February 5, 2025

The Honorable Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Recommendations for the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (MPFS)

Dear Acting Administrator Wu:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to share recommendations for consideration as the Centers for Medicare and Medicaid Services (CMS) begins work on the calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule.

We appreciate CMS' responsiveness to our past input, such as the expanded use of G2211 in conjunction with modifier 25.We also appreciate the many ways in which CMS continues to update its policies to reflect its clearly stated belief in primary care as foundational to a high-performing health system, including the addition of the advanced primary care management codes in 2025. On behalf of family physicians who deliver the majority of primary care in the US, these changes are essential to the stabilization and future security of this much needed workforce, and we are grateful to CMS for these changes.

AAFP's other priorities for updates and changes to the MPFS have been clearly articulated in past letters.[i] In this letter, **we focus our comments on recommended changes to the supervision of primary care resident physicians. We believe that addressing requirements that are largely outdated due to enhancements in graduate medical education, will meaningfully improve Medicare beneficiaries' access to high quality services and help to address the family physician workforce shortage.**

The AAFP greatly appreciates CMS' request for information on primary care exception (PCE) reform in the CY 2025 MPFS proposed rule. The AAFP and many other stakeholders submitted extensive comments in support of expanding the list of services included in the PCE. We feel strongly that CMS has sufficient evidence to warrant proposing a permanent change to regulations governing the PCE in the 2026 NPRM. **Specifically, we recommend CMS add the following services to the PCE list:**

- **level 4 and 5 office/outpatient evaluation and management (E/M) visits,**
- **preventive services,**
- **patient continuity and integration of care codes.**

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Background

Existing rules concerning the services of teaching physicians were created in large part by the CY 1996 MPFS at which time the agency created a general requirement that teaching physicians be present during the key portion of the visit, otherwise the visit would not be eligible for payment.[ii] However, the agency also recognized that applying this policy to payment in family medicine residency programs raised special concerns about the financial viability of these programs.[iii] Family medicine residents are assigned a panel of patients for whom they provide care throughout their training, and the agency noted that requirements for a teaching physicians' physical presence during all visits would undermine a resident's ability to develop physician/patient relationships.[iv] The agency also noted that physical presence requirements for Part B payment would "unfairly deny reimbursement for the activities of teaching physicians in these programs and endanger the financial viability of these programs."[v] Accordingly, the agency created an exception, which ultimately applied to all primary care rather than family medicine alone.

Currently, the PCE is limited to certain evaluation and management services of "lower and mid-level complexity (as specified by CMS in program instructions)."[vi] Lower and mid-level complexity codes that can be furnished under the PCE are specified in Section 100 of Chapter 12 of the Medicare Claims Processing Manual, which limits the PCE to level 1- 3 E/M codes and annual wellness visit codes for new and established patients.

Since its creation, the PCE has provided invaluable experience for applicable medical residents, expanded patient access to primary care, and improved relational continuity of the patient and primary care physician in teaching centers. In the 2025 MPFS proposed rule, CMS stated the PCE "broadens opportunities for teaching physicians to involve residents in furnishing services … and promote safe, high-quality patient care."[vii] We agree: the PCE is an integral element that allows teaching physicians to provide the experiences necessary for residents to become autonomous family physicians who provide safe, comprehensive, quality care. Practice patterns imprinted during residency training persist beyond graduate training.[viii]

Need for Reform

Historically, our members have reported that the absence of many high-value services on the PCE list discourages their integration into residency training, which has a negative impact on physician training, patient access, and longer-term outcomes. We also note below that the current PCE list unnecessarily limits teaching physicians, residents, and residency programs but does not meaningfully enhance patient safety. Expanding the list of services allowed under the PCE may also improve utilization of several under-utilized but high-value services, which is particularly important as HHS advances toward its goal of "a health care system that not only treats those who are sick but also keeps people well."

1. The current PCE list creates an arbitrary standard that does not enhance patient safety

The AAFP appreciates CMS' desire to protect Medicare beneficiaries by ensuring residents are not performing services that are beyond their capabilities. Historically, limiting the services that may be performed without the physical presence of the teaching physician was a reasonable

method to achieve this goal. However, there are several reasons these limitations are no longer necessary:

- Residency programs are best suited to determine the appropriate level of supervision;
- Teaching physicians should be given the flexibility to supervise the resident with the greatest need; and
- Non-physicians with less training have lower supervision standards than residents under the PCE.

Residency Programs are Best Suited to Determine the Appropriate Level of Supervision

Residency programs regularly evaluate resident physicians to determine the level of supervision required by teaching physicians. In 2023, the Accreditation Council for Graduate Medical Education (ACGME) updated core residency program requirements to ensure every residency curriculum includes "competency-based goals and objectives for each educational experience designed to promote progress on a trajectory toward autonomous practice."[ix] The emphasis on competency-based assessments enables residency programs to adjust resident supervision based on an individual's progression and needs. ACGME core requirements state, "The trajectory to autonomous practice is documented by Milestones evaluations…" Residents must demonstrate their competency against a set of requisite goals and objectives to decrease their level of supervision. Residency programs, through their ACGME-required Clinical Competency Committee process, must assess and determine when and under what circumstances (considering level of complexity, acuity, urgency, etc.) each resident has the appropriate competency to provide care without direct supervision. **This requirement ensures residency programs have proper guardrails in place to ensure patient safety, while allowing the resident the autonomous experience necessary to practice independently once the program is complete**.

In addition to the core program requirements, the AGCME program requirements for family medicine note, "The program must demonstrate that the appropriate level of supervision in place for all residents is based on **each resident's level of training and ability, as well as patient complexity and acuity**." The requirements further state, "Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables."[x]

Accordingly, residency programs are currently equipped to make personalized decisions about a resident's competency to deliver care.

Teaching Physicians should be given flexibility to supervise the resident with the greatest need

Currently, regardless of the resident's personal ability and competency, teaching physicians must be physically present during the delivery of services not included on the PCE list. This means that the teaching physician is not available to supervise any other resident during this time. Some residents even after six months may require or desire assistance during lower-level E/M services but may be forced to choose between attempting the service without supervision or waiting for the teaching physician to conclude their supervision of another more experienced

resident performing a higher complexity service. Accordingly, expanding the PCE list would allow teaching physicians the flexibility to spend their time with the resident who needs the most guidance at any given time, regardless of the services being performed.

Including additional services under the PCE would not impede the teaching physician's ability to remain available for up to four residents and direct care. If a resident reviews the patient's visit with the teaching physician before, during, or after a visit, it does not reduce the availability of the teaching physician or impose additional time burdens. Without the requirement to be physically present during a visit, the teaching physician has more time available to other residents. This allows teaching physicians the flexibility to focus on whichever resident needs guidance the most at any given time, rather than which resident is performing a specific service without consideration of their ability to do so.

Non-physician clinicians have lower supervision standards than residents under the PCE

Many of the services we propose for inclusion under the PCE are often furnished by non-physician clinicians with less training and clinical experience than residents with six months of residency training. Although the physician's physical presence in the exam room is not required for "incident-to" billing of these services, the physician remains sufficiently involved as to merit MPFS payment. **If this level of supervision is safe for non-physician clinicians and sufficient for payment by CMS, we believe residents who meet the relevant competency requirements could also provide additional services without a teaching physician being physically present in the exam room when the service is provided to the patient.**

While we make the comparison to non-physician clinicians to emphasize the potential inconsistency in the approach to payment for supervision of physician residents, it is important to recognize that residents' education and training is significantly more rigorous and better prepares physician residents to work under general supervision without the physical presence of the teaching physician than nurse practitioners. Residents have completed a four-year education program compared to the two-year education most nurse practitioners complete. Residents also have more clinical training than the minimum 500 hours required for nurse practitioners to seek certification.[xi] There are no standardized residency training or post-graduate requirements for nurse practitioners.[xii] However, residents who furnish services under the PCE must also have at least six months of clinical program training experience. Even though licensed nurse practitioners have less education than family medicine residents, they may furnish more complex E/M services and bill either under their own provider number or incident to physicians without the presence of the teaching physician.

2. The current PCE list restricts residents' ability to learn proper billing, financially impairs residency programs, and contributes to the workforce shortage.

With a shortage of family and other primary care physicians, ensuring the sustainability of existing residency programs is crucial to maintaining primary care access. Many residency programs have expenses that exceed allocated resources and funding, and residency program directors are often pressured by their sponsoring organization to demonstrate a financial benefit (or at minimum, a break-even) to continue the program. An analysis of financial data from family medicine residency programs found increases in average expenses per resident outpaced growth in graduate medical education (GME) funding, forcing programs to rely on other sources

of funding, including clinical revenue, to remain solvent.[xiii] Family medicine residency clinics must also remain financially viable to cover the salary and benefits of a sufficient number of trained teaching physicians.

Because of the tight financial margins in most family medicine residency programs, accurate coding and billing patterns are critical to program sustainability. Research suggests residency clinics may be using lower-complexity codes when a higher-level code is more accurate.[xiv,xv] This coding pattern results in decreased resources for family medicine programs at a time when CMS is otherwise investing more in primary care (e.g., by implementing and expanding code G2211). Over time, the potential revenue loss from under-coding may reduce access by reducing the number of primary care residency training programs, which ultimately reduces the number of new family medicine physicians.

Coding is difficult in residency clinics because while it may be clear that a visit will meet the medical decision-making (MDM) criteria for a level 4 or 5 visit, it cannot be billed as such unless the teaching physician is present at the time of the visit. As a result, some experienced residents may furnish a visit that meets the MDM criteria of a level 4 or 5 E/M visit, but unless they stop the visit to call in the teaching physician, they are unable to report the visit based on the actual MDM level involved. These visits do not surpass the resident's skill or ability but require a teaching physician's presence solely for regulatory compliance because the PCE policy does not encompass higher-complexity codes.

This assertion is supported by studies seeking to understand the effects of the temporary expansion of the PCE during the COVID-19 PHE. During the PHE, CMS allowed office/outpatient E/M visits at any level to be furnished under the PCE.[xvi] A recent analysis of billing data from one residency program during the COVID-19 PHE found that the use of higher-complexity visit codes increased for patients seen by residents, while coding patterns generally remained the same for attending physicians (patients seen without the presence of a resident).[xxvi] This suggests the overall frequency of higher-complexity visits did not change and lifting the restriction for residents allowed for more accurate coding based on MDM.

When the temporary PCE expansion expired, it restored limitations on the types of visits residents can furnish. Now, even those residents determined by faculty to have the necessary clinical competencies for this level of care are required to have personal supervision for level 4 and 5 visits, which adds administrative barriers that ultimately reduce access. As described above, the exclusion of more complex E/M codes may also prevent the clinic from being paid for services furnished under the direction of the teaching physician. Over time, this weakens clinic finances and makes recruiting and retaining teaching physicians challenging. Allowing higher-level E/M codes under the PCE would therefore improve patient access and strengthen family medicine residency programs — a critical pipeline for primary care physicians.

Accordingly, we urge CMS to expand the list of services available under the PCE to include (1) all levels of office/outpatient E/M services, (2) additional preventive services, and (3) additional codes related to patient continuity and integration of care.

<u>(1) Higher-level office/outpatient E/M services to allow under the PCE</u>

We recommend CMS allow all levels of office/outpatient E/M visits (99202-99205, 99212-99215) under the PCE to provide residency programs with the resources needed to support workforce development and improve access and patient continuity of care—all without compromising patient safety or impeding the teaching physician's overall management of care. At a minimum, CMS should add level 4 E/M codes to the PCE list.

The PCE was established nearly 30 years ago, when level 4 E/M codes were considered complex visits, often involving patients with acute or unstable chronic conditions requiring the teaching physician to personally examine and assess the patient to assure a high standard of care. However, the share of Medicare beneficiaries with three or more chronic conditions is predicted to jump sharply by 2030, increasing from 26 percent to 40 percent compared to 2010.[xvii] **Accordingly, higher level E/M codes will not only become more prevalent, but they will become the norm, not just for initial visits with new patients, but also follow-up visits with established patients**. These encounters require a level of time and decision-making consistent with a level 4 code for management of multiple chronic conditions, but do not involve a level of diagnostic complexity that is beyond the resident physician's ability to provide quality care with general supervision. Resident physicians must be given the opportunity to provide these services with less supervision, so long as their residency program has determined they are competent to do so.

As noted, existing ACGME requirements set resident supervision levels based on individual assessments of a resident's competencies**.** These requirements ensure residency programs have proper guardrails in place to ensure patient safety, while allowing the resident the autonomous experience necessary to practice independently once the program is complete. In updating the PCE, **CMS should affirm that the residency program is the only authority which can make the assessment of competency to ensure that these guardrails are respected and that a change in policy is not misinterpreted as deeming all residents competent to furnish level 4 or 5 E/M codes under the exception.**

We also note that teaching physicians would remain sufficiently involved in directing these services to warrant MPFS payment for directing and managing additional E/M services furnished by qualified residents. Currently, non-physician practitioners (such as nurse practitioners) may furnish level 4 and 5 visits and bill "incident to" a supervising physician without the physician being present during the service. Expanding the PCE to include all levels of E/M service is therefore compatible with existing CMS policy because it is the same amount of physician involvement (not the physician's physical presence during the service) which justifies payment for non-physician clinicians. Resident physicians would still review patient care with the teaching physician just as non-physician clinicians do when billing a service "incident to" a supervising physician.

Finally, including these services under the PCE would not impede the teaching physician's ability to remain available for up to four residents and direct care. If a resident reviews the patient's visit with the teaching physician before, during, or after a visit, it does not reduce the availability of the teaching physician or impose additional time burdens. Without the blanket requirement to be physically present during all Level 4 or 5 visits, the teaching physician has more time available to residents who might need greater levels of guidance. This level of involvement coupled with the ACGME requirements tying the degree of physician supervision to the resident's level of competency, allows teaching physicians to focus their time supervising

more complex visits with residents who continue to require physical supervision, assuring appropriate care for Medicare beneficiaries.

(2) Additional preventive services to allow under the PCE

We request CMS include the following preventive services under the PCE:

- **G0442** – Alcohol misuse screening
- **G0443** – Brief face-to-face behavioral counseling for alcohol misuse
- **G0444** – Annual depression screening
- **G0446** – Annual, face-to-face intensive behavioral therapy for cardiovascular disease
- **G0447** – Face-to-face behavioral counseling for obesity
- **99406** – Smoking and tobacco use cessation counseling visit; intermediate
- **99407** – Smoking and tobacco use cessation counseling visit; intensive

We recommend CMS expand the PCE to include this list of services which will encourage the integration of all high-value services, including these preventive services, in resident training. CMS has previously recognized the need to expand the PCE to include additional preventive services to further integrate them into residency training. For example, the PCE allows teaching physicians to bill for Medicare wellness visits (G0402, G0438, G0439) furnished by a resident without a teaching physician present during the service. Additional opportunities for teaching physicians to integrate these preventive services into training are needed to ensure residents include these services in their day-to-day practice after program completion.

Alcohol screening and behavioral counseling services are underutilized.[xviii] Research suggests insufficient training and a lack confidence in their ability to furnish services are primary barriers to residents incorporating alcohol misuse screening and intervention into regular practice.[xix] Additionally, approximately half of US adults over age 35 are not screened for depression.[xx] Expanding the PCE to include these services will increase utilization during residency and post-residency.

Screening and interventions for tobacco use have increased over time yet there is still an opportunity to increase the use of screening and interventions in the primary care setting.[xxi] Research indicates physicians who use best practices for tobacco use screening and cessation with patients during residency training are twice as likely to continue to furnish tobacco-related screening and interventions upon program completion, compared to physicians who only received training but did not have the opportunity to apply their learnings with patients during residency.[xxii] We believe allowing these services to be furnished by residents under the primary care exception would allow teaching physicians to increase opportunities for residents to practice these services during residency.

The AAFP believes the existing requirements related to resident training are sufficient to ensure safe and effective care for these additional preventive services. As discussed throughout this letter, the ACGME competency-based program requirements ensure all resident physicians demonstrate the competencies required to furnish a particular service without a teaching physician's physical presence.

Further, the preventive services listed above would be furnished in an ambulatory setting where patients are typically not acute. Compared to surgical, high-risk, interventional and other complex procedures, we believe the risk of patient harm is low for these preventive services, making the physical presence of a teaching physician unnecessary for patient safety. Existing PCE requirements ensure residents would still have immediate access to the teaching physician, allowing the resident to seek immediate feedback if needed. Allowing these preventive services under the PCE would not compromise patient safety.

Non-physician clinical staff often furnish these preventive services under the direct, but not personal supervision of the physician, with the physician receiving full MPFS payment under "incident to" billing despite the lack of their personal presence during the service. Standardized screening instruments are frequently used for alcohol misuse and depression screening, and they are often administered by nurses or other auxiliary staff under the direct supervision of a physician. Additionally, tobacco cessation counseling may be provided by non-physician clinicians with less clinical training and experience than a resident with six months of training experience. Allowing these additional preventive services under the PCE would not hinder the teaching physician from maintaining sufficient involvement to warrant payment, as the level of physician involvement required to merit billing would be the same or more when furnished under the PCE.

Adding these preventive services to the PCE would not preclude a teaching physician from providing a greater degree of involvement in supervision of services furnished by a resident if the teaching physician deemed it necessary based on their assessment of the resident's level of demonstrated competency. Teaching physicians are still required to be on site for resident supervision, and residents must review all encounters with the teaching physician—even if the teaching physician does not directly see the patient. All documentation must be reviewed and countersigned by the teaching physician. Thus, teaching physicians would remain highly involved with resident delivery of these services if allowed as services under the PCE.

(3) Additional patient continuity and integration of care codes to include under the PCE

In addition to the preventive services and E/M services discussed above, we ask CMS to consider allowing the following codes under the PCE:

- **99421-99423** – Online digital E/M service for an established patient
- **99495** – Transitional care management
- **99497** – Advance Care Planning, including explanation and discussion of advance directives
- **99498** – Add-on code for CPT 99497 (Advance Care Planning, each additional 30 minutes)
- **99490** – Chronic Care Management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional
- **99439** – Add-on code for CPT 99490 for each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional

Residency programs must provide the experiences necessary to develop family physicians who can integrate care across settings and serve as a longitudinal source of care. **Adding codes related to patient continuity and integration of care under the PCE will improve utilization**

and encourage residents to provide these high-value services after graduation. It will also expand access for Medicare beneficiaries by allowing qualified residents to provide these services to their patient panel without the face-to-face presence of a teaching physician.

Residency programs often have very limited financial resources and may be unable to employ a full team. Adding these services to the PCE would help to ensure residency programs are appropriately resourced for the care being delivered to Medicare beneficiaries and can hire sufficient medical assistants, nurses, and other necessary staff. We also note that many of these codes help to provide the resources needed to employ appropriate staff for team-based care. The ability for residency programs to hire additional staff, such as social workers and/or behavioral health providers who form the basis of an integrated primary care team, is essential for resident physicians' ability to learn how to successfully lead an engaged and impactful multidisciplinary care team.

These services may be provided without the teaching physician physically present without compromising patent safety. Many of these services, including Advance Care Planning and Chronic Care Management, are often provided by other less qualified staff under general or direct supervision by the patient's physician. Allowing eligible resident physicians to direct these services would provide teaching physicians with an opportunity to train residents in the skills needed to be an effective physician leader of a multidisciplinary care team. **Residents would still review care with the teaching physician for these services, allowing the physician to effectively manage patient care and remain sufficiently involved as to warrant MPFS payment.**

AAFP asserts that adding the aforementioned codes to the list of services available under the PCE would improve the ability of the teaching physician to remain immediately available for up to four residents at a time. As previously expressed, many residents are perfectly capable of furnishing these services without the physical presence of the teaching physician. However, because those codes are not included as part of the PCE, regardless of the resident's competence, they must request the presence of the teaching physician. This means the teaching physician is not available to assist the other three residents. Additions to the PCE list would expand teaching physician availability rather than harm it in any way.

Conclusion

The AAFP greatly appreciates CMS' ongoing work to support family physicians' ability to provide comprehensive, longitudinal primary care, and we appreciate this opportunity to offer our recommendations. We look forward to continued collaboration with CMS to support equitable access to high-quality, holistic, person-centered primary care. Thank you again for your consideration of our recommendations. Should you have any questions, please contact Kate W. Gilliard, Senior Manager of Federal Policy and Regulatory Affairs at kgilliard@aafp.org.

Sincerely,

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