418.106(b)(1)(iii) to remove any notion of qualifiers to authorize PAs employed by a hospice to order medications for hospice patients. Further, AAPA recommends that CMS revise Section 40.1.3.3 of Chapter 9 of the Medicare Benefit Policy Manual to authorize PAs employed by a hospice to serve in the role of a patient's attending physician if an attending physician was not previously selected by the patient.

Underutilization of hospice can lead to prolonged use of expensive and ineffective care. The causes of postponement in electing hospice care are numerous and may include the difficulty of a provider concluding a patient's prognosis is terminal and the difficulty with patients confronting and accepting mortality. With so many factors delaying the use of hospice care, as well as creating access delays for those undergoing hospice care, unnecessary policy barriers create additional challenges. AAPA believes removing regulatory barriers and increasing PA utilization could promote more efficient delivery of appropriate care.

Meanwhile, AAPA believes there is much to be gained in increasing the efficiency of care for hospice patients through CMS communicating certain recommendations to Congress for future consideration. Specifically, AAPA believes the terminal illness certification and hospice admission process would benefit from Congress expanding the ability to provide this service to other non-physician health professionals qualified to make these determinations, such as PAs. Currently, PAs and NPs are statutorily unable to certify or recertify a patient's terminal illness or admit a patient to a hospice. In addition, PAs are not authorized to conduct a face-to-face encounter prior to recertification after a patient has been in hospice for 180 days. Both statutes threaten the efficiency of care delivery, as they may result in periods when a beneficiary must wait to receive necessary care if a physician is not available to perform these tasks in a timely manner. As such, AAPA recommends that CMS work with the Congress to modify 42 U.S.C. 1395f(a)(7)(A) to authorize PAs and NPs to certify and recertify terminal illness, and 42 U.S.C. 1395f(a)(7)(D)(il) to authorize PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days.

A similar statutory provision that may restrict the efficient delivery of care to hospice beneficiaries is the requirement for at least one physician to participate as a member of each beneficiary's interdisciplinary group (IDG). Because hospices have a finite number of physicians, requiring their presence on every IDG when similarly qualified health professionals like PAs are available may reduce hospice capacity to care for patients. CMS should support the inclusion of PAs as members of IDGs in the position currently allotted solely to physicians, expanding with it the number of possible IDGs that could care for hospice patients. AAPA recommends that CMS work with the Congress to modify 42 U.S.C. 1395x(dd)(2)(B)(i)(I) to authorize PAs to participate in the same role on an IDG as physicians.

Select Skilled Nursing Facility Services

Currently, Medicare does not recognize PAs as authorized to perform the initial comprehensive visit to skilled nursing facility (SNF) patients and requires PAs to alternate every other subsequent required visit with physicians. These restrictions are not based on medical evidence but on outdated policies that need to be modernized to reflect current medical practice and improve system efficiency. AAPA recommends that CMS revise restrictive regulations to authorize PAs to perform the initial comprehensive visit and all required visits in SNFs. Specifically, §483.30, §483.30(b) and §483.30(b)(1), §483.30(c) and §483.30(c)(1) and (2) should be revised to be inclusive of PAs. §483.30(c)(3) and (4) and §483.30(e)(1), (e)(1)(i), (e)(1)(ii), and(e)(1)(iii) should be rescinded. Additionally, §483.30(e)(2) and §483.30(e)(3) should be revised to be inclusive of PAs and §483.30(e)(4) should be rescinded.

During the COVID-19 public health emergency, CMS authorized the delegation of "physician-only" visits in SNFs to PAs if there was no conflict with state law or facility policy. This authorization allowed additional qualified health professionals to provide care they are competent to provide and was based on years of experience showing that

PAs offer high-quality care in SNFs. In a recent CMS report, the agency acknowledged the waiver's benefits, noting that it helped address workforce shortages, increased care delivery, and protected residents' health and safety by maximizing the use of available personnel. The report stated, "Practices that authorized physician delegation of tasks to other clinicians saw higher quality of care for older populations and better interdisciplinary team management."[38] However, this authorization for PAs to help expand access to care in SNFs has since expired.

PAs are educated, clinically prepared, and competent to deliver the full range of clinical care needed in SNFs. Unnecessary regulatory requirements in SNFs necessitate physician involvement that may not be readily available in rural settings or in a timely fashion in high-demand settings. Allowing PAs to provide these services will give SNFs and their health professionals the option to determine which care delivery processes most efficiently meet patient needs and ensure patients do not have to wait to see a physician when a PA is available.

Select Inpatient Rehabilitation Facility Services

Currently, federal regulations regarding inpatient rehabilitation facilities (IRFs) are overly physician-centric, preventing other qualified health professionals, such as PAs, from meeting patient demand. Sections §412.622(a)(3)(iv) and §412.29(e) identify the need to conduct face-to-face visits with an IRF patient three days a week to assess medical status and functionality and to modify the course of treatment as necessary. However, this section of the CFR also requires that, for the first week, a physician must do all three visits, and in each subsequent week, a non-physician health professional, such as a PA, may do only one of the three visits per week. A different section, §412.622(a)(4)(ii), requires a rehabilitation physician to develop a plan of care for a patient within four days of admission. §412.29(h) indicates that a physician must establish, review, and revise a plan of treatment in an IRF. §412.29(d) requires that a patient's preadmission screening be reviewed and approved by a physician. Requiring a physician to perform these duties is inefficient and may impact patient treatment if a patient must wait to see a physician for care that another health professional is qualified to provide.

To address concerns of regulatory burdens in IRFs and ensure an adequate healthcare workforce in these settings, CMS had previously expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs to fulfill many of the medical responsibilities previously assigned only to rehabilitation physicians. AAPA supported CMS's proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place. Unfortunately, CMS did not finalize the flexibilities as initially proposed and maintained many of the physician-centric requirements.

[38] Centers for Medicare and Medicaid Services. Report to Congress. Fiscal Year 2023. The Centers for Medicare & Medicaid Services' COVID-19 Public Health Emergency Response and Use of Section 1135 Waivers and other Flexibilities. January 2025 https://www.cms.gov/files/document/covid-19-phe-report-congress.pdf

AAPA requests that CMS revisit removing these inefficient barriers to care. CMS should revise sections §412.622(a)(3)(iv), §412.29(e), §412.29(h), §412.622(a)(4)(ii), §412.29(d) to authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, when those services are within the PA's scope of practice under applicable state law. PAs have the appropriate training to ensure that IRF patients will continue to receive high-quality care when PAs provide services. CMS shows its agreement by authorizing PAs to provide one of the three weekly required visits. Restricting PAs to only one weekly encounter when the needs of an IRF may require more is an arbitrary restriction that may prevent patients from accessing high-value, underutilized rehabilitation services.

Granting an expanded authorization in this setting would not impose a requirement on IRFs; rather, it would give rehabilitation facilities maximum flexibility by allowing them to use appropriately qualified PAs in the same manner as rehabilitation physicians, ensuring a robust rehabilitation workforce that provides patients with timely access to care. Each IRF would continue to determine which health professionals have the education, training, and experience needed to meet patients' care needs. IRFs should decide which qualified health professionals provide care based on staffing needs, not arbitrary restrictions on available care options.

Home Blood Glucose Monitors

CMS National Coverage Determination (NCD) 40.2 regarding home blood glucose monitors[39] indicates that coverage for these monitors is limited to patients who have either a) been determined by a physician to be capable of or b) can be monitored by a person determined capable of being trained to use the equipment. Further, special glucose monitors are covered only when a physician certifies that a patient has a severe visual impairment that requires this monitoring system. This NCD conflicts with the regulatory authority of 42 CFR § 410.38(C)(2) for PAs to order/prescribe/certify Durable Medical Equipment (DME). PAs commonly provide care to patients with chronic conditions, including diabetes. According to AAPA's 2021 Practice Survey, nearly 70% of PAs have screened, diagnosed, or treated patients with diabetes. A study in the American Journal of Medicine found that PAs provide comparable care to physicians when managing patients with diabetes, both at diagnosis and during four years of follow-up care.[40] PAs are qualified and capable of making these determinations. As such, the NCD should be revised to authorize PAs to certify the need for coverage of this DME. Revising the NCD will improve chronic disease management, reduce the administrative burden of requiring an otherwise unnecessary physician order for patients cared for by PAs, and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain an order/certification that their treating PA could otherwise provide.

[39] Centers for Medicare and Medicaid Services. 2006. Home Blood Glucose Monitors. https://www.cms.gov/medicarecoverage-database/view/ncd.aspx?NCDId=222

[40] Yang, Y; Long, Qi; Jackson, S; Rhee, M; Tomolo, A; Olson, D; Phillips, L. 2017. Nurse Practitioners, Physician Assistants, and Physicians Are Comparable in Managing the First Five Years of Diabetes. https://www.amjmed.com/article/S0002-9343(17)30904-X/abstract

Podiatric Services

Section 290, Chapter 15 of the Medicare Benefit Policy Manual[41] contains exceptions to the routine foot care exclusion (see Section 290 C), systemic conditions that might justify coverage (see Section 290 D), and presumption of coverage (see Section 290 F) that require patients to have been evaluated and treated by a physician. As written, these requirements may require patients receiving care from a PA to schedule a separate visit with a physician to document a need for podiatric care that PAs are qualified to determine, potentially increasing cost and burden. These policies should be revised to authorize coverage of podiatry services for beneficiaries with certain conditions when under the care of a PA. Revising the policy will improve chronic disease management, reduce administrative burden, and could improve program integrity by reducing waste if patients do not need otherwise unnecessary physician care when already being evaluated and treated by PAs.

Screening Colonoscopies

42 CFR § 410.37(f) authorizes coverage of screening colonoscopies only when performed by a physician. This regulation should be rescinded to authorize coverage of screening colonoscopies performed by PAs. A study[42] indicated no significant differences in cecal intubation time or success, adenoma detection rate, or adverse reactions reported related to the endoscopic procedure up to 30 days post-colonoscopy for PAs compared to gastroenterologists. The researchers, who included five allopathic physicians, concluded that the findings support the use of trained PAs to perform average-risk screening colonoscopies and that "this approach may be particularly relevant to underserved populations and resource-poor areas where access to and cost of colonoscopy limits the optimization of colorectal cancer screening strategies."

Interpretation of Electrocardiograms

CMS's National Coverage Determination (NCD) 20.15 titled "Electrocardiographic Services" regarding interpretation of electrocardiograms (EKGs) indicates, "Coverage includes the review and interpretation of EKGs only by a physician." AAPA recommends that CMS revise its policy to authorize PAs to provide professional interpretation of EKGs. Medicare data indicate that Medicare Administrative Contractors are currently reimbursing for EKGs interpreted by PAs. Modifying the NCD would align formal policy with this widespread practice. Furthermore, the

[41] Centers for Medicare and Medicaid Services. 2024. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. https://www.cms.gov/RegulationsandGuidance/Guidance/Manuals/downloads/bp102c15.PDF
[42] Kern LM, Zhou Y, Rajendran N, et al. Quality metrics of screening colonoscopies. JAAPA. 2020;33(4):35–41. https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx

interpretation of EKGs is consistent with PA education, training, and scope of practice.[43, 44] This policy conflicts with Section 1861(s)(2)(k)(i) of the Social Security Act (SSA) for PAs to provide "physicians' services" they are authorized to perform by the State.

Physician Requirements in Critical Access Hospitals

Several policies within Critical Access Hospitals (CAHs) are unnecessarily physician-centric. For example, 42 CFR §485.639(a) indicates that only physicians may perform surgeries for CAH patients. AAPA believes that this restriction conflicts with the statutory authority of section 1861(s)(2)(K)(i)) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State, including minor surgery. PAs are also authorized by Medicare policy to perform minor surgery in medical offices, inpatient facilities, and other places of service. PAs often perform endoscopies, orthopaedic procedures, epidural injections, excisional biopsies, and other procedures safely and effectively in different settings. Amending these regulations will increase workforce adequacy and improve efficiency. As such, §485.639(a) should be revised to authorize PAs to perform surgical procedures in CAHs.

In addition, 42 CFR §485.631(b) requires physician co-signature of medical records for patients not cared for by a physician in CAHs and a periodic physician presence at CAHs. 42 CFR § 485.631(b)(1)(iv) and (v) and 42 CFR § 485.631(b)(2) conflict with the statutory authority of section 1861(s)(2)(K)(i)) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State, as well as section 1820(c)(2)(B)(iv)(III) of the Social Security Act, which authorizes PAs to provide inpatient care in a CAH without the need for a physician to be present in the facility and without the requirement for physician co-signatures of medical records. Amending these regulations will improve workforce adequacy, increase efficiency, and reduce administrative burden. Consequently, AAPA requests that CMS rescind §485.631(b)(1)(iv) and (v) to remove the requirement of physician co-signature for medical records of patients cared for by PAs and other non-physician practitioners in CAHs, and §485.631(b)(2) should be revised to remove the requirement that a physician be present at a CAH for "sufficient periods of time."

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[43] Accreditation Review Commission on Education for the PA. *Accreditation Standards for PA Education.* Sixth Edition. Updated September 1, 2025. https://www.arc-pa.org/wp-content/uploads/2025/10/Standards-6e-10-03-25-Pub-10-09-25.pdf

[44] National Commission for the Certification of PAs. *Content Blueprint for the Physician Assistant National Certifying Examination (PANCE).* Updated January 2025. https://www.nccpa.net/wp-content/uploads/PANCE-Blueprint.pdf

Physician Requirements in Rural Emergency Hospitals

Like in CAHs, select policy language surrounding Rural Emergency Hospitals (REHs) is unnecessarily physician-centric. Specifically, 42 CFR §485.528(c) requires physician co-signature of medical records for patients not cared for by a physician to the extent required by state law and a periodic physician presence at REHs. The regulation conflicts with the statutory authority of section 1861(s)(2)(K)(i) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State. Suggesting that a physician co-signature is needed if required by the state, when most states do not require co-signature, is unnecessary and potentially confusing. Similarly, the requirement that a physician be present at REHs for a "sufficient period of time" is not sourced in the authorizing statutory language. Amending these regulations will improve workforce adequacy, increase efficiency, and reduce administrative burden. AAPA recommends that CMS rescind §485.528(c)(1)(iv) to remove the language that a physician co-signature of records in REHs is needed if required by state law, and §485.528(c)(2) should be revised to remove the requirement that a physician be present at an REH for "sufficient periods of time."

Another restriction inhibiting efficiency in this setting can be found at 42 CFR §485.524(d)(1), which indicates that only physicians can perform surgery for REH patients. PAs are state licensed to provide medical and surgical services and have the statutory authority of Section 1861(s)(2)(K)(i)) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State, including surgical procedures. PAs are also authorized by Medicare policy to perform minor surgery in medical offices, inpatient hospital facilities, and other places of service. PAs often perform endoscopies, orthopaedic procedures, epidural injections, excisional biopsies, and other procedures safely and effectively in different settings. Amending these regulations will increase workforce adequacy and improve efficiency. As such, §485.524(d)(1) should be revised to authorize PAs to perform surgical procedures in REHs.

Physician Requirements in Ambulatory Surgical Centers

Similar to restrictions found in CAHs and REHs, policies regarding certain services performed in Ambulatory Surgical Centers (ASCs) are unnecessarily restrictive and inhibit efficient care delivery. For example, 42 CFR §416.42 states that only physicians can perform surgeries or evaluate risk for procedures, and only physicians or anesthetists may evaluate anesthesia risk for ASC patients. This regulation conflicts with the statutory authority of Section 1861(s)(2)(K)(i)) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State, including minor surgery. PAs are also authorized by Medicare policy to perform minor surgery in medical offices, inpatient facilities, and other places of service. PAs often perform endoscopies, orthopaedic procedures, epidural injections, excisional biopsies, and other procedures safely and effectively in different settings. Additionally, other payers generally cover minor surgical procedures performed by PAs.

Amending these regulations will increase workforce adequacy and improve efficiency. AAPA requests that CMS revise §416.42 to authorize PAs to perform surgical procedures in ASCs. §416.42(a)(1)(i) and (ii) should be revised to authorize PAs to evaluate the risk of the procedure to be performed and the risk of anesthesia in ASCs.

In addition, 42 CFR §416.48 requires reporting adverse reactions to medications to a physician; allows only physicians or registered nurses to administer blood and blood products; and allows only physicians to order drugs and biologicals for ASC patients. This regulation conflicts with the statutory authority of section 1861(s)(2)(K)(i)) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden. As such, AAPA requests that CMS revise §416.48(a)(1) to authorize PAs to receive reporting of adverse reactions. §416.48(a)(2) should be revised to authorize PAs to administer blood and blood products. §416.48(a)(3) should be revised to authorize PAs to order drugs and biologicals in ASCs.

Finally, 42 CFR §416.52 indicates that only physicians are authorized to discharge patients, provide follow-up appointments, and determine if patients are exempted from being discharged in the company of a responsible adult for ASC patients. The regulations conflict with the statutory authority of section 1861(s)(2)(K)(i)) of the Social Security Act for PAs to provide "physicians' services" they are authorized to perform by the State. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden. AAPA requests that CMS revise §416.52(c)(1) to authorize PAs to provide follow-up appointments. §416.52(c)(2) should be revised to authorize PAs to discharge patients (and issue and sign discharge orders), and §416.52(c)(3) should be revised to authorize PAs to determine if patients are exempted from being discharged in the presence of a responsible adult.

Care Transparency and Provider Directories/Care Compare

In addition to its commitment to efficiency, CMS also supports increased transparency in healthcare. Examples from the 2027 Physician Fee Schedule proposed rule of CMS's support for increased transparency include policies surrounding the objective valuation of codes, global surgical package pricing, electronic prior authorization, public reporting of ACO quality and cost performance, ACO beneficiary notifications, and standardized definitions. CMS also notes that it is working to improve the transparency of "incident to" services. CMS explicitly identifies transparency as an important aspect of patient-centered care and labels transparency as one of the primary tools of the administration's Make America Healthy Again initiative.

AAPA has long supported increased transparency in healthcare, as evidenced in our vociferous advocacy to fix the transparency pitfalls of "incident to" billing (Details on our position on "incident to" and our recommendations on how to address transparency issues can be found under the section of Advance Care Planning in our comments to

this rule). However, like with policies that may enhance efficiency, AAPA is aware of additional policies that could help improve transparency as well. One example is the opportunity to make direct improvements to provider directories.

Medicare's Care Compare, as well as provider directories for some of the payers with whom CMS works, withhold useful data from their beneficiaries regarding available care delivery options. CMS has recognized the inadequacy of provider directories as recently as its 2022 RFI,[45] noting that provider directories often display inaccurate or redundant information and are frequently missing essential information that may be valuable to beneficiaries and patients. For provider directories to be successful, the information they contain must be complete, accurate, and navigable.

Some provider directories omit information notifying beneficiaries of all available care options. For example, while not always the case, payers occasionally omit PAs from their provider directories. As essential members of healthcare teams, PAs must be included explicitly in all public and private payer provider directories. The No Surprises Act requires most payers to ensure their provider directories are accurate and up to date regarding available care options, without exception. We urge CMS to provide sufficient oversight and enforcement of this requirement, especially in the initial years, to support the transition to these positive practices. Omission from a provider directory should be easily reportable, with subsequent investigation of whether the reported absence is a one-off omission or the systematic exclusion of an entire class of health professionals. AAPA also supports extending this requirement to payers not currently covered by the No Surprises Act, such as several public payers that may also operate provider directories.

Even when PAs are included in provider directories, such as Medicare's Care Compare, incomplete information may hinder beneficiary choice and access. Provider directories are typically designed to prompt beneficiaries to search for a potential provider based on the specialty in which a provider practices. PAs are often not enrolled with payers in a particular specialty and, consequently, are not listed in many provider directories under the specialty in which they practice. Instead, provider directories often list PAs under the generic category of "physician assistant" or "PA."

If a beneficiary is looking for dermatology care, a PA who practices in dermatology may not be identified in the directory as a dermatology provider. The beneficiary may instead be forced to select a provider listed under dermatology, but who may be farther away and/or have substantially longer wait times, both of which create

[45] Centers for Medicare and Medicaid Services, US Department of Health and Human Services. Request for Information; National Directory of Healthcare Providers & Services. October 7, 2022. https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directoryofhealthcare-providers-and-services

access issues. To remedy this, PAs should be identified in provider directories under the specialty in which they practice, not placed in a generic "physician assistant" or "PA" category. This can be accomplished by authorizing PAs to report the specialty/specialties in which they practice to the payer.

A core principle of the PA profession is clinical flexibility to meet the changing healthcare needs of patients. Unlike physicians, who are typically board-certified in a particular specialty, PAs are nationally certified to practice in all medical and surgical specialties. The profession's comprehensive, generalist medical education, training, and preparation give PAs the capability and expertise to practice in different specialties and change specialties in response to changing healthcare needs. Maintaining this practice flexibility is especially important because of 1) challenges facing the healthcare workforce, including the current and growing shortage of physicians and the increasing problem of attrition of health professionals due to provider burnout and/or retirement; 2) the need to deliver increased access to care for patients in rural and underserved communities; and 3) the necessity to rapidly respond to future public health emergencies. Authorizing PAs to report their practice specialty to Medicare and the payers with whom they work will improve provider directory transparency, inform beneficiaries of all available care options, and support the PA profession's continued ability to meet the evolving needs of the US healthcare delivery system

These are just a few examples of the efficiency and transparency issues PAs face. While AAPA has met with CMS several times over the past year on many of these issues, AAPA would welcome continuing these discussions with the agency to arrive at resolutions that optimally support patient care efficiency and transparency.

AAPA Positions and Recommendations on this Topic

- **AAPA advises CMS to rescind §418.106(b)(1)(iii)(A) and (B) and revise the language in §418.106(b)(1)(iii) to remove any notion of qualifiers to authorize PAs employed by a hospice to order medications for hospice patients.**
- **AAPA urges CMS to revise Section 40.1.3.3 of Chapter 9 of the Medicare Benefit Policy Manual to authorize PAs employed by a hospice to serve in the role of a patient's attending physician if an attending physician was not previously selected by the patient.**
- **AAPA recommends that CMS work with Congress to modify 42 U.S.C. 1395f(a)(7)(A) to authorize PAs and NPs to certify and recertify terminal illness, and 42 U.S.C. 1395f(a)(7)(D)(il) to authorize PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days.**
- **AAPA recommends that CMS work with the Congress to modify 42 U.S.C. 1395x(dd)(2)(B)(i)(I) to authorize PAs to participate in the same role on an interdisciplinary group as physicians.**
- **AAPA suggests that CMS revise restrictive regulations to authorize PAs to perform the initial comprehensive visit and all required visits in SNFs. Specifically, §483.30, §483.30(b) and §483.30(b)(1), §483.30(c) and §483.30(c)(1) and (2) should be revised to be inclusive of PAs. §483.30(c)(3) and (4) and**

§483.30(e)(1), (e)(1)(i), (e)(1)(ii), and(e)(1)(iii) should be rescinded. Additionally, §483.30(e)(2) and §483.30(e)(3) should be revised to be inclusive of PAs and §483.30(e)(4) should be rescinded.

- AAPA counsels CMS to revise sections §412.622(a)(3)(iv), §412.29(e), §412.29(h), §412.622(a)(4)(ii), §412.29(d) to authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician in IRFs, when those services are within the PA's scope of practice under applicable state law.
- AAPA encourages CMS to revise NCD 40.2 regarding home blood glucose monitors to authorize PAs to certify the need for coverage of this DME.
- AAPA proposes that CMS revise Section 290, Chapter 15 of the Medicare Benefit Policy Manual to authorize coverage of podiatry services for beneficiaries with certain conditions when under the care of a PA.
- AAPA recommends CMS rescind 42 CFR § 410.37(f) to authorize coverage of screening colonoscopies performed by PAs.
- AAPA suggests CMS revise "National Coverage Determination (NCD) 20.15 - Electrocardiographic Services" to authorize PAs to provide professional interpretation of EKGs.
- AAPA advises CMS to revise §485.639(a) to authorize PAs to perform surgical procedures in CAHs
- AAPA counsels CMS to rescind §485.631(b)(1)(iv) and (v) to remove the requirement of physician co-signature for medical records of patients cared for by PAs and other non-physician practitioners in CAHs, and §485.631(b)(2) should be revised to remove the requirement that a physician be present at a CAH for "sufficient periods of time."
- AAPA urges CMS to rescind §485.528(c)(1)(iv) to remove the language that a physician co-signature of records in REHs is needed if required by state law. §485.528(c)(2) should be revised to remove the requirement that a physician be present at an REH for "sufficient periods of time."
- AAPA encourages CMS to revise §485.524(d)(1) to authorize PAs to perform surgical procedures in REHs
- AAPA proposes that CMS revise §416.42 to authorize PAs to perform surgical procedures in ASCs. §416.42(a)(1)(i) and (ii) should be revised to authorize PAs to evaluate the risk of the procedure to be performed and the risk of anesthesia in ASCs.
- AAPA recommends that CMS revise §416.48(a)(1) to authorize PAs to receive reporting of adverse reactions in ASCs. §416.48(a)(2) should be revised to authorize PAs to administer blood and blood products in ASCs. §416.48(a)(3) should be revised to authorize PAs to order drugs and biologicals in ASCs.
- AAPA suggests that CMS revise §416.52(c)(1) to authorize PAs to provide follow up appointments in ASCs. §416.52(c)(2) should be revised to authorize PAs to discharge patients (and issue and sign discharge orders) in ASCs. §416.52(c)(3) should be revised to authorize PAs to determine if ASC patients are exempted from being discharged in the presence of a responsible adult.
- AAPA supports the extension of the requirement within the No Surprises Act that payers ensure that their provider directories are accurate and up-to-date regarding available care options, without

exception, to payers that are not currently covered by the No Surprises Act, such as several public payers that may also operate provider directories.

- **AAPA proposes that PAs should be identified in provider directories under the specialty in which they practice and not placed into a generic "physician assistant" or "PA" category. This can be accomplished by authorizing PAs to report the specialty/specialties in which they practice to the payer.**

The Medicare Shared Savings Program

In the 2027 Physician Fee Schedule proposed rule, CMS proposes various updates to the Medicare Shared Savings Program (MSSP). AAPA addresses a few of these changes below, identified by topic.

Beneficiary Assignment – The Role of PAs

In the 2027 Physician Fee Schedule proposed rule, CMS proposes several changes to the MSSP assignment methodology to begin in calendar year 2028. These assignment proposals aim to increase the number of beneficiaries who qualify for and participate in the MSSP. AAPA agrees with the intent of these proposals and suggests that modifications to the assignment methodology relating to non-physician health professionals like PAs and NPs may further advance CMS's goal of increased beneficiary involvement in Accountable Care Organization (ACO) relationships. At one point in the rule, CMS explicitly solicits feedback regarding how the agency can account for care delivered by PAs and NPs in assignment methodologies and what role PA/NP-led care plays in supporting beneficiary attribution.

AAPA appreciates CMS's efforts in recent years to reform ACO assignment policies to be more inclusive of PAs and NPs. In the 2024 Physician Fee Schedule, CMS finalized a policy for a new Step 3 for ACO beneficiary assignment. Step 3 allows for an "expanded window," begun in 2025, in which a beneficiary must have seen a primary care physician within the last 24 months (as opposed to the past 12 months) to trigger the ability to be assigned to an ACO. Meanwhile, the requirement to see a physician within a 12-month window was changed, and a beneficiary can now be assigned if they have seen a PA or other non-physician health professional within that period.

This expanded window seeks to capture additional beneficiaries who qualify for ACO assignment, such as patients who have received all their recent care from non-physician health professionals like PAs and NPs. Patients who will likely benefit from Step 3 include patients in rural and underserved areas where a PA is the only health professional in the community. AAPA supported the creation of this new Step 3 with the hope that a greater number of

beneficiaries would be able to access the coordinated care at the center of an ACO's mission and ACOs with a greater number of beneficiaries may be more fiscally sound.

Unfortunately, expanding the assignment process through Step 3 does not extend the ability to be assigned to an ACO for all patients. Some beneficiaries will continue to be seen exclusively by a PA or other nonphysician health professional and will be unable to see a primary care physician separately within the two-year timeframe. For such beneficiaries, if they wish to be associated with an ACO, they must take the extra step of going online to select a PA (or NP) as their ACO provider to be proactively assigned. However, in previous rules, CMS has recognized that claims-based assignment is the methodology by which the "vast majority of beneficiaries are assigned."[46]

AAPA recognizes the agency has likely reached the boundaries of what it can reform through regulation alone, given the statutory limitations on the assignment process. As a result, AAPA continues to urge CMS to work with Congress to remove the statutory physician-centric assignment language, which would simplify the process.

Beneficiary Assignment Calculations

Under the MSSP, CMS assigns beneficiaries to ACOs based on assessments (using a stepwise process) of where the beneficiary receives a plurality of its primary care. In the 2027 Physician Fee Schedule proposed rule, CMS is proposing that, starting in plan year 2028, when conducting ACO assignment calculations, it will exclude allowed charges for any primary care services provided by an ACO professional that are billed through a non-ACO taxpayer identification number (TIN). This would exclude from competition the allowed charges for services provided outside an ACO, leading to the determination of assignment based on which ACO provided a plurality of the remaining care. This exclusion would ensure that, if the beneficiary received services from at least one ACO and meets all other qualifying conditions, the beneficiary would be assigned to an ACO and not fall under a designation indicating no care from an ACO. As a result, this proposed change would assign more beneficiaries to an ACO.

AAPA approves of the proposed policy to exclude non-ACO TINs when calculating beneficiary assignment, as it is likely to not only increase the beneficiary population assigned to an ACO but may also see pronounced clinical benefits for the types of beneficiaries that are currently excluded from assignment on the basis of the current methodology. CMS notes that beneficiaries previously attributed to non-ACO TINs were among the most at-risk and potentially costliest. AAPA believes that these are exactly the type of beneficiaries that may benefit most from

[46] Centers for Medicare and Medicaid Services. 2018. Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017. https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicareprogram-medicaresharedsavings-program-accountable-care-organizations-pathways-to-success

the coordinated care associated with an ACO and that these beneficiaries, now assigned to an ACO, may see meaningful quality improvements.

In the proposed rule, CMS also proposes modifying the definition of "primary care services" used for beneficiary assignment under the MSSP to better align with other payment policy proposals under the Physician Fee Schedule. CMS is also proposing to add certain services as primary care services for beneficiary assignment, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, Advance Care Planning (ACP) services, and Vaccine Adverse Effects Management.

AAPA approves of CMS actions to expand the definition of "primary care services" used in assignment of Medicare beneficiaries to the appropriate ACO. We note that an expanded definition supports the expanded role of primary care providers in offering more holistic care to patients and is likely to lead to a more accurate and expanded assignment of Medicare beneficiaries.

Efforts to Balance Participation Incentives in the BASIC and ENHANCED MSSP Tracks

Eligible ACOs can enter into an agreement period under one of two tracks of the MSSP: The BASIC track or the ENHANCED track. The BASIC track provides a path from one-sided models to incrementally higher levels of performance-based risk, ultimately culminating at Level E. Meanwhlie, the ENHANCED track offers both the highest level of risk and the highest level of reward.

Recent policy changes have allowed ACOs to maintain BASIC Level E indefinitely without a requirement to move to the ENHANCED track within a certain period. CMS seeks to balance incentives to maintain participation in an effective voluntary program like MSSP that expands high-quality, value-based care and incentivizes improving quality of care. The agency determined that allowing the option to return to BASIC Level E should an ACO discover that the ENHANCED track is not as appropriate for them would reduce the number of ACOs that may choose to drop out of the MSSP.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to make changes to the financial methodology to encourage additional savings in two-sided risk. CMS is concerned that the superior financial rewards of the ENHANCED track are enticing participants to select this track and assume maximum risk, even if the ACOs are not adequately prepared to do so. The agency is concerned that failure by ACOs to meet the stricter requirements and inability to recognize the financial benefits may cause certain ACOs to stop participating altogether. CMS has also noted that declining participation in the BASIC Level E (which has already been seen and is projected to continue further if not addressed) will have negative financial consequences on the Medicare Trust Fund, as BASIC Level E has been shown to have higher net savings.

Consequently, CMS is seeking to make changes that will make Level E of the BASIC track more financially enticing. Specifically, CMS indicates the current large discrepancy in the sharing rate makes the ENHANCED track more appealing. While the ENHANCED track has a sharing rate of 75 percent, the BASIC track has a sharing rate of only 50 percent. To reduce this gap, CMS now proposes to increase the sharing rate under the BASIC track from 50 to 60 percent for agreements that begin after January 1, 2027.

AAPA approves of CMS efforts to bring the financial incentives of the BASIC and ENHANCED tracks closer together, while still maintaining a clear advantage for the ENHANCED track and those ACOs that are ready to participate in the higher risk/higher reward opportunity. We agree that ACOs quitting in frustration after seeking higher shared savings would be a much less desirable outcome and that ACOs must be encouraged to join and maintain participation until familiarity is established and competency can be increased. From a patient care perspective, while the goal must continue to be to eventually transition ACOs to high-risk/high-reward scenarios, the program itself must be protected to maintain the availability of coordinated care.

Proposal to Discontinue Availability of the Option of Prepaid Shared Savings

Based on the success seen under the advanced investment payments provided to ACOs newly entering the MSSP, as well as successes under the Next Generation ACO model, in the 2025 Physician Fee Schedule CMS proposed that starting January 2026, the agency would let historically successful ACOs (those who have successfully earned shared savings while participating in the program) access to an advanced payment for shared savings, as opposed to having to wait months after the end of each performance year. These prepaid shared savings could be used to 1) make investments, such as staffing and infrastructure, and 2) fund direct beneficiary services, such as vision, hearing, and dental. At least 50% of these prepaid shared savings must go to improving direct services to beneficiaries. Payments would be made quarterly, and if the ACO does not earn sufficient shared savings to offset the advanced payments, CMS may withhold future payments. AAPA approved this financial arrangement because we believed earlier receipt of funds would help ACOs meet patients' needs, incentivize practice improvements, and promote greater benefits for patients.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to discontinue this payment option after plan year 2027. CMS indicates that uptake of this option has been very low, as only four ACOs have participated in prepaid shared savings in 2026.

Because prepaid shared savings have been authorized for less than a year, AAPA questions whether current uptake can determine success mere months after initial availability. We suggest that CMS decide the future of prepaid shared savings on the merits of its potential, and instead invest in expanded education for ACOs on the advantages

of participating. To address stakeholder feedback on why some ACOs are not participating, CMS could instead modify documentation and use-of-funds requirements while maintaining sufficient guardrails and beneficial incentives. While we support CMS proposals to allow for cost-sharing support, detailed in other sections of the 2027 Physician Fee Schedule proposed rule, we view the proposal as complementary and not a binary choice. AAPA suggests that CMS make minor changes to the payment options and encourage repeat applications by at least the 23 ACOs that submitted applications for year one; if the numbers improve, CMS should reconsider sunsetting prepaid shared savings.

Proposal to Allow ACOs to Reduce or Eliminate Part B Cost Sharing for Patients

Cost sharing support was offered and widely used under the ACO Reach model. Under this model, ACOs reimbursed ACO participants for uncollected beneficiary cost sharing. ACOs had significant discretion to determine eligible beneficiaries and services, provided the services were not at higher risk for waste, fraud, or abuse, such as durable medical equipment or prescription drugs.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to implement similar cost sharing support under the MSSP, allowing ACOs to enter into Part B cost sharing support agreements with ACO participants under which those participants would reduce or eliminate cost sharing for categories of Part B items and services and eligible beneficiaries identified by the ACO. CMS states this cost sharing may come in the form of deductible or coinsurance relief. Interested ACOs must apply with a compulsory implementation plan detailing the beneficiaries, items, and services eligible for cost-sharing support; how this relief will meet certain clinical goals; and other requirements detailed in the proposed rule. CMS anticipates relief may begin as early as April 2027.

CMS proposes certain stipulations for implementation of cost sharing support. These include that the beneficiary does not have secondary insurance that covers the Part B items and services targeted by the relief and that the support must target patients whose health is expected to improve or be maintained through receipt of these services. As with REACH, CMS will allow ACOs to reduce or eliminate beneficiary cost sharing for all Medicare FFS Part B items and services except certain high-risk items like durable medical equipment, prosthetics, orthotics, supplies (DMEPOS), and prescription drugs. CMS also indicates that cost sharing relief must meet one of four clinical goals: 1) Adherence to a treatment regime, 2) Adherence to a drug regime, 3) Adherence to a follow-up care plan, 4) Management of a chronic disease or condition. ACOs would then be required to establish a cost-sharing support agreement with interested ACO participants and must finance all payments from the ACO's own funds.

AAPA supports CMS efforts to incentivize ACOs to reduce or eliminate cost sharing for eligible patients. We believe the proposed cost sharing relief may particularly benefit certain financially vulnerable patients. As noted in the

proposed rule, some beneficiaries do not have supplemental/secondary insurance and, as a result, face higher out-of-pocket costs. These potential out-of-pocket costs may then cause some beneficiaries to postpone or forgo care. Cost sharing relief may mitigate this barrier to care. AAPA also agrees that cost sharing relief may support increased use of proposed modifiers like MOD2, detailed elsewhere in the rule, as providers will feel less hesitant to use these modifiers if they know their patients are insulated from any associated cost sharing obligations. AAPA recommends CMS finalize this proposal.

AAPA Positions and Recommendations on this Topic

- **AAPA continues to urge CMS to work with Congress to remove the statutory physician-centric language regarding ACO assignment methodology.**
- **AAPA approves of the proposed policy to exclude non-ACO TINs when calculating beneficiary assignment, as it is likely to not only increase the beneficiary population assigned to an ACO but may also see pronounced clinical benefits for the types of beneficiaries that are currently excluded from assignment on the basis of the current methodology.**
- **AAPA supports CMS actions to expand the definition of "primary care services" used in the assignment of Medicare beneficiaries to the appropriate ACO.**
- **AAPA approves of CMS efforts to bring the financial incentives of the BASIC and ENHANCED tracks closer together.**
- **AAPA suggests that CMS decide the future of prepaid shared savings on the merit of their potential and consider instead investing in expanded education of ACOs regarding the advantages of participating.**
- **AAPA recommends that, to address stakeholder feedback regarding the reasons some ACOs choose not to participate in prepaid shared savings, CMS could instead make modifications to documentation and use of funds requirements while maintaining sufficient guardrails and beneficial incentives.**
- **AAPA supports CMS efforts to incentivize ACOs to reduce or eliminate cost sharing for eligible patients.**

The Quality Payment Program (QPP)

The Transition from Traditional MIPS to MIPS Value Pathways (MVPs).

To move away from a cumbersome system in which health professionals and groups choose what to report from a large set of measures that are often not comparable, CMS has developed a method of reporting in which a health professional or group selects from a narrower and more focused set of measures that better reflect the type of care the health professional or group typically provides. These sets of more focused measures, or MVPs, are structured around a specialty or medical condition. The measures included in the MVPs consist of a foundation of

claims-based population health and care coordination measures and are supplemented with measures directly relevant to the clinical practice of the chosen specialty/medical condition on which the MVP focuses. Measures reported under an MVP would be like those reported by other health professionals who have also chosen that same pathway, increasing comparability of clinician quality, outcome, and cost performance data. CMS hopes this will reduce complexity and burden, streamline reporting, improve measurement, and enable quicker administrative and clinical feedback to health professionals to improve care. CMS further indicates these changes will help remove barriers to alternative payment model participation and accelerate the transition to value-based care.

In the 2025 Physician Fee Schedule, CMS issued a request for information on the timeline for sunsetting traditional MIPS and mandating MVP participation in its place. In response to that RFI, AAPA encouraged CMS to propose and finalize an official date well in advance, as updating provider systems and work processes may take years.

In the 2027 Physician Fee Schedule proposed rule, CMS officially announced that traditional MIPS will be sunset at the end of the calendar year 2028 performance period and will transition to MVPs as the only MIPS reporting option beginning with the calendar year 2029 performance period/2031 MIPS payment year. After years of preparing stakeholders for this transition, AAPA is pleased that CMS has set a date for the official transition from traditional MIPS to MVPs. We approve the proposed timeline and believe that, given CMS projections on how many specialties can now identify an MVP to which it will report, the 2029 performance-year transition is reasonable.

AAPA supports the transition from traditional MIPS to MVPs, largely because it increases comparability between like professionals. AAPA cautions that CMS's efforts at comparability remain encumbered by billing provisions such as "incident to" that obscure the accurate attribution of services to the appropriate health professional. That is, scores representing an individual health professional's performance when some of their services have been attributed to another health professional or the services of another professional are attributed to them are inaccurate. While CMS is developing methods to improve data reporting under MIPS, AAPA again requests that CMS take necessary steps to rectify the problem of data accuracy by addressing the complications of inaccurate data collection caused by the "incident to" billing method, which attributes services personally performed by PAs and NPs to a physician.

In support of the transition from MIPS to MVPs, CMS will maintain the performance threshold it set in the 2026 Physician Fee Schedule. Under the QPP, MIPS eligible clinicians with a final score above a designated "performance threshold" receive a positive payment adjustment. Eligible clinicians with a final score at the performance threshold receive a neutral adjustment, and those with a final score below the threshold receive a negative payment adjustment. In the 2026 Physician Fee Schedule proposed rule, CMS set the performance threshold for

the MIPS program at 75 points through performance year 2028/payment year 2030, the same level it has been at since the 2022 performance/2024 payment period. AAPA appreciates that CMS has chosen to maintain its established performance threshold through 2028 as this offers predictability and stability to MIPS participants during the final years of the traditional MIPS program. AAPA supports making the transition to MVPs as minimally burdensome as possible, which will be particularly beneficial to small or solo practitioners who already face challenges participating in the program. However, once the transition to MVPs is complete and sufficient data regarding performance under MVPs has been accumulated, we encourage CMS to revisit the performance threshold level at that point to ensure that participants who are performing well are being adequately compensated for their high performance.

AAPA suggests that, in addition to consistency in reporting and scoring requirements, CMS may further support the transition from traditional MIPS to MVPs by providing new educational resources and more technical assistance. These resources and assistance should target specific aspects of MVP participation that differ from traditional MIPS and that health professionals who have already participated in MVPs have identified as most challenging. CMS may also wish to direct some educational resources to target those who have not yet voluntarily reported to an MVP, or those in their initial year doing so. CMS must ensure that all relevant stakeholders are properly educated about the MVP choices, how to enroll, what is required for reporting, the potential monetary effects, and how to receive and act on feedback in a meaningful way. AAPA suggests educational efforts include examples of MVPs and their corresponding measure sets with a detailed description of how one would be rated on these measures, as well as clinical vignettes of various scenarios that vary by specialty and reporting method. CMS should use public meetings, webinars, and online resources to broaden awareness and expand the understanding of the MVP process and receive feedback directly from participants.

CMS continues establishing MVPs by proposing three additional pathways for voluntary reporting in 2027, in addition to those proposed in previous years. The new pathways proposed include diabetic disease, hypertension and hospitalist. If finalized, the number of MVPs would increase to 30. CMS now estimates that its MVP inventory would provide a relevant reporting option for approximately 98% of specialties. AAPA finds the projections of robust specialty coverage admirable and appreciates the accelerated adoption of these MVPs to ensure near universal applicability prior to the onset of mandatory participation in MVPs. AAPA requests that should CMS plan to develop additional MVPs to cover the estimated remaining 2% it do so by the next fee schedule to allow participants in these final MVPs enough time to voluntarily participate before being required to do so. By the suggested transition date of 2029, six or seven years of voluntary participation will have been in place, but only for those covered under the initial array of MVPs. Others who have yet to have an MVP established that represent their specialty will have very few years under which to participate voluntarily. AAPA recommends that CMS work with the provider community to identify potential gaps in MVP specialty concentration so there are no health professionals who cannot appropriately report to any of the available MVPs. AAPA encourages the agency to seek

input from various types of affected health professionals when determining which specialties/conditions CMS will recognize as pathways. CMS should oversample those health professionals that fall into the 2% it estimates are yet to be covered by an existing MVP. PAs should be included in the process as they have unique perspectives and concerns regarding implementation details because of their practice in multiple specialties.

AAPA cautions that, because MVP participation is voluntary until 2029, many health professionals will be participating under this new method for the first time that year. Consequently, AAPA encourages maximum flexibility and fiscal leniency in the first few years, as was provided during the implementation of traditional MIPS, to ease the transition to MVP reporting.

Finally, AAPA encourages CMS to consider implementing other flexibilities prior to the 2029 transition, such as the ability to report to an MVP as a virtual group. Individual MIPS eligible clinicians or groups consisting of not more than 10 MIPS eligible clinicians may elect to form a virtual group with at least one other such individual MIPS eligible clinician for a performance period. Health professionals must state in advance their intention to form a virtual group, and each participating clinician will participate for the entire performance year in only that virtual group. In the 2027 Physician Fee Schedule proposed rule, CMS indicates that this reporting for MVPs can begin in the 2029 performance period when reporting to an MVP becomes mandatory. CMS considered finalizing virtual groups as an MVP participant under the 2022 Physician Fee Schedule but declined at the time because of concerns about the potential implementation burden for interested parties and the agency, as well as other potential issues. However, statutory obligations surrounding MVP implementation require virtual groups to be able to participate. As such, CMS is now moving forward. AAPA believes that authorizing reporting through virtual groups prior to the 2029 date (such as in 2028) would be preferable to allow for experience with this option prior to the mandatory transition. CMS notes it must first refine participation criteria before implementation, but AAPA questions whether developing such criteria justifies the two-year delay in allowing virtual groups to report, since comparable criteria must already have been established for virtual group participation under traditional MIPS. To assess whether virtual groups want and can participate sooner, CMS should use virtual groups' feedback on perceived additional burdens and what must be addressed before they can report MVPs to guide whether to consider earlier implementation.

MIPS Core Measures

In the 2027 Physician Fee Schedule proposed rule, CMS proposes implementing MIPS Core Measures in order to increase the comparability of clinician performance data. Specifically, CMS proposes that, starting in 2027, MVP participants will be required to choose one quality measure from a smaller core set of outcome measures that best reflect the specialty, medical condition, or episode of care around which the MVP is centered (“Core Measures”).

Each MVP would have at least three core measures available. These would replace the current requirement to submit on measures with high-priority designation and outcomes measures.

CMS requested feedback regarding MIPS "Core Elements" in its 2026 Physician Fee Schedule proposed rule. AAPA supported these efforts to increase, to an extent, standardization of reporting under MVPs to provide more directly comparable clinician data, as well as to incentivize high performance on measures that capture the focus of the MVP. We cautioned that, because the intention is to produce data comparing health professional performance to aid patients in their decision-making when choosing an appropriate health professional, CMS must ensure it selects appropriate Core Elements and that data from these comparisons can be translated into understandable comparisons for patient discernment.

AAPA's approval of the concept of core measures remains. We approve of setting the number of core measures, rather than the previously identified method of setting the number as a percentage of the total available measures, which may have led to more core measures in MVPs with large measure sets. While AAPA notes that CMS is proposing to "select a minimum of three MIPS core measures," we advise CMS not to choose more than this amount if not necessary to reflect the care that is central to the specialty of the MVP. AAPA notes that if comparability is the goal, then the smaller the group of core measure options, the better.

CMS further proposes that core measures be reported by both MVP participants, who must choose their core measure from those selected for their MVP, and traditional MIPS participants, who may choose their core measure from the entire catalog of core measures resulting from all those used in the individual MVPs. Consequently, traditional MIPS participants must report on six quality measures (if applicable), one of which would be the core measure, and MVP participants must report on four quality measures (if applicable), one of which would be the core measure. AAPA concurs that requiring core measures for traditional MIPS would be a sufficient replacement for outcome/high-priority designated measures (as a core measure is to be outcome focused and determined to be high priority), may help with the impending transition to MVPs, and will allow for increased data on performance that may extend further back than participation in an MVP.

Meanwhile, if a core measure is not available for an MVP, CMS is proposing to authorize providers to attest to the unavailability of an applicable core measure and replace it with another quality measure. Small practices are also exempt from the MIPS core measure reporting requirement, requiring them to report six quality measures under traditional MIPS and four quality measures under MVPs (with the option for small practices to voluntarily report core measures if they choose to). AAPA supports the flexibility CMS offers small practices. Small practices tend not to have the same resources as large ones. AAPA also supports flexibility for those who, for justifiable reasons, cannot report a core measure, but encourages monitoring of larger practices that repeatedly indicate an inability to report a core measure for periodic verification.

Regarding a process to identify core measures, we appreciate that CMS is taking from the existing set of measures assigned to an MVP. In the proposed rule, CMS proposes this designation would apply to 78 measures in the MIPS inventory so far. In comments to the 2026 Physician Fee Schedule proposed rule, AAPA suggested that CMS could examine what limited data it has on MVP reporting to identify alignment between frequently reported measures and those CMS identifies as Core Elements. Overlap in these measures may illuminate ones that meet requirements to be representative of the MVP focus, have broad applicability, and have not been found difficult to report. CMS should then annually release its proposed core measures for public comment.

AAPA acknowledges that requiring reporting on a measure from a core set reduces reporting flexibility. However, we believe that the necessity for only one measure of the four being required to be from the core set is an acceptable tradeoff to increase comparability, which was the rationale for the transition from traditional MIPS to MVPs.

Other MIPS Measures Proposals

In the 2027 Physician Fee Schedule proposed rule, CMS proposes modifying the quality performance category measure inventory to include 180 MIPS quality measures, including 10 new measures. Among these 10 new measures are measures focused on patient-reported outcomes and chronic disease management. AAPA approves of the inclusion of these new measures. We believe the ability to measure successful care provision from a patient's perspective, as well as effective management of chronic disease, aligns with AAPA's and CMS's shared goals for patient-centered care.

In the proposed rule, CMS also proposes to include six new improvement activity measures beginning in the calendar year 2027 performance period/2029 MIPS payment year. These measures include 1) Use of data to improve practice workflows, 2) Understand and improve diagnostic performance, 3) Systematic screening and intervention for nutrition and other health-impacting, non-clinical issues, 4) Advance Care Planning conversations to support patient wellness and care preferences, 5) Clinician use of Artificial Intelligence to improve patient care, and 6) Lifestyle approaches to Diabetes remediation. AAPA approves of the proposed improvement activities for addition. AAPA has already approved a focus on data, upstream drivers, preventive care, Advance Care Planning, Artificial Intelligence use, and Diabetes remediation efforts elsewhere in our comments to the proposed rule. We support incentivizing practitioners to use these options that emphasize both care coordination and wellness through the QPP.

In addition, in the proposed rule, CMS asks how to modify requirements for electronic prior authorization to further incentivize the practice. First, CMS is proposing to make the electronic prior authorization measure an

optional/bonus measure for the calendar year 2027 performance period, then make it required in the calendar year 2028 performance period. Second, CMS is looking long-term as to how to incentivize greater use of electronic prior authorization in the future. The current metric for achieving electronic prior authorization (achieving "at least one" electronic prior authorization) is an important starting point but will not meaningfully increase electronic prior authorization use. CMS wishes to modify requirements to make this practice more common. AAPA supports increasing this standard over time to promote greater use of electronic prior authorization to meet Promoting Interoperability requirements. AAPA has long supported expanding interoperability because it can improve care coordination. We believe increased use of electronic prior authorization may reduce submission burden, expedite the prior authorization process, and provide patients with needed care more quickly. However, AAPA also suggests that CMS allow exemptions, as it has in the past, for small, rural, or underserved practices that may not possess the resources to adopt electronic prior authorization and consider what steps the agency could take (direct financial support, technical assistance, etc.) to help these practices eventually possess these capabilities.

MVP Scoring

In the 2027 Physician Fee Schedule proposed rule, CMS issues a request for information seeking feedback regarding the idea of modifying MIPS scoring under MVPs to normalize a participant's score to others in the MVP, as opposed to across all MVPs. AAPA approves of this concept. MVPs were developed to shift the focus of comparability from each health professional with all other health professionals to a comparison with other similar health professionals. We believe that accounting for the focus of the health professional results in a more meaningful comparison for Medicare to make and would be more valuable for beneficiaries examining care options, likely between various professionals of the same specialty.

Currently, MVP scoring follows traditional MIPS scoring policies. This was done to reduce complexity during the transition from traditional MIPS to MVPs. However, MVPs may have different contexts for the measures applicable to that specialty. One MVP may have more topped-out measures than others. Another MVP may not yet have core measures that adequately capture services provided as well as core measures that exist in other MVPs. For these reasons, it makes more sense to compare health professionals that have access to the same measures based on the same type of work.

AAPA recommends that CMS proceed with normalizing MVP scores so that MIPS eligible clinicians reporting a given MVP would have their scores compared to other MIPS eligible clinicians reporting the same MVP. However, we caution that comparison across MVPs may still prove challenging. AAPA questions whether this general comparison of health professionals is necessary, or whether payment adjustments and public ratings can be based on relative performance within one's MVP.

Regarding the timing of implementing a new MVP scoring methodology, AAPA suggests a pilot rollout before the calendar year 2029 performance period to allow health professionals to familiarize themselves with the new requirements while participation in traditional MVPs is still available.

Advanced Alternative Payment Models (APMs) Incentive Payment

When the Medicare Access and CHIP Reauthorization Act of 2015 established the Quality Payment Program, it included incentives to encourage the formation of, and participation in, Advanced Alternative Payment Models (APMs). Advanced APMs seek to increase quality while decreasing costs. The Advanced APM incentives were intended to encourage more health professionals to participate in Advanced APMs rather than the concurrent Merit-based Incentive Payments System (MIPS) track. The incentives were statutorily set at a 5% bonus level and designated to expire in performance year 2022 (payment year 2024). After the bonus expired, CMS was to begin paying Advanced APM participants at a higher Physician Fee Schedule rate beginning in performance year 2024 (payment year 2026). However, this timeline left one year (performance year 2023/payment year 2025) in which there was no financial incentive for Advanced APM participation. In the 2024 Physician Fee Schedule, CMS implemented a section of the Consolidated Appropriations Act of 2023 that sought to bridge the gap year by offering a reduced rate of 3.5% (as opposed to 5%) in performance year 2023 (payment year 2025). Subsequently, through the Consolidated Appropriations Act of 2024, Congress again established an incentive bonus, this time for a rate of 1.88% for payment year 2026.

While the establishment of two separate conversion factors, one for qualifying participants in Advanced APMs (QPs) and one for non-QPs, is a statutorily mandated requirement resulting from the termination of the Advanced APM bonus, AAPA has continued to worry about the expiration of the separately available Advanced APM incentive bonus and that a shift to a modestly elevated payment rate may be viewed as insufficient and encourage some participants to move away from the value-based models found under Advanced APMs and move back to the MIPS track, which more closely resembles fee-for-service. We believe this would be counter to CMS's long-term goals of transitioning to fee-for-value.

In past comments we have urged CMS to analyze whether there is a resulting decline in Advanced APM participation due to the change in incentive. AAPA requested that, should CMS identify adverse results, the agency investigate ways to continue to financially encourage participation in Advanced APMs to a greater extent than the MIPS program.

Consequently, AAPA is pleased that, in the 2027 Physician Fee Schedule proposed rule, CMS is implementing a section of the Consolidated Appropriations Act of 2026, which again revives the APM incentive payment. The incentive payment is statutorily set at 3.1% for the payment year of 2028. While we note that this still leaves no

incentive payment available for 2027, we appreciate actions taken to provide the incentive payment for 2028. However, much like annual Congressional intervention to make payment adjustments to counteract cuts to the conversion factor, we believe that occasional annual Congressional intervention to maintain an incentive bonus does not provide surety regarding the availability of these funds. We continue to recommend that CMS work with Congress to extend the payment incentive for a longer period to more firmly motivate transition to, and increase participation in, Advanced APMs.

APM QP and Partial-QP Determinations at the TIN Level

Currently, while QP determinations are made at the entity level, QP status is applied at the individual level. That is, if an individual were determined to be a QP under one TIN/NPI arrangement, that QP status would be applied to all the individual's TIN/NPI relationships. When this occurs, an individual is a QP at each of their TINs, irrespective of whether those TINs are participating in Advanced APMs.

As a result of QP status being applied at each TIN the QP works, regardless of Advanced APM status, TINs that are not part of an Advanced APM still may enjoy the benefits intended for QPs. These benefits include the ability to be excluded from MIPS, but also financial incentives. Initially, financial incentives for Advanced APM participation consisted of a lump sum incentive payment, which CMS could try to direct toward Advanced APM participating TINs by assigning the payment to the TIN under which the QP received APM status. However, as of 2026, the Social Security Act requires that QPs receive a higher conversion factor update than non-QPs. This change means that the financial incentive of being a QP is now provided in every claim's reimbursement.

CMS is concerned that, under the current structure, these financial incentives paid for QP status are being paid to TINs that are not part of an Advanced APM, and as such that these TINs now have little incentive to join an Advanced APM. To remedy this, in the 2027 Physician Fee Schedule proposed rule, CMS is proposing that QP status and partial QP status would only apply to the clinician at a TIN that's participating in an Advanced APM. This proposal would ensure that the financial benefits, such as the APM incentive payment and the QP conversion factor adjustment, would only apply to the TINs participating as Advanced APMs.

AAPA understands the value of CMS's proposal. We expect that not only would this policy prevent an unearned financial windfall for TINs that do not participate in Advanced APMs, but that there may be positive behavioral adjustments as well. With this requirement, it is possible that QP participants may choose to provide more care at the site of service in which they're determined to be a QP, increasing the availability of care in settings that incentivize care quality while being accountable through financial risk. It is also possible that as a result, TINs that are not formerly participating in Advanced APMs may feel motivated to participate in Advanced APMs in order to secure financial benefits they had become accustomed receiving prior, increasing the number of locations in which

financial incentives and risk are elevating quality of care. AAPA is also pleased by CMS's analysis that clinician experience has not been significantly impaired by a similar NPI/TIN arrangement that exists under MIPS. While we are aware this may immediately reduce the financial benefits accrued by some QPs who are receiving elevated payment regardless of site of service, we find the continuation of the current process difficult to justify from a fiscal responsibility perspective, and the possible incentives for behavioral change to be enticing. AAPA encourages CMS to finalize its proposal that QP status and partial QP status would only apply to a clinician at a TIN that is participating in an Advanced APM.

Proposal to Remove the Public Reporting Requirements for MVP New Measures

In the 2022 Physician Fee Schedule, CMS finalized a policy that the agency would not publicly report any data on a new improvement activity or promoting interoperability measure, objective, or activity for the first year the new measure is included in an MVP. This policy was intended to encourage participation in MVPs by allowing time for participants to transition to MVPs without concern of public reporting on performance of new measures. However, CMS no longer believes that this policy has been an adequate incentive as most improvement activities and promoting interoperability measures are not considered new due to their longtime existence in MIPS. This minimal applicability has led this flexibility to only apply to a handful of MVP participants. CMS continues that, to deprive consumers of this information, which they find understandable and useful, may negatively impact beneficiary decision-making.

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to remove the previously established incentive to not publicly report any data on new improvement activity or promoting interoperability measures, objectives, or activities for the first year the measure is included in the MVP. Instead, the agency would revert to the policy in place before this incentive, which is to include all available performance data in public reporting on Care Compare.

In light of CMS data showing minimal impact of the intended incentive, AAPA approves of CMS's proposal in the 2027 Physician Fee Schedule proposed rule to remove its previously established incentive to not publicly report any data on new improvement activity or promoting interoperability measures, objectives, or activities for the first year the measure is included in the MVP. We note that the minimal effect it may have had in incentivizing MVP participation will soon be moot after the compulsory transition in the calendar year 2029 performance period. In addition, the removal of this incentive will increase transparency of care as beneficiaries will be able to access complete information on provider performance.

Request for Information Regarding Star Rating Assignment Methodology for Administrative Claims Quality Measures

Care Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals and display the professional's overall quality of care based on a Medicare-computed performance score. On this website, a provider's performance is often displayed in easy-to-understand five-star ratings, determined by the Achievable Benchmark of Care 5-star methodology. These ratings are expected to be used by beneficiaries to make comparative care decisions.

In the 2027 Physician Fee Schedule proposed rule, CMS is requesting feedback on potential revisions to Star Ratings. CMS's intention is to make adjustments that would more accurately reflect care provided by health professionals and ensure the information could be more easily understood by patients. CMS indicates that a standard-deviation-based approach could be more straightforward and better understood.

AAPA supports CMS's goals to increase accuracy of publicly available information and for the information to be reflective of the actual care provided. However, we contest that data used in star ratings will never be accurate or reflective, regardless of the scoring methodology, if the agency does not take action to address inaccurate attribution of services by one health professional to another.

When services performed by PAs or NPs are hidden due to "incident to" billing, not only is Medicare unable to accurately determine PA or NP quality scores, but these scores may not appear on the Care Compare site if the health professional does not exceed the low-volume threshold because of a limited number of services being attributed to them. PAs and NPs not being identified on Care Compare, or not being accurately portrayed, impedes patients from making fully informed decisions regarding their choice of healthcare provider. For more information regarding steps CMS can take to mitigate the detrimental effects of "incident to" billing, we encourage the agency to read our more comprehensive comments on this issue, found in the Advance Care Planning section of this letter.

Proposed Removal of the Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure

In the 2027 Physician Fee Schedule proposed rule, CMS proposes to remove the MIPS quality measure "Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure" (PCPCM PRO-PM). The measure is intended to provide broad feedback on receipt of primary care from the patient's perspective. The agency claims that this removal is due to its underutilization and the inability to subsequently establish a benchmark, a situation not unique among MIPS quality measures.

AAPA opposes the removal of the PCPCM PRO-PM. We have long supported the use of patient-reported outcomes to elevate the patient voice and perceived experience in determinations of adequate care. Elsewhere in the proposed rule, AAPA applauds CMS for the inclusion of patient-reported outcomes in the ten new quality measures proposed and suggests patient-reported outcomes as a potential metric for determining improved outcomes that result from advanced use of technology. We are particularly surprised regarding the proposed

removal of this measure due to the emphasis throughout the proposed rule on advancing and reimagining primary care. Patient-reported outcomes by design provide accountability of sufficient care provision, a subject CMS requests feedback regarding under its primary care request for information. CMS may wish to maintain this measure to provide information that will help inform what the future of patient-centered primary care will look like, provide accountability, and determine success in CMS achieving its stated goals for primary care.

AAPA Positions and Recommendations on this Topic

- **AAPA is pleased that CMS has assigned a date for the official transition from traditional MIPS to MVPs. AAPA supports the transition from traditional MIPS to MVPs, specifically because it increases comparability between like professionals.**
- **AAPA approves of the proposed timeline to transition from traditional MIPS to MVPs and believes that, given CMS projections regarding how many specialties can now identify an MVP to which it will report, the 2029 performance year transition is reasonable.**
- **AAPA cautions that CMS's efforts at comparability remain encumbered by billing provisions such as "incident to" that obscure the accurate attribution of services to the appropriate health professional.**
- **AAPA supports a restrained approach to the MIPS performance threshold in light of the ongoing transition to MVPs. However, once the transition to MVPs is complete and sufficient data on performance under MVPs has been accumulated, we encourage CMS to revisit the performance threshold to ensure that participants performing well are adequately compensated for their high performance.**
- **AAPA suggests that CMS may further assist in the transition to MVPs by providing more educational resources and technical assistance. AAPA recommends prioritizing educational outreach to practitioners who have not yet voluntarily reported to an MVP or are in their first year of doing so and suggests including examples of MVPs and their corresponding measures, as well as clinical vignettes of various scenarios that vary by specialty and reporting method.**
- **AAPA encourages CMS not to wait until the fee schedule rule directly before compulsory participation to complete a first round of established MVPs in which it feels comfortable nearly everyone will be able to report. AAPA encourages the agency to seek input from various types of affected health professionals when determining which specialties/conditions CMS will recognize as pathways, as well as the applicability of various measures to an MVP.**
- **AAPA encourages maximum flexibility and fiscal leniency in the first few years of compulsory MVP reporting, similar to what was provided under the implementation of traditional MIPS.**
- **AAPA encourages CMS to consider implementing other flexibilities prior to the 2029 transition, such as the ability to report to an MVP as a virtual group in 2028 instead of 2029. To accurately assess whether earlier participation is desired and feasible from the standpoint of virtual groups, CMS should use**

feedback from virtual groups on perceived additional burdens and what requires addressing before the ability to report MVPs.

- **AAPA supports the concept of establishing core measures to increase, to an extent, standardization of reporting under MVPs to provide more directly comparable clinician data, as well as to incentivize high performance on measures that capture the focus of the MVP.**
- **AAPA approves of the concept of setting the number of core measures, as opposed to the previously identified method of setting the number as a percentage of the total available measures. While AAPA notes that CMS is proposing to "select a minimum of three MIPS core measures," we advise CMS not to choose more than this amount unless necessary to reflect the care central to the MVP specialty.**
- **AAPA concurs that core measures would be a sufficient replacement for outcome/high-priority designated measures (as a core measure is to be outcome focused and determined to be high priority), may help with the impending transition to MVPs, and will allow for increased data on performance that may extend further back than participation in an MVP.**
- **AAPA supports flexibility regarding the reporting of core measures offered by CMS for small practices, as well as for those who for justifiable reasons cannot report a core measure, but encourages monitoring of larger practices that repeatedly indicate a lack of ability to report a core measure for periodic verification.**
- **AAPA approves of the inclusion of new quality measures focused on patient-reported outcomes and chronic disease management.**
- **AAPA approves of the improvement activities CMS proposes to add.**
- **AAPA approves of the idea of increasing the standard for electronic prior authorization over time. However, AAPA also suggests that CMS allow exemptions, as it has in the past, for small, rural, or underserved practices that may not be possess the resources to adopt electronic prior authorization, and consider what steps the agency could take (direct financial support, technical assistance, etc.) to help these practices eventually possess these capabilities.**
- **AAPA recommends that CMS proceed with normalizing MVP scores so that MIPS eligible clinicians reporting a given MVP would have their scores compared to other MIPS eligible clinicians reporting the same MVP. AAPA suggests a pilot rollout prior to the calendar year 2029 performance period to allow health professionals to familiarize themselves with new requirements while participation in traditional MVPs is still available.**
- **AAPA is pleased that, in the 2027 Physician Fee Schedule proposed rule, CMS is implementing a section of the Consolidated Appropriations Act of 2026 which revives the APM incentive payment. We continue to recommend that CMS work with Congress to extend the payment incentive for a longer period to more firmly incentivize transition to, and increase participation in, Advanced APMs.**
- **AAPA encourages CMS to finalize its proposal that QP status and partial QP status would only apply to a clinician at a TIN that's participating in an Advanced APM.**

- **AAPA approves of CMS's proposal in the 2027 Physician Fee Schedule proposed rule to remove its previously established incentive not to publicly report any data on new improvement activity or promoting interoperability measures, objectives, or activities for the first year the measure is included in an MVP.**
- **AAPA supports CMS's goals to increase accuracy of publicly available performance information and for the information to be reflective of the actual care provided. However, we contest that data used in star ratings will never be accurate or reflective, regardless of the scoring methodology, if the agency does not take action to address inaccurate attribution of services by one health professional to another.**
- **AAPA suggests that CMS may wish to maintain the PCPCM PRO-PM to provide information that will help inform what the future of patient-centered primary care will look like, provide accountability, and determine success in CMS achieving its stated goals for primary care.**

Professional Title

AAPA requests that all references to PAs in regulations and policies be listed as "Physician Assistants/Physician Associates," as recognized in 20 CFR § 220.46 (a)(9).[47] This accurately reflects PAs who graduate with degrees as either "physician assistant" or "physician associate" and are state-licensed as a "physician assistant" or "physician associate."

The synonymous titles are recognized as follows:

- The Accreditation Review Commission for the Physician Assistant (ARC-PA) recognizes and accredits "physician assistant" and "physician associate" programs.[48]
- The National Commission for the Certification of Physician Assistants (NCCPA) recognizes the titles "physician assistant," "physician associate," and "PA" as being synonymous.[49]
- The Code of Federal Regulations and the Railroad Retirement Board (RRB) recognize the titles and professional practice of "physician assistants" and "physician associates" as being the same.[50]

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[47] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. https://public-inspection.federalregister.gov/2025-00515.pdf

[48] Accreditation Review Commission on Education for the Physician Assistant. *ARC-PA accreditation handbook for entry-level PA programs.* November 2024. https://www.arc-pa.org/wp-content/uploads/2025/05/Accreditation-Handbook-Nov2024.pdf

[49] National Commission on Certification of Physician Assistants. *NCCPA board certification and title change*. Accessed September 10, 2025. https://www.nccpa.net/resources/board-certification-and-title-change/

[50] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. https://public-inspection.federalregister.gov/2025-00515.pdf

- The Joint Commission recognizes "physician assistants" and "physician associates" regardless of the title, as long as they are "practicing within the scope of their license as defined by law/regulation."[51]

Although the profession has been known as "physician assistant," the title of the profession is now recognized as "physician associate" to more accurately reflect the breadth of education, training, experience, and services of PAs. This is reflected in the title of multiple state and territory laws and licensures, professional training programs, and the name of the AAPA and other professional organizations.[52] Additionally, a committee of the New Hampshire Medical Board[53] found that, to address misconceptions of the PA profession, all laws and regulations should be changed from "physician assistant(s)" to "physician associate(s)." Despite the recognized title of "physician associate," it is anticipated that it will take some time for the title change from "physician assistant" to "physician associate" to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to "physician assistant" and "physician associate" is recommended to avoid confusion. **AAPA urges CMS to reference the profession by the dual title "physician assistant/physician associate."**

Thank you for the opportunity to provide comments regarding the 2027 Physician Fee Schedule proposed rule. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Sondra DePalma, AAPA Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

David J. Bunnell, PhD, PA-C, DFAAPA
President & Chair of the Board

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[51] Joint Commission. Email correspondence. September 10, 2025.
[52] OR Rev. Stat. § 677, MN Stat. 316; WI. Stat. § 448.974(1)(a)(2)-(6); 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p); DEL. CODE ANN. tit 24, § 1770A(5); and IOWA CODE § 148C.1(7) [effective July 1, 2026].
[53] New Hampshire Committee to Research Physician Assistant Scope of Practice. *Final report of the committee to research physician assistant scope of practice, HB 1222, Chapter 264, Laws of 2024*. November 1, 2024. https://www.aapa.org/wp-content/uploads/2024/11/HB-1222-2024-Report.pdf