American Academy of Ambulatory Care Nursing

Shaping Care Where Life Happens

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

The American Academy of Ambulatory Care Nurses (AAACN) is pleased to offer comments on the proposed rule related to the CY 27 proposed rules for the 2027 Payment Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.

AAACN is the only specialty nursing association that focuses on excellence in ambulatory care and represents more than 1 million of the 4.7 million registered nurses across the US. Our members practice in settings such as hospital-based outpatient clinics/centers; solo, group and system ambulatory primary care and specialty care practices; ambulatory surgery and diagnostic procedure centers; telehealth service environments; university and community hospital clinics; military and Veterans Administration settings; nurse-managed clinics; managed care organizations; colleges and educational institutions; as well as organizations supporting care coordination, nurse coaching, and care management services[1].

The mission of AAACN is Shaping Care Where Life Happens with a vision of a healthier world through nursing excellence, leadership, and innovation, and revolutionizing healthcare. To that end, we have promulgated standards of practice in ambulatory care nursing to support high-quality nursing practice. Review of these standards and scope of practice demonstrate to CMS the important range of services provided by Registered Nurses (RNs) in ambulatory care settings that create high-quality patient care.

GENERAL COMMENTS ON THE PROPOSED RULE

Below we offer general comments on major elements of the proposed rule. Later in the document we offer specific feedback on other specific provisions in the proposed rule.

The need to modernize Medicare and Medicaid billing to better capture and reflect team-based care delivery

For the past two years, AAACN has submitted comments on the need to recognize Registered Nurses (RNs) for professional activities conducted by RNs in the ambulatory setting and to remove RNs from being considered merely as clinical staff along with other non-licensed

members of the care team. Were it not for the current restrictions of Medicare reimbursement policies which recognize patient care activities as being "incident to" a physician, many of these activities (such as activities related to transition care management, and chronic care management as well as Annual Wellness visits,) could be conducted independently by RNs within their legal licensed scope of practice. AAACN recognizes that CMS has certain limitations within the statutory language of the Social Security Act as it relates to reimbursement for services under Medicare. We also argue that the current physician centric reimbursement model, created in 1965 under the original legislation which launched the Medicare and Medicaid programs, no longer serves our patients, our healthcare team members, or the nation well, as healthcare is delivered by teams.

Full role utilization is supported by AAACN along with the National Academy of Medicine (NAM), Agency for Healthcare Research and Quality (AHRQ), Institute of Medicine and National Academy of Medicine as a strategy to meet the increasing health care demands. The current model of reimbursement, creates incentives that conflict with the evidence of the effectiveness of team-based care delivery and, combined with role confusion about team member capabilities, [2-6] and has created care delivery systems in which medical providers are seen as revenue producing professionals (regardless of whether they actually performed the activities), and others are seen as labor costs to the practice. This creates incentives for the practice to reduce labor costs by utilizing the least expensive clinical care team members when possible or driving the makeup of the care team based on who has or has not been recognized as qualified to delivery services under these rules, rather than approaching patient care needs from a perspective about who brings the skills and expertise needed to support the patient's needs.

As mentioned above, AAACN recognizes that CMS must create regulations within the scope as outlined in the original statute but also stresses the need to modernize the way Medicare and Medicaid pay for services delivered by teams rather than the physician-centric model created in the 1960s. The use of hybrid, or prospective bundled payment amounts can help support incentives to engage in team-based care delivery models but need to have associated outcome benchmarks as well as clear guidelines outlining who is qualified to provide services to ensure that individuals engaging in care delivery activities are best qualified to do so. We also recommend that HCPCS codes for services include modifiers to better identify contributions of care team members other than physicians.

For example, in the absence of specific guidance on who is considered qualified to perform services (on behalf of the physician) as is outlined in some of these rules, many regulations differ to the physician's judgement to determine to whom they can delegate activities. This practice is based on a large assumption that the physician is well qualified to delegate (using best practices and the 5 rights of proper delegation) or understands the training and capabilities of the person who is being delegated to (right person being one of these 'rights'). Many of our members have reported situations in which this assumption can lead to situations in which activities may be inappropriately delegated to medical assistants, who are often referred to as being 'nurses' (a protected title in many states) or delegation of medical care activities to a licensed practical nurse, which assumes that the physician understands the

practice of the LPN (which does not include independent ability to determine the patient's nursing care needs and in no way relates to the practice of medicine). These comments are not intended to infer that these are not important members of the care team, but that the current model of reimbursement and these assumptions may not always support the intended outcome of assuring that care is being delivered by qualified team members. Even activities requiring "direct supervision" such as delegation of sensitive conversations about advanced care planning as described in this proposed rule, may be delegated to clinical staff-wholly on the assumption of the physician's knowledge of the capabilities of their clinical staff- and not identifying who is educationally or professionally qualified to engage in these conversations. The idea that the physician is "directly supervising" these activities- is highly unlikely- in that they are probably seeing other patients when these conversations may be occurring.

The need to recognize RN and other licensed healthcare team members contributions to the care delivery team and the future of care management, serious illness and palliative care services

Again, we stress that the current designation of RNs as "clinical staff" fails to acknowledge the professional education, experience, training and demonstrated competencies of RNs in the care for patients with chronic conditions and in health promotion. Our practice is heavily based on the RNs' role in supporting health promotion and self- management of chronic diseases. RNs hold broad competencies in provision of effective education of patients and caregivers, with strong skills in coordination of care across settings, specialties, and populations. These capabilities are recognized by the independent licensure of RNs by states to conduct nursing practice, which includes assessment, planning, nursing interventions and evaluation of the patient response to health and illness. For example, creation of a nursing care plan to support a medical treatment plan and activities related to care management plan fall within the independent licensed scope of nursing practice for RNs.

Evidence is mounting that connects the contributions of RNs in primary and specialty care to high-quality outcomes, safety, and cost- effective service [7-9]. RNs practicing at the full scope of their education and experience have the capacity to improve outcomes and access, support implementation of the medical care plan, and more importantly, improve care connections across the health care continuum and settings. Hlebichuk and colleagues conducted a scoping review on top of license practice of registered nurses[8]. They found that when nurses work to the top of their scope workforce efficiency improved and benefited overall patient outcomes. Darby et al. conducted a study examining RN-led interventions for patients with two or more chronic conditions[10]. Participants established self-management goals and met monthly with an RN or APRN to monitor progress and receive ongoing support. The intervention was associated with improvements in key physical health outcomes, including blood pressure, body mass index (BMI), and hemoglobin A1C levels. Additionally, participants demonstrated statistically significant improvements in several factors known to influence long-term health outcomes, including patient assessment of chronic illness care ($p < .001$), trust in their healthcare provider ($p < .001$), self-efficacy ($p < .001$), and patient activation ($p = .002$). These findings highlight the

potential of RN-led interventions to improve both clinical outcomes and patient engagement, supporting their value in the long-term management of chronic disease.

AAACN is partnering with Oculi Data to accelerate the development of national ambulatory care measures, analytics, and benchmarking tools. In 2025, the American Academy of Ambulatory Care Nurses (AAACN) initiated Project ACTION (Ambulatory Care practice Taxonomy in Outpatient Nursing) as an effort to begin describing what nurses do, following the path paved by physicians and the AMA that led to billable descriptor codes. To begin with, Project ACTION reviewed the various taxonomies that already exist for the nursing profession such as Nursing Interventions Classification (NIC) and Clinical Care Classification (CCC) [11,12].It was determined that the feasibility of utilizing already established taxonomies was not realistic due to copyright, complexity, or misalignment with project deliverables. Project ACTION's goals are to create, then pilot the use of a new taxonomy via documentation in the electronic health record by ambulatory care nurses to promote nursing visibility and value. The initial code set describes nursing interventions conducted as part of Transitional Care Management[13]. It includes domains in care coordination, health education and self-management, medication management, and procedural services. Each of these domains are required components for TCM [13]. In addition, an additional domain is intended to capture nursing interventions that result in risk detection and response. Work is underway to extrapolate this initial code set to nursing work aligned with chronic disease management. We welcome the opportunity to meet with CMS to explore how this work can support the work of CMS in refining value-based reimbursement practices. At the very least, consideration of other ways to capture the effort provided by licensed members of the clinical staff is warranted.

As certain services fall within the licensed scope of practice for RNs, these services should all be moved to general and/or virtual supervision when conducted by an RN. Furthermore, RNs should be recognized through the addition of the term Registered Nurse (RN) as billable medical professional providers for certain services, such as:

- Annual Wellness Visits (G0438/G0439),
- Advance Care Planning (99497, 99498)
- All Care Management Services (CCM (99490/99439/99487/99489),
- BHI (99484),
- CoCM (G2214/99492/99493/99494),
- PCM (99426/99427) CHI (G0019/G0022),
- PIN (G0023/G0024/G0140/G0146)),
- Health Coaching (0591T/0592T0593T),
- Care Giver Education and Training (97550/97551/97552/G0541/G0542/G0543/G0539/G0540/96202/96203,
- Social Determinant risk assessments (G0136),
- Atherosclerotic Cardiovascular Disease Risk Assessment and
- ASCVD Care Management (G0537/G0538)
- Advanced Care Planning
- Lactation Services (with CLC certification)
- RPM services

- Smoking and Tobacco Cessation Counseling
- Preventive Care Visits (99391)
- Interdisciplinary Team Conference Codes (99366, 99368)
- Preventive Counseling and Risk Reduction Services (99401, 99401)

Additionally, integration of RN expertise to support the goals of the Ambulatory Specialty Model demonstration to enhance care coordination between specialists and primary care providers for people with low back pain and heart failure can help to support the goals of this program. Importantly, CMS needs to know that in many systems managed primary care practices, rural health clinics and federally qualified health centers- it is RNs leading teams doing this work and many practices have recognized the value of RN expertise and have the ability to "front load" support for the costs of RN integration. This, however, is not the case for many privately owned and medical provider owned practices, who are heavily reliant on fee for service reimbursement and simply lack the capacity to make these important investments in creating a team to support the work of the medical providers, and more importantly, to better address patient needs and reduce duplication and fragmentation of care delivery, which leads to unnecessary costs for the American taxpayer.

CMS is requesting information about to differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries. People with serious illnesses have complex care management needs as well as need for other services to support caregivers. The advent of caregiver training as a billable service is a first step in enhancing care management services impact in supporting family caregivers. As mentioned in our comments on the CY2026 PFS, we argue that registered nurses are best equipped to provide these services. AAACN encourages CMS to maintain HCPCS codes G0541, G0542, and G0543 as separately payable Caregiver Training Services. These codes should be able to be applied as stand-alone interventions or in conjunction with other services. CMS should retain general supervision requirements when conducted by registered nurses and re-evaluate payment rates to better reflect the clinical expertise and staffing level required to deliver high-quality caregiver training safely and effectively. It is important for CMS to recognize that caregiver training often relates to nursing care needs- thus RNs are best suited to provide these trainings.

However, there are huge needs for additional services for people with serious, degenerative diseases such as dementia, which is expected to increase given the aging population demographic trends. There remain huge gaps between what is provided through primary care driven care management until the time at which an individual may qualify for long term skilled nursing care. Fragmentation within the system between eligibility requirements and services under home health care, serious illness care, advanced care management, palliative care and hospice care further complicates individuals and families living with these conditions being able to have their care needs met. AAACN encourages CMS to consider how it might create a bundle of billing codes along a continuum that addresses these services which could simplify billing practices. The GUIDE program provides a model for nurse-led care services.

AAACN agrees that essential service elements that must be included include continuity with a

designated team member, (ideally an RN care manager), access to timely clinical support, comprehensive symptoms and caregiver assessment (which can also be conducted by an RN), electronic care plans, coordination with treating medical providers, patient/caregiver education, timely follow up after ED/ discharge. AAACN encourages CMS to include nursing (also considered custodial care) services which are often required by individuals with chronic, degenerative conditions, (serious illnesses).

Reliance on CPT codes for reimbursement

AAACN is pleased that CMS is responding to concerns from Med Pac and the NASEM related to the obvious conflict of interest which exists through heavy reliance on use of CPT codes, created, copyrighted, and driven by the American Medical Association (AMA) as well as reliance on the AMA to serve as the primary expertise on RUC and RVU valuation.

We agree with these concerns and would support the proposal to develop an interdisciplinary panel to develop a more streamlined, health promotion focused set of codes that could be used that may more fully reflect and capture the contributions of team members, including RNs to patient care delivery and patient outcomes. Reliance on the AMA for other guidance such as calculation of practice related expenses further reflects an over-reliance on medicine as the only experts driving care delivery.

AAACN also applauds CMS for its efforts to expand HCPCS codes to increase coverage of services, but we also stress the need to reduce complexity across coding for care management and other services such as home health, palliative care, serious illness care and hospice services. The need to simplify quality measures that practices are being asked to capture is also warranted. Any new coding scheme needs to be developed with a focus on holistic care (not just medically focused care) and in a way to simplify, rather than complicate the process of billing for (and paying for) healthcare services.

As described in the proposed rule, CPT codes were initially designed to reflect physician services and to ''encourage the use of standard terms and descriptors to document procedures in the medical record'' and ''help communicate accurate information on procedures and services to agencies concerned with insurance claims,'' and it ''provided the basis for a computer oriented system to evaluate operative procedures and contributed basic information for actuarial and statistical purposes.'' As we have already emphasized, this coding scheme does not fully reflect the way care is delivered or provides the ability to capture the contributions of the care delivery team to patient outcomes.

We recommend that any new coding scheme recognize services provided by clinical team members who hold independent licenses to practice their discipline, as well as the need for a mechanism to document their involvement in care teams to track their contributions to patient outcome and services they provide. This could be accomplished through use of modifiers on HCPCS codes for services provided by individuals other than physicians or APPs.

We recognize that these systems were initially developed in a time when the majority of ambulatory services were independent physician owned practices, and there were no other APPs to provide medical services. But healthcare is more than medical diagnoses and medical treatment plans. Indeed, our healthcare system is designed to recognize medically driven disease treatment as opposed to health promotion. And patient needs are best supported by teams of healthcare professionals who bring rich perspectives to support patient needs and positive health outcomes. Thus, new mechanisms are needed to capture inputs of various members of the healthcare team for the purpose of billing, reimbursement and to identify potential cost efficiencies while supporting positive patient outcomes.

AAACN supports the expansion of new G and HCPCS codes and appreciates CMS's efforts to improve identification and reporting of services delivered in team-based care and ambulatory settings. We urge CMS to add descriptors and modifiers that make licensed clinical staff roles and resulting work identifiable to be able to crosswalk with patient outcome data as well as to better calculate direct practice expenses. As stated above, AAACN recommends including clear descriptors of services or interventions, providing modifiers that identify the clinical staff role and supporting identification of licensed clinical team members (such as RNs) intervention contributions to outcomes. AAACN recommendations do not intend to alter the fundamental services provided under these codes. Rather the recommended descriptors and modifier would make currency underrepresented clinical work visible and measurable with the administrative data aligning with CMS goals to better represent the care teams contributions in care delivery with these additions these codes can go beyond administrative billing, and also provide meaningful data elements for evaluating quality, outcomes, and workforce contributions within the ambulatory care setting.

While AAACN supports the use of Community Health Workers and Licensed Professionals working in community settings, such as Community Health Hubs providing services to help patients navigate issues related to social determinants of health, AAACN supports these services provided and financed outside of the physician fee schedule. Physicians do not have the capacity to supervise non-licensed staff with variable credentials providing services in community settings. There is no meaningful connection between services and physicians. Further AAACN advocates for standardized educational pathways for CHWs and to incorporate licensed professionals to provide continuing education, supervision, and services to patients with multiple chronic conditions. Models exist for Community Health Hub funding that includes significant accountability requirements.

DIRECT RESPONSE TO THE CY 2027 PHYSICIAN FEE SCHEDULE PROPOSED RULE

Below we highlight our response to specific sections within the proposed rulemaking.

CMS CY 2027 Physician Fee Schedule Proposed Rule

Section	Topic	PFS request language (faithful condensation)	Notes/Comments
II.B	Professional/technical component RVUs	CMS requests comment regarding utility of displaying separate RVUs for professional and technical aspects of services that cannot currently be billed with TC/26 modifiers; use in evaluating site-of-service payment differences.	AAACN recommends consideration of development of methodologies to capture services provided by other licensed qualified members of the healthcare team as part of the professional aspects of services. Cost containment and recognition of team-based care delivery would warrant use of bundled/global payment with no modifiers. The concept of supervision widely varies depending on the makeup of the members of the care team, which may include other licensed professionals who may or may not require physician oversight based on their practice scope and service being provided.
II.D	Maternity coding - Comment Solicitation	Whether CMS should create 15 HCPCS G-codes preserving the prior maternity global-code structure rather than adopting the new CPT structure; evidence supporting or opposing that approach.	AAACN supports that general reduction of reliance on CPT codes for services other than services directly provided by physicians would be a good general step. Maintaining global code structure can reduce administrative burden and control costs, but coding systems need to better reflect activities that involve professional delivery of services of other licensed healthcare professionals.

II.D	CPT 95X18-95X20	Additional information about increases in direct-PE staff/equipment time across low-, moderate-, and high-complexity services.	CMS needs to redefine practice expenses to remove any effort provided by other licensed members of the care team (i.e. RNs). RNs who hold independent licensure (which includes the activities of care coordination and care management) should be considered qualified provider-s not just clinical staff. Movement to bundled and global payment services can reduce administrative burden and control costs. AAACN supports development of coding structures that capture effort of other licensed healthcare providers on the care team to be able collect and analyze data on different costs associated with direct physician activities versus activities conducted by professional members of the healthcare team. For example, if an RN conducts the AWV, with final consultation with the medical provider, the labor costs associated with that service are far less than if it is directly conducted directly by the medical provider. However, current mechanisms do not easily allow capture of this type of effort to determine these cost analyses.
II.D	RPM/RTM - Comment Solicitation	Whether to bundle existing RPM/RTM code families into four new HCPCS G-codes; structure and valuation; alternative coding; applicability in RHCs and FQHCs.	AAACN supports the concept of collecting data on PE costs associated with RPM services. Given that many of these services align with care management activities, collecting data to determine PE could support more accurate valuation of the services. Practices may contract

			with outside vendors of these kinds of services (i.e. a home sleep study) and better coordination of how the incoming data is monitored is warranted. While requiring a face-to-face provider visit to initiate these services may seem to increase accountability, it may also create additional burdens on patients needing to utilize RPM- especially in rural areas with transportation challenges. It is our position that RNs are well equipped to initiate these services for the practice and provide the necessary education to the patient on the use of the devices. Patients requiring RPM should be considered as needing care management support to ensure coordination of care and good communication to the provider in terms of incoming data to support the treatment management component of RPM. CMS should recognize that the current billing structures which bundle RNs along with other clinical staff and the associated incentives to limit direct clinical labor costs to maximize revenue fails to distinguish RPM, CCM or TCM services that may just be delegated to an unlicensed clinical staff member, such as a medical assistant, or included as part of care coordination and care management activities which require professional judgement and skills in coaching, educating and use of clinical judgement to assess patient response to the

			treatment plan, all of which RNs are independently qualified to do. Thus, we continue to argue for the need to better capture the kind of clinical staff who are conducting these services to be able to examine their alignment with patient outcomes as well as more accurately reflecting PE. Our general position is that RNs should be separated from the category of clinical staff and designated as licensed qualified providers for specific services, such as TCM, CCM and RPM being aligned with care management. AAACN supports movement to bundled payment and use of HCPCS codes (GRPM1, GRMP2, GRMT1, GRMT2) for these services but recommends that any crosswalk that is created include a mechanism to capture what type of clinical staff is providing this service with specific descriptors for when these services are conducted by a registered nurse. However, CMS should not require these clinical staff to be directly employed by the same practice. Contracted clinical staff should be allowed as long as they are properly integrated into the practice, follow its clinical protocols, have access to the patient's medical record, and can communicate directly and promptly with the billing practitioner. The focus should be on clinical integration and accountability, not employment status.

			CMS should also simplify RPM and RTM coding but should keep device costs separate from clinical management services. CMS should: ● Pay separately for the device and clinical treatment management. ● Include patient and device education in the treatment management service. ● Keep the 20-minute time-based structure for treatment management. ● Allow payment for the device when the practice supplies it and there are at least two readings or transmissions This approach would simplify billing while maintaining accountability, supporting team-based care, and ensuring patients receive timely and continuous clinical support. CMS should finalize the requirement for an initiating visit and strengthen requirements that RPM and RTM clinical staff be meaningfully integrated with the billing practitioner and care team. However, CMS should define the workforce requirement based on clinical and operational integration rather than direct employment status, allowing contracted clinical staff when they function as integrated members of the billing practice and have direct and timely access to the billing practitioner. CMS should also simplify the RPM and RTM coding structure but should not bundle device supply and treatment management into a single monthly code. Instead, CMS should maintain separate

			payment for device supply and clinical treatment management, incorporate patient education and device-related education into the ongoing treatment management service, maintain the first 20-minute and subsequent 20-minute time-based structure for treatment management, and allow device supply payment with a minimum threshold of two readings or transmissions when the practice actually supplies the device. This approach would simplify coding while preserving accountability, accurately distinguish device costs from clinical care, support integrated team-based remote monitoring, and maintain the clinical responsiveness and continuity of care that give RPM and RTM their value.
II.D	Health coaching services	Appropriate certification standards for auxiliary personnel/health coaches furnishing services.	RNs are already qualified to provide health coaching, but requiring national certification can provide a level of consistency in supporting effective services. However, the proposal to require this to be under direct supervision is not necessary when conducted by someone who is already certified to provide these services. Herein is the structural problem of how the current CMS reimbursement model creates a complicated structure limiting practice of healthcare professionals who would otherwise be qualified to independently provide these services through their licensure to meet the incident to requirement as outlined in the original statute. As we are moving to team-based care, the

			reimbursement model under Medicare needs to be updated to streamline administrative burden, control costs, support health promotion and disease management interventions provided by licensed qualified professionals on the healthcare team, such as RNs.
II.D	Software as a Medical Service (SaMS)	CMS requests comment regarding terminology change to Software as a Medical Service for certain algorithmic clinical technologies.	Software should not be considered a medical service. Instead of creating a new code, adjust for software costs in PE indirect costs or bundled payments. The proposed strategy will only increase costs and could result in abuse in outsourcing medical decision-making.
II.D	Physician-patient clinical trial discussions - Comment Solicitation	Whether Medicare should separately recognize/pay for physician discussions about clinical-trial participation, including coding, valuation, telehealth, and documentation.	AAACN supports further exploration of the addition of codes to compensate providers and qualified personnel regarding discussions of open clinical trials. Adding these codes has the potential to help eliminate barriers to having these discussions. We do recommend that these codes should specifically call out who is eligible to have these discussions (ie: patients care team vs study team) and the types of research that would qualify. Currently, recruitment for trials is often carried out by non-clinical personnel vs the primary investigator (PI). PI may not be a medical professional. Furthermore, ethical considerations regarding the addition of this code should be considered.
II.E	Redesigning Primary Care to Make	CMS requests comment regarding relative valuation of primary care; payment implications of technology/clinical AI; prospective	AAACN agrees with concerns about the undervaluation of primary care services. We are participating in the Primary Care Collaborative and support movement to prospective bundled

	America Healthy Again - RFI	primary-care payment in Shared Savings/Original Medicare.	payment models to assist primary care practices' ability to provide robust care coordination and care management services and have sufficient revenue streams to support development of highly qualified teams which include integration of RNs to provide these services, improve patient outcomes and reduce overall costs the system from uncontrolled chronic diseases. Nursing practice is heavily focused on health promotion, and AAACN applauds the Administration's interest in supporting health promotion activities. AAACN strongly feels that use of AI to support clinical decision making should be reflected in reductions in CPT code medical decision making (i.e. "the work") or as increases in practice expense. This work is currently being done by physicians and QHPs. Paying for AI separately, while still paying physicians/QHPs at the same level has the potential to significantly increase cost. It is concerning that CMS is considering the use of software to be acknowledged for decision making but other licensed qualified staff such as RNs continue to be bundled in with other non-licensed and administrative staff. AAACN also does not support use of AI to provide or collect data as part of the AWV. Patients need to have the ability to interact with a trusted member of the care team to develop trust and be able to ask questions of the care team members.

			However, use of AI to analyze data to support pre-visit planning for AWV or other visits could provide useful information and support time efficiencies. Use of AI to capture ambient documentation is being integrated into various EMR programs, but guardrails need to exist to ensure that any documentation derived from use of ambient charting AI is properly reviewed and certified as correct. AAACN created a position statement directed to the AMA in July 2026 around these proposed codes for use of AI technology.
G.	Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2)		AAACN applauds CMS recognition of the need to better capture inputs of other care team members in supporting ACP services. AAACN is in support of CMS to finalize GACP1 and GACP2. However, there is a vital need to define who is qualified to do ACP, and these services should not be completed by unlicensed clinical staff members. We recommend that these services only are conducted by licensed clinical staff. AAACN recommends GACP1 be a stand-alone ACP service allowing licensed clinical staff time to apply when time is independently met versus creating a combined code. AAACN also recommends the addition of GACP1 and GACP2 to the Medicare Telehealth List

II.E.3	Care Management Code Family	Whether care-management payment should change; code duplication; simplification of the code family; support for longitudinal management.	AAACN supports any efforts to simplify coding for care management services with new mechanisms to capture effort of licensed clinical staff members.
II.E	Clinical AI/technology-enabled primary care	CMS requests comment regarding private-payer lessons; payment/coverage of clinical AI; safety, privacy and program-integrity safeguards; incorporation of technology into primary-care payment.	AAACN recognizes some AI applications may create value and efficiencies but reminds CMS about the relational aspects of primary care and the need to ensure that these relationships with the primary care team are not denied by integration of AI technologies to replace human to human interactions.
II.E	Primary-care capitation / prospective payments	CMS requests comment regarding capitation eligibility; risk experience; participation design; enhanced payments; reconciliation; advanced payment; specialist alignment; possible full capitation.	Prospective hybrid payment (as promoted by the Primary Care Collaborative can create better cash flow for independent primary care practices to be able to staff up the team (i.e. integration of RN on the team to support health promotion and care management) with the competencies needed to care for patients with high chronicity.
II.G.2	Community-Based Palliative Care - RFI	CMS requests comment regarding eligibility; prognosis/function/caregiver burden; care-management structure; interdisciplinary services; payment adequacy; MIPS/MVP reporting; quality measures.	AAACN agrees with the findings from the CMS report that community based palliative care be expanded to include access to interdisciplinary teams, home visits, and shared-decision-making to improve care for Medicare beneficiaries. The issue of low enrollment is likely due to confusion that exists among providers and the public about the intent and goals of palliative care to support people living with chronic conditions versus hospice care which is more focused on comfort care at the end of life. That these services

			are also offered by agencies providing both services further contributes to this confusion. AAACN does not support requiring a life expectancy requirement for eligibility for palliative care services- for individuals with serious illnesses- these may last for years or decades of their life- palliative care, unlike hospice care should be expanded to support people with long term life-limiting conditions. Palliative care needs to also cover nursing (also considered custodial care) services which are often required by individuals with chronic and degenerative conditions, such as ALS, Parkinsons and dementia, AAACN supports expansion of palliative care services to include additional services and integration of interprofessional care delivery- as is the case with home health and hospice services. Of note, further development of palliative care services has the potential to reduce cost, since these services often prevent or delay need for admission to a skilled nursing facility. Findings from the newly initiated GUIDE model for patients with dementia may also provide valuable information on the needs of individuals with long term serious illnesses, like dementia- which is expected to increase. Expansion of palliative care support could be an important investment in addressing the current and future needs of people living with dementia. See https://www.alz.org/getmedia/ef8f48f9-ad36-

			48ea-87f9-b74034635c1e/alzheimers-facts-and-figures.pdf
II.G.3	Intensive Lifestyle Interventions to Slow Alzheimer's Progression - RFI	CMS requests comment regarding evidence and service design; eligible populations; intervention components; outcomes; delivery models; technology support; CMS Health Technology Ecosystem.	AAACN applauds CMS' efforts to identify ways to reduce risks for Alzheimer's progression. Current preventative services such as the Silver Sneakers program have resulted in benefits to both Medicare beneficiaries and the Medicare program. One of the greatest risk factors for development of Alzheimer's related dementia is aging. As individuals are living longer, the prevalence of Alzheimer's and other forms of dementia is expected to increase. The inclusion of ILI can provide benefits to Medicare beneficiaries with all forms of chronic disease, including dementia and could be added to the portfolio of care management services provided under the care management codes. However, support to maintain engagement in lifestyle focused interventions will be necessary as the disease progresses. For example, teaching someone with dementia on specific exercises or food choices may not be retained without intensive redirection as disease progresses. Additionally, to reduce family caregiver burden, nursing and support for custodial services in addition to described lifestyle interventions are necessary. AAACN believes that integration of RNs on the care management team for individuals with dementia is warranted and recommends use of a

			qualifier for Nurse led intensive care management for prevention of progression of dementia as a chronic disease.
II.H	CPT Request for Information	CMS requests comment regarding CMS reliance on CPT as coding standard, including governance, access, alternatives, transparency, burden, and Medicare payment implications.	AAACN supports that movement to HCPCS codes is warranted. The current system has extended far beyond its original purpose which was to develop a set of codes that describe medical care. By setting CPT codes up as **the** national billing system, the AMA has limited or even prevented other professional disciplines from providing care that reflects their education and scope, even when that care is clearly within the state regulated scope and could be provided at a lower cost. The code system is monopolistic and blocks competition. This level of control by one discipline in addition to the limitations of the original Medicare statute that relies on the 'incident to' model of reimbursement fails to recognize qualifications and scope of practice of other members of the healthcare team in providing services to patients. It frankly creates a restriction of practice for licensed healthcare professionals who otherwise would be fully capable and legally allowed to provide services that fall within their scope under their independent licensure.
III.G	Shared Savings Program: Specialty Care - RFI	CMS requests comment regarding integrating specialists into ACOs; engagement models; CMS data/tools and shadow bundles; specialty attribution/benchmarks; incentives;	Attribution challenges which already exist will become more pronounced if specialists are integrated into the ACO. If, movement is to invest in primary care, we suggest keeping ACO and attribution at PCP practice.

		quality/performance measures and accountability.	Also, the complexity of different quality measures to keep up with across payers and providers of services contribute to excessive burdens on primary care practices.

Table 2. New, Potential, and Comment-Solicited HCPCS G-Codes in the CY 2027 PFS Proposed Rule

Code	Status	Policy area	Description / proposed use	PFS location	
GSMAS	Proposed new HCPCS G-code	Shared Medical Appointment	Group-based medical session for 2-10 patients combining individualized assessment with group education/counseling/peer support; proposed work RVU 1.73.	PI PDF 183-190	AAACN supports inclusion of a new code to identify group-based sessions.
GACP1, GACP2	Proposed new HCPCS G-code	Advance Care Planning	First 20 minutes of clinical-staff ACP time under direct supervision; proposed work RVU 1.00.	PI PDF 290-292 Need to define who is qualified to do this. Should not be unlicensed staff.	AAACN is in support of CMS to finalize GACP1 and GACP2. There is a need to define who is qualified to do ACP and should not be completed by unlicensed staff. We recommend that these

					services only are conducted by trained clinical staff. To help ensure the clinical team member is trained appropriately. We recommend that CMS consider including clinical staff qualification expectations in code descriptors or billing guidelines. AAACN recommends GACP1 be a stand-alone ACP service allowing licensed clinical staff to apply when time is independently

					met versus creating a combined code. AAACN recommends the addition of GACP1 and GACP2 to the Medicare Telehealth List.

References
1. Nursing AAoAC. *Scope & Standards of Practice for Professional Ambulatory Care Nursing*. ; 2017.
2. Flinter M, Hsu C, Cromp D, Ladden MD, Wagner EH. Registered Nurses in Primary Care: Emerging New Roles and Contributions to Team-Based Care in High-Performing Practices. *J Ambul Care Manage*. Oct/Dec 2017;40(4):287–296. doi:10.1097/jac.0000000000000193
3. Norful AA, Muir KJ, Cramer E, Jung HJ, Nikpour J. Financial models used to embed registered nurses in primary health care settings in the United States: A scoping review. *Nurs Outlook*. Sep–Oct 2025;73(5):102533. doi:10.1016/j.outlook.2025.102533
4. Déry J, Paquet M, Boyer L, Dubois S, Lavigne G, Lavoie-Tremblay M. Optimizing nurses' enacted scope of practice to its full potential as an integrated strategy for the continuous improvement of clinical performance: A multicentre descriptive analysis. *J Nurs Manag*. Jan 2022;30(1):205–213. doi:10.1111/jonm.13473
5. Aerts N, Van Bogaert P, Bastiaens H, Peremans L. Integration of nurses in general practice: A thematic synthesis of the perspectives of general practitioners, practice nurses and patients living with chronic illness. *J Clin Nurs*. Jan 2020;29(1-2):251–264. doi:10.1111/jocn.15092
6. Norful A, Martsolf G, de Jacq K, Poghosyan L. Utilization of registered nurses in primary care teams: A systematic review. *Int J Nurs Stud*. Sep 2017;74:15–23. doi:10.1016/j.ijnurstu.2017.05.013
7. Lukewich JA, Tranmer JE, Kirkland MC, Walsh AJ. Exploring the utility of the Nursing Role Effectiveness Model in evaluating nursing contributions in primary health care: A scoping review. *Nurs Open*. Jul 2019;6(3):685–697. doi:10.1002/nop2.281

8. Hlebichuk J, Lancaster RJ, Vizgirda V, Quinlan S. Top-of-license practice for registered nurses: A scoping review. *Nurs Outlook*. May–Jun 2025;73(3):102397. doi:10.1016/j.outlook.2025.102397
9. Li Y, Liu S, Cai Y, Cun W, Zhang X, Jiang Y. Effectiveness of nursing interventions on patient experiences with health care: A systematic review and meta-analysis. *Int Nurs Rev*. Sep 2025;72(3):e13075. doi:10.1111/inr.13075
10. Darby M, Smith L, Waldron B, Fiandt K. Intensive Primary Care Nursing: Exploring the Impact of a Nurse-Led Model for Medically and Social Complex Patients. *Clin Nurs Res*. Jun 2024;33(5):384–394. doi:10.1177/10547738241253654
11. Wagner CM, Butcher, H. K., & Clarke, M. F. . *Nursing interventions classification (NIC)* 8ed. 2023.
12. Clinical Care Classification System. Clinical Care Classification System: Coding for nurses. . https://clinicalcareclassification.org/
13. Centers for Medicare & Medicaid Services. MLN908628: Transitional care management services [Booklet]. (2025).