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September 12, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: ACAAI's Comments on the 2026 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule (CMS-1832-P)

Dear Administrator Oz:

The American College of Allergy, Asthma and Immunology ("ACAAI") and its Advocacy Council appreciate the opportunity to submit comments on the 2026 Medicare Physician Fee Schedule and Quality Payment Program proposed rule ("Proposed Rule"). The Advocacy Council and the ACAAI represent the interests of more than 6,000 allergists-immunologists and allied health professionals. Our members provide patient services across a variety of settings, ranging from small or solo physician offices to large academic medical centers.

In the Proposed Rule, the Centers for Medicare and Medicaid Services ("CMS") offers numerous proposals impacting provider payment under Medicare. Our comments are confined to the following proposed policies and concepts in the Proposed Rule:

- Changes to the Medicare physician fee schedule conversion factor and related reimbursement rates;
- Practice expense value of Current Procedural Terminology ("CPT") Code 95165 and practice expense methodology;
- Direct supervision flexibilities;
- Efficiency adjustment changes;
- Evaluation and management ("E/M") complexity add-on code utilization estimates;
- Geographic Practice Cost Index Floor;
- Request for Information ("RFI") on Prevention and Management of Chronic Disease;
- Telehealth; and
- Quality Payment Program proposals;

Physician Reimbursement

The Advocacy Council and the ACAAI support the proposed 2026 conversion factors of $33.5875 for Qualifying Alternative Payment Model ("APM") Participants and $33.4209 for all other items or services, which reflect an increase of 3.83% and 3.32%, respectively. We appreciate CMS's recognition of the financial pressures facing physician practices—particularly those in small and rural settings—that continue to operate under challenging economic conditions. The proposed increase to the conversion factor represents a meaningful step toward addressing the growing gap between the cost of providing care and the reimbursement physicians receive. Rising inflation, persistent workforce shortages, escalating administrative demands, and the increasing cost of medical supplies and technology all compound the strain on practices striving to meet patient needs. By adjusting the conversion factor upward, CMS acknowledges these realities.

That said, the Advocacy Council and the ACAAI recognize that annual updates to the conversion factor alone cannot fully resolve the instability of the Medicare payment system. We therefore urge the agency to work closely with Congress to develop and advance long-term, sustainable solutions that move beyond short-term adjustments.

Practice Expense Value of CPT Code 95165

On February 7, 2025, ACAAI submitted a request to CMS to update the supply costs for CPT code 95165. The letter indicated that the current reimbursement levels for allergen immunotherapy services described by CPT code 95165 are inadequate, adversely impacting providers and the patients they serve. The current direct cost input for this supply is $8.96. Based on the invoices that we received from our members across the country, we requested that the cost input for 1 mL of SH007, antigen, multi (pollen, mite, mold, cat) be increased to $17.07.

In this Proposed Rule, CMS has proposed to increase the direct cost input for CPT code 95165 from $8.96 to $13.00, a 45% increase. We greatly appreciate CMS's recognition that current direct cost inputs are inadequate to compensate allergists for the costs of providing allergen immunotherapy services. However, we have significant concerns that the direct cost input for CPT code 95165 continues to be undervalued and is based on flawed assumptions regarding purchase volumes.

In calculating $13.00, CMS averaged the 50 mL prices provided to CMS, operating under the assumption that it is not typical for practitioners to purchase the smaller and more expensive 5 mL quantities. We wish to take the opportunity to underscore that allergists often purchase smaller quantities of allergens. The majority of allergy practices in the United States are small practices, including solo practitioners, and it is unlikely that these practices would administer a sufficient volume of allergy immunotherapy to justify the need for bulk 50 mL purchases. Additionally, allergy practices must observe USP 797's one-year beyond-use date ("BUD") when the extract is "mixed." If certain allergy practices, particularly small and independent practices, were to purchase the antigens in 50 mL quantities, they may have to discard a significant volume at the end of the year, leading to unnecessary waste of natural resources.

Therefore, we respectfully request that CMS recalculate the value of SH007 based on the average of *all* invoices of antigens.

Practice Expense Methodology

We commend CMS for its decision to refrain from utilizing the practice expense data in the American Medical Association's ("AMA's") 2023-2024 Physician Practice Information Survey ("PPI Survey") to establish updates to the Medicare Economic Index ("MEI") and the Resource Based Relative Value Scale ("RBRVS"). We believe that the data on practice expense of allergy practices and hours spent in direct patient care by allergy practices were not accurately represented in the PPI Survey report.

When the AMA initially contracted with Mathematica to conduct the PPI Survey, the data collection effort was endorsed by more than 170 organizations, including ACAAI. At that time, the AMA communicated to specialty societies that it would report the PPI Survey data at the aggregate and specialty level.[1] Although we appreciate the AMA's intent and willingness to field this survey, unfortunately, the final report deviated materially from what the AMA originally communicated and what we had endorsed. The AMA did not provide ACAAI with specialty level data (i.e., data specific to allergy/immunology), and did not provide allergy/immunology data to CMS.

Instead, data from several discrete, unrelated specialties were consolidated into a larger category of providers—"Office Based Proceduralists." The term "Office Based Proceduralists" encompasses a wide range of distinct medical specialties: Allergy/Immunology, Interventional Pain Management, Maxillofacial Surgery, Plastic and Reconstructive Surgery, Sleep Medicine, and Urology. Due to the combination of various medical specialties into a single category of "Office Based Proceduralists," the practice expenses of allergy practices were not accurately represented in the PPI Survey report submitted to CMS.

In the 2023-2024 PPI Survey, the total practice expense per hour of direct patient care ("DPC") for "Office Based Proceduralists" (which includes allergists) was approximately $174. This represents a significant, inaccurate decrease in practice expenses of allergy practices since 2007/2008. In the 2007-2008 PPI survey,[2] the allergy/immunology practice expense per hour of DPC was approximately $241. Accordingly, the 2023-2024 PPI Survey represents an astonishing 28% decrease from the 2007-2008 data for allergy/immunology. We believe this significant decrease is not reflective of the expenses of allergy practices, and instead, is due to the arbitrary combination of various medical specialties into the "Office Based Proceduralists" category.

Notably, the practice expense of allergy practices differs significantly from that of other specialties. For instance, urology was also included under the term "Office Based Proceduralists." Comparatively, the urology practice expense per hour of DPC was approximately $133 in the 2007-2008 PPI survey—considerably lower than the data for

[1] AMA, *Physician Practice Survey*, https://www.ama-assn.org/system/files/physician-practice-information-survey-summary.pdf.
[2] AMA, Physician Practice Information Survey, *Practice Expense per Hour 2007/2008* (on file with author).

allergy/immunology ($241) in the same survey. Yet, in the 2023-2024 PPI Survey, urology and allergy/immunology were lumped together. This consolidation, therefore, benefited urology practices and had a devastating impact on allergy practices.

Practice Expense
Specialties Included in Office Based Proceduralist Group
2007/2008 PPI Survey vs. 2023/2024 Survey

	2007/2008	2023/2024	
Specialty	**Total $PE/HR**	**Total $PE/HR**	**% Change**
Allergy and Immunology	**241**	**174**	-28%
Interventional Pain Medicine	**224**	**174**	-22%
Plastic Surgery	**182**	**174**	-5%
Sleep Medicine	**156**	**174**	12%
Urology	**133**	**174**	31%
Maxillofacial Surgery	**N/A**	**174**	N/A
All Physicians	**117**	**134**	14%

There is ample evidence of increased practice expenses in the field of allergy/immunology since the 2007-2008 PPI survey, none of which would support a *decrease* in practice expenses for allergy practices in 2023-2024. For instance, ACAAI recently sent CMS a letter indicating there has been a dramatic increase in antigen costs, which is not reflected in the current practice expense associated with CPT code 95165. Specifically, based on invoices collected from allergists/immunologists across the country and from practices of varying sizes, the current per mL cost of SH007 should be increased to $17.07.[3] Further, in 2023, CMS acknowledged the rising costs of the two supply items for venom immunotherapy (SH009 (single antigen) and SH010 (3-vespid mix)).[4] The prior cost inputs for these supply items were $30.93 and $60.24, respectively. CMS recalculated the cost inputs, which increased to $35.58 and $69.21.

In addition, healthcare staffing costs have increased dramatically in recent years, driven by a combination of labor shortages and the inflationary impact on medical staff salary expenses. Allergy practices require a comparatively high number of staff per physician due to allergy testing and allergy immunotherapy services. In addition, allergy practices must expend funds to comply with the applicable provisions of USP Chapter 797's standards on sterile

[3] Letter from ACAAI and AAAAI to Jeff Wu, Acting Administrator, CMS (February 7, 2025).
[4] Letter from ACAAI and to Chiquita Brooks-LaSure, Administrator, CMS (February 10, 2023).

preparations (Section 21). Further, medical office rental rates have followed this growth and will continue to do so. Just in the next two years, rental growth in the healthcare real estate market is predicted to increase between 1.4% and 1.8%.[5]

Given the general increase in costs and the unique nature of the practice expenses of allergy/immunology, the practice expenses for allergy practices should have *increased*—not significantly decreased—in the 2023-2024 PPI Survey, compared to the 2007-2008 PPI survey. Therefore, we strongly believe that the 2023-2024 PPI Survey data does *not* reflect the true practice expenses of allergy practices. Again, this inaccuracy is due to the arbitrary consolidation of unrelated medical specialties. We understand the creation of the "Office Based Proceduralists" group resulted from the lack of responses to the PPI Survey, notwithstanding ACAAI's repeated encouragement of practitioners to participate. We suspect this could be because the PPI Survey was seen as burdensome and complex to complete. Unfortunately, the structure of the survey did not lend itself to broad participation by allergists/immunologists. While consolidating these medical specialties may have been convenient, it resulted in devastating, inaccurate results for allergy practices.

Therefore, we applaud CMS for not adopting the 2023-2024 PPI Survey data for purposes of allergy/immunology. If CMS decides to move forward with revising practice expense and Relative Value Unit ("RVU") relative weights, we recommend that the agency first issue an RFI on this matter and then promulgate a proposed rule after reviewing the response to the RFI. In addition, CMS should ensure that the accompanying MEI impact tables are broken down by proposal and specialty, particularly for the conversion factor, work RVUs, and practice expense distribution, so that stakeholders may evaluate the data.

Direct Supervision

Medicare direct supervision rules require "incident to" services performed by clinical staff to be under the direct supervision of a physician, which historically meant that the physician was required to be immediately available on-site. During the COVID-19 public health emergency ("PHE"), and extended thereafter, CMS relaxed the direct supervision of clinical staff requirement, allowing the supervising physician/practitioner to be immediately available through virtual real-time audio/visual technology. Now, CMS is proposing to permanently adopt the broader definition of direct supervision, allowing the supervising physician/practitioner to provide such supervision through real-time audio/visual technology for most incident-to services (except for those with global surgery indicators of 010 or 090 that are not applicable to allergists).

The Advocacy Council and the ACAAI strongly support this proposal, as it aims to maintain flexibility in care delivery while addressing the needs of specific patient populations and practice settings. If adopted, the following allergy services would permanently fall under this definition:

[5] CBRE, *2025 U.S. Healthcare Real Estate Outlook* (Nov. 12, 2024), https://www.cbre.com/insights/reports/2025-us-healthcare-real-estate-outlook.

CPT Code	Description
95165	preparation and provision of antigens for allergen immunotherapy
95115/95117	allergen immunotherapy single injection/multiple injections
94010	spirometry
95004	allergy percutaneous test(s) (scratch, puncture, prick)
95044	allergy patch or application test(s)
95076/95079	ingestion challenge test- initial 120 minutes of testing/each additional 60 minutes of testing
95180	rapid desensitization procedure

Efficiency Adjustment

The Advocacy Council and the ACAAI oppose CMS's proposed efficiency adjustment. The agency is proposing to apply an efficiency adjustment of -2.5% for 2026 to the Work RVU and the corresponding intraservice portion of physician time of non-time-based services. This adjustment is based on the sum of the MEI productivity adjustment percentages over the past five years. In proposing this decrease, CMS reasoned that physicians have become more efficient in providing these aspects of services through experience, technology, and operational improvements.

However, the agency's assumption does not consider factors such as increases in care complexity, patient acuity, staff salaries, AI-generated insights, and the electronic health ("EHR") systems that require the same or more resources than in the past. Further, the methods used by CMS to come up with a -2.5% adjustment are inherently flawed and unreliable. First, it is difficult to understand how an across-the-board cut of -2.5% can be accurate across all codes and services. Efficiencies will vary based on the type of care that is provided. Second, we are concerned that the proposal does not have a sunset date. While ACAAI disagrees with CMS's assessment that there are efficiencies that necessitate this adjustment, even taking CMS's adjustment as warranted, it does not follow that efficiencies can continue to be gained year over year. At some point, there is a maximum efficiency that can be realized, and going beyond that point will compromise patient care. Third, CMS's proposal unfairly applies the efficiency adjustment to codes that were recently reviewed and evaluated for accuracy. Lastly, we question whether CMS has the authority to implement an across-the-board efficiency adjustment in this manner.

Due to the numerous flaws with CMS's proposed efficiency adjustment, the Advocacy Council and the ACAAI respectfully request that CMS not finalize this proposal.

E/M Visit Complexity Add-On

The Advocacy Council and the ACAAI respectfully request that CMS revisit its estimate of utilization for G2211. Past utilization assumptions for this code were far higher than actual utilization. Medicare claims data analysis indicates the previous administration severely overestimated utilization of this code, dramatically impacting the Medicare conversion factor via a budget neutrality adjustment. CMS can correct this problem by prospectively increasing the 2026 Medicare conversion factor to prevent this overestimate of budget neutrality from continuing to reduce Medicare payment rates year after year. The $1 billion adjustment to the conversion factor to correct this error would have a much greater impact than the $400 million adjustment for the proposed efficiency adjustment. **CMS should implement a correction to the utilization assumptions for G2211, leading to a positive $1 billion budget neutrality adjustment to the Medicare conversion factor.**

Telehealth

Need for a Permanent Extension

In 2020, rapid action by the administration made telehealth services available to Medicare patients in their homes nationwide for the first time. Its immediate adoption by physicians illustrates the critical role of payment policy as both a barrier and potential catalyst for the uptake of care delivery reforms with known potential to improve value. The 2020 expansion in access was made possible only when long-standing payment barriers were removed. It served as a catalyst for an acceleration in the use of digitally enabled medical care, combining in-person, virtual, remote monitoring, and other service modalities to deliver care that meets patient needs. It is critically important that patients with Medicare all over the United States be able to continue receiving telehealth services and that they can continue receiving them in their homes. The ACAAI strongly urges the current administration to work for the passage of legislation to permanently extend these Medicare telehealth policies.

Potential Requirement to Report Physician's Home Address

Although it is not mentioned in the current proposed rule, the ACAAI is concerned about any potential requirement for physicians who provide telehealth services to report their home address. We urge CMS to permanently remove this requirement and allow physicians to render telehealth services from their homes without reporting their home address on their Medicare enrollment form while continuing to bill from their currently enrolled location. Last year's final rule extended the policy that physicians do not have to report their home address only through the end of CY 2025. We are concerned that requiring physicians to report their home address could disincentivize telehealth services. This is particularly concerning at a time when remote care is used as a necessary tool to address the nationwide physician shortage.

Physician privacy and safety are of the utmost concern, and we fear the unintended consequences of this personal information becoming publicly available. Concerns for privacy and safety are not new, and escalating trends in violence towards physicians and other health professionals demonstrate that they have never been at greater risk of injury due to work-related violence. Any effort towards preserving the privacy and safety of health professionals

must be a top priority for CMS. It is imperative that CMS not allow this flexibility to expire and additionally take the necessary step of removing this requirement permanently.

Geographic Practice Cost Index Floor

Section 1848(e)(1)(A) of the Social Security Act ("SSA") establishes geographic indices that adjust physician payment to reflect the relative costs of goods and services across different areas of the country.[6] Section 1848(e)(1)(E) of SSA sets a Geographic Practice Cost Index ("GPCI") floor of 1.0. Unfortunately, the GPCI floor is set to expire on September 30, 2025. We encourage CMS to work with Congress to ensure that the 1.0 work GPCI floor is renewed. The floor is critical to ensuring allergists are sufficiently compensated for the services they provide, particularly allergists in the west and deep south, who may otherwise fall below this floor.

RFI on Prevention and Management of Chronic Disease

CMS is seeking to better understand and lower chronic disease rates, including focusing on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, the safety and quality of food and drugs. Given this focus, CMS is broadly soliciting feedback on how the agency could enhance the prevention and management of chronic disease.

We would like to take this opportunity to underscore that respiratory allergies rank as the 5th most common chronic disease overall and the 3rd most common among children.[7] Allergies arise when a patient's immune system overreacts to an otherwise harmless substance—known as an allergen—such as dust, pollen, or pet dander. This immune response triggers a range of physical symptoms, from mild manifestations (e.g., sneezing and itching) to severe, potentially life-threatening reactions (e.g., anaphylaxis). Given the substantial health risks and economic burden associated with respiratory allergies, early diagnosis and timely intervention should be a priority. Allergen immunotherapy is a treatment designed to reduce sensitivity to specific allergens and remains one of the few truly disease-modifying therapies available. Allergen-specific immunotherapy has been proven to prevent the onset of asthma, a chronic disease that affects 8.6% of U.S. adults and 6.5% of children under 18 years of age[8]. Additionally, allergen-specific immunotherapy reduces health care costs by avoiding the need for future pharmacology, outpatient, and inpatient services.[9] Generally, 85% to 90% of patients undergoing maintenance allergen immunotherapy experience a significant reduction in allergic symptoms, along with decreased reliance on additional medications. Ensuring access to allergen immunotherapy will lower the incidence of asthma, one of the country's most prevalent chronic diseases, as well as greatly improve patients' quality of life.

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[6] 42 U.S.C. § 1395w-4(e)(1)(A).

[7] Laura Summer, Greg O'Neill & Lee Shirey, National Academy on an Aging Society, Chronic Conditions: A Challenge for the 21st Century (1999).

[8] Centers for Disease Control and Prevention. Interactive Summary Health Statistics for Adults: National Health Interview Survey, 2019-2024

[9] Cheryl S. Hankin et al., Allergy Immunotherapy : Reduced Health Care Costs in Adults with Allergic Rhinitis, 131 J. Allergy and Clinical Immunology 1084 (2013).

Treatment begins with a build-up phase, during which patients receive increasing concentrations of antigen, generally up to three times per week. To prevent anaphylaxis during build-up, doses are smaller and may have to be adjusted. This phase typically lasts three to six months, after which the patient transitions to maintenance therapy. Maintenance therapy means that the patient has reached the highest concentration of antigens, and under most situations, this is the dosage the patient will receive for the remainder of the time they are on allergy immunotherapy. Injections are typically administered every two to four weeks.

Allergists prepare a set of vials (a "treatment set")—typically 4-5 vials that contain different concentrations of allergens—that will last a patient up to an entire year. The treatment set may contain multiple allergen components and cannot be used for a different patient. Because allergen extracts are biologic in nature, mixing certain allergens may be problematic (e.g., molds and pollens) and need to be supplied in separate vials. The physician must, therefore, make a sound professional judgment regarding an appropriate treatment plan, with consideration of the specialty recommendations. It is standard practice to bill all doses in a treatment set at the time that the treatment set is prepared, at the time the first injection is administered, or at the time it is mailed out of the office. The number of doses billed is based on the total number of doses the allergist expects to administer based on the prescribed dosage and frequency schedule. Total doses frequently range from 120 to 180 doses during the first year, which includes the build-up phase. Medicare policy specifically states that payment can be made for "a reasonable supply of antigens" up to 12 months.[10]

Medicare defines a "dose" as "a 1cc aliquot," regardless of the amount administered to the patient. We believe that CMS's definition of a dose does not reflect clinical standards of care and imposes a billing structure that is inconsistent with real-world practice. In clinical practice, a "dose" is typically less than 1cc and varies based on the patient's phase of treatment and tolerance level, and is almost never more than 0.5 cc. Medicare's definition of a "dose" not only complicates billing and documentation processes but also increases the risk of dosing errors, potentially compromising patient safety. Further, CMS's definition of a dose places a significant administrative burden on allergy practices because they must navigate varying payer definitions of a "dose" under CPT code 95165. **Therefore, we respectfully request that CMS rescind this definition and instead adopt the dose definition set forth by the AMA CPT codebook.** The AMA's CPT definition accurately captures the practice of allergen immunotherapy dosing and reflects long-standing consensus in the medical community. Aligning with the AMA CPT standard would support consistency in billing practices, reduce administrative burden, more accurately reimburse providers for the care they deliver, and promote patient safety and access to care.

We recognize the importance of program integrity and the need to prevent potential fraud or abuse. If there are concerns about overutilization, this can be addressed through annual (rather than daily) limits with a higher limit for the first year of treatment that includes the build-up phase. **To that end, we recommend CMS adopt reasonable annual limits on doses billed under CPT 95165:**

[10] *See* CMS, Medicare Benefit Policy Manual, Pub. 100-02, Ch. 15, § 50.4.4.1.

- **Up to 150 doses per year** during the first year of therapy (including the **build-up phase)**

- **Up to 120 doses per year** after the first year of therapy (during **maintenance therapy)**

These limits would provide meaningful safeguards while maintaining access to appropriate care for Medicare beneficiaries. They reflect that a higher number of doses is needed during the first year of immunotherapy due to the build-up phase. ACAAI believes these limits are soundly based on common clinical practice. The following demonstrates how these limits would apply in practice.

3 vial set starting at 1:10,000 (vol/vol) building to 1:1(vol/vol) = 150 units
Each set has 5 vials, each vial has 5 ml, and the typical maintenance dose is up to .5 ml

In light of the proposed annual limits, we do not believe that a daily medically unlikely edit ("MUE") of 30 is necessary. Currently, Medicare has in place an MUE of 30 units per claim for CPT Code 95165. MUEs are not coverage policy–they are edits that identify claims with more than a certain number of units as "medically unlikely." If fewer than 30 doses are billed for a patient by a provider on a given date, the MUE is not triggered. However, claims on the same date of service that exceed the MUE may be denied in their entirety. A 30-unit MUE would be unnecessary and excessively restrictive in light of the proposed annual limit.

Our goal is to support a policy that is both clinically sound and operationally feasible for providers and payers alike. This will help ensure access to allergen immunotherapy.

Merit-Based Incentive Payment System ("MIPS") Proposals

I. Performance Threshold

The Advocacy Council and the ACAAI applaud CMS's decision not to increase the performance threshold for the 2026 performance period. The establishment of a higher, more rigorous performance threshold would increase administrative burden on physicians and place a financial strain on smaller practices. The payment cuts associated with a higher performance threshold would compound the financial distress currently facing physicians who are dealing with high inflation and workforce shortages. These burdens would be magnified for small physician practices. Accordingly, we support CMS's proposal to maintain a performance threshold of 75 points for the 2026 performance year.

II. Quality Measures in the MIPS Program

Clinicians need access to a sufficient range of clinically relevant measures to reflect the complexity and nuances of the care they provide. A broad range of clinically meaningful measures is consistent with the goals of the MIPS program, which is to accurately assess and improve the quality of care. However, in recent years, CMS has steadily reduced the number of quality measures available under MIPS. Arbitrarily reducing quality measures leaves clinicians with limited or irrelevant reporting options. Although CMS's intent in reducing measures is to

ease clinician burden, eliminating meaningful and clinically appropriate measures can have the opposite effect. Narrowing reporting pathways may force clinicians to report on measures outside their scope of practice. Without applicable measures, CMS cannot fairly evaluate practitioner performance or generate an accurate picture of quality of care. Therefore, the Advocacy Council and ACAAI urge CMS to refrain from limiting the number of quality measures available in the MIPS program in order to preserve reporting flexibility and ensure accurate quality assessment.

III. Promoting Interoperability ("PI") Performance Category: New Measure Suppression Policy

Beginning in the 2026 performance period, CMS is proposing a new measure suppression policy that would provide the agency with the flexibility to suppress and not score a measure in an applicable performance period for MIPS-eligible clinicians in certain circumstances. We urge CMS to finalize this policy, as it appropriately recognizes that external factors can negatively impact a MIPS-eligible clinician's ability to report certain measures. This proposal will help ensure that the assessment of performance under the MIPS program is fair.

IV. Cost Performance Category: Total Per Capita Cost ("TPCC") Measure

CMS is proposing to exclude events initiated by an advanced care practitioner if all other non-advanced care practitioners in their group are excluded based on specialty exclusion criteria, and to require second candidate events to be an E/M or other primary care service. We support CMS's proposal to update the attribution policy for the TPCC measure beginning in the 2026 performance period. The TPCC measure is a population-based cost measure that evaluates a patient's overall cost of care. The current methodology has resulted in the misattribution of data to clinicians who should be excluded from the measure, frequently leading to inaccurate cost scores and unjust penalties. The proposed policy will help improve attribution accuracy.

V. Cost Performance Category: Informational-Only Feedback Period

Beginning in the 2026 performance period, CMS is proposing to offer informational-only scoring for two years for new cost measures. MIPS eligible clinicians, groups, virtual groups, and subgroups would receive a score on a new cost measure for the first two years, but the score would not count toward their final score until the third year. The Advocacy Council and the ACAAI support CMS's informational-only feedback period proposal for cost measures. The proposed informational-only feedback period will allow clinicians to gain familiarity with new measures and help identify where there may be deficiencies in the cost measure methodology.

VI. MIPS Timely Data Access Issues

We are disappointed that the Proposed Rule does not address MIPS data access issues. Physicians across the country are united in agreement about the need for timely data to improve care for patients and reduce avoidable costs. Unfortunately, CMS provides physicians with an annual Medicare MIPS Feedback Report that includes information about their performance on quality and cost measures six to 18 months after they have provided a service to a Medicare patient. Without this information at any point during the actual performance year, physicians

have no way to understand gaps in care and identify opportunities to improve health outcomes, reduce variations in care delivery, or eliminate avoidable services—all steps that can improve quality and lower costs for patients and the Medicare program. CMS must fulfill the requirements in the Medicare Access and CHIP Reauthorization Act ("MACRA") statute to provide timely (e.g., quarterly) feedback reports and Medicare claims data to physicians.

MIPS Value Pathways ("MVPs")

I. Sunsetting the Traditional MIPS Program

CMS has announced its intention to phase out the traditional MIPS program by the 2029 performance period. We urge caution with this approach and emphasize that MVP participation should remain voluntary. Moving too quickly to eliminate traditional MIPS, risks disenfranchising clinicians, particularly those for whom no meaningful MVP options currently exist. At this stage, the MVP framework requires additional refinement to simplify reporting requirements and ensure that it functions as a viable replacement for traditional MIPS. Until these improvements are made and a sufficient range of specialty-relevant MVPs are available, it would be premature to retire the traditional program. Therefore, we strongly recommend that CMS maintain MVP participation as voluntary for the foreseeable future.

II. MVP Development

In developing the MVP program, we encourage the agency to adopt MVP policies that will remedy the substantial administrative burdens of the current, traditional MIPS program. We strongly believe that CMS should work closely with medical societies, including ACAAI, to develop MVPs that are clinically relevant and meaningful to their clinicians. We urge the agency to enhance transparency in the development of MVPs and to clearly articulate the rationale when MVPs—or quality measures within MVPs—advanced by medical societies are not adopted by CMS.

The Advocacy Council and the ACAAI have repeatedly urged the agency to either (1) develop a separate MVP for the practice of allergy, or (2) include quality measures that are clinically meaningful to allergists in the Pulmonology Care MVP. Unfortunately, the agency declined to adopt either recommendation. Currently, the Pulmonology Care MVP is not a viable reporting option for allergists. Only 3 quality measures in that MVP (Quality ID #398: Optimal Asthma Control; Quality ID #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention; and Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan) are regularly utilized by allergists. In response, the Advocacy Council recommended the addition of three quality measure that are utilized by allergists: Q130: Documentation of Current Medications in the Medical Record, Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) Sinusitis, and Q332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use).

However, CMS declined to include these quality measures in the final MVP, instead stating, "We may consider the inclusion of additional quality measures and improvement activities through the MVP Maintenance Process and future rulemaking." CMS did not provide any justification for

why the aforementioned measures should not be included in the Pulmonology Care MVP. Notably, the agency's listed practitioners who would typically utilize this MVP did not include allergists. The agency states that the Pulmonology Care MVP will be "most applicable to clinicians who treat patients within the practice of pulmonology and sleep medicine, including nonphysician practitioners (NPPs) such as nurse practitioners, and physician assistants." Allergists were not identified.

As we approach the 2029 performance period, we believe that it is imperative that CMS works with ACAAI to identify an appropriate path forward to ensure that allergists have a viable MVP that is meaningful to allergists.

Core Elements RFI

CMS is considering a policy that would categorize certain MVP quality measures as "core elements." MVP participants would be required to report on quality measure(s) within the "core element" subset. Although the agency intends to promote greater comparability among clinicians reporting within an MVP, ACAAI is concerned that such a policy would restrict reporting flexibility and compel allergists to report on measures that are not clinically relevant to their practice. Before mandating the reporting of specific measures, CMS should first ensure that every specialty, including allergy, has a relevant MVP, and that each MVP contains a sufficient number of meaningful measures that accurately capture the care delivered by that specialty. Absent these assurances, moving forward with the "core elements" proposal would increase the reporting burden and risk, misrepresenting the quality of care provided by allergists.

Procedural Codes for MVP Assignment RFI

CMS is considering a policy that would use procedural billing codes to assign clinicians to an MVP. Under this model, CMS would limit clinicians' current flexibility to choose an MVP, and the agency is considering setting a volume threshold that clinicians must meet to be assigned to a particular MVP. The Advocacy Council and ACAAI believe this proposal is premature, particularly given that allergists currently lack sufficient reporting options under the MVP framework. Without relevant MVPs available, allergists risk being inappropriately assigned to MVPs that do not reflect their scope of practice. Such misalignment would undermine accurate performance assessment and increase administrative burden without advancing quality improvement. For these reasons, we urge CMS not to pursue this concept. Allergists themselves are best positioned to determine which MVP appropriately captures the care they provide.

Ambulatory Specialty Model ("ASM")

CMS is proposing a new mandatory alternative payment model focused on high-volume and high-cost chronic conditions that require management by specialists. Certain clinicians who treat heart failure and low back pain would be required to participate. CMS indicated that the model is focused on clinicians in the ambulatory setting who have ongoing relationships with patients and co-manage their conditions with the patient's primary care provider. CMS would require certain specialists who treat heart failure and low back pain to report on a select set of "episode-based

cost measures" that assess quality, cost, interoperability, and care coordination. Participating clinicians would be evaluated against their peers on these measures, and, like with the MIPS program, would receive a positive, neutral, or negative payment adjustment based on their performance.

While the ASM is currently focused on clinicians who treat heart failure and low back pain, and therefore does not apply to allergists, ACAAI is concerned with the fundamental approach of this model and the harm it would cause to allergists if expanded beyond its current focus. ACAAI disagrees with the model's measurement of clinicians against their peers. This approach unfairly pits clinicians against one another. The proposal will harm small and rural practices, which typically do not have the staff and resources to compete with larger practices. Small and rural practices will therefore disproportionately receive neutral or negative payment adjustments, diverting further resources away from small practices to large ones. This has the potential to exacerbate the resource divide between rural and urban practices. ACAAI encourages CMS to work with stakeholders to develop models that improve care quality without disadvantaging small and rural practices in this manner.

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We appreciate your consideration of our comments and recommendations. If you have any questions regarding this letter, please contact Susan Grupe, Director of Advocacy Administration, at suegrupe@acaai.org.

Sincerely,

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