American Academy of PAs

September 9, 2024

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 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 178,000 PAs (physician assistants/physician associates) throughout the United States, would like to provide comments on the 2025 Physician Fee Schedule proposed rule. PAs currently provide hundreds of millions of patient visits each year, and many of those visits are with Medicare beneficiaries. As such, PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies in the proposed rule.

AAPA seeks to work in partnership with the Centers for Medicare and Medicaid Services (CMS) to advance policies that would increase access to high-quality care for all Medicare beneficiaries. It is within this context that we draw your attention to our comments.

Advanced Primary Care Management

Having identified lessons from the CMS Innovation Center's primary care models, CMS proposes payment for Advanced Primary Care Management (APCM) services in the 2025 Physician Fee Schedule proposed rule. This approach represents a significant step toward recognizing the importance of advanced primary care services and their role in our healthcare system, especially in addressing the needs of patients with chronic conditions and complex care requirements.

Under the proposed rule, APCM services would be furnished under the direction of a physician or other qualified healthcare professional who is responsible for all a patient's primary care and acts as the continuing focal point for all needed services in a month. Due to the overlap in services provided, CMS clarifies that health professionals who use APCM could not separately bill for similar services for the same patient, such as Chronic Care Management, Principal Care Management, and Transitional Care Management.

As a condition of APCM payment, practices must demonstrate certain capabilities such as 24/7 patient access to the care team, comprehensive care management and coordination, enhanced communication opportunities, population health management, and more. Another condition of payment for APCM services is the measurement of practice performance. CMS suggests such measurement could be satisfied by reporting to the Value in Primary Care MIPS Value Pathway. Reporting through this pathway may begin in 2026, based on performance in 2025. An initiating visit is required, and patient consent must be secured to alert patients that only one health professional may furnish these services to them per month, that they have the right to stop receiving these services from the specific provider, and that cost-sharing may apply.

AAPA approves of CMS's requirement to secure consent from patients for receipt of APCM services. While we recognize that notifying patients of potential cost sharing may risk those patients declining APCM services, AAPA supports transparency regarding foreseeable patient expenses. CMS notes that receipt of consent may also lead to a reduction in duplicative costs as patients will be aware that they can grant this authorization to only one practitioner. However, AAPA notes that this responsibility should not rest with the patient. Other programs under Medicare, such as the Medicare Shared Savings Program, have determined a method to link patients with a health professional. We encourage CMS to explore the tradeoffs of implementing a similar method under APCM to eliminate duplicative APMC billing for the same patient. We further encourage CMS to develop brief educational materials that explain the benefits of APCM that could be given to patients to ensure patients sufficiently understand the benefits of increased care coordination and the various services available to them as a result of their consent to participate. A singular resource could reduce provider burden of having to repeat the extensive details and benefits of the program with each patient to whom they determine eligible to provide primary care.

Payment for APCM services will be based on three new HCPCS G-codes (GPCM1, GPCM2, and GPCM3), each representing a different level of patient complexity and estimated resource utilization. GPCM1 would apply to patients with one or fewer chronic conditions. GPCM2 includes all the base requirements of GPCM1 but applies to patients with two or more chronic conditions. GPCM3 will similarly include all the base requirements of GPCM1 but applies to Qualified Medicare Beneficiaries (QMBs) with two or more chronic conditions. In the case of GPCM3, QMB status is being used to denote an increase of social risk factors.

While the introduction of the APCM program marks a significant step forward in recognizing the complex nature of primary care services, there are concerns that the proposed payment amounts associated with the three corresponding G-codes may be insufficient to fully support the program's goals. CMS proposes a payment of $10 for GPCM1, and $50 for GPCM2. The APCM program rightly emphasizes the importance of comprehensive care management, but the proposed payment rates must adequately reflect the resource intensity and time

commitment required to deliver those services effectively. We note that even a patient with one chronic condition may require significant provider time and resources.

Primary care providers, including PAs, play a critical role in managing patients with chronic conditions and coordinating care across multiple settings. These tasks often require substantial time, effort, and resources. If the payment rates do not sufficiently compensate for the full scope of these responsibilities, there is a risk that providers may be unable to sustain the level of care that the APCM model envisions.

Moreover, inadequate payment could undermine the CMS's stated objectives by discouraging provider participation, particularly in underserved areas where the need for comprehensive, team-based care is greatest. Smaller practices located in rural areas may determine that, due to the low reimbursement for relatively fewer patients, a lack of potential to benefit from economies of scale does not support the ability to implement the level of infrastructure necessary to meet APCM care provision and reporting requirements. It is essential that CMS carefully evaluate the proposed payment structures to ensure they align with the realities of modern primary care delivery and the financial sustainability of practice, especially for those providers serving vulnerable populations.

AAPA urges CMS to reconsider the payment rates associated with the APCM codes, considering the full spectrum of services that primary care providers will deliver under this model. Adequate compensation is vital to ensuring the success of APCM and the broader goals of improving care quality, reducing healthcare costs, and enhancing patient outcomes.

PAs are well-positioned to play an essential role in this new push towards team-based care. As versatile, highly trained healthcare providers, PAs work collaboratively with physicians, nurses, and other healthcare professionals to deliver high-quality, coordinated care. When providing APCM services, PAs can lead care management efforts, particularly for patients with complex healthcare needs, while also working to break down the silos that currently exist between different specialties. PAs' ability to work across various settings and specialties while providing high-quality care makes them invaluable in ensuring that the APCM goals of improved care quality and patient outcomes are met.

Furthermore, AAPA strongly supports the program's emphasis on technology integration and care coordination. The bundling of communication technology-based services with APCM codes demonstrates CMS's commitment to the evolving landscape of healthcare delivery, where virtual and asynchronous interactions are increasingly common. This not only ensures better patient engagement but also supports the provision of continuous, patient-centered care.

AAPA supports the implementation of the proposed APCM services and appreciates CMS's demonstrated willingness to accept ongoing feedback for expanding and refining the proposal. We encourage CMS to reconsider the payment amounts proposed in the initial rule to ensure providers are adequately compensated for the time and resources required to provide comprehensive advanced primary care management. By doing so, CMS will not

only enhance the quality of care provided to Medicare beneficiaries but also support healthcare providers, including PAs, in delivering efficient and effective care management services.

AAPA commends CMS's proposal to introduce payment for APCM services, including the focus on technology integration and care coordination. We further agree with the requirement to receive patient consent. However, AAPA encourages CMS to explore methods to identify the health professional approved for APCM services for each patient and request that, to reduce provider burden, CMS develop educational resources regarding APCM services that can be provided to patients. We urge CMS to reconsider the payment rates associated with the APCM codes, considering the full spectrum of services that primary care providers will deliver.

A Focus on Primary Care

Many of the provisions in CMS's 2025 Physician Fee Schedule proposed rule are related to the concept of supporting and advancing primary care, from Advanced Primary Care Management to updating the requirements for code G2211. AAPA supports CMS doing more to bolster primary care. According to a report from the Health Resources and Services Administration, the US health system is experiencing a clinician shortage, particularly in primary care.[1] 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.[2] A decrease in the availability of primary care may also lead to a less equitable supply of healthcare services.[3]

AAPA notes the solicitations for additional ideas to support primary care that recur throughout the proposed rule. In response to similar requests, AAPA has and continues to recommend varying types of payment approaches and methodologies to boost primary care participation and solvency, such as:

- Reducing fee-for-service payment with the addition of a modified risk-adjusted monthly payment
- Enhancing scholarship and loan repayment assistance programs in exchange for a certain number of years practiced in primary care
- Testing through the Center for Medicare and Medicaid Innovation the concept of 100% reimbursement for PAs when providing primary care
- Promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA practice in federal health programs
- Encouraging states to eliminate legislative and regulatory barriers that hinder PAs from practicing to the highest level of their education and expertise

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

- Creating ways to incentivize health professionals to practice in primary care such as increasing the autonomy 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 co-signatures or direct oversight.

AAPA suggest various methods to boost primary care, including 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 when providing primary care, promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA practice in federal health programs, encouraging states to eliminate legislative and regulatory barriers that hinder PAs from practicing to the highest level of their education and expertise, increasing the autonomy of health professionals practicing in primary care, as well as eliminating and working with states to encourage the elimination of burdensome practice requirements, such as requirements for physician co-signatures or direct oversight.

Expansion of Colorectal Screenings

In the 2025 Physician Fee Schedule, CMS makes multiple proposed changes to expand coverage of colorectal cancer screenings. These include adding coverage of computed tomography colonography (CTC), expanding Medicare's approach to "complete colorectal cancer screening" to include a blood-based biomarker test alongside a non-invasive stool-based test, and indicating that follow-on colonoscopies would not incur beneficiary cost sharing. AAPA broadly approves of efforts to increase access to care that might provide early detection of treatable illnesses. AAPA also appreciates explicit mention in the rule of the ability of PAs to order CTC. We note that CMS has proposed many provisions in recent Physician Fee Schedule rules that have sought to expand coverage for colorectal screenings. However, AAPA notes that there are other barriers to colorectal cancer screenings that, when removed, would increase access to these services. Specifically, CMS should further increase access to colorectal cancer screening procedures by authorizing PAs to order immunoassay (or immunochemical) fecal occult blood tests (iFOBT) and blood-based biomarker tests and perform colonoscopies.[4]

PAs are authorized (42 CFR 410.32(a)(2)) to order and interpret Medicare-covered diagnostic laboratory tests. As such, requiring a physician order is unnecessarily administratively burdensome. The requirement for a patient to receive an order from a physician may interrupt the efficient provision of care by forcing the patient to seek a separate appointment with a physician. These increased visits may produce extra financial burdens on the patient, effecting those underserved patients most acutely.

[4] Centers for Medicare and Medicaid Services. 2023. Medicare Claims Processing Manual, Chapter 18. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf

The condition that colonoscopies be performed only by a doctor of medicine or osteopathy may lead to unnecessary delays in patient care to meet the requirements that a physician perform the procedure. This delay when other health professionals are qualified to perform this service is inefficient and may negatively affect patient outcomes. No such limitation on the type of provider is included in the Social Security Act[5] 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[6] demonstrated 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 increased demand for colonoscopies due to more patients being eligible for the procedure because of earlier recommended screening ages and the eventual removal of patient coinsurance for Medicare beneficiaries when there is a need for associated procedures along with the screening colonoscopies, 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.

AAPA requests that, in alignment with other efforts to expand patient access to colorectal cancer screenings, CMS authorize PAs to order immunoassay (or immunochemical) fecal occult blood tests (iFOBT) and **perform colonoscopies.**

Global Surgery Payment Accuracy

For nearly a decade, CMS has expressed concern regarding the accuracy of the valuations of global surgical packages and whether payments are consistent with the type and number of services being provided. CMS points to OIG reports suggesting that fewer post-operative services are provided than are accounted for in global surgical package valuations. CMS's initial policy to address these issues was to change all 10- and 90-day global packages to 0-day global packages. However, Congress prevented this policy from being implemented through its 2015 Medicare Access and CHIP Reauthorization Act. Instead, CMS began collecting data, formulating reports, and

[5] Social Security Administration. Part E – Miscellaneous Provisions. Definitions of Services, Institutions, etc. May 2024. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm

[6] Fejleh, M. Phillip MD; Shen, Ching-Chieh MD; Chen, Jacqueline MD; Bushong, Joseph A. PA-C; Dieckgraefe, Brian K. MD, PhD; Sayuk, Gregory S. MD, MPH. Quality metrics of screening colonoscopies performed by PAs. Journal of the American Academy of Physician Assistants 33(4):p 43-48, April 2020. | DOI: 10.1097/01.JAA.0000657192.96190.ab. https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx

soliciting further feedback from stakeholders on post-operative services to improve the accuracy of global surgical package valuations.

Through the years, AAPA has provided comments on this subject urging caution in making major policy changes without fully understanding the impact of those changes beyond the issue of accuracy in global surgical valuations. We noted that certain policy decisions surrounding this issue could have immediate negative effects on patients. If CMS chose to eliminate post-operative visits from the global surgical package, requiring patients to receive individual evaluation and management (E/M) services for post-operative care, those post-operative visits that were formerly provided without any fees in the global bundle would be subject to deductibles and/or co-payments for each visit. These new payments would be a financial burden to beneficiaries and may cause some not to seek needed follow-up care following surgery. We also noted that any future modifications to the current global surgical payment for 90-day global procedures should not be done in a way that inadvertently penalizes health professionals who serve as surgical assistants. A decision to separate the post-operative payment from the global surgical bundle would create an unfair lowering of reimbursement for surgical assisting services, which are paid at a percentage of the total global surgical package reimbursement amount. This potential substantial reimbursement reduction for assisting at surgery could occur even though the professional work and intensity of the surgical assistant services have not changed.

While statutorily prohibited from moving forward with revaluing 10- and 90-day global packages, CMS indicates it has payment adjustment opportunities available. However, instead of making revaluations using data collected over the last 9 years, CMS admits the data may be incomplete due to the uncertainty of claims-based counts of post-operative visits from under-reporting transfers of care.

In the 2025 Physician Fee Schedule proposed rule, CMS proposes to use three existing transfer of care modifiers to secure a greater understanding regarding 90-day global surgical services. Under current policy, transfer of care modifiers are used when the proceduralist formally documents an agreement with practitioners outside the proceduralist's practice to provide distinct portions of the global surgical package. Modifier 54 refers to when the proceduralist performs only the surgical procedure portion of the global surgical package. Modifier 55 denotes that a practitioner performed only post-operative management of the global surgical package. Modifier 56 denotes that a practitioner performed only the pre-operative portion of the global surgical package. These modifiers automatically adjust payment for the global surgical package based on percentages identified in the Physician Fee Schedule Relative Value Files. However, as these modifiers are found by CMS to be rarely used, the agency predicts there are many situations in which an unofficial transfer occurs for legitimate reasons. Consequently, CMS is proposing that beginning in 2025, the transfer of care modifiers should be used for all 90-day global packages when a practitioner plans to provide care for only one portion of the global surgical package. This would continue to apply to formal transfers of care, as well as informal, non-documented, but expected transfers of care.

CMS hopes this method will function as a first step toward more accurate valuations and payment for global surgical packages and provide more information regarding the resource use of the three global surgical package components. CMS also expects the use of these modifier codes to reduce the likelihood of duplicative billing, as

the use of the modifier will adjust the payment amount for the global surgical package, resulting in post-operative care not being paid both under the package and separately under an E/M visit.

AAPA understands and appreciates the goals of determining the appropriate values and levels of reimbursement for surgical services. However, AAPA urges continued caution regarding conclusions that may result from analyzing data collected, even if the proposed use of the modifiers is finalized. While the data received after the implementation of these proposals may be more accurate, it will likely still be incomplete, as it will only apply to expected transfers of care. AAPA also suggests that, when the modifiers are used and the global surgical package is adjusted, payment to the surgical assistant not be reduced as well. We note that payment for surgical assistant services is calculated as a percentage of the global surgical fee in its entirety. As the global surgical package is not being broken up, surgical assistant reimbursement should not be negatively affected by the rebalancing of payments resulting from the use of the modifiers. In addition, AAPA requests confirmation that, by keeping the existing structure in place, patients will not be charged extra for post-operative care even when such care has been transferred to another health professional. Finally, AAPA notes that the success of these proposed policies depends significantly on whether the assigned payment percentages for the three portions of the global surgical package are correct. We expect there to be competing perspectives of fairness on this matter. Consequently, we encourage CMS to rely most heavily on its collected data but to still convene relevant stakeholders to determine whether any unforeseen context is relevant to setting portion rates.

CMS also proposes that for 2025, an add-on code (GPOC1) may be used after an informal transfer of care by practitioners who provide post-operative care but did not perform the surgical procedure. CMS expects this add-on code to account for the increased complexity and the added resources a practitioner providing post-operative care would incur in this situation. This add-on code could not be billed by other health professionals in the same group or same specialty as the proceduralist and would only be able to be billed once during the 90-day global surgical period.

AAPA approves of this add-on code. We concur this will more adequately reimburse health professionals who were not involved in the surgical aspect of care, and thus would require greater resources to obtain and assess appropriate information to provide the level of care patients deserve. This add-on code would also support patient flexibility in allowing them to see a different health professional for their follow-up care than the practice that provided the original surgery. For example, if the patient had to travel a long distance for the original surgery it would potentially be more convenient to seek subsequent care closer to the patient's residence.

AAPA supports efforts for increased transparency regarding code valuations, including the broadened applicability of transfer of care modifiers proposed in this rule. However, we note that any resulting data, while improved, will still be incomplete. Also, AAPA recommends that, consistent with the current policy regarding surgical assistant payment being a percentage of the total global package, when the modifiers are used and the global surgical package portion payment is adjusted, payment to the surgical assistant not be reduced as well. AAPA further requests confirmation that, by keeping the existing structure in place, patients will not be charged extra for post-operative care even when such care has been transferred to another health professional. AAPA

encourages CMS to rely most heavily on its collected data when determining portion payment percentages but to still convene relevant stakeholders to determine whether there are remaining limitations in the data collected relevant to setting portion rates. Finally, AAPA supports CMS's proposal to pay for an add-on code for practitioners who provide post-operative care but did not perform the surgical procedure, after an informal transfer of care.

Telehealth

Telehealth has become an integral part of care delivery, expanding access to care and reducing patient and provider burden. The 2025 Physician Fee Schedule proposed rule includes multiple provisions that seek to ensure continued telehealth flexibility, where possible, that were implemented during the COVID-19 public health emergency. AAPA provides comments on these provisions by subject.

Statutory Expirations of Telehealth Flexibilities

The COVID-19 pandemic accelerated the use and familiarity of telehealth so that it is firmly interwoven into the routine provision of care. The effect of telehealth can be seen most acutely in rural or underserved areas, but its impact extends beyond such locations.

In the 2025 Physician Fee Schedule, CMS cautions that, because of statutory expirations, CMS is no longer authorized to extend many telehealth flexibilities. Most prominent among these expirations are flexibilities regarding geography and site of service. As a result of the COVID-19 pandemic, waivers and Congress had temporarily authorized flexibilities that allowed many services to be provided via telehealth with a patient's home serving as an originating site, and no need to be in a rural area. These flexibilities were extended under section 4113 of the Consolidated Appropriations Act of 2023, temporarily removing statutory restrictions on geographic location and site of service through the end of 2024. As a result, short of further Congressional intervention, as of January 1, 2025, Medicare beneficiaries receiving telehealth services will need to be in a rural area and will need to be in an approved medical facility for most services. The allowance for a patient to receive care in their home will now be restricted to patients receiving behavioral or ESRD-related clinical assessments.

AAPA is aware of ongoing efforts within Congress to extend these flexibilities. AAPA favors making many of these flexibilities permanent, at the discretion of CMS. We urge the agency to work with Congress to resolve the issue before the end of the year. If Congress is unable to act before the end of the year, we urge CMS to explore temporary opportunities to mitigate the negative effects of such a sudden change by exploring their options to interpret various definitions under section 1834(m)(4) of the Social Security Act.

AAPA also recommends that CMS prepare potential educational communications regarding this issue to ensure proper billing methods beginning January 1, 2025. We note that such communications would be necessary whether Congress fails to extend any flexibilities or temporarily extends them beyond 2024. We encourage CMS to

utilize a broad range of partners, including associations like AAPA, to share information of potential policy modifications that may change how health professionals provide care to their patients.

Telehealth Flexibility Extensions Within CMS Purview

While AAPA recognizes some telehealth flexibilities are beyond the purview of CMS to implement past 2024, we are pleased to see the agency has proposed extending other telehealth flexibilities where possible. AAPA encourages CMS to finalize most of their proposed extensions, as well as to identify additional opportunities to enhance flexibilities to offset the potential impending end of a large number of telehealth services.

One such telehealth extension is the proposal to continue the suspension of frequency limitations on Medicare telehealth subsequent care services in inpatient and skilled nursing facility settings and for critical care consultations through 2025. These frequency limitations, which existed before the pandemic, were reinstituted, but not yet enforced, following the end of the COVID-19 public health emergency, before being officially extended in the 2024 Physician Fee Schedule. AAPA again supports the renewed removal of these limits as CMS gathers more information as to how the pandemic has shifted practice patterns. However, we urge CMS to reconsider the temporary nature of this extension. Past commenters to CMS have identified these limitations as arbitrary and we concur there may be instances in which access to care is harmed. Removing these frequency limitations permanently would defer to health professional assessment of need and clinical judgment to determine whether in-person care is required. Consequently, AAPA recommends that CMS use the one-year extension to review relevant data regarding evolving practice patterns and, should no noticeable detriment to patient care be identified, consider permanently removing frequency limitations on select Medicare telehealth services.

Finally, CMS is proposing to allow audio-only communications technology to permanently meet the definition of a "telecommunications system." Since the 2022 Physician Fee Schedule, CMS has evolved in their perspective of audio-only technology. Currently it has finalized a policy authorizing audio-only equipment to be used, "for telehealth services furnished to established patients in their homes for purposes of diagnosis, evaluation, or treatment of a mental health disorder if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined previously, but the patient is not capable of, or does not consent to, the use of video technology." With the expiration of many telehealth flexibilities at the end of 2024, including the ability to designate the home as the originating site for most telehealth services, only certain services will be eligible to be provided in this setting, including the diagnosis, evaluation, or treatment of mental health or substance use disorder, and monthly ESRD-related clinical assessments. CMS is proposing that those telehealth services that continue to be authorized to occur within a patient's home as the originating site be authorized to occur via audio-only communication at the discretion of the patient. AAPA acknowledges the potential challenges experienced by many Medicare beneficiaries regarding the use of audio-video technology. A lack of access to computers and technological devices, a lack of knowledge of how to use technology, or a lack of internet availability all act as deterrents to beneficiaries using two-way, audio-video technology. For many beneficiaries, audio-only technology is the only practical way to access services via telehealth. For other beneficiaries, some may not feel comfortable communicating from their home via video. AAPA's previous comments have requested that

CMS authorize a telehealth service to be delivered via audio-only technology if the beneficiary indicates they are unable or unwilling to use two-way, audio-visual technology. Moreover, many of the telehealth services that remain available to be conducted within a patient's home as the originating site can be accomplished via audio-only communication. Consequently, AAPA supports the agency's proposal to allow the use of audio-only technology for telehealth services still authorized to occur in the home should the patient not be capable of or consent to the use of audio-video technology. In addition, we also support the requirement to use an identifying modifier to gather more data on these services.

Direct Supervision by Real-Time, Audio/Video Technology

In the 2025 Physician Fee Schedule proposed rule, CMS proposes to make permanent the authorization to meet direct supervision requirements using real-time, audio/visual technology for a subset of services, while extending this flexibility for other services through 2025. While AAPA supports CMS's efforts to make this authorization permanent in specific low-risk circumstances, we continue to oppose a broad permanent application of this authorization to all billing providers, such as PAs, due to transparency concerns.

To increase patient access and enhance workforce capacity, CMS is proposing to permanently define direct supervision to allow "immediate availability" of the supervising practitioner by audio/video real-time communication technology for a subset of services. These include:

1. Services furnished "incident to" a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'
2. Services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional)

CMS notes that auxiliary personnel nearly always exclusively provide services of this level. As such, these services frequently do not require in-person supervision or intervention by a supervising practitioner, and CMS determines these services to be lower risk regarding patient safety.

However, for all other services, CMS is proposing this flexibility only through the end of 2025. 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 billing for PAs and nurse practitioners, puts competing priorities of CMS at risk, such as appropriate attribution of services. Consequently, while we will again not oppose a one-year extension of direct supervision via real-time, audio/visual technology for higher-risk services, we continue to advocate that this flexibility not be made permanent.

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 COVID-19 public health

emergency, CMS indicated through IFC 1744[7] 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.

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 was necessary to minimize exposure to COVID-19 and reduce the detrimental impacts of the pandemic on the timely provision of care. However, 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 and nurse practitioners and the transparency complications that come with it. As CMS is aware, "incident to" is a Medicare billing provision that allows medical services performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of another health professional. Of particular interest to us is "incident to" billing on services performed by PAs and nurse practitioners that are attributed to a physician.

Due to how services billed "incident to" are reported through Medicare's claims process, a substantial percentage of medical services rendered 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 provided 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 and nurse practitioners.

One of the key elements 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) 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 did not see 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 and assess 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

[7] The Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. https://www.cms.gov/files/document/covid-final-ifc.pdf

unable to accurately 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. 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 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, distorts 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.[8] Similarly, in CMS's 2019 Physician Fee Schedule final rule, the agency acknowledged limitations in data usage and burden reduction estimations due to the ability to report services "incident to" billing.[9] Another concern regarding the negative impact of "incident to" billing on the accuracy and validity of value-based programs was noted in a Health Affairs Blog in a January 8, 2018 posting.[10] While claims data 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 and nurse practitioner healthcare contributions.

---

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

[9] The Department of Health and Human Services. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf

[10] "The Integrity of MACRA May Be Undermined By "Incident To Billing" Coding", Health Affairs Blog, January 8, 2018. DOI: 10.1377/hblog20180103.135358. https://www.healthaffairs.org/content/forefront/integrity-macra-may-undermined-incident-billing-coding

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 recommend 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 adversely affecting transparency. PAs and nurse practitioners can provide and bill for services under their own names instead of a physician's name, and at a lower cost of care (reimbursement rate) to the Medicare program. Any further extension of direct supervision by audio/visual communication for PAs and nurse practitioners would only serve to increase costs and further impair data transparency through the potential proliferation of "incident to" billing.

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

During the COVID-19 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. In the 2024 Physician Fee Schedule final rule, in response to overwhelming concern expressed by the provider community regarding the expiration of this authorization, CMS continued to permit distant site providers to use their business practice location when providing telehealth services from their home, as opposed to the practitioner's home address, through 2024. In the 2025 Physician Fee Schedule proposed rule, CMS proposes to extend the ability of distant site providers to use their enrolled practice address through 2025.

Citing feedback from affected health professionals, AAPA was among those concerned parties that encouraged CMS to not let this flexibility expire. We noted this was not merely a matter of privacy but may also be a matter of public safety. Consequently, AAPA requested a permanent process that would allow health professionals to avoid using their home addresses. While we support the temporary extension of this flexibility, we reaffirm our request to resolve this issue permanently before the new expiration.

AAPA urges CMS to work with Congress to extend expiring telehealth flexibilities. If Congress does not extend the expiring flexibilities before the end of 2024, AAPA requests that CMS explore options to mitigate the potential resulting affects on access by exploring flexibilities of interpretation under 834(m)(4) of the Social Security Act. AAPA also requests that CMS prepare educational communications regarding statutorily dependent telehealth flexibilities, whether Congress acts or not. AAPA commends CMS for extending telehealth flexibilities

under their purview, such as allowing the use of audio-only technology for telehealth services that are still authorized to occur in the home. We encourage CMS to analyze data to determine if certain flexibilities, like the suspension of frequency limitations on select Medicare telehealth services, should be made permanent. AAPA supports CMS making permanent the authorization to meet direct supervision requirements using real-time, audio/visual technology for a subset of low-risk services. However, 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 proposed in the rule. Finally, AAPA requests that CMS develop a permanent process through which distant site providers can use their practice location for enrollment when providing telehealth services from their home, as opposed to the practitioner's home address.

Continued Expansion of Access to Behavioral/Mental Health Services

The 2025 Physician Fee Schedule proposed rule introduces a number of proposals that seek to make it easier for Medicare beneficiaries to access needed behavioral/mental health services. One proposed change is to add a billing code for safety planning for high-risk patients in crisis (those at risk of suicide or overdose). As noted in the proposed rule, death by suicide reached nearly 50,000 people in 2022 and is becoming more prevalent among older adults who are more likely to be Medicare beneficiaries. CMS is proposing to establish an add-on G-code (GSPI1) for safety planning interventions to be billed alongside an E/M visit or psychotherapy.

The code descriptor reads: "*Safety planning interventions, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health professionals or agencies; and making the environment safe; (List separately in addition to an E/M visit or psychotherapy).*"

AAPA approves of this add-on code. While such safety planning may already be occurring, payment for this service by Medicare may increase the frequency of its use, bring more attention to its potential benefits, and appropriately pay practitioners for the time and work involved in such planning. AAPA recommends that CMS, in addition to being used as an add-on code, authorize this G code to be billed as a standalone service, separate from an E/M visit or psychotherapy. AAPA could envision instances when a health professional deems the need to develop a safety plan for his or her patient without requiring an additional visit by the patient. With a service that aims to save lives from a crisis that could affect an at-risk individual at any moment, there is a sense of immediacy in getting resources to a patient who may not be able to wait until there is time or availability for both safety planning and an E/M or psychotherapy visit. Due to the lack of behavioral/mental health professionals in certain geographic locations, appointment availabilities may require waiting a length of time in which a delay to receive necessary safety planning could be deadly. AAPA further recommends that CMS authorize all health professionals currently allowed to bill for behavioral/mental health services be authorized to provide and bill for safety planning on its own.

A second proposed change CMS hopes will advance access to behavioral health services is the agency's proposal to pay for post-discharge telephonic follow-up contact intervention (FCI). FCI includes a series of telephone contacts between a provider and a patient at risk of suicide following discharge. The expectation is that regular follow-up may reduce the risk of negative future outcomes. These FCI audio-only telephone calls typically encourage patients to utilize previously established safety planning and last approximately 10-20 minutes. Studies highlighted in the proposed rule are hopeful regarding these and other suicide prevention initiatives. CMS is proposing to establish a monthly billing G-code (GFCI1) to pay for post-discharge telephonic FCI. Due to cost-sharing, verbal or written consent from the beneficiary is required.

AAPA approves of CMS covering post-discharge telephonic FCI. Like with safety planning, this practice, as CMS notes, is currently underutilized and we hope that Medicare payment may increase awareness and utilization of these practices. AAPA recommends that CMS not set a stringent specified duration for which this service can be billed, as everyone's behavioral health needs vary in severity and duration. AAPA defers to the expertise of behavioral health professionals to provide feedback to CMS as to the exact number of calls and months that may be appropriate, but recommends the agency consider flexibility in the possible extension of FCI services beyond an initial range if medical necessity is determined by the involved provider.

A third change CMS hopes will expand access to behavioral health services is payment for Digital Mental Health Treatment (DMHT) devices. CMS's proposed G-code (GMBT1) would make payment for practitioners supplying FDA-cleared digital mental health treatment devices and the initial education and onboarding. These devices would augment an established behavioral therapy plan. CMS then proposes G-codes GMBT2 and GMBT3 to capture monthly treatment management services directly related to a patient's therapeutic use of DMHT devices, as well as time spent reviewing data generated from the DMHT devices, and at least one interactive communication between the patient and caregiver in the month.

AAPA supports CMS making payments for the use of DMHT devices. We view it as a recognition of emerging technologies that may supplement broader treatment plans, should the billing practitioner determine such devices would be beneficial to a patient's care. Such devices have the potential to provide access to treatment outside of what health professionals can provide at specified appointment times.

AAPA recognizes that these proposals seek to expand the ability of health professionals to meet the increasing demand for behavioral/mental health services. AAPA supports these proposals made by CMS to increase access to behavioral/mental healthcare; however, AAPA believes more can be done by CMS to help bolster patient access to such services.

AAPA advises that PAs can play an important role in increasing beneficiary access to behavioral/mental health services. 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 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 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 the public health emergency having officially ended on May 11, 2023, this does not mean the burdens of the pandemic on the health system have receded. 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.[11] A recent New York University study found that while demand for mental health services is increasing, patient access is decreasing.[12] Untreated mental and behavioral health conditions can result in disability, lost productivity, substance abuse issues, family discord, and even death.[13]

122 million people live in communities with limited access to mental healthcare services.[14] 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.[15] 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.[16] 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.[17] 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

---

[11] 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. https://www.samhsa.gov/data/

[12] Heath, Sara. Patient EngagementHIT. 2017. Mental Healthcare Access Shrinks as Patient Demand Grows. https://patientengagementhit.com/news/mental-healthcare-access-shrinks-as-patient-demand-grows

[13] Mayo Clinic. 2019. Mental Illness. https://www.mayoclinic.org/diseasesconditions/mentalillness/symptomscauses/syc20374968#:~:text=Untreated%20mental%20illness%20can%20cause,Family%20conflicts

[14] Health Resources and Services Administration. Health Workforce Shortage Areas. https://data.hrsa.gov/topics/health-workforce/shortage-areas

[15] National Council for Behavioral Health. 2017. The psychiatric shortage: Causes and solutions. https://www.thenationalcouncil.org

[16] 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. https://www.hrsa.gov

[17] Ibid

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 noncontrolled medications.[18] 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.[19]

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.[20] In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral/mental health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

PAs, 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.[21] 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 27% increase in PAs from 2022 to 2032.[22] This growth projection, along with PAs' qualifications, suggest an increased utilization of PAs will be an effective method to address the country's mental and behavioral health workforce deficiencies and access concerns.

---

[18] American Academy of PAs. What is a PA? https://www.aapa.org/what-is-a-pa/
[19] Ibid
[20] 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. https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext
[21] Medicare Payment Advisory Commission. 2019. Report to the Congress: Medicare and the health care delivery system. https://www.medpac.gov
[22] US Bureau of Labor Statistics. 2024. Occupational Outlook Handbook. Physician Assistants. https://www.bls.gov/ooh/healthcare/physician-assistants.htm

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,[23] CMS's inclusion of PAs as authorized providers in community mental health centers,[24] 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 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 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 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 add-on G-code (GSPI1) for safety planning interventions and recommends this code to be billed as a standalone service, separate from an E/M visit or psychotherapy. AAPA further recommends that CMS authorize all health professionals eligible to bill for behavioral/mental health services to provide safety planning along with other services or individually. AAPA supports CMS covering post-discharge telephonic FCI, recommends that CMS not set a stringent specified duration during which this service can be billed, and recommends the agency consider flexibility in the possible extension of FCI services beyond an initial range, if medical necessity is determined by the involved provider. AAPA supports CMS making payment for DMHT devices. 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

[23] 21st Century Cures Act. Public Law No: 114-255 2016. https://www.congress.gov/bill/114thcongress/housebill/34/text
[24] Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. https://www.law.cornell.edu/cfr/text/42/485.904

offered on the Federally Facilitated Exchange, to eliminate prohibitive policies regarding PAs providing behavioral/mental health services.

Updates to the Medicare Shared Savings Program

In the 2025 Physician Fee Schedule proposed rule, CMS again proposes various changes to the Medicare Shared Savings Program (MSSP). Many of the changes proposed this year seek to ease the provider burden to participate in the MSSP Accountable Care Organizations (ACOs). AAPA addresses a few of these changes below, identified by topic.

Prepaid Shared Savings

Based on the success seen under the advanced investment payments provided to ACOs newly entering the MSSP, as well as successes under the Next Generation ACO model, CMS proposes that starting January 2026, the agency would let historically successful ACOs (those who have successfully earned shared savings while participating in the program) access to an advanced payment for shared savings, as opposed to having to wait months after the end of each performance year. These prepaid shared savings could be used to 1) make investments, such as staffing and infrastructure, and 2) fund direct beneficiary services, such as vision, hearing, and dental. At least 50% of these prepaid shared savings must go to improving direct services to beneficiaries. Payments would be made quarterly, and if the ACO does not earn sufficient shared savings to offset the advanced payments, CMS may withhold future payments. The initial application cycle for participation for prepaid shared savings would be for a January 1, 2026 start date.

AAPA approves of this arrangement. We support financial arrangements that incentivize practice improvements and greater benefits provided to patients. We believe that the earlier receipt of funds will help ACOs more expeditiously meet the needs of their patients. AAPA recommends CMS finalize this proposed policy.

Health Equity Benchmark Adjustment

Based on the success seen under the ACO REACH model, CMS proposes to adopt a health equity benchmark adjustment. This adjustment is intended to incentivize ACOs to serve more beneficiaries from underserved communities and to encourage more safety-net providers to participate under the MSSP.

AAPA approves of this adjustment. We believe this policy may increase access to ACO providers in underserved areas, which is a priority for CMS. AAPA recommends finalizing this proposed policy.

ACO Assignment Methodology

In the 2025 Physician Fee Schedule proposed rule, CMS makes multiple changes to the ACO assignment methodology including amending the definition of primary care services to include a broader array of applicable services. AAPA applauds CMS's ongoing efforts to continue to find ways to increase participation in the program. However, we note that ACO assignment remains constrained by restrictive statutory language.

AAPA appreciates CMS' efforts in recent years to reform ACO assignment policies to be more inclusive. In the 2024 Physician Fee Schedule, CMS finalized a policy for a new Step 3 for ACO beneficiary assignment. Step 3 allows for an "expanded window," 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 have seen a PA or other non-physician health professional within that period.

This expanded window seeks to capture additional beneficiaries who qualify for ACO assignment such as patients who have received all their recent care from non-physician health professionals like PAs and nurse practitioners. Patients who will likely benefit from Step 3 include patients in rural and underserved areas where a PA is the only health professional in the community. AAPA supported the creation of this new step 3 with the hope that a greater number of beneficiaries would be able to access the coordinated care at the center of an ACO's mission and ACOs with a greater number of beneficiaries may be more fiscally sound.

Unfortunately, the expansion of the assignment process through Step 3 will not extend the ability to be assigned to an ACO for all patients. There will continue to be people who have been seen exclusively by a PA or other 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 to be assigned to an ACO. However, in previous rules, CMS has recognized that claims-based assignment is the methodology by which the "vast majority of beneficiaries are assigned."[25]

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

AAPA approves of CMS's proposed prepaid shared savings, as well as the proposed health equity benchmark adjustment. AAPA continues to urge CMS to work with Congress to remove the continued statutory physician-centric language regarding assignment.

---

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

Certification of Therapy Plans of Care

In the 2025 Physician Fee Schedule proposed rule, CMS seeks to reduce the administrative burden of certifying physical therapy, occupational therapy, and speech-language pathology plans of care. Current rules require that if a plan of care is established by a physical therapist, occupation therapist, or speech-language pathologist, the plan is forwarded to the referring health professional who then must sign an initial certification of the patient's plan of care within the first 30 days of treatment. While treatment can begin prior to receipt of the signature, any services are provided at financial risk to the therapists, as the signature is required prior to the deadline to authorize payment.

CMS has received feedback from stakeholders that this process is burdensome to both therapy providers and the health professionals that are required to certify these plans. Therapists have described instances in which they have needed to make repeated outreach to overburdened health professionals to secure a signature and be able to receive payment. As a result, the agency is proposing that if a physician or other health professional provides a signed and dated order/referral for the therapy, and documentation has been made in the medical record of the order/referral as well as the submission of the treatment plan to the ordering/referring health professional, there would be an exception to the requirement to have a health professional sign a therapist established treatment plan for initial certification, as long as the treatment plan was sent to the health professional within 30 days of the initial evaluation. That is, CMS would take the signature on the order/referral as equivalent to a signature on the plan of treatment. CMS proposes no such policy for recertifications.

AAPA shares CMS's concerns regarding the overburdening of health professionals and suspects the process as currently required may lead to delays in care provision. We believe the initial order itself sufficiently demonstrates the medical necessity of the services. Consequently, AAPA supports the increased flexibility proposed by CMS as it not only encourages more timely and efficient care delivery to patients but reduces health professional burden. AAPA also concurs that recertifications should still be required to receive certification from the patient's healthcare professional to reduce the likelihood of therapies continuing beyond need.

CMS solicits further feedback on whether there should be time limits in which to modify the plan of care. The agency indicates that interested parties have suggested a ten-business day response window from the date of receipt of a plan of care to modify the plan. AAPA recommends not instituting any such window. We remind CMS that part of the reason for the increased flexibility in the initial certification proposed in the rule was to relieve the burden on health professionals. AAPA could envision instances in which a health professional is unable to respond within the ten-day period, but upon later review determines a modification to the care plan is needed. CMS further enquires as to whether there should be a 90-calendar day limit between the order/referral for outpatient therapy services and the initial treatment of the patient when the order is intended to be used as a substitute for certification under the proposed policy change. AAPA supports such a limit, as an extended period between

order/referral and receipt of care may result in a change in the patient's condition that may require reevaluation and assessment of specific therapy needs.

AAPA supports CMS's proposed modifications to streamline the process of initial certification for therapy plans of care and concurs with CMS's decision not to extend this flexibility to recertifications. AAPA further advises that while a ten-business-day window for modifications of care plans may not be in line with the goals of this proposed rule, a 90-calendar-day window for initiation of treatment may be reasonable to ensure a current diagnosis.

Payment for Caregiver Training Services

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

In comments to the 2024 Physician Fee Schedule, AAPA expressed approval for CMS's payment for caregiver training in recognition that other individuals who are not the patients themselves are often essential in successfully implementing treatment plans. Proper training allows caregivers to improve patient function and alleviate symptoms.

Services finalized in the 2024 Physician Fee Schedule rule focused on behavior management and facilitating functional performance in the home or community. In the 2025 Physician Fee Schedule rule, CMS proposes to expand these covered services to include direct care services and supports. Specifically, CMS would pay for health professionals to provide caregivers with specific clinical skills to monitor and provide hands-on treatment to the patient, such as infection control and wound dressing.

CMS proposes three new caregiver training services HCPCS G-codes: GCTD1 for the initial 30 minutes, GCTD2 for each additional 15 minutes, and GCTD3 for multiple sets of caregivers. Any direct care services must be relevant to the established treatment plan. Those policies finalized in the 2024 Physician Fee Schedule, such as a requirement for an established treatment plan, documentation of need for caregiver training, and consent of patients or their representatives, would apply to the newly proposed covered services.

AAPA approves of this expansion of authorized caregiver training services. Caregivers will be the ones providing routine care for patients. Properly equipping them with certain skills can reduce reliance on the healthcare system for either routine care or readmissions due to exacerbating symptoms.

CMS also proposes to add caregiver training services codes to the Medicare Telehealth Services List, authorizing caregiver training services to be provided via telecommunications, as appropriate. AAPA approves of this authorization. While we concur with CMS that these services would largely be provided through in-person interactions, if the knowledge and skills required can be effectively provided by the billing practitioner by electronic means, this would provide flexibility as to when and how such training can be offered. Often, patients and caregivers may not be aware of certain considerations until after they have left the immediate care of health professionals, and the ability to return in person to have questions answered or receive necessary skills may be burdensome, and make the receipt of such training less likely. However, while CMS plans to authorize caregiver training services to be added to the Medicare Telehealth Services List on a provisional basis for 2025, we urge the agency to collect all appropriate information to consider making this authorization permanent, and to continue this flexibility past 2025 if CMS believes at the time that it does not yet have enough data to determine whether these services should be permanent or not.

AAPA approves of CMS expanding the focus of caregiver training to include direct care services and supports. AAPA further supports CMS authorizing health professionals to provide caregiver training services via telehealth and recommends this authorization be made permanent. We urge the agency to collect all appropriate information to consider making this authorization permanent, and to continue this flexibility past 2025 if CMS believes at the time that it does not yet have enough data to determine whether these services should be permanent or not.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

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

Specifically, the code descriptor reads:

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

G2211 is meant to account for the resource costs and cognitive effort associated with the longitudinal care of complex patients. In comments to the 2024 Physician Fee Schedule, AAPA supported CMS's activation of HCPCS add-on code G2211, noting the benefit of additional payment to properly compensate for the intangible but necessary actions of tracking, monitoring, and reviewing that go into providing the care patients deserve. We believed the code could incentivize and strengthen longitudinal care relationships between patients and their

providers. We also supported the code activation due to its likely benefit to primary care in the face of serious challenges in maintaining a robust primary care delivery model.

However, in the 2024 Physician Fee Schedule, CMS clarified that G2211 should not be used with payment modifier -25 (indicating a significant, separately identifiable evaluation and management service by the same practitioner on the same day of a procedure or other service). In a partial reversal of this position, CMS indicates it will authorize G2211 to be billed on any O/O E/M when the base code is reported by the same practitioner on the same day as an Annual Wellness Visit, vaccine administration, or other Part B preventive service in an office or outpatient setting. AAPA supports this decision. Not authorizing this add-on code to be billed in certain clinical scenarios may be disruptive to the way care is provided, as frequently certain preventive services are provided on the same day as a separately identifiable O/O E/M visit, and modifier -25 is used. As currently implemented, this restriction may cause 1) a modification in the way care is typically provided by avoiding the provision of the preventive service, or else 2) cause the code not to be utilized to minimize negative effects on the provision of efficient care. We note that CMS implemented this code because it believed the RVS Update Committee recommended values, which the agency adopted, did not sufficiently reflect the resource costs involved in the provision of primary care or similar longitudinal care for a single, serious, or complex condition. Consequently, if G2211 is being underutilized, it may not sufficiently confront one of the problems CMS finalized the code to address. We recommend that CMS finalize its proposed revised policy.

AAPA recommends CMS finalize its policy to authorize G2211 to be billed on any O/O E/M when the base code is reported by the same practitioner on the same day as an Annual Wellness Visit, vaccine administration, or other Part B preventive service in an office/outpatient setting.

Services Addressing Health-Related Social Needs Request for Information

In the 2024 Physician Fee Schedule, CMS finalized payment for various G codes[26] that seek to support health professionals spending greater time and resources dedicated to helping patients find and receive appropriate care. Those codes mentioned specifically under this request for information include:

The Social Determinants of Health Risk (SDOH) Assessment

Since January 1, 2024, CMS reimburses for a "social determinants of health risk assessment" (G0136). This risk assessment can be performed either during the Medicare Annual Wellness Visit, as a standalone service, or in conjunction with another E/M or behavioral health visit. The code may only be billed every six months, would occur as part of the social history, and would require the use of an SDOH risk assessment tool that has been

[26] Centers for Medicare and Medicaid Services. 2024. Health Equity Services in the 2024 Physician Fee Schedule Final Rule. https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

deemed standardized and evidence-based. All identified needs would then be documented in the medical record. This risk assessment was also added permanently to the Medicare Telehealth Services List.

Community Health Integration Services

Since January 1, 2024, CMS has reimbursed (G0019, G0022) healthcare professionals to address identified SDOH that are interfering with appropriate treatment for a diagnosed condition. These services are performed by certified or trained auxiliary personnel (e.g., a community health worker, social worker, etc.) incident to the professional services and under the general supervision of a billing practitioner. These services can be furnished monthly, as medically necessary, following an initiating E/M visit or in certain instances an Annual Wellness Visit by the billing practitioner during which the practitioner identifies potential SDOH that may impede proper diagnosis or care for a patient condition. The billing practitioner must establish an effective treatment plan and document how addressing the unmet SDOH needs would help with a diagnosis or treatment. Only one practitioner per beneficiary per calendar month may bill for community health integration services. Written or verbal patient consent must be obtained and documented in the medical record before the initiation of community health integration services.

Principal Illness Navigation

Since January 1, 2024, CMS has reimbursed for navigation services (G0023, G0024, G0140, G0146) for patients with a serious high-risk condition/illness/disease. CMS defines serious, high-risk conditions as lasting at least three months, putting the patient at significant risk of hospitalization, being placed in a nursing home, functional decline, acute exacerbation/decompensation, or death. The condition must also require development/monitoring/revision of a disease-specific care plan as well as frequent adjustment of regimens or substantial assistance from a caregiver. An initiating E/M visit by a billing practitioner, and in certain instances an Annual Wellness Visit or visit by a clinical psychologist, is required to determine the medical necessity of principal illness navigation services, and a treatment plan. Subsequent services are furnished by certified or trained auxiliary personnel (e.g., care navigators, peer support specialists, etc.) incident to the professional services and under the general supervision of a billing practitioner. Any needs identified and resulting activities must be documented in the medical record. Principal illness navigation services can't be performed more than once per practitioner per month for any single serious high-risk condition. Written or verbal patient consent is required prior to the initiation of principal illness navigation services and must be documented in the medical record as well.

A Broad Request for Feedback

In the 2025 Physician Fee Schedule proposed rule, CMS is soliciting broad feedback on these codes. CMS enquires whether these codes are helping address unmet social needs that interfere with a practitioner's ability to diagnose and treat their patients.

In AAPA's comments to the 2024 Physician Fee Schedule proposed rule, we expressed broad support for these new codes, acknowledging the opportunity they present to promote health equity. Specifically, we noted our approval of CMS's ongoing focus on SDOH and identifying obstacles that may hinder or prevent health professionals from providing effective care. 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. In previous rules, CMS has cited that such factors may account for as much as 50% of an individual's health.[27] We expect the proposals finalized for 2024 will better inform treatment plans, as well as identify further opportunities for supplementary care management. We further support the provision of these services, as appropriate, by telehealth.

AAPA recognizes that data collected on usage of these three new services so far would be limited, as these opportunities were only available as of the beginning of this year. However, AAPA believes that CMS may find early assessments of uptake educational. AAPA recommends the agency review early data on the usage of these codes to determine if there are specific groups or geographic locations that have lagged in meeting the level of application anticipated by CMS. Such data could help inform subsequent educational and outreach efforts. We have heard anecdotal evidence from a range of health professionals that knowledge of these codes may not be widespread. AAPA encourages CMS to work with stakeholders such as provider associations and patient advocacy groups to better inform health professionals and their employers regarding the potential benefits of using these newly established codes.

AAPA also requests that CMS revisit its policy that the Social Determinants of Health Risk Assessment be billed only once every six months. If a patient is seeking care more frequently than six months, this may suggest continued or changing SDOH factors that are adversely affecting effective treatment. Early identification of ongoing or changed conditions that affect one's SDOH will be essential to effective treatment. An outdated assessment of a patient's SDOH may negatively bias any remediating steps, such as those under community health integration services. CMS should leave the need for a renewed risk assessment to the judgment of the clinician, who is best able to determine if patient circumstances warrant reassessment.

A Request for Additional Opportunities to Address Barriers

AAPA applauds CMS's ongoing commitment to health equity. In the 2025 Physician Fee Schedule proposed rule, CMS solicits information broadly as to whether other policies could be reviewed that seek similar goals as those codes noted. Specifically, CMS requests information identifying barriers to high-value, potentially underutilized services by Medicare beneficiaries. Consequently, AAPA provides the below list of regulatory barriers that, if addressed, may further support CMS health equity, access, and efficiency goals. We request that CMS consider these additional steps, all of which are within the power of the agency to address regulatorily, to alleviate patient burden in navigating an already complex system.

---

[27] Whitman, A; De Lew, N; Chappel, A; Aysola, V; Zuckerman, R; Sommers, B. 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

- Remove Restrictions Placed on Hospice-Employed PAs: The Request for Information specifically requested the identification of barriers to "underutilized" services. Hospice care is underutilized.[28] In CMS's 2024 and 2025 Hospice Wage Index proposed rules, the agency concurs with this, indicating that while utilization of the benefit has substantially grown, there may be an underutilization of the program by beneficiaries despite the benefits of hospice. Underutilization of hospice can lead to prolonged patient usage of expensive and ineffective care. The causes of postponement in electing hospice care are numerous and may include the difficulty of a provider concluding a patient's prognosis is terminal and the difficulty with 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 create additional challenges.

  While AAPA does not claim that Medicare's hospice policies pertaining to PAs are the primary reason for the underutilization of hospice, we believe the removal of regulatory barriers and the subsequent improved utilization of PAs has the potential to reduce care barriers and move toward ameliorating the problem of eligible beneficiaries not sufficiently accessing hospice services. The effective use of PAs will help ensure that hospice organizations are appropriately staffed with health professionals who can provide a broad array of services, increasing capacity and bolstering the benefit to patients.

  CMS should augment the amount of care and attention available to those beneficiaries who elect hospice by removing arbitrary restrictions on PAs who work in hospice settings from providing needed care. For example, CMS restricts PAs who work for a hospice from ordering medications for patients (42 CFR § 418.106(b)(1)(iii)). In addition, 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 by either a physician or nurse practitioner who works for the hospice as an attending physician (Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.3). This policy unnecessarily limits the number of PAs that can fill the important role of an attending physician under specific circumstances. This is not a question of qualification or competence, as CMS policy indicates that when not employed by a hospice, PAs are authorized to serve in the role of a hospice attending physician. AAPA recommends that CMS remove these barriers to PAs employed by a hospice providing these necessary services.

- 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 to perform 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 outdated policies that need to be modernized to reflect current medical practice and bring efficiencies to the system. During the COVID-19 public health

[28] Fine PG. Hospice Underutilization in the U.S.: The Misalignment of Regulatory Policy and Clinical Reality. J Pain Symptom Manage. 2018 Nov;56(5):808-815. doi: 10.1016/j.jpainsymman.2018.08.005.

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 in the re-institution of these outdated practice restrictions when years of experience have demonstrated the high-quality care PAs deliver in SNFs. During the public health emergency, SNFs, because 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. AAPA recommends that CMS modify 42 CFR § 483.30(c)(4) to authorize PAs to provide the initial comprehensive visit and all required visits in SNFs.

- 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 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 visits, and in each subsequent week, a non-physician health professional such as a PA 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 must 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 Non-Physician Health Professionals to Certify Patient Ambulance Transfers: Physician certification is required for nonemergency, scheduled, repetitive ambulance services.[29] 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 inefficient and a barrier to care. 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 who provide care to patients who require nonemergency, scheduled, repetitive ambulance care to be authorized to provide the required certifications to ensure these patients have access to needed services.

- Authorize PAs to provide required documentation and certifications on orders for home blood glucose monitors: A CMS National Coverage Determination (NCD)[30] indicates that coverage for home blood glucose monitors is limited to situations that meet certain criteria. Among these criteria are the requirements that a physician document that a patient or other responsible individual can be trained to use prescribed devices appropriately. Another specific home blood glucose monitor requires that a physician certify that a patient has a visual impairment severe enough to require the use of such monitoring systems. These restrictions are unnecessary and overly burdensome. PAs commonly provide care to patients with chronic conditions, including diabetes. According to AAPA's 2021 Practice Survey, nearly 70% of PAs have screened, diagnosed, or treated patients with diabetes. In addition, the physician-centric language is not justified by quality concerns. A study in the American Journal of Medicine found that PAs provide comparable care to physicians when managing diabetic patients, both at the diagnosis and during four years of follow-up care.[31] PAs are qualified and capable of making these determinations. Consequently, AAPA recommends that CMS extend to PAs the ability to document and certify the need for home blood glucose monitors for patients with diabetes.

---

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

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

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

- Authorize PAs to Provide Documentation for Podiatric Services for Patients with Certain Systemic Conditions: In Chapter 15 of the Medicare Benefit Policy Manual,[32] CMS identifies several podiatric services for patients with certain systemic conditions that would only be covered "if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition." AAPA is not aware of any statute or regulation that mandates this restriction. Instead, this requirement may result in patients receiving care from a PA needing to schedule a separate visit with a physician just to document a need for podiatric care that PAs are qualified to determine. This requirement would potentially provide additional time and financial burden to patients. AAPA recommends that CMS authorize PAs to provide the required documentation for these podiatric conditions.

- 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 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 could lead to gaps in coverage and potentially increased costs and confusion for vulnerable populations. Other payers aligning with best-practice Medicare policies would make patient navigation simpler if there were not a range of divergent, unnecessary, and complicated restrictions patients must confront. Consequently, AAPA recommends that Medicare encourage other payers to examine restrictive coverage policies that are inconsistent with Medicare policy.

AAPA continues to broadly support CMS's proposed additional payments for patient assistance, including payment for the social determinants of health risk assessment, community health integration services, and principal illness navigation services. However, we suggest it may be useful to authorize the social determinants of health risk assessment to be conducted more frequently than every six months. In addition, we request that CMS review preliminary data on the uptake of these services to determine any identifiable variances in usage of these codes, and to utilize its network of partners should further education be merited. In recognition of these codes that CMS finalized for 2024 that 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 barriers on PAs employed by a hospice, authorizing PAs to provide physician-required

[32] Centers for Medicare and Medicaid Services. 2024. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF

services in Skilled Nursing Facilities, removing restrictions on care for patients in Inpatient Rehabilitation Facilities, authorizing PAs to certify patient ambulance transfers, authorizing PAs to provide required documentation and certifications on orders for home blood glucose monitors, authorizing PAs to provide documentation for podiatric services for patients with certain systemic conditions, and promoting Medicaid and private payer alignment with Medicare policies.

Cardiovascular Risk Assessment and Management

In the 2025 Physician Fee Schedule proposed rule, CMS proposes to establish coding and make payment for atherosclerotic cardiovascular disease (ASCVD) risk assessment and management. CMS explains this addition is warranted based on the success demonstrated under the Million Hearts Model, an innovation center model that coupled a quantitative 10-year risk assessment with management and led to reduced mortality rates. CMS states that a new stand-alone G-code (GCDRA) representing the risk assessment would be separately billable but furnished in conjunction with an E/M visit. The risk assessment would eligible for payment if a patient exhibits at least one predisposing condition to cardiovascular disease but has yet to be diagnosed. The assessment could occur once every 12 months and consists of reviewing demographic information, as well as modifiable risk factors and risk enhancers for cardiovascular disease. CMS also indicates that cardiovascular-focused risk management (GCDRM) could subsequently be provided if determined necessary by the risk assessment. This management would include an ASCVD-specific individualized care plan, promotion of preventive services, medication management, and monitoring, among other requirements. Management services are expected to be provided by auxiliary personnel under the general supervision of a billing practitioner, no more than once per calendar month. Consent regarding receipt of services and potential cost sharing, as well as sufficient documentation, would be required.

CMS acknowledges in the proposed rule the burden heart disease has on patients, the magnitude of the effect on the health system, and the disproportionate burden on black Americans. CMS also acknowledges that a significant amount of cardiovascular disease is a result of behavioral causes and thus may be mitigated with proper detection and modifications. AAPA concurs with CMS's well-documented claims and consequently supports the addition of these ASCVD risk assessment and management codes. We believe in the importance of early detection that would allow for conversations between patients and trained health professionals as to proper interventions to reduce risk. By identifying risk early, health professionals can intervene to reduce the likelihood of potential negative outcomes through care plans that incorporate lifestyle changes or the prescription of appropriate medications. AAPA further supports flexibility in determining which ASCVD risk assessment tool can be used, as long as certain standards and requirements are met. AAPA notes the existence of multiple ASCVD risk assessment tools that may be utilized by different health professionals for varying reasons. However, CMS may choose to develop a list of risk assessment tools that meet the agency's stated standards for those health professionals who are unfamiliar with such options or who may not have the time to assess whether a specific tool meets CMS requirements.

AAPA supports the establishment of codes and payments for ASCVD risk assessment and management. AAPA further supports flexibility in which risk assessment tool to use and encourages the creation of a list by CMS to simplify the selection process for providers.

Rural Health Clinics (RHCs) Provision of Primary Services

In the 2025 Physician Fee Schedule proposed rule, CMS proposes to clarify requirements regarding the provision of primary care in RHCs. Current sub-regulatory guidance, found in the CMS State Operations Manual for RHCs as it relates to §491.9(a)(2), indicates that RHCs must not be "primarily engaged in specialized services." CMS notes this interpretation does not accurately reflect the language in §491.9(a)(2), which requires RHCs to be "primarily engaged" with providing outpatient health services. This has led to confusion and the interpretation that robust specialty services cannot be provided. The current phrasing and interpretation of "primarily engaged" has likely led some RHCs to rebalance offered services to ensure most services provided were primary care services as opposed to offering services based on the needs of the population being served. In the proposed rule, CMS seeks to implement new language that protects both primary care, as well as access to specialty care, as needed.

CMS offers to modify §491.9(a)(2) to instead indicate that RHCs must provide primary care, but no longer must be primarily engaged in furnishing primary care services. To protect primary care access, the language will note that RHCs cannot be a rehabilitation agency or facility primarily for the care and treatment of behavioral health conditions. This proposed modification both protects the provision of primary care and allows for increased outpatient-specialty services to meet patient needs. AAPA approves of this modification. We concur with CMS regarding the importance and potential of primary care but believe that, especially in rural or underserved areas, health providers must be flexible to meet the unique needs of the population, as opposed to ensuring that a percentage of services are of a specific types. We appreciate CMS's clarification that offering primary care is required, but this does not need to be a majority of services provided, and we urge finalization of this policy.

AAPA recommends CMS finalize its proposed modification to indicate that RHCs must provide primary care, but no longer must be primarily engaged in furnishing primary care services.

Proposed Reduction in the 2025 Conversion Factor

In the 2025 Physician Fee Schedule proposed rule, CMS again proposes to reduce the Medicare conversion factor. In dollar terms, CMS has proposed a decrease of approximately 93 cents, from $33.29 to $32.36, for 2025. This payment reduction is primarily due to the expiration of the temporary 2.93% payment increase provided by Congress through the Consolidated Appropriations Act of 2024 for March through December of 2024, a 0.05 positive budget neutrality update, and a 0% update adjustment factor.

As this is the fifth year of a decreased conversion factor, AAPA is troubled by the resulting pattern. Each year Congress provides a temporary fix to partially remedy these cuts, but the patchwork nature of these transitory fixes is untenable. The impact of cuts to the conversion factor in 2025 is further compounded by similar decreases over the past few years. AAPA remains concerned that financial losses incurred by health professionals may cause practice adaptations that may in turn negatively affect the ability of patients to access care in an equitable or timely manner. At a time when health professionals continue to be tasked with meeting increasing demands for care, medical practice costs have simultaneously been affected by rising inflation.

AAPA urges CMS to prioritize working with Congress to remove current and future financial constraints on health professionals. Until a long-term fix can be identified, CMS should encourage Congress to again provide conversion factor relief through a payment increase for 2025. However, the expectation that Congress will continue to provide such relief to remedy cuts to reimbursement indefinitely is not a sustainable strategy. Congress must consider long-term options, such as addressing the budget neutrality requirements responsible for these cuts to reimbursement. As such, AAPA again requests that CMS prioritize working with Congress and affected stakeholders 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 again requests that CMS prioritize working with Congress and affected stakeholders to both produce immediate relief for health professionals in 2025, as well as to design and pass a more equitable long-term system of provider reimbursement.

Quality Payment Program (QPP) Updates

Threshold Levels

In the 2025 Physician Fee Schedule, CMS leaves many aspects of the traditional Merit-based Incentive Payment System (MIPS) program untouched, including performance and data completeness thresholds. We recognize this may, in part, be because CMS wishes to transition entirely away from traditional MIPS toward MIPS Value Pathways (MVPs).

AAPA does not fault the agency for not wanting to implement new changes in such proximity to a proposed elimination of the traditional MIPS program. We support making any transition from traditional MIPS to MVPs as least burdensome as possible. An increase in the performance threshold, while certainly providing a larger bonus for certain health professionals, would result in more providers receiving a negative adjustment due to budget neutrality requirements. Due to continued uncertainty in the direction of the program, we endorse an increasingly cautious approach to raising the performance threshold.

Additionally, we note that CMS also initiated a timeline in the 2024 Physician Fee Schedule that set the data completeness threshold at 75% for the 2024 through 2026 performance periods, before increasing this threshold to 80% for the 2027 performance period. In response to this, AAPA recognized the need to raise thresholds in pursuit of meaningful value-based reimbursement and expressed appreciation for the gradual increase in percentage with sufficient advanced notice. We continue to support this timeline.

Due to the likelihood of a full transition to MVPs in the coming years, as well as the associated burdens (especially incurred by smaller practices), AAPA supports keeping threshold levels the same this year.

MIPS Reporting Simplification

AAPA supports efforts by CMS to simplify and lessen the burden of MIPS reporting. Examples of these efforts include no longer requiring the selection of a population health measure, indicating that CMS will compute all available population health measures for an MVP participant and apply the highest-scoring measure to the quality performance category score. Another example is the removal of "high" and "medium" weights regarding Improvement Activity reporting requirements and instead simplifying the reporting requirements to choose any two under traditional MIPS, or one if categorized as a small practice, rural, in a provider-shortage area, or non-patient facing, or if reporting under MVPs. AAPA encourages CMS to identify additional simplifications to make the process of reporting less burdensome.

The Transition to MIPS Value Pathways (MVPs)

To move away from a cumbersome system in which health professionals and groups choose what to report from a large set of measures that are often not comparable, CMS has developed a method of reporting in which a health professional or group selects from a narrower and more focused set of measures that better reflect the type of care the health professional or group typically provides. These sets of more focused measures, or MVPs, are structured around a specialty or medical condition. The measures included in the MVPs consist of a foundation of claims-based population health and care coordination measures and are supplemented with measures directly relevant to the clinical practice of the chosen specialty/medical condition on which the MVP focuses. Measures reported under an MVP would be like those reported by other health professionals who have also chosen that same pathway, increasing comparability of clinician quality, outcome, and cost performance data. CMS hopes this will reduce complexity and burden, streamline reporting, improve measurement, and 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 2025 Physician Fee Schedule proposed rule, CMS includes a Request for Information on the timeline for sunsetting traditional MIPS in favor of MVPs. CMS suggests mandating MVP participation starting in the 2029 performance/2031 payment year. AAPA encourages CMS to propose and finalize an official date, as updating provider systems and work processes may take years.

CMS continues the process of establishing MVPs by proposing six additional pathways for voluntary reporting in 2025, in addition to those pathways proposed in previous years. The new pathways proposed include complete ophthalmologic care, dermatologic care, gastroenterology care, optimal care for patients with urologic conditions, pulmonology care, and surgical care. If finalized, CMS estimates that it will have established pathways that apply to 80% of the provider population. While AAPA finds this number admirable, we note that with a suggested 2029 performance year in which MVP participation will be required, CMS must accelerate establishing the number and variety of MVP options to cover the remaining 20%. We recognize that one obstacle to a swift transition is the need to develop new or improved quality and cost measures in those specialties that do not currently have an established or proposed MVP. In the 2025 Physician Fee Schedule proposed rule, CMS suggests several options to address the problem of health professionals in specialties that do not yet have an MVP established to which they could report. These suggestions include expanding current MVPs to make them more applicable to new specialties and targeting multiple specialties within future MVPs. AAPA cautions against this approach. We note that broadening the focus of MVPs risks turning MVPs into something counter to the stated goals of being less generalized than traditional MIPS and enhancing comparability. Instead, AAPA recommends CMS prioritize the development of a greater number of MVPs to which the remaining health professionals can report. AAPA could support these broader options temporarily if the agency feels it is unable to produce the necessary number of new MVPs in time, but only if participants in broader MVPs have a timeline in place for eventual transition to MVPs that represent them, and CMS first prioritizes expediting the development of new MVPs with sufficient measures over a catch-all alternative.

AAPA encourages CMS not to wait until the fee schedule rule directly before compulsory participation to complete a first round of established MVPs to which it feels comfortable nearly everyone will be able to report. AAPA suggests allowing several years with a full array of MVP choices under voluntary participation to leave time to determine which, if any, health professionals are unable to find an applicable CMS MVP and to rectify the issue. By the suggested transition date of 2029, six or seven years of voluntary participation will have been in place, but only for those covered under the initial array of MVPs. Others who have yet to have an MVP established that represent their specialty will have very few years under which to participate voluntarily. AAPA recommends that CMS work with the provider community to identify potential gaps in MVP specialty concentration so there are no health professionals who cannot appropriately report to any of the available MVPs. AAPA encourages the agency to specifically seek input from various types of affected health professionals when determining which specific specialties/conditions will be recognized by CMS as pathways. CMS should oversample those health professionals that fall into the 20% it estimates are yet to be covered by an existing MVP. PAs should be included in the process as they have unique perspectives and concerns regarding implementation details because of their practice in multiple specialties.

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

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

Health professionals like PAs 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 comprehensive assess 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 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. The importance of this outreach is only magnified by a suggested date by which participation will be compulsory, and outreach activities should be accelerated when a transition date is finalized. Educational efforts should prioritize outreach to those who have not yet voluntarily reported to an MVP, or those in their initial year doing so. Efforts to educate those affected will also require adequate time for review, analysis, and 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.

Subgroup Identification of Provider Specialty

In the 2023 Physician Fee Schedule, CMS indicated that subgroup reporting is voluntary for the CY 2023-2025 performance years, but multispecialty groups will be required to report as subgroups starting in CY 2026. At that time, a single specialty group will be able to continue to submit at the group level, but a multispecialty group must form subgroups to report to those MVPs that are most relevant to them. Any remaining health professionals who are not in assigned subgroups could then submit to MVPs or traditional MIPS as individuals, or else the entire group could choose to submit at the group level under traditional MIPS.

In past comments, AAPA expressed opposition to CMS determining specialty through the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). We noted how it would disadvantage PAs who are viewed by Medicare as practicing only in the specialty "physician assistant" and not the actual specialty in which they practice clinically. If PECOS is the determining factor of specialty in a single-specialty subgroup, PAs working in cardiology, for example, would be restricted from reporting with cardiologists in their office who provide similar care to comparable patients. We expressed further caution regarding CMS's subsequent proposal to identify specialty by claims data due to the potential misalignment of health professionals' artificial groupings determined by CMS, and by CMS collected data that may be incomplete (because of billing mechanisms such as "incident to") or inconclusive. CMS recognizes additional nuances in using Medicare Part B claims data to determine specialty such as health professionals in multiple specialties all providing team-based care for one clinical area, or when a primary specialty designation of certain practitioner types, such as PAs and nurse practitioners, do not reflect the scope of care provided. As noted in the proposed rule, PAs and nurse practitioners in large group practices could be involved an array of services.

AAPA believes that subgroup composition should not be defined by Medicare-assigned specialty, but instead by the shared relevance of an MVP for all subgroup participants. AAPA could conceive subgroups that are made up of health professionals from more than one specialty if they are reporting to an MVP that is focused on a condition that requires cross-specialty cooperation. For example, a Heart Valve Clinic may submit to an MVP focused on comprehensive valve care, and the group of practitioners could include an interventional cardiologist, cardiothoracic surgeon, cardiologist, and PA practicing in cardiology. Allowing varying compositions of subgroups and collecting the resulting data may allow for CMS comparisons of the most effective composition of health professionals in providing beneficial outcomes.

Much like in the selection of an MVP, AAPA believes health professionals should self-select themselves into appropriate subgroups. We believe that health professionals are incentivized to choose both the most appropriate subgroup and the most appropriate MVP for them since, if they do not, their ability to score well on specialty-specific measures will be compromised and will negatively affect their reimbursement. AAPA is pleased to hear that CMS is considering letting a group determine and inform CMS of their specialty and subgroup composition. This is consistent with our long-recommended proposal that groups attest to their specialty and subgroup composition. We support CMS's proposal and encourage its finalization.

CMS further enquires whether the agency should provide information to practices regarding which types of services their providers have been shown to provide through Medicare claims data. We believe this information could be instructive, as long as it is for informational purposes and not a requirement to report under the identified specialty. AAPA continues to note the limitations of such data due to billing methods like "incident to" and the ambiguity of what specialty certain services fall under. Consequently, this information could be used in conjunction with practice attestation, as guidance to group practices as to which professionals may best fit under what subgroup. We continue to note that professionals are incentivized not to misidentify the MVP to which they should report.

In recognition of the complexity of subgroups, CMS is considering a temporary flexibility for small multi-specialty practices to not have to report as subgroups. As small practices tend not to have the same resources available to large ones, AAPA supports this temporary flexibility, allowing small practices additional time to identify which requirements need to be met and to adapt.

Finally, after not having done so for years, CMS is considering putting some limits on subgroup composition. AAPA cautions against this action as putting limits on the size of subgroups may create duplication by forcing a multispecialty group to break down into multiple subgroups that report to the same MVP.

The Ending of the Advanced Alternative Payment Model 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 (APMs). Advanced APMs seek to increase quality while decreasing costs. The Advanced APM incentives were intended to encourage more health professionals to participate in Advanced APMs, 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. In the 2024 Physician Fee Schedule, CMS implemented a section of the Consolidated Appropriations Act that sought to bridge the gap year by offering a reduced rate of 3.5% (as opposed to 5%) in performance year 2023 (payment year 2025).

AAPA remains concerned that a 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. We believe this would be counter to CMS's long-term goals of transitioning to fee-for-value. Consequently, AAPA recommends that CMS investigate ways to continue to financially encourage participation in Advanced APMs to a greater extent than the MIPS program. We recommend that CMS also work with Congress to potentially extend the payment incentive for a longer period to more firmly incentivize transition to, and increased participation in, Advanced APMs.

AAPA supports an increasingly cautious approach to the performance threshold and continues to support the timeline regarding the data completeness threshold proposed in the 2024 Physician Fee Schedule. AAPA supports efforts by CMS to simplify and lessen the burden of MIPS reporting, such as modifications to the process of reporting population health measures and the simplification of reporting on Improvement Activities. AAPA encourages CMS to identify additional simplifications to make the process of reporting less burdensome. AAPA encourages CMS to finalize as soon as possible an official date that MVP reporting becomes mandatory to allow for sufficient preparation. AAPA requests that CMS accelerate establishing the number and variety of MVP options in advance of the requirement to report to MVPs. AAPA cautions against an approach to broaden current or future MVPs and instead recommends CMS prioritize the development of a greater number of MVPs

to which health professionals can report. AAPA could support broader MVPs as a temporary option if the agency feels it is unable to produce the necessary number of new MVPs in time, but only if participants in broader MVPs have a timeline in place for an eventual transition to MVPs that represents them. AAPA encourages CMS not to wait until the fee schedule rule directly before compulsory participation to complete a first round of established MVPs in which it feels comfortable nearly everyone will be able to report. AAPA encourages the agency to 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. AAPA encourages maximum flexibility and fiscal leniency in the first few years, similar to what was provided under the implementation of traditional MIPS, to ease the transition to MVP reporting. AAPA cautions that CMS's efforts at comparability remain encumbered by billing provisions such as "incident to" that obscure the accurate attribution of services to the appropriate health professional. AAPA recommends that educational outreach should be prioritized to practitioners who have not yet voluntarily reported to an MVP or those in their initial year of doing so and suggests the inclusion of examples of MVPs and their corresponding measures, as well as clinical vignettes of various scenarios that vary by specialty and reporting method. AAPA strongly supports CMS's suggestion of letting a group determine and inform CMS of their specialty and subgroup composition. AAPA supports the temporary flexibility for small multi-specialty practices to not have to report as subgroups. AAPA cautions against putting limits on the size of subgroups as it may cause a multispecialty group to divide into multiple subgroups that report on the same MVP. Finally, AAPA recommends that CMS work with Congress to potentially extend the Advanced APM payment incentive for a longer period.

Technical Correction to CMS's Use of the PA Profession Title

In the subsection titled "Allowable and Prohibited Uses of Prepaid Shared Savings," CMS provides examples of the type of staff that an ACO may use prepaid shared savings to hire. Among the examples are "physicians' assistants," listed between physicians and nurse practitioners. The placement of this example among billing professionals, and the absence of other mentions of PAs, leads us to believe this example was meant to reference "physician assistants". Unfortunately, the way in which it is written may be interpreted as referring to assistants to physicians. However, PAs are not assistants to physicians and any implied ownership due to the apostrophe would be incorrect.

Due to the proper usage of the term "physician assistants" elsewhere in the rule and other CMS materials, we do not believe this usage to be intentional. While correction in the final rule may be unnecessary, AAPA would like to bring this improper identification of the profession to the agency's attention to ensure future consistency with the widely accepted usage of the profession's title found in state and federal laws and regulations.

AAPA also requests that all references to PAs in regulations and policies be listed as "Physician Assistants/Physician Associates". This accurately reflects PAs who currently graduate with degrees as either "physician assistant" or "physician associate" and are state-licensed as a "physician assistant" or "physician

associate," but who all graduate from programs accredited by the same accrediting organization (Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (National Commission on Certification of Physician Assistants), and have the same scopes of practice. Although the profession has been known as "Physician Assistant," the official title of the profession is now recognized as "Physician Associate."[33] This is reflected in the title of the AAPA, other professional organizations[34], professional training programs[35], and state and territory laws and licensure.[36] Despite the recognized title of "Physician Associate," it is anticipated to take one or two decades for the title change from "Physician Assistant" to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to "Physician Assistant" and "Physician Associate" is recommended to avoid confusion.

AAPA urges CMS to properly refer to the PA profession as "physician assistants" in all official documents. We also encourage CMS to begin to reference the profession by the dual title "physician assistant/physician associate."

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 Sondra DePalma, AAPA Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

Jason Prevelige, DMSc, MBA, PA-C, DFAAPA
President and Chair, Board of Directors

---

[33] American Academy of PAs. 2024. Title Change. https://www.aapa.org/title-change
[34] Several Constituent Organizations, which are independent organizations affiliated with AAPA, have reflected the title Physician Associate in their professional organization's legal name. For example, The Academy of Physician Associates in Cardiology https://www.cardiologypa.org/; The Association of Physician Associates in Obstetrics and Gynecology https://apaog.wildapricot.org/; The Connecticut Academy of Physician Associates https://connapa.org/about-connapa/; and The Kansas Academy of Physician Associates https://kansaspa.mypanetwork.com/.
[35] Yale School of Medicine, Physician Associate Program, https://medicine.yale.edu/pa/. Wichita State University, Physician Associate Program, https://www.wichita.edu/academics/health_professions/pa/.
[36] American Academy of PAs, Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/news-central/2024/04/oregon-governor-tina-kotek-signs-law-changing-pa-title/. *See also*, Or. Rev. Stat. § 677. *See also,* Wis. Stat. § 448.974(1)(a)(2)-(6). *See also,* 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p).