October 21, 2026

Amol S. Navathe, M.D., Ph.D.
Chair
The Medicare Payment Advisory Commission
425 I Street NW, Suite 701
Washington, DC 20001

RE: October 2026 Public Meeting

Submitted via email: meetingcomments@medpac.gov

Dear Chair Navathe,

The American Association of Nurse Practitioners (AANP), representing the interests of the over 461,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on the proceedings of the October 2026 meeting of the Medicare Payment Advisory Commission (MedPAC). We appreciate the Commission's continued commitment to supporting policies which reflect the importance of all health care providers to Medicare patients. We support the Commission's continued focus on transparency by reiterating the importance of reforms to "incident to" billing. However, we strongly object to Commission staff's decision to exclude NPs from its analysis of Medicare Advantage (MA) provider networks. The Commission has historically emphasized the importance of NPs to the Medicare program through the increasing amount of care they provide. Therefore, an analysis of provider networks which does not include NPs is inadequate and will not accurately reflect the access landscape for Medicare patients. We appreciate many of the Commissioners raising the importance of NPs during the discussion and respectfully request Commission staff revise their analysis commensurate with the points raised by the Commissioners.

As you know, NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform nearly one billion patient visits annually. Currently, twenty-seven states, the District of Columbia and two U.S. territories have adopted full practice authority (FPA), granting patients full and direct access to nurse practitioners.

NPs practice in nearly every geographic region and health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and provide the most home-based care to Medicare beneficiaries.

NPs provide a substantial portion of the high-quality[1], cost-effective[2] care that our communities require. According to the Centers for Medicare and Medicaid Services (CMS), as of 2024, there were over 243,000 NPs billing for Medicare services, making NPs the largest Medicare designated provider

[1] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[2] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.

specialty,[3] and approximately 80% of NPs are seeing Medicare and Medicaid patients.[4] NPs have a particularly large impact on primary care as approximately 70% of all NP graduates are prepared in primary care.[5] Included below are our comments on topical areas of discussion during the meeting.

Physician participation in Medicare Advantage provider networks: Comparing provider directories with encounter data

In this section, Commission staff presented information on provider participation in MA networks. In direct conflict with previous work performed by the Commission, including its most recent discussion in March of 2026, staff purposefully chose to exclude NPs and physician assistants (PAs) from this analysis. Any analysis of provider participation in MA is inaccurate and incomplete without inclusion of NPs. The Commission has repeatedly emphasized the importance of NPs and PAs to the Medicare program, and the staff decision to exclude them based on variables in data is contrary to the Commission's previous work.

In fact, according to the Commission's own data, APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[6] As stated in the July 2025 data book, Medicare "encounters with APRNs and PAs grew rapidly from 2018 to 2023 (50 percent in total), and encounters with primary care physicians declined substantially (–22 percent)."[7] Further, the Commission highlights that these changes "continue a longer-term trend of declines in services billed by primary care physicians and rapid increases in the number of services billed by APRNs and PAs."[8] Fifty-seven percent of Medicare beneficiaries received a primary care service from an NP or PA, and sixty-six percent of rural Medicare patients received a primary care service from an NP or PA.[9] Utilizing the Commission's own data, it is clear that any discussion of this topic which does not include NPs provides an incomplete analysis of provider participation in MA networks.

In the discussion of their decision to exclude these providers from their calculations, staff cited numerous data challenges in identifying provider participation in networks. These include the practice of "incident to" billing which obscures certain provider participation statistics, as well as the variation in how NPs are included in provider directories by plans. It should be noted that staff cited 'scope of practice' here as well, which does not impact whether a provider participates in Medicare advantage. We agree with staff that these challenges reflect the current state of MA plans for both patients and providers. We believe it is important for the analysis to reflect that reality, rather than exclude providers from an analysis because of it.

CMS highlighted these challenges in a recently proposed rule to implement key sections of the Consolidated Appropriations Act of 2026 including section 6220 (Requiring Enhanced and Accurate Lists of (REAL) Health Providers Act.[10] The REAL Health Providers Act establishes new provider directory verification and accuracy requirements for Medicare Advantage organizations beginning in contract year 2028. Section 1857(e)(6)(A) of the Act requires that beginning with plan years beginning on or after January 1, 2028, each MA organization must conduct an annual analysis estimating the accuracy of the provider directory information of each specified MA plan using a random sample of providers included in such provider directory. This sample has to include a random sample of each specialty of providers with a

[3] https://www.cms.gov/files/zip/cy-2026-pfs-proposed-rule-specialty-impacts-practitioner.zip
[4] https://storage.aanp.org/www/documents/NP_Infographic.pdf
[5] Ibid
[6] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[7] July 2025 Data Book: Health Care Spending and the Medicare Program – MedPAC
[8] Ibid
[9] Ibid
[10] 2026-21420.pdf

high inaccuracy rate of provider directory information relative to other specialties of providers, as determined by the Secretary, and one type of specialty may be providers specializing in mental health or substance use disorder treatment. The proposed rule includes psychiatric mental health NPs as a mental health or substance use disorder treatment provider specialty type with high provider directory inaccuracy rates under the NUCC taxonomy code 363LP0808X.[11]

The Commission's work should reflect the impact of these challenges. Rather than excluding providers because of these challenges, including NPs and PAs in the analysis could provide significant insight into the actual adequacy and accuracy of MA plan networks. There are plan provider directories which exclude nurse practitioners or make it a challenge for patients to select them as a provider, simply because of their level of licensure. If the purpose of this analysis is to examine provider networks and directories, we believe it must reflect the reality rather than ignore it because of the difficulties. We appreciate Commissioners Konetzka, Upchurch, Pierotti, Masi and Casale raising the importance of NPs in their remarks. It is our hope that the Commission staff will revise their analysis commensurate with the discussion points raised by the Commissioners. We would be happy to work with Commission staff on ways to capture NP participation within MA plans.

"Incident To" Billing and Payment Accuracy

We strongly support the Commission's continued focus on the impact of "incident to" billing on payment accuracy within the Medicare program. As noted in this presentation, the concerns over "incident to" billing were expressed by the Commission in the June 2019 report.[12] MedPAC recommended "eliminating incident to billing for APRNs", which would "update Medicare's payment policies to better reflect current clinical practice."[13] The analysis stated that "the recommendation is expected to reduce Medicare program spending by $50 million to $250 million in the first year and by $1 billion to $5 billion over the first five years compared with current law." Further, MedPAC noted that it is "not expected to adversely affect beneficiaries' access to care" while it would also improve "policymakers' knowledge of who provides care for Medicare beneficiaries."[14]

Since the 2019 report, further research has been conducted examining the impact of this policy on the Medicare program. A study published in *Health Affairs* found that in 2018, 19.9 million visits performed by NPs were billed 'incident-to' comprising 35.6% of visits performed by NPs.[15] As noted by the researchers, within administrative claims data a service performed by an NP, but billed incident to a physician, is indistinguishable from a service performed by the physician directly.[16] A recent study published in the Journal of the American Medical Association further underscores these issues. This study found that in 2022, of all office encounters provided by an advanced practice clinician (APC), 38.9% were billed indirectly and if all indirectly billed APC-provided care was billed directly by the APC, Medicare would have saved $270 million in 2022.[17]

In its July 2026 data book, the Commission found that NP participation in the Medicare Shared Savings Program (MSSP) and other Alternative Payment Models (APMs) was high, with 54% of NPs who billed at least one Medicare fee-for-service beneficiary participating in the MSSP in 2023.[18] APRNs and PAs

[11] Ibid
[12] jun19_medpac_reporttocongress_sec.pdf
[13] Ibid.
[14] Ibid
[15] oi: 10.1377/hlthaff.2021.01968 HEALTH AFFAIRS 41, NO. 6 (2022): 805–813.
[16] Ibid.
[17] Quantifying Indirect Billing Within the Medicare Physician Fee Schedule - PMC
[18] https://www.medpac.gov/wp-content/uploads/2026/07/July2026_MedPAC_DataBook_SEC.pdf, at page 45.

were also one of the largest categories of clinicians who qualified for an A-APM bonus, with 34% qualifying for the bonus. However, APRNs and PAs only received 13% of the bonus payments.[19] MedPAC attributed this disparity to three primary causes: the historic 15% payment disparity that APRNs and PAs receive relative to physicians, providing a greater number of services that Medicare reimburses at lower rates, and "incident to" billing which could lead to additional bonuses being paid to physicians based on services performed by APRNs or PAs.[20]

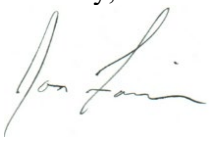
These studies also underscore the difficulties in obtaining accurate data on the utilization of "incident to" billing in Medicare. Beginning in 2027, Congress is requiring a modifier for telehealth visits furnished "incident to", but this requirement does not exist for non-telehealth visits. We applaud the Commission's recommendation to eliminate the utilization of "incident to" billing for NPs. In absence of Congressional action on this policy, we also believe that CMS should establish a modifier for "incident to" billing for NPs. As noted by MedPAC and other outside studies, the agency does not currently have a method to track the utilization of incident to billing. Establishing a modifier will ensure the agency can determine the rates of this billing mechanism and determine if it is being properly utilized within the guidelines established by the agency.

Finally, we do have concern with the statistics utilized in this presentation as it relates to NPs in primary care. In 2026, approximately 84 percent of NPs were prepared in primary care.[21] The Commission's own surveys show that 57 percent of Medicare beneficiaries report seeing an NP or PA for any of their primary care, with that number rising to 66 percent for rural beneficiaries.[22] According to the Commission's reports, APRNs and physician assistants (PAs) comprise approximately one-third of our primary care workforce, and up to half in rural areas.[23] The study cited by staff in this presentation adopts a restrictive viewpoint of what is considered "primary care" and as a result, underestimates the portion of primary care provided by NPs. We would be happy to work with the Commission on establishing an accurate representation of the proportion of primary care provided by NPs.

Conclusion

We appreciate the opportunity to provide comment on the proceedings of the October 2026 meeting of MedPAC. We support the Commission's continued commitment to policies which reflect the importance of all health care providers to Medicare patients. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,



Jon Fanning, MS, CAE, CNED
Chief Executive Officer
American Association of Nurse Practitioners

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[19] *Ibid at page 48.*
[20] *Ibid.*
[21] All About NPs
[22] *MedPAC, A Data Book: Health Care Spending and the Medicare Program, July 2025, Charts 7-15 and 7-24.*
[23] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)