



September 12, 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 and Medicaid Programs; CY 2026 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

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), on behalf of the nearly 190,000 PAs (physician associates/physician assistants) throughout the United States, would like to provide comments on the 2026 Physician Fee Schedule proposed rule. AAPA seeks to work in partnership with the Centers for Medicare and Medicaid Services (CMS) to advance policies that meet those goals expressed throughout the rule, including increased efficiency of care, decreased burden to providers and patients, a commitment to evidence-based determinations, a focus on prevention and wellness, increased transparency, and more. We believe such values are consistent with advancing high-quality care for all Medicare beneficiaries.

PAs currently provide hundreds of millions of patient visits each year, many with Medicare beneficiaries. As such, PAs and the patients they serve will be significantly impacted by many of the proposed modifications to coverage and payment policies in the proposed rule. Due to the essential role PAs play in meeting many of the challenges faced by the healthcare system, AAPA hopes that CMS continues to advance policies that allow PAs to meet the care needs of Medicare beneficiaries and expand that role in ways that align with the values CMS conveys. It is within this context that we draw your attention to our comments.

Direct Supervision by Use of Two-Way Audio/Video Communications Technology

Historically, direct supervision has required the supervising health professional to be present within the suite of offices and immediately available to provide direction and assistance if necessary. During the COVID-19 Public Health Emergency, CMS initiated flexibilities regarding this requirement, allowing for the condition for immediate availability under direct supervision to be met by virtual presence. While CMS's stated intention was for this authorization to be temporary, the agency has since extended this flexibility in multiple Physician Fee Schedule final rules beyond the end of the public health emergency, most recently through the end of 2025. In the 2026 Physician Fee Schedule proposed rule, CMS proposes to permanently allow for direct supervision of services to be provided using two-way audio/visual communications technology.

Specifically, in the 2026 Physician Fee Schedule proposed rule, CMS proposes to permanently adopt a definition of "direct supervision" that authorizes the requirement for "immediate availability" to be met using audio/video real-time communications technology for all "incident to" services and other services described under §410.26, except those with global surgical indicators 010 or 090. CMS is making a similar modification under § 410.32(b)(3)(ii), which will affect direct supervision for diagnostic tests, as well as cardiac, pulmonary, and intensive cardiac rehabilitation. Elsewhere in the rule, CMS proposes to make permanent a similar flexibility in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) under (§405.2401(b)). While AAPA appreciates CMS's intention to carve out certain services to preserve quality care and patient safety, our concerns with this policy remain with its proliferation of a billing mechanism that hinders transparency. This lack of transparency then has subsequent effects that negatively impact various stakeholders.

AAPA opposes CMS's proposal, as written, to make permanent the ability to meet the requirements of direct supervision using two-way audio/video communication technology. While AAPA supported this flexibility initially to protect health professionals and patients from exposure to COVID-19, and in subsequent years due to a shared desire with CMS to not end this flexibility abruptly, our support was conditional on the understanding that the policy would be temporary. As we expressed in our comments to the 2025 Physician Fee Schedule when CMS proposed to make this provision permanent for a subset of services, AAPA supports CMS's efforts to enhance access to services by making this authorization permanent in specific low-risk circumstances, however, we oppose a broad permanent application of this authorization to all billing providers, such as PAs and nurse practitioners.

As CMS is aware, "incident to" is a Medicare billing provision that allows medical services performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed

under the name of another health professional. Of particular interest to us is “incident to” billing for services performed by PAs and nurse practitioners that are attributed to a physician.

Due to how services billed “incident to” are reported through Medicare’s claims process, a substantial percentage of medical services rendered to Medicare beneficiaries by PAs and nurse practitioners may be attributed to physicians with whom they work. When this occurs, it is nearly impossible to accurately identify the type, volume, or quality of medical services provided by PAs and nurse practitioners. Accurate data collection and appropriate analysis of workforce utilization are lost.

The transparency concerns regarding “incident to” billing are well-documented. The Medicare Payment Advisory Commission (MedPAC), in its report released on June 14, 2019, noted the increasing role of PAs and nurse practitioners in providing care to Medicare beneficiaries, estimated that a significant share of services provided by PAs and nurse practitioners was billed “incident to,” and identified many of the adverse consequences of “incident to” billing stemming from compromised data quality.¹

CMS demonstrates its shared concern for transparency and data accuracy in other provisions of the 2026 Physician Fee Schedule proposed rule, emphasizing a preference for empirical studies and even issuing a request for information (RFI) on data quality, integrity and transparency under the Quality Payment Program section of the rule. Below, we have provided examples of how this lack of transparency under “incident to” and the resulting threat to data accuracy has a negative impact on patients, health policy researchers, the Medicare program, and PAs and nurse practitioners.

Inaccurate Data and the Effect on Patients

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

¹ Medicare Payment Advisory Commission. 2019. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. <https://www.medpac.gov/document-type/report/>

Care Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals and display the professional's overall quality of care based on a Medicare-computed performance score. When services performed by PAs or nurse practitioners are hidden due to "incident to" billing, not only is Medicare unable to accurately determine PA or nurse practitioner quality scores, but these scores may not appear on the Care Compare site if the health professional does not exceed the low-volume threshold because of a limited number of services being attributed to them. PAs and nurse practitioners not being identified on Care Compare, or not being accurately portrayed, impedes patients from making fully informed decisions regarding their choice of healthcare provider.

Inaccurate Data and the Effect on Research

With a substantial number of services provided by PAs and nurse practitioners attributed to physicians through "incident to" billing, data analysis regarding those services leads to incomplete or inaccurate conclusions. Consequently, health policy research using such data is similarly biased by a lack of attribution to the PA or nurse practitioner who delivered the care. Publicly available Medicare claims information, such as Medicare Physician and Other Supplier Data, distorts the ability to analyze individual provider contribution or productivity and may unintentionally lead to imprecise or erroneous conclusions despite the use of otherwise sound research evaluation methodologies.

Inaccurate Data and the Effect on the Medicare Program

Under "incident to" billing, claims data collected and used by the Medicare program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This hinders the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, quality of care, and resource use allocation.

As example, in CMS's 2019 Physician Fee Schedule final rule, the agency acknowledged limitations in data usage and burden reduction estimations due to the ability to report services using "incident to" billing.²

² The Department of Health and Human Services. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

Another concern regarding the negative impact of “incident to” billing on the accuracy and validity of value-based programs was noted in a Health Affairs Blog in a January 8, 2018 posting.³

Inaccurate Data and the Effect on PAs and Nurse Practitioners

While claims data are by no means the only measure of a health professional’s value and productivity, it is an essential component and widely utilized proxy. The inability to demonstrate economic and clinical value, both within the Medicare program and to an employer, can influence the analysis of PA and nurse practitioner healthcare contributions.

All detrimental effects of “incident to” mentioned thus far are a result of the subsequent lack of transparency. However, there is evidence that “incident to” decreases efficiency. Two studies^{4,5} demonstrate the benefits of increasingly autonomous billing by PAs and nurse practitioners, showing a significant increase in efficiency and productivity of PAs and nurse practitioners, as well as a mild increase in efficiency and productivity for physicians.

AAPA is concerned that CMS’s proposed policy to broadly redefine direct supervision to include audio/visual communication for all health professionals in nearly all circumstances under §410.26 would continue to make it easier for practices to use “incident to” billing when it comes to services provided by PAs and nurse practitioners. It may also convince practices that had previously been hesitant to use “incident to” with virtual direct supervision to begin doing so, expanding the use of the billing mechanism.

Finalizing the policy as proposed, without an exception for those services provided by PAs and nurse practitioners, would exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional. While AAPA is aware CMS cannot eliminate the statutorily

<https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

³ “The Integrity of MACRA May Be Undermined By “Incident To Billing” Coding”, *Health Affairs Blog*, January 8, 2018. DOI: 10.1377/hblog20180103.135358. <https://www.healthaffairs.org/content/forefront/integrity-macra-mayundermined-incident-billing-coding>

⁴ Brooks PB, Fulton ME. Demonstrating advanced practice provider value: Implementing a new advanced practice provider billing algorithm. *JAAPA*. 2019 Feb;32(2):1-10. doi: 10.1097/01.JAA.0000550293.01522.01. PMID: 30694959.

⁵ Brooks PB, Fulton ME. Driving high-functioning clinical teams: An advanced practice registered nurse and physician assistant optimization initiative. *J Am Assoc Nurse Pract*. 2020 Jun;32(6):476-487. doi: 10.1097/JXX.0000000000000415. PMID: 32511193.

established “incident to” billing, it is within the power of CMS to refrain from implementing policies that would increase its usage.

Consequently, due to our ongoing concerns with “incident to” billing for PAs and its harm to transparency, AAPA recommends that CMS revise its proposed policy to allow for direct supervision by audio/visual communication only for the supervision of health professionals who are not authorized to bill Medicare for their services. Extending direct supervision by audio/visual communication for health professionals such as registered nurses, medical assistants, and technicians, allows for expanded patient access to care by increasing flexibility in supervisory requirements for such professionals to perform their duties while not adversely affecting transparency. PAs and nurse practitioners can provide and bill for services under their own names instead of a physician’s name, and at a lower cost of care (reimbursement rate) to the Medicare program.

As direct supervision of PAs and nurse practitioners is not required for such health professionals to provide the services, but only to secure the additional rate of reimbursement, excepting services provided by PAs and nurse practitioners for “incident to” would not likely inhibit access to those services. Making permanent direct supervision by audio/visual communication for PAs and nurse practitioners would only serve to increase costs and further impair data transparency through the potential proliferation of “incident to” billing. We again urge CMS to modify its proposed policy, or else establish a method through which CMS can collect the information of the health professional providing the service under “incident to.”

AAPA Positions and Recommendations on this Topic

- **AAPA strongly opposes CMS’s proposal, as written, to make permanent the ability to meet the requirements for direct supervision using two-way audio/video communication technology due to concerns regarding the proliferation of “incident to” billing. Instead, AAPA recommends that CMS revise its proposed policy to allow for direct supervision by audio/visual communication only for the supervision of health professionals who are not authorized to bill Medicare for their services.**
- **While AAPA is aware CMS cannot eliminate the statutorily established “incident to” billing, it is within the power of CMS to refrain from implementing policies that would increase its usage.**
- **Alternatively, AAPA encourages CMS to establish a method through which CMS can collect the information of the health professional providing the service under “incident to.”**

Prevention and Management of Chronic Disease Request for Information

The 2026 Physician Fee Schedule proposed rule includes an RFI that seeks broad input on how to improve prevention and management for chronic disease, a priority issue for the administration. Under the RFI, CMS identifies the magnitude of the problem, indicating that six in ten people have at least one chronic disease, with four in ten having at least two. AAPA concurs that any action that can be taken to prevent or mitigate chronic disease is a worthwhile endeavor. We applaud CMS for this holistic focus on prevention and improved management of chronic disease and propose several suggestions for Medicare to improve the ability of health professionals to facilitate such care.

Prevention of Chronic Disease

Under the RFI, CMS identifies several factors that may contribute to chronic disease, including poor nutrition, a lack of physical activity, environmental impacts, and social isolation/loneliness. The agency then poses a series of questions asking what steps, if any, Medicare could take to initiate care that may prevent chronic disease resulting from, or being exacerbated by, these factors. AAPA supports CMS taking concrete steps to incentivize such prevention efforts.

- **Motivational Interviewing**: One option that is within the purview of CMS is to identify new treatment options for which CMS will reimburse, encouraging health professionals to provide care options that have been demonstrated to have a positive effect on overall health. Several suggestions were put forward by CMS in the rule, including establishing coding and payment for motivational interviewing, which is a collaborative, goal-oriented focus on change. AAPA sees benefit to promoting these forward-looking discussions and encourages CMS, should it establish such payment in future rulemaking, to take a broad approach to which health professionals may conduct motivational interviewing. This expanded provision of health coaching should be able to be supervised and billed for by billing practitioners. If appropriate, billing practitioners should also be authorized to for these services themselves. The specific needs within motivational interviewing may vary, from discussions that are highly clinical and thus would require discussion with a PA, nurse practitioner, or physician, to more broad conversations regarding general wellness best practices. AAPA also suggests that CMS take a similarly broad perspective regarding authorized sites of service, and to allow motivational interviewing services to be provided by telehealth.
- **Annual Wellness Visits**: Under the RFI, CMS also asks for thoughts regarding how better to incentivize beneficiary use of the Annual Wellness Visit. AAPA commends CMS's request as the Annual Wellness

Visit allows beneficiaries to have regular discussions with their health professionals regarding care concerns, as well as provides for the establishment of benchmarks to identify trends that may portend chronic disease. We suggest that CMS seek further information through surveys of beneficiaries regarding the primary reason those who choose not to partake in an Annual Wellness Visit made that decision. We suggest that financial incentives are limited, as the Annual Wellness Visit is already free to beneficiaries by nature of its status as a preventive service. However, we note that there may be educational opportunities as some beneficiaries may not be aware of the option or that it can be done free of charge. CMS may also wish to distribute best practices to health professionals regarding outreach to beneficiaries regarding Annual Wellness Visits, which may include incentive campaigns that have been shown to work, methods of reminders, and more.

Another option may be to incorporate motivational interviews, which CMS is considering paying separately for, as an add-on item in which a health professional conducting an Annual Wellness Visit may receive an extra payment for conducting, but for which a patient will not have to pay extra. Having ongoing communication and regularly collected measurements for success that result from such conversations may help beneficiaries remember and adhere to regular annual visits. Finally, while PAs and nurse practitioners are authorized to perform the annual wellness visit, they are statutorily prohibited (42 U.S.C. 1395x (hhh)(3)(C)) from supervising other medical professionals/staff performing these services. Instead, the direct supervision of a physician is required. This may be limiting the number of Annual Wellness Visits that could be performed, as some settings may not have a physician available to provide such supervision. As such, AAPA requests that CMS work with Congress to revise 42 U.S.C. 1395x (hhh)(3)(C) to allow PAs to supervise other medical professionals and staff performing Annual Wellness Visit services.

- Wearable Devices: Under the RFI, CMS also mentions wearable devices. These technologies may include, but are not limited to, the use of “wellness devices,” which may measure biometric data such as heart rate, activity levels, and sleep patterns, and “personal emergency response systems” that may alert a caregiver or local emergency response services to a fall or elopement of an individual with memory impairment.⁶ Medicare and Medicaid beneficiaries frequently present this data to their healthcare provider(s), which, subsequently, contributes to objective data reviewed during the medical-decision-making process. Such data has been shown to not only improve patient satisfaction,

⁶ Knight SR, Ng N, Tsanas A, Mclean K, Pagliari C, Harrison EM. Mobile devices and wearable technology for measuring patient outcomes after surgery: a systematic review. *NPJ Digit Med.* 2021;4(1):157. Published 2021 Nov 12. doi:10.1038/s41746-021-005251

but can significantly improve clinical outcomes and reduce post-operative complications.^{7,8} CMS may further wish to examine potential reimbursement options beyond existing and limited remote patient monitoring for review of this data, as well as distribute best practices for effective use, to promote widespread adoption of this emerging technology.

- Environmental Impacts and Social Determinants of Health: Under the RFI, CMS also notes potential environmental impacts on chronic disease. AAPA concurs with this assessment that external factors may play a role in disease development and severity, and adherence to treatment regimens that may prevent or address such diseases. For these reasons, AAPA reiterates its support for past CMS efforts to better identify social determinants of health. The importance of access to healthcare, education, transportation, housing, food, and economic stability to patient health is well documented both in prior Physician Fee Schedule rules, and elsewhere, with CMS citing the Department of Health and Human Services paper that suggests such factors may account for as much as 50% of an individual's health.⁹ If providers are unaware of such barriers, medical care and subsequent care plans may be hindered with little understanding as to why. Lack of adherence to care plans may prove costly to the patient and the system, resulting in ineffective interventions or prolonged inpatient care. As a result of the potential for identification of these confounding factors on improving prevention and management of chronic disease, we request that CMS reconsider its proposals, found elsewhere in the 2026 Physician Fee Schedule proposed rule, to no longer reimburse for the Social Determinants of Health Risk Assessment and to remove this service from the Medicare telehealth services list. We suggest that separate payment for such an assessment may align with the intentions of this RFI. Specifically, identification of environmental impacts may allow for early interventions that prevent or mitigate chronic disease. With the emphasis placed on the identification of such factors, both under this RFI and throughout the proposed rule, we believe CMS would choose to prioritize a detailed review by health professionals of the intersection between such social determinants of health (now more broadly termed by CMS as "upstream drivers"). In order to cover the breadth of potential upstream drivers, the Social Determinants of Health Risk Assessment would allow for greater attention, time, and resources than what is currently paid for under evaluation and management (E/M) visits.

⁷ Ibid

⁸ Nichols JH, Assad RS, Becker J, et al. Integrating Patient-Generated Health Data from Mobile Devices into Electronic Health Records: Best Practice Recommendations by the IFCC Committee on Mobile Health and Bioengineering in Laboratory Medicine (CMHBLM). *EJIFCC*. 2024;35(4):324-328. Published 2024 Dec 30

⁹ Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers, B; 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>

- Social Isolation: Regarding social isolation, AAPA notes that while CMS has implemented certain opportunities that may help address this issue, we believe there may be more the agency could do. For example, in the 2025 Physician Fee Schedule final rule, CMS finalized policies that sought to help beneficiaries with severe behavioral health conditions. Specifically, CMS finalized payment for safety planning interventions for high-risk patients in crisis (those at risk of suicide or overdose) that included using social contacts, social settings, family members, caregivers, and significant others in a way that may help resolve crises. In the same rule, CMS finalized payment for post-discharge telephonic follow-up contact interventions, which seek to incentivize regular provider check-ins with at-risk patients. While these payments are an excellent first step, AAPA encourages CMS to go further. Currently, these payments are focused on interventions for those beneficiaries determined to be high risk. We suggest that similar payment could be warranted to establish social plans and regular check-ins for those who are at moderate risk of depression or determined to be socially isolated because of answers to an intake survey.
- Primary Care: Finally, similar to the RFI's suggestion that increased participation in Annual Wellness Visits may help prevent and manage chronic illness, AAPA suggests that enhanced focus on primary care generally may help do the same. CMS has demonstrated a preference for an increased focus on primary care in recent years, with provisions ranging from Advanced Primary Care Management (APCM) and G2211 in past years, to integration of behavioral health into APCM services in this rule. AAPA supports CMS doing more to bolster primary care. According to a report from the Health Resources and Services Administration, the US health system is experiencing a clinician shortage, particularly in primary care.¹⁰ A shortage in the primary care workforce may lead to insufficient patient access to needed healthcare services and the need for more intensive and high-cost interventions such as hospitalization or emergency care.¹¹ As such, AAPA recommends exploring varying types of payment approaches and methodologies to boost primary care participation and solvency, such as:
 - Reducing fee-for-service payment with the addition of a modified risk-adjusted monthly payment
 - Enhancing scholarship and loan repayment assistance programs for PAs in exchange for a certain number of years practiced in primary care
 - Testing through the Center for Medicare and Medicaid Innovation the concept of 100% reimbursement for PAs when providing primary care

¹⁰ Westat. 2015. Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4. <https://aspe.hhs.gov/reports/impact-state-scope-practicelaws-other-factorspractice-supplyprimary-care-nurse-practitioners>

¹¹ Shi, Leiyu. 2012. The impact of primary care: a focused review. <https://pubmed.ncbi.nlm.nih.gov/24278694/>

- Promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA practice in federal health programs
- Encouraging states to eliminate legislative and regulatory barriers that either hinder PAs from practicing to the highest level of their education and expertise, or hinder their ability to autonomously practice, like requirements for physician co-signatures or stringent oversight

Management of Chronic Disease

Prevention of chronic diseases by incentivizing change in care delivery and patient behavior is an important and worthy goal. However, these efforts will be unable to eliminate some chronic disease, as not all chronic diseases are preventable. As such, methods to detect chronic disease early and provide proper care coordination must also be incentivized. These efforts may identify chronic disease in early stages, and, with appropriate interventions, may in some instances mitigate or reverse the disease state.

While preventive efforts will largely benefit from new reimbursement opportunities, many options for screening and care coordination have already been established. Consequently, CMS can remove barriers for existing covered services, to promote the use of interventions that have demonstrated to make a positive difference. AAPA is aware of several examples of interventions to identify and manage chronic disease that are limited by their exclusion of health professionals who are qualified to provide the service from doing so.

- Nonemergency, scheduled, repetitive ambulance services: Certain patients are unable to travel for services such as routine screenings, dialysis, or wound care due to a contraindication to other modes of transportation. If certified by a physician, such individuals can receive nonemergency, scheduled, repetitive ambulance services.¹² Requiring that a physician provide this certification, instead of a qualified health professional already familiar with the patient, is inefficient and a barrier to care for chronic conditions. An inability to receive a timely authorization for such transportation may also contribute to necessary services being delayed or unused. CMS previously extended the ability of PAs and nurse practitioners to sign a certification statement for other types of ambulance transfers (for unscheduled or scheduled but not repetitive). Consequently, AAPA requests that CMS modify § 410.40(e)(2) to authorize PAs who provide care to patients who require nonemergency, scheduled, repetitive ambulance care to be authorized to provide the required certifications to ensure these patients have access to needed services.

¹² Palmetto GBA. 2021. Physician Certification Statement for Ambulance Services.
<https://www.palmettogba.com/palmetto/jmb.nsf/DID/8T4MAF7511>

- Home blood glucose monitors: CMS National Coverage Determination (NCD) 40.2 regarding home blood glucose monitors¹³ indicates that coverage for these monitors is limited to patients who have either a) been determined by a physician to be capable of or b) can be monitored by a person determined capable of being trained to use the equipment. Further, special glucose monitors are covered only when a physician certifies that a patient has a severe visual impairment that requires this monitoring system. This NCD conflicts with the regulatory authority of 42 CFR § 410.38(C)(2) for PAs to order/prescribe/certify Durable Medical Equipment (DME). 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. 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.¹⁴ PAs are qualified and capable of making these determinations. As such, the NCD should be revised to authorize PAs to certify the need for coverage of this DME. Revising the NCD will improve chronic disease management, reduce the administrative burden of requiring an otherwise unnecessary physician order for patients cared for by PAs, and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain an order/certification that their treating PA could otherwise provide.
- Podiatric services: Section 290, Chapter 15 of the Medicare Benefit Policy Manual¹⁵ contains exceptions to the routine foot care exclusion (see Section 290 C), systemic conditions that might justify coverage (see Section 290 D), and presumption of coverage (see Section 290 F) that require patients to have been evaluated and treated by a physician. These requirements, as currently written, may result in patients receiving care from a PA needing to schedule a separate visit with a physician to document a need for podiatric care that PAs are qualified to determine, potentially increasing the cost and burden to patients. These policies should be revised to authorize coverage of podiatry services for beneficiaries with certain conditions when under the care of a PA. Revising the policy will improve chronic disease management, reduce administrative burden, and could improve program integrity by reducing waste if patients do not have to have otherwise unnecessary physician care when already being evaluated and treated by PAs.

¹³ Centers for Medicare and Medicaid Services. 2006. Home Blood Glucose Monitors.

<https://www.cms.gov/medicarecoverage-database/view/ncd.aspx?NCDId=222>

¹⁴ Yang, Y; Long, Qi; Jackson, S; Rhee, M; Tomolo, A; Olson, D; Phillips, L. 2017. Nurse Practitioners, Physician Assistants, and Physicians Are Comparable in Managing the First Five Years of Diabetes.

[https://www.amjmed.com/article/S0002-9343\(17\)30904-X/abstract](https://www.amjmed.com/article/S0002-9343(17)30904-X/abstract)

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

- Colorectal cancer screening tests: CMS National Coverage Determination (NCD) 210.3 regarding Colorectal Cancer Screening Tests indicates that Fecal Occult Blood Tests (FOBT) and Blood-based Biomarker Tests (BBT) for colorectal cancer screening are only covered when ordered by a physician. This NCD conflicts with the regulatory authority of 42 CFR §410.37(b) authorizing payment of FOBT ordered by PAs and 42 CFR §410.32 authorizing payment for diagnostic laboratory tests ordered by PAs. As such, the NCD should be revised to authorize payment for FOBT and BBT for colorectal cancer screening ordered by PAs. Revising the NCD will improve screening and detection of colorectal cancer to promote earlier and more effective management of the disease, promote disease prevention, reduce the administrative burden of requiring an otherwise unnecessary physician order for patients cared for by PAs, and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain an order that their treating PA could otherwise provide.
- Screening colonoscopies: 42 CFR § 410.37(f) authorizes coverage of screening colonoscopies only when performed by a physician. This regulation should be rescinded to authorize coverage of screening colonoscopies performed by PAs. A study¹⁶ indicated no significant differences in cecal intubation time or success, adenoma detection rate, or adverse reactions reported related to the endoscopic procedure up to 30 days post-colonoscopy for PAs compared to gastroenterologists. The researchers, who included five allopathic physicians, concluded that the findings support the use of trained PAs to perform average-risk screening colonoscopies and that “this approach may be particularly relevant to underserved populations and resource-poor areas where access to and cost of colonoscopy limits the optimization of colorectal cancer screening strategies.”
- Medical Nutrition Therapy (MNT): MNT is a preventive service that CMS itself has previously identified as an example of a high-value, potentially underutilized service. One explanation of the fact that this existing service is underutilized is the narrow definition of MNT, indicating that only physicians are authorized to order MNT services. PAs are professional medical providers for patients with diabetes, cancer, kidney disease and other conditions in which MNT may be a necessary part of the treatment plan. However, language in the US Code, section 42 U.S.C. 1395x (vv)(1) reads as follows: “The term “medical nutrition therapy services” means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).” This physician-only requirement results in administrative burden and delay in care for patients in need of these services, as patients must wait for a physician order. While the restriction is statutory, if CMS seeks to expand therapeutic nutrition options for Medicare

¹⁶ Kern LM, Zhou Y, Rajendran N, et al. Quality metrics of screening colonoscopies. *JAAPA*. 2020;33(4):35–41. https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx

beneficiaries, the agency should work with Congress to modify 42 U.S.C. 1395x (v)(1) to add “or a PA (as defined in subsection (aa)(5))” after (r)(1), which would authorize PAs to order Medical Nutrition Therapy.

- Restrictions on health professionals of the same specialty and the effects on care coordination: CMS allows one E/M service per beneficiary, per day, per provider specialty type. Because PAs are enrolled in Medicare under a single specialty taxonomy code (i.e., CMS specialty code ‘97’) rather than the specialty in which they practice, when services are provided by two PAs (e.g., primary care and orthopaedics) on the same day, one of the visits is often not paid due to the assumption that practitioners of the same specialty performed both visits. This is particularly burdensome in multispecialty groups, which by design can offer care coordination for patients between the specialties represented. Chronic illnesses are seldom one-dimensional and may frequently require treatment from multiple health professional to manage the illness. This restriction impedes any efficiencies that may benefit a patient from visiting a multispecialty group. This has led to a high number of claims denials and overturns on appeal, resulting in several Medicare Administrative Contractors (including NGS)¹⁷ creating a workaround of including a secondary specialty on the claims form to reduce otherwise unnecessary and costly appeals that result in significant administrative burden and unnecessary documentation and reporting. Patients with chronic illnesses should be allowed to see two PAs working in different specialties during a visit. Consequently, Medicare should authorize a PA to use a secondary code on claim forms.

AAPA Positions and Recommendations on this Topic

- **AAPA approves of CMS taking concrete steps to incentivize prevention efforts, including coding and payment for motivational interviewing. We encourage a broad approach to allowed site of service and which health professionals may conduct motivational interviewing, and support authorizing these services to be provided by telehealth.**
- **In order to further incentivize beneficiary utilization of the Annual Wellness Visit, AAPA recommends that CMS first seek further information through surveys of beneficiaries regarding the primary reason those who choose not to partake made that decision. AAPA also proposes additional ideas, including educational opportunities for those not aware of the visit as an option or of the fact that it can be done free of charge, the distribution of best practices to health professionals regarding outreach to beneficiaries regarding Annual Wellness Visits, and the incorporation of motivational**

¹⁷ National Government Services. Evaluation and Management Services. Published September 30, 2024. Accessed June 26, 2025. <https://www.ngsmedicare.com/web/ngs/evaluation-andmanagement?selectedArticleId=768586&artfid=2072831&lob=96664&state=97118®ion=93623>

interviews as an add-on service. Finally, AAPA requests that CMS work with Congress to revise 42 U.S.C. 1395x (hhh)(3)(C) to allow PAs to supervise other medical professionals and staff performing Annual Wellness Visit services.

- Regarding wearable devices, AAPA recommends that CMS develop additional information for health professionals regarding appropriate collection and utilization of data from these sources, notes that standards for secure transfer, storage, and privacy of data from these devices may further legitimize and standardize this form of data collection, and encourages CMS to examine potential reimbursement options beyond existing and limited remote patient monitoring for review of this data, as well as distribute best practices for effective use.
- AAPA reiterates its support for past CMS efforts to better identify social determinants of health and we request that CMS reconsider its proposals, found elsewhere in the 2026 Physician Fee Schedule proposed rule, to no longer reimburse for the Social Determinants of Health Risk Assessment and to remove this service from the Medicare telehealth services list.
- Regarding social isolation, AAPA recommends that CMS explore payment for establishing social plans and regular check-ins, perhaps as follow-ups for the previously suggested motivational interviews, for those who are at moderate risk of depression or determined to be isolated as a result of answers to an intake survey.
- AAPA identifies various opportunities to boost primary care, including some level of reduced fee-for-service payment with the addition of a modified risk-adjusted monthly payment, additional scholarship and loan repayment assistance programs in exchange for a certain number of years practiced in primary care, testing through the Center for Medicare and Medicaid Innovation the concept of 100% reimbursement for PAs when providing primary care, promoting federal regulatory and statutory policy changes to eliminate unnecessary restrictions on PA practice in federal health programs, encouraging states to eliminate legislative and regulatory barriers that hinder PAs from practicing to the highest level of their education and expertise, increasing the autonomy of health professionals practicing in primary care, as well as eliminating and working with states to encourage the elimination of burdensome practice requirements, such as requirements for physician co-signatures or direct oversight.
- AAPA is aware of several examples of interventions to identify and manage chronic disease that are limited by their exclusion of health professionals who are qualified to provide the service. As such, AAPA recommends that:
 - CMS modify § 410.40(e)(2) to authorize PAs who provide care to patients who require nonemergency, scheduled, repetitive ambulance care to provide the required certifications
 - CMS revise NCD 40.2 regarding home blood glucose monitors to authorize PAs to certify the need for coverage of this DME

- **CMS revise Section 290, Chapter 15 of the Medicare Benefit Policy Manual to authorize coverage of podiatry services for beneficiaries with certain conditions when under the care of a PA**
- **CMS revise NCD 210.3 regarding Colorectal Cancer Screening Tests to authorize payment for FOBT and BBT for colorectal cancer screening ordered by PAs**
- **CMS rescind 42 CFR § 410.37(f) to authorize coverage of screening colonoscopies performed by PAs**
- **CMS work with Congress to modify 42 U.S.C. 1395x (vv)(1) to authorize PAs to order Medical Nutrition Therapy**
- **CMS authorize PAs to use a secondary code on claim forms so that a patient doesn't encounter care coordination obstacles due to needing to see PAs who work in two different specialties**

Code Valuations

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to make several policy changes that it anticipates will increase the accuracy of code valuations. Two prominent policies are the establishment of an “efficiency adjustment” and the update to the practice expense methodology.

The Efficiency Adjustment

In the 2026 Physician Fee Schedule proposed rule, CMS provides background regarding its historical process for establishing Relative Value Units (RVUs) for services. Historically, CMS has relied significantly on data submitted to the agency from the American Medical Association (AMA) Specialty Society Relative Value Scale (RVS) Update Committee, commonly referred to as the RUC. The RUC, comprising representatives from various specialties and provider groups, conducts surveys of health professionals to collect information on the estimated practitioner time, work intensity, and practice expense required for each service. The RUC then reviews this information, establishes formal recommendations, and passes these along to CMS. The agency can then choose to accept or reject the suggested valuations when finalizing a code's official RVUs under the physician fee schedule. Code examination and subsequent revaluations are cycled based on the time since last reviewed or changes to the code or context.

While CMS has long relied on RUC data, the agency has in the past expressed openness to alternative methods of valuing codes, especially if these alternatives were informed by empirical evidence. In the 2026 Physician Fee Schedule proposed rule, CMS expresses concerns with what it views as the limitations of the RUC data. First, CMS expresses reservations about the use of surveys to collect this information. The surveys, CMS explains, have at times shown low response rates and have presented significant variations in responses provided. Second, CMS expresses concern regarding response biases, speculating that those inclined to respond to the surveys may be different than those who do not. Third, CMS expresses concern with the potential for a conflict of interest, as those reporting the time and intensity it takes to perform a service have a financial interest in the results through subsequent adjustments to payments that those same providers later receive. Finally, CMS expresses concerns with the process of identifying similar codes for comparison and the applicability of associated clinical vignettes. These concerns have led the agency to believe that the RUC survey data it uses have over-inflated the value of codes.

In the proposed rule, CMS also expresses concerns regarding the current timeline of code revaluations. The agency notes that codes often take years to be revalued (some never have), as the RUC only reviews a few hundred out of the more than 9,000 codes each year. Further, it may be years between when a survey is conducted and when CMS implements a code revaluation based on that data.

As a result of these perceived shortcomings, CMS expresses an interest in using more empirical data in code valuations. The agency indicates that, while CMS has traditionally had to rely on RUC surveys, new methods to identify this same information have recently been developed. Feedback CMS received in response to a request for information on this topic included in the 2024 Physician Fee Schedule identified that resources used in furnishing the work portions of E/M services are primarily a function of the time spent with the patient, and do not reflect efficiency gains, leading to a diminished valuation of E/M services as a result of budget neutrality requirements.

CMS notes that it has long been concerned regarding a lack of accounting for increased efficiencies in work RVUs for non-time-based services, and that this concern is supported through various study results and MedPAC's 2018 report to Congress. CMS believes that non-time-based services should become more efficient as they become more common, technology is improved, professionals gain more experience with the service, and alternative operational workflows are implemented.

For this reason, in the 2026 Physician Fee Schedule, CMS is proposing to establish an "efficiency adjustment" to the work RVUs and the corresponding updates to the intraservice portion of physician time inputs for non-time based services (that is, it would not apply to E/M visits, care management services, behavioral health services, services on the Medicare telehealth list, and certain maternity codes). This proposal is modeled in

part on one of MedPAC's 2018 recommendations. CMS proposes to calculate the efficiency adjustment using the Medicare Economic Index (MEI) productivity adjustment, a measure of inflation with respect to practice costs and wages levels calculated by the CMS Office of the Actuary annually. CMS is proposing that, for 2026, the efficiency adjustment will use a look-back period of five years. CMS will sum the productivity adjustments from the final MEI updates from the past five years, which will result in a 2.5 percent downward adjustment for calendar year 2026. Going forward, CMS expects to update the efficiency adjustment every three years.

AAPA acknowledges some of CMS's concerns regarding the RUC process, but cautions against assumptions of inherent bias, as we have witnessed firsthand the professionalism and integrity of its surveyors, respondents, and reviewers. These participants seek to share their personal experiences regarding resource utilization to appropriately value cost of care. Many of the shortcomings of the use of RUC data for code valuations are inherent in survey processes generally. AAPA does, however, find great value in CMS's intended increased focus on empirical evidence in the code valuation process, and we commend CMS for proposing a process that seeks to make adjustments with timely data. However, we note that the proposed efficiency adjustment is only likely to ever adjust services downward, when the cost of providing some services may increase over time. AAPA further notes that empirical data regarding resource use is not available for all codes and so we encourage ongoing participation from the RUC in the valuation process.

AAPA is also concerned about a blanket efficiency adjustment that treats all non-time-based services equally. We note that there will be variation in the existence and extent of efficiencies service by service. CMS does address this concern and justifies moving forward by noting that the physician fee schedule intraservice time is higher than empirical intraservice times on average for studied non-time-based services. However, these represent an average, indicating that some services may be in line with, or below, empirical assessments. These services may then be disadvantaged by a blanket application of the efficiency adjustment. AAPA recommends that CMS consider broad input on the efficiencies attained in various types of services, before having to remedy a significant number of codes through the "potentially misvalued codes" process. CMS should then consider exempting those services that have either been determined not to have benefited significantly from increased efficiencies, or whose physician fee schedule intraservice times have been identified as either in line with or below what has been determined by empirical studies. Alternatively, CMS could consider multiple efficiency adjustments of varying rates that apply to different types of services.

AAPA also notes that CMS's policy within the proposed rule is to be implemented without an assumption of a ceiling of gained efficiencies. We do not believe that services experience unlimited potential for efficiency gains. As such, CMS should determine a maximum number of efficiency adjustments that a service can receive, which may vary by type of service. AAPA would then be supportive of subsequent applications of an efficiency adjustment (beyond the initial capped amount) to targeted services if there have been

demonstrated advances that meaningfully affect the efficiency with which a service is provided (for example, a new technology or technique that aids in the provision of a service).

AAPA accepts the initial lookback period, finding it to be reasonable considering it aligns with the sum of future expected adjustments of three years with the two-year calculated delay from valuations being determined by the RUC to actual CMS implementation. Meanwhile, AAPA notes that the impacts of artificial intelligence are only beginning to be realized and will require significant study before assessments of impact on efficiency can be fully realized and quantified. We would expect there to be significant but potentially uneven implications from artificial intelligence use that will depend on concurrent technologies, regulations, and potential for gains in medical benefit, but the specifics of how artificial intelligence will be applied are only in their infancy, and will require further study and data before any details about how it affects efficiency, for what services, and to what magnitude can be discussed and incorporated into subsequent payment policies.

Finally, CMS also states that efficiencies gained over time may be more likely in services that take less time to perform. Using this reasoning, CMS solicits comments on whether there should be additional efficiencies considered for services that could be performed multiple times a day. AAPA cautions that before CMS considers extracting data on the frequency of provided procedures and using that to determine additional payment adjustments, that the agency seek to justify through empirical evidence the base assumption that increased efficiencies are more likely to be found in such services.

Updates to the Practice Expense Methodology

In the 2026 Physician Fee Schedule proposed rule, CMS expresses interest in addressing site of service payment differentials between facility and non-facility settings. The agency notes that, since the adoption of the practice expense methodology, the healthcare delivery landscape has undergone a significant evolution in the manner and settings in which health professionals provide care. Specifically, CMS explains that there has been a significant decline of physicians working in private practice (over a 50% decrease in the past 36 years) with a corresponding increase in physicians either employed by hospitals or hospital-owned practices.

Despite these drastic changes in the locations in which health professionals primarily provide services, the current practice expense methodology assumes equal indirect costs incurred by physicians in both the facility and non-facility setting. This is because when the practice expense methodology was established, it was assumed that most physicians who practiced in facility settings maintained a separate office-based practice. CMS now believes that the even allocation overstates the indirect costs incurred by physicians in facility-

based settings. CMS believes this arrangement may result in duplicative payments and is concerned that it provides a financial incentive for health professionals to practice in higher-cost settings like hospitals, negatively affecting payers and beneficiaries as a result. In the proposed rule, CMS quotes both RAND and MedPAC to demonstrate support for this position and the action to be taken.

In the 2026 Physician Fee Schedule proposed rule, CMS is proposing to reduce the portion of the facility practice expense RVUs allocated based on work RVUs to half the amount allocated to non-facility practice expense RVUs. AAPA understands CMS's position and its justification for reducing payments for indirect costs for services provided in facility-based settings. However, we question the method by which the agency arrived at the 50% reduction in the work RVUs to calculate the indirect practice expense RVUs. We appreciate that CMS has indicated flexibility and openness to modifying the extent of the reduction. We encourage CMS to base the actual reduction on a mixture of feedback received from comments to the proposed rule and available empirical evidence that the agency prioritizes in other code valuation provisions of the proposed rule. As the impact on facility-employed professionals could be significant, we urge CMS not to rush to finalize the cut at its current rate if it is not confident in the level of reduction after receipt and review of public comments and empirical evidence analysis.

Further, like our comments regarding the efficiency adjustment, AAPA is concerned with the broad applicability of the practice expense methodology change without consideration of individual circumstances. We note that there are some health professionals who provide care in facilities who are still responsible for overhead costs either separately or made to pay to some extent by the facility. As such, AAPA believes there should be an exemption process in place regarding the reduction of payments accounting for assumed lower indirect costs that considers the circumstances of individual health professionals.

AAPA Positions and Recommendations on this Topic

- **AAPA acknowledges some of CMS's concerns regarding the RUC process and finds great value in CMS's intended increased focus on empirical evidence and timely adjustments. AAPA notes that there are gaps in what existing empirical data can tell us regarding resource use for many services and thus encourages ongoing participation from the RUC, whose integrity as a body we find creditable.**
- **AAPA is concerned about a blanket adjustment that treats all non-time-based services equally and we recommend that CMS consider broad input on the efficiencies attained in various types of services, prior to having to remedy a significant number of codes through the "potentially misvalued codes" process.**

- AAPA recommends that CMS should consider exempting those services that have either been determined to not have benefited significantly from increased efficiencies, or whose physician fee schedule intraservice times have been identified as either in line with or below what has been determined by empirical studies, or, alternatively, consider multiple efficiency adjustments of differing rates that apply to different types of services.
- AAPA recommends that CMS determine a maximum number of efficiency adjustments per service, which may vary by type of service. CMS could then subsequently apply efficiency adjustments (beyond the initial capped amount) to targeted services if there have been demonstrated advances that meaningfully affect the efficiency with which a service is provided.
- AAPA accepts the initial lookback period when determining the efficiency adjustment, finding it to be reasonable.
- AAPA notes that the impacts of Artificial Intelligence are only beginning to be felt and will require significant study before assessments of impact on efficiency can be fully realized, quantified, and incorporated into payment-related policies like the efficiency adjustment.
- AAPA cautions that before CMS considers extracting data on the frequency of provided procedures and using that to determine additional payment adjustments, it justify through empirical evidence the base assumption that increased efficiencies are more likely to be found in services that take less time to perform and can be performed multiple times a day.
- While AAPA understands CMS's position and its justification for reducing payments for indirect costs for services provided in facility-based settings, we question the method by which the agency arrived at the 50% reduction in the work RVUs to calculate the indirect practice expense RVUs. We encourage CMS to base the reduction on a mixture of feedback received from the proposed rule and available empirical evidence that the agency prioritizes in other code valuation provisions of the proposed rule.
- AAPA believes there should be an exemption process in place regarding the reduction of payments accounting for assumed lower indirect costs that considers the circumstances of individual health professionals working the facility setting.

Efficiencies in the Medicare Program

CMS's focus on identifying and accounting for gained efficiencies when computing code values is only one example of the agency's commitment to promoting and quantifying efficiency under the program. Elsewhere in the rule, efficiency is used as a justification for FQHC and RHC changes regarding the definition of care coordination services, supervision changes, increasing access to remote technologies and telehealth,

establishing payment models and methodologies under the Medicare Shared Savings Program, and more. AAPA appreciates CMS's broad focus on increasing efficiency under the Medicare program and shares the agency's desire to implement policies that increase efficiency for the betterment of patient care. As such, AAPA would like to suggest additional policies that CMS may seek to modify to improve practice efficiency.

First, there are several examples of services for which Medicare continues to have physician-centric language. Second, there are several policies that inefficiently require a physician's on-site presence or co-signature. The use of such language and requirements for services PAs are trained and qualified to provide may cause inefficiency, administrative burdens, and increase healthcare costs. In some circumstances, a patient may be required to see a physician when a more readily available health professional who has been providing care to the patient is available. In other circumstances, to meet the requirement for a physician to provide a service, care provided to a patient may have to be delayed, potentially to the detriment of the patient's health. A patient may also be required to travel further to see a physician if one is not available nearby or the patient may be required to wait an unreasonable amount of time until a physician is available. PAs have been demonstrated to improve access to care while providing high levels of quality and patient satisfaction similar to physicians.¹⁸ The PA profession is one of the fastest growing occupations per the Bureau of Labor Statistics, with a projected 28% increase in PAs from 2023 to 2033.¹⁹ This growth projection, along with PAs' qualifications, suggests an increased utilization of PAs will be an effective way to enhance care delivery and efficiency.

Examples of Inefficient Regulatory Restrictions on PAs Providing Services They Are Qualified to Provide

- Select Hospice Services: Current regulatory language prohibits PAs who work for a hospice from ordering medications for patients (42 CFR § 418.106(b)(1)(iii)). This restriction prevents PAs from providing needed treatments to hospice patients, which may result in delays to care, and in turn may increase costs and be detrimental to patient quality of life. PAs not employed by a hospice, who are acting in the role of a patient's attending physician, are authorized to order medications on a patient's behalf.

In addition, Medicare policy contained within the Medicare Benefits Policy Manual states that if a beneficiary does not have a physician, nurse practitioner, or PA who provided primary care to them

¹⁸ Medicare Payment Advisory Commission. 2019. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. <https://www.medpac.gov/document-type/report/>

¹⁹ US Bureau of Labor Statistics, US Department of Labor. Occupational Outlook Handbook. Physician Assistants. 2024. <https://www.bls.gov/ooh/healthcare/physician-assistants.htm>.

prior to, or at the time of, terminal illness, the beneficiary is given the choice of having either a physician or nurse practitioner who works for the hospice as an attending physician (Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3.3). This policy unnecessarily limits the number of PAs that can fill the important role of an attending physician under specific circumstances, contrary to Section 1861(dd)(3)(B) of the SSA that authorizes PAs to serve as “attending physicians” for hospice.

The Medicare hospice population should not have to experience additional, unnecessary inconveniences to care delivery that may cost time, money, exacerbate medical conditions, and impose additional burdens on select providers. CMS should augment the efficiency of care provided to hospice beneficiaries by removing arbitrary restrictions on PAs who work in hospice settings. As such, AAPA recommends that CMS rescind §418.106(b)(1)(iii)(A) and (B) and revise the language in §418.106(b)(1)(iii) to remove any notion of qualifiers to authorize PAs employed by a hospice to order medications for hospice patients. Further, AAPA recommends that CMS revise Section 40.1.3.3 of Chapter 9 of the Medicare Benefit Policy Manual to authorize PAs employed by a hospice to serve in the role of a patient’s attending physician if an attending physician was not previously selected by the patient.

Underutilization of hospice can lead to prolonged patient usage of expensive and ineffective care. The causes of postponement in electing hospice care are numerous and may include the difficulty of a provider concluding a patient’s prognosis is terminal and the difficulty with patients confronting and accepting mortality. With so many factors delaying the use of hospice care, as well as creating access delays for those undergoing hospice care, unnecessary policy barriers create additional challenges. AAPA believes the removal of regulatory barriers and greater utilization of PAs has the potential to promote a more efficient delivery of appropriate care.

- Select Skilled Nursing Facility Services: Currently, Medicare does not recognize PAs as authorized to perform the initial comprehensive visit to skilled nursing facility (SNF) patients and requires PAs to alternate every other subsequent required visit with physicians. Such restrictions are not based on medical evidence but on outdated policies that need to be modernized to reflect current medical practice and bring greater efficiency to the system. AAPA recommends that CMS revise restrictive regulations to authorize PAs to perform the initial comprehensive visit and all required visits in SNFs. Specifically, §483.30, §483.30(b) and §483.30(b)(1), §483.30(c) and §483.30(c)(1) and (2) should be revised to be inclusive of PAs. §483.30(c)(3) and (4) and §483.30(e)(1), (e)(1)(i), (e)(1)(ii), and(e)(1)(iii) should be rescinded. Additionally, §483.30(e)(2) and §483.30(e)(3) should be revised to be inclusive of PAs and §483.30(e)(4) should be rescinded.

During the COVID-19 public health emergency, CMS authorized the delegation of “physician-only” visits in SNFs to PAs if there was no conflict with state law or facility policy. This authorization allowed additional qualified health professionals to provide care they are competent to provide and was based on years of experience that demonstrated that PAs offer high-quality care in SNFs. In a recent report by CMS,²⁰ the agency acknowledged the benefit of this waiver, indicating that it helped address workforce shortages, increased the provision of care, and protected the health and safety of residents by maximizing the use of available personnel. The report stated, “Practices that authorized physician delegation of tasks to other clinicians saw higher quality of care for older populations and better interdisciplinary team management.” However, this authorization for PAs to support expansion of access to care in SNFs has since expired.

PAs remain educated, clinically prepared, and competent to deliver the full range of clinical care needed in SNFs. Unnecessary regulatory requirements in SNFs necessitate physician involvement that may not be readily available in rural settings or in a timely fashion in high-demand settings. Allowing PAs to provide these services will ensure the option for SNFs and their health professionals to determine which care delivery processes would most efficiently meet patient needs and ensure that a patient will not have to wait to see a physician when a PA is available.

- Select Inpatient Rehabilitation Facility Services: Currently, federal regulations regarding inpatient rehabilitation facilities (IRFs) are overly physician-centric, preventing other qualified health professionals, such as PAs, from meeting patient demand. Sections §412.622(a)(3)(iv) and §412.29(e) identify the need to conduct face-to-face visits with an IRF patient three days a week to assess medical status and functionality and to modify the course of treatment as necessary. However, language contained in this section of the CFR also requires that for the first week, a physician must do all three visits, and in each subsequent week, a non-physician health professional, such as a PA, may only do one of the three visits per week. A different section, §412.622(a)(4)(ii), requires a rehabilitation physician to develop a plan of care for a patient within four days of admission. §412.29(h) indicates that a physician must establish, review, and revise a plan of treatment in an IRF. §412.29(d) requires that a patient’s preadmission screening be reviewed and approved by a physician. Requiring a physician to perform these duties is inefficient and may impact patient treatment if a patient must wait to see a physician for care that another health professional is qualified to provide.

To address concerns of regulatory burdens in IRFs and ensure an adequate healthcare workforce in these settings, CMS had previously expressed interest in amending requirements under

²⁰ <https://www.cms.gov/files/document/covid-19-phe-report-congress.pdf>

§412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs to fulfill many of the medical responsibilities previously assigned only to rehabilitation physicians. AAPA supported CMS's proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place. Unfortunately, CMS did not choose to finalize the flexibilities as initially proposed, maintaining many of the physician-centric requirements.

AAPA requests that CMS revisit removing these inefficient barriers to care. CMS should revise sections §412.622(a)(3)(iv), §412.29(e), §412.29(h), §412.622(a)(4)(ii), §412.29(d) to authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, when those services are within the PA's scope of practice under applicable state law. PAs have the appropriate training to ensure that IRF patients will continue to receive high-quality care when PAs provide services. CMS shows its agreement by authorizing PAs to provide one of the three weekly required visits. Restricting PAs to only one weekly encounter when the needs of an IRF may require more is an arbitrary restriction that may prevent patient access to high-value, underutilized rehabilitation services.

Granting an expanded authorization in this setting would not impose a requirement on IRFs, but rather give rehabilitation facilities maximum flexibility by allowing them to utilize appropriately qualified PAs in the same manner as rehabilitation physicians to ensure a robust rehabilitation workforce that provides patients with timely access to care. Each IRF would continue to be able to determine which health professionals have the necessary education, training, and experience to meet the care needs of their patients. Decisions regarding which qualified health professional provides care to a patient should be made according to IRF staffing needs and not limited by arbitrary restrictions on available care options.

Examples of Inefficient Regulatory Requirements for Physician Involvement

- Physician Requirements in Critical Access Hospitals: 42 CFR § 485.631(b) requires physician co-signature of medical records for patients not cared for by a physician in Critical Access Hospitals (CAHs) and a periodic physician presence at CAHs. At nearly all other sites of service under Medicare, PAs are authorized to provide inpatient care without a physician's presence. Meanwhile, the requirement for physician co-signature of medical records for services PAs are qualified to provide compromises facility efficiency by placing an unnecessary administrative burden on physicians. To meet these requirements, physicians must take time from patient care to perform an administrative requirement that does not improve quality of care. For these reasons, §485.631(b)(1)(iv) and (v)

should be rescinded to remove the requirement of physician co-signature for medical records of patients cared for by PAs and other non-physician practitioners in CAHs and §485.631(b)(2) should be revised to remove the requirement that a physician be present at a CAH for “sufficient periods of time.”

- Physician Requirements in Rural Emergency Hospitals: 42 CFR §485.528(c) requires physician co-signature of medical records for patients cared for by PAs if required by state law in rural emergency hospitals (REHs) and periodic physician presence at REHs. At nearly all other sites of service under Medicare, PAs are authorized to provide inpatient care without the need for a physician to be present. Meanwhile, a hypothetical requirement for physician co-signature of medical records that is generally not required by state law is confusing and could create administrative burdens if misinterpreted. As such, §485.528(c)(1)(iv) should be rescinded to remove the requirement of a physician co-signature of records in REHs, and §485.528(c)(2) should be revised to remove the requirement that a physician be present at an REH for “sufficient periods of time.”

AAPA Positions and Recommendations on this Topic

- **AAPA appreciates CMS’s focus on increasing efficiency and as such suggests additional policies that CMS may seek to modify in the name of improved practice efficiency. These include that:**
 - **CMS should rescind §418.106(b)(1)(iii)(A) and (B) and revise the language in §418.106(b)(1)(iii) to remove any notion of qualifiers to authorize PAs employed by a hospice to order medications for hospice patients**
 - **CMS should revise Section 40.1.3.3 of Chapter 9 of the Medicare Benefit Policy Manual to authorize PAs employed by a hospice to serve in the role of a patient’s attending physician if an attending physician was not previously selected by the patient**
 - **CMS should revise restrictive regulations to authorize PAs to perform the initial comprehensive visit and all required visits in SNFs. Specifically, §483.30, §483.30(b) and §483.30(b)(1), §483.30(c) and §483.30(c)(1) and (2) should be revised to be inclusive of PAs. §483.30(c)(3) and (4) and §483.30(e)(1), (e)(1)(i), (e)(1)(ii), and(e)(1)(iii) should be rescinded. Additionally, §483.30(e)(2) and §483.30(e)(3) should be revised to be inclusive of PAs and §483.30(e)(4) should be rescinded.**
 - **CMS should revise sections §412.622(a)(3)(iv), §412.29(e), §412.29(h), §412.622(a)(4)(ii), §412.29(d) to authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician in IRFs, when those services are within the PA’s scope of practice under applicable state law**

- **CMS should rescind §485.631(b)(1)(iv) and (v) to remove the requirement of physician co-signature for medical records of patients cared for by PAs and other non-physician practitioners in CAHs**
- **CMS should revise §485.631(b)(2) to remove the requirement that a physician be present at a CAH for “sufficient periods of time”**
- **CMS should rescind §485.528(c)(1)(iv) to remove the requirement of a physician co-signature of medical records of patients cared for by PAs and other non-physician practitioners in REHs**
- **CMS should revise §485.528(c)(2) to remove the requirement that a physician be present at an REH for “sufficient periods of time”**

Payment Accuracy for Global Surgical Packages

CMS pays for surgical services under “global surgical packages” which provide one payment for the surgery, pre-, and post-operative care. There are three types of global surgical packages that are defined by their expected post-operative care coverage periods: 0-day, 10-day, and 90-day periods. When billed, payment for the global surgical package is made to the primary surgeon’s practice, with anyone outside the practice who provided post-operative care able to bill for those services separately.

For over a decade, CMS has expressed concern regarding the accuracy of the valuations of global surgical packages, and whether payments are consistent with the type and number of post-operative services being provided. Office of Inspector General reports and CMS internal analyses have suggested to the agency that practitioners are providing fewer post-operative services than Medicare had assumed when previously valuing payment for global surgical packages. This was relevant information for the 10- and 90-day global packages, which comprise 4,200 of the 5,500 global surgical packages for which CMS reimburses.

CMS’s initial policy to address the perceived overvaluation of global surgical packages, finalized through the 2015 Physician Fee Schedule, was to change all 10- and 90-day global surgical packages to 0-day global surgical packages so that postoperative services would be billed separately. While AAPA applauded the intended increase in transparency and accuracy of payments, we were concerned with the potential unintended effects of the policy, such as post-operative visits that were formerly provided without separate fees for the beneficiary, because they were under the global bundle, would now be subject to deductibles and/or co-payments for each visit. These new payments would have been a financial burden to beneficiaries and may have caused some not to seek needed follow-up care following surgery.

However, Congress prevented this policy from being implemented through its 2015 Medicare Access and CHIP Reauthorization Act. Instead, the act required CMS to collect data on the number of post-operative visits being conducted and to use this data for future revaluations of global surgical packages. CMS began collecting data, formulating reports, and soliciting further feedback from stakeholders on post-operative services to improve the accuracy of global surgical package valuations. Working with RAND since 2017, CMS has made efforts to collect data from health professionals and practices on the number and intensity of post-operative visits being performed within the global package.

In its 2017 Physician Fee Schedule final rule, CMS reduced its proposed reporting requirements from an overly burdensome mandate that required all health professionals to submit a series of G codes to demonstrate ten-minute increments of post-operative global surgical E/M services to a more manageable method of data collection. Specifically, the new reporting requirements were aimed primarily at surgical practices in nine states that had ten or more health professionals. CMS asked for information on certain high-volume surgical services and a Healthcare Common Procedure Coding System code became the method of reporting.

In the 2019 Physician Fee Schedule proposed rule, CMS explained that it had not yet received a robust data-submission response. Additional research and data collection activities by RAND, including an updated report published in 2021, reaffirmed the ongoing internal analyses of CMS, that only a portion of the post-operative services CMS expected when it valued global surgical packages were being provided.

When one health professional conducts the surgery, and a separate health professional in a different practice provides the post-operative care, CMS relies on the reporting of transfer of care modifiers to then split the valuation between the two parties. In its 2025 Physician Fee Schedule rule, CMS expanded the use of these modifiers, now requiring their use for all cases when the surgeon does not intend to provide the post-operative care.

Complimentary policy in the 2025 Physician Fee Schedule rule created a new add-on code, G0559, to identify post-operative services provided by practitioners outside the same practice as the surgeon who performed the surgery. CMS expects this add-on code to account for the increased complexity and the added resources a practitioner providing post-operative care would incur in this situation. AAPA approved of this add-on code. Still in its first year of use, we believe this will more adequately reimburse health professionals who were not involved in the surgical aspect of care, and thus would require greater resources to obtain and assess appropriate information to provide the level of care patients deserve. This add-on code would also support patient flexibility in allowing them to see a different health professional for their follow-up care than the

practice that provided the original surgery. For example, if the patient had to travel a long distance for the original surgery, it would potentially be more convenient to seek subsequent care closer to the patient's residence.

In its 2026 Physician Fee Schedule proposed rule, CMS is again soliciting additional strategies to improve payment accuracy for global surgical packages. The agency also specifically identified three alternatives to how shares of the payment are determined for the procedure versus the post-operative care when the transfer of care modifier 54 is reported. Of the three, CMS appears to favor a method that calculates a procedure's work RVUs by subtracting the work RVUs for postoperative visits provided as part of global surgical packages. This is done by multiplying "the number of post-operative visits typically provided for the global procedure HCPCS code (defined as the median count of post-operative visits reported to CMS using no-pay code 99024 among procedures without overlapping global periods with other global surgical services) by the average valuation per post-operative visit calculated for the mix (that is, number and level) of post-operative visits for the global procedure HCPCS code as listed in the Physician Time File."

While AAPA cannot speak to which alternative method of determining payment shares is preferable, we assure CMS that AAPA understands and appreciates the goals of determining both the appropriate value of services, as well as the levels of reimbursement for the respective procedure and post-operative components of surgical services. While AAPA appreciates that CMS arrived at the need for revaluations after appropriately collecting evidence internally and externally on the matter, we urge continued caution regarding conclusions that may result from analyzing data collected. CMS has in the past questioned the completeness of the data it has collected and now proposes to use it for potential revaluations. Further, CMS has, by its own admission, received little in the form of feedback thus far regarding appropriate levels of revaluation via the comment process. To remedy these shortcomings, AAPA recommends a two-part strategy. First, we believe CMS may benefit from further data collection regarding transfers of care now that the modifier is required to report on all anticipated transfers. Second, we recommend an in-person discussion with affected stakeholders (e.g., PAs and other health professionals, patient groups, medical societies and associations, and payers). We encourage CMS to rely most heavily on its collected data but to still convene relevant stakeholders to determine whether any unforeseen context is relevant to setting portion rates.

Meanwhile, as CMS has made clear that the actions taken last year to expand the use of the transfers of care modifiers were only its first step in moving toward greater transparency on this issue, we continue to remind CMS that any future modifications to the current global surgical payment for 90-day global procedures should not be done in a way that inadvertently penalizes health professionals who serve as surgical assistants. Payment for surgical assistant services is calculated as a percentage of the global surgical fee in its entirety. When the post-operative payment is reimbursed separately from the procedure, payment should not be

lowered for surgical assisting services, as the professional work and intensity of the surgical assistant services have not changed.

Finally, AAPA requests that patients not be penalized in the pursuit of increased transparency. We request CMS provide explicit confirmation that, by keeping the existing structure in place, patients will not be charged extra for post-operative care even when such care has been transferred to another health professional.

AAPA Positions and Recommendations on this Topic

- **AAPA supports efforts for increased transparency regarding global surgical package valuations. However, we note that any resulting data, while improved, will still be incomplete.**
- **While imperfect, AAPA encourages CMS to rely most heavily on its recently collected data when determining portion payment percentages for the procedure versus post-operative care, but to still convene relevant stakeholders to determine whether there are remaining limitations in the data collected relevant to setting portion rates.**
- **AAPA recommends that, consistent with the current policy regarding surgical assistant payment being a percentage of the total global package, when the modifiers are used and the global surgical package portion payment is adjusted, payment to the surgical assistant not be reduced as well.**
- **AAPA requests confirmation that, by keeping the existing structure in place, patients will not be charged extra for post-operative care even when such care has been transferred to another health professional.**

Continued Expansion of Access to Behavioral/Mental Health Services

The 2026 Physician Fee Schedule contains multiple provisions seeking to improve behavioral health under Medicare. These provisions include policies that continue CMS's ongoing efforts to increase beneficiary access to behavioral health services. AAPA has long found CMS's goals of increased access to behavioral health services a worthy goal that could benefit from ongoing creative policies that seek to expand coverage, methods of access, and types of treatments available.

Medicare beneficiaries face various obstacles to accessing behavioral health services. Mental and behavioral health, much like healthcare generally, is experiencing worsening provider shortages, compounding already existing access issues. As many as 65% of nonmetropolitan counties have no practicing psychiatrists and limited numbers of psychologists or social workers, significantly limiting access to needed behavioral health

treatment and contributing to inadequate care and unsafe conditions.²¹ Demand for mental health services is increasing, causing patient access to decrease.²² Untreated mental and behavioral health conditions can result in disability, isolation, substance abuse, family discord, and death.²³

122 million people live in communities with limited access to mental healthcare services.²⁴ The National Council for Mental Wellbeing cites a US Department of Health Study to suggest that in 2025, there will be a 12-25% deficit in the psychiatric workforce to sufficiently address patient needs.²⁵ The National Center for Health Workforce Analysis indicates that by 2030, 44 states are projected to have fewer psychiatrists than needed to meet the demand for services.²⁶ An inadequate supply of providers of behavioral/mental health services may lead to delays in diagnosis and care, rationing of resources, ineffective care, and increased negative consequences of mental illness and substance use.²⁷ These problems will be further magnified in rural and underserved areas.

The Role of PAs in Expanding Access to Behavioral Health Services

To meet these challenges, all qualified health professionals must be authorized to practice to the full extent of their education, training, experience, and license. As qualified providers of behavioral and mental health services, PAs can play an important role in increasing beneficiary access to needed care.

²¹ Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. *J Clin Transl Sci.* 2020;4(5):463-467. May 4 2020. doi:10.1017/cts.2020.42

<https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/#r6>

²² American Psychological Association. Increased need for mental health care strains capacity.

<https://www.apa.org/news/press/releases/2022/11/mental-health-care-strains>. Nov, 2022.

²³ Mayo Clinic. Mental Illness. <https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc20374968>. Dec 13, 2022.

²⁴ Health Resources and Services Administration, Department of Health and Human Services. Health Workforce Shortage Areas. January 9, 2025. <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

²⁵ National Council for Mental Wellbeing. The psychiatric shortage: Causes and solutions.

<https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/>. March 2018.

²⁶ National Center for Health Workforce Analysis, Bureau of Health Workforce, Health Resources and Services Administration, Department of Health and Human Services. State-Level projections of supply and demand for behavioral health occupations: 2016-2030. September 2018. <https://bhw.hrsa.gov/sites/default/files/bureau-healthworkforce/data-research/state-level-estimates-report-2018.pdf>

²⁷ National Council for Mental Wellbeing. The psychiatric shortage: Causes and solutions.

<https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/>. March 2018.

PAs are trained and qualified to treat behavioral and mental health conditions through their medical education,²⁸ including didactic instruction and clinical practice experience in psychiatry, behavioral and mental health conditions, substance use disorders, and other relevant disciplines, and have national certification, state licensure, and authority to prescribe controlled and noncontrolled medications. Based on their graduate-level medical education, PAs graduate with more than 2,000 hours in clinical rotations, including experience in behavioral and mental health, emergency medicine, primary care, internal medicine, and other specialties across the lifespan, from pediatrics to geriatrics.²⁹ This provides a foundation for addressing the diverse medical needs of people with mental illness or substance use issues. PAs working in behavioral and mental health provide high-quality, evidence-based care and improve access to needed behavioral and mental health services.

PAs perform psychiatric evaluations, assessments, and pharmaceutical management services; order, perform, and interpret diagnostic psychological and neuropsychological tests; establish and manage treatment plans; and collaborate with psychiatrists and other healthcare professionals. PAs work in mental health facilities and psychiatric units, often in rural and public hospitals where there are inadequate numbers of psychiatrists.³⁰ In outpatient practices, PAs conduct initial assessments, perform maintenance evaluations and medication management, and provide other services for individuals with behavioral/mental health needs. Additional PA practice areas include assertive community treatment teams, psychiatric emergency departments, pediatric and geriatric psychiatry, addiction medicine, and care for individuals with mental disorders.

The number of PAs practicing in psychiatry has remained low due to restrictions placed on PAs by some payers. However, the recognition of PAs as qualified providers of mental and behavioral health services can increasingly be seen in federal and state laws and regulations identifying PAs as providers under opioid treatment programs, the inclusion of PAs as high-need providers under the 21st Century Cures Act,³¹ CMS's inclusion of PAs as authorized providers in community mental health centers,³² and the establishment of PAs as mental and behavioral health providers at the state level.

²⁸ ARC-PA. Accreditation Standards for PA Education. Fifth Edition. <https://www.arc-pa.org/wpcontent/uploads/2024/07/Standards-5th-Ed-July-2024.pdf>. 2024

²⁹ American Academy of Physician Associates. What is a PA? <https://www.aapa.org/what-is-a-pa/>. Accessed January 13, 2024.

³⁰ Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. *Am J Prev Med*. 2018. <https://pubmed.ncbi.nlm.nih.gov/29779543/>

³¹ 21st Century Cures Act. Public Law No: 114-255 2016. <https://www.congress.gov/bill/114th-congress/house-bill/34>

³² Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. <https://www.law.cornell.edu/cfr/text/42/485.904>

PAs work to ensure the best possible care and outcomes for patients in every specialty and setting, interacting with patients with mental and behavioral conditions in psychiatry, family medicine, internal medicine, emergency medicine, and other specialties. Payers authorizing PAs to deliver high-quality behavioral and mental healthcare to patients, as is largely allowed under Traditional Medicare, can alleviate ongoing and worsening trends in access to behavioral and mental health services.

Deficiencies in Coverage of PA-Provided Behavioral Health Services under Traditional Medicare

As noted, coverage of behavioral health services provided by PAs under Traditional Medicare is fairly permissive. However, notable arbitrary exceptions continue to exist that limit the ability of PAs to provide needed behavioral health services to Medicare patients.

First, PAs are limited in their ability to help patients receive needed inpatient psychiatric care. Specifically, 42 CFR §424.14 contains policies that require physician certification/recertification of need for inpatient psychiatric services. These restrictions present a significant barrier to timely access and coordination of care, especially in rural and underserved areas where psychiatrists are in short supply. PAs are trained and authorized to diagnose and manage behavioral and mental health conditions, including determining medical necessity for psychiatric hospitalization. They perform psychiatric evaluations, manage medications, and develop treatment plans in collaboration with psychiatrists and other clinicians. The inability to certify care they are already delivering undermines both patient access and the efficiency of psychiatric facilities. AAPA recommends that CMS revise section §424.14(a) and (b) to include PAs.

Second, some restrictions remain on PAs helping formulate treatment plans and providing certain services that are occasionally used in behavioral health treatment and management. Specifically, Local Coverage Determination (LCD) L34353 regarding Outpatient Psychiatry and Psychology Services indicates that only physicians may prescribe and establish an individualized treatment plan for outpatient psychiatry and psychology services and bill for electroconvulsive therapy. Removing these limitations would improve access to behavioral and mental health services and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain services and treatment plans that their PA could otherwise provide. AAPA recommends that CMS revise the LCD to authorize PAs to prescribe and establish individualized treatment plans for outpatient psychiatry and psychology services and bill for electroconvulsive therapy.

Third, there remain restrictions on non-physician health professionals providing certain services in Community Mental Health Centers. Specifically, 42 CFR §485.914(e)(3)(iii) and §485.916(a)(3) use physician-centric language regarding Community Mental Health Centers, including a requirement for the inclusion of only physician orders on a discharge summary and the lack of explicit inclusion of PAs on the interdisciplinary treatment team. Physician-centric language regarding “physician orders” on a discharge summary may be strictly interpreted in a manner that would result in only a subset of orders related to a patient’s care (i.e., those issued by a physician) being included in the summary, and omit orders made by non-physician health professionals. This may then provide patients with incomplete information regarding the care they received. Meanwhile, the omission of PAs by name in the list of those who may participate on an interdisciplinary team starkly conflicts with §485.916(a)(1), which authorizes PAs to lead such teams. AAPA recommends that CMS revise §485.914(e)(3)(iii) and §485.916(a)(3) to be inclusive of PAs.

Deficiencies in Coverage of PA-Provided Behavioral Health Services Among Other Payers

While Traditional Medicare, many state Medicaid programs, and some commercial payers cover most behavioral and mental health services provided by PAs, some private payers, many of which interact with Medicare and its beneficiaries, do not. Private payers should authorize payment for all behavioral and mental health services provided by PAs that are performed in compliance with state law.

Private payers removing policies that may act as barriers to behavioral and mental healthcare will allow for greater utilization of the PAs that currently practice in behavioral and mental health, as well as encourage a greater number of PAs to practice in psychiatry and related specialties. The increased demand for behavioral and mental health services requires the contribution of all qualified health professionals without restrictions constraining access to care.

AAPA requests that CMS require all payers who provide a plan under the purview of the agency, such as Medicare Advantage Plans, Medicaid fee-for-service and managed care plans, CHIP fee-for-service and managed care plans, and plans offered on the Federally Facilitated Exchange, to eliminate prohibitive policies and authorize PAs to provide behavioral and mental health services. This would align the behavioral and mental health policies under these plans with Traditional Medicare and ensure beneficiaries covered by such plans have additional qualified care options.

Behavioral Health Integration and Advanced Primary Care Management (APCM)

In the 2017 Physician Fee Schedule final rule, CMS finalized payment to practitioners who provide Behavioral Health Integration (BHI) services to patients, where BHI is a term that refers broadly to collaborative care that integrates primary care and behavioral health services, focusing on those patients who require both medical and mental health treatments. In this same rule, CMS began making separate BHI payments to patients using the Psychiatric Collaborative Care Model (CoCM), a model that utilizes a team including a primary care provider, health care manager, and psychiatric consultant.

CMS recognizes that patients with chronic health conditions are more likely to have related behavioral health concerns. Consequently, the agency notes that the integration of behavioral health into primary care can improve both outcomes and the care experience. In response to comments received as part of the 2025 Physician Fee Schedule, CMS acknowledged that BHI services are complementary to APCM services.

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to create three new optional add-on G codes (HCPCS codes GPCM1, GPCM2, GPCM3) for APCM services that would facilitate providing BHI services. GPCM1 and GPCM2 are added to the APCM base code in instances of initial and subsequent encounters for CoCM services delivered to patients also receiving APCM services, while GPCM3 is an add-on code for general BHI services for patients receiving APCM services. The option to include these add-on codes removes the time-based requirements that exist for BHI and CoCM codes outside of the APCM add-on opportunity. AAPA approves of this increased flexibility. We concur with CMS that a reduction in the documentation burden from removing time-based requirements for BHI and CoCM will make it more likely that practitioners providing APCM will furnish these services. We recommend finalization of this policy as the decreased burden to provide these additional services stands to increase access to behavioral health care options for the APCM population.

Behavioral Health Codes Added to the Medicare Telehealth Services List

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to add multiple behavioral health services to the Medicare telehealth services list. These additions include multiple-family group psychotherapy and group behavioral health counseling for obesity. As discussed further in the telehealth section of our comments to this rule, AAPA appreciates CMS's commitment to authorizing services to be provided by telehealth based on a basic assessment of whether a service in question can be furnished using an interactive telecommunications system. AAPA believes that services that rely primarily on discussion between patients and health professionals, such as counseling, medication management, and various forms of therapy, meet

the necessary safety and logistical standards and serve to expand access to these needed services. This is particularly beneficial in allowing participants to join from separate locations for services that require the presence of multiple individuals such as group therapy and counseling services. AAPA encourages CMS to more broadly review its list of covered services, particularly regarding behavioral health and group services, to determine what other services may be offered by telehealth without sacrificing quality or safety standards.

Behavioral Health Visits and Community Health Integration Services

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

CMS has examined initial data regarding community health integration and discovered that these services are being used to address, among other things, social determinants of health needs that significantly limit the ability to diagnose or treat mental illness. As such, in the 2026 Physician Fee Schedule proposed rule, CMS proposes to now allow certain behavioral health visits (CPT code 90791 (Psychiatric diagnostic evaluation) or the Health Behavior Assessment and Intervention (HBAI) services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 (and any subsequent HBAI codes)) to serve as initiating visits for community health integration services.

AAPA supports this proposal. As noted elsewhere in the proposed rule, behavioral health conditions are some of the most prevalent chronic diseases in the country, suggesting that these conditions, which CMS has and continues to demonstrate priority in addressing, may have a large impact on the success of diagnosing and treating non-behavioral medical conditions. As intertwined as health for the mind and body are, it is evident that behavioral health would be a frequent social determinant of health identified in screening processes that require attention through community health integration services for the betterment of the patient.

Digital Mental Health Treatment

In the 2025 Physician Fee Schedule final rule, CMS established payment for Digital Mental Health Treatment (DMHT) devices. CMS's G-code (G0552) makes payment for practitioners supplying FDA-cleared digital mental health treatment devices and the initial education and onboarding. These devices would augment an established behavioral therapy plan. CMS then finalized G-codes G0553 and G0554 to capture monthly treatment management services directly related to a patient's therapeutic use of DMHT devices, as well as time spent reviewing data generated from the DMHT devices, and at least one interactive communication between the patient and caregiver in the month.

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

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to expand policies surrounding these G codes to also make payment for DMHT devices classified at § 882.5803, Digital therapy device for Attention Deficit Hyperactivity Disorder (ADHD), which seek to provide therapy as an adjunct to clinician supervised treatment. AAPA supports this expansion of CMS's DMHT coding and payment policies. The agency acknowledges that DMHT technologies are evolving quickly, and as such, we believe that CMS must be similarly nimble, and with proper evidence be able to update the types of technologies covered in this space.

The rule also identifies additional devices it is considering establishing coding and payment policies regarding, including computerized behavioral therapy devices for treating symptoms of gastrointestinal conditions at § 876.5960, digital therapy devices to reduce sleep disturbance for psychiatric conditions at § 882.5705, and computerized behavioral therapy device for the treatment of fibromyalgia symptoms to be codified at § 882.5804. AAPA encourages CMS to strongly consider all such devices that meet FDA standards to get ahead of this rapidly proliferating field that may offer innovative opportunities for a broader group of patients to receive behavioral health treatments.

CMS notes that the established G-codes have thus far remained low in volume. AAPA suggests that the reasons for this may be multiple, including their novelty (effective the beginning of this year), lack of awareness of these opportunities, and a still somewhat narrow coverage of these devices. To promote wider usage of these G-Codes, AAPA recommends further educational materials developed and released to targeted (behavioral health) professionals, in addition to a constant willingness to examine and potentially broaden the

types of devices covered. CMS notes that it is considering the possibility of establishing coding and payment for a broader set of services describing digital tools that are intended to promote a healthy lifestyle as part of a mental health treatment plan of care. AAPA supports CMS establishing such policies as they would align with CMS's focus on prevention, wellness, and management of chronic disease. Coverage should be broad, including situations in which the health professional furnishes the digital tool, provides education regarding the tool, or even uses an established tool as an ongoing part of the plan of care.

Finally, in the proposed rule CMS clarifies that the patient who uses DMHT devices must have a mental health condition diagnosis, but the billing practitioner does not need to be the same health professional who made the diagnosis. AAPA appreciates this clarification as it will account for devices that were used by patients prior to a current health professional. While patients may change health professionals for any number of reasons, the devices they use may have shown to be effective and worthy of continuation in conjunction with care received from subsequent health professionals.

AAPA Positions and Recommendations on this Topic

- **CMS should address the few remaining arbitrary restrictions on PAs providing/facilitating behavioral health services under Traditional Medicare by:**
 - **Revising section §424.14(a) and (b) to include PAs as authorized to certify/recertify need for inpatient psychiatric services**
 - **Revising LCD L34353 to authorize PAs to prescribe and establish individualized treatment plans for outpatient psychiatry and psychology services and bill for electroconvulsive therapy**
 - **Revising §485.914(e)(3)(iii) and §485.916(a)(3) to include PA orders on discharge summaries and explicitly include PAs on interdisciplinary teams in Community Mental Health Centers**
- **AAPA requests that CMS require all payers who provide a plan under the purview of the agency, such as Medicare Advantage Plans, Medicaid fee-for-service and managed care plans, CHIP fee-for-service and managed care plans, and plans offered on the Federally Facilitated Exchange, to eliminate prohibitive policies and authorize PAs to provide behavioral and mental health services.**
- **AAPA approves of CMS's proposal to create three new optional add-on G codes for APCM services that would facilitate providing BHI services.**
- **AAPA approves of the adding of multiple behavioral health services to the Medicare telehealth services list and encourages CMS to more broadly review its list of covered services, particularly in regard to behavioral health and group services, to determine what other services may be offered by telehealth without sacrificing quality or safety standards.**

- **AAPA supports allowing certain behavioral health visits to serve as an initiating visit for community health integration services.**
- **AAPA supports CMS making payments for the use of DMHT devices and agrees with its proposed expansion to make payment for digital therapy devices for ADHD. Due to the low volume in which these codes have thus far been used, AAPA encourages CMS to strongly consider expansion of coverage to all such devices that meet FDA standards and recommends further educational materials developed and released to targeted (behavioral health) professionals. AAPA recommends that CMS broaden its payment of these devices to cover when a health professional furnishes the digital tool, provides education regarding the tool, or even uses an established tool as an ongoing part of the plan of care. Finally, AAPA appreciates and agrees with CMS’s clarification that the billing practitioner for DMHT does not need to be the same health professional who made the diagnosis.**

Telehealth Services

Telehealth has become an integral part of care delivery, reducing patient burden by allowing access to care providers not immediately geographically available to them. As telehealth has become engrained in provider practice protocols and work plans, it also faces an uncertain future with several potential positive expansions, as well as an abrupt curtailing of its usage if Congress does not act.

As a result of the COVID-19 pandemic, regulatory waivers and temporary, Congress-authorized flexibilities have allowed many services to be provided via telehealth with a patient’s home serving as an originating site, and no need to be in a rural area. These flexibilities were extended under section 4113 of the Consolidated Appropriations Act of 2023, temporarily removing statutory restrictions on geographic location and site of service through the end of 2024, and then again by legislation through September 2025.

However, as noted in the 2026 Physician Fee Schedule proposed rule, short of further Congressional intervention, as of October 1, 2025, Medicare beneficiaries receiving telehealth services will need to be in a rural area and in an approved medical facility for most services. The allowance for a patient to receive care in their home would be restricted to patients receiving behavioral or ESRD-related clinical assessments. Other statutorily-granted waivers have allowed providers at FQHCs and RHCs to continue to provide telehealth services, allowed certain services to be provided audio-only (as opposed to requiring a visual component), authorized telehealth to be used for the required face-to-face encounters before recertification for hospice

care, and delayed the reimplementation of requirements that a patient receiving behavioral health services via telehealth must first have an in-person visit with their provider and periodically after.

AAPA has heard, anecdotally, that, even prior to the October 1 date, the lack of certainty over the ending of these flexibilities has led to more restrictive telehealth practices, limiting beneficiary care options. We believe that broader use of telehealth greatly expands patient access to services. As such, AAPA urges CMS to work with Congress to make these waivers permanent.

Meanwhile, CMS has implemented various policies under past physician fee schedule rules, as well as proposed several policies under the 2026 Physician Fee Schedule proposed rule, that seek to expand access to telehealth services further. AAPA provides comments on several of these proposed policies below.

Changes to the Medicare Telehealth Services List

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to simplify the process of determining which services should and shouldn't be on the Medicare telehealth services list. Previous CMS policy assigned potential services under review to multiple categories such as those that were similar to already existing codes on the list, those that were not, and those that were temporarily added in response to the COVID-19 Public Health Emergency. In 2024 Physician Fee Schedule final rule, these three categories were replaced with a five-step process, to begin in calendar year 2025, for modifying which services are added or deleted from the list and earned each service an identifier of "permanent" or "provisional" (for those services that require further study). In the 2026 Physician Fee Schedule proposed rule, CMS suggests that it will again change the process, removing steps 4 and 5, which designate "permanent" or "provisional" status. Instead, CMS intends to focus more acutely on whether a service in question can be furnished using an interactive telecommunications system. The change comes in response to confusion expressed by requestors and a determination by CMS to better trust the professional judgement of providers as to when furnishing a service via telehealth is appropriate.

AAPA approves of CMS's revised methodology for determining which services are on the Medicare telehealth services list. We favor simplified processes and appreciate CMS's stated trust in the professional judgment of health professionals who are best able to assess the context and clinical appropriateness of telehealth services in each situation. We encourage CMS to finalize the simplified process and allow for all current provisional services to become permanent, while maintaining the right to review later and remove services if negative data are presented.

Frequency Limitations on Subsequent Care Services

In the past, CMS added frequency restrictions on how often health professionals may furnish certain services via telehealth, citing concerns regarding patient acuity and complexity. Such services include those provided subsequent to inpatient and nursing facility care and critical care consultations. During the COVID-19 public health emergency, CMS temporarily halted these frequency limitations. After the expiration of the public health emergency, CMS used enforcement discretion to continue to suspend many of these requirements. During that time, CMS received feedback that these limitations were arbitrary and that reinstating frequency restrictions would decrease essential access to care. AAPA was among those who expressed support for the continued removal of these restrictions and urged CMS to consider permanently removing frequency limitations on select Medicare telehealth services. We noted that, in removing these frequency limitations permanently, CMS could instead defer to a health professional's assessment of need and clinical judgment to determine whether in-person care is required.

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to permanently remove frequency limits on subsequent inpatient, subsequent nursing facility, and critical care consultation services by telehealth. AAPA approves of CMS making this policy permanent. We note that best practices, technologies, and patient and provider preferences, have evolved because of the COVID-19 public health emergency to the point that prior restrictions on care modality no longer make sense. AAPA appreciates that CMS again cites a deferral to the professional judgment of health professionals who best understand the patient's clinical context in determining the appropriate modality of follow-up care.

Telehealth in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to, temporarily, continue to facilitate payment for non-behavioral health visits furnished by telecommunication technology in RHCs and FQHCs. AAPA appreciates CMS efforts to minimize access burdens for patients who receive care through RHCs and FQHCs, as these telehealth services have become a regular method of care provision since the COVID-19 pandemic. We urge CMS to work with Congress to establish a more permanent solution to the problem of expiring telehealth flexibilities within RHCs and FQHCs.

In-person Visit Requirement Prior to Mental Health Services

In the 2026 Physician Fee Schedule proposed rule, CMS adjusts the implementation date to conform with recently statutorily imposed dates regarding the requirement for an in-person visit with a physician or non-physician practitioner within six months prior to initiating mental health telehealth services, and again at subsequent 12-month intervals for RHCs and FQHCs. However, this requirement exists more broadly beyond the RHC and FQHC settings. AAPA would like to bring to CMS' attention language that may impose barriers to this in-person requirement being met. Specifically, in section § 410.78 (b)(3)(xiv), subsection C indicates that these requirements may be "met by another physician or practitioner of the same specialty and subspecialty in the same group as the physician or practitioner who furnishes the telehealth service, if the physician or practitioner who furnishes the telehealth service described under this paragraph is not available."

Requiring the health professional who provided the in-person visit to be the same specialty and sub-specialty as the health professional who provides the telehealth services in unnecessarily limiting. Health professionals who work for the same practice, and who are deemed qualified to provide these services, should be interchangeable for these purposes, as efficient workflows often require a division of labor. Similarly, if a patient is receiving team-based care from multiple health professionals with different taxonomies (e.g., physicians and PAs), this policy could be interpreted to unnecessarily require more than one in-person visit to meet the requirement for each specialty. AAPA suggests that CMS review the origins of this requirement to determine whether it is within the agency's purview to remove the restriction, or whether it is explicitly statutory. We encourage CMS not to impose any additional requirements beyond those required by law, as it may harm access to needed behavioral health services. Meanwhile, if the origin is statutory in nature, we encourage CMS to work with Congress to remove this prohibitive policy.

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

Not addressed in the 2026 Physician Fee Schedule proposed rule is the matter of listing a health professional's home address when telehealth services are provided from the provider's home. During the COVID-19 public health emergency, CMS authorized health professionals who provided telehealth services from home to list their previously enrolled location, as opposed to stating their home address, on their enrollment. This was to protect the privacy of health professionals as the public reporting of this practice location, in this case a home address, could be accessed by patients or others.

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

Citing feedback from affected health professionals, AAPA was among those concerned parties that encouraged CMS to not let this flexibility expire. We noted this was not merely a matter of privacy but may also be a matter of public safety. Consequently, AAPA requested a permanent process that would allow health professionals to avoid using their home addresses. With the new expiration date looming, we are surprised to not see the issue addressed in the proposed rule. As this has been an issue CMS has neglected to include in proposed fee schedule rules in the past but subsequently commented on in the final rule due to public petition for such, we have decided to include a request within our comments to again extend the previously instituted flexibility and to meanwhile propose a permanent solution to the problem.

AAPA Positions and Recommendations on this Topic

- **AAPA urges CMS to work with Congress to make the statutory telehealth waivers permanent.**
- **AAPA approves of CMS's simplified methodology for determining which services are on the Medicare telehealth services list.**
- **AAPA approves of CMS permanently removing frequency limits on subsequent inpatient, subsequent nursing facility and critical care consultation services by telehealth and a deferral to the professional judgment of health professionals in determining the appropriate modality of follow-up care.**
- **AAPA approves of CMS actions to continue to facilitate payment for non-behavioral health visits furnished telecommunications technology in RHCs and FQHCs and urges CMS to work with Congress to establish a more permanent solution to the problem.**
- **AAPA suggests that CMS review § 410.78 (b)(3)(xiv), subsection C, which requires the health professional who provided the required in-person visit to be the same specialty and sub-specialty as the health professional who provides the telehealth services to determine whether it is within the agency's purview to remove the restriction personally, or whether it is explicitly statutory. We encourage CMS not to impose any additional requirements beyond those required by law, as it may harm access to needed behavioral health services. Meanwhile, if the origin is statutory in nature, we encourage CMS to work with Congress to remove this prohibitive policy.**

- **AAPA requests that CMS both extend the existing flexibility, and develop a permanent process through which distant site providers can use their practice location for enrollment when providing telehealth services from their home, as opposed to the practitioner’s home address.**

Provisions Relating to the Medicare Shared Savings Program

In the 2026 Physician Fee Schedule proposed rule, CMS again proposes various changes to the Medicare Shared Savings Program (MSSP). Many of the changes proposed this year seek to ease provider burden to participate in the MSSP Accountable Care Organizations (ACOs). AAPA addresses a few of these changes below, identified by topic.

Assigned Beneficiary Minimum Eligibility

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to modify ACO eligibility requirements to participate in the MSSP. Currently, ACOs that wish to participate in the MSSP must have at least 5,000 assigned Medicare beneficiaries in each of the three historical benchmark years. Starting in January 2027, CMS is proposing flexibility in this requirement, indicating that ACOs applying to enter a new agreement period must reach the previously required threshold of 5,000 Medicare beneficiaries by benchmark year three, but in benchmark years one and two, fewer are allowed. As conditions, ACOs that at any time during the agreement period have fewer than 5,000 assigned beneficiaries during any of the benchmark years are only authorized to participate in the BASIC track, and shared savings and shared losses are capped.

AAPA appreciates CMS’s flexibility. We believe that creating the opportunity for lower beneficiary thresholds may encourage additional ACOs to participate. ACO participation in MSSP helps CMS progress toward its goals of establishing payment systems that are based on value and outcomes, as opposed to the number of services provided. AAPA also approves of the corresponding safeguards placed on ACOs that have fewer than 5,000 beneficiaries to protect against greater variation in expenditures caused by the reduction in the benchmark years.

Web-based Survey Mode for CAHPS Surveys

To meet quality reporting requirements, ACOs participating in the MSSP are required to administer the CAHPS for MIPS Survey annually. Currently, this survey is administered and data collected by mail and phone. Following a successful field test in 2023, in the 2026 Physician Fee Schedule proposed rule, CMS proposes to allow CAHPS Surveys to be administered by a web-based option, in addition to mail and phone, starting in 2027. AAPA appreciates additional methods provided to ACOs to meet imposed requirements and supports this change. Significant portions of the population are computer literate and able to participate in a web-based survey mode. We suggest that many may find it easier to do so than through the traditional mail-phone administration protocol, improving response rates as was seen in the field test.

Expansion of the Extreme and Uncontrollable Circumstances Exception

Currently, MSSP quality reporting and financial performance requirements Extreme and Uncontrollable Circumstances (EUC) exceptions align with the EUC policies found under the Merit-Based Incentive Payment System (MIPS), allowing for flexibility in payments and reporting as a result of public health emergencies and natural disasters. In the 2026 Physician Fee Schedule proposed rule, CMS is proposing that, starting with reporting year 2025, ACOs can also submit a MIPS EUC Exception Application to the Quality Payment Program due to a cyberattack, including ransomware/malware.

AAPA approves of the addition of cyberattacks to those conditions that may allow for EUC exceptions. Today's hackers are increasingly savvy in their methods and severe in their impacts. In a world that has come to rely extensively on electronic systems, the prevalence of such attacks is not likely to diminish. AAPA appreciates CMS's recognition of the rapidly evolving technological environment that has reached nearly every corner of the healthcare industry and the implementation of such a policy that recognizes the manner and extent cyberattacks could damage otherwise well-intentioned bodies.

Primary Care and MSSP Beneficiary Assignment

Under the MSSP, beneficiaries are assigned to ACOs based on CMS assessments of who the beneficiary receives most of its primary care from. In the 2026 Physician Fee Schedule proposed rule, CMS proposes to again amend the definition of primary care services to include behavioral health integration and psychiatric

collaborative care management add-on services when furnished with APCM services for the purposes of ACO assignment.

AAPA approves of CMS's proposed modification to the definition of primary care services for the purposes of ACO assignment. We believe that the definition of primary care under the MSSP should align with the definition of primary care under the Medicare physician fee schedule. As elsewhere in the proposed rule, CMS proposes to pay for new add-on G-codes for behavioral health integration and psychiatric collaborative care management for APCM services. We believe the update to this definition under the MSSP is appropriate. We encourage CMS to review its various programs and identify additional definitions to align when possible.

While AAPA appreciates CMS expanding the definition of what may count as qualified primary care services for the purposes of assignment under the MSSP, we disagree with CMS's proposed policy elsewhere in the rule to remove payment for the Social Determinant of Health Risk Assessment, and so also urge reconsideration of its removal of as a primary care service for the purpose of assignment. Elsewhere in our comments, under our response to the chronic care request for information, AAPA reiterated its support for past CMS efforts to better identify social determinants/drivers of health. Identification of these factors may allow for early interventions that prevent or mitigate chronic disease, support adherence to treatment regimens, and improve outcomes. Due to the importance of identifying upstream drivers and the potential positive effects on patient care and outcomes, AAPA urges CMS to reconsider removing the risk assessment from the definition of primary care services for the purpose of ACO assignment. Similarly, CMS should reconsider removing Quality ID: 487 Screening for Social Drivers of Health from the APP Plus quality measure set.

ACO Assignment Methodology

In the 2026 Physician Fee Schedule proposed rule, CMS makes changes to its assignment methodology by amending the definition of primary care services. CMS makes this change to include a broader array of applicable services and increase participation in the program. AAPA appreciates CMS's ongoing efforts toward this goal. However, we note that ACO assignment remains constrained by restrictive statutory language.

AAPA appreciates CMS's efforts in recent years to reform ACO assignment policies to be more inclusive. In the 2024 Physician Fee Schedule, CMS finalized a policy for a new Step 3 for ACO beneficiary assignment. Step 3 allows for an "expanded window," begun in 2025, in which a beneficiary must have seen a primary care physician within the last 24 months (as opposed to the past 12 months) to trigger the ability to be assigned to an ACO. Meanwhile, the requirement to see a physician within a 12-month window was changed, with a

beneficiary now able to be assigned if they have seen a PA or other non-physician health professional within that period.

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

Unfortunately, the expansion of the assignment process through Step 3 does not extend the ability to be assigned to an ACO for all patients. There will continue to be beneficiaries who have been seen exclusively by a PA or other nonphysician health professional and are unable to separately see a primary care physician within the two-year timeframe. For such beneficiaries, should they wish to be associated with an ACO, the beneficiary must take the extra step of going online to select a PA (or nurse practitioner) as their ACO provider to be proactively assigned. However, in previous rules, CMS has recognized that claims-based assignment is the methodology by which the "vast majority of beneficiaries are assigned."³³

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

AAPA Positions and Recommendations on this Topic

- **AAPA appreciates CMS's flexibility regarding the minimum number of assigned beneficiaries under the MSSP, as well as the corresponding safeguards CMS proposes putting in place.**
- **AAPA supports CMS's proposal to allow CAHPS Surveys to be administered by a web-based option.**
- **AAPA approves of the addition of cyberattacks to those conditions that may allow for EUC exceptions.**

³³ Centers for Medicare and Medicaid Services. 2018. Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017. <https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicare-program-medicaresharedsavings-program-accountable-care-organizations-pathways-to-success>

- **AAPA approves of CMS’s proposed modification to the definition of primary care services to include certain behavioral health services for the purposes of ACO assignment and we encourage CMS to review its various programs and modify definitions to align when possible.**
- **AAPA urges CMS to reconsider removing the Social Determinants of Health Risk Assessment from the definition of primary care services for the purpose of ACO assignment. AAPA similarly requests that CMS reconsider removing Quality ID: 487 Screening for Social Drivers of Health from the APP Plus quality measure set.**
- **AAPA continues to urge CMS to work with Congress to remove the statutory physician-centric language regarding ACO assignment methodology.**

The Ambulatory Specialty Model

In the 2026 Physician Fee Schedule proposed rule, CMS is proposing to establish a new Ambulatory Specialty Model (ASM). The ASM is a mandatory payment model focused on specialty care for beneficiaries with either low back pain or heart failure. These two conditions represent significant areas of spending for Medicare. CMS proposes the model would last for five years, starting in 2027 and extending through 2031. The goal of the model is to reward and apply accountability to certain specialists for improving upstream chronic disease management, adhering to best practices, and practicing effective care communication and coordination.

Broadly, AAPA approves of developing new models to emphasize public health priorities and incentivize new innovative methods of practice. We believe there is significant potential in utilizing these methods to test flexibilities that may hinder access to care. Information gathered from observation of these models may also then provide valuable data that could inform policymakers regarding making such flexibilities contained in the models permanent. For example, CMMI’s ACO Reach currently trials several flexibilities pertaining to PA practice, such as authorizing PAs to order diabetic shoes and Medical Nutrition Therapy. If data are produced from this model that demonstrates no harm, then this data may inform Congress to make these policies permanent, thereby expanding access to these services. However, models that exclude health professionals limit their potential in promoting desired policies and testing potential innovative practices.

AAPA appreciates several flexibilities proposed under the ASM, such as telehealth flexibilities that will continue to allow included health professionals to provide care to patients that may have mobility issues. However, the rule also details several restrictions on provider participation. Of most concern to AAPA is a prohibition on the participation of non-physician health professionals such as PAs and nurse practitioners. CMS indicates that non-physician health professionals were excluded due to their inability to meet the

proposed eligibility criteria, which require ASM participants to be assigned one of several enumerated specialty codes. However, PAs and nurse practitioners are enrolled in Medicare under a single specialty taxonomy code (i.e., CMS specialty code ‘97’ for PAs) that reflects their profession, rather than the specialty in which they practice.

AAPA cautions that excluding PAs and nurse practitioners due to the inability to determine their specialty will exclude health professionals who serve a prominent role, and will increasingly do so, in meeting the care needs of Medicare beneficiaries. Of the estimated 1.5 million practitioners in the U.S. in 2033, about 50% will be physicians and 50% will be PAs and other non-physician practitioners.³⁴ Further, a report stated, “This growth is not arbitrary but stems from the pivotal contributions these professionals make to our healthcare system.”³⁵ Excluding PAs and nurse practitioners may bias any data collected as a result of the ASM and may also minimize the reach of the intended incentives.

AAPA recommends that CMS not exclude PAs and nurse practitioners from participating in the ASM and, instead, make participation voluntary for these practitioners. To meet the proposed eligibility requirements, CMS could establish methods to collect data regarding the specialties in which PAs and nurse practitioners practice. To accomplish this, we recommend two potential solutions. First, CMS could allow for PAs and nurse practitioners to attest to the specialty in which they practice. Second, CMS could authorize PAs and nurse practitioners to provide, through PECOS, secondary or tertiary specialty designations that could be used in instances such as this. We believe that health professionals are incentivized to choose the most appropriate specialty since, if they do not, their ability to score well on specialty-specific measures will be compromised and will negatively affect their reimbursement. This is especially true in the case of ASM, which CMS proposes as a mandatory model.

AAPA Positions and Recommendations on this Topic

- **While AAPA appreciates several flexibilities proposed under the ASM, we are concerned regarding a prohibition on the participation of non-physician health professionals, such as PAs and nurse practitioners, because of their specialty designation.**

³⁴ The 50/50 statistic comes from comparison of total number of providers from footnote 2 along with those of footnote 1 combined with: Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. <https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>

³⁵ Singh, L, & Gurjar, R, Insight Brief: The Increasingly Important Role of NPs and PAs in Healthcare Sales Targeting, IQVIA. April 26, 2024. <https://www.iqvia.com/locations/united-states/library/insight-brief/theincreasingly-important-role-of-nps-and-pas-in-healthcare-sales-targeting>

- **AAPA recommends that CMS authorize voluntary participation for PAs and nurse practitioners and establish methods to collect data regarding the specialties in which they practice or authorize PAs and nurse practitioners to provide, through PECOS, secondary or tertiary specialty designations that could be used in instances such as this.**

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

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

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

AAPA supported CMS's activation of HCPCS add-on code G2211, noting the benefit of additional payment to properly compensate for the intangible but necessary actions of tracking, monitoring, and reviewing that go into providing the longitudinal care patients with complex conditions deserve. We also supported the code activation due to its likely benefit to primary care in the face of serious challenges in maintaining a robust primary care delivery model and the promise of the code in helping health professionals build effective and trusted long-term relationships with patients.

In the 2026 Physician Fee Schedule proposed rule, CMS reiterates that the application of G2211 should be based on the relationship between provider and patient, and not the characteristics of the patient. In noting the intent of G2211 to recognize resource costs inherent in building long-term relationships that are not included in the valuation of the O/O E/M code set, the agency proposes to expand G2211's applicability. CMS suggests that the resources not captured in the valuation of the O/O E/M code set are also not captured by the home and residence E/M code set and is consequently proposing that G2211 may be authorized to be billed as an add-on code to the home and residence E/M code family, as well.

AAPA supports CMS's proposed expansion of G2211. We concur with CMS that building relationships between practitioners and patients who receive home and residence care is similarly important, as these visits frequently occur at regular intervals to implement longitudinal care plans. Health professionals who provide

home and residence E/M services are meeting patients where they are, as these patients are frequently unable to leave their residence to receive primary care. These patients should not be treated differently due to a site of service that is beyond their control. Codes like G2211 are meant to reward effective long-term care relationships like those that exist between providers and their home-bound patients and we encourage the finalization of this expansion.

AAPA Positions and Recommendations on this Topic

- **AAPA supports CMS’s proposed expansion of G2211 to be billed as an add-on code to the home and residence E/M code family.**

Advanced Primary Care Management and Prevention Request for Information

As a commitment to supporting primary care, CMS, in the 2025 Physician Fee Schedule final rule, established payment for Advanced Primary Care Management (APCM) services. APCM services are furnished under the direction of a physician or other qualified healthcare professional who is responsible for all a patient’s primary care and acts as the continuing focal point for all needed services in a month. Services include principal care management, transitional care management, chronic care management, and technology-based services, all billed as a bundle, once per patient per month. Payment rates for patients vary based on resource use derived from assessments of each patient’s medical complexity. Specific requirements must be met by health professionals seeking to bill for APCM services, including receipt of consent from patients, maintaining certain capabilities and offering, but not necessarily providing, these options to all APCM patients, and the measurement of practice performance through the Value in Primary Care MIPS Value Pathway or other ACOs/models.

As noted in the 2026 Physician Fee Schedule proposed rule, dependable sources of primary care are likely to increase the likelihood of receipt of recommended preventive services, as well as support the effective management of chronic illness, two of CMS’s stated priorities. As such, CMS is looking for ways to improve APCM. After reviewing several comments submitted on the topic in response to the 2025 Physician Fee Schedule proposed rule, CMS is considering whether patient cost sharing should be eliminated for preventive services under APCM to make participation more attractive. AAPA supports this proposal. We note that several services received under APCM could be considered “preventive,” and thus should be exempt from patient cost sharing. This will require CMS to determine which services under the APCM bundle are preventive, and which may be covered under Part B and would require cost sharing. AAPA recommends that

exempt services should include the initiating visit, the systemic needs assessment, regular medical and psychological screenings, oversight of self-management service elements, and the development of the patient-centered comprehensive care plan.

For APCM participants to identify to CMS which services provided were preventive, and thus exempt from cost sharing each month, when a Level 1 or Level 2 patient is billed for, there should be an indication (via new coding system) of whether the services provided were entirely preventive (and thus would require no cost sharing), a mixture of preventive and treatment services (in which case a discounted cost sharing could be applied), or all treatment services (in which case the usual post-deductible 20% Medicare Part B cost sharing would apply). Level 3 patients, due to their Qualified Medicare Beneficiary status, would not have cost sharing under any mixture of services.

Further, CMS should provide prospective payments to Medicare Shared Savings Program ACOs to reward primary care practices for participation with advanced payment. As noted in the proposed rule, ACOs with a larger proportion of primary care clinicians saw greater savings. As AAPA supports transparency regarding foreseeable patient expenses/cost sharing, patient consent must still be required, and these advanced payments can be subsequently reconciled based on how many patients elected to receive APCM services.

As CMS solicits ideas for further updates to APCM payment policies or the Shared Savings Program that may increase participation of primary care practitioners in ACOs, the agency may wish to assess the possibility of higher payments. Under our comments to the 2025 Physician Fee Schedule proposed rule, AAPA expressed concern regarding the proposed payment rates (for which one level CMS subsequently modified). We noted that managing patients with chronic conditions and coordinating care across multiple settings often requires substantial time, effort, and resources. If the payment rates do not sufficiently compensate for the full scope of these responsibilities, there is a risk that providers may be unable to sustain the level of care that the APCM model envisions. Inadequate payment could undermine CMS's stated objectives by discouraging provider participation, particularly in underserved areas where the need for comprehensive, team-based care is greatest. Smaller practices located in rural areas may determine that, due to the low reimbursement for relatively fewer patients, a lack of potential to benefit from economies of scale does not support the ability to implement the level of infrastructure necessary to meet APCM care provision and reporting requirements. AAPA has already heard anecdotal evidence of health professionals choosing not to take part in APCM services after reviewing what was required versus the low level of reimbursement. We continue to urge CMS to evaluate data regarding APCM utilization and determine whether health professionals may be abstaining from participating due to the existing payment structure not aligning with the realities of modern primary care delivery and the financial sustainability of practice. In order to further increase participation of primary

care practitioners in ACOs, CMS may wish to consider a bonus increase in reimbursement when submitting for APCM services as part of an ACO.

AAPA Positions and Recommendations on this Topic

- **AAPA supports the elimination of patient cost sharing for preventive APCM services to make participation more attractive.**
- **AAPA recommends that APCM preventive services should include the initiating visit, the systemic needs assessment, regular medical and psychological screenings, oversight of self-management service elements, and the development of the patient-centered comprehensive care plan.**
- **AAPA recommends that each month, when a Level 1 or Level 2 patient is billed for, there should be a code indication of whether the services provided were entirely preventive (and thus would require no cost sharing), a mixture of preventive and treatment services (in which case a discounted cost sharing could be applied), or all treatment services (in which case the usual post-deductible 20% Medicare Part B cost sharing would apply).**
- **AAPA supports prospective payments to Medicare Shared Savings Program ACOs to reward primary care practices for participation with advanced payment.**
- **AAPA continues to urge CMS to evaluate APCM utilization and determine whether health professionals may be abstaining from participating due to the existing payment structure not aligning with the realities of modern primary care delivery, and if beneficial, to boost APCM payment, with an additional financial incentive for ACO participants.**

Proposed Update to the Conversion Factor

As a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), starting in 2026, CMS will be statutorily required to establish two separate conversion factors: an elevated one for qualifying participants under Alternative Payment Models (APMs), or “QPs,” and one for all those who are not considered QPs. In a positive development, for the first time in six years, the conversion factors increased. In terms of dollar terms, CMS has proposed an increase of \$1.24 for QPs from \$32.35 in 2025 to \$33.59 in 2026 (3.83%), and an increase of \$1.07 for non-QPs from \$32.35 in 2025 to \$33.42 in 2026 (3.3%). The payment increases are primarily a result of a one-year payment increase of 2.5% that was included in the recent budget reconciliation legislation, a .55% positive budget neutrality adjustment, and the provision within MACRA that boosted payment for QPs by .75%, and for non-QPs by .25%

While AAPA is grateful that this year has seen a positive adjustment, we reaffirm that Congress providing temporary fixes to boost the conversion factor to an acceptable level is not a sustainable strategy. With the unpredictability of what next year's computation will produce and the compounding effects of the series of decreases over the past five years, while medical practice costs have been affected by rising inflation, AAPA remains concerned that financial losses incurred by health professionals may cause practice adaptations that could negatively affect the ability of patients to access care.

Health professionals deserve a reliable method of payment that sufficiently compensates for their work. In a time of rising demand for care, AAPA continues to urge CMS to work with Congress to finalize a long-term fix by designing and passing a more equitable long-term system of provider reimbursement. Congress must consider the feasibility of alternative, long-term options, such as addressing budget neutrality requirements and the possibility of automatic annual inflation adjustments.

MedPAC agrees with this necessity. On April 10, 2025, MedPAC voted affirmatively that Congress should replace the current-law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index. This recommendation was formalized in its June 2025 report³⁶ to Congress.

Finally, while the establishment of two separate conversion factors, one for QPs and one for non-QPs, is a statutorily mandated requirement resulting from the termination of the Advanced APM bonus, we urge CMS to analyze whether there is a resulting decline in Advanced APM participation due to the change in incentive. AAPA remains concerned that a shift to a modestly elevated payment rate starting in 2026 may encourage some participants to move away from the value-based models found under Advanced APMs and move back to the MIPS track, which more closely resembles fee-for-service. We believe this would be counter to CMS's long-term goals of transitioning to fee-for-value. If the agency identifies such adverse results, we urge CMS to identify new methods of financially encouraging participation in Advanced APMs and to work with Congress to potentially extend the payment incentive bonus for a longer period to more firmly incentivize transition to and increased participation in Advanced APMs.

AAPA Positions and Recommendations on this Topic

- **While AAPA is grateful that this year has seen a positive adjustment, we reaffirm that Congress providing temporary fixes to boost the conversion factor to an acceptable level is not a sustainable**

³⁶ Medicare Payment Advisory Commission. 2025. June 2025 Report to the Congress: Medicare and the Health Care Delivery System. <https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/>

strategy. AAPA continues to urge CMS to work with Congress and affected stakeholders to finalize a long-term fix by designing and passing a more equitable long-term system of provider reimbursement.

- **AAPA urges CMS to analyze whether there is a resulting decline in Advanced APM participation as a result of the change in financial incentive to participate, and if so, requests that CMS work with Congress to potentially extend the payment incentive bonus for a longer period to more firmly incentivize transition to and increased participation in Advanced APMs.**

Urgent Care Centers

In the calendar year 2025 PFS proposed rule, CMS sought public comment on how urgent care centers (UCCs) could serve as an appropriate setting to treat patients with non-emergent urgent care needs, and how UCCs could play a role in addressing some of the capacity issues confronting many emergency departments (EDs). In this rule, CMS follows up on that comment solicitation by requesting further input on whether separate coding and payment would be needed to advance this objective. CMS specifically references the possibility of a new add-on code and a new place of service (POS) code to differentiate between urgent care centers that more closely resemble a provider office and “enhanced” UCCs that have more advanced capabilities and more extensive operating hours.

The AAPA is pleased that CMS continues to be interested in exploring ways to improve system capacity and workforce issues broadly, and that CMS is specifically looking at how UCCs can help address these challenges. AAPA believes that CMS should establish payment policies that incentivize the creation of enhanced UCCs to provide Medicare beneficiaries with more and better access to clinician services for urgent but non-emergent needs in settings outside of both EDs and provider offices. By bridging the gap between these settings, enhanced UCCs can alleviate system capacity constraints, reduce avoidable ED visits, and offer a cost-effective alternative for patients who require same-day attention. Enhanced UCCs can also extend the reach of primary care—particularly when beneficiaries cannot secure timely appointments—and frequently serve as essential access points in rural communities where hospital closures, workforce shortages, and geographic barriers limit other options for care.

As CMS references, services delivered in enhanced UCCs are paid at the same rate as services provided in other non-facility settings, like providers’ offices. Current codes do not adequately capture the additional complexity of the clinical work inherent in enhanced UCC visits or the additional practice expense costs associated with enhanced diagnostics capabilities and extended operating hours. Therefore, we urge CMS to

take steps necessary – including payment changes – that would appropriately recognize the additional cognitive effort and higher practice expense associated with enhanced UCC visits and that would help promote the development of these centers going forward.

Quality Payment Program Updates

The Performance Threshold and Transition to MVPs

Under the Quality Payment Program (QPP), MIPS eligible clinicians with a final score above a designated “performance threshold” receive a positive payment adjustment. Eligible clinicians with a final score at the performance threshold receive a neutral adjustment, and those with a final score below the threshold receive a negative payment adjustment. In the 2026 Physician Fee Schedule proposed rule, CMS sets the performance threshold for the MIPS program at 75 points through performance year 2028/payment year 2030. CMS expects that this will continue to provide stability and predictability for participants, as this is the same level it has been at since the 2022 performance/2024 payment period.

AAPA does not fault the agency for wanting to maintain consistency for participants during the transition from the traditional MIPS program to MIPS Value Pathways (MVPs). AAPA supports making this transition as minimally burdensome as possible. We concur that holding this threshold constant for three more years may be particularly beneficial to small or solo practitioners who already experience challenges to program participation. An increase in the performance threshold, while certainly providing a larger bonus for certain health professionals, would result in more providers receiving a negative adjustment due to budget neutrality requirements. Due to continued uncertainty in the direction of the program, AAPA endorses a restrained approach to raising the performance threshold. However, once the transition to MVPs is complete, and sufficient data regarding performance under MVPs has been accumulated, we encourage CMS to revisit the performance threshold level at that point to ensure that participants who are performing well are being adequately compensated for their high performance.

AAPA suggests that, in addition to consistency in reporting and scoring requirements, CMS may further assist in the transition from traditional MIPS to MVPs by providing new educational resources and more technical assistance. These resources and assistance should be targeted at specific aspects of MVP participation that differ from traditional MIPS and that health professionals who have already participated in MVPs have identified as the most challenging.

AAPA also notes that data on performance under MVPs are still relatively new and minimal when compared to data on performance under traditional MIPS. As such, CMS should continue to analyze data regarding performance under MVPs as it becomes available to proactively identify divergence in performance patterns between MVPs and traditional MIPS and determine whether there's a necessity to adjust the corresponding threshold in one program.

MVP Core Elements Request for Information

In the 2026 Physician Fee Schedule proposed rule, CMS is issuing a RFI regarding methods to increase the comparability of clinician performance data under MVPs. Specifically, CMS is considering that, starting in 2027, participants in an MVP will be required to choose one of their quality measures from a smaller core set of likely outcomes measures ("Core Elements") that most reflect the specialty, medical condition, or episode of care around which the MVP is centered. AAPA supports CMS efforts to increase, to an extent, standardization of reporting under MVPs to provide more directly comparable clinician data, as well as to incentivize high performance on measures that capture the intention of the MVP. As the intention is to produce data comparing health professional performance to aid patients in their decision-making processes when choosing an appropriate health professional, CMS must ensure that it selects appropriate Core Elements and that data from these comparisons can be translated into understandable comparisons for patient discernment.

CMS is considering setting the number of core measures as a percentage of the total available to the MVP. AAPA suggests that doing so would be an arbitrary way of determining core measures. We recommend that CMS assess the available measures for each MVP and individually determine which may be the most reflective of the MVP focus. CMS should then release its proposed Core Elements for public comment before implementation of the new policy. AAPA notes that if comparability is the goal, then the smaller the group of core measure options, the better. However, if CMS sets the percentage of the larger set small enough, the number of measures in the core set may not meaningfully diverge.

AAPA cautions that if certain measures are becoming increasingly central to one's final score, those measures must also be broadly applicable to participants and be able to be reported through multiple modalities. To aid in this, CMS could examine what limited data it has on MVP reporting to identify alignment between frequently reported measures and those CMS identifies as Core Elements. Overlap in these measures may illuminate ones that meet requirements to be representative of the MVP focus, have broad applicability, and have not been found difficult to report. AAPA acknowledges that requirements to report on a measure from a core set reduce reporting flexibility; however, we believe that the necessity for only one measure of the four

being required to be from the core set is an acceptable tradeoff to increase comparability, which was the rationale for the transition from traditional MIPS to MVPs.

Procedure Codes Request for Information

Current Medicare policy under the QPP authorizes health professionals to select the MVP to which they will report. In the 2026 Physician Fee Schedule proposed rule, CMS is issuing an RFI regarding the use of a provider's billed procedural codes to encourage and potentially require specialists to report to a specific MVP. CMS explains that this could result in specialists reporting to MVPs most applicable to their specialty and increase participation.

AAPA agrees that it is important for health professionals to report to an MVP that is representative of the type of care they provide. However, we believe health professionals should be able to determine which MVP is most appropriate for them to report. Because it is in the best interest of health professionals to select an MVP in which they can best report, we do not anticipate a conflicting incentive to choose otherwise. We caution that use of claims data may mask the specific context of a health professional's practice. Certain health professionals may provide services that do not readily identify the primary specialty in which they practice.

While AAPA would support the collection and dissemination of procedural code data to health professionals to guide or recommend their choice of MVP, we believe that requiring a health professional to select a specific MVP based on that data would not be appropriate. We believe this data could be instructive, if it is for informational purposes and not a requirement to report under a specific MVP.

CMS considers going further and using procedural codes to identify specific measures within an MVP that require reporting by a health professional. We find this limitation on measure flexibility similarly unwarranted. Although AAPA approves of the establishment of Core Elements for comparability purposes, as noted in a separate RFI under the rule, we believe that identifying all the reported measures required to be submitted using procedural codes would be an excessive limitation on provider reporting flexibility.

Well-being and Nutrition Measures Request for Information

In the 2026 Physician Fee Schedule proposed rule, CMS is issuing an RFI regarding whether to add measures pertaining to well-being and nutrition in future years of the QPP. AAPA finds significant value in these proposed future measure concepts but urges caution in their implementation.

Regarding measures pertaining to patient well-being, AAPA cautions that, while well-intended, the concept is fairly broad and may be difficult to define. We note that the components of well-being, in other rules noted as 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 and to take time to receive feedback from stakeholders able to provide in-depth feedback before adding this measure concept.

AAPA also supports the eventual inclusion of measures regarding nutrition. Doing so may encourage 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 proxy measures, and each would require confirmation that it is within the realm of health professionals 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 will vary by patient. Consequently, success in these areas may include demonstrating completed processes as opposed to outcomes, such as the development of nutritional and preventive plans specific to each individual and demonstrating that the provider offers an environment conducive to healthy dietary and preventive practices.

Timeline for Qualified Clinical Data Registries (QCDR) and Qualified Registry Supporting MVPs

In the 2026 Physician Fee Schedule proposed rule, CMS proposes to allow one year between when a new MVP is finalized and when a QCDR or Qualified Registry must be able to support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. AAPA believes that it is important that QCDRs and Qualified Registries be able to report on all MVPs, to enable additional methods of measure reporting for MVP participants. However, we support CMS's proposed timeline to allow them sufficient time to make modifications and demonstrate their readiness to report on all new MVPs.

The time between when an MVP is finalized (at the time of the Physician Fee Schedule final rule) and when it is effective (typically January 1) is very brief (approximately two months), and QCDRs and Qualified Registries have suggested that they may struggle to prepare their systems and to program all required measures in time. While this flexibility would allow QCDRs and Qualified Registries a year before they must demonstrate the ability to support new MVPs, AAPA recommends that CMS urge QCDRs and Qualified Registries not to use this extended timeline to delay, but rather to complete any necessary modifications by the earliest practicable convenience. This would allow MIPS participants to utilize these reporting methods as soon as available, as well as make completion, testing, and usability likely to be complete before the one-year mark.

Informational-Only Feedback Period for New Cost Measures

In the 2026 Physician Fee Schedule proposed rule, CMS is proposing that, beginning in performance year 2026/payment year 2028, it will adopt a two-year informational-only feedback period for newly implemented cost measures. This gap between when CMS will begin new measurements of provider costs and when there are payments adjustments because of these measures on the MIPS cost performance category scores and final score impact will allow clinicians to receive no-consequence scores and feedback and take steps to better address costs without initial consequence.

AAPA supports this period in which providers can collect and adapt to cost measure data. We believe the goal of the QPP is not to implement penalties, but rather to encourage improved behavior such as cost reductions.

Qualifying APM Participant (QP) Determination at the Individual Level

To address what CMS perceives as conflicting incentives between the ability for eligible clinicians to achieve QP status and the goals of Advanced APMs, CMS proposed in its 2024 Physician Fee Schedule proposed rule to conduct all QP determinations at the individual QP level, as opposed to the APM entity level. AAPA expressed concern regarding this proposal based on the possible adverse effects on Advanced APM participation resulting from Medicare policies that obfuscate the actual level of care provided by certain health professionals, such as PAs.

Historically, most determinations of QP status were made at the APM entity level. To become a QP, certain thresholds must be met regarding the percentage of Medicare Part B payments received, or the percentage of patients seen, through an Advanced APM entity during a performance period. CMS justified its proposed transition by its belief that, to qualify, prospective APM entities are excluding specialists and other health professionals that individually do not meet those thresholds because they provide care elsewhere and thus may decrease the average of the whole entity and lead to the exclusion of other health professionals. CMS reasons that the exclusion of these health professionals would work against the intended goals of APMs to encourage different types of health professionals to work together to manage and coordinate care. Instead, CMS proposed to determine QP eligibility for each health professional individually at the NPI level and allow only individuals to make QP status (preventing potentially unwarranted payment bonuses for practitioners under the APM entity that do not meet QP requirements, as well as discouraging APM entities from excluding health professionals whose care may be important to meeting patient-centered care goals).

AAPA noted that while it appreciates these concerns, if finalized, this policy change would have had unintended effects on certain health professionals, such as those who are required by an employer to utilize “incident to” billing. PAs and nurse practitioners whose services are entirely, largely, or in part attributed to a physician with whom they work may individually fail to meet QP or partial QP payment or patient thresholds, preventing them from receiving associated financial benefits and burden reductions. The inability to meet QP or partial QP payment or patient thresholds would be more likely if CMS chose to raise such thresholds. We recommended that, if CMS proceeded with this policy, that CMS should implement a method to determine when a PA provides a service under “incident to” and to use such data in consideration for meeting the QP thresholds. Until proper attribution of services is addressed, we also recommended a maintaining the current QP threshold levels, so as not to exacerbate the effect of “incident to” on a health professional’s inability to meet payment/patient threshold scores necessary to secure QP or partial QP status.

CMS chose not to finalize the transition to QP determinations at the individual level at the time. However, CMS believes that there is the potential that eligible clinicians who fully engage with an Advanced APM are still unable to earn QP status because the APM entity for which they work fails to do so. Currently, CMS does provide exceptions to this policy and allows determinations at the individual level under certain limited circumstances.

In the 2026 Physician Fee Schedule proposed rule, CMS is proposing to add QP determination at the individual level for all Advanced APM participants beginning with the 2026 QP Performance Period. CMS envisions that this addition would not change its policy of determining QP status at the APM entity level but rather would be supplemental to identify those health professionals that may fall through the gaps.

AAPA supports this revised plan of concurrent determination methods as we believe it addresses concerns expressed by CMS while not leading to the exclusion of PAs who may work for an APM but have their services attributed to someone else. These simultaneous determinations are likely to result in more health professionals who can achieve QP status, which acts as an important incentive to participate in Advanced APMs and furthers CMS goals of progressing toward value-based care.

Subgroup Reporting

In the 2022 Physician Fee Schedule final rule, CMS finalized the option for eligible clinicians to participate in subgroups for reporting to MVPs. In the 2023 Physician Fee Schedule, CMS indicated that subgroup reporting was voluntary for the calendar year 2023-2025 performance years. Beginning with performance year 2026, multispecialty groups would no longer be listed under the definition of an MVP participant, preventing

multispecialty groups from reporting an MVP as a single group and requiring instead that such reporting would have to occur as subgroups or as individuals, or else the entire multispecialty group could continue to report at the group level under traditional MIPS.

In the 2026 Physician Fee Schedule, CMS makes two proposals regarding MVP reporting. First, CMS proposes to continue a temporary flexibility for small (15 or fewer eligible clinicians) multispecialty practices to not have to report as subgroups. Second, CMS proposes to allow groups to self-identify their specialty composition during the MVP registration process.

Regarding CMS's first proposal, to allow multi-specialty groups to report as a single entity if they identified as a small practice, AAPA has supported this in the past and continues to do so. Small practices tend not to have the same level of resources as those available to large ones. In addition, small practices, if forced to divide into subgroups, may no longer meet quality measure minimum requirements, which could negatively affect their scores. AAPA shares CMS's concern that increased burden and the potential for decreased scores would push more small practices to report under the less comparable traditional MIPS option, a program CMS seeks to transition away from.

Regarding CMS's second proposal, to allow groups to self-identify their specialty composition, AAPA approves of this authorization. Groups are best equipped to decide on the type of care they provide, and any third-party determinations made through claims assessments are bound to have shortcomings that occasionally unintentionally mischaracterize the types of care a group provides. Further, groups are financially incentivized to make the proper determination of their specialty composition if they hope to be successful under MVPs.

In past comments, AAPA expressed concern regarding CMS's proposal to identify specialty compositions by claims data due to the potential misalignment of health professionals' artificial groupings determined by CMS, and by CMS collected data that may be incomplete or inconclusive (because of billing mechanisms such as "incident to"). In the rule, CMS recognizes additional complications in using Medicare Part B claims data to determine specialty, such as groups of health professionals across multiple specialties all providing team-based care for one clinical area, or when a primary specialty designation of certain practitioner types, such as PAs and nurse practitioners, does not reflect the specialty of care provided. As noted in the proposed rule, PAs and nurse practitioners in large group practices could be involved in a range of services. AAPA appreciates CMS's acknowledgement of these complications.

Like our past comments on subgroup composition, AAPA believes that group composition should be defined by the shared relevance of an MVP for all group participants. AAPA could conceive of multispecialty groups that are focused on a condition that requires cross-specialty cooperation. For example, a Heart Valve Clinic

may submit to an MVP focused on comprehensive valve care, and the group of practitioners could include an interventional cardiologist, cardiothoracic surgeon, cardiologist, and PA practicing in cardiology.

For these reasons, instead of using claims-based data when determining specialty composition, in past comments AAPA had recommended the use of attestation to signify specialty. We believe that health professionals are incentivized to choose both the most appropriate subgroup and the most appropriate MVP because, if they do not, their ability to score well on specialty-specific measures will be compromised and will negatively affect their reimbursement.

AAPA is pleased that CMS agrees with the deficiencies in using claims-based data in determining specialty composition and has instead proposed a method of attestation. CMS has indicated agreement with the fact that groups that contain health professionals in different specialties may still share a single focus, and as such, should still register as a single group for the purposes of MVP reporting. Consequently, CMS is proposing that, if intending to report an MVP, a multispecialty group has the option of identifying as a single group (if there is one shared focus that aligns with the intended MVP) or identifying as a multispecialty group with 15 or fewer participants (a small practice). Otherwise, a multispecialty group could split into subgroups for MVP reporting, participate as individuals, or else report as a group under traditional MIPS. AAPA believes the process of attestation will prove to be less cumbersome, more accurate, and ultimately reflect more comparable data. We support CMS's proposal and encourage its finalization.

Data Quality Request for Information

In the 2026 Physician Fee Schedule proposed rule, CMS includes an RFI among its QPP provisions regarding what can be done to enhance data quality. Data quality is a topic AAPA is acutely focused on, as there are several examples of data not capturing services provided by PAs. We frequently communicate several negative effects that result from poor data quality and have made several recommendations for policy modifications that may ameliorate deficiencies.

Regarding data accuracy, we refer CMS to our position regarding "incident to" billing (found in detail in the first section of these comments: Direct Supervision by Use of Two-Way Audio/Video Communications Technology) and the negative ramifications of incorrect and incomplete data. AAPA discusses the consequences of this inaccurate data for stakeholders such as the Medicare program, patients, employers, and PAs and nurse practitioners. In that section, we encourage CMS not to implement policies that make data less accurate and provide concrete recommendations for remedying the larger problems with "incident to" billing.

We note that “incident to” is only one example of a policy that hinders the accuracy of data regarding PAs. Some commercial payers, such as those who work in concert with CMS through Medicare Advantage plans, Medicaid Managed Care plans, and plans on the Federally Facilitated Exchange, may have provider enrollment practices that do not include PAs and thus have a similar effect as “incident to” in that they do not attribute services to the health professionals who provided them. Such practices bias any data based on such services. We encourage CMS to release a series of best practices to its partners, encouraging provider enrollment of PAs for the purposes of proper attribution.

- Provider Directories: Regarding data completeness, Medicare’s Care Compare, as well as provider directories for some of the payers with whom CMS works, withhold useful data from their beneficiaries regarding available care delivery options. CMS has recognized the inadequacy of provider directories as recently as its 2022 RFI³⁷, noting that provider directories often display inaccurate or redundant information and are frequently missing essential information that may be valuable to beneficiaries and patients. For provider directories to be most successful, information contained in them must be complete, accurate, and navigable.

Some provider directories omit information notifying beneficiaries of all available care options. For example, while not always the case, PAs are occasionally omitted from a payer’s provider directory. As essential members of healthcare teams, PAs must be included explicitly in all public and private payer provider directories. The No Surprises Act requires that most payers ensure that their provider directories are accurate and up-to-date regarding available care options, without exception. We urge CMS to provide sufficient oversight and enforcement regarding the implementation of this requirement, especially in the initial years to support the transition to these positive practices. Omission from a provider directory should be easily reportable, with subsequent investigation of whether the reported absence is a one-off omission, or the systematic exclusion of an entire class of health professionals. AAPA also supports the extension of this requirement to payers that are not currently covered by the No Surprises Act, such as several public payers that may also operate provider directories.

Even when PAs are included in provider directories, such as Care Compare, there is a potential for incomplete information to be made available that hinders beneficiary choice and access. Provider directories are typically designed so a beneficiary is prompted to search for a potential provider based

³⁷ Centers for Medicare and Medicaid Services, US Department of Health and Human Services. Request for Information; National Directory of Healthcare Providers & Services. October 7, 2022.
<https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-ofhealthcare-providers-and-services>

on the specialty in which a provider practices. PAs are often not enrolled with payers in a particular specialty and, consequently, are not listed in many provider directories under the specialty in which they practice. Instead, PAs are often listed in provider directories under the generic category of “physician assistant” or “PA.”

If a beneficiary is looking for care in dermatology, a PA who practices in dermatology may not be identified in the directory as a dermatology provider. The beneficiary may instead be forced to select a provider specifically listed under the category of dermatology but who might be located at a greater distance from the beneficiary and/or have substantially longer wait times, both of which create access issues for beneficiaries. To remedy this situation, PAs should be identified in provider directories under the specialty in which they practice and not placed into a generic “physician assistant” or “PA” category. This can be accomplished by authorizing PAs to report the specialty/specialties in which they practice to the payer.

One of the core principles of the PA profession is flexibility and the ability to change practice specialties. This flexibility is essential in helping to meet the changing healthcare needs of patients. Unlike physicians, who are typically board-certified in a particular specialty, PAs are nationally certified to practice in all medical and surgical specialties. The profession’s comprehensive, generalist medical education, training, and preparation give PAs the capability and expertise to practice in different specialties and change specialties in response to the changing healthcare needs of patient populations. Maintaining this practice flexibility is especially important because of 1) challenges facing the healthcare workforce, including the current and growing shortage of physicians and the increasing problem of attrition of health professionals due to provider burnout and/or retirement; 2) the need to deliver increased access to care for patients in rural and underserved communities; and 3) the necessity to rapidly respond to future public health emergencies. Authorizing PAs to report their practice specialty to Medicare and the payers with whom they work will improve provider directory transparency, inform beneficiaries of all available care options, and support the PA profession’s continued ability to meet the evolving needs of the US healthcare delivery system.

These are just some examples of data quality and transparency issues PAs face. AAPA would welcome a broad discussion with CMS regarding our concerns pertaining to the transparency of services provided by PAs and the data quality complications that result.

AAPA Positions and Recommendations on this Topic

- **AAPA supports a restrained approach to the MIPS performance threshold in light of the ongoing transition to MVPs. However, once the transition to MVPs is complete, and sufficient data regarding performance under MVPs has been accumulated, we encourage CMS to revisit the performance threshold level at that point in order to ensure that those participants that are performing well are being adequately compensated for their high performance.**
- **AAPA suggests that CMS may further assist in the transition to MVPs by providing more educational resources and technical assistance.**
- **AAPA recommends that CMS continue to analyze data regarding performance under MVPs as it becomes available in order to proactively identify divergence from traditional MIPS in performance patterns and determine a necessity to adjust the corresponding performance threshold.**
- **AAPA supports CMS efforts to increase standardization of reporting under MVPs, to an extent, including the establishment of Core Elements.**
 - **AAPA suggests that setting the number of core measures as a percentage of the total available to the MVP would be an arbitrary way of determining the number of measures to include and instead recommends that CMS review the available measures for each MVP and individually determine which may be the most reflective of the MVP focus**
 - **AAPA believes that CMS must then release its proposed Core Elements for public comment prior to implementation of the new policy**
 - **AAPA notes that if comparability is the goal, then the smaller the group of core measure options, the better**
 - **AAPA recommends that any measures that make up the Core Elements be broadly applicable to participants and be able to be reported through multiple modalities. To aid in this, CMS could examine what limited data it has on MVP reporting to identify alignment between frequently reported measures, and those CMS identifies as Core Elements. Overlap in these measures may illuminate ones that meet requirements to be representative of MVP focus, have broad applicability, and have not been found difficult to report**
- **While AAPA would support the collection and dissemination of procedural code data to health professionals to guide or recommend their choice of MVP, we believe that requiring a health professional select a specific an MVP based on that data would not be appropriate. Instead, we believe health professionals should be able to determine which MVP is most appropriate for them to report.**
- **AAPA believes that using procedural codes to identify all the measures required to be reported would be an excessive limitation on provider reporting flexibility.**

- **AAPA finds significant value in adding measures pertaining to well-being and nutrition in future years of the QPP, however, we urge caution regarding implementation.**
 - **Well-being is a fairly broad concept and may be difficult to define with distinct multi-faceted components that do not always have easily derived proxy measures. As such, AAPA encourages the assessment of patient well-being through validated measures and to take time to receive feedback from stakeholders able to provide in-depth feedback before adding this measure concept**
 - **Measuring success regarding nutrition will require multiple proxy measures, and each would require confirmation that it is within the realm of health professionals to address and measure, with definitions of success that will vary by patient. Success in these areas may include demonstrating completed processes as opposed to outcomes, such as the development of nutritional and preventive plans specific to each individual and demonstrating that the provider offers an environment conducive to healthy dietary and preventive practices**
- **AAPA supports CMS’s proposed timeline to allow QCDRs and Qualified Registries sufficient time to make modifications and demonstrate their readiness to report on new MVPs.**
- **AAPA supports CMS’s proposed two-year informational-only feedback period for newly implemented cost measures.**
- **AAPA supports CMS adding QP determination at the individual level, in addition to the determination at the APM entity level, for all Advanced APM participants.**
- **AAPA agrees with CMS’s proposal to allow multi-specialty groups to report MVPs as a single entity if they’re identified as a small practice.**
- **AAPA approves of CMS’s proposed policy to allow groups to self-identify their specialty composition for reporting MVPs.**
- **In response to CMS’s RFI on data quality, AAPA again draws the agency’s attention to our recommendations regarding minimizing the effects and resolving the attribution issues that are inherent in “incident to” billing, encourages CMS to release a series of best practices to its private payer partners regarding enrollment policies and provider directories, and requests that CMS allow for attestation regarding PA specialty to properly capture all health options available to beneficiaries.**

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).³⁸ This accurately reflects PAs who currently graduate with degrees as either “physician assistant” or “physician associate” and are state-licensed as a “physician assistant” or “physician associate,” but who all graduate from programs accredited by the same accrediting organization (Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (National Commission on Certification of Physician Assistants), and have the same scopes of practice. Although the profession has been known as “physician assistant,” the official title of the profession is now recognized as “Physician Associate” 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 organizations³⁹, professional training programs⁴⁰, and state and territory laws and licensure.⁴¹ 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.”

AAPA Positions and Recommendations on this Topic

- **AAPA urges CMS to refer to the PA profession as “physician assistant/physician associate” in all official documents.**

³⁸ Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. <https://public-inspection.federalregister.gov/202500515.pdf>

³⁹ 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>.

⁴⁰ 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>.

⁴¹ 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)

Thank you for the opportunity to provide comments regarding the 2026 Physician Fee Schedule proposed rule. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Sondra DePalma, Vice President of Reimbursement and Professional Practice, at sdepalma@aapa.org.

Sincerely,

A handwritten signature in black ink that reads "T Pickard". The signature is written in a cursive style with a large initial "T" and a stylized "Pickard".

Todd Pickard, DMSc, PA-C, DFAAPA, FASCO
President and Chair, Board of Directors