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September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & 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: File Code CMS-1832-P; Medicare Program; CY 2026 Payment Policies under the Physician Payment Schedule and Other changes to Part B Payment and Coverage Policies; (July 16, 2025)

Dear Administrator Oz:

On behalf of the members of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), we appreciate the opportunity to provide comments in response to the Notice of Proposed Rulemaking for Revisions to Payment Policies under the Medicare Physician Fee Schedule (MPFS) and updates to the Quality Payment Program (QPP) for 2026. We appreciate the outreach by the Centers for Medicare & Medicaid Services (CMS) to the physician community during this comment period and we hope that this open dialogue will continue in the future.

The AANEM is comprised of over 7,000 neurologists, physical medicine & rehabilitation (PM&R) physicians, technologists, and other collaborators interested in neuromuscular (NM) and musculoskeletal diseases. Our physician members perform electrodiagnostic (EDX) testing to diagnose and treat patients with disorders of muscles and nerves, such as carpal tunnel syndrome, cervical and lumbar radiculopathies, Guillain- Barre syndrome, Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's disease"), diabetic and other forms of peripheral neuropathy, myasthenia gravis (MG), and muscular dystrophy (MD).

General Comments

AANEM appreciates CMS' ongoing efforts to engage the physician community in the development of the 2026 MPFS and QPP proposed rule. While we welcome the increased payment rates, our members remain deeply concerned that these changes do not keep pace with the rapid growth in practice expense (PE) and continuing inflation. The proposed adoption of four separate conversion factors (CFs), broad efficiency adjustments, and restructuring of PE methodology contribute to ongoing uncertainty for NM and EDX physicians. Without reliable, evidence-based updates reflective of real-world costs, these policies increase financial instability and threaten patient access to subspecialty care.

We urge CMS to prioritize predictable, transparent payment policies rooted in robust cost data and to continue working closely with specialty societies as reforms are implemented. Our detailed comments below outline both positive developments and ongoing challenges, with the overarching goal of ensuring sustainable, high-quality care delivery for Medicare beneficiaries.

Physician Fee Schedule

Conversion Factor (CF)

For the first time in decades, CMS is proposing four separate CFs, a substantial departure from previous years' methodology. Beginning January 1, 2026, the CFs will reflect two different, small permanent updates under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), providing slightly higher payments for physicians who qualify as participants in advanced payment models (APMs) compared to those who do not. The four factors are as follows:

- $33.5875 for Advanced APM qualifying participants (QPs) (3.8 percent increase from 2025)
- $33.4209 for other clinicians (a 3.3% increase)
- $20.6754 for anesthesia services by qualifying APMs
- $20.5728 for anesthesia services by non-APMs

This structure reflects new statutory requirements under MACRA, applying modest permanent increases (0.75 percent for APM QPs, 0.25 percent for non-APM QPs), a temporary one-year 2.5 percent increase enacted by Congress for 2026, and a 0.55 percent positive budget neutrality adjustment. However, it also incorporates a -2.5 percent "efficiency adjustment" that reduces work Relative Value Units (RVUs) for many non-time-based services, which most directly impacts procedural specialties. This move to four CFs adds administrative complexity and underscores the need for ongoing monitoring of payment fairness across specialties and modalities.

While AANEM appreciates the conversion factor increasing after several consecutive years of reductions, these "increases" remain well below the actual growth in practice costs facing our members. Data from the AMA make clear that between 2001 and 2025, Medicare physician pay remained essentially flat, while practice costs – measured by the Medicare Economic Index (MEI) – rose by nearly 60 percent. Adjusted for inflation, physicians have experienced a cumulative 33 percent decline in real payment over that period. These payment updates have not come close to offsetting escalating expenses for rent, staff, technology, supplies, and regulatory compliance. By contrast, hospital providers have received annual, inflation-based payment updates close to 2.5 percent per year, totaling nearly 80 percent over the same period.

We also note that CMS has not proposed an adjustment to address the prior overestimation of utilization of the office/outpatient complexity add-on code G2211 during 2024 rulemaking. While we recognize that budget neutrality requirements constrain CMS' options, this error continues to dampen payment levels for 2026. AANEM joins the AMA and others in urging CMS to work with Congress to explore corrective solutions, while emphasizing that our primary concern is ensuring future forecasts and budget neutrality calculations reflect utilization as accurately as possible.

Ultimately, even with the proposed increase, the conversion factor does not adequately reflect the inflationary realities facing physicians. While AANEM welcomes the movement upward after years of cuts, the growth remains insufficient to meet escalating practice costs, and past forecasting errors – such as those affecting G2211 utilization – underscore the need for greater transparency and accuracy in budget neutrality calculations. Payment stability and predictability are especially critical for subspecialists like NM and EDX providers, who face disproportionately high equipment and workforce expenses. Without corrective action, rising costs will continue to jeopardize access to specialized care for Medicare beneficiaries. **AANEM strongly encourages CMS to support congressional action to establish a permanent, annual inflation-based update tied to the MEI.**

Efficiency Adjustment

CMS has introduced a proposed 2.5 percent efficiency adjustment to most non-time-based service codes in the 2026 MPFS, targeting both the work RVUs and intra-service physician time for calendar year 2026 and beyond. This adjustment is intended to annually reflect supposed productivity gains in medical practice; however, serious concerns about its rationale and methodology have emerged. The change will be applied broadly to thousands of codes, including those that have undergone recent valuation reviews, thereby compounding past reductions rather than periodically updating values based on new specialty society survey data. Notably, the proposal exempts time-based services – such as evaluation and management (E/M), maternity care, behavioral health, care management, and telehealth-listed services – from the adjustment.

Critically, CMS plans to recalculate and reapply this adjustment every three years, which could produce compounding payment reductions to codes that have already been recently reviewed for accuracy using specialty survey data. This broad, arbitrary -2.5 percent adjustment is not supported by the actual costs of furnishing physician services, deviating from the individualized, data-driven updates recommended by the RVS Update Committee (RUC) and specialty societies. CMS' justification is built on the assumption that physician intra-service times are generally overstated, suggesting systemic efficiency gains. However, recent multi-specialty surveys reveal that many codes show stable or even increased intra-service time. A large, peer-reviewed study from the Journal of the American College of Surgeons found that, in over 1.7 million surgical cases, operative times increased between 2019 and 2023, directly refuting the assumption of universal efficiency gains driven by technology or workflow changes. In fact, modern advancements such as AI-enabled imaging often add interpretative and documentation burden, requiring more physician time rather than less.

Applying the adjustment uniformly across thousands of services is inappropriate, as it ignores the diversity in case complexity, technological impacts, and clinical workflow, undermining the relativity principle that ensures payment fairness and accuracy in the Resource-Based Relative Value Scale (RBRVS) framework. This broad-based approach threatens the stability of physician compensation and practice budgeting. Over half of the nation's physician payment arrangements and practice budgets are tied directly to work RVU, and recurrent, non-specific cuts introduce volatility and uncertainty into these budgeting models.

Furthermore, CMS' rationale about review lag is flawed. The actual average time between specialty survey data collection and PFS implementation is 13 to 21 months, not the two to three years cited by CMS, ensuring more timely updates than claimed.

To address these issues, **CMS should reject blanket, assumption-driven efficiency cuts and instead implement a targeted review cycle for high-volume and high-expenditure codes.** Efficiency updates must be based on actual, service-specific data reflecting demonstrated changes in physician time or practice resources, rather than macro-level productivity factors that are unrelated to direct patient care

Practice Expense (PE) Methodology Overhaul

Site of Service Payment Differential
CMS is proposing a major revision to how the indirect component of PE RVUs is calculated. Specifically, for services furnished in the facility setting, CMS would reduce the portion of the PE RVU allocated based on work RVUs to 50 percent of the non-facility amount, reflecting the agency's view that office-based practices incur higher overhead costs compared to facility-based physicians. According to CMS' impact analysis, this change would reduce total MPFS payments for services in the facility setting by approximately 7 percent, while raising non-facility payments by about 4 percent. Certain specialties, including ophthalmology, otolaryngology, and gastroenterology, would face even greater reductions for their facility-based services.

The AMA and AANEM are concerned that this change may not accurately reflect the ongoing administrative and clinical costs incurred by independent physician practices providing services in facility settings. For example, both hospital-employed and non-hospital-employed physicians manage their own billing, scheduling, and other overhead expenses, whether delivering care in hospitals or ambulatory surgical centers. Data from the AMA's 2024 Physician Practice Information (PPI) Survey show that practices incur significant indirect expenses per hour of direct patient care in hospital-based medicine and surgery – costs that would not be compensated adequately under the proposed policy.

The AMA appropriately warns that reducing indirect PE RVUs in the facility setting could further accelerate practice consolidation, as many small and independent practices may find it financially unsustainable to continue providing facility-based services. This proposal could unintentionally increase physician employment by hospitals and large health systems, undermining CMS' stated objective to bolster independent private practice. The proposal would have especially negative consequences for hospital-based specialists, who may have no choice but to consolidate to absorb uncompensated costs or find employment with larger organizations.

Given these significant concerns and the potential for market disruption, **the AANEM supports the AMA's recommendation that CMS reconsider or modify this policy to ensure that independent and facility-based practices are fairly compensated for their real-world expenses, and urges CMS to fully integrate updated, representative PPI Survey data in future rulemaking on practice expense RVUs.**

Physician Practice Information (PPI) Survey
CMS has elected not to implement the results of the AMA's PPI Survey for 2026, providing critique of the PPI survey's response rates, representativeness, and reliability, suggesting limitations in using the data for setting practice expense values. The AANEM supports the AMA's response defending its survey, which emphasized the rigor of survey design and methodology contracted out by Mathematica, engagement with a broad range of specialties, and extensive outreach for participation. The AMA noted the improvements in the 2024 PPI Survey over prior data from the 2007 PPI Survey, with the 2024 results being arguably the most accurate and current measure of practice costs available.

While AANEM acknowledges that the 2024 PPI Survey and resultant data may have limitations, we are concerned that the alternative methodology CMS proposes is not rooted in sound evidence and undermines payment predictability. Adjustments of this magnitude, particularly in the absence of reliable and validated data, create instability for physician practices and risk disproportionate effects on smaller specialties such as NM and EDX medicine.

AANEM supports using the PPI and the Consumer Price Index (CPI) to implement new MEI shares beginning in 2026, resulting in the following distribution: work = 54.4 percent, PE = 43.8 percent, and professional liability insurance (PLI) = 1.7 percent. We also align with the RUC's recommendation that CMS reconsider its proposal to reduce indirect PE for facility-based services, as this approach does not accurately capture the resources practices must invest even when care is furnished in a facility setting. Instead, CMS should work with the AMA to consider the 2024 AMA PPI survey recommendations more fully, including updates to the PE/Hospital Resource (HR) groupings and specialty-specific data.

Predictable, evidence-based updates are essential to ensuring Medicare payments accurately reflect the real costs of providing care. **AANEM urges CMS to avoid implementing sweeping methodological changes until robust practice cost data are available and validated, and instead to pursue a transparent, phased-in process informed by the PPI Survey and other appropriate data sources.**

Updates to GPCIs and Malpractice Risk Index

For 2026, the Geographic Practice Cost Indices (GPCIs) and Malpractice Risk Index (MRI) have been modestly updated with refreshed data, but no substantial methodological changes – the index still consists of physician work, PE, and malpractice components. Most localities will see minimal payment changes, though the prior work GPCI floor will expire everywhere except Alaska (which retains its 1.5 floor) and certain frontier states (Montana, Nevada, North Dakota, South Dakota, Wyoming) that keep a 1.0 floor. The impact on malpractice RVUs is minor overall, with less than a 1 percent shift for nearly all specialties.

AANEM urges CMS to continue to improve the collection and use of specialty-specific data – particularly for malpractice premiums – to better reflect the real risk profiles and costs of all physician types. In addition, **AANEM calls for CMS to provide transparency in both methods and results, including publishing detailed, specialty-level impacts rather than broad aggregation or crosswalks, to ensure physicians are accurately represented in geographic and risk adjustments.**

Telehealth Policy

Telehealth has provided a way for Medicare beneficiaries to safely access routine healthcare services in their homes when they are unable to access in-person care. For patients with mobility issues, such as those with ALS, telehealth appointments are extremely important because often patients need to travel long distances to receive and maintain the level of care needed for their condition since neuromuscular specialists are often only available in major US cities at large institutions. **AANEM strongly supports policies that remove unnecessary barriers to telehealth, ensure the sustainability of care delivery, and promote high-quality, patient-centered care.**

Simplification of Telehealth Service Additions
The CY 2026 PFS proposed rule includes significant changes to Medicare telehealth policy, most notably a simplification of the process for adding services to the Medicare Telehealth Services List. Specifically, CMS would eliminate the distinction between "provisional" and "permanent" categories so that all services are regarded as permanent if they are (1) separately payable under the MPFS, (2) subject to Medicare telehealth provisions, and (3) can be delivered via an interactive telecommunication system. The proposed changes also remove the requirement for detailed mapping to an in-person comparator service, instead empowering practitioners to rely on clinical judgement and focusing on reducing unnecessary administrative burden. Among the new additions, CMS proposes to include specific caregiver training codes to the telehealth list, thereby enhancing patient and caregiver support for remote care management. **AANEM supports these efforts to simplify and modernize telehealth service additions, provided they continue to maintain high-quality standards for care delivery.**

Removal of Frequency Limitations, Expansion of Audio-Only Technology
Alongside these updates, the proposal would permanently remove existing frequency limitations on certain telehealth visits, including subsequent inpatient hospital visits, subsequent nursing facility visits, and critical care consultations. Such regulatory relief is particularly meaningful for patients with frequent or ongoing care needs who face significant barriers to in-person specialist access. The proposed changes also extend the permanent use of audio-only technology for telehealth services in circumstances where audiovisual communication is not feasible, which is essential to ensuring equitable access for patients with mobility or technological limitations. **AANEM strongly supports these proposals for removing care barriers and expanding care modalities, recognizing their critical importance for the most vulnerable patient populations.**

Direct Supervision and Supervision of Resident Physicians
CMS seeks to make virtual direct supervision via real-time audio-video communications standard for qualified services, with select exceptions, thereby modernizing oversight requirements while upholding clinical standards. However, CMS also proposes to end certain COVID-era telehealth flexibilities by returning to pre-pandemic requirements for teaching physician supervision in non-rural settings, once again mandating physical presence for resident-furnished services and retaining virtual supervision options only in rural areas, consistent with previous statutory intent. **AANEM supports the permanent extension of virtual direct supervision and virtual supervision of resident physicians in all locations and opposes CMS's proposal to restrict virtual teaching physician supervision to rural settings only.**

Originating Site of Service Policy
The rule maintains the patient's home as a permissible originating site for specified telehealth services and raises the originating site facility fee by 2.7 percent to $31.85 per encounter in line with the MEI. **AANEM supports the preservation of the home as a telehealth site and recognizes the site fee update as an important measure to keep pace with inflation and costs of care.**

Efficiency Adjustment Exemption
CMS proposes to exclude services on the Medicare Telehealth List from the newly proposed 2.5 percent "efficiency adjustment" to work RVUs. While the intent is clear, the proposed rule does not consistently or accurately reflect this important exemption across all relevant codes and services, creating ambiguity for future implementation. **AANEM's support for these telehealth provisions is therefore contingent on a clear and comprehensive exemption of all telehealth services from the efficiency adjustment within the final rule.**

Evaluation and Management (E/M) Visits

The 2026 MPFS proposed rule includes notable updates to E/M services, with a specific focus on expanding use and modifying the Complexity Add-on code G2211. The proposals aim to broaden where G2211 can be used and address budget neutrality concerns stemming from its implementation.

G2211 Complexity Add-on Code Expansions
The 2026 MPFS proposed rule introduces a significant expansion for the E/M Complexity Add-on code G2211 by allowing it to be billed not just with office and outpatient visits, but also for services provided in home, residence, and nursing facility settings. This change is designed to better recognize the complexity and resource requirements of caring for patients with ongoing or complex health needs across a broader array of care environments. CMS' proposal underscores its continued commitment to supporting primary and longitudinal care – especially for those beneficiaries who require relationship-based, coordinated management for chronic or multifaceted conditions. **The AANEM strongly supports this expansion, highlighting the importance of adequately valuing the coordination work performed by physicians who serve as continuing focal points for their patients' care.**

Budget Neutrality Adjustments
Alongside this policy advancement, however, there are ongoing concerns related to the budget neutrality impact of G2211's implementation. When G2211 was initially activated in 2024, CMS projected that the code would be billed with 38 percent of all office/outpatient E/M visits, but actual claims data for 2024 revealed a much lower utilization rate of only about 11.2 percent. This overestimate caused a substantially larger, and ultimately unwarranted, reduction to the Medicare CF for 2025 – negatively affecting physician payment rates beyond what was justified by real-world billing patterns. **The AANEM and other stakeholders have urged CMS to rely on actual utilization data in future calculations and to make prospective adjustments to the budget neutrality formula**. Such action is necessary to prevent further unwarranted payment reductions and to ensure that reimbursement levels more accurately reflect true patterns of care and coding in clinical practice.

Other Policy Changes

Supply Pack and Equipment Pricing Corrections

CMS proposes several important updates regarding supply and equipment pricing that are highly relevant for AANEM and similarly sized specialties. The agency continues to correct longstanding mathematical errors in supply pack pricing, implementing a phased transition to bring aggregated pack costs in line with the sum of their components—changes that impact both commonly used and less common procedure packs, and which could affect payment rates for codes central to NM and EDX medicine. At the same time, CMS is maintaining its recent policy of considering public input and invoices for annual review of both supply and equipment prices, while discussing the potential for new HCPCS codes to separately track high-cost disposable supplies.

Overrides For Low-Volume Codes, CPT Code Time and Input Corrections

The proposed rule also reaffirms CMS' use of expected specialty overrides for low-volume codes, with updated recommendations from the RUC to better align specialty assignments and prevent inappropriate volatility in practice expense and professional liability adjustments for services with small Medicare sample sizes, an issue especially pertinent for AANEM's core codes. Additionally, the agency is correcting technical errors in reported clinical labor times, equipment minutes, and direct input assignments for select CPT codes, some stemming from previous cycles where errors went unaddressed; these corrections reflect a collaborative process between CMS, the AMA, and specialty societies to ensure methodological accuracy and fair payment.

Overall, these actions demonstrate CMS' ongoing effort, shaped by detailed advocacy from organizations like AANEM, to reconcile pricing anomalies, enhance data precision for practice inputs, and support more equitable physician payment updates moving forward.

Malpractice (MP) Risk Data

The 2026 MPFS proposed rule includes a routine update to MP risk data and RVUs, with changes described as modest and methodological refinements minor compared to past cycles. Most specialties – including NM medicine – will see little to no change in MP RVUs or payment, and the data update primarily reflects better direct premium capture for more specialties, resulting in relatively small payment shifts (nearly all under one percent) for most groups.

For AANEM, there are no acute issues requiring urgent comment, but it may be prudent to **encourage CMS to continue improving data collection and accuracy, especially for smaller or underrepresented specialties, and to ensure input from specialty societies on imputation practices and risk index mapping.** Transparency in published specialty-level impact data will also help AANEM monitor for any future adverse effects

Social Determinants of Health (SDOH) Risk Assessment

AANEM agrees with CMS' proposal to delete Healthcare Common Procedure Coding System (HCPCS) code G0136, as the resource costs and documentation for SDOH risk assessments are already embedded within existing CPT codes, particularly under the E/M services framework. SDOH assessment, including factors such as food security, housing stability, and transportation access, can be appropriately captured and reported through E/M coding without the need for a distinct G-code. CMS changes to E/M coding guidelines since 2021 make it possible to document SDOH complexity, such as when a diagnosis or treatment is significantly limited by social risk factors, within the typical scope of an office visit. By maintaining SDOH assessment as an integral part of E/M services, CMS avoids duplication and ensures that it remains central to patient care.

Continued education for providers on coding and payment for these services is essential for addressing the underlying social risks that impact patient outcomes, especially those with complex needs, such as individuals with neuromuscular disease. **We encourage CMS to further educate providers on recognizing and coding interventions for SDOH needs using the revised E/M coding guidelines so that issues impacting patients' health – such as food, housing and transportation – are continually addressed in clinical care.**

Quality Payment Program (QPP)

AANEM continues to have significant concerns regarding proposed QPP rule changes, particularly as they affect the unique practice patterns of NM medicine, EDX medicine, and/or neurophysiology. Our physician members care for a highly select and complex patient subset and, in many situations, such as with EDX testing, the interaction with the patient is often limited to a single evaluation, with ongoing management and follow-up care provided by the referring provider. This structure has made it difficult for NM and EDX providers to identify quality measures that meaningfully reflect the care they provide and making most outcome-based or chronic-management measures unreportable. For example, many of our physicians perform diagnostic testing on diabetic patients to check for neuropathy but they are not involved in the management of the patient's diabetes, and it would be inappropriate to measure them based on any of the diabetes measures.

This challenge has been exacerbated by the shift from process-based measures to outcome-based measures, combined with the lack of longitudinal follow-up inherent in many of our members' practices as referenced herein. Our members struggle to identify quality measures in the QPP that meaningfully reflect the care they provide their patients. Consequently, many AANEM members cannot reasonably meet the current QPP standards and remain unable to find suitable APMs that recognize the realities of subspecialized care. **AANEM urges CMS to simplify QPP participation to be more understandable and less administratively burdensome for providers.**

Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs) and Subgroup Reporting

AANEM recognizes CMS' intent to simplify MIPS through the transition to the MVPs and supports creating a more cohesive and meaningful reporting structure. However, we have serious concerns that the current and proposed MVPs do not adequately reflect the diversity and complexity of subspecialty practices. **CMS should ensure that MVP development, maintenance, or removal is transparent, stakeholder-driven, and includes robust specialty-specific consultation.**

AANEM remains opposed to any mandatory subgroup reporting within MVPs. Subgroup reporting should remain voluntary, particularly for multispecialty and highly subspecialized practices, to preserve flexibility in choosing the most appropriate reporting pathways. Practices should have the option to determine which MVP or MIPs measures are most relevant to the providers in their practice. Mandatory subgroup reporting may create significant operational challenges, especially for the growing number of large, multi-specialty practices, which may discourage participation in MVPs.

If a transition from MIPS to MVPs is made, AANEM supports a gradual transition, starting with voluntary participation in MVPs with incentives to encourage participation. However, the requirements must be simplified, and CMS must demonstrate the viability of MVPs in a meaningful way before discussing a mandated transition. AANEM urges CMS not to mandate participation in MVPs without sufficient time for providers to gain experience. While AANEM supports CMS' goal of transitioning to value-based care, we are concerned that the proposed timeline does not provide enough time to develop better cost measures or address the structural issues and longstanding measure gaps in MIPS. **AANEM urges CMS to not set a hard sunset date for MIPS before MVPs are shown to be viable and relevant for every clinical practice area.**

MIPS Performance Threshold

AANEM supports CMS maintaining the MIPS performance threshold at 75 points through at least 2028, but notes that this does not address the disproportionate burden on small, rural, and independent practices, exacerbating health care inequities and failing to capture meaningful clinical outcomes. Small practices have historically struggled to meet the performance threshold compared to larger group practices that have more resources in place for data collection and reporting. **AANEM urges CMS to collaborate with the medical community and Congress on statutory reforms that eliminate steep penalties that disproportionately impact small and rural practices, prioritizing access to timely and actionable data, reducing administrative burdens, and ensures that facility and non-facility quality programs are aligned.**

Quality Performance Category

CMS continues to propose significant changes to the MIPS Quality Performance Category for the 2026 performance year, including the addition of new measures, removal of those lacking benchmarking or specialty relevance, and substantive modifications to others. Of the 190 total proposed measures, five are new and ten are slated for removal. Changes to topped out measure handling and increased emphasis on outcome and patient-reported metrics may further disadvantage providers whose practices are episodic or consultative in nature. Further, reducing the total number of available quality measures forces providers to report on measures of little relevance to their practice which increases administrative effort and decreases meaningfulness of reported outcomes.

AANEM urges CMS to prioritize the development and retention of clinically relevant, actionable quality measures that reflect the nature of subspecialty care, and to maintain flexibility so providers are not unfairly penalized by a lack of applicable measures. We support efforts to simplify measure selection and reporting, and recommend that future measure development efforts involve ongoing, robust specialty society input.

Topped Out Measures
AANEM supports CMS' direction in refining MIPS quality measure scoring, including efforts to address the challenges posed by topped-out measures and to better align benchmarking methodologies. AANEM urges CMS to apply the flat benchmark methodology and related policies to all topped-out measures, rather than a select few to address ongoing inequities impacting solo practitioners and small practices. AANEM also supports the AMA's recommendation to refine the methodology by removing the lowest decile instead of the ninth for greater consistency and fairness in scoring across all quality measures.

Administrative Claims-Based Quality Measures Scoring
AANEM also supports CMS' proposal to align the benchmarking of administrative claims-based quality measures with cost measures and urges that this methodology be extended to all quality measures. AANEM urges CMS to reduce the data completeness requirement for measure reporting and recommends lowering the threshold to ease administrative challenges, particularly for solo practitioners and small practices and those with less advance health IT systems.

Data Completeness Requirements
AANEM commends CMS for acknowledging the complexities faced by providers in highly specialized fields and strongly encourages adoption of clear and fair minimum data submission requirements. Providers should receive credit for their best data submissions rather than solely their most recent. This approach reflects a commitment to continuous quality improvement. The current 75 percent data completeness threshold is unduly burdensome for many subspecialty practices, and we urge CMS to revisit and lower this threshold to accommodate administrative and technical realities. It is critical that quality and improvement activity measures are continually aligned with the clinical realities and workflow patterns of highly specialized groups, ensuring they are not unfairly penalized as MIPS evolves.

<u>Cost Performance Category</u>

Relevant, actionable quality and cost measures remain lacking for many subspecialties. The ongoing removal of process measures, without suitable replacements for episodic or one-time consultative care, is problematic. In the cost category, current measures frequently fail to reflect costs that are directly attributable or manageable by NM or EDX providers. While development of more specialty relevant cost measures is imperative, specialty societies like AANEM lack the resources to develop meaningful cost measures given the lack of access to Medicare cost data.

Two-Year Informational-Only Feedback Period
AANEM supports the proposal to adopt a two-year informational-only feedback period for new cost measures and requests further ongoing dialogue between CMS and specialty societies to ensure measures reflect specialty practice and are used in a fair, actionable manner, giving providers an opportunity to validate measures before they impact payment.

Promoting Interoperability (PI) Performance Category

AANEM recognizes the importance of certified electronic health record technology (CEHRT) for Medicare program objectives but is concerned that the PI requirements continue to increase in complexity and administrative burden. The proposed rule would require attestations both for conducting a Health Insurance Portability and Accountability Act (HIPAA) Security Risk Analysis and for implementing measures to manage security risk. These duplicative requirements add unnecessary reporting burden, offer little additional practical benefit, and overlap with existing HIPAA obligations.

Additionally, while CMS plans to add Public Health Reporting using Trusted Exchange Framework and Common Agreement (TEFCA) as an optional bonus measure, **AANEM urges CMS to maintain all public health and registry reporting as attestation-based and voluntary.** We support ongoing modernization of public health data systems and recognize the value of Fast Healthcare Interoperability Resources (FHIR) standards and other secure data exchange systems, but CMS should align timelines and requirements with the readiness of small and specialty practices and EHR vendors. **AANEM urges CMS to prioritize incentives and technical support, rather than imposing new penalties or advancing premature performance-based PI measures.**

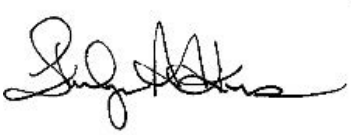
Advanced Alternative Payment Models (APMs)

AANEM supports CMS efforts to align MIPS with Advanced APM tracks, promoting efficient transition between participation categories and maximizing opportunities for specialty and small practices. However, NM and EDX providers continue to face a near-total absence of applicable APMs or Advanced APMs. We have done extensive research into the viability of developing an APM that may be applicable to our members, but it became quickly apparent that such an endeavor requires resources well beyond the capacity of smaller societies. It is important to provide specialists more opportunities to participate in APMs, but an APM must be designed to support the specific types of care specialists deliver to their patients. We continue to request that CMS provide additional resources for specialty and subspecialty-driven APM development. **AANEM opposes forcing specialists into inapplicable APMs that threaten patient care and practice viability.**

Conclusion

We thank you for your consideration of our recommendations on these important issues. We urge the agency to carefully consider the unique needs and perspectives of subspecialized providers as it finalizes the QPP rule. We hope that this letter will serve as part of a continuing collaborative discussion with CMS in shaping policies that advance quality, reduce administrative burden, promote equity, and sustain physician-patient relationships vital to the highest standards of NM and EDX care. We welcome meeting with CMS to answer questions related to any of our suggestions.

Sincerely,



Shirlyn Adkins, JD
AANEM Executive Director