September 12, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The American Academy of Dermatology Association (AADA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) proposed rule. The AADA represents more than 17,500 dermatologists nationwide who are committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease.

Our comments in response to the Medicare PFS and Quality Payment Program (QPP) are provided below.

I. Medicare Physician Fee Schedule

A. Medicare Physician Payment

The AADA is deeply alarmed by the ongoing instability of the Medicare PFS. As written, the CY 2026 proposed rule will increasingly strain physicians' ability to care for patients. While we appreciate Congress' recognition of the need for payment stability through the reconciliation package and its passage of the "One Big Beautiful Bill Act," which provides a temporary 2.5 percent payment

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increase for CY 2026, this measure is only a stopgap. It does not address the underlying need for a permanent, sustainable solution that provides positive payment updates tied to inflation.

Physicians have already endured five consecutive years of payment cuts, with cumulative reductions exceeding 10 percent since 2020. Although the 2026 Medicare PFS proposed rule includes a moderate increase, it does not offset past reductions. Worse, it sets the stage for additional cuts to physician payment in 2027.

The AADA maintains that longstanding flaws in the Medicare PFS, including the lack of an inflationary update and rigid budget neutrality requirements, combined with new policies in this proposed rule, threaten patient access to care, undermine physicians' ability to provide services, and accelerate practice consolidation. **The AADA urges CMS to work with Congress and the medical community to enact permanent reforms to the Medicare physician payment system.**

Dual Conversion Factors

The AADA has significant concerns with the creation of two separate conversion factors for 2026 and beyond, as it creates long-term inequities in physician payment. Under current law, beginning in 2026, Medicare will apply two separate conversion factors for determining payments under the PFS. Clinicians who are qualifying Advanced Alternative Payment Model (APM) Participants (QPs) will receive a 0.75 percent base payment update, while all other clinicians will receive only a 0.25 percent base update. This two-tiered system creates confusion and inequity because physicians would be paid differently for the same service based solely on QP status.

The Medicare Payment Advisory Commission (MedPAC) has warned against this policy approach, noting that it is particularly unfair for specialties that lack meaningful opportunities to achieve QP status.[1] Although many specialties have invested heavily in developing value-based care (VBC) models, the Center for Medicare and Medicaid Innovation (CMMI) has not vetted or approved such models in the past six years. As a result, whether physicians attain QP status often depends less on their willingness to participate in VBC and more on CMMI's inaction.

MedPAC has further explained that while the payment differential may start small, it compounds over time and will widen to a 10.5percent gap by 2045.[2] Such a large incentive is inequitable and unwarranted, particularly since many clinicians will continue to have limited access to Advanced APMs due to their specialty, practice setting, or geography.

The AADA urges CMS to ensure that all physicians, including specialists, have meaningful opportunities to participate in voluntary APMs so they have a fair chance to qualify for the higher conversion factor. Until such opportunities are available, CMS should work with Congress to delay

[1] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2025. Chapter 1: "Reforming physician fee schedule updates and improving the accuracy of relative payment rates." Available at: https://www.medpac.gov/.../Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf. Accessed August 19, 2025.
[2] Id.

or replace the two conversion factors with a single, equitable update that applies to all physicians.

Lack of Inflationary Updates
Physician practice costs have risen sharply, as measured by the Medicare Economic Index (MEI). MEI growth has consistently outpaced Medicare PFS updates, with cumulative increases of 52 percent from 2000 to 2023 compared to just 14 percent in payment updates.[3] The growing gap between practice costs and Medicare payment updates leaves practices unable to cover the rising expenses associated with workforce shortages, higher supply costs, and mounting administrative burdens. This disparity fuels physician burnout, prompting many to sell their practices, reduce the number of Medicare patients they treat, or leave the workforce entirely.

Solo and small-group dermatology practices are particularly vulnerable to the ongoing instability of the Medicare PFS. Many dermatologists report difficulty retaining staff because they cannot offer wages that compete with retail employers. Constant staff turnover increases training costs and shifts more administrative responsibilities onto physicians themselves, diverting time from clinical care and raising concerns about the long-term financial viability of physician-owned practices.

Both the Medicare Trustees and MedPAC warn that the current payment policy is unsustainable. The Medicare Trustees Report noted that statutory updates are not expected to keep pace with the average rate of physician cost increases and predicted that access to Medicare-participating physicians will become a significant issue without reform.[4] Similarly, MedPAC's June 2025 Report to Congress recommended replacing current-law updates with an annual increase tied to growth in the MEI.[5]

In addition, regulatory and administrative demands, including quality reporting and prior authorization requirements, further strain practices that lack the resources to invest in technology and staff. Without sufficient payment, many practices will struggle to comply, further eroding stability. Physicians cannot withstand minimal updates that fail to keep pace with rising practice and labor costs, nor can they absorb ongoing cuts triggered by budget neutrality adjustments, as further discussed below. **The AADA therefore urges CMS to work with Congress to establish long-term statutory reforms that provide positive, inflation-adjusted annual updates tied to MEI.**

Budget Neutrality
The AADA emphasizes the urgent need to reform budget neutrality policies. Current law requires CMS to offset changes in spending of more than $20 million per year. While intended as a safeguard,

[3] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2025. Chapter 1: "Reforming physician fee schedule updates and improving the accuracy of relative payment rates." Available at: https://www.medpac.gov/.../Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf. Accessed August 19, 2025.
[4] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Medicare Trustees Report. CMS; 2024. Accessed August 19, 2025. https://www.cms.gov/oact/tr/2024
[5] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2025. Chapter 1: "Reforming physician fee schedule updates and improving the accuracy of relative payment rates." Available at: https://www.medpac.gov/.../Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf. Accessed August 19, 2025.

these adjustments often result in significant redistribution of payments that destabilize the system. For example, in the CY 2021 PFS final rule, changes to office and outpatient evaluation and management (E/M) codes triggered a -10.2 percent budget-neutrality adjustment to the conversion factor. Without congressional intervention, many physicians would have faced devastating cuts despite no change in the care they provide.

Budget neutrality adjustments are also frequently overstated because they rely on utilization assumptions that often do not materialize. When CMS overestimates use of new services, the resulting reductions to the conversion factor remain uncorrected under current policy, leading to permanent and unwarranted losses in physician payments. Experience with transitional care management codes illustrates this problem well, as overestimates for 2013 led to an irreversible $5.2 billion reduction in physician payments between 2013 and 2021. More recently, CMS's assumptions about the E/M complexity add-on code G2211 have similarly contributed to excessive and unwarranted payment reductions tied to budget neutrality adjustments. **We believe that CMS has the authority to rectify utilization assumption errors that have contributed to overstated budget neutrality adjustments, and we urge CMS to correct for documented errors in estimated utilization when they are identified.**

Lastly, the $20 million budget neutrality threshold has remained unchanged since 1992. Raising this threshold to reflect inflation would provide greater flexibility and mitigate unnecessary instability. **Therefore, the AADA supports an increase to the budget neutrality threshold in a manner that would account for inflation that has occurred since the original threshold was established. We urge CMS to work with Congress to implement this important change.**

B. Practice Expense Methodology
Site-of-Service Payment Differential
The AADA opposes CMS's proposal to reduce indirect practice expense (PE) when a service is performed in the facility setting because it does not reflect the resources physician practices must invest to support patient care across settings. CMS is correct that the site-of-service payment differential between facility and non-facility settings is a concern, but the true driver of this disparity is the lack of an annual inflationary update to the Medicare PFS. Without addressing this underlying problem, simply reducing support for facility-based services risks worsening inequities rather than solving them.

Unlike facility payment systems, physician payments under the Medicare PFS have not kept pace with rising costs. Hospital outpatient departments and ambulatory surgical centers receive routine updates based on the hospital market basket. In contrast, Medicare PFS updates under MACRA have been far below inflation. Until this structural problem is addressed, proposals such as adjusting the PE methodology will not resolve site-of-service inequities and will instead further exacerbate and threaten Medicare beneficiaries' timely access to care.

CMS points to a national decline in private practice physicians as part of its rationale, noting that only 35.4 percent of physicians remain independent. This is not the case in dermatology, where the majority continue to practice independently. Physicians are already facing mounting challenges under a Medicare payment system that imposes annual cuts and provides no automatic inflationary update. For dermatologists in private practice who also provide services in the facility setting, the proposed policy would worsen financial pressures by disregarding the administrative and clinical resources their individual practices must still contribute to scheduling, billing, and care coordination.

Moreover, the decline in private practice is a symptom of a broken payment system, with broader consequences for local economies and small businesses. It should not be used as a justification to cut reimbursement in the facility setting.

Approximately one-quarter of our membership provides services in a facility setting. Maintaining access to dermatology in hospitals is vital for patient care and cost control. In fact, research shows that establishing inpatient dermatology consultation services can reduce the average hospital length of a dermatologic inpatient stay by 1.04 days, from 4.27 to 3.23 days ($p = 0.046$), as well as increase the rate of outpatient dermatology follow-up from 6.2 percent to 24.4 percent ($p < 0.001$).[6] If hospitals are forced to scale back dermatology services because of reduced support, patients could face longer hospitalizations or higher complication rates. Missed opportunities for coordinated follow-up can also lead to poorer outcomes and more costly downstream care. In short, reducing support for facility-based dermatology would undermine patient access, worsen health outcomes, and run counter to CMS's stated goals of promoting efficiency and supporting high-quality, cost-effective care.

The AADA urges CMS to work with Congress to address the root cause of the site-of-service payment differential by establishing a permanent, positive inflationary update for physician payments tied to the MEI.

AMA Physician Practice Information Survey

The AADA appreciates CMS's recognition of the limitations in the Physician Practice Information (PPI) survey and agrees that it is not appropriate to use the data as the basis for updating the MEI or the resource-based relative value scale (RBRVS). While we supported the AMA PPI survey efforts and encouraged our members to participate, the survey ultimately failed to produce data that was reliable or representative of physician practices across specialties.

Another significant challenge was the limited availability of practice financial information. Most practices do not maintain expense data at the level of specialty detail required by CMS, which made it difficult to respond in the requested format, even when surveys were successfully received.

The AADA strongly urges CMS to identify data sources that incorporate physician input and can be updated more regularly, accurately, and reliably, ensuring that physician practice costs are

[6] Reimer C, Lee E, Wysong A, Georgesen C. Quantitative benefit of inpatient dermatology services on hospital length of stay in an academic hospital. Cureus. 2023;15(8):e43519. doi:10.7759/cureus.43519. PMID: 37719626; PMCID: PMC10501321.

appropriately reflected in Medicare payment policy.

High-Cost Disposable Supplies

The AADA urges CMS to establish separate payment for high-cost disposable supplies. These items significantly distort the current PE RVU methodology. Disposable supplies priced above $500 now make up a substantial portion of direct supply costs, yet CMS continues to fold them into PE Relative Value Units (RVUs) rather than reimbursing them separately.

In the 2025 Medicare PFS, high-cost medical supplies represented $1.32 billion in direct costs and account for 19 percent of all direct PE medical supply costs in the non-facility setting.[7] In some cases, Medicare payments do not even cover the purchase price of the supply itself.

CMS should recognize that when Current Procedural Terminology (CPT) codes include high-cost disposable supplies, a disproportionate share of indirect PE is shifted to practices performing these services, which all other providers effectively subsidize. To address this inequity, **the AADA calls for high-cost disposables to be reimbursed separately using appropriate Health Care Common Procedural Code System (HCPCS) codes.**

C. Efficiency Adjustment

The AADA strongly opposes CMS's proposal to apply a 2.5 percent "efficiency adjustment" policy as it is not supported by valid data, is inconsistent with the Medicare statute, undermines the relativity of RBRVS, and most importantly, risks harming patient care.

Arbitrary Methodology

CMS has not explained the rationale for selecting 2.5 percent for the efficiency adjustment beyond citing productivity adjustments in the MEI, which has no meaningful relationship to physician work. Applying an economy-wide productivity factor to physician services is arbitrary and ignores the realities of clinical care. Further, reliance on the MEI is particularly misplaced in this policy because, unlike hospitals and other Medicare payment systems that receive routine inflationary updates, physician services do not benefit from an automatic adjustment for rising costs.

There is no evidence that dermatologists, or physicians in general, are performing procedures more efficiently today than in the past. The time it takes for local anesthesia to become effective or for a patient to stop bleeding has not changed and cannot be made more efficient simply through repetition. In fact, many modern tools require additional physician time, including the use of artificial intelligence. Advanced imaging systems and artificial intelligence tools produce far more data that must be carefully reviewed, interpreted, and documented. A recent national study of 1.7 million surgical procedures found that operative times have increased over the past five years, while patient complexity has also grown. The

[7] CPT-RUC Joint Workgroup. High-Cost Supplies Letter [letter]. Chicago, IL: American Medical Association; 2022. Available at: https://www.ama-assn.org/system/files/cpt-ruc-joint-workgroup-high-cost-supplies-letter.pdf
. Accessed September 4, 2025.

authors concluded that there is no evidence to support CMS's assumption that physicians are performing procedures more efficiently today.

The efficiency adjustment policy is further flawed because it applies to codes whose valuations have recently been reviewed and reduced through the RBRVS Update Committee (RUC) process in the past five years. Even more concerning, CMS proposes to apply the adjustment to new codes that have not yet taken effect. For example, a code surveyed in 2024 and implemented in 2026 would still be reduced by an "efficiency adjustment" tied to years when the code was not in use and could not possibly have accrued efficiency gains.

Another serious flaw arises in how the efficiency adjustment applies to global surgical codes. While CMS proposes to exclude time-based codes from the efficiency adjustment, reducing work RVUs by 2.5 percent for 0-day versus 10-day versus 90-day global codes would reduce payment for follow-up E/M visits included in the global codes and improperly penalize physicians providing global services when efficiencies for the time-based follow-up visits could not be achieved.

Finally, CMS's proposal applies a blanket cut to all services without relying on any service-specific data or clinical evidence, which runs counter to the Social Security Act's requirement that RVU adjustments be based on actual changes in medical practice, coding, or new data. By imposing an across-the-board adjustment without valid clinical evidence, CMS disregards this statutory requirement.

Disruption of Resource-Based Relative Value Scale Relativity
The RBRVS is designed to rank services relative to one another based on physician time and intensity. An across-the-board adjustment distorts that relativity by reducing all values equally, regardless of the actual time, effort, and complexity each service requires. This creates rank-order anomalies where services that take less time or require fewer resources may end up valued the same as, or higher than, more complex and labor-intensive services. Such distortions weaken the link between physician work and payment rates, compromise the accuracy of current valuations, and erode the validity of future reviews, leading to inequitable reimbursement across specialties and settings.

Impact on Procedural Specialties and Patients
The proposed "efficiency adjustment" disproportionately harms procedural specialties by layering new payment cuts on top of an already unstable system. Procedural care has already absorbed reductions from the redistribution of E/M values, since postoperative visits included in 10-day and 90-day global codes remain based on pre-2021 valuations, which leaves them undervalued compared to standalone E/M services. Coupled with ongoing conversion factor reductions, these cumulative income pressures exacerbate financial instability. Applying yet another across-the-board adjustment, while excluding time-based services, unfairly penalizes physicians who provide procedures and further threatens practice sustainability.

Additionally, undervaluing procedural services not only destabilizes physician practices but also directly harms Medicare beneficiaries. If specialists are not adequately reimbursed for their services, they may be

less able to treat Medicare patients or provide the follow-up care that is essential to recovery and positive health outcomes. Applying efficiency adjustments in these areas ignores clinical realities and, most importantly, jeopardizes patient safety.

We urge CMS to withdraw the "efficiency adjustment" proposal. We maintain that if CMS believes that certain services are overvalued, the appropriate approach is to designate them as potentially misvalued and allow the RUC to conduct a full review.

D. Strategies for Improving Global Surgery Payment Accuracy

The AADA recognizes CMS's request for feedback on possible methodologies to revalue 10- and 90-day global codes but cautions CMS against relying on the alternative approaches outlined in the proposed rule, as each of these approaches is based on flawed data or faulty assumptions. Implementing them would risk undervaluing global surgical services, misrepresenting the role post-operative care plays in patient recovery, and ultimately leading to worse health outcomes and higher overall costs to the health care system.

CPT 99024-based Approach

The AADA opposes adopting a 99024-based methodology because physicians frequently underreport 99024, producing incomplete and misleading data on post-operative care. CMS has indicated that it is especially interested in feedback on the CPT 99024-based approach; however, many physician practices do not report CPT code 99024 due to the high administrative burden and cost associated with submitting a zero-value code that is not reimbursed. The code is used to report post-operative follow-up visits that are already bundled into the global payment for a surgical procedure. This means practices must incur the time and expense of reporting with no direct financial return. In addition, many practice staff are unaware of the reporting requirement because of overly complicated rules and a lack of targeted education. This underreporting of 99024 has been clearly documented in a recent HHS Office of Inspector General report.[8] As a result, CMS may be left with the misleading impression that some high-volume procedures involve little or no follow-up care, when in reality, post-operative visits are a critical part of patient recovery and achieving positive health outcomes. Relying on reporting of CPT 99024 data leads to an inappropriately high estimate of the procedure share for global services.

Physician Time File–based Approaches

The AADA opposes adopting the Physician Time File–based alternatives because they misallocate work and risk fracturing relativity. CMS has two alternatives for improving global surgery payment accuracy that rely on the Physician Time File: one which would calculate procedure work RVUs by subtracting work RVUs assigned to each post-operative visit listed in the Physician Time File for a global procedure HCPCS code from the total valuation of the global surgical package, and another, which would calculate procedure RVUs as the product of total physician time (in minutes) for each global procedure HCPCS code from the Physician Time File and the ratio of physician time (in minutes) assigned to post-operative visits for the code in the Physician Time File. Both formulas treat minutes and component RVUs

[8] CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries. HHS Office of Inspector General, Office of Audit Services. A-05-20-00021. June 2025.

as interchangeable building blocks, even though global surgical values were not constructed that way. The time ratio approach also fails to account for the intensity of services furnished during the global procedure. As a result, these options would overvalue the post-operative component and reduce surgical work. Furthermore, we note that these approaches rely on the integrity of the data in the Time File, but CMS's previous failure to increase the valuation of E/M codes in global packages has fractured relativity across the fee schedule, and its current efficiency adjustment proposal would contribute to further distortions.

Next Steps
Recent revaluations of global surgical codes demonstrate that targeted RUC review, not subtraction or time-ratio formulas built from the Physician Time File, is the appropriate, evidence-based path to maintain accuracy and preserve relativity. **The AADA maintains that the RUC process is the most effective and efficient way to review procedure valuations, including global surgical codes.**

Ensuring Fair Payment for E/M Services in Global Surgical Codes
The AADA strongly urges CMS to update the E/M component of global surgical codes without further delay. CMS has long recognized that post-operative care is complex, yet the bundled E/M visits in 10- and 90-day global codes have never been updated to reflect the increases applied to standalone E/M codes implemented on January 1, 2021. Changing the values for some E/M services, but not for others, disrupts the relativity mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which was implemented in 1992 and refined over the past 27 years. In the past, whenever payments for new and established office visits were increased, CMS also adjusted the global surgery bundled payments to account for the increased values for the E/M portion of these codes. By not applying the increases, the E/M portion of these codes remains undervalued, resulting in global surgical codes being devalued compared to standalone E/M services. This fractures relativity within the fee schedule and results in physicians being paid differently for providing the same work.

Since CMS increased the values of standalone E/M codes in 2021, nearly every major medical society has urged the agency to apply the increases to the E/M portion of the global surgical codes. CMS has already recognized the need for consistency by updating maternity global codes in 2024 to incorporate the same E/M increases. Importantly, we are not asking CMS to revalue post-operative visits using a building block approach. Rather, we are urging CMS to restore the long-standing practice of maintaining relativity by applying across-the-board increases in E/M values consistently, as has always been done when E/M codes were updated in the past. Failing to update 10- and 90-day global surgical codes is inconsistent and violates Medicare law, which prohibits payment differentials between specialties for the same work.

The AADA urges CMS to apply the updated values for standalone E/M codes to the bundled E/M visits in global surgery codes, as it would restore relativity within the fee schedule, ensure fair payment across specialties, and maintain compliance with Medicare statute.

E. Physician Work and Practice Expense Refinements: Superficial Radiation Therapy

The AADA supports CMS's decision to adopt the RUC-recommended work RVUs for the two new Superficial Radiation Therapy (SRT) codes that include physician work. We do not support the proposal to remove the direct PE inputs for SRT CPT codes 77X05, 77X07, and 77X09 in favor of calculating PE RVUs using Hospital Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) relative weights. The RUC-recommended direct PE inputs more accurately reflect the resources typically required in office-based settings and ensure appropriate relativity within the Medicare PFS.

Physician Work (CPT codes 77X05 and 77X09)
The AADA appreciates that CMS is proposing to accept the RUC-recommended work RVUs for the two codes in the SRT family that have physician work components, CPT codes 77X05 and 77X09. We also appreciate that CMS is proposing to delete HCPCS G-code G6001 and recognize the newly revised CPT codes for payment under the Medicare PFS.

Practice Expense
For both the Radiation Oncology Treatment Delivery and SRT code families, CMS believes that using the relationship between the relative weights of the hospital OPPS APCs assigned to these codes is a more accurate way to reflect their actual costs than relying on direct PE inputs and allocation methodologies. CMS proposes to use OPPS cost data to develop PE RVUs by applying the relationship of the APC relative weights to the codes within each family. This approach is part of a broader effort to revise the valuation of radiation therapy services, based on the assumption that these services require long-term capital investments more consistent with facility-level costs.

OPPS APC cost weights are based on the geometric mean costs of all services assigned to an APC, derived from hospital charges that are converted to estimated costs using each hospital's cost-to-charge ratio (CCR). Because CCRs are calculated at the department level, they represent an average markup across a wide range of items and services. This averaging can result in "charge compression," where higher-cost items are undervalued and lower-cost items are overvalued. In contrast, the Medicare PFS PE methodology uses a detailed, "bottom-up" approach that identifies and prices each specific resource used in furnishing a service. Applying facility-based OPPS relativity to office-based SRT fails to capture these setting-specific resource costs and risks misrepresenting the actual expenses involved.

The AADA contends that CMS's assumption regarding capital-intensive resources does not hold for SRT codes 77X05, 77X07, and 77X09, as it fails to account for how and in what setting these services are typically furnished. Primarily, CMS's assumption that office-based SRT services described by codes 77X05, 77X07, and 77X09 involve capital-intensive resources more like facility costs is flawed. SRT services are overwhelmingly performed by dermatologists in office-based settings using low-energy (≤150 kV) x-rays delivered through compact, mobile units that can be moved between treatment rooms. The shielding requirements and equipment required to furnish SRT differ significantly from other modalities of radiation therapy and treatment delivery, such as linear accelerators or radiation treatment vaults. Capital-intensive resources attributable to other radiation services, as cited in the rule to support CMS's proposed PE methodology for radiation therapy, are clearly not applicable to office-based SRT.

Given that the SRT service is almost exclusively performed in the office setting, there is no OPPS crosswalk data to apply to PE for 77X05, 77X07, and 77X09. RUC has provided current and valid PE inputs for these codes. Although CMS opines that these inputs will overestimate PE costs, the RUC-based inputs more accurately measure the typical cost for providing care in the office setting than do nonexistent OPPS data.

CMS is also proposing to bundle the PE associated with ultrasound image guidance into the treatment code 77X07 under the OPPS crosswalk. The AADA has several concerns with this bundling. Under the new CPT coding structure, 77X09 (ultrasound guidance) is only billable once per course of treatment. Given that 77X07, which would include the bundled PE for ultrasound guidance, is typically billed 10 to 20 times per treatment course, bundled payment of 77X09 PE in the 77X07 code would be reimbursed 10 to 20 times per course, while the CPT code only allows for once per course billing. Not all SRT machines are equipped with ultrasound capabilities, and even when radiation devices include an integrated ultrasound wand, ultrasound is not necessarily performed with each fraction of radiation delivery. Nonetheless, CMS has proposed PE RVUs for the new CPT code 77X07 that incorporate the cost of ultrasound, resulting in payment regardless of whether ultrasound is furnished.

Further, image guidance in the context of SRT was not deemed medically necessary in the recently proposed Local Coverage Determination for superficial radiation therapy for the treatment of nonmelanoma skin cancers, developed by five Medicare Administrative Contractors (MACs) based on their review of the current literature. While we acknowledge that image-guided SRT (IGSRT) is an emerging area in the treatment of nonmelanoma skin cancers, we note that the overall body of current evidence does not allow definitive determination of the value of image guidance for planning, ongoing evaluation, or final determination of treatment status during a course of SRT. The AADA anticipates reviewing the scientific literature as it continues to develop; however, bundling ultrasound image guidance into SRT treatment delivery at this time would result in payment for a service that five of the MACs have proposed to exclude from coverage. We are concerned this could lead to inconsistencies between coverage and payment policy in the Medicare program and increase the potential for billing confusion among physicians.

The AADA strongly urges CMS to continue utilizing direct PE inputs and the existing RUC process to establish PE RVUs for SRT codes 77X05, 77X07, and 77X09 and to accept the RUC-recommended direct PE inputs for these codes rather than relying on OPPS-derived relative weights that may misrepresent office-based costs and distort relativity across the fee schedule.

F. Excimer Laser Treatment for Psoriasis (CPT codes 96920, 96921, and 96922) and Non-Condition-Specific HCPCS G-code

The AADA strongly supports patient access to medically necessary laser treatment for inflammatory and autoimmune skin diseases beyond psoriasis and continues to emphasize that the CPT and RUC processes are the most appropriate and transparent mechanisms for defining and valuing physician services.

At the May 2025 CPT Editorial Panel meeting, revisions were approved to CPT codes 96920–96922 to expand their use beyond psoriasis to include inflammatory or autoimmune skin diseases. These revised descriptors will take effect January 1, 2027. Until that time, alternative methods are available for physicians to bill for laser treatment of inflammatory skin diseases beyond psoriasis, ensuring patient access.

We reiterate our longstanding concerns about the broader use of G-codes developed outside the established CPT and RUC frameworks. Such codes can lead to duplication, billing confusion, and valuation inconsistencies, particularly when G-codes may overlap with existing CPT codes in terms of services, physician work, and/or PE inputs. Furthermore, G-codes may not be recognized by commercial payers, placing an additional administrative burden on physicians and billing staff, and potentially impacting access to care.

The CPT process involves thorough vetting of medical services based on literature support, expert panel input, and assessments of medical necessity across specialties. Bypassing this process may result in inefficiencies and inappropriate valuation, despite CMS's goals of promoting cost savings and value-based care.

If CMS proceeds with the establishment of a non-condition-specific G-code, the AADA strongly urges the agency to clearly designate the code as transitional in nature. The code should sunset upon implementation of the revised CPT descriptors on January 1, 2027, to avoid confusion regarding appropriate reporting or potential displacement of the CPT codes. Long-term policy should continue to rely on the CPT and RUC processes to ensure consistency, transparency, and appropriate valuation of physician services.

G. Complexity Add-on Code (G2211)
Correcting Flawed Utilization Assumption
The AADA urges CMS to revisit its utilization assumptions for HCPCS code G2211, the E/M complexity add-on code. When CMS finalized the 2024 Medicare PFS, it assumed G2211 would be billed with 38 percent of all office/outpatient visits, but actual claims data for the first three quarters of 2024 show it was used in only about 11 percent of visits. This massive overestimate led CMS to impose a budget neutrality adjustment three times larger than warranted, cutting the 2024 conversion factor by 2.18 percent instead of the more appropriate 0.79 percent. That error removed an unnecessary $1 billion from the Medicare PFS, further destabilizing physician payments.[9] **The AADA strongly urges CMS to correct this mistake and prospectively adjust the final 2026 conversion factor based on actual utilization data.**

G2211 Code Expansion

[9] Robeznieks A. Overestimate tripled budget-neutrality Medicare physician pay cut. AMA News Wire. Published May 30, 2025. American Medical Association. Accessed September 5, 2025. https://www.ama-assn.org/practice-management/medicare-medicaid/overestimate-tripled-budget-neutrality-medicare-physician-pay

CMS proposes to expand G2211 to home and residence E/M visits, but the AADA is concerned that the policy still limits its use with modifier-25 to only wellness, vaccine, and preventive services. This narrow restriction overlooks the needs of dermatology patients with complex or chronic conditions who may require both a significant E/M service and a minor procedure at the same encounter. By excluding these scenarios, CMS underestimates the value of physician work and risks disrupting timely and comprehensive care. **The AADA strongly urges CMS to expand the allowance of G2211with modifier-25 to ensure fair and appropriate reimbursement for physicians longitudinally treating complex patients across all applicable settings and scenarios.**

H. Payment for Skin Substitutes

The AADA appreciates CMS's continued efforts to improve transparency, enhance payment consistency, and address inappropriate pricing practices associated with skin substitute products; however, the AADA does not support CMS's proposal to pay for skin substitute products under the RBRVS as incident-to supplies.

We are concerned that shifting payment for skin substitute products to the RBRVS could introduce substantial new costs into the physician payment system, triggering across-the-board reductions to reimbursement due to budget neutrality requirements. This could have far-reaching consequences for the stability of the physician payment system, potentially affecting access to a wide range of services furnished in office-based settings and jeopardizing the viability of practices that deliver them.

CMS indicates that, if finalized, PE RVUs for these products would be incorporated into the Medicare PFS relativity framework beginning in CY 2027. As a result, any increase in payment future rates would place further downward pressure on PE RVUs for services across the PFS.

The incorporation of over 200 existing Q-codes into the RBRVS could result in substantial additional supply costs over time, placing significant strain on the PE pool and increasing the risk of payment distortions across physician services. Even if the unit costs of these products decrease under the new pricing methodology, the overall magnitude of aggregate spending means that their inclusion in the RBRVS system could have long-term consequences for the payment adequacy of other, unrelated services.

We also raise concerns with CMS's proposal to apply geographic adjustments to payments for skin substitute products, which is required for any service paid under the PFS. We do not believe geographic adjustment is appropriate for products like skin substitutes, whose costs do not vary based on local market conditions. By treating skin substitute products as supplies under the PFS, as proposed, CMS would necessitate that geographic adjustments be applied consistent with statutory PFS requirements, which could reduce access to these products, particularly in rural and underserved areas.

An additional consideration regarding the treatment of skin substitutes as supplies under the PFS is whether CMS intends for the payment rate to be based on the PFS conversion factor that applies to QPs or to non-QPs. As CMS is aware, most practitioners do not qualify as QPs. Effectuating a payment for skin

substitutes based on the conversion factor that applies to QPs will result in the majority of physicians receiving payment for these products that is lower than the calculated cost – a deficiency that will be further exacerbated as the differential between the QP and non-QP conversion factors grows over time. And even if CMS assigns PE RVUs based on expected payment tied to the non-QP conversion factor, moving skin substitutes under the PFS will ensure that payments are not uniform across settings, given the differential conversion factor and higher payments for QPs.

For these reasons, **the AADA does not support CMS's proposal to pay for skin substitute products under the RBRVS as incident-to supplies. We encourage CMS to maintain a separate, product-level payment mechanism outside of the RBRVS that preserves transparency, mitigates unintended redistribution of RVUs, and protects the integrity of the broader PFS.**

We further urge CMS to conduct and publish additional modeling to assess the long-term impact of this proposal on the PE RVU pool and other physician services. Specifically, we ask that CMS outline any safeguards it is considering to mitigate potential distortions in relativity and ensure stability across the Medicare PFS.

We appreciate CMS's continued engagement on this issue and the agency's commitment to ensuring the pricing consistency of skin substitute products. However, we recommend that the agency:

- **Reconsider its proposal to incorporate these products into the RBRVS;**
- **Maintain a separate payment mechanism that preserves product-level pricing;**
- **Conduct modeling to assess the impact of this policy on the broader PE RVU pool; and**
- **Identify and implement safeguards to protect relativity and maintain stability across the PFS.**

I. Telemedicine

Proposal to Modify the Medicare Telehealth Services List and Review Process

The AADA supports CMS's proposed revisions to the Medicare Telehealth Services review process, as they appropriately simplify the current framework and better reflect clinical realities. By condensing the process into three steps and focusing on whether a service can be furnished using interactive audio-video technology, CMS eliminates unnecessary distinctions between 'permanent' and 'provisional' services and provides greater stability for physicians and patients alike.

The AADA also appreciates CMS's recognition that professional judgment is central to determining whether telehealth or in-person care is most appropriate. These policy modifications to the Medicare Telehealth Service List and Review Process prioritize patient safety, defer to provider expertise, and reduce administrative burden.

Direct supervision

The AADA supports the proposal to permanently adopt the definition of direct supervision via real-time two-way audio/video communication for all incident-to services, except for 10- and 90-

day global procedures. This proposal ensures ongoing access to care and scheduling flexibility, particularly in underserved or rural areas. In addition, the AADA believes that the supervising physician or a designated alternate physician must be available, either in person or through real-time audio and video technology, at all times when the non-physician clinician is caring for patients. The AADA also emphasizes the importance of written protocols to guide non-physician clinician care.

Teaching physician supervision
The AADA opposes CMS's proposal to end the flexibility that allows teaching physicians to meet presence requirements through real-time audio-video technology when residents provide virtual services in non-rural areas. This policy has proven valuable by making scheduling more flexible and allowing residents to receive timely supervision when an in-person teaching physician is unavailable. The AADA strongly urges CMS to extend the teaching physician supervision policy beyond 2025 to ensure patient access regardless of geographic location.

Distant site address
The AADA was surprised that the proposed rule does not address the current flexibility that allows physicians to list their enrolled practice address, rather than their home address, on Medicare enrollment and billing forms when providing telehealth services from home. This flexibility, introduced during the COVID-19 PHE and extended in the CY 2025 final rule, is scheduled to expire December 31, 2025.

Requiring physicians to list their home addresses raises serious safety and privacy concerns, exposing them and their families to potential risks while offering no benefit to patients or the Medicare program. **The AADA urges CMS to permit physicians to provide telehealth services from their homes indefinitely without requiring disclosure of their home address on Medicare enrollment forms.**

J. Drugs and Biological Products Paid Under Medicare Part B
The AADA supports CMS's efforts to improve transparency in the calculation of manufacturers' Average Sales Price (ASP) but urges the agency to implement safeguards to prevent unintended consequences that could limit patient access to dermatologic therapies.

Improved transparency in the ASP methodology has the potential to enhance the accuracy of reimbursement and ensure that ASP more closely reflects actual acquisition costs in the real world. Clarifying how price concessions and related inducements are treated in the ASP calculation is an important step toward a more consistent and reliable system, and we encourage CMS to continue this work.

At the same time, ASP-based reimbursement must remain aligned with the actual costs physicians face in acquiring and administering Part B drugs and biologics. If reimbursement falls below acquisition costs, smaller or independent practices may be unable to continue offering in-office treatment, forcing patients to seek higher-cost sites of care and delaying needed therapy. This is especially concerning for patients with inflammatory dermatologic conditions such as psoriasis, hidradenitis suppurativa, atopic dermatitis, and alopecia areata because disease control often depends on uninterrupted access to biologic

therapies. Interruptions in treatment can cause painful flares, worsen symptoms, reduce quality of life, and increase health care costs.

The AADA urges CMS to implement ASP changes with caution. CMS should monitor ASP trends by specialty, maintain open communication with affected specialties, including dermatology, and publish recalculated ASPs and corresponding payment changes for Part B drugs prior to implementation. Additionally, CMS should publish all discounts and rebates it counts when setting drug prices. Without this clarity, the transparency policy could backfire by distorting official prices, leading to insufficient reimbursement for these drugs and ultimately making it harder for patients to access essential dermatology treatments.

K. Ambulatory Specialty Model

The AADA strongly opposes CMS's proposal to make participation in the Ambulatory Specialty Model (ASM) mandatory. While this proposal does not directly impact the AADA, we maintain that mandatory models impose unnecessary administrative and financial burdens on clinicians, particularly small and solo practices, and undermine physician autonomy. CMS's rationale that mandatory participation is needed to eliminate selection bias and ensure sufficient volume for evaluation is not sufficient to require broad participation in an untested model. Forcing physicians into this ASM creates high risks for clinicians. Rather than imposing mandatory models, CMS should focus on creating more opportunities for specialists to participate in voluntary APMs that are designed to support patient care, improve outcomes, and reduce costs, particularly models that qualify as Advanced APMs.

We also oppose CMS's proposals to extract savings from physicians through the ASM by not distributing the full amount of the payments withheld as incentives. Under the model, CMS is proposing to reduce the amount of funds available for incentive payments by 15 percent, which would remain in the Medicare Trust Funds. As noted earlier, physicians already suffer from insufficient payment, with payment decreases in the immediate past five years, plus decades of updates that have failed to keep pace with inflation. Extracting savings through the ASM or future physician-focused payment models would further destabilize physician payment. Additionally, this approach amounts to nothing more than a payment cut without any connection to care transformation. Instead, CMS should prioritize developing models that create meaningful opportunities for clinicians to engage in care transformation activities, generating Medicare savings through innovative practice redesign and measurable improvements in patient quality of care.

The AADA is also deeply concerned that the ASM is built on CMS's flawed Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) framework. Requiring physicians to report on a fixed set of measures without flexibility exacerbates the shortcomings of MVPs and traditional MIPS. This approach risks penalizing physicians for factors beyond their control and fails to account for differences in specialty and patient populations. Physicians must retain the ability to choose models and measures that best align with their clinical practice to support fair evaluation and meaningful quality improvement.

Lastly, the proposed performance adjustment methodology begins at plus or minus 9 percent in 2029 and escalates to plus or minus 12 percent by the end of the model. This creates significant financial risk for a model that has not been tested. These penalties would be particularly destabilizing for practices with limited resources and could accelerate practice consolidation, further limiting patient access to specialty care.

For these reasons, **the AADA urges CMS to withdraw its proposal to mandate participation in the ASM and instead test the model on a voluntary basis with appropriate safeguards, flexibility, and support for physician practices. We also urge CMS to remove the 15 percent redistribution withholding to ensure that the full amount of available incentive payments is distributed to high-performing clinicians.**

II. Quality Payment Program

A. Sunsetting the Traditional Merit-based Incentive Payment System

The AADA strongly opposes sunsetting traditional MIPS and replacing it with MVPs. The AADA believes that clinicians must have access to the full inventory of MIPS measures and activities so that they can select those most relevant to their practice and patient populations. While we appreciate CMS's effort to streamline reporting by assembling more focused sets of measures, and we support the goal of burden reduction, we also believe these goals can be achieved without imposing an entirely new and mandatory framework on physicians. Since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS has consistently introduced new changes to MIPS, requiring physicians to invest limited time and resources into continually adapting to evolving requirements. The constant changes have led to confusion and growing frustration among physicians, who face significant administrative burdens without adequate incentive payments to compensate for the time and resources required to meet these new demands.

While we acknowledge CMS's effort to address some of these challenges by introducing MVPs, which aim to offer more targeted measures and a comprehensive assessment of care quality and value, the MVP framework is falling short of achieving its intended goals. MVPs, as currently structured, are overly broad and fail to address ongoing gaps in measures for subspecialists. Until the MIPS measure inventory can fully account for the diversity in specialties and practice settings, physicians should not be forced to report from a limited set of measures.

The AADA has significant concerns about MIPS and the increased burdens on physicians. Numerous studies have highlighted persistent challenges associated with MIPS, including practices serving high-risk patients and those that are small or in rural areas. For instance, in a study titled "Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk," researchers examined whether MIPS disproportionately penalized surgeons who care for patients at high social risk. This study found a connection between caring for high social risk patients,

lower MIPS scores, and a higher likelihood of facing negative payment adjustments.[10] Additionally, the Government Accountability Office (GAO) was tasked with reviewing several aspects concerning small and rural practices in relation to Medicare payment incentive programs, including MIPS. The GAO's findings indicated that physician practices with 15 or fewer providers, whether located in rural or non-rural areas, had a higher likelihood of receiving negative payment adjustments in Medicare incentive programs compared to larger practices.[11] At a time when rural medicine is at a crisis of sustainability, the added burden of MIPS and structural issues of negative adjustments puts access to care in many states on the brink.

However, as long as CMS is required by statute to maintain MIPS, the AADA strongly urges CMS to maintain traditional MIPS as a viable reporting option, allowing clinicians to choose the participation pathway that best aligns with their practice and patient population. By maintaining flexibility in the program, CMS can better support clinicians in providing high-quality care while minimizing administrative burdens.

B. Dermatological Care MVP

As noted in the previous section, the AADA is deeply concerned with CMS's approach to developing MVPs, as it is using excessively broad measure sets that lack alignment and are incapable of offering meaningful feedback to enhance patient care. Furthermore, the decoupling of cost (melanoma) and quality (inflammatory disease) in the current Dermatological Care MVP undermines value-based care principles, which require that quality and cost for the same condition be measured together. The AADA believes the most effective way to improve the current MVP approach is to develop MVPs tailored to specific health conditions, episodes of care, and major procedures. The AADA has communicated this recommendation to CMS on multiple occasions.

The specialty of dermatology is diverse, and dermatologists' practices vary greatly. **It is, therefore, critical that CMS compare clinicians performing the same procedures and conditions if it wishes to accurately assess quality and overall value rather than assuming that all members of a specialty are the same**. According to the CMS MVP Feedback webpage, if a clinician reports an MVP, CMS will provide comparative feedback highlighting how the clinician's performance compares at the category level to other clinicians reporting the same MVP. As we have shared, there are ten subspecialties in dermatology, each providing significantly different care for diverse patient populations (e.g., pediatric dermatology compared to dermatopathology), with notable differences in workflow and costs, making comparison extremely challenging and inappropriate. For example, dermatologists who treat psoriasis would select a different set of quality measures than those who treat melanoma, making a quality category-level comparison of these clinicians meaningless and inappropriate, even if it is provided solely for the purpose of confidential feedback. On the cost side, those treating melanoma might be scored on

[10] Byrd JN, Chung KC. Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk. JAMA Surg. 2021;156(11):1018-1024. doi:10.1001/jamasurg.2021.3746.
[11] Medicare Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-Based Incentive Payment System Report to Congressional Requesters United States Government Accountability Office.; 2018. Accessed August 13, 2023. https://www.gao.gov/assets/gao-18-428.pdf.

the Melanoma Resection cost measure, while those treating psoriasis might not have a cost score. Again, it would be inappropriate to compare the cost category scores of these clinicians. Such comparisons will not only lead to confusion among physicians and patients analyzing performance data, but also to misleading comparisons that do not accurately reflect the true "value" or the nuances of each subspecialty's practice.

Overall, AADA has concerns about CMS adopting MVPs that lump together specialty-specific measures without distinguishing between different lines of care. As noted below, we appreciate the newly proposed clinical groupings, which will help subspecialists navigate the measure set and help CMS identify ongoing gaps in measures. However, this new organizational method does not address some of our most serious concerns regarding MVPs. For example, the Dermatological Care MVP combines a cost measure for an oncologic disease with quality measures related to inflammatory disease, thereby uncoupling the critical nexus of cost and quality to determine value in patient care. The AADA has recommended narrowing the scope of this MVP to focus on skin cancer; however, CMS has maintained that it does not want a proliferation of MVPs and is concerned that a skin cancer MVP will be too narrow in scope.

If CMS is not willing to create more specific MVPs, then it is imperative that it at least adopt policies to ensure that MVP participants are only eligible for scoring on cost measures that are included within a specific clinical grouping and related to the participant's specific focus of care. For example, under the proposed Dermatological Care MVP, which is organized into clinical groupings, only clinicians reporting on skin cancer quality measures, such as Q397: Melanoma Reporting, should be eligible for scoring on the Melanoma Resection cost measure. At the same time, clinicians reporting Inflammatory Condition quality measures, such as Q486: Dermatitis- Improvement in Patient-Reported Itch Severity, should be protected from accountability on the Melanoma Resection cost measure since the clinical grouping identifies that quality measure as having no associated cost measure. **Separately, we strongly urge CMS not to conduct MVP-level or category-level comparisons among participants reporting the same MVP, even if only offered as confidential feedback**. MVP participants should only be compared against clinicians reporting and being scored on the same measures.

Clinical Groupings

The AADA supports the proposed clinical groupings, which appear appropriate for most dermatology services. However, we remain concerned that the attribution of nearly all cost linkage to melanoma resection is overly broad and risks misrepresenting the cost profile of dermatology practices. As alluded to in our comments in the previous section, CMS clearly illustrates through its clinical grouping proposal that MIPS dermatological quality measures focused on inflammatory diseases continue to lack an associated cost measure. **If a quality measure (or even an entire clinical grouping) within an MVP is designated as having no relevant cost measure, then a clinician reporting that measure should not be scored on a cost measure until one is available. That being said, we support the development of an appropriate inflammatory cost measure, as well as the creation of multiple MVPs to better reflect dermatology subspecialties and the diverse care they provide.**

In addition, CMS proposes adding MIPS Quality Measure Q503, Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM), within the "experience" domain. We recommend moving this measure instead to the "advancing health and wellness" domain, as it specifically evaluates a patient's knowledge, skills, and confidence in managing their health and healthcare.

Quality Measures in the MVP
The AADA appreciates CMS's efforts to include additional measures in the proposed Dermatological Care MVP to ensure subspecialties like dermatopathologists can participate. However, some subspecialties in dermatology still lack a sufficient number of measures to participate successfully in the program, which the MVP framework does nothing to address. For example, in the current Dermatological Care MVP, there are only two quality measures that someone who exclusively practices dermatopathology can report: Q440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician and Q397: Melanoma Reporting. Similarly, the newly proposed Pathology MVP only includes three measures relevant to dermapathology, only two of which—Q440 and Q397—are non- Qualified Clinical Data Registry (QCDR) measures, leaving these subspecialists with no viable pathway to participate through an MVP. **The AADA urges CMS to collaborate with specialty societies to ensure there are enough measures for all dermatologists to participate successfully and that those without sufficient measures are not unfairly penalized. Until that time, MVPs should not be mandatory but offered as an option.**

To minimize confusion and maximize reporting options, the AADA maintains that, at a minimum, all measures from the dermatology specialty set should be included in the MVP for Dermatological Care to provide participants with a full choice of potentially relevant measures. This includes Q374: Closing the Referral Loop: Receipt of Specialist Report and Q317: Screening for High Blood Pressure and Follow-Up Documented. CMS has already identified these measures as the most relevant to the specialty within the MIPS inventory, and their exclusion appears both confusing and arbitrary, raising concerns about the consistency of the measure selection process.

The AADA supports CMS's proposal to add two MIPS quality measures to the Dermatological Care MVP:

- **Q047: Advance Care Plan.** This quality measure provides a meaningful assessment for patients undergoing dermatological care.
- **Q238: Use of High-Risk Medications in Older Adults.** This measure supports patient safety by assessing the use of high-risk medications.

The AADA does not support CMS's proposal to remove the following from the Dermatological Care MVP:

- **Q130: Documentation of Current Medications in the Medical Record.** This measure is clinically relevant and critical to safe prescribing practices.
- **AAD17: Continuation of Anticoagulation Therapy in the Office-Based Setting for Closure and Reconstruction After Skin Cancer Resection Procedures.** This measure addresses patient safety for dermatologists performing surgical procedures.

- **AAD18: Avoidance of Opioid Prescriptions for Closure and Reconstruction After Skin Cancer Resection.** This measure is essential to ensuring safe postoperative prescribing practices.

While we acknowledge CMS's proposal to remove Q487 (*Screening for Social Drivers of Health*), we emphasize that eliminating Q130, AAD17, or AAD18 would reduce dermatologists' ability to report on measures that are frequently used, highly relevant to their scope of practice, and not duplicated by Q238. These measures should be retained to ensure dermatologists can continue to report meaningful quality data that reflects safe and effective care.

MVP Subgroup Reporting
The AADA opposes CMS's subgroup reporting requirement, which mandates that starting in the 2026 performance year, MIPS-eligible clinicians in multispecialty groups reporting MVPs will be limited to individual, subgroup, or APM Entity-level reporting. This change would eliminate the option for group reporting, potentially placing unnecessary administrative burdens on practices. **The AADA maintains that physicians and practices should have the flexibility to choose the reporting strategy that best aligns with their practice structure rather than being constrained by CMS policy.**

Mandatory subgroup reporting marks yet another change to the MIPS program, forcing physicians and their staff to dedicate additional resources to compliance and other administrative tasks, as well as adjustments in workflows. Consequently, some practices may deem these new reporting requirements excessively burdensome and opt out of the Medicare program, thereby limiting patients' access to care.

The AADA recognizes that CMS has already finalized mandatory subgroup reporting for multispecialty group practice MVP participants, beginning in 2026, as outlined in previous rulemaking. **The AADA maintains that CMS should not move forward with this requirement.**

If CMS does move forward with this policy, at a minimum, it should finalize its proposal to allow group practices to attest to meeting CMS's definition of a single specialty group or a multispecialty small practice when registering for an MVP, beginning with the CY 2026 performance period. It is critical that CMS allow practices to declare the composition and focus of their group rather than CMS using what is often flawed, incomplete claims data to automatically designate a group as either a single or a multispecialty group. As part of this proposal, CMS also proposes important updates to the definitions of single and multi-specialty groups to account not only for the specialty types in the group, but the group's clinical focus, which would permit multi-specialty groups with a single clinical focus (e.g., dermatological care) to continue to report MVPs at the group level and not break into subgroups. **The AADA strongly supports these revised definitions, but requests that CMS make minor adjustments to the proposed language to ensure the two definitions will achieve their intended goal, including:**

- Multispecialty group means a group as defined at § 414.1305 that consists of clinicians in two or more specialty types NOT involved in a single focus of care or clinicians in two or more specialty types involved in multiple foci of care.

- Single specialty group means a group that consists of one specialty type or consists of clinicians in two or more specialties involved in a single focus of care.

C. Small Practice Accommodations

The AADA appreciates CMS's ongoing efforts to support small and solo practices within the MIPS program, including 6 bonus points in the quality category, the option to report quality measures via Part B claims, and automatic reweighting of the Promoting Interoperability category. We also strongly support the proposed changes to simplify MVP participation for small multi-specialty groups by allowing them to report as a single entity without forming subgroups.

However, challenges remain for small dermatology practices. The complexity and costs of implementing and maintaining certified EHR systems, combined with limited staff and administrative resources, continue to pose significant barriers to meaningful participation in MIPS. The AADA encourages CMS to further simplify data submission requirements, expand free technical assistance and training, and develop dermatology-relevant cost measures that reflect our specialty's unique care delivery.

Moreover, performance thresholds and scoring methodologies should be calibrated to avoid disproportionately penalizing small practices that may have less patient volume or fewer opportunities to achieve high scores. **The AADA urges CMS to continue providing flexibility for small and solo dermatology practices to ensure the program evolves in a way that supports their sustainability and ability to deliver high-quality care.**

D. MIPS Performance Threshold

The AADA thanks CMS for proposing to maintain the performance threshold at 75 points for the 2026-2028 performance year. Research has shown that MIPS creates an excessive administrative burden, particularly affecting small, rural, and independent practices. These practices often lack the resources to meet the program's complex requirements, which puts them at a disadvantage. Maintaining the performance threshold at 75 points would limit any new demands placed on these practices, thereby increasing their ability to avoid a negative payment adjustment for the 2027 payment year.

While the AADA supports maintaining the performance threshold at 75 points through the 2028 performance period, we urge CMS to work with Congress to go further and freeze the performance threshold at 60 points for at least three years, introducing much-needed stability into the program.

E. MIPS Scoring Methodology

Regarding the proposed modification to the scoring methodology for administrative claims-based quality measures, we support CMS's efforts to make scoring more equitable and reflective of actual clinician performance and appreciate CMS proposing to begin applying these modifications with the CY 2025 performance year. By awarding clinicians performing near the median with achievement points closer to the performance threshold, this approach can help reduce scoring disparities—especially benefiting smaller practices that may otherwise be disproportionately impacted

under the current decile-based system. This change promotes a fairer evaluation and supports smaller practices in maintaining competitive scores within MIPS. We encourage CMS to continue refining these methodologies to ensure balanced assessments across practice sizes and specialties.

F. Quality Performance Category

The AADA supports the additional QCDR measures from DataDerm that will be added to the self-nomination for 2026 MIPS, including:

- AAD 6: Skin Cancer: Biopsy Reporting Time – Clinician to Patient
- AAD 8: Chronic Skin Conditions: Patient Reporting Quality-of-Life
- AAD 12: Melanoma: Appropriate Surgical Margins
- AAD 15: Psoriasis – Appropriate Assessment & Treatment of Severe Psoriasis
- AAD 16: Avoidance of Post-operative Systemic Antibiotics for Office-Based Reconstruction After Skin Cancer Resection Procedures
- AAD 17: Continuation of Anticoagulation Therapy in the Office-based Setting for Closures and Reconstruction After Skin Cancer Resection Procedures
- AAD 18: Avoidance of Opioid Prescriptions for Closures and Reconstruction After Skin Cancer Resection
- AAD 20: Actinic Keratosis: Self-reported AK Treatment or Management Outcomes
- New AK Measure - TBD
- New AK Measure - TBD

Data Completeness Threshold

The AADA supports CMS's decision last year to maintain the data completeness threshold at 75 percent through the 2027 and 2028 performance periods for all available collection types, but urges CMS to reconsider the policy and reduce the data completeness criteria to 60 percent. Reducing the threshold to 60 percent helps strike a balance between ensuring robust data collection and avoiding excessive administrative burdens, particularly for small practices without certified EHR systems, as further increases would disproportionately affect those relying on manual reporting.

Incentivize Reporting of Measures Without Benchmarks

The AADA urges CMS to implement a policy that incentivizes the reporting of measures without benchmarks. Currently, CMS applies a scoring floor of 7 and 5 points for the first two years that a new measure is in the program, starting with the 2022 performance year. However, measures that were already in the program before 2022 and still lack a benchmark do not receive the same scoring benefits. The measure AAD8, for example, would benefit from such a policy. Adopting such a policy would remove a major ongoing barrier to the use of more specialty-specific measures.

Policy for Topped-Out Measures

The AADA urges CMS to apply its proposed policy to remove topped-out scoring caps to all topped-out measures subject to the scoring cap, rather than only a select list of measures relevant to specialties that CMS has determined have limited choice of measures and/or face challenges participating successfully in the program.

If CMS insists on limiting this policy to select measures, it should conduct a more granular analysis, rather than relying solely on specialty sets. As noted earlier, some dermatologists specialize in melanoma care, while others may focus on psoriasis or dermatitis, making broad assumptions about measure relevance and availability inappropriate. CMS's current proposal mistakenly assumes that all measures within a specialty set apply equally to all clinicians within that specialty.

These more granular analyses should also apply to MVPs. CMS should conduct analyses of MVPs to assess whether all potential types of clinicians reporting through the MVP, including both specialists and subspecialists, can reasonably succeed in the program based on the available set of measures.

G. Promoting Interoperability Performance Category

Modify the Security Risk Analysis Measure

The AADA opposes the modification to the Security Risk Analysis measure. While the AADA supports efforts to align quality reporting with HIPAA requirements, we have concerns about the added administrative burden the proposed changes to the Security Risk Analysis measure may place on clinicians. Requiring a second, separate attestation for security risk management could increase complexity without significantly enhancing data protection. **The AADA requests CMS to consider whether existing HIPAA compliance activities sufficiently address security risk management objectives before requiring additional attestations that may not improve patient data protection.**

Modify the High Priority Practices Safety Assurance Factors for EHR Resilience Guide Measure

The AADA supports CMS's proposal to require the use of the 2025 Safety Assurance Factors for EHR Resilience (SAFER) Guides, as it ensures clinicians apply the latest health IT safety standards. Updating the measure reflects advancements in EHRs and promotes ongoing improvements in patient safety.

Adopt Public Health Reporting Using Trusted Exchange Framework and Common Agreement Measure

The AADA supports CMS's proposal to adopt the Public Health Reporting Using Trusted Exchange Framework and Common Agreement (TEFCA) measure as an optional bonus under the Public Health and Clinical Data Exchange objective. This measure offers MIPS-eligible clinicians an additional opportunity to earn bonus points toward their Promoting Interoperability score while encouraging participation in a standardized, secure, and interoperable data exchange framework.

Adopt measure suppression policy

The AADA supports CMS's proposal to suppress the Electronic Case Reporting measure for the CY 2025 performance period because it ensures clinicians aren't penalized for circumstances outside their control (the CDC onboarding pause). The proposal appropriately maintains fairness while still encouraging clinicians to report by attesting "Yes" or "No" or claiming an applicable exclusion.

H. Cost Performance Category

Scoring

The AADA strongly supports CMS's proposal for a two-year informational-only feedback period for new MIPS cost measures. There have been significant challenges with cost measure attribution and methodologies, which have raised concerns about fairness and accuracy across specialties. Providing confidential feedback without scoring consequences will allow dermatologists time to become familiar with the measures, understand their attribution and methodology, and prepare their practices before the measures affect MIPS scores or payment adjustments.

This approach promotes transparency and clinician readiness while avoiding unintended financial penalties during the early years of implementation. We agree that delaying the incorporation of new cost measures into the cost performance category until their third year in MIPS strikes an appropriate balance between advancing cost measurement and ensuring fairness for clinicians adapting to new requirements.

Melanoma Resection Cost Measure

Although CMS does not propose changes to the Melanoma Resection Cost Measure, the AADA would like to express ongoing concerns about the risk adjustment and subgrouping methodologies applied to the measure, which was adopted for MIPS beginning in the 2022 performance year. Based on performance results from 2022 and onward, the AADA believes that the measure fails to adequately account for unique subspecialty services that justifiably cost more. As a result, dermatologists who perform more complex skin cancer treatment procedures and reconstructions, such as staged excisions and flaps and grafts, are receiving significantly lower scores than their peers despite providing clinically appropriate care.

Complex reconstructions after skin cancer removal are typically necessary not only for larger melanomas but also for smaller ones in sensitive or functionally critical areas, such as near the eyes or nose, where more intricate repairs are required to preserve both function and appearance. Moreover, staged melanoma excision to ensure complex removal pathologically is critical for high cure rates in head and neck melanomas that are often clinically ill-defined. AADA members who participated in the cost measure development workgroup were under the impression that these factors would be accounted for by subgrouping and risk adjustment, but the final scores suggest otherwise. This discrepancy has left our members confused and frustrated, as it creates a perverse incentive to avoid certain patients in order to perform well on this measure. Flawed measures should never dictate clinically appropriate decision-making.

To address these issues, the AADA recommends that CMS reconvene the Melanoma Resection workgroup as soon as possible to re-evaluate this cost measure. In late 2024, we were told by CMS that there would be an opportunity to potentially re-evaluate this measure in the spring of 2025. When no opportunities were announced, we followed up with Acumen in June of 2025, and were told that "CMS and the measure developer are reviewing the Wave 3 measures, and we will follow up as we have more information to share." As of September 2025, we have not heard anything about the re-evaluation of this

measure. Given our ongoing serious concerns about this measure's existing methodology, we ask that CMS expedite this process and our request.

Total Per Capita Cost Measure Reevaluation

The AADA is pleased to see that CMS is refining the Total Per Capita Cost Measure (TPCC) measure in response to concerns raised about inappropriate attributions, which extend to dermatologists despite their exclusion from this measure. We received examples of 2022 MIPS feedback reports where dermatologists were attributed the TPCC measure despite being excluded. Our understanding is that this misattribution may occur when Advanced Care Practitioners (such as nurse practitioners [NPs], physician assistants [PAs], and certified clinical nurse specialists [CNS]) in a practice bill Medicare directly under the dermatologist's TIN.

In general, the AADA does not support using the TPCC measure in MIPS since it holds clinicians accountable for costs beyond their direct control. While we support CMS's goal of incentivizing better care coordination between providers, a measure targeting total cost of care is more appropriate for a hospital or accountable care organization (ACO), not an individual clinician or group practice. **Ideally, we would like to see CMS remove this measure from the program.**

At the same time, we appreciate CMS's effort to revise the measure specifications, but have concerns that the revisions are not sufficient. For example, the second proposed criteria would only exclude Advanced Care Practitioners from attribution in situations where 100 percent of physicians in a group are excluded based on the specialty exclusion criteria, which is an unreasonably high bar. We urge CMS to consider alternative approaches to ensure that excluded specialists are not scored on this measure, such as the use of self-reported patient-relationship codes or other similar attestations. In addition, we strongly urge CMS to apply any finalized improvements beginning with the 2025 performance period, rather than delaying changes until 2026.

I. Core Elements Request for Information (RFI)

The AADA strongly opposes requiring all physicians to report on the same "Core Elements" across MVPs. A uniform set of measures undermines the purpose of specialty specific reporting, lacks clinical logic, and imposes irrelevant requirements on physicians delivering highly varied services that cannot be meaningfully compared through a single set of measures.

For dermatologists, mandatory reporting on measures that are not clinically relevant or broadly applicable would distort performance results and increase administrative burden without improving patient care. Physician practices are highly diverse, and rigid Core Elements cannot capture the scope of services provided or reflect meaningful outcomes for patients.

The AADA therefore urges CMS not to move forward with a formal Core Elements proposal. Instead, the focus should be on developing more episodic MVPs with clinically relevant measures, which would allow for more appropriate comparisons of cost and quality of care. If CMS disregards this

feedback and pursues Core Elements, the AADA recommends ensuring that they are clinically relevant, low burden, broadly applicable, and available across multiple collection types, with an attestation option if no Core Element is appropriate for a given practice.

J. *Procedural Codes for MVP Assignment RFI*

The AADA does not support assigning clinicians to MVPs through the use of procedural billing codes. Reliance on procedure codes alone risks significant misclassification across overlapping specialties and would undermine the intent of MVPs to promote accurate, specialty-specific reporting.

Rather than mandating assignment through procedure codes, CMS should focus on designing MVPs that are clinically meaningful, supported by valid measures, and reinforced through targeted education and direct collaboration with specialty societies. These efforts would do more to encourage voluntary specialty reporting than automatic assignment.

K. *Toward Digital Quality Measurement in CMS Quality Programs RFI*

The AADA supports CMS's efforts to improve interoperability and standardization in quality reporting through the use of Fast Healthcare Interoperability Resources (FHIR)-based electronic clinical quality measures (eCQMs). Consistent data exchange is critical to reducing burden and enabling more meaningful quality measurement across specialties.

However, any transition to FHIR-based eCQMs must first ensure that all Certified EHR Technology (CEHRT) systems are fully FHIR-ready and capable of complying with these standards. Without this foundational work, physicians and registries will face increased costs and administrative challenges without realizing the benefits of improved interoperability. We urge CMS to work in close coordination with the Office of the National Coordinator for Health IT (ONC) to set the standards, validate readiness, and provide clear timelines before imposing new requirements.

Qualified Clinical Data Registries (QCDRs) play an essential role in supporting specialty reporting, and their ability to adopt FHIR standards depends on seamless integration with Certified EHR Technology. CMS should therefore work directly with the Assistant Secretary for Technology Policy (ASTP), EHR vendors, and registries to ensure that FHIR-based measures are technically feasible, clinically relevant, and minimally burdensome for physicians. Only after CEHRT systems are fully FHIR-enabled and validated should CMS move forward with requiring QCDRs to incorporate FHIR-based specifications.

L. *FHIR-based API Standards*

The AADA recognizes that CMS may be moving toward adopting FHIR to improve healthcare data sharing and quality measurement. While this may represent a positive step forward, from the perspective of dermatology practices, particularly smaller or independent ones, there may be significant challenges that need to be carefully considered.

Many dermatologists may rely heavily on their EHR vendors for reporting and might not have the in-house technical expertise or resources to manage these systems independently. FHIR integration may

not be automatic; it could require development and implementation by the EHR vendors. As a result, if vendors are not fully prepared, practices may face difficulties and could potentially be held accountable for factors beyond their control.

It may also be the case that many dermatology providers and staff are unfamiliar with FHIR, its role, or how to assess their vendor's readiness. For this reason, CMS might consider offering straightforward, practical resources tailored to small practices—such as checklists, short videos, and simple explanations of expected changes and required actions—instead of more complex technical manuals.

A transition period of at least two years, during which practices may continue reporting through existing methods while FHIR is phased in, may be beneficial. However, this timeframe might not be sufficient for all, especially if vendor adoption is slow or unexpected costs arise. CMS may want to monitor vendor readiness closely and consider providing extensions or additional support as needed. Smaller practices may find it challenging to absorb costs associated with software upgrades, IT support, or training without external assistance. If FHIR eventually becomes mandatory, offering funding or other support mechanisms for small providers may be helpful.

If implementation largely occurs behind the scenes with minimal impact on daily workflows, training demands may be low. However, if new data entry requirements or workflow changes are introduced, clear and practical training may be necessary. Such training should ideally provide simple navigation instructions and outline expected changes, so both providers and staff can adapt smoothly.

CMS might also want to ensure that quality measures used in dermatology are meaningful, achievable, and reflective of the care provided. Capturing structured data within EHRs can be challenging, and many dermatology practices may not interact with multiple hospitals or systems, which limits the relevance of some advanced interoperability tools. Despite this, practices might still be expected to comply, which could raise concerns.

While dermatologists may not be directly responsible for technical implementation, they generally support CMS's efforts to improve and test these technologies. It may be important, however, that vendors remain primarily responsible for technical development and ensuring system compatibility—not the providers themselves— and that vendors do not inappropriately pass unreasonable costs on to providers.

Lastly, CMS should proceed cautiously when introducing additional initiatives, such as TEFCA. Many dermatology practices may be unfamiliar with these programs and might lack the infrastructure to manage additional reporting unless accompanied by strong vendor support and simplified tools. Efforts to reduce duplicative reporting and streamline requirements could potentially help mitigate administrative burdens and provider burnout.

Dermatologists are committed to delivering high-quality care and may recognize the importance of accurate quality measurement. To be successful, the transition to FHIR may need to be feasible for all

providers, not only large health systems with dedicated IT resources. **The AADA encourages CMS to maintain flexibility, provide clear guidance, and offer adequate support so small practices may navigate this change successfully.**

III. Conclusion

The AADA appreciates the opportunity to comment and looks forward to ongoing engagement and providing stakeholder input. If you have any questions regarding this letter, please contact Jillian Dunn, Associate Director, Health Policy & Payment, at jdunn@aad.org or 202-712-2603.

Sincerely,

Susan C. Taylor, MD, FAAD
President, American Academy of Dermatology Association