



September 15, 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: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency – Attention: CMS-1834-P

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 Outpatient Prospective Payment System 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, 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 to 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 OPPS proposed rule, CMS proposes to permanently allow for direct supervision of services to be provided using two-way audio/visual communications technology. In its proposal, CMS expresses a desire for uniformity on this topic between the 2026 Physician Fee Schedule (PFS) and the OPPS.

Just like with our comments regarding this proposed change in the 2026 PFS proposed rule, AAPA strongly 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 in order to protect health professionals and patients alike from further 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, as written, 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 make 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.

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 (under §410.26(a)(2)), with the exception of 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 with the objective of preserving 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.

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.

Concerns regarding “incident to” billing transparency 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 and OPPS proposed rule, emphasizing a preference for empirical studies and even issuing an RFI on data quality, integrity and transparency under the Quality Payment Program section of the PFS 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,

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/>

which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

Care Compare is a Medicare-sponsored website designed to list individual Medicare-enrolled health professionals and 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.

For 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 Another concern

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

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 reason to believe that “incident to” may also have a negative impact on the productivity of all stakeholders involved due to decreased efficiency of practice. Two studies^{4,5} demonstrate the benefits of increasingly autonomous billing by PAs and nurse practitioners, showing a significant increase in work RVUs and collections attributed to PAs and nurse practitioners, as well as a mild increase in work RVUs and collections for attending 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.

Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

<https://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.

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 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 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 the purposes of “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 is able to collect the information of the health professional actually 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 is able to collect the information of the health professional actually providing the service under “incident to.”**

Request for Information for the Hospital Outpatient, REH and ASC Quality Reporting Programs

In recent comments to CMS, AAPA identified regulations related to PAs regarding both rural emergency hospitals and ambulatory surgical centers, which arbitrarily and unnecessarily exclude PAs. Below is a list of these regulations and policies. The examples demonstrate increased burdens on physicians and PAs for outdated and unnecessary oversight requirements, which may potentially harm patients through inefficiency of care.

42 CFR §485.524(d)(1)

Current Policy: This regulation uses physician-centric language regarding who may perform surgery for patients in Rural Emergency Hospitals (REHs)

Change Request: §485.524(d)(1) should be revised to authorize PAs to perform surgical procedures in REHs.

Reason for Change: Amending these regulations will increase workforce adequacy and improve efficiency.

42 CFR §485.528(c)

Current Policy: This regulation 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.

Change Request: §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.”

Reason for Change: 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.

42 CFR §416.42, §416.48, §416.52

Current Policy: These regulations contain physician-centric language regarding the provision of services in Ambulatory Surgical Centers (ASCs).

Change Request: §416.42 should be revised to authorize PAs to perform surgical procedures in ASCs, §416.42(a)(1)(i) and (ii) should be revised to authorize PAs to evaluate the risk of the procedure to be performed and the risk of anesthesia in ASCs, §416.48(a)(1) should be revised to authorize PAs to receive reporting of adverse reactions, §416.48(a)(2) should be revised to authorize PAs to administer blood and blood products, §416.48(a)(3) should be revised to authorize PAs to order drugs and biologicals in ASCs, §416.52(c)(1) should be revised to authorize PAs to provide follow up appointments, §416.52(c)(2) should be revised to authorize PAs to discharge patients (and issue and sign discharge orders), and §416.52(c)(3) should be revised to authorize PAs to determine if patients are exempted from being discharged in the presence of a responsible adult.

Reason for Change: States authorize PAs to perform minor surgeries, risk assessments, and other medical services. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden.

Professional Title

AAPA requests that all references to PAs in regulations and policies be listed as “Physician Assistants/Physician Associates,” as recognized in 20 CFR § 220.46 (a)(9).⁶ This accurately reflects PAs who currently graduate with degrees as either “physician assistant” or “physician associate” and are state-licensed as a “physician assistant” or “physician associate,” but who all graduate from programs accredited by the same accrediting organization (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 organizations⁷, professional training programs⁸, and state and territory laws and licensure.⁹ Despite the recognized title of “physician associate,” it is anticipated to take some time for the title change from “physician assistant” to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to “physician assistant” and “physician associate” is recommended to avoid confusion. AAPA urges CMS to reference the profession by the dual title “physician assistant/physician associate.”

⁶ Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. <https://public-inspection.federalregister.gov/202500515.pdf>

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

⁸ Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARCPA), have Physician Associate Programs and graduate students in Physician Associate Studies. Examples: Yale School of Medicine, Physician Associate Program, <https://medicine.yale.edu/pa>, Wichita State University, Physician Associate Program https://www.wichita.edu/academics/health_professions/pa/, Alvernia University, Physician Associate Program <https://www.alvernia.edu/academics/ug/bio-pa>.

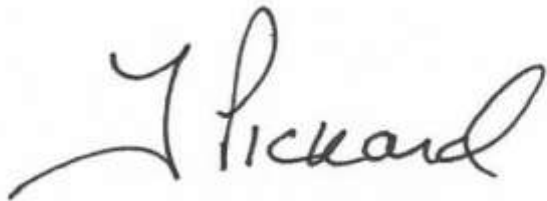
⁹ Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) <https://www.aapa.org/news-central/2024/04/oregongovernor-tina-kotek-signs-law-changing-pa-title/>. See also, Or. Rev. Stat. § 677. See also, Wis. Stat. § 448.974(1)(a)(2)-(6). See also, 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p)

AAPA Positions and Recommendations on this Topic

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

Thank you for the opportunity to provide comments regarding the 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems proposed rule. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Sondra DePalma, AAPA Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

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

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