February 23, 2026

Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services (HHS)
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: HHS Health Sector AI RFI

Dear Secretary Kennedy,

The American Academy of Physician Associates (AAPA), on behalf of the over 190,000 PAs (physician associates/physician assistants) throughout the United States, would like to provide comments on the Artificial Intelligence (AI) Request for Information (RFI). In the RFI, HHS seeks feedback from a broad range of stakeholders on how best to harness the transformative potential of AI while ensuring consumer protections. Specifically, HHS identifies three approaches (regulation, reimbursement, and research/development) that it hopes to apply to support rapid adoption and use of AI.

The PA profession is at the forefront of care provision, working in concert with other health professionals to provide high-quality care to patients. PAs have been shown to improve access to care while providing high levels of quality and patient satisfaction comparable to physicians.[1] The positive impact of PAs on patient care stands to grow. The PA profession is one of the fastest-growing occupations, per the Bureau of Labor Statistics, with a projected 20% increase in PAs from 2024 to 2034.[2] As such, PAs are currently, and will increasingly be, immersed in several of the direct clinical and indirect processes in which AI is expected to be integrated.

AAPA appreciates HHS's commitment to improving beneficiary experience through increased use of AI. We share HHS's optimism regarding this burgeoning technology. AAPA has long supported HHS's efforts to incentivize

[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/
[2] US Bureau of Labor Statistics, US Department of Labor. *Occupational Outlook Handbook. Physician Assistants*. August 28, 2025. https://www.bls.gov/ooh/healthcare/physician-assistants.htm

2318 Mill Road, Suite 1300 | Alexandria, VA 22314 | P 703.836.2272 | F 703.684.1924 | aapa.org

expanded use of modern technology to increase productivity, improve patient outcomes, and reduce healthcare costs. As society is still beginning to understand the various ways AI can be applied to meet these goals, we continue to support HHS's proactive efforts to ensure sufficient regulation that promotes safety and public trust, while incentivizing the development and broad adoption of AI for the betterment of patient care. It is within this context that we draw your attention to our comments.

AAPA Recognizes the Various Potential Benefits of AI

AAPA concurs with HHS that AI can transform care processes and delivery. One way we anticipate AI will positively affect healthcare is by enabling the aggregation of large amounts of research data and drawing initial conclusions. As such, AI may provide early disease detection, assess whether treatments and care regimens are effective, and illuminate trends in patient adherence.

A second way AAPA foresees AI's positive impact is its potential to expedite administrative processes, thereby improving efficiency and reducing provider burnout. In prior rules and RFIs, CMS has postulated on the potential for AI to reduce the burden of the prior authorization process, automating the identification of when prior authorizations are necessary, compiling portions of the required information a payer needs that can be found in a health information system to process a prior authorization, and drafting a prompt payer response to providers. AAPA supported these concepts in previous comments.[3]

A third way AI can positively impact healthcare is by reducing provider burnout by taking and organizing notes during a patient encounter and using these notes to develop suggested diagnoses and personalized treatment plans for qualified health professionals to review. These AI-proposed diagnoses and treatment plans would effectively act as supplemental data for health professionals to consider. However, while AAPA recognizes the transformative power of AI, we similarly recognize the need for guidelines to ensure proper development and use of AI-integrated technologies.

Considerations for the Implementation of AI in Healthcare

Given AI's significant potential in healthcare, there is a corresponding risk of negative outcomes if AI policy is not thoroughly developed and oversight is insufficient. AAPA has noted several considerations and corresponding recommendations below.

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[3] American Academy of Physician Associates. *Comments to the Request for Information; Health Technology Ecosystem.* Submitted June 12, 2025. https://www.aapa.org/download/146978/?tmstv=1770047702

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Avoid Unnecessary Restrictions on AI Usage

During the initial development of AI policies, HHS must avoid restrictive language that could create unintended barriers to care. Ensuring appropriate and provider-inclusive language at the outset will avoid the need for rectification later. Specifically, language in any developed federal code, as well as accompanying explanatory text, should not use physician-centric language that confines the usage of AI to this subset of health professionals. Instead, language should be broad enough to include any appropriate health professional. Language that unnecessarily confines health professionals, who provide a significant share of patient care can blunt the use of AI and minimize its potential advantages. Meanwhile, scope of practice determinations regarding who is qualified to provide services involving AI should be made at the state level.

- **AAPA Recommendation: Ensure developed language regarding AI is broad enough as not to restrict health professionals like PAs from providing these services and guarantee that the patients PAs serve can benefit from AI.**

Avoid Unnecessary Restrictions on AI Reimbursement

As HHS develops inclusive language on which health professionals are authorized to use AI technology, as recommended by AAPA in the previous section, the agency should also ensure that any language regarding reimbursement for AI services is not physician-centric. Language regarding who may bill and receive reimbursement for AI services must include any health professional authorized to directly bill for medical services under Medicare. This is important because, 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.[4]

- **AAPA Recommendation: Ensure developed language regarding AI reimbursement is broad enough as not to restrict health professionals otherwise authorized to bill for services under Medicare, like PAs, from billing for these services.**

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[4] 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/nurseanesthetists-nurse-midwives-and-nurse-practitioners.htm

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Align Reimbursement with the Value Proposition of AI

AI technologies used in clinical care are intended to generate value by improving efficiency, reducing administrative burden, enhancing clinical decision-making, and preventing unnecessary utilization. These benefits are often realized at the system level rather than through discrete, billable services. Under fee-for-service payment models, efficiency gains may be unrewarded or penalized, creating a disincentive for adoption even when AI may improve quality and patient outcomes. Reimbursement policy should avoid framing AI as an add-on service and instead support payment structures that enable providers and payers to capture the value of improved efficiency and care delivery.

Premature creation of AI-specific billing codes, modifiers, or payment add-ons risks incentivizing volume and utilization rather than value. Historically, such approaches have contributed to spending growth without commensurate improvements in patient outcomes. Maintaining flexibility in payment policy is essential to allow AI use cases to mature without creating artificial incentives.

- **AAPA Recommendation: HHS should avoid the unnecessary creation of standalone billing codes or service-level payment add-ons for AI and instead prioritize reimbursement approaches that reward outcomes, efficiency, and total cost of care through value-based, population-based, and shared-savings payment models.**

Safeguard Sensitive Information

The development of AI technologies must incorporate patient privacy protections regarding the inadvertent dissemination of personal and sensitive information. Sufficient protection must be included to ensure that patients using AI technologies integrated into a system cannot access individualized information about other patients. Similarly, providers should not be able to access identifiable, individualized patient information outside their care. Vendors of AI technology must be treated as HIPAA-covered entities, and all relevant patient protections must be incorporated into the AI technologies they develop.

- **AAPA Recommendation: HHS must ensure or develop regulatory requirements that users and vendors of AI technology are considered and regulated as HIPAA-covered entities.**

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Ensure Appropriate Oversight of AI Diagnoses and Authorizations

AI has significant potential to aggregate data to identify accurate diagnoses and treatments and to expedite processes. However, as with any technology, results are not guaranteed to be flawless from inception. This is especially true of AI, which requires regular informational feedback to learn and improve. In healthcare, an incorrect diagnosis, treatment, or coverage determination can harm a patient's health. Incorrect inputs, biases, or incomplete context considered by AI could prove deadly. As such, healthcare-related AI technology cannot be granted an assumption of veracity without oversight from a licensed clinician.

- **AAPA Recommendation: HHS should include in code and accompanying text a clear requirement for safeguards, which could include human review of information generated by AI, surrounding diagnoses, treatment recommendations, or coverage determinations.**

Support Adoption of AI Among Providers

AAPA believes the use of AI by health professionals will present a significant opportunity to streamline processes and improve patient care. However, new technologies take time and money to implement. Frequently, infrastructure needs to be adopted, processes developed, and training provided. However, HHS could expedite AI adoption by providing financial incentives for implementation, producing educational materials, and offering training and best practices.

While the technology is new, HHS should refrain from making the adoption of AI technologies compulsory. Health professionals, like society at large, are still trying to understand the capabilities and limitations of this new technology and how to adopt and implement it into their workflows. However, HHS may wish to set potential timelines for the inclusion of AI adoption and utilization in existing and future incentive programs, with the financial benefits and corresponding penalties for AI adoption and use increasing over a predetermined time. However, multiple timelines for AI adoption may be required, as AI integration will take many distinct forms with varying purposes (e.g., diagnostic technology, EHR integration, prior authorization). HHS should further consider additional financial support for small provider groups to offset the costs of software and necessary infrastructure.

- **AAPA Recommendation: HHS should consider developing a timeline under which it will incorporate financial bonuses and penalties for AI adoption and usage into its current and future incentive programs. HHS should also consider providing training and educational materials, as well as supplementary financial support for small provider groups to subsidize the initial adoption of required infrastructure.**

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AI and the Importance of Accurate Data in Incentivizing and Publicly Reporting the Use of AI

AAPA views the integration of AI into clinical services as an opportunity to improve the provision of care. We believe that health professionals who appropriately use AI technology stand to benefit financially from improved quality of care and reduced costs. As a result, it is likely that health professionals using AI in a useful manner will see improvement in performance metrics and corresponding financial benefits under various incentive programs. This may act as an additional incentive for AI adoption and use. However, these financial incentives can only be recognized if services are accurately attributed to the health professional who provided them.

CMS has acknowledged in previous technology-related rules the importance of appropriately attributing services to the health professional who provided them. AAPA concurs with CMS's assessment. Unfortunately, certain current fee-for-service Medicare policies obscure the actual provider of care. "Incident to" is a Medicare billing provision that allows medical services personally performed by one health professional in the office or clinic setting to be submitted to the Medicare program under the name of another health professional. Of particular interest to us is when "incident to" is performed by PAs and attributed to physicians. PA services submitted under Medicare's "incident to" billing provision and attributed to physicians skew assessments of provider care quality, resource utilization, and other measures relevant to value-based care, creating inaccurate data regarding both PAs and physicians. Consequently, AAPA requests that HHS work with Congress to address the complications of inaccurate data collection caused by "incident to" by ensuring services are accurately attributed to the health professional who rendered the service. CMS should further evaluate how policies such as split (or shared) visit billing and global surgical packages obfuscate the contributions of individual health professionals. Addressing policies that incorrectly identify the provider of care will ensure that any financial or publicly facing ratings regarding the proper use of AI are attributed to the health professionals who deserve them.

- **AAPA Recommendation: AAPA recommends that HHS work with Congress to address the complications of inaccurate data collection caused by "incident to" and further explore similar transparency concerns brought about by split (or shared) visit billing and global surgical packages so the benefits of AI are attributable to the appropriate health professional.**

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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).[5] 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 organizations,[6] professional training programs,[7] and state and territory laws and licensure.[8] 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 further requests that HHS implement federal protections regarding the use of health professional titles by AI. Specifically, we recommend that HHS review a law[9] implemented by California as of January 1, 2026, which enforces existing license misrepresentation laws against any person or entity that develops or deploys AI or GenAI that, in the AI's or GenAI's advertising or functionalities, uses one or more "terms, letters, or phrases to indicate or imply possession of a license or certificate to practice a health care profession…" This law may serve as a roadmap to a similar federal protection of heath professional titles. Similarly, we suggest that the transition to increased use

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[5] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46. 2025. https://www.ecfr.gov/current/title-20/chapter-II/subchapter-B/part-220/subpart-F/section-220.46

[6] 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.

[7] 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.

[8] Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/newscentral/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)

[9] AB-489 Health care professions: deceptive terms or letters: artificial intelligence. California Legislative Information. Accessed February 19 2026. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB489

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of AI will require a broad review of existing protectionary laws, beyond those related to title, to determine applicability to those responsible for technology that has yet to be included in regulatory language.

Thank you for the opportunity to provide comments regarding the Artificial Intelligence request for information. AAPA welcomes further discussion with HHS 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,

Todd Pickard, DMSc, PA-C, DFAAPA, FASCO
President & Chair of the Board
American Academy of Physician Associates

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