January 23, 2025

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
File Code: CMS-4208-P

RE: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Administrator Brooks-LaSure,

The American Academy of PAs (AAPA), on behalf of the more than 178,000 PAs (physician assistants/physician associates) throughout the United States, would like to provide comments on the 2026 Medicare Advantage Program proposed rule. PAs provide hundreds of millions of patient visits each year, many which are with Medicare beneficiaries, including those with Medicare Advantage (MA). As such, many of the provisions in the proposed rule affect PAs and their patients. AAPA has organized our comments according to topics that CMS identifies in the proposed rule.

<u>Provider Directories</u>

In the proposed rule, CMS proposes to require that data regarding an MA plan's provider directories be submitted to Medicare. This data will then be used to help populate the Medicare Plan Finder, which helps beneficiaries identify care options available under their plan and in their geographic location. It is also proposed that, when submitting the data, MA plans must attest that the data is accurate and consistent with separately reported network adequacy requirements. CMS indicates that these changes will increase transparency and, as a result, enhance beneficiaries' understanding of the care options available to them.

AAPA approves of policies that offer beneficiaries increased transparency and more information regarding care availability. It is our hope that the submission of such data to Medicare, and requirements for alignment with separately reported data, will enhance accountability for payers to maintain accurate provider directories. CMS has recognized the inadequate state of provider directories as recently as its 2022 RFI[1] on the subject, noting that provider directories in their current form often display inaccurate or redundant information and are often missing essential information that may be valuable to beneficiaries/patients. AAPA believes the value of provider directories is in helping beneficiaries identify both those providers who are available to provide care, as well as those most suited for their care needs. Consequently, provider directories are most successful when the information contained in them is 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. However, even when PAs are included in provider directories, there is a potential for incomplete information to be made available that hinders beneficiary choice and access. Provider directories are typically designed so that a beneficiary is prompted to search for a potential provider based upon the alignment of their care needs and 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 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 MA plan.

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 rapidly 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

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[1] 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-of-healthcare-providers-and-services

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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 losing health professionals due to provider burnout; 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 MA plans 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.

AAPA further believes that mandating the inclusion of PAs in provider directories in a searchable manner aligns with the goals of CMS's proposal within the rule to define "direct furnishing entity" and require their inclusion in provider directories. CMS is clear that the intention of such an addition is that beneficiaries have the right to know what care options are available and who provides care to them and accesses their private information. AAPA concurs with this notion and believes beneficiaries should have access to all necessary information regarding those who are, or may be, providing their services. Consequently, to further CMS's goals of increased transparency and enhanced patient access to care, AAPA urges the agency to require PA inclusion in provider directories to be intuitively searchable to beneficiaries.

Behavioral Health Services Under Medicare Advantage Plans

The proposed rule contains multiple provisions seeking to improve behavioral health under MA plans. Among these provisions are efforts to reduce access burdens for beneficiaries to receive behavioral health services. Specifically, CMS proposes that starting in 2026, in-network cost-sharing for behavioral health services be no greater under MA plans than for Traditional Medicare. AAPA approves of this proposal to reduce MA beneficiary burden in accessing these timely and necessary services. We encourage CMS to make additional access-enhancing requirements for parity between MA and Traditional Medicare, such as ensuring that private payers implementing MA plans are not prohibiting qualified health professionals like PAs from providing behavioral health services to their beneficiaries.

Both Traditional Medicare and MA beneficiaries are already facing 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.[2] Demand for

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[2] 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

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mental health services is increasing, causing patient access to decrease.[3] Untreated mental and behavioral health conditions can result in disability, isolation, substance abuse, family discord, and death.[4]

122 million people live in communities with limited access to mental healthcare services.[5] 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.[6] 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.[7] 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.[8] These problems will be further magnified in rural and underserved areas.

To meet these challenges, all qualified health professionals must be authorized to practice to the fullest 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.

PAs are trained and qualified to treat behavioral and mental health conditions through their medical education,[9] 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.[10] This provides a foundation for addressing the diverse medical needs of people with

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[3] American Psychological Association. *Increased need for mental health care strains capacity.* https://www.apa.org/news/press/releases/2022/11/mental-health-care-strains. November 2022.
[4] Mayo Clinic. *Mental Illness.* https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968. Dec 13, 2022.
[5] 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.
[6] National Council for Mental Wellbeing. *The psychiatric shortage: Causes and solutions.* https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/. March 2018.
[7] 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-health-workforce/data-research/state-level-estimates-report-2018.pdf
[8] National Council for Mental Wellbeing. *The psychiatric shortage: Causes and solutions.* https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/. March 2018.
[9] ARC-PA. *Accreditation Standards for PA Education. Fifth Edition.* https://www.arc-pa.org/wp-content/uploads/2024/07/Standards-5th-Ed-July-2024.pdf. 2024
[10] American Academy of Physician Associates. *What is a PA?* https://www.aapa.org/what-is-a-pa/. Accessed January 13, 2024.

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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.[11] 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.

PAs have been demonstrated to improve access to care while providing high levels of quality and patient satisfaction similar to physicians.[12] 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 health care to patients, as is allowed under Traditional Medicare, can alleviate ongoing and worsening trends in access to behavioral and mental health services.

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.[13] This growth projection, along with PAs' qualifications, suggests an increased utilization of PAs will be an effective method to address the country's mental and behavioral health workforce deficiencies and access concerns.

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,[14] CMS's inclusion of PAs as authorized

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[11] 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/

[12] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the health care delivery system.* https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_medpac_reporttocongress_sec-pdf/. June 2019.

[13] US Bureau of Labor Statistics, US Department of Labor. *Occupational Outlook Handbook. Physician Assistants*. 2024. https://www.bls.gov/ooh/healthcare/physician-assistants.htm.

[14] 21st Century Cures Act. Public Law No: 114-255 2016. https://www.congress.gov/bill/114th-congress/house-bill/34

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providers in community mental health centers,[15] and establishing PAs as mental and behavioral health providers at the state level.

While Traditional Medicare, many state Medicaid programs, and some commercial payers cover behavioral and mental health services provided by PAs, some private payers, many of which interact with Medicare and its beneficiaries through the provision of MA plans, 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 more qualified care options.

Reporting of Prior Authorization Data

Prior authorization is a utilization management tool in which a payer requires a healthcare professional to receive approval for a medical or surgical service prior to providing care to a patient. Payers establish it to reduce the excessive utilization of services, ensure medical necessity, control costs, confirm standards of care are met, and verify service coverage. However, health professionals and, as a result, patients have found that the additional administrative burden created by the prior authorization process can sometimes lead to delays in the timely provision of care. Patients may then wait longer to receive needed care or forgo care, potentially leading to an increase in payer expenditures and/or deterioration of a patient's medical condition and the need for additional, potentially more expensive care.

[15] Condition of participation: Personnel qualifications. 42 CFR § 485.904. 2021. https://www.law.cornell.edu/cfr/text/42/485.904

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AAPA has advocated for reforms to the prior authorization process in prior comment letters to CMS. Reforms AAPA has recommended include objective assessments of which services may require prior authorization, data-driven assessments of whether specific prior authorization requirements are improving health outcomes or are merely deterring care, enhanced automation of the prior authorization process, and timely completion of reviews required for service approvals. AAPA reiterates these recommendations and wishes to commend CMS for significant progress in many of these areas.

In a previously finalized rule, CMS required MA payers to report certain prior authorization metrics publicly. Examples of such metrics include the payer's volume of approvals and denials, the timelines for approval or denial, the number of appeals processed, and other requirements. AAPA approved of this requirement for public reporting as it fosters accountability. We suggested in previous comments that CMS further consider requiring reporting of approvals and denials by the types of medical and surgical services provided to increase transparency.

Consequently, AAPA is pleased that, in the 2026 proposed rule, CMS seeks to require that, as a part of annual health equity analyses of utilization management, data reported on prior authorization be categorized by item or service rather than aggregated for all services. Stratifying prior authorization data by services allows for essential distinctions, such as which services are being disproportionately denied and which may overlap with services CMS has separately identified as underutilized.

MA plans frequently require prior authorizations as a cost-saving mechanism.[16] Accountability for the proper use of this utilization management tool is essential to maintain health equity and access standards. We urge CMS to finalize its proposed policy.

<u>Artificial Intelligence</u>

In the proposed rule, CMS again brings attention to the emerging issue of artificial intelligence (AI) in healthcare. Specifically, CMS indicates that coverage determination tools using AI should not lead to inequitable treatment. The use of AI increases the risk of automated bias if decisions are based on insufficient or incorrect data that are common in large datasets reflecting underserved communities. The agency is concerned that biased data inputs or algorithmic flaws could result in discrimination against such underserved communities.

In the rule, CMS clarifies that new tools such as AI may not violate existing CMS rules regarding equitable beneficiary access to treatment. As such, if an MA plan uses AI or automated systems, it must be done in a manner

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[16] Wang, P. *The Pros and Cons of Medicare Advantage.* Consumer Reports. November 2022. https://www.consumerreports.org/medicare/pros-and-cons-of-medicare-advantage-a6834167849/.

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that meets previously codified standards for equitable access to services. Responsibility for ensuring continued equitable access is placed on MA plans, with CMS oversight and enforcement.

AAPA approves of CMS's clarification of requiring plans that use AI to ensure continued adherence to equitable access rules. The promise of automated decision-making tools is limited by the data quality used. As such, our organization has long encouraged CMS to take action to address the use of "biased data inputs" to mitigate the negative effects such biased data may have on PAs and the patients who receive services from PA. The risk of adverse decisions resulting from biased data could be amplified as AI assumes more roles in decision-making processes.

One example of biased data having deleterious effects, noted frequently by AAPA, is the use of incomplete or inaccurate data resulting from Medicare's "incident to" billing provision. "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 concern is "incident to" billing of 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 service utilization are lost. This lack of transparency could adversely affect the assessment of a practitioner's appropriate use of diagnostic tests and resource utilization, resulting in improper determination decisions and possibly delaying a patient's access to care.

In the future, AI may be utilized for myriad functions, including approving or denying prior authorization requests, assessing quality and assigning payment in value-based care models, and helping beneficiaries identify care options. The accuracy of conclusions determined under these examples is hindered by inaccurate data regarding provider attribution of services, which can result from the use of the "incident to" billing provision. For example, data-driven interpretations biased by "incident to" could cause AI to deny a prior authorization request for a health professional to provide a service they are qualified to perform but whose services have been attributed to another practitioner, such as a physician. Such an erroneous conclusion could lead to unnecessary denials and delays in treatment. Further, quality assessment and determinations of resource utilization are skewed when services are not attributed to the rendering provider of a service, and both the PAs having their services billed "incident to" and the physicians to whom those services are attributed have incomplete or inaccurate data that can bias assessments and determinations made based on those assessments. This would undermine the intention of value-

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based care to incentivize health professionals based on their performance. It could also lead to inaccurate depictions of provider quality and value, making information on websites like Care Compare flawed.

These examples are only a subset of the potential pitfalls of inaccurate data used by emerging AI systems, with the negative effects compounding as AI use broadens. As there are many potential benefits to the increased use of AI in healthcare, we expect that the role of AI will continue to expand. As such, AAPA urges CMS to further address biased data inputs by eliminating policies that seek to obscure attribution transparency as expeditiously as possible. AAPA also expects AI systems to assess all practitioners similarly and not impose biases based on differences in training, certification, or licensure.

Coverage of Anti-Obesity Medications

Under Medicare Part D, drugs used for weight loss have traditionally been excluded, regardless of medical necessity. In addition, coverage of these drugs has been optional under Medicaid programs. However, due to the prevalence of and risks associated with obesity, CMS proposes to authorize Part D and Medicaid coverage for anti-obesity medications (AOMs) when used to treat obesity. These AOMs would remain excluded under Medicare Part D and optional under Medicaid for patients without obesity or another medically accepted indication who use them for weight loss or chronic weight management.

While some of these medications are authorized for use with other medically accepted conditions prior to this proposed rule, the expanded authorization extends the ability to use these drugs for people with obesity. AAPA approves of CMS's reinterpretation of statutory drug exclusions. The coverage of AOMs to treat obesity recognizes obesity as a disease, as it is by various health authorities and institutions, including the World Health Organization[17] and the Centers for Disease Control and Prevention[18].

Obesity, or the presence of excessive fat resulting in a Body Mass Index of 30 or higher, presents a significant health risk to nearly 33% of adults in the United States.[19] A medical concern in its own right, obesity has also been

[17] World Health Organization. *Obesity and overweight.* https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight#:~:text=Overview,the%20risk%20of%20certain%20cancers. March 2024.
[18] Centers for Disease Control and Prevention, Department of Health and Human Services. *About Obesity*. January 2024. https://www.cdc.gov/obesity/php/about/index.html
[19] Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Department of Health and Human Services. *Data, Trends, and Maps*. https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByTopic&islClass=OWS&islTopic=&go=GO

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shown to be a compounding factor in other diseases such as diabetes, heart disease, certain cancers, high blood pressure, and other diseases.[20] Like many chronic diseases, in addition to the direct health harms, obesity can affect an individual's mental health and reduce quality of life.[21]

For many years, obesity has been of great importance to AAPA from both a public health and health equity perspective, resulting in obesity being one of AAPA's national health priorities.[22] AAPA, in conjunction with other groups, developed the Primary Care Obesity Management Certificate Program,[23] which supports PAs and NPs in treating patients who have obesity. We have worked on strategies to mitigate the obesity epidemic through the Obesity Care Advocacy Network, providing public comments on the importance of a broad approach to treatment, including the coverage of AOMs. AAPA has included obesity-related educational opportunities at our national conferences,[24] and has ongoing efforts to provide resources,[25] education,[26] and training[27] to PAs on obesity and nutritional, behavioral, and pharmacologic interventions for obesity.

AAPA appreciates CMS's proposal to extend coverage under Medicare Part D and Medicaid to include AOMs when medically necessary, including to treat obesity. AAPA had previously written comments to the agency supporting this.[28] In those comments we asserted that the interventions used to address the obesity epidemic are as multi-faceted as the contributing factors to the disease and that the effectiveness of interventions can vary depending on an individual and their circumstances. Health professionals such as PAs must be authorized to utilize all available treatments that have been proven to be safe and effective in treating obesity. Consequently, AAPA urges

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[20] Mayo Clinic. *Obesity.* https://www.mayoclinic.org/diseases-conditions/obesity/symptoms-causes/syc-20375742#:~:text=Obesity%20is%20a%20complex%20disease,blood%20pressure%20and%20certain%20cancers July 2023.

[21] The Nutrition Source. *Obesity*. https://nutritionsource.hsph.harvard.edu/obesity/.

[22] American Academy of Physician Associates. AAPA's National Health Priorities & PA Resources. https://www.aapa.org/cme-central/national-health-priorities/

[23] American Academy of Physician Associates. 2024-2025 Obesity Management in Primary Care Professional Development and Certificate Program. https://www.aapa.org/cme-central/primary-care-obesity-management-certificate-program/#tabs-3-about-the-program

[24] American Academy of Physician Associates. Conference on Demand 2020. https://www.aapa.org/conference-2020/

[25] American Academy of Physician Associates. National Health Priority Toolkit: Nutrition. https://www.aapa.org/cme-central/national-health-priorities/nutrition-toolkit/#tabs-3-overview

[26] American Academy of Physician Associates. AAPA and Abbott Partner to Offer Monthly Nutrition-Related Content to PAs. https://www.aapa.org/news-central/2020/03/aapa-and-abbott-partner-to-offer-monthly-nutrition-related-content-to-pas/. March 2020.

[27] American Academy of Physician Associates. Nutrition Resources Help Serve Diverse Communities. https://www.aapa.org/news-central/2021/03/nutrition-resources-help-serve-diverse-communities/. March 2021.

[28] Comments re: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. American Academy of Physician Associates website. https://www.aapa.org/download/95317/?tmstv=1734453102. March 2022.

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CMS to finalize its proposed coverage of AOMs in the identified circumstances under Medicare Part D and Medicaid.

Professional Title

AAPA requests that all references to PAs in regulations and policies be listed as "Physician Assistants/Physician Associates", as is .[29] 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 (i.e., Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (i.e., 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,[30] professional training programs,[31] and state and territory laws and licensure.[32] 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 properly refer to the PA profession as "physician assistants" in all official documents. We also encourage CMS to begin to reference the profession by the dual title "physician assistant/physician associate."

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[29] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. https://public-inspection.federalregister.gov/2025-00515.pdf

[30] 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.

[31] Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), 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.

[32] Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/news-central/2024/04/oregon-governor-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).

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Thank you for the opportunity to provide comments regarding the 2026 Medicare Advantage Program 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,

Jason Prevelige, DMSc, MBA, PA-C, DFAAPA
President and Chair, Board of Directors

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