American Academy of Physician Associates

August 18, 2025

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

RE: Medicare Program; CY 2026 Home Health Prospective Payment System Rate Update

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), on behalf of the more than 190,000 PAs (physician assistants/physician associates) throughout the United States, appreciates the opportunity to provide comments on the 2026 Home Health Prospective Payment System Rate Update proposed rule. While primarily a technical adjustment to the prospective payment system (PPS), the rule includes various policies that seek to streamline processes, decrease burden, and maximize the efficiency of care. Several outdated policies limiting the efficient provision of care persist in this setting. AAPA seeks to continue to work in partnership with CMS to identify and remove barriers to efficient care in home health settings, for the sake of patients, health professionals, and the Medicare program. It is within this context that we draw your attention to our comments

Proposed Regulation Change to Face-to-Face Encounter

AAPA supports CMS's proposed change to 42 CFR § 424.22(a)(1)(v)(A) allowing any practitioner to perform the required face-to-face encounter, including PAs. We applaud CMS's commitment to efficient and coordinated care, recognizing that the face-to-face encounter may be performed by the practitioner who is most knowledgeable of the patient's condition at the time of certification for eligibility for home health services.

DME Restrictions on PAs

CMS cites its focus on process improvement and policy efficiency within the DMEPOS competitive bidding program (CBP), including a specific proposal to allow payment under DMEPOS CBP for certain continuous glucose monitors and infusion pumps, as well as all necessary supplies and accessories, on a bundled monthly rental basis. AAPA welcomes this opportunity to request that CMS authorize PAs to provide required documentation and certification on orders for home blood glucose monitors.

A CMS National Coverage Determination (NCD)[1] 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 outdated, burdensome, and conflict with federal statute.

Specifically, Section 1834(a)(11)(B)(ii) of the Social Security Act (SSA), authorizes PAs to order and certify the need for DME. The continued use of physician-centric language in NCDs, including those governing home blood glucose monitors creates unnecessary barriers to care and conflicts with current statutory authority.

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.[2] 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.

Proposed Payment Rate Adjustment

AAPA is concerned about the proposed cuts to the payment rate for home health CMS is proposing in the CY 2026 proposed rule and the impact they may have on the access and quality of care of Home Health Agencies (HHAs). CMS is proposing a permanent -4.059 adjustment to correct for coding and

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[1] Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Home Blood Glucose Monitors (40.2). Published June 19, 2006. Accessed July 21, 2025. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=222

[2] Yang Y, Long Q, Jackson S, et al. Nurse Practitioners, Physician Assistants, and Physicians Are Comparable in Managing the First Five Years of Diabetes. *American Journal of Medicine*. 2018;131(3):276-283.e2. https://www.amjmed.com/article/S0002-9343(17)30904-X/abstract

utilization changes under the Patient-Driven Groupings Model (PDGM). This adjustment is intended to account for changes in provider behavior when submitting claims to maximize reimbursement. CMS used claims data from CY 2020 - 2022 to compare actual provider behavior to what was assumed under the original PDGM model, using simulations to determine what payments would have been without behavioral changes and compared them to actual payments. CMS determined that providers coded in ways that increased their case-mix weights leading to higher-than-expected payments. CMS is also proposing a temporary -5.0% reduction for CY 2026 using their authority under section 1985(b)(3)(D)(iii) of the Social Security Act to apply temporary adjustments to begin recoupment of retrospective overpayments.

This amounts to a nearly 10% reduction for CY 2026, AAPA recognizes the statutory basis for the proposed cuts, with the Bipartisan Budget Act of 2018 requiring the PDGM to operate in a budget neutral manner and that CMS adjust payments to account for behavioral changes in how providers may change coding or utilization to maximize reimbursement. However, AAPA remains concerned that the steep cuts to providers in CY2026, in combination with previous rate cuts in the CY 2023, CY 2024, and CY 2025 final rules, may undermine access to home health care for Medicare beneficiaries. The National Alliance for Care at Home cites CMS data showing half of all U.S. counties lost HHAs from 2000 – 2024, and HHAs in 70% of counties treated fewer Traditional Medicare beneficiaries.[3] This is a concerning trend that only stands to worsen as additional payment rate cuts threaten to further limit access and make it more difficult for HHAs to maintain their current standards and quality of care. While we understand CMS citing the March 2025 Medicare Payment Advisory Commission (MedPAC) analysis to support prosed payment reductions[4], AAPA is concerned that these recommendations are based solely on fee-for-service (FFS) Medicare data. As of 2024, more than half of Medicare beneficiaries are enrolled in Medicare Advantage (MA), yet MA beneficiaries are excluded from both MedPAC's analysis and the data used to inform CMS' proposed adjustments. MedPAC acknowledges this barrier in this and other reports as MA enrollment has continued to grow.

AAPA urges CMS to evaluate whether its current methodology for determining home health payment rates aligns with the goal of utilizing home health as a cost-effective substitute for other care in more expensive, facility-based settings. AAPA also requests that CMS consider how payment reductions based on FFS-only analyses may inadvertently disrupt care for beneficiaries given differences in utilization management, network design, and services authorization in MA plans.

[3] The Alliance for Care at Home. The Alliance Responds to CY 2026 Home Health Proposed Rule. June 30, 2025. https://allianceforcareathome.org/cms-releases-calendar-year-2026-home-health-proposed-rule/
[4] Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare Payment Policy. Chapter 7: Home Health Care Services. Washington, DC: MedPAC; March 2024. Accessed July 21, 2025. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf

Efforts to Streamline and Simplify Processes in the Proposed Rule

In the HH PPS proposed rule, CMS suggests several policies with the aim of streamlining processes and reducing burden. One such policy, found in a request for information, is to utilize discretion granted to the Secretary regarding timeframes of data reporting to potentially reduce the final data submission deadline for the HH Quality Reporting Program (QRP) from 4.5 months to 45 days. This reduction, a decrease of three months from the timeline to report data, would similarly allow public reporting and feedback provided to SNFs to be released up to three months earlier (at six months, as opposed to the current nine months). CMS suggests this reduction would allow consumers to use the most current information when making care decisions and allow any feedback to HHAs regarding quality, resource use, and other measures to be timelier and more actionable.

AAPA approves of the revised timeline and more timely and actionable data for HHAs and consumers. The quicker administrative and clinical feedback can be returned to HHAs, the sooner SNFs can use that information to improve care quality. In addition, more timely public reporting would provide more value for consumers as they make care decisions. A prompter timeline benefits the HHA, its health professionals, and its patients. However, AAPA cautions that, as the 4.5-month timeframe is currently aligned with other data submission and correction timeframes, CMS should simplify the process for those submitting data by updating all similar reporting programs to the new 45-day submission timeframe.

In the HH PPS proposed rule, CMS makes other proposals to simplify and streamline processes. For example, CMS proposes to remove four standardized patient assessment data elements beginning with the FY 2027 HH QRP. These four elements fall under the Social Determinants of Health (SDOH) category, including one regarding living situation, two regarding food, and one regarding utilities. The rule justifies the proposed removal, citing the potential burden of this reporting. While AAPA approves of continuous review of reporting requirements to increase efficiency and maximize the balance between useful data collection and reporting burden, we emphasize the importance of data collection surrounding SDOH, and the implications it may have regarding care efficiency.

Previous rules have defined SDOH as “socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health.” In previous rules, CMS has also cited that such factors may account for as much as 50% of an individual’s health.[5] Information on SDOH is often collected to improve health outcomes through recognizing and possibly remedying confounding factors. Collecting data on SDOH allows providers to identify barriers to care access and medical plan adherence that may not otherwise be identified. If providers are unaware of such barriers, medical care and subsequent management plans may be hindered with little understanding as to why. Lack of adherence to care plans

[5] Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R; Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy. Addressing social determinants of health: examples of successful evidence-based strategies and current federal efforts. Washington, DC: US Dept of Health and Human Services; April 1, 2022. Accessed July 21, 2025. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-9918589885806676-pdf

may prove costly to the patient and the system, resulting in ineffective interventions or prolonged inpatient care.

SDOH seeks to enhance care efficiency by removing unforeseen mitigating factors to care provision. This aligns with CMS's stated objectives of the QRP, cited in the rule, of "improvement of care, quality, and health outcomes." As such, AAPA suggests reconsidering the removal of SDOH measures that could improve care delivery and health outcomes.

Future Measures Concepts

CMS is soliciting feedback in the HH PPS proposed rule on future quality measure concepts under the HH QRP that are most appropriate for the setting. In the rule, CMS identifies four such concepts: interoperability, cognitive function, well-being, and nutrition.

AAPA has long recognized the importance of interoperability to improve the efficiency, quality, and functionality of patient health information and data. Effective interoperable systems can assist in care delivery, enhance the patient experience, and support care coordination for the entire healthcare team. In the past, AAPA has communicated to CMS its support for increased interoperability between systems and has advocated for the agency to provide necessary educational, financial, and logistical support to ensure widespread adoption of steps that would encourage interoperability. As such, we support CMS's ongoing and future efforts to better capture the extent of successful adoption of interoperable systems. We note the importance of system interoperability between all communicating parties, including patients (to access personal healthcare information, communicate with their health team, and to view authorizations and other communications between their care team and payers that are relevant to their personal care experience), health professionals (in communications directly with patients, to transfer care information to other professionals, and to receive authorizations from payers), and payers (to communicate authorizations to providers and patients, as well as with other payers regarding transitions and overlapping coverage).

AAPA also recognizes the importance of interoperability for data collection and use. As such, AAPA supports CMS including interoperability measures in future updates to the HH QRP to ensure system readiness and sufficient capabilities. We note that interoperability measurements exist already and recommend that CMS consult these when seeking to identify effective measures of successful implementation of interoperability.

AAPA also finds significant value in the second proposed future measure concept of patient well-being. However, we caution that, while well-intended, it is fairly broad and may be difficult to define. We note that the examples provided of happiness, purpose, fulfillment, satisfaction, social connectedness, emotional well-being, and overall health are distinct, multi-faceted concepts that do not always have

easily derived proxy measures. As such, AAPA encourages the assessment of patient well-being through validated measures.

The third future measure concept, nutrition, is a worthy aspect to try to measure as well. Doing so may encourage HHAs and their health professionals to promote, educate on, and recommend dietary adaptations (and other salutary practices such as physical activity and sleep) that may benefit patient health. However, we again caution that these factors will require multiple measures, and each would require confirmation that it is within the realm of HHAs to address and measure. We note also that nutritional requirements, quantity of needed sleep, the type of appropriate physical activity, and mitigating factors that address receptivity and success will vary by patient. Consequently, HHA success in these areas may include demonstrating the development of nutritional and preventive plans specific to each individual and demonstrating that the HHA operates a manner conducive to healthy dietary and preventive practices.

AAPA also supports CMS's interest in the addition of cognitive function as a future quality measure under the HH QRP. Cognitive function is a critical determinant of patient safety, independence, and care outcomes in the home setting. As the population continues to age and the number of beneficiaries with cognitive impairments increases, it is essential that HHAs are equipped to assess and respond to cognitive decline. We encourage CMS to consider the use of previously validated tools to capture this information, and to ensure that any future measure is clinically actionable as well as administratively feasible with minimal additional burden on providers through integration into existing workflows. AAPA appreciates CMS's commitment to advancing person-centered care and look forward to continued engagement on this, and other, future measure concepts.

Professional Title

AAPA requests that all references to PAs in regulations and policies be listed as "physician assistants/physician associates", as recognized in 20 CFR § 220.46 (a)(9).[6] 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 (i.e., Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (i.e., 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

[6] Code of Federal Regulations. Title 20: Employees' Benefits. § 220.46 – Medical evidence. Washington, DC: Office of the Federal Register, National Archives and Records Administration. Accessed July 21, 2025. https://www.ecfr.gov/current/title-20/chapter-II/subchapter-B/part-220/subpart-F/section-220.46

associate" to more accurately reflect the breadth of education, training, experience, and services of PAs. This is reflected in the title of the AAPA, other professional organizations[7] , professional training programs[8], and state and territory laws and licensure.[9] Despite the recognized title of "physician associate," it is anticipated to take some time 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 reference the profession by the dual title "physician assistant/physician associate."

Thank you for the opportunity to provide comments regarding the 2026 Home Health Prospective Payment System Rate Update. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Sondra DePalma, Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

Todd Pickard, DMSc, PA-C, DFAAPA, FASCO

President and Chair, Board of Directors

[7] Several Constituent Organizations, which are independent organizations affiliated with AAPA, have reflected the title Physician Associate in their professional organization's legal name. Examples: Connecticut Academy of Physician Associates https://connapa.org/aboutconnapa, Kansas Academy of Physician Associates https://kansaspa.mypanetwork.com, Academy of Physician Associates in Cardiology https://www.cardiologypa.org, and Association of Physician Associates in Obstetrics and Gynecology https://apaog.wildapricot.org

[8] Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARCPA), have Physician Associate Programs and graduate students in Physician Associate Studies. Examples: 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/, Alvernia University, Physician Associate Program https://www.alvernia.edu/academics/ug/bio-pa

[9] Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/news-central/2024/04/oregongovernor-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).