



October 13, 2026

The Medicare Payment Advisory Commission
425 I Street NW, Suite 701
Washington, DC 20001

Dear Medicare Payment Advisory Commission,

Thank you for the opportunity to discuss Medicare's "incident to" billing policy and its implications for physician associate/physician assistant (PA) services. We appreciated the opportunity to share the American Academy of Physician Associates' (AAPA) perspective on behalf of the more than 200,000 PAs in the United States.

As we discussed, AAPA shares MedPAC's concerns about the lack of transparency and attribution when PA services are billed "incident to" a physician. As such, claims billed "incident to" should identify both the name and National Provider Identifier (NPI) of the actual practitioner who provided the service, and a modifier analogous to that used for split (or shared) services should be used. These requirements would help quantify the use of "incident to" billing and more accurately attribute services, quality, and resource use to the actual provider. Additionally, Congress should consider ending PA services billed "incident to" a physician while preserving the billing mechanism for ancillary staff, such as nurses and pharmacists, so those services can be billed "incident to" a PA or a physician. However, if such changes are made to "incident to," it is critical that they be accompanied by an appropriate increase in the payment rate for PAs relative to physicians and the removal of various statutory payment barriers.

AAPA regards the 85 percent PA payment rate, a 15 percent reduction from the physician rate, as arbitrary rather than reflecting a factual difference in services, as MedPAC has noted in the past.¹ MedPAC and others² have suggested that PAs should receive comparable payment as physicians for similar services and

¹ Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment to Advanced Practice Nurses and Physician Assistants*. Published June 2002. Accessed October 6, 2026. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun02_NonPhysPay.pdf

² Waxman S, Dechene J. Expanding the scope of practice for nurse practitioners and physician assistants to enhance healthcare. *Annals of Health Law and Life Sciences*. 2024;33(1):101-127. <https://lawecommons.luc.edu/annals/vol33/iss1/3>.

outcomes. Under the current valuation methodology (derived from a relative value unit comprising a work component, practice expense, and professional liability), the only potential difference in an appropriate payment value would come from the liability component, which accounts for less than 5 percent of the calculation.³ Although limited malpractice relative value unit differences may warrant consideration for some payment differential, they do not justify a blanket 15 percent reduction.

The elimination of statutory barriers should also be addressed. Current PA limitations have necessitated reliance on the “incident to” physician billing pathway. For example, PAs may only certify the need for therapeutic shoes for patients with diabetes “incident to” a physician.⁴ Therefore, ending “incident to” billing without resolving the relevant limitations could remove a pathway clinicians and patients rely on.

The suggested changes would also benefit beneficiaries. A key element in ensuring healthcare is consumer-centric is providing patients with relevant, accurate information about their health status, the care they receive, and the health professionals delivering it. After receiving care, each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB). The MSN/EOB identifies the service the patient received and who delivered the care, along with other visit details. “Incident to” billing often confuses patients because the name of the health professional who provided care does not appear on the MSN/EOB notice. When PA services are billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who did not see the patient, which can cause patients, who are increasingly aware of issues such as fraud, to question the accuracy of the MSN/EOB and whether they need to correct what appears to be erroneous information regarding their visit. Additionally, eliminating “incident to” without removing statutory barriers, such as in the example of therapeutic shoes currently being able to be ordered by a PA “incident to”, could result in patients with diabetes having an additional visit with a physician, solely to meet Medicare’s physician certification and order requirements. This may cause additional access burdens or decrease patient satisfaction with the care experience. It may also increase costs to the patient and the Medicare system.

AAPA also requests that MedPAC refer to the PA profession as “physician associate/physician assistant” in meetings, reports, and materials. The PA profession is currently transitioning the title to “physician associate” at the state and federal level. Eight states⁵ recognize the title “physician associate” in clinical

³ American Medical Association. *RBRVS overview*. Updated November 14, 2025. <https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview>.

⁴ Centers for Medicare & Medicaid Services. Therapeutic shoes for persons with diabetes—policy article (A52501). *Medicare Coverage Database*. Revision effective December 5, 2024. Accessed October 6, 2026. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52501>

⁵ American Academy of Physician Associates. *Title change*. Accessed October 6, 2026. <https://www.aapa.org/advocacy-central/title-change/>

practice, and accrediting bodies⁶, certifying entities⁷, and federal agencies⁸ (including in 20 CFR § 220.46(a)(9)) recognize both titles. Additionally, a national taxonomy update is pending, with the National Uniform Claims Committee accepting AAPA's code request change for 363A00000X from "physician assistant" to "physician assistant/associate", which will take effect in 2027. As claims-level data changes and the title change initiative continues at the state and federal level, we ask MedPAC to use "physician associate/physician assistant" for clarity to inform current and future policy decisions.

Thank you again for considering AAPA's perspective. We welcome the opportunity to work with MedPAC to improve transparency and attribution, recognize PA services, and protect patient access. For any questions you may have, please do not hesitate to contact Sondra DePalma, AAPA Vice President of Reimbursement and Professional Practice, at sdepalma@aapa.org or Tate Heuer, VP of Federal Advocacy, at theuer@aapa.org.

Sincerely,

Sondra M. DePalma, DHSc, PA-C, Vice President, Reimbursement and Professional Practice

Tate Heuer, VP, Federal Advocacy

⁶ Accreditation Review Commission on Education for the Physician Assistant. *ARC-PA accreditation handbook for entry-level PA programs*. November 2024. <https://www.arc-pa.org/wp-content/uploads/2025/05/Accreditation-Handbook-Nov2024.pdf>

⁷ National Commission on Certification of Physician Assistants. *NCCPA board certification and title change*. Accessed September 10, 2025. <https://www.nccpa.net/resources/board-certification-and-title-change/>

⁸ Code of Federal Regulations: Medical evidence. 20 CFR § 220.46 . 2025. <https://public-inspection.federalregister.gov/2025-00515.pdf>