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September 14, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: ACAAI's Comments on the 2027 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule (CMS-1848-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 2027 Medicare Physician Fee Schedule and Quality Payment Program ("QPP") proposed rule. The ACAAI represents 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. As a result, our membership brings a broad perspective on how Medicare payment policies affect the quality of and access to high-quality allergy and immunology services.

In the proposed rule, the Centers for Medicare and Medicaid Services ("CMS") sets forth numerous proposals that would affect practitioners and the patients they serve. Our comments focus on the policies of particular relevance to allergists-immunologists, including:

- Changes to the Medicare Physician Fee Schedule conversion factors;
- Proposed changes to the practice expense methodology;
- Policies impacting allergen immunotherapy;
- Remote physiologic monitoring ("RPM") and remote therapeutic monitoring ("RTM") services;
- The efficiency adjustment;
- Policies concerning the evaluation and management ("E/M") visit complexity add-on and payment for same-day E/M services; and
- Proposals related to the QPP.

Conversion Factors

CMS proposes two conversion factors for 2027: a qualifying alternative payment model ("APM") conversion factor of $33.1693 and a non-qualifying APM conversion factor of $32.8409. Both represent a decrease from 2026. While we recognize that the proposed conversion factors are largely the result of statutory requirements and the expiration of the one-time 2.5% increase that applied in 2026, the proposed decreases further exacerbate longstanding concerns regarding

physician payment adequacy. These reductions come at a time when allergy practices continue to face significant and growing financial pressures (i.e., rising inflation, persistent workforce shortages, escalating administrative demands, and the increasing cost of medical supplies and technology), all of which fall especially hard on the small and solo practices that make up the majority of the allergy specialty. A year-over-year reduction in the conversion factors only widens the gap between the cost of furnishing care and the reimbursement physicians receive for it. We therefore urge CMS to work closely with Congress to develop and advance long-term, sustainable payment reforms that move beyond year-to-year fluctuations and provide the predictability that practices need to plan for and invest in patient care.

Practice Expense Methodology

ACAAI and its Advocacy Council urge CMS to defer implementation of the proposed practice expense methodology changes. The practice expense methodology is inherently complex, and even seemingly technical changes can produce substantial consequences for individual services. Before proceeding with the practice expense methodology changes, we urge CMS to provide stakeholders with sufficient detail and analysis to understand and evaluate these changes to ensure that they accurately account for the resources required to furnish services. Unfortunately, CMS did not provide an impact analysis that isolates each of the interconnected practice expense methodology proposals.

Moreover, as CMS continues to evaluate practice expense methodology changes, we continue to urge the agency 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"). The ACAAI and its Advocacy Council have consistently raised serious concerns that the data on practice expense of allergy practices and hours spent in direct patient care ("DPC") by allergy practices are not accurately represented in the PPI Survey report.

Notably, the AMA did not provide PPI Survey data specific to allergy/immunology to ACAAI or 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 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,[1] 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

[1] AMA, Physician Practice Information Survey, *Practice Expense per Hour 2007/2008* (on file with author).

arbitrary combination of various medical specialties in to 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 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, there has been a dramatic increase in antigen costs, which is not reflected in the current practice expense associated with Current Procedural Terminology (“CPT”) code 95165. In 2023, CMS acknowledged the rising costs of the two supply items for venom immunotherapy (SH009 (single antigen) and SH010 (3-vespid mix)). 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 expense. 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

preparations (Section 21). Further, medical office rental rates have followed this growth and will continue to do so.

Given the general increase in costs and the unique nature of the practice expenses of allergy services, 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. While consolidating these medical specialties may have been convenient, it resulted in devastating, inaccurate results for allergy practices. Therefore, we continue to applaud CMS for not adopting the 2023-2024 PPI Survey data.

Allergen Immunotherapy –CPT Code 95165

For purposes of CPT code 95165, CMS is examining (1) whether Medicare's current definition of a "dose" reflects contemporary practice, and (2) whether the 30-dose-per-claim Medically Unlikely Edit ("MUE") should be replaced with an annual dose limit. We strongly believe that Medicare's definition of a "dose" is outdated and that CMS should adopt reasonable *annual* limits on doses billed under CPT 95165.

I. Importance of Allergen Immunotherapy

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. It is individualized based on a comprehensive evaluation that includes the patient's symptoms, medical history, and allergy testing. Because allergic responses and sensitivities vary significantly between individuals, it is highly uncommon for two patients to receive identical allergen extract prescriptions.

Allergen immunotherapy involves the gradual administration of increasing quantities of allergen extracts, custom-mixed for each patient based on their individual sensitivities. Allergists prepare a set of vials (a "treatment set") 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 treatment sets. The physician must, therefore, make a sound professional judgment regarding an appropriate treatment plan, with consideration of national recommendations.

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.

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.[2]

Generally, 85% to 90% of patients undergoing maintenance allergen immunotherapy experience a significant reduction in allergic symptoms, along with decreased reliance on additional medications. Immunotherapy for allergic rhinitis patients has also been shown to reduce the likelihood of developing asthma and other allergic conditions.[3] Moreover, allergen immunotherapy has been shown to lower overall healthcare costs by reducing the frequency of medical visits and the need for emergency interventions related to severe allergic reactions.[4]

II. Medicare's Current Definition of a "Dose"

Medicare currently defines a "dose" as "a 1cc aliquot," regardless of the amount administered to the patient. The ACAAI and its Advocacy Council continue to 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, however, a "dose" is typically less than 1cc and varies based on the patient's phase of treatment and tolerance level, and almost never more than 0.5 cc. This inconsistency places a significant administrative burden on allergy practices, which must navigate varying payer definitions of a "dose" under CPT code 95165. 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.

Therefore, we respectfully request that CMS rescind the current definition and instead adopt the dose definition set forth by the AMA's CPT codebook. **Specifically, CMS should define a dose as "a single injection from a multidose vial."** 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.

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[2] *See* CMS, Medicare Benefit Policy Manual, Pub. 100-02, Ch. 15, § 50.4.4.1.
[3] Diamant Q, vanMaaren M, Muraro A, Jesenak M, Striz I. Allergen immunotherapy for allergic asthma: the future seems bright. Res Med 210; 2023 107125.
[4] Hankin CS, Cox L, Bronstone A and Wang Z. Allergy immunotherapy: Reduced health care costs in adults and children with allergic rhinitis. JACI; 2012.12.662.

III. Replacement of MUE

We recognize the importance of program integrity and the need to prevent potential fraud or abuse. If there are concerns about overutilization of CPT code 95165, CMS can address this 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:**

- **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. We believe these limits are sound 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 MUE of 30 is necessary. Currently, Medicare has in place an MUE of 30 per claim for CPT code 95165. MUEs are not coverage policy–they are edits that identify claims with over 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 exceeds the MUE may be denied in its entirety. A 30 MUE would be unnecessary and excessively restrictive in light of the proposed annual limit.

Efficiency Adjustment

In the 2026 Medicare Physician Fee Schedule final rule, CMS finalized an efficiency adjustment of -2.5% to the Work Relative Value Unit ("RVU") and corresponding intraservice portion of physician time of non-time-based services, applied every three years and subject to certain exemptions. The ACAAI and its Advocacy Council opposed the policy, and we would like to take this opportunity to reiterate our concerns.

CMS has reasoned that physicians have become more efficient in furnishing these aspects of services through experience, technology, and operational improvements. That assumption does not account for the offsetting realities of contemporary practice, including increases in care complexity and patient acuity, rising clinical staff salaries, and the resources required to adopt and maintain artificial intelligence tools and electronic health record systems, which frequently demand the same or greater resources than in the past.

Beyond that flawed premise, the methodology itself remains problematic. First, an across-the-board 2.5% reduction cannot accurately capture efficiency gains across all codes and

services; any such gains vary considerably with the type of care furnished. Second, the policy has no sunset. Even accepting that some efficiencies have been realized, it does not follow that additional efficiencies can be gained year over year in perpetuity. At some point a maximum is reached, beyond which continued reductions compromise patient care rather than reflect genuine efficiency. Third, the adjustment is applied even to codes that have recently been reviewed and valued for accuracy, undermining the integrity of that review. Therefore, we believe that CMS should revisit this policy.

Remote Physiologic and Remote Therapeutic Monitoring

CMS proposes several changes to the RPM and RTM services. Notably, the agency is proposing to only allow payment for RPM or RTM services when:

1. The clinical staff is a *direct employee* of the practice;
2. The clinical staff are under the *general supervision* of the billing practitioner; and
3. All other *requirements of the "incident to" regulations at 42 C.F.R. § 410.26 are met*.

In other words, the proposed rule would *not* allow contracting to third-party companies. This deviates from currently policy, which allow RPM/RTM services to be outsourced to third-party companies that provide services via telephone and online contact.

While utilization of remote monitoring varies across allergy practices, those that use remote monitoring services rely on them to monitor medication adherence, identify patients who may be struggling with therapy, and detect worsening disease before more serious complications occur. These services support more proactive management of chronic conditions and may help reduce avoidable exacerbations and other higher-cost interventions.

Given the operational burden of administering a remote monitoring program, many allergy practices depend on outside vendors to handle the day-to-day data collection and management that make the programs feasible. Because the majority of allergy practices are small or solo practices, they often lack the staff, infrastructure, and capital needed to build and maintain this capacity internally. If CMS prohibits third-party arrangements, these practices would be forced to choose between absorbing substantial new costs to bring these functions in-house or discontinuing their remote monitoring programs altogether. Either outcome would fall hardest on small practices and the patients who benefit from remote monitoring.

We recognize CMS's stated concern that outsourcing RPM and RTM services could fragment care or reduce the billing practitioner's involvement and oversight. That concern, however, is already addressed by the existing supervision and "incident to" framework, under which the billing practitioner remains responsible for the service and for the clinical staff furnishing it. A categorical prohibition on third-party arrangements is not necessary to ensure appropriate oversight, and it would disproportionately harm the small and independent practices that CMS has elsewhere expressed a commitment to sustaining. We therefore urge CMS not to finalize the proposal.

E/M Visit Complexity Add-On and Same-Day E/M Payment Policies

I. Complexity Add-On (G2211 and Proposed Modifiers MOD1 and MOD2)

CMS proposes to discontinue HCPCS code G2211, the office/outpatient E/M visit complexity add-on, and to replace it with two modifiers applied to the underlying E/M service: MOD1, valued at 16% of the base E/M code, and MOD2, valued at 32% of the base E/M code for practitioners participating in certain accountable care arrangements, including Shared Savings Program Accountable Care Organizations ("ACOs"). We are concerned that valuing MOD2 at twice the level of MOD1 based solely on a practitioner's participation in an accountable care arrangement would create a two-tiered payment structure for the same visit complexity. We urge CMS to ensure that the complexity add-on recognizes the complexity of the underlying E/M visit based on the care actually furnished, rather than on a practitioner's participation in a particular payment model.

II. Same-Day E/M Payment Reduction

Separately, CMS proposes to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure. Under the proposal, the highest-valued service would be paid at 100% and all other same-day services would be paid at 50%. The ACAAI and its Advocacy Council oppose this proposal. As an initial matter, CMS premises the reduction on a hypothesis of duplication without offering evidence that duplication actually exists or, if it does, its magnitude. If the agency moves forward with the proposal, CMS should explicitly exclude services carrying an "XXX" global indicator and refrain from expanding the policy to allergy and immunology services.

Quality Payment Program Proposals

I. Sunsetting Traditional MIPS

CMS proposes to retire the traditional MIPS reporting option at the end of the 2028 performance period. Beginning with the 2029 performance period, clinicians who do not participate in an APM would be required to report through a MIPS Value Pathway ("MVP").

We urge CMS not to mandate MVP participation or retire traditional MIPS. Eliminating traditional MIPS before the MVP framework is sufficiently mature risks disadvantaging clinicians without a meaningful or appropriate pathway for participation. Rather than establishing an arbitrary deadline for the transition, CMS should confidently determine that the MVP program is a viable replacement for traditional MIPS for every clinician across every practice settings.

Currently, the MVP framework requires further refinement to ensure that clinicians have access to measures and activities that meaningfully reflect the care they provide. As discussed below, allergists currently lack a clinically relevant MVP and therefore would have *no* pathway for participation if traditional MIPS were eliminated. Requiring allergists to report through an MVP that does not appropriately reflect their specialty would undermine the goals of quality

improvement and unnecessary penalize allergists based solely on the lack of clinically appropriate measures.

Therefore, ACAAI and its Advocacy Council strongly recommend that CMS maintain traditional MIPS as a reporting option and offer MVP participation on a voluntary basis.

II. Lack of MVP Reporting Options for Allergists

As stated above, there is no MVP specifically tailored to the practice of allergy medicine. Although the Pulmonology Care MVP; the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP; and Primary Care MVP contain several measures that may be applicable to allergists, the number of relevant measures is limited and do not adequately reflect the clinical activities most commonly reported by allergists. As a result, allergists would be significantly penalized under the MVP framework.

- **Pulmonology Care MVP**: The Pulmonology Care MVP is not a clinically appropriate or viable reporting option for allergists. The Pulmonology Care MVP is currently intended for use by pulmonology, sleep medicine specialists, nonphysician practitioners, nurse practitioners, and physician assistants. The quality measure set largely reflects the services associated with pulmonary medicine rather than allergy practice. Although allergists treat certain respiratory conditions, most notably asthma, that overlap does not make a pulmonology-focused MVP an appropriate substitute.

  Of the quality measures included in the Pulmonology Care MVP, only three are regularly utilized by allergists: 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.

  The remaining measures either are not meaningful to allergy practice or address services or practice settings that generally fall outside the scope of care provided by the average allergist. Quality ID #47: Advance Care Plan and Quality ID # 503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months are not routinely incorporated into allergy practices. Reporting these measures would require practices to modify their clinical and administrative workflows primarily for the purpose of satisfying MIPS reporting requirements. In addition, Quality ID# ACEP25: Tobacco Use: Screening and Cessation Intervention for Patients with Asthma and COPD applies to patients evaluated in the emergency department and discharged from that setting and, therefore, does not reflect the typical setting of allergy practice. Similarly, Quality ID# Q052: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy focuses on the management of COPD, a condition predominantly managed by pulmonologists rather than allergists. Therefore, we believe that this is not a viable reporting option for allergists.

- **Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP**: The Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP does not fare better. This MVP is intended primarily for otolaryngologists and audiologists. For 2027, only three measures could be reasonably used by allergists: Quality ID #331: Adult

Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis; Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan, and Quality ID #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. The remaining measures clearly fall outside the scope of allergy practice. Accordingly, this would not be an appropriate MVP for allergists.

- **Value in Primary Care MVP**: CMS has alluded that allergists could report the Value in Primary Care MVP; however, this MVP does not provide sufficient measures for allergists. Only two measures could be reasonably used by allergists: Quality ID #236, Controlling High Blood Pressure and Quality ID #493, Adult Immunization Status. Therefore, this is not a viable reporting option for allergists.

ACAAI and its Advocacy Council have repeatedly expressed these concerns to CMS and have 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 existing MVPs. Unfortunately, the agency declined to adopt either recommendation to date.

In June of 2026, CMS declined to adopt the ACAAI's, in partnership with the American Academy of Allergy, Asthma and Immunology ("AAAAI"), candidate submission for an "Improving Allergy & Immunology Chronic Disease Control and Value" MVP. CMS reasoned that "a standalone allergy MVP isn't viable at this time" as it would not have enough allergy-specific and immunology-specific measures. CMS specifically cited the lack of an allergy-specific QCDR as a barrier to development of an allergy-specific MVP. We object to this conclusion and respectfully request that CMS adopt an allergy-specific MVP. A number of MVPs do not include QCDR measures, so the lack of a QCDR should not disqualify allergists from the ability to utilize their own specialty-specific MVP. For example, the Improving Care for Lower Extremity Joint Repair MVP does not utilize any QCDR measures. The seven quality measures it utilizes are either MIPS clinical quality measures ("MIPS CQMs"), Medicare Part B claims measures, or administrative claims measures. In CMS's June feedback on ACAAI's candidate submission request, CMS supported the inclusion of eight of the quality measures identified by ACAAI as relevant for inclusion in the allergy MVP. Given this precedent, we believe our proposed Improving Allergy & Immunology Chronic Disease Control and Value MVP has enough available measures to be adopted by CMS.

We also wish to take this opportunity to underscore that submitting allergy-specific measures through the Call for Measures process or qualifying as a QCDR is a financially unsustainable solution for a small specialty. Developing, testing, maintaining, and stewarding quality measures requires substantial and ongoing financial and administrative resources, as does operating a QCDR under CMS's extensive program requirements. More fundamentally, CMS should not condition access to a meaningful MIPS reporting pathway on a specialty society's ability to finance and maintain its own quality-measure infrastructure. Such an approach disproportionately disadvantages smaller specialties. If CMS intends to mandate MVP participation, the agency must take greater responsibility for ensuring that all specialties have access to clinically relevant measures and a viable reporting pathway.

However, there are existing measures that should be added to the Pulmonology Care MVP and the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP so that allergists have more meaningful reporting options. In February of 2026, ACAAI provided

recommendations for allergy-related measures that could be included in these two MVPs. Specifically, for the Pulmonology Care MVP, ACAAI recommended including:

- Quality ID #317: Screening for High Blood Pressure and Follow-Up Documented
- Quality ID #322: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)
- Quality ID #493: Adult immunization status

For the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP, ACAAI recommended including:

- Quality ID #317: Screening for High Blood Pressure and Follow-Up Documented
- Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report
- Improvement Activity ID #IA_AHW_1: Chronic Care and Preventative Care Management for Empaneled Patients
- Improvement Activity ID #IA_EPA_2: Use of telehealth services that expand practice access
- Improvement Activity ID #IA_BE_23: Integration of patient coaching practices between visits

For the reasons stated below, we believe that CMS should keep Quality ID# 332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) in this MVP.

If CMS both declines to adopt an allergy-specific MVP and to utilize additional measures relevant to allergists in existing MVPs, we urge the agency to identify creative solutions to ensure clinicians without a relevant MVP have meaningful reporting option if the agency proceeds with sunsetting traditional MIPS. Clinicians should not be placed at a disadvantage simply because CMS has not developed an appropriate MVP for their specialty. Potential approaches include:

- **Cross-MVP Measure Reporting:** CMS should permit clinicians without a sufficiently relevant individual MVP to satisfy MVP reporting requirements by selecting applicable measures and activities across two or more MVPs. For example, an allergist could report clinically relevant quality measures drawn from both the Pulmonology Care MVP and the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP to satisfy the applicable reporting requirements. This approach would recognize that some specialties, including allergy, span clinical areas represented across multiple existing MVPs even though no single MVP adequately captures their scope of practice. Allowing cross-MVP reporting would provide clinicians with greater flexibility to select measures that meaningfully reflect the care they provide. Importantly, CMS should design such an option so that it does not impose additional reporting requirements or administrative burden on clinicians who must rely on measures from multiple MVPs.

- **Automatic Relief**: At a minimum, clinicians should not be subject to negative MIPS payment adjustments when CMS has not made available an MVP that meaningfully applies to their specialty or scope of practice. If CMS makes MVP participation

mandatory, the agency should establish an automatic exception or other form of relief for clinicians who lack an applicable MVP.

III. Core Measure Designation and Exception

CMS proposes that, beginning with the 2027 performance period, clinicians will no longer be required to report an outcome measure (or if one is unavailable, a high priority measure). Instead, clinicians participating via MIPS would be required to report a MIPS core measure as one of their six reported quality measures, and clinicians participating via MVPs would be required to report a MIPS core measure as one of their four quality measures. If a clinician does not have an available and applicable MIPS core measure, they must attest during the data submission period that a MIPS core measure is not available and applicable for them to report. The clinician would then be required to choose another measure to report instead of the MIPS core measure. Small practices would be exempt from the core measure requirement.

We support the removal of the outcome measure requirement, as this proposal would provide allergists with greater flexibility in selecting measures that are relevant to their practice. However, we urge CMS not to finalize the proposed core measure reporting requirement. Before mandating the reporting of specific measures, CMS should first ensure that every specialty, including allergy, has a viable MVP with a sufficient number of meaningful measures.

Requiring clinicians to report from a predetermined set of core measures would unnecessarily limit allergists' ability to select measures that meaningfully reflect their practice and patient population. Such a requirement could also undermine the QPP's goal of accurately assessing and improving the quality of care. For example, the required core measure would account for 25% of the quality measures reported under an MVP. If that measure is not clinically meaningful to an allergist's practice, a quarter of the allergist's quality reporting would not accurately reflect the care they provide.

If CMS moves forward with the core measure policy, we support the exception for small practices. We similarly support the proposed flexibility to allow clinicians who do not have a relevant core measure to self-attest and instead report an alternative measure. We also support CMS's proposal that core measures that are topped out and subject to the 7-point scoring cap would no longer be subject to that cap and instead would be scored via defined topped out measure benchmarks (with a 10-point maximum). This flexibility is important to ensure that clinicians are not unfairly penalized for complying with mandatory core measure reporting requirements.

IV. Removal of Quality Measure ID #322 on Adult Sinusitis

CMS proposes to remove Quality Measure ID #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) from MIPS. As a result, this measure would also no longer be listed in the Allergy/Immunology Specialty Measure Set. CMS reasons that this measure is duplicative of Quality Measure ID # 331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse). We respectfully disagree and urge CMS to retain Measure ID #332 in traditional MIPS, the Allergy/Immunology Specialty Measure Set, and applicable MVPs.

Quality Measures #331 and #332 assess clinically distinct aspects of antibiotic stewardship. Measure ID #331 evaluates whether clinicians appropriately avoid prescribing antibiotics to patients with acute viral sinusitis, for whom antibiotic therapy is not indicated. In contrast, Measure ID #332 evaluates whether clinicians select the recommended first-line antibiotic (amoxicillin with or without clavulanate) when a patient has acute bacterial sinusitis and antibiotic treatment is clinically indicated. These measures therefore address two separate decisions: whether to prescribe an antibiotic and, when antibiotic treatment is warranted, which antibiotic to prescribe. Performance on one does not necessarily predict performance on the other.

Maintaining both measures is important to provide a more complete assessment of antibiotic stewardship. Inappropriate selection of unnecessarily broad-spectrum agents can contribute to antimicrobial resistance, expose patients to avoidable adverse effects, and undermine broader goals even when the decision to prescribe an antibiotic is otherwise appropriate. Because Measures #331 and #332 evaluate different aspects of quality of care, Measure ID #332 should not be considered duplicative of Measure ID #331. We therefore urge CMS to retain Quality Measure ID #332 in traditional MIPS, the Allergy/Immunology Specialty Measure Set, and applicable MVPs.

V. Automatic Extreme and Uncontrollable Circumstances Reweighting

Beginning with the 2027 performance period, instead of relying on Provider Enrollment, Chain, and Ownership System ("PECOS") data to determine if a clinician is located in an area that has been identified as being affected by an extreme or uncontrollable circumstance ("EUC"), CMS will use "whatever data is most current and reliable" (e.g., zip codes on billed claims). We support this proposal. Use of multiple data sources would increase the ability of the EUC exception to accurately identify the clinicians that qualify for the exception due to location-based circumstances that disrupt their ability to participate in quality reporting.

VI. Performance Threshold

ACAAI and its Advocacy Council applaud CMS's decision not to increase the performance threshold for the 2027 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 the performance threshold of 75 points for the 2027 performance year.

VII. Data Completeness

We also support maintaining the data completeness threshold at 75 percent for the 2027 performance period. Any increase in the threshold would be inconsistent with the agency's goals of reducing burden on practitioners in the MIPS program. Higher data completeness thresholds have a disparate impact on participants that manually extract and report quality data.

VIII. Promoting Interoperability Category Changes

a. Removal of the Office of the National Coordinator for Health Information Technology ("ONC")-Related Attestations

Beginning with the 2026 performance period, CMS proposes to remove the requirement that clinicians annually attest to compliance with ONC Health IT certification and information blocking requirements, including the required Direct Review Attestation and the optional Authorized Certified Bodies ("ACB") attestation. We support the removal of these attestation requirements as they are duplicative of existing oversight processes. Removing these attestations would reduce unnecessary administrative burden on clinicians.

b. Removal of the Security Risk Analysis Measure

CMS proposes to remove the Security Risk Analysis measure, reasoning that the measure is duplicative of Health Insurance Portability and Accountability Act ("HIPAA") Security Rule requirements that similarly require clinicians to attest that they have conducted or reviewed a security risk analysis regarding potential vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information ("ePHI"). We believe that this measure is duplicative of HIPAA Security Rule requirements and urge the agency to eliminate this measure.

IX. Electronic Prior Authorization Measure Changes; New Electronic Prior Authorization Measure for Drugs

CMS proposes to revise the existing Electronic Prior Authorization measure for items and services by requiring the use of specific Fast Healthcare Interoperability Resources ("FHIR")-enabled ONC-certified health IT modules. CMS proposes to make the measure optional in the 2027 performance year and mandatory beginning with the 2028 performance year. CMS also proposes a new Electronic Prior authorization measure for drugs, which would become both available and mandatory in the 2028 performance year.

The ACAAI and its Advocacy Council support the use of electronic prior authorization ("e-PA") as it improves efficiency and reduces administrative burden on clinicians. However, we recommend that CMS make both the measures voluntary for the foreseeable future. Clinicians vary considerably in their experience with e-PA, including differences in electronic health record capabilities, health information technology ("IT") infrastructure, payer connectivity, and the availability and functionality of FHIR-enabled technologies. Mandating the use of these measures may create significant implementation challenges, particularly for smaller practices and clinicians operating with limited health IT resources.

Request for Information

CMS is seeking comment on the CPT coding system and the AMA's process for developing these codes as components of the physician payment policy framework. Specifically, CMS is

seeking information regarding how the CPT coding system can be improved and input on possible alternatives to CPT codes.

ACAAI and its Advocacy Council support CMS's goal of ensuring that Medicare physician payment is objective, transparent, and reflective of the resources required to deliver high-quality patient care. As a specialty society actively engaged in both the CPT Editorial Panel and the RUC process, we recognize that the current system is not without shortcomings and should continue to evolve. However, we believe it remains the most clinically grounded mechanism available for translating medical practice into accurate coding and valuation.

We strongly support maintaining physician leadership in the development of CPT codes and the clinical recommendations that inform Medicare payment. CPT codes are developed through an open, multidisciplinary process that reflects advances in medicine, evolving standards of care, and physician expertise. Likewise, the RUC provides CMS with recommendations based on detailed surveys and specialty input, while CMS appropriately retains final authority over payment decisions.

We caution against replacing this physician-driven process with methodologies that rely primarily on administrative data or diagnosis codes. ICD-10 codes were designed to describe diseases and medical conditions—not the physician work, clinical judgment, practice expense, or malpractice costs associated with providing care. Patients with the same diagnosis frequently require dramatically different levels of physician time, expertise, and resources. Basing reimbursement primarily on diagnosis codes would therefore risk creating significant inaccuracies and unintended consequences across specialties.

That said, we believe there are meaningful opportunities to strengthen the current process, including:

- Increasing transparency in CPT Editorial Panel and RUC deliberations while preserving appropriate protections for proprietary information.
- Expanding the use of objective data—including real-world utilization, practice expense information, and technological advances—to supplement physician survey data.
- Improving the timeliness of code valuation as medical practice evolves.
- Continuing to ensure that cognitive, preventive, and chronic disease management services are appropriately recognized alongside procedural services.

Any future payment methodology should preserve the critical role of practicing physicians in determining how medical services are described and valued. While objective data should continue to inform payment policy, it cannot replace the clinical expertise necessary to understand the complexity, intensity, and resources required to care for patients.

We appreciate CMS's willingness to seek stakeholder input on this important issue and look forward to working collaboratively to improve the Medicare physician payment system while preserving a physician-led approach that promotes innovation, high-quality patient care, and equitable reimbursement.

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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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