



September 11, 2023

The Honorable Chiquita Brooks-LaSure, MPP  
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 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program - Attention: CMS-1784-P**

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 168,300 PAs (physician assistants/associates) throughout the United States, are pleased to provide comments on the 2024 Physician Fee Schedule proposed rule. PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies in the proposed rule. PAs currently provide hundreds of million patient visits each year and many of those visits are with Medicare beneficiaries.

AAPA believes that PAs play an essential role in meeting many of the challenges currently faced by the healthcare system. A recent Harris Poll conducted on behalf of AAPA indicated that approximately nine in ten patient respondents agreed that PAs add value to the healthcare team, provide safe and effective healthcare, increase access, improve health outcomes, improve the quality of care, are well educated, and have more time for patients.<sup>1</sup> As such, PAs stand ready to work in partnership with CMS to advance policies that increase access to high quality care for all Medicare beneficiaries. It is within this context that we draw your attention to our comments.

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<sup>1</sup> <https://www.aapa.org/download/113513/?tmstv=1684243672>

## **Authorizing of PAs to Supervise Cardiac, Intensive Cardiac, and Pulmonary Rehab Services**

Implementing legislative language contained in the Balanced Budget Act of 2018, the 2024 Physician Fee Schedule proposed rule proposes to authorize PAs, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation services. Currently, only physicians are authorized to supervise and prescribe these services. If a physician is not available to supervise these services, patient access may be delayed or, in certain cases, not received at all.

AAPA approves of the proposal and encourages finalization. The ability to supervise cardiac, intensive cardiac, and pulmonary rehabilitative services such as the establishment of an exercise program, counseling, education, and outcomes assessment, is within the level of expertise of PAs.

With the inclusion of PAs, nurse practitioners, and clinical nurse specialists as authorized to supervise cardiac, intensive cardiac, and pulmonary rehabilitation services, AAPA further requests that CMS now modify language regarding “physician prescribed exercise” to include PAs. Previous justifications<sup>2</sup> by CMS for not modifying the term included the fact that language in the Social Security Act (§1861(eee)(3)) stated that the program was under the supervision of a physician. As legislation has now changed this section of the Social Security Act<sup>3</sup> to include PAs and other health professionals as authorized to supervise this program, AAPA requests that, while adding PAs to 42 CFR §410.49 for the purpose of supervision, CMS should now further modify this section accordingly. AAPA would prefer the use of a more general term such as “provider prescribed exercise,” however, if the exact wording is unable to be modified due to statutory constraints, we request that CMS reinterpret the intent of the section to indicate that health professionals now authorized to supervise may prescribe exercise as well. We encourage CMS to make similar modifications when the term is used elsewhere in the CFR (such as 42 CFR §410.47).

Similarly, despite PAs having received authorization to supervise cardiac, intensive cardiac, and pulmonary rehabilitation, statutory language maintains that only a physician may order these services. AAPA contends that there is no medical justification for this ongoing restriction which serves only to limit patient access to such services. We urge CMS to work with Congress to modify physician-centric language in the US Code that prohibits PAs and other health professionals from ordering cardiac, intensive cardiac, and pulmonary rehabilitation.

**AAPA approves of CMS implementing the authorization for PAs, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation services. We request that CMS additionally modify language regarding “physician prescribed exercise” to include PAs. Finally, AAPA urges CMS to work with Congress to modify physician-centric language that prohibits PAs and other health professionals from ordering cardiac, intensive cardiac, and pulmonary rehabilitation.**

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<sup>2</sup> <https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=270>

<sup>3</sup> [https://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](https://www.ssa.gov/OP_Home/ssact/title18/1861.htm)

### **New Step 3 for Accountable Care Organization (ACO) Beneficiary Assignment**

In the 2024 Physician Fee Schedule proposed rule, CMS is again proposing significant changes to the Medicare Shared Savings Program. These include the establishment of a new collection type (Medicare Clinical Quality Measures) to help ACOs begin the transition to greater digital data reporting, revisions in the risk adjustment methodology, and the adjustment of the health equity underserved multiplier.

One change proposed seeks to partially remedy a concern AAPA has long expressed: only patients who have had at least one visit by a physician are eligible to be assigned/attributed to an ACO.<sup>4</sup> As a result of this requirement, Medicare beneficiaries treated solely by a PA or other non-physician health professional cannot be automatically assigned to an ACO. This is especially problematic for patients in rural and underserved areas where a PA is the only health professional in the community. As Medicare beneficiaries in these areas deserve access to the type of coordinated care ACOs provide, AAPA supports CMS's proposed assignment reforms in the 2024 Physician Fee Schedule that seek to bolster Medicare beneficiary participation.

Specifically, CMS is proposing to create a new "Step 3" under the ACO assignment process. While still confined by statutory requirements for a beneficiary to see a primary care physician prior to ACO assignment, CMS seeks to implement greater flexibility in how such a requirement is implemented. Step 3 would allow for an "expanded window," beginning in 2025, in which a beneficiary would have to 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 would be changed, with a beneficiary now able to be assigned if they've seen a PA or other non-physician health professional within that time period.

CMS hopes the creation of the expanded window will capture additional beneficiaries to qualify for ACO assignment than under the previous two-step process. AAPA approves of CMS using the flexibilities within its powers to expand the number of beneficiaries able to be assigned to an ACO. We support the agency's efforts to identify additional beneficiaries who have received most of their care from non-physician health professionals.

AAPA recognizes CMS can only go so far considering statutory limitations on the assignment process and we appreciate the agency's efforts. The proposed expansion of the assignment process will not extend the ability to be assigned to an ACO to all patients. There will continue to be those who have been seen exclusively by a PA or non-physician health professional and are unable to separately see a primary care physician within the two-year timeframe. For such beneficiaries, should they wish to be associated with an ACO, the beneficiary must take the extra step of going online to select a PA (or nurse practitioner) as their ACO provider in order to be assigned to an ACO. As in previous comments CMS has recognized that claims-based assignment is the methodology by which the "vast majority of beneficiaries are assigned,"<sup>5</sup> AAPA believes that CMS's proposal bringing more beneficiaries who are seen mostly by PAs (though still not those seen exclusively) into the

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<sup>4</sup> <https://www.law.cornell.edu/cfr/text/42/425.402>

<sup>5</sup> <https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicare-program-medicare-shared-savings-program-accountable-care-organizations-paths-to-success>

ACO assignment process through an automatic trigger instead of the more cumbersome self-selection, will improve the situation. We urge the agency to finalize its proposed three-step process. As a result, 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. In addition, we continue to urge CMS to work with Congress to remove the continued statutory physician-centric assignment language, which would allow for a simplification of the process.

**AAPA supports CMS establishing a new “step 3” in the ACO assignment process to identify additional beneficiaries who have received most of their care from PAs and non-physician health professionals. We continue to urge CMS to work with Congress to go further by removing the continued statutory physician-centric assignment language.**

### **Continued Delay in the Definition of “Substantive Portion” Under Split (or Shared) Visit Billing**

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to again delay implementation of its modified definition of “substantive portion” to be based solely on time. As such, Medicare's split (or shared) visit billing policy for 2024 will remain unchanged from the requirements for 2023. This continued flexibility is consistent with the requests of AAPA and other medical societies, but its temporary nature ultimately does not provide a definitive policy that providers and healthcare organizations require.

#### *Historical Definition of Split (or Shared) Visit Billing*

A split (or shared) visit refers to an E/M service that is performed “split” or “shared” by both a physician and a PA or nurse practitioner in a hospital or facility setting and billable by the physician at 100% of the physician fee rate. Prior to 2022, CMS defined a substantive portion as, “all or some portion of the history, exam or medical decision making key components of an E/M service.”

#### *CMS's Proposed Modifications to the Definition of Substantive Portion in the 2022 and 2023 Physician Fee Schedule Rules*

In CMS's 2022 Physician Fee Schedule final rule, the agency modified the description of “substantive portion,” defining it differently for the years 2022, 2023, and beyond. For the year 2022, CMS defined “substantive portion” for non-time-based services, as one of the key components (i.e., history, examination, or medical decision making (MDM)) in its entirety or more than half the total time spent on the service. For time-based services, such as critical care and discharge management, the “substantive portion” would be met only if the physician performed more than half the total time spent on the service. For the years 2023 and beyond, CMS intended to modify the definition to be only more than half the total time spent on the service.

CMS asserted that it was modifying the definition of “substantive portion” to provide greater transparency and more accurate attribution of services as to who provided split (or shared) visit services. For similar

transparency reasons, the agency also began to require the submission of an FS modifier to accompany split (or shared) visit claims.

In the 2023 Physician Fee Schedule, CMS partially acknowledged significant concerns expressed by various stakeholders with its transition timeline. The agency proposed to delay for one year (until 2024) the definition of “substantive portion” as only based on time. Consequently, in 2023, instead of “substantive portion” being defined solely as a physician performing more than half the total time of the service, the definition could be met using 2022’s standards of either the history, examination, MDM or spending more than half the time.

#### *CMS’s Proposed Continued Delay to the Definition of Substantive Portion in the 2024 Physician Fee Schedule Proposed Rule*

In the 2024 Physician Fee Schedule proposed rule, CMS again seeks to delay the implementation of using only time to determine who provided a “substantive portion” of the visit. Consequently, the current definition of “substantive portion,” which is determined as one of either the history, physical examination, or MDM or more than half of the total combined time spent on the service by a PA and a physician, will continue through “at least December 31, 2024.” While CMS continues to frame the delay as offering providers more time to transition to the new definition, AAPA continues to be concerned the agency’s plan, against significant opposition, will merely delay it for another year.

#### *AAPA Comments*

AAPA agrees the provider performing the substantive portion of the visit should be identified as the rendering provider of the service. However, requiring a physician to spend and document more than 50% of the time with a patient is a significant change from practices prior to 2022 and, if implemented, would be a significant administrative burden. This burden may be more significant in hospital and facility settings where visits may be interrupted by other necessary services or procedures and exact time spent with each patient may be challenging to monitor. Furthermore, time may not be the best determinant of a substantive portion or contribution to a split (or shared) encounter. One practitioner could perform a substantive portion even though another practitioner spent more than half of the total time on other important aspects of care, such as the history, examination, care coordination, medical record documentation, accurate computerized provider order entry, and other components of a service. In addition, time may be influenced by the individual attributes of a practitioner and by uncontrollable variables such as whether family or caregivers are present, social determinants of health are being addressed, or considerable care coordination is required.

AAPA continues to believe the concept of determining whether a “substantive portion” has been met based solely on who performed more than half the time spent on the service has inherent flaws. AAPA urges CMS to retain the current definition of a “substantive portion” as either more than half of the total time or all of either the history, examination, or MDM, except for strictly time-based services (i.e., hospital discharge management services and critical care services) for which the substantive portion would only be determined by time. AAPA also believes that a continued delay of a final definition a “substantive portion” is significantly

problematic for PAs and organizations who have been in limbo for several years. This has negatively affected determinations regarding practitioner staffing, workflows, documentation and billing processes, productivity bonuses, and contracts. A continued and prolonged delay in a final definition will only exacerbate this problem.

Additionally, if CMS is committed to furthering the transparency of who provides split (or shared) visit services, AAPA recommends that CMS require, in addition to a modifier indicating that care was provided under split (or shared) visit billing, that the name and NPI of the PA or nurse practitioner participating in a split (or shared) visit be included on the claim. This is a step that could be taken irrespective of a final decision by CMS regarding the appropriate definition of “substantive portion.”

**AAPA proposes that CMS make permanent the policy of allowing either all of the history, examination, or MDM or more than half the time spent on a patient’s care as the two choices in determining whether a substantive portion has been met. In addition, AAPA strongly recommends that CMS require the name and NPI of the PA or nurse practitioner participating in a split (or shared) visit be included on the claim, as this will provide the greatest transparency.**

### **Extension of Direct Supervision by Real-time, Audio/Video Technology**

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to extend the authorization to meet direct supervision requirements using real-time, audio/visual technology. CMS extends this authorization through 2024. While AAPA recognizes CMS is attempting to provide continued flexibility to health professionals, we caution that further extension of this authorization, as it pertains to the direct supervision of PAs and nurse practitioners, risks competing priorities of CMS, such as appropriate attribution of services. Consequently, while we will not oppose a one-year extension of direct supervision via real-time, audio/visual technology, we continue to advocate that this flexibility not be made permanent for PAs and nurse practitioners.

Direct supervision is the level of supervision Medicare requires for “incident to” billing, some diagnostic tests, and certain other services. Direct supervision requires the supervising health professional to be immediately available (in-person, but not in the same room) to the professional delivering care. During the public health emergency, CMS indicated through IFC 1744<sup>6</sup> that direct supervision requirements could be met by the supervising clinician being available via audio/visual (real-time, interactive) communication. This flexibility was granted to minimize the transmission of COVID-19, meet the increased needs of patients, facilitate the utilization of telehealth, and mitigate the risk of patients not receiving timely medical care during a pandemic. CMS had subsequently elected to not move forward with making the temporary exception permanent. However, the agency has continued to seek feedback on the matter.

In previous comments to CMS, AAPA expressed our appreciation for the flexibility in meeting direct supervision requirements during the COVID-19 public health emergency. We recognized that this flexibility

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<sup>6</sup> <https://www.cms.gov/files/document/covid-final-ifc.pdf>

was necessary to minimize exposure to COVID-19 and reduce detrimental impacts of the pandemic on the timely provision of care. However, at the same time we were concerned about the impact of such a policy on transparency and data collection efforts, and on increased costs to the Medicare program.

AAPA continues to have significant concerns regarding “incident to” billing for services provided by PAs/nurse practitioners and the transparency complications that come with it. As you are aware, “incident to” is a Medicare billing provision that allows medical services personally 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 us is “incident to” billing pertaining to services performed by PAs and nurse practitioners that are attributed to a physician. Due to the manner in which services billed “incident to” are reported through Medicare’s claims process, a substantial percentage of medical services delivered to Medicare beneficiaries by PAs and nurse practitioners 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 delivered by PAs and nurse practitioners. Accurate data collection and appropriate analysis of workforce utilization is lost. This lack of transparency has a negative impact on patients, health policy researchers, the Medicare program, and PAs/nurse practitioners.

One of the key issues in ensuring that healthcare is consumer-centric is to provide patients with relevant and accurate information about their health status, the care they receive, and the health professionals delivering that care. Each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB) notice after receiving care. The MSN/EOB identifies the service the patient received and who delivered the care, among other details of the visit. “Incident to” billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the MSN/EOB notice. When PA or nurse practitioner services are billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who was not seen by the patient, which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

Care Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals coupled with an assessment of the professional’s overall quality of care based on a Medicare computed performance score. When services performed by PAs or nurse practitioners are hidden due to “incident to” billing, not only is Medicare unable to determine PA or nurse practitioner 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. In addition, if PAs or nurse practitioners have all their services billed under “incident to,” those PAs and nurse practitioners may not appear on the Care Compare website at all. PAs and nurse practitioners not being identified on Care Compare, or not being accurately portrayed, impedes patients from making a fully informed decision regarding their choice of a healthcare provider.

With a substantial number of services provided by PAs and nurse practitioners attributed to physicians through “incident to” billing, data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research performed using such data is similarly biased by a lack of attribution to the PA or nurse practitioner who delivered the care. Publicly available Medicare claims

information, such as Medicare Physician and Other Supplier Data, distort the ability to analyze individual provider contribution or productivity and may unintentionally lead to imprecise or erroneous conclusions despite the use of otherwise sound research evaluation methodologies. 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 hinders the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, quality of care, and resource use allocation.

The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, noted the increasing role of PAs and nurse practitioners in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and nurse practitioners was billed “incident to,” and identified many of the adverse consequences of “incident to” billing stemming from compromised data quality.<sup>7</sup> Similarly, in CMS’s 2019 Physician Fee Schedule final rule, the agency acknowledged that estimates of burden reduction and the impact on practitioner wages due to documentation of evaluation and management services were unclear due to the ability to report services “incident to” a physician when furnished by a PA or nurse practitioner.<sup>8</sup> The absence of data attributed to PAs and nurse practitioners for the services they provide affects their ability to appropriately participate in performance measurement programs, such as the CMS Quality Payment Program, and threatens their ability to be listed along with other health professionals on performance measure websites, such as Care Compare. Similar concern regarding the negative impact of “incident to” billing on the accuracy and validity of value-based programs has been echoed in a Health Affairs Blog in a January 8, 2018, posting.<sup>9</sup> While claims reimbursement is by no means the only measure of a health professional’s value and productivity, it is an essential component. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, can influence the analysis of PA/nurse practitioner healthcare contributions.

AAPA remains concerned that CMS continuing to authorize direct supervision requirements by audio/visual communication would only make it easier to use “incident to” billing, thereby leading to expanded use of the billing mechanism. This would exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional.

Consequently, due to our ongoing concerns with “incident to” billing and its harm to transparency, AAPA continues to suggest that direct supervision by audio/visual communication be authorized only for the supervision of health professionals who are not authorized to bill Medicare for their services. Extending direct supervision by audio/visual communication for these health professionals, such as registered nurses, medical assistants, and technicians, will allow for expanded patient access to care as it will increase flexibility in supervisory requirements for such professionals to perform their duties while not having an adverse impact on transparency. PAs and nurse practitioners are able to 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. Any further extension of direct supervision by audio/visual communication for PAs and nurse

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<sup>7</sup> <https://www.medpac.gov/document-type/report/>

<sup>8</sup> <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>

<sup>9</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20180103.135358/full/>



practitioners would only serve to further impair data transparency through the potential proliferation of “incident to” billing.

**AAPA strongly encourages CMS to not extend the authorization for direct supervision by real-time, audio/video technology for medical services performed by PAs and nurse practitioners beyond the time period proposed in the rule.**

## **Telehealth Provisions**

### *General Provisions*

The 2024 Physician Fee Schedule proposed rule continues to expand flexibilities regarding the use of telehealth to provide care to Medicare beneficiaries. AAPA believes that, through significantly increased usage during the COVID-19 pandemic, telehealth has demonstrated its ability to improve and extend patient access to care. Telehealth continues to be an essential modality of care, especially in rural and underserved communities, even after the public health emergency has ended.

In the 2024 Physician Fee Schedule proposed rule, CMS continues to add to its Medicare Telehealth Services List. Specifically, it adds the ability to provide Health and Well-being Coaching services via telehealth, on a temporary basis (through 2024). Meanwhile, it adds the social determinants of health risk assessment (see section below) on a permanent basis. AAPA approves of these additions. We encourage CMS to remain vigilant in reviewing additional evidence regarding the services it proposes to add on a temporary basis, so that, if warranted, a determination of permanent inclusion can be made when CMS receives a level of evidence it deems sufficient.

In addition, CMS proposes to once again remove frequency limits on the number of telehealth subsequent inpatient or nursing facility visits. If finalized, the removal of these frequency limits will last through 2024 to align with the extension of other flexibilities through 2024 under the Consolidated Appropriations Act (see below). These frequency limitations, that existed prior to the pandemic, were reinstated, but not yet enforced, following the end of the public health emergency. AAPA supports the renewed removal of these limits as CMS gathers more information as to how the pandemic has shifted practice patterns. We request CMS make broad inquiries as to whether such services are occurring frequently, whether they influence care quality, and to what extent they affect practice efficiency and access.

Finally, CMS also seeks to expand the usage of telehealth in teaching hospitals. The agency states that, through 2024, teaching physicians may use audio/visual real-time communications technology when a resident furnishes Medicare telehealth services, in all residency training locations. In addition, CMS is planning to identify clinical treatment situations when it may be appropriate to allow virtual presence of a teaching physician. AAPA approves of CMS exploring the greater use of telehealth in these settings.

### *Telehealth Provisions of the Consolidated Appropriations Act of 2023*

In our comments to CMS's 2023 Physician Fee Schedule proposed rule, AAPA expressed support for the concept of permanently defining a telehealth originating site of service to be any site where the beneficiary is located. We are pleased to see that the 2024 Physician Fee Schedule is implementing a provision of the Consolidated Appropriations Act of 2023 which temporarily expands, through the end of 2024, the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service. However, while the extension of this policy through the end of 2024 is welcome, AAPA continues to urge CMS to work with Congress to make this expanded definition permanent. A statutory change to the definition of originating site will ensure that patients with logistical, mobility, transportation, and other challenges will continue to have access to appropriate and timely care.

Other flexibilities, which were previously extended until 151 days after the end of the public health emergency by the Consolidated Appropriations Act of 2022, have now been extended through the end of 2024 by the Consolidated Appropriations Act of 2023. These include:

- The expansion of the definition of eligible telehealth professionals (to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists. This term will also now include marriage and family therapists and mental health counselors)
- A methodology for payment for telehealth services furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- A delay in the requirement for an in-person visit with a physician or non-physician practitioner within six months prior to initiating mental health telehealth services, and again at subsequent intervals the Secretary deems appropriate (as well as similar requirements for RHCs and FQHCs), and
- Continued coverage and payment for services on the Medicare Telehealth Services List, such as audio-only telephone visits

AAPA approves of these extensions. These flexibilities will reduce confusion and burden for health professionals as they would provide some consistency in requirements from the 2023 calendar year. AAPA believes the ways in which care is delivered have, in some ways, been permanently changed by the public health emergency. This includes an increased comfort and reliance on telehealth. CMS and Congress are still grappling with what expanded use of telehealth, with both its promises and pitfalls, may look like. Until this has been determined, AAPA supports continued flexibility to encourage use of this care resource as needed. We also encourage that, upon completion of the flexibilities, the Secretary does not reinstitute mental health in-person visit requirements that are beyond those explicitly required by statute.

### *Payment for Certain Telehealth Services at the Non-Facility Rate*

In the 2024 Physician Fee Schedule proposed rule, CMS is proposing that claims for telehealth services provided when the patient is located in their home (place of service 10) would be paid at the non-facility rate. Meanwhile, claims for telehealth services provided in locations other than a patient's home (place of service

02) will be reimbursed at the facility rate, whether in an office or a hospital setting. As the non-facility rate is typically higher than the facility rate, CMS expects that the payment for telehealth services in the home at the non-facility rate would better support behavioral health services, which are now authorized to be provided in this setting. CMS notes the increase in demand for behavioral health services that has outlasted the public health emergency and the evolution of the way in which behavioral health services are now provided. The agency believes that the non-facility rate would more accurately reflect the resources used for these services.

AAPA supports CMS's reimbursement for home-based telehealth services at the non-facility rate. We believe that financial incentive for the delivery of such services is an important component in meeting increased demand for behavioral healthcare. However, we question whether it is appropriate to assign all telehealth services that do not occur in the home to be paid at the (reduced) facility rate. During the public health emergency, the determination of facility vs. non-facility rate was made based on where the service most likely would have occurred should it have been held in person. AAPA recommends further examination of whether practice expenses are properly met under the new system, or whether telehealth services that would have taken place in an office if in person, are now being under-reimbursed.

#### *The Listing of a Health Professional's Home Address as a Result of Telehealth Services Provided from the Provider's Home*

While not explicitly mentioned among CMS's telehealth services provisions within the 2024 Physician Fee Schedule proposed rule, AAPA would like to voice concern over a telehealth issue brought to our attention. Specifically, during the public health emergency, CMS authorized health professionals who provided telehealth services from home to list their previously enrolled location, as opposed to stating their home address, on their enrollment. This was to protect the privacy of health professionals as the public reporting of this practice location, in this case a home address, could be accessed by patients or others. A guidance document released in late July of 2023 indicates the waiver that allowed health professionals to not post their home address is expected to continue until the end of the year (through 2023).<sup>10</sup> Consequently, the phrasing of the document implies that the ability to not publicly declare one's home address will expire at that time. AAPA has heard feedback expressing concern regarding the potential future requirement to publicly report the home address of health professionals who provide telehealth from their home. This issue is not only a matter of privacy, but also provider safety. We encourage CMS to establish a new permanent process that allows health professionals to avoid disclosing their home address.

**AAPA approves of additions to the Medicare Telehealth Services List and encourages those additions made on a temporary basis to be revisited for permanent inclusion upon receipt of sufficient additional evidence. AAPA supports CMS again removing the limitations on telehealth subsequent inpatient and nursing facility visits, as well as CMS exploring greater use of telehealth in teaching hospital settings. AAPA continues to support a permanent expansion of the definition of originating site and supports those extensions of telehealth flexibilities through 2024 that are required by the Consolidated Appropriations Act of 2023. We also encourage that, upon completion of the**

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<sup>10</sup> <https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf>

**flexibilities, the Secretary does not reinstitute mental health in-person visit requirements that are beyond those explicitly required by statute. AAPA supports CMS paying for telehealth services provided in the home at the non-facility rate and encourages additional scrutiny of when other telehealth services also may consist of an elevated practice expense that would justify a non-facility rate of reimbursement as well. Finally, AAPA encourages CMS to refrain from requiring health professionals who provide telehealth services from their home to publicly list their home address.**

### **Update to the Hospice Conditions of Participation**

AAPA is pleased to see CMS implement changes to the Hospice Conditions of Participation in order to increase access to needed services. Specifically, in the 2024 Physician Fee Schedule proposed rule, CMS proposes to implement sections of the Consolidated Appropriations Act to establish a new benefit category for marriage and family therapist (MFT) services and mental health counselor (MHC) services under hospice. The intent of the provision is to provide further flexibility regarding who may fulfill an important role on the interdisciplinary group (IDG) in order to meet the individualized needs of hospice patients. MFTs and MHCs are added to the section in which the composition of an IDG is spelled out. As proposed, the section would now indicate that the IDG must now include a social worker, MFT, or MHC. AAPA approves of the implementation of this provision. The expanded list of health professionals who may meet the requirements for compulsory members of the IDG is a recognition that flexibility in IDG composition is essential to meet hospice demand and to provide appropriate, context-driven care to hospice participants. We note that a similar rationale should be used for allowing PAs and nurse practitioners to substitute in the place of a physician as a required member of the IDG when appropriate. Currently, CMS finds the physician-centric language in [42 U.S.C. 1395x\(dd\)\(2\)\(B\)\(i\)\(I\)](#) to be prohibitive of such an authorization. However, to further achieve comparable IDG flexibility, CMS should work with Congress to modify the language in this section to allow for PAs and nurse practitioners to serve as a required member of the IDG in the position currently allotted solely for physicians.

AAPA approves of CMS efforts in this rule, and others, to increase beneficiary access to hospice services. Hospice care is underutilized.<sup>11</sup> In CMS's 2024 Hospice Wage Index proposed rule,<sup>12</sup> the agency concurs with this, indicating that while utilization of the benefit has substantially grown, despite the benefits of hospice, there may be an underutilization of the program by beneficiaries. Underutilization of hospice can lead to a prolonged patient usage of expensive and ineffective care. The causes of postponement in electing hospice care are multiple and may include the difficulty of a provider concluding a patient's prognosis is terminal and the difficulty in people 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 are only additive in harm.

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<sup>11</sup> <https://pubmed.ncbi.nlm.nih.gov/30142388/>

<sup>12</sup> <https://www.federalregister.gov/documents/2023/04/04/2023-06769/medicare-program-fy-2024-hospice-wage-index-and-payment-rate-update-hospice-conditions-of>

Much like the proper utilization of MFTs and MHCs codified in this rule, greater use of qualified PAs has the potential to reduce care barriers and move toward ameliorating the problem of eligible beneficiaries not adequately accessing hospice services. Proper utilization of PAs will help ensure that hospice organizations are sufficiently staffed with health professionals who can provide a broad array of services, increasing capacity and bolstering the benefit to patients. AAPA suggests five additional ways in which CMS can support greater utilization of PAs to increase access to hospice care.

CMS correctly states that, “We have broad statutory authority for most provider and supplier types to establish health and safety regulations, which includes the authority to establish health and safety requirements that advance health equity for underserved communities.” As such, the agency has the authority to remove non-statutory restrictions that inhibit patient access but have no basis in safety. One such restriction can be found within the Hospice Conditions of Participation at [42 CFR § 418.106\(b\)\(1\)\(iii\)](#). This restriction, not specifically based in statute, indicates that PAs who are employed by a hospice are unable to order medications for hospice patients. This arbitrary restriction prevents PAs who work in hospice settings from providing needed care. This restriction is also within the purview of CMS to address by regulatory means. AAPA recommends CMS modify 42 CFR § 418.106(b)(1)(iii) to authorize PAs employed by a hospice to order medications for hospice patients.

Similarly, CMS has a policy whereby if a beneficiary does not have a physician, nurse practitioner, or PA who provided primary care to them prior to, or at the time of, terminal illness, the beneficiary is given the choice of being served in the role of attending physician by either a physician or nurse practitioner who works for the hospice. This policy unnecessarily limits the number of health professionals who can fill the important role of an attending physician under specific circumstances. When not employed by a hospice, PAs are authorized by CMS to serve in the role of a hospice attending physician. Much like the previous restriction, this is within the purview of CMS to address, in this case by modification of agency policy. AAPA recommends CMS modify the [Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.3](#) to authorize PAs employed by the hospice to serve in the role of a patient’s attending physician if an attending physician was not previously selected by the patient.

Third, CMS should promote the concept that, after the election of the hospice benefit, beneficiaries be allowed to keep the health professional with whom they feel comfortable as part of their care team in the form of their hospice attending physician. Currently, Medicare policy authorizes PAs to act as attending physicians for Medicare hospice patients. As such, a patient who receives their care from a PA prior to their terminal illness may continue to have the health professional with whom they’ve built a relationship involved in their care decisions after hospice election. However, while Medicare authorizes PAs to be attending physicians, CMS also defers to state law/regulations and facility policies as to whether PAs are authorized to practice in this role. If language prohibiting PAs from acting as hospice attending physicians exists in state law/regulations or facility policies, PAs in the state would not be able to do so until the restrictive language is removed. AAPA requests that CMS communicate the myriad benefits of authorizing PAs to serve as attending physicians through best practices bulletins, and in doing so encourage any states or facilities with restrictive policies to authorize PAs to be attending physicians under Medicare hospice.

Finally, CMS should support the removal of direct barriers to patient certification/recertification and admission to a hospice. The agency can do this by advocating the removal of two policy prohibitions. First, PAs and nurse practitioners are currently unable to certify or recertify a patient's terminal illness, which is necessary for patient admission to a hospice. Second, PAs are not authorized to conduct a face-to-face encounter prior to recertification after a patient has been in hospice for 180 days. These prohibitions are a direct barrier to patients gaining access to needed hospice care. AAPA recommends that CMS work with Congress to remove these legislative restrictions by modifying [42 U.S.C. 1395f\(a\)\(7\)\(A\)](#) to authorize PAs and nurse practitioners to certify and recertify terminal illness, and [42 U.S.C. 1395f\(a\)\(7\)\(D\)\(i\)\(I\)](#) 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 supports CMS proposals to add MFTs and MHCs as options on the IDG. AAPA requests CMS work with Congress to modify the language in this section to allow PAs and nurse practitioners to serve as a required member of the IDG in the position currently allotted solely for physicians. AAPA suggests five additional ways in which CMS can support greater utilization of non-physician health professionals to increase access to hospice care, including modifying 42 CFR § 418.106(b)(1)(iii) to authorize PAs employed by the hospice to order medications for hospice patients, modifying the Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.3 to authorize PAs employed by the hospice to serve in the role of a patient's attending physician if an attending physician was not previously selected by the patient, encouraging states that prohibit PAs from serving as attending physicians to update their policies to be in alignment with Medicare policy, modifying [42 U.S.C. 1395f\(a\)\(7\)\(A\)](#) to authorize PAs and nurse practitioners to certify and recertify terminal illness, and updating [42 U.S.C. 1395f\(a\)\(7\)\(D\)\(i\)\(I\)](#) 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.**

### **Expansion of Access to Behavioral/Mental Health Services**

In the 2024 Physician Fee Schedule proposed rule, CMS identifies a number of proposals that seek to make it easier for Medicare beneficiaries to access needed behavioral/mental health services. The proposed changes include implementing several sections of the Consolidated Appropriations Act of 2023, such as the authority of marriage and family therapists (MFTs) and mental health counselors (MHCs) to bill for their services under Medicare Part B, allowing addiction counselors to enroll in Medicare as MHCs (as long as applicable requirements are met), allowing these health professionals to provide integrated behavioral healthcare in primary care settings (as well as increasing the valuation for General Behavioral Health Integration Care Management), and establishing new HCPCS codes for psychotherapy for crisis services in certain settings. CMS is also proposing to allow Health Behavior Assessment and Intervention services to be billed by clinical social workers, MFTs, MHCs, and clinical psychologists, proposing to increase the valuation of psychotherapy codes over a four-year horizon, and authorizing auxiliary personnel to furnish behavioral health services in RHCs and FQHCs under general supervision of a physician or non-physician practitioner (and when being performed incident to the services of the physician or non-physician practitioner).

AAPA recognizes that these proposals seek to expand the number of health professionals available to meet rising demand for behavioral/mental health services and expand, as well as more properly compensate, for psychotherapy services. AAPA supports these proposals made by CMS to increase access to behavioral/mental healthcare as we believe they can be important contributing factors to addressing the rising demand for behavior/mental health services. However, AAPA believes more can be done by CMS to help bolster patient access to such services.

In the 2024 Physician Fee Schedule proposed rule CMS also seeks general comment on additional ways the agency can help expand access to behavioral/mental health services. AAPA advises that PAs can play an important role in increasing beneficiary access. PAs practice in psychiatry and provide behavioral/mental health services across multiple specialties. With PAs demonstrating that they are qualified providers of behavioral/mental health services, further action by CMS on this issue, including the encouragement of private payers with whom the agency contracts to remove outdated barriers to PAs providing this care, can bolster the number of PAs practicing in relevant specialties to alleviate access concerns in a time when demand is increasing.

The CMS 2023 Physician Fee Schedule proposed rule correctly identified the pandemic as exacerbating existing barriers to behavioral/mental healthcare at a time of increasing demand. However, despite a recent declaration that the public health emergency has officially ended, this does not mean the burdens of the pandemic on the health system will recede. Specifically, access to behavioral/mental healthcare is expected to continue to be a problem due to increased demand and worsening workforce shortages.

Mental and behavioral health, much like healthcare generally, is experiencing worsening provider shortages, compounding already existing access issues. Sixty percent of US 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.<sup>13</sup> A recent New York University study found that while demand for mental health services is increasing, patient access is decreasing.<sup>14</sup> Untreated mental and behavioral health conditions can result in disability, lost productivity, substance abuse issues, family discord, and even death.<sup>15</sup>

The National Center for Health Workforce Analysis indicates that by 2030, 44 states are projected to have fewer psychiatrists than needed to meet the demand for services.<sup>16</sup> 156 million people live in communities

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<sup>13</sup> Substance Abuse and Mental Health Services Administration. 2019. Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>

<sup>14</sup> Heath, Sara. PatientEngagementHIT. 2017. Mental Healthcare Access Shrinks as Patient Demand Grows. Retrieved from <https://patientengagementhit.com/news/mental-healthcare-access-shrinks-as-patient-demand-grows>

<sup>15</sup> Mayo Clinic. 2019. Mental Illness. Retrieved from <https://www.mayoclinic.org/diseasesconditions/mentalillness/symptomscauses/syc20374968#:~:text=Untreated%20mental%20illness%20can%20cause,Family%20conflicts>

<sup>16</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. Rockville, Maryland. Retrieved from <https://www.hrsa.gov>

with limited access to mental healthcare services.<sup>17</sup> The National Council for Behavioral Health expects that, by 2025, there will be a deficit of 12% in the psychiatric workforce to sufficiently address patient needs.<sup>18</sup> 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.<sup>19</sup> These problems will be further magnified in rural and underserved areas.

Increased practice flexibilities for behavioral/mental health professionals will have a positive impact in addressing such access issues. All qualified health professionals must be authorized to practice to the fullest extent of their license and training. As qualified providers of behavioral and mental health services, PAs can play an important role in increasing beneficiary access to needed care.

PAs are trained and qualified to treat behavioral and mental health conditions through their medical education, including didactic instruction and clinical practice experience in psychiatry and other medical specialties, and have national certification, state licensure, and authority to prescribe controlled and non-controlled medications.<sup>20</sup> PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral/mental health services. Based on their graduate level medical education, PAs practicing in mental health and substance use treatment can expand access to necessary care. PA education includes more than 2,000 hours in clinical rotations, including experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan from pediatrics to geriatrics, providing a foundation to address the diverse medical needs of people with mental illness or substance use issues.<sup>21</sup>

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.<sup>22</sup> 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.

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<sup>17</sup> <https://data.hrsa.gov/topics/health-workforce/shortage-areas>

<sup>18</sup> National Council for Behavioral Health. 2017. The psychiatric shortage: Causes and solutions. Retrieved from <https://www.thenationalcouncil.org>

<sup>19</sup> Ibid

<sup>20</sup> American Academy of PAs. What is a PA? Retrieved from <https://www.aapa.org/what-is-a-pa/>

<sup>21</sup> Ibid

<sup>22</sup> Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. American Journal of Preventive Medicine. 2018. Geographic variation in the supply of selected behavioral health providers. Retrieved from [https://www.ajpmonline.org/article/S0749-3797\(18\)30005-9/fulltext](https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext)



PAs, working with other members of the healthcare team, have been demonstrated to improve access to care while providing high levels of quality and patient satisfaction similar to that of physicians.<sup>23</sup> Payers authorizing PAs to deliver high-quality behavioral/mental health care to patients, such as is allowed under fee-for-service Medicare, can alleviate ongoing and worsening trends in access to behavioral and mental health services.

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.

The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics, with a projected 31% increase in PAs from 2018 to 2028.<sup>24</sup> This growth projection, along with PAs' qualifications, suggest that the increased utilization of PAs will be an effective method to address the country's mental and behavioral health workforce deficiencies and access concerns.

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,<sup>25</sup> CMS's inclusion of PAs as authorized providers in community mental health centers,<sup>26</sup> and the establishment of PAs as mental and behavioral health providers at the state level.

While Medicare, many state Medicaid programs, and commercial payers cover behavioral and mental health services provided by PAs, some private payers, many of which interact with Medicare and its beneficiaries, 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 outdated policies that may act as barriers to behavioral and mental healthcare will allow for greater utilization of the PAs that currently practice in behavioral/mental health, as well as encourage a greater number of PAs to practice in psychiatry and related specialties. The increased demand for behavioral and mental health services requires the contribution of all qualified health professionals without outdated restrictions, which have not been demonstrated to be needed, constraining access to care.

AAPA requests that CMS strongly encourage 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

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<sup>23</sup> Medicare Payment Advisory Committee. 2019. Report to the Congress: Medicare and the health care delivery system. Retrieved from <https://www.medpac.gov>

<sup>24</sup> U.S. Bureau of Labor and Statistics. 2020. Occupational outlook handbook: Physician assistants. Retrieved from <https://bls.gov>

<sup>25</sup> 21st Century Cures Act. Public Law No: 114-255 2016. Retrieved from <https://www.congress.gov/bill/114thcongress/housebill/34/text>

<sup>26</sup> Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. Retrieved from <https://www.law.cornell.edu/cfr/text/42/485.904>

and managed care plans, and plans offered on the Federally Facilitated Exchange, to eliminate prohibitive policies regarding PAs providing behavioral/mental health services. This would align the behavioral/mental health policies under these plans with Medicare, and ensure beneficiaries covered by such plans have more qualified care options available to them.

**AAPA supports the various proposals mentioned in this letter that seek to expand patient access to needed behavioral/mental health services. To further expand patient access to behavioral/mental health services, AAPA requests that CMS strongly encourage 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 regarding PAs providing behavioral/mental health services.**

### **Proposed Reduction in the 2024 Conversion Factor**

Following a recent trend, the 2024 Physician Fee Schedule proposed rule again reduces the Medicare conversion factor. In dollar terms, CMS has proposed a decrease of approximately \$1.14, from \$33.89 to \$32.75, for 2024. This payment reduction is primarily due to the expiration of the 2.5% payment increase provided by Congress for 2023, a 1.25% physician fee schedule payment increase for 2024, a 0% update adjustment factor, and a budget neutrality adjustment of -2.17% to E/M Current Procedural Terminology (CPT) codes.

AAPA is concerned regarding the impact of this proposed update to the conversion factor, especially when compounded with similar decreases over the past few years. The financial losses incurred by health professionals generally, and specialists in particular, may cause practice adaptations that may in turn negatively affect the ability of patients to access care in an equitable or timely manner. Medical practice costs have not been immune to the rise in inflation, all at a time when health professionals are being asked to meet a greater demand for care.

CMS and Congress must work together to remove current and future financial constraints on health professionals. In the short term, CMS should support Congress again providing conversion factor relief through a payment increase. However, relying on Congress to provide an annual patchwork of transitory fixes is not sustainable. Congress must consider addressing issues like budget neutrality, that are responsible for these short-sighted cuts to reimbursement. As such, AAPA reiterates its request for CMS to work with Congress to design and pass a more equitable long-term system of provider reimbursement. As part of this process, CMS may work with Congress to review the feasibility of addressing budget neutrality and the possibility of automatic annual inflation adjustments.

**AAPA reiterates its request for CMS to work with Congress to find immediate relief for health professionals, as well as to design and pass a more equitable long-term system of provider reimbursement.**

## **HCPCS Add-On Code G2211**

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to make active HCPCS add-on code G2211, after a multi-year delay that was statutorily required by the Consolidated Appropriations Act of 2021. HCPCS add-on code G2211 would be reported in conjunction with office/outpatient E/M visits, as CMS did not believe that the RVS Update Committee recommended values, which the agency adopted, sufficiently reflected the resource costs involved in the provision of primary care or similar longitudinal care for a single, serious or complex condition.

The code descriptor reads:

*“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.”*

In an update to previous policy on this code, CMS now indicates HCPCS add-on code G2211 would not be payable when an office/outpatient E/M visit is reported with payment modifier 25, which denotes a separately billable E/M service by the same practitioner furnished on the same day. CMS is also updating its estimate of the uptake and resulting budgetary effects of activating this code. Using data on the uptake of new codes in previous years, and factoring in its conclusions that HCPCS add-on code G2211 would not be appropriate to be utilized for every office/outpatient E/M service (including those in which a longitudinal care relationship are not appropriate or expected), CMS revised its utilization assumptions estimates from 90% uptake by certain specialties, to initially being billed with 38% of office/outpatient E/M visits, and 54% of office/outpatient E/M visits when fully adopted. This revised estimate reduced the expected negative effect on the budget neutrality adjustment and the conversion factor.

AAPA supports the CMS activation of HCPCS add-on code G2211. We recognize that some provider groups have expressed opposition to activating G2211 due to the conversion factor reductions resulting from required budget neutrality adjustments (for example, for 2024, the activation of HCPCS add-on code G2211 accounts for approximately 90% of the overall budget neutrality adjustment). However, AAPA believes that the benefits of activating HCPCS add-on code G2211 outweigh these valid concerns. Many intangible but necessary actions that are not currently reimbursed for, such as tracking/monitoring/reviews, go into providing the care patient deserve. Providing additional payment to properly compensate for these actions will help sustain these actions.

While not restricted to primary care or any set of specialties, CMS admits that primary care is more likely to use HCPCS add-on code G2211 than most specialists, who in turn are more likely to use the code than surgical specialists. Consequently, one primary goal of CMS in activating HCPCS add-on code G2211 is to help bolster the provision of primary care. AAPA has long maintained that in a well-organized, efficiently run healthcare system, primary care is the backbone of the care delivery model. We believe the ability to maintain a robust primary care delivery model in the US is facing serious challenges.

According to a report from the Health Resources and Services Administration, the US health system is experiencing a clinician shortage, particularly in primary care.<sup>27</sup> A shortage in the primary care workforce may lead to insufficient patient access to needed healthcare services and the need for more intensive and high-cost interventions such as hospitalization or emergency care.<sup>28</sup> A decrease in the availability of primary care may also lead to a less equitable supply of healthcare services.<sup>29</sup> Increased financial incentives to sufficiently fund the resources necessary to provide superior primary and complex care will benefit patients. This may also benefit the system at large by reducing costs through proper preventive care and condition management.

In comments to the Department of Health and Human Services (HHS) last year, AAPA proposed increasing payment for primary care services to a point that makes practicing in primary care more financially attractive to current and future health professionals. In those comments, we also suggested HHS investigate other types of payment approaches/methodologies to boost primary care participation and solvency, such as:

- Some level of reduced fee-for-service payment with the addition of a modified risk-adjusted, monthly payment
- 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/nurse practitioners when providing primary care.

AAPA reiterates these suggestions here.

Meanwhile, AAPA laments that budget neutrality requirements place specialties in competition with each other. We request that CMS work with Congress to explore the feasibility of a new compensation system that lessens the pitting of one group against another. CMS should be willing to explore various payment options in its attempt to appropriately resource and compensate for primary care, while ensuring the financial security of other specialties do not suffer as well.

AAPA further suggests that there are methods of strengthening primary care that do not directly affect the conversion factor. These methods include promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA and nurse practitioner practice in federal health programs, and encouraging states to eliminate legislative and regulatory barriers that hinder PAs/nurse practitioners from practicing to the highest level of their education and expertise. CMS could also explore additional creative ways to incentivize health professionals to practice in primary care, such as increasing the autonomy/scope of practice of health professionals practicing in primary care, as well as eliminating, and working with states

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<sup>27</sup> 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. Retrieved from: <https://aspe.hhs.gov/reports/impact-state-scope-practice-laws-other-factors-practice-supplyprimary-care-nurse-practitioners>

<sup>28</sup> Shi, Leiyu. 2012. The impact of primary care: a focused review. Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/24278694/>

<sup>29</sup> IBID

to encourage the elimination of, burdensome practice requirements, such as requirements for physician countersignatures or direct oversight.

**AAPA supports the CMS activation of HCPCS code G2211. As HCPCS code G2211 is seen as a way to boost primary care, AAPA suggests additional methods in support of this goal such as some level of reduced fee-for-service payment with the addition of a modified risk-adjusted/monthly payment, additional scholarship and loan repayment assistance programs in exchange for a certain number of years practiced in primary care, testing through Center for Medicare and Medicaid Innovation the concept of 100% reimbursement for PAs/nurse practitioners when providing primary care, promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA and nurse practitioner practice in federal health programs, encouraging states to eliminate legislative and regulatory barriers that hinder PA/nurse practitioners from practicing to the highest level of their education and expertise, increasing the autonomy/scope of practice of health professionals practicing in primary care, as well as eliminating, and working with states to encourage the elimination of, burdensome practice requirements, such as requirements for physician countersignatures or direct oversight. AAPA requests that CMS work with Congress to explore alternative compensation systems that don't result in pitting one provider group against another.**

### **Additional Payments for Patient Assistance**

AAPA is pleased to find numerous proposals under the 2024 Physician Fee Schedule proposed rule that support health professionals and other qualified providers spending greater time and resources dedicated to helping patients find and receive appropriate care. AAPA believes the proposals detailed below, which financially incentivize the provision of information, resources, and care management to patients and their representatives, have the potential to be beneficial to patient health. We largely approve of these proposals and provide additional comments below.

#### *Payment for Caregiver Training*

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to pay healthcare professionals for the process of properly training caregivers when a caregiver is necessary to carry out a prescribed treatment plan. In order to bill for caregiver training services, a health professional must first have established a treatment plan, have previously identified and documented the need for caregiver training, and have received consent from the patient or representative to provide the training to the caregiver or caregivers.

Previously, it was CMS's stated position not to reimburse for services that were not directly applied to a patient. Patients are pleased to see the agency has recognized that other individuals, who are not the patient themselves, are often essential in successfully implementing a patient's treatment plan, and as a result has reconsidered its prior restrictive interpretation. As noted in the proposed rule, properly trained caregivers have the potential to help improve a patient's symptoms, functioning, and adherence to treatment. AAPA supports financial compensation for health professionals to provide this training, as medically necessary.

### *Social Determinants of Health Risk Assessment*

AAPA is pleased to see the attention CMS continues to place on social determinants of health. The importance of access to healthcare, education, transportation, housing, food, and economic stability to patient health are well documented both in the proposed rule, and elsewhere, with CMS citing the Department of Health and Human Services paper that suggests such factors may account for as much as 50% of an individual's health.<sup>30</sup>

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to both establish a separate G code that would allow for a "social determinants of health risk assessment" during an E/M visit, as well as allow the provision of this risk assessment during the Medicare Annual Wellness Visit for additional payment. CMS believes that patients will benefit from the agency's proposal to compensate health professionals to spend adequate time identifying factors that may prohibit or diminish effective treatment plans. The discovery of any confounding factors would then support health professionals in tailoring those plans to a patient's individualized situation. This assessment would occur as part of the social history and would require the use of tested and validated social determinants of health risk assessment tools that are deemed standardized, and evidence based. Any identified needs would be documented in the medical record using ICD-10-CM Z codes.

AAPA approves of these options to conduct the social determinants of health risk assessment. We believe any identified obstacles that may hinder or prevent health professionals from providing effective care may inform not only a treatment plan but may further elucidate opportunities for supplementary care management (see section on "community health integration" services below). As noted in our telehealth section, we also approve of the social determinants of health risk assessment being added to the Medicare Telehealth Services List on a permanent basis. However, we note that CMS proposes that this code may only be billed once every six months. AAPA questions this timeline. We recognize that social determinants of health do not live in a vacuum and may exacerbate each other, causing a frequent flux in patient well-being and the need for timely effective interventions.

### *Community Health Integration*

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to pay for community health integration services. These services, performed by auxiliary personnel incident to the professional services and under the general supervision of a billing practitioner, would seek to address identified social determinants of health that are interfering with appropriate treatment for a diagnosed condition. These services could be furnished monthly, as medically necessary, and would follow an initiating E/M visit by the billing practitioner during which the practitioner identifies potential social determinants of health that may impede proper care for a diagnosed problem. Any needs identified and resulting activities would be documented in the medical record. Only one practitioner per beneficiary per calendar month could bill for community health integration services.

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<sup>30</sup> <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>

AAPA approves of this proposal as it demonstrates the agency's commitment to properly incentivizing an amelioration of patient social determinants of health. We recommend that, in addition to an E/M service, CMS authorize the Medicare Annual Wellness Visit to act as the initiating visit, especially in light of CMS's proposed "social determinants of health risk assessment," which may occur during such visits.

### *Principal Illness Navigation*

In the 2024 Physician Fee Schedule proposed rule, CMS proposes to pay for navigation services for patients with cancer or other serious illnesses. Patients with serious illnesses should be tasked with as minimal burden as possible beyond the management of their current condition. Navigation services can help patients in these situations, especially those with fewer resources to do so, to develop a plan for appropriate treatment. Navigation may include identifying suitable health professionals and additional supportive care, attaining transportation, coordination of services from various providers, and more. CMS hopes this new reimbursement will fill in potential gaps of current care management codes by seeking to address social, as well as clinical, needs. Principal illness navigation services are likened to the community health integration services proposed in the rule (see above), but would focus on those with "serious illness" (a term defined by CMS in the rule as lasting at least three months, putting the patient at serious risk, and requiring development/monitoring/revision of a care plan as well as frequent adjustment of regimens or substantial assistance) and not necessarily social determinants of health, which are covered under community health integration.

Like with community health integration services, there exists the requirement for an initiating E/M visit by a billing practitioner to determine the medical necessity of principal illness navigation services, and a treatment plan. Subsequent services are furnished by auxiliary personnel incident to the professional services and under the general supervision of a billing practitioner. Any needs identified and resulting activities would be documented in the medical record. Only one practitioner per beneficiary per calendar month could bill for principal illness navigation services.

AAPA approves of CMS payment for these services. Vulnerable patients, such as those facing a serious illness, should receive sufficient help as would allow them to focus on addressing their condition. AAPA is pleased CMS is financially incentivizing this assistance. We again suggest that, in addition to an E/M service, CMS authorize the Medicare Annual Wellness Visit to act as the initiating visit.

### *A Focus on Minimizing Patient Burden in Navigating a Complex System*

AAPA appreciates that CMS recognizes the work already being performed by health professionals, as well as the potential to increase the volume of that work, to properly coordinate patient care. AAPA agrees that care management, while increasingly utilized, is still undervalued and underemployed. Financial compensation for spending this time with patients and their caregivers will ideally increase the number of patients receiving these services when medically beneficial. As such, we again urge CMS to finalize all policies mentioned above.

AAPA notes that the services proposed for coverage in this section follow a theme of CMS seeking to assist patients, their representatives, and their health professionals in properly addressing situations and impediments that inhibit the efficient provision of care. AAPA finds this goal commendable. We agree that proper coordination is a powerful tool in ensuring quality care for patients. We support CMS efforts to make the system more navigable, and, in support of this goal, AAPA would like to suggest additional steps the agency could take by regulatory modifications that would similarly promote efficient receipt of care by patients. We propose CMS consider these additional steps, all of which are within the power of CMS to address regulatorily, to alleviate patient burden in navigating an already complex system.

- Remove Restrictions on Care for Patients at Inpatient Rehabilitation Facilities: Currently, federal regulatory language (CFR §412.622(a)) regarding care in Inpatient Rehabilitation Facilities (IRFs) is overly physician-centric, preventing other qualified health professionals such as PAs and nurse practitioners from meeting patient demand. For example, §412.622(a)(3)(iv) identifies 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, language contained in this section of the CFR also requires that for the first week, a physician must do all three, and in each subsequent week, a non-physician health professional such as a PA or nurse practitioner may only do 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. Requiring a physician to perform these duties is inefficient and may impact patient treatment if a patient has to wait to see a physician for care 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 ultimately choose to finalize the flexibilities it initially proposed. AAPA requests that CMS reconsider. CMS should 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 services are provided by PAs. CMS shows its agreement in its authorization for PAs to provide one of the three weekly required visits. Restricting PAs to only one service when the needs of an IRF may require more is an arbitrary restriction that may prevent patient access to high value, underutilized rehabilitation services. Granting an expanded authorization in this setting would not impose a requirement on IRFs, but rather give rehabilitation facilities maximum flexibility by providing them with the option to utilize appropriately qualified PAs in the same manner as rehabilitation physicians to ensure a robust rehabilitation workforce that provides patients with timely access to care. Each IRF would continue to be able to determine which health professionals have the necessary education, training, and experience to meet the care needs of their patients.



- Authorize PAs to Perform Colonoscopies: Provisions in recent Physician Fee Schedule rules have sought to expand coverage for colorectal cancer screenings. AAPA believes CMS should further increase access to colorectal cancer screening procedures by authorizing PAs to perform colonoscopies and eliminate current policy that payment for colonoscopies only be made when performed by a doctor of medicine or osteopathy.<sup>31</sup> Again, this requirement for the interruption of care for a patient to see a physician is inefficient and may negatively affect patient treatment. No such limitation on the type of provider is included in the Social Security Act<sup>32</sup> and PAs have demonstrated the competency to perform colonoscopies, including biopsies when medically necessary, comparable to gastroenterologists in technical performance and quality metrics. Specifically, a study<sup>33</sup> demonstrated that there were 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.”

The lowering and eventual removal of patient coinsurance, along with an increased demand due to more patients being eligible for the procedure, will place a serious strain on the availability of colonoscopy services. The increased demand for colonoscopies will likely have a disproportionately negative impact on rural populations obtaining access to this important preventive service. This lack of access would be counterproductive to CMS’s goal of increased health equity. Consequently, AAPA recommends that CMS authorize PAs to perform colonoscopies.

- Authorize Non-Physician Health Professionals to Interpret Electrocardiograms: CMS’s policy regarding interpretation of electrocardiograms (EKGs) indicates that, “Coverage includes the review and interpretation of EKGs only by a physician.”<sup>34</sup> The interpretation of EKGs is consistent with PA training, education, and scope of practice. Rhythm interpretation is included in the Physician Assistant National Recertifying Examination (PANRE).<sup>35</sup> PAs deliver a wide range of professional services and there should not be unnecessary and unfounded barriers to the care delivery process. Requiring a physician to provide this service when PAs are qualified to do so is inefficient and a waste of patient time. AAPA recommends that CMS modify the physician-centric language in its policy to authorize PAs and nurse practitioners to provide the professional interpretation for EKGs.
- Promote Medicaid and Private Payer Alignment with Medicare Policies: For many Medicare beneficiaries, the Medicare program is not the only payer with whom they have coverage. Some

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<sup>31</sup> <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf>

<sup>32</sup> [https://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](https://www.ssa.gov/OP_Home/ssact/title18/1861.htm)

<sup>33</sup> [https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality\\_metrics\\_of\\_screening\\_colonoscopies.8.aspx](https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx)

<sup>34</sup> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r26ncd.pdf>

<sup>35</sup> <https://www.nccpa.net/wp-content/uploads/2021/05/CoreBlueprint-ContentCategory.pdf>

Medicare beneficiaries may have Medicare coverage through a private payer, either due to enrollment in Medicare Advantage or because some beneficiaries under traditional Medicare may retain supplemental coverage through Medigap. Some Medicare beneficiaries are dually eligible for both Medicare and Medicaid. Although Medicare may be the primary payer of dual eligible beneficiaries, a claim may often then be sent to the secondary payer, Medicaid, for additional coverage. If a Medicaid program does not enroll PAs or authorize them to perform a service, the agency may decline to provide additional monetary coverage. Consequently, it is in the best interest of Medicare beneficiaries if there is consistency in coverage policies across such payers. Private payers or Medicaid programs that do not enroll PAs or restrict PAs from providing a service Medicare authorizes them to perform risk leading to gaps in coverage and potentially increased costs and confusion for vulnerable populations. Like those policies proposed by CMS in the rule, other payers aligning with best-practice Medicare policies would make patient navigation simpler if there aren't a range of divergent complicated and unnecessary restrictions patients must confront. Consequently, AAPA recommends that Medicare encourage other payers to examine restrictive coverage policies that are inconsistent with Medicare policy.

- Authorize Non-Physician Health Professionals to Certify Patient Ambulance Transfers: Physician certification is required for nonemergency, scheduled, repetitive ambulance services.<sup>36</sup> This mode of transportation may be the only option available to patients who receive services like dialysis or wound care and who have a contraindication to other modes of transportation. Requiring that a physician provide this certification, instead of a qualified health professional already familiar with the patient, is a waste of patient and physician time. An inability to receive a timely authorization for such transportation may also contribute to necessary services being delayed or unused. CMS previously extended the ability of PAs and nurse practitioners to sign a certification statement for other types of ambulance transfers (for unscheduled, or scheduled but not repetitive). Consequently, AAPA requests that CMS modify § 410.40(e)(2) to authorize PAs and nurse practitioners who care for those patients who require nonemergency, scheduled, repetitive ambulance care to be able to provide the required certifications to ensure these patients have access to needed services.

Similar barriers exist in emergency ambulance transfers. In certain instances, patients are unable to access the care that is most appropriate to their healthcare needs. Patients should be able to transfer with minimal difficulty to another care setting better able to provide such care. However, if a patient requires an emergency transfer under EMTALA and a physician is present, the physician must certify the transfer. If a physician is not present, a PA may certify the transfer, but only after consultation with a physician who must subsequently co-sign the certification. Such requirements are antiquated, potentially leading to a disruption in the efficient delivery of medically necessary care. PAs can authorize a transfer in most nonemergency situations and should be authorized to do so in emergency situations.

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<sup>36</sup> <https://www.palmettogba.com/palmetto/jmb.nsf/DID/8T4MAF7511>

Requiring a physician signature is administratively burdensome. When a physician is not present, the requirement for physician consultation, especially in areas with a deficient number of available physicians, may prolong the transfer process to a facility more equipped to meet a patient's immediate needs, thereby delaying access and potentially endangering the patient's health and increasing care costs. In addition, the requirement for co-signature is then superfluous, as the determination to transfer a patient has already occurred and adds administrative burden. AAPA recommends that PAs should be able to certify the need for transfer under EMTALA without physician consultation and co-signature.

- Authorize PAs to Provide Physician-Required Services in Skilled Nursing Facilities: For years, PAs have been authorized to deliver care to Medicare beneficiaries in skilled nursing facilities (SNFs). However, PAs are not recognized by Medicare for the purposes of performing the comprehensive visit to SNF patients. Also, PAs are required to alternate every other required visit to SNF patients with physicians. These restrictions were not based on medical evidence but were merely a vestige of old, outdated policies that need to be modernized to reflect current medical practice and bring efficiencies to the system. 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. AAPA sees no clinical justification for re-instituting these outdated practice restrictions when years of experience have demonstrated the high-quality care PAs deliver in SNFs. During the public health emergency, SNFs, as a result of decreased time spent by patients in hospital settings, felt extraordinary strain and saw worsening results that would have been more severe if CMS had not granted the ability of PAs to ameliorate access burdens. PAs remain clinically prepared, educated, and competent to deliver the full range of needed clinical care in SNFs. Regulatory requirements in SNFs necessitate physician involvement that may not be readily available in rural settings, or available in a timely fashion in high-demand settings. Allowing PAs to provide these services will expand patient access to needed care, as patients will no longer have to wait to see a physician when a PA is available.
- Allow Care in Hospitals to be Under the Care of a PA: During the public health emergency, CMS waived requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) that require Medicare patients in hospitals to be under the care of a physician. Consequently, inpatient Medicare beneficiaries were able to be under the care of a PA. PAs provide care in teams with physicians and other healthcare professionals, and there is nothing in statute or in the medical evidence that would preclude a hospitalized patient from being “under the care of” a PA.

Authorizing patients to be under the care of a PA would eliminate outdated regulations that make delivering care less efficient. For example, the requirement that every Medicare beneficiary be “under the care of a doctor” in a hospital has led to an interpretation that when an authorized health professional other than a physician writes an order for admission, a physician must co-sign it. Medicare policy permits PAs to determine the necessity of an inpatient hospital admission, write the admission order, and perform the accompanying history and physical examination. Despite this, the CMS requirement for a patient to be under the care of a physician and the additional unnecessary

requirement of a physician co-signature, potentially days after a PA's determination of medical necessity, is an inefficient use of a physician's time and does not lead to higher quality care for beneficiaries. Furthermore, if a physician is not available, the patient's discharge from the hospital may be delayed, resulting in an increased length of stay in the hospital and increased cost to the Medicare program.

**AAPA supports CMS's proposed additional payments for patient assistance, including payment for caregiver training, the social determinants of health risk assessment, community health integration, and principal navigation services. However, we question whether the social determinants of health risk assessment may be useful to be conducted more frequently and propose that under both community health integration and principal navigation services, a Medicare annual wellness visit qualify as the required initiating visit. In recognition that the additional payments CMS proposes seek to make patient navigation of the system less burdensome, AAPA identifies additional regulatory policy changes CMS could enact to ease unnecessary patient care burdens. These policies include removing restrictions on care for patients in Inpatient Rehabilitation Facilities, authorizing PAs to perform colonoscopies, authorizing non-physician health professionals to interpret electrocardiograms, promoting Medicaid and private payer alignment with Medicare policies, authorizing non-physician health professionals to certify patient ambulance transfers, authorizing PAs to provide physician-required services in Skilled Nursing Facilities, and allowing care in hospitals to be under the care of a PA.**

### **Quality Payment Program (QPP) Updates**

#### *Threshold Increases*

In the 2024 Physician Fee Schedule proposed rule, CMS makes a few minor updates to Merit-based Incentive Payment System (MIPS) program under the QPP. First, unlike last year, CMS is proposing to increase the performance threshold to 82 points for the 2024 performance year/2026 payment year. This increase, up from 75 points, is based on a mean final score from the 2017-2019 performance years. AAPA supports the idea of using a rolling average to account for score variations that may see deviations from the norm. In addition, we support CMS using pre-pandemic years for reference, but request CMS provide additional information regarding how it will approach a rolling average in the coming years that would incorporate the atypical years of the COVID-19 pandemic.

We note that, due to budget neutrality requirements, should CMS continue to increase the performance threshold, an increasing number of health professionals will see some negative adjustment (now at an exacting -9%), while a smaller group of health professionals will see a larger bonus than seen now for exceeding the threshold. AAPA understands the need for CMS to raise submission standards and outcomes expectations as it continues the progression toward meaningful value-based reimbursement. As the intent is to incentivize an elevation in the performance of healthcare providers, as well as provide more robust data

for practice improvement, AAPA suggests CMS properly communicate to MIPS participants the elevating stakes of proper reporting and the resulting scores.

CMS further indicates that the agency is proposing to increase the data completeness threshold from data on 70% of denominator eligible cases (a rate it has been set at for the past three years) to 75% for the 2024 through 2026 performance period. CMS will then increase this threshold to 80% for the 2027 performance period. Again, AAPA understands the need for CMS to raise submission standards as it continues the progression toward meaningful value-based reimbursement. We appreciate that CMS is identifying these thresholds well in advance so that practices may plan accordingly. AAPA also appreciates the recognition by CMS of the concern by some groups, AAPA included, regarding the increase of these thresholds at a rate some practices may find challenging. We appreciate the gradual increase in percentage with sufficient advance notice. Regarding both thresholds, AAPA encourages CMS to continue to be mindful of unexpected burdens, especially those incurred by smaller practices, in the final years of traditional MIPS and through the transition to MIPS Value Pathways.

#### *Care Compare (Compare Tool) Updates*

In CMS's 2023 Physician Fee Schedule rule, CMS made additions to its Care Compare/Compare Tool (formerly "Physician Compare") website in order to better aid patients in determining the most appropriate care for them. Specifically, CMS added a telehealth indicator of whether a health professional furnishes telehealth services, as well as utilization data that indicates conditions treated or procedures performed. AAPA supported these additions in principle, stating in our comments to the 2023 Physician Fee Schedule proposed rule that we believe the additions could help address health equity by increasing access for underserved populations that would benefit from telehealth care, as well as potentially increase care efficiency by identifying to prospective patients the type of care typically performed by individual health professionals. In the 2024 Physician Fee Schedule proposed rule, CMS makes updates to these categories.

Regarding the telehealth indicator, CMS is seeking to move away from identifying specific place of service codes and instead allowing some flexibility to identify the most recent codes that signify whether a health professional has furnished telehealth services. CMS is proposing this change out of concern that prospective users of the Care Compare tool might be "receiving incorrect information" if not all telehealth services are properly captured and identified on the website.

Regarding utilization data, CMS proposes to incorporate Medicare Advantage data in its public reporting. This will allow for more robust data and help some health professionals meet thresholds that will trigger the identification of the volume of a service they provide. CMS is proposing this due to a limited ability "to contextualize low volume clinician experience with procedures in a way that is useful and easily understandable for patients and caregivers who may be looking for a clinician with experience performing a specific procedure."

AAPA approves of both of these policy proposals. We share CMS's concern regarding users of Care Compare receiving incorrect information and receiving insufficient context surrounding the appearance of a health

professional not providing a service. AAPA expressed these concerns in our comments to the 2023 Physician Fee Schedule proposed rule surrounding these same negative consequences resulting from the use of “incident to” and the fact that many services provided by health professionals such as PAs and nurse practitioners are attributed to a physician. Consequently, if a PA or nurse practitioner reports individually through MIPS, the information on their Care Compare webpage may be an incomplete representation of the types of conditions treated and care provided. This could give patients an inaccurate understanding of care options available to them, including, in cases like this, may falsely indicate a health professional doesn’t offer telehealth or provide certain services.

To remedy this, in the absence of the elimination of “incident to” billing, AAPA again requests that CMS seek regulatory solutions regarding how to properly identify PAs and nurse practitioners on claims submitted using “incident to” billing and ensure they are able to extrapolate such information when making information available about the types of services a health professional performs. CMS may also wish to put a disclaimer (in addition to the disclaimer proposed last year that states that services listed only apply to those provided to Medicare patients) on any public display of information regarding services rendered that the examples provided are only a sampling and that the health professional may provide additional services than what is presented. However, such a qualifier would still not allow certain health professionals to be discovered and accurately portrayed when a patient uses the Care Compare system to search for care options based on types of services provided. This will require addressing the transparency harms brought about by “incident to” billing.

#### *MIPS Value Pathways (MVPs)*

To move away from a 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 a pathway, structured around a specialty or particular medical condition, that best aligns with the type of care typically provided. These pathways, or MVPs, would be built on a base of claims-based population health and care coordination measures and would be supplemented with measures that reflect activities one would perform for 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 clinical quality, outcome, and cost performance data. CMS hopes this will reduce complexity and burden, streamline reporting, improve measurement, and allow for quicker administrative and clinical feedback provided to health professionals to improve care. CMS further believes these changes will help remove barriers to alternative payment model participation and accelerate the transition to value-based care.

In the 2024 Physician Fee Schedule proposed rule, CMS continues the process of implementing MVPs by proposing five additional pathways for voluntary reporting in 2024, in addition to the twelve pathways proposed in previous years (though now two primary care MVPs are proposed to be consolidated into one). While no end date has yet been announced for traditional MIPS, AAPA believes CMS must greatly increase the number and variety of MVP options available to providers before that day comes. A swift release of MVP

options, with development subject to feedback through the QPP website and CMS webinars, may also encourage more health professionals to partake in this voluntary participation.

When CMS is developing its full array of MVPs, it must work with the provider community to identify potential gaps in MVP subject concentration so there are no health professionals who cannot appropriately report to any of the available MVPs. It will be imperative that CMS ensure there are a sufficient number and variety of MVPs to cover all participating health professionals. AAPA encourages the agency to specifically seek input from various types of affected health professionals when determining which specific specialties/conditions will be recognized by CMS as pathways. PAs should be included early in the process as they have unique perspectives and concerns regarding implementation details because of their practice in multiple specialties.

AAPA continues to support CMS efforts to reduce complexity in the MIPS program and enhance comparability. We caution 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, are incomplete and 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 nurse practitioners to a physician.

Health professionals like PAs and nurse practitioners also have an interest in ensuring that newly developed measures are structured or phrased in a way that is inclusive. In addition, measures must be able to adequately capture various roles and responsibilities that may be filled by different health professionals on the care team. If CMS wishes to receive a comprehensive picture of activities performed under a specialty with which to construct their pathways, the various types of health professionals that deliver care and will be expected to report must be consulted. The more accurately CMS can capture the contribution of health professionals like PAs and nurse practitioners through appropriately worded measures, the more successful CMS's goal of enhanced comparability will be.

To further alleviate concerns regarding the transition to another reporting method, 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. Efforts to educate those affected will also require adequate time for review, analysis, and a robust system to provide feedback. 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.

**AAPA supports the idea of using a rolling average of previous year scores when establishing the MIPS performance threshold. We request that CMS detail how it will approach rolling averages in the coming years in which the years of the atypical COVID-19 pandemic will be incorporated. AAPA appreciates the gradual increase of the data completeness threshold and asks that CMS properly communicate the growing financial stakes of the increased performance threshold to MIPS participants. We encourage CMS to continue to consider ways to mitigate negative financial implications for small practices. AAPA shares CMS's concerns regarding incorrect information and insufficient context on Care Compare. To lessen this, AAPA again requests that CMS identify a method to properly identify PAs and nurse practitioners on claims submitted using "incident to" billing and ensure the ability to extrapolate such information when making information available about the types of services a health professional performs. In addition, AAPA requests that CMS include a disclaimer on any public posting of services rendered by an individual that examples provided are only a sampling and that the health professional may provide additional services than what is presented. AAPA requests that CMS increase the number of MVPs available as quickly as possible, including MVPs that focus on issues that may appeal to large groups of providers. AAPA encourages the agency to specifically seek input from various types of affected health professionals when determining which specific specialties/conditions will be recognized by CMS as pathways, as well as regarding the applicability of various measures to an MVP. Finally, 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.**

### **Qualified Practitioner (QP) Determination at the Eligible Clinician Level**

In the 2024 Physician Fee Schedule proposed rule, CMS is proposing to end the use of Alternative Payment Model (APM) entity-level QP determinations, instead transitioning to exclusively determining QP status by the individual clinician level. AAPA provided comments to CMS's 2023 Physician Fee Schedule proposed rule expressing concerns regarding this potential transition based on the possible negative effects on Advanced APM participation resulting from Medicare policies that obfuscate the actual level of care provided by certain health professionals such as PAs. Our concerns with this transition remain. However, instead of recommending a halt to CMS's proposed transition from determining QPs at the entity level to the eligible clinician level, we instead recommend that CMS separately seek to remedy the larger problem of properly attributing services to the health professionals who provide them.

Previously, most determinations of QP status were made at the APM entity level. To become a QP, certain thresholds must be met regarding the percentage of Medicare Part B payments received, or the percentage of patients seen, through an Advanced APM entity during a performance period. CMS justifies the transition by its belief that, in order to qualify, prospective APM entities are excluding specialists and other health professionals that individually do not meet those thresholds because they provide care elsewhere, and thus may decrease the average of the whole entity and lead to the exclusion of other health professionals. CMS reasons that the exclusion of these health professionals would work against the intended goals of APMs to



encourage different types of health professionals to work together to manage and coordinate care. Instead, CMS proposed to determine QP eligibility for each health professional individually at the NPI level and allow only individuals to make QP status (preventing potentially unwarranted payment bonuses for practitioners under the APM entity that do not meet QP requirements, as well as discouraging APM entities from excluding health professionals whose care may be important to meeting patient-centered care goals).

While AAPA continues to appreciate these concerns, if finalized, this policy change will have unintended effects on certain other health professionals, such as those who are required by an employer to utilize “incident to” billing. PAs and nurse practitioners whose services are entirely, largely, or in part attributed to a physician with whom they work may individually fail to meet QP or partial QP payment or patient thresholds, preventing them from receiving associated financial benefits and burden reductions. The inability to meet QP or partial QP payment or patient thresholds is more likely if CMS proceeds with raising such thresholds for the 2024 performance/2026 payment year. AAPA recommends that CMS implement a method to determine when a PA provides a service under “incident to” and to use such data in consideration for meeting the QP thresholds. Until proper attribution of services is addressed, we also recommend a freezing at current QP threshold levels, so as not to exacerbate the effect of “incident to” on a health professional’s inability to meet payment/patient threshold scores necessary to secure QP or partial QP status.

**AAPA requests that CMS develop a method to determine when a PA provides a service under “incident to,” by either eliminating this billing mechanism or requiring the reporting of the NPI of the health professional who provided the service, and to use such data in consideration of whether individuals meet the QP thresholds. Until proper attribution of services is addressed, we also recommend freezing QP threshold requirements at their current level.**

### **Extension of the Advanced Alternative Payment Models Incentive Bonus**

When the Quality Payment Program was established by the Medicare Access and CHIP Reauthorization Act of 2015, incentives were included to encourage the formation of, and participation in, Advanced Alternative Payment Models (Advanced APMs). Advanced APMs seek to increase quality while decreasing costs. The intention of the Advanced APM incentives was to encourage an increasing number of health professionals to participate in Advanced APMs, over 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 expiration of the bonus, CMS was to begin paying Advance 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 Advance APM participation.

The lack of an incentive bonus in payment year 2025, and to a lesser extent the shift to a modestly elevated payment rate starting in 2026, may encourage some participants to move away from the fee-for-value models found under Advanced APMs and move back to the MIPS track, which more closely resembles fee-for-service. In the 2024 Physician Fee Schedule proposed rule, CMS is implementing a section of the Consolidated

Appropriations Act that seeks to bridge the gap year by offering a reduced rate of 3.5% (as opposed to 5%) in performance year 2023/payment year 2025.

AAPA supports CMS's goal of gradual transition to fee-for-value. As such, we believe that even a reduced rate is preferable to no incentive payment bonus. AAPA supports the policy as proposed but recommends CMS investigate ways to continue to financially encourage participation in Advanced APMs to a greater extent than the MIPS program. While some incentive will naturally result from the increasing risk that comes with the elevating MIPS performance threshold, we recommend that CMS also work with Congress to potentially extend the 5% payment incentive for a longer time horizon in order to more firmly incentivize transition to, and increased participation in, Advanced APMs.

**AAPA supports CMS bridging the Advanced APMs bonus gap year with a financial incentive for participation in performance year 2023/payment year 2025. We recommend CMS investigate ways to continue to financially encourage participation in Advanced APMs to a greater extent than the MIPS program and suggest the agency work with Congress to potentially extend the 5% payment incentive for a longer time horizon in order to more firmly secure participation in the program.**

Thank you for the opportunity to provide comments regarding the 2024 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 Michael Powe, AAPA Vice President of Reimbursement & Professional Advocacy, at [michael@aapa.org](mailto:michael@aapa.org).

Sincerely,



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