COLLEGE of AMERICAN PATHOLOGISTS

September 11, 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 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; (July 16, 2025)

Dear Administrator Oz:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making on the revisions to Medicare payment policies under the Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) for 2026, published in the July 16, 2025, Federal Register (Vol. 90, No. 134 FR, pages 32352-33261).

As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

Executive Summary

The CAP has concerns regarding several proposals that could adversely affect pathology and laboratory medicine. Key CAP recommendations include:

- **Proposed Efficiency Adjustment:** CMS has proposed a physician work efficiency adjustment to address concerns about the accuracy of American Medical Association (AMA) Relative Value Scale Update Committee (RUC) survey data and to account for efficiencies gained through practitioner experience, technological advances, and other operational improvements. The CAP opposes this proposal, maintaining that the adjustment is unnecessary and improperly undermines both the methodology and role of the AMA RUC. Moreover, by applying the adjustment to non-time-based services while exempting time-

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based Evaluation and Management (E/M) services, CMS risks introducing substantial distortions in PFS relativity. The CAP instead recommends that CMS collaborate with the AMA RUC to ensure that PFS services are valued using the most current and accurate data.

If CMS finalizes the efficiency adjustment, the CAP urges that CPT codes 80503, 80504, 80505, and 80506 be classified as time-based services and excluded from the adjustment. These pathology clinical consultation codes are billed on the basis of medical decision-making or total time and align with the time-based framework already applied to excluded E/M services such as CPT code 99213.

- **Site of Service Payment Differential:** CMS seeks to address what it views as a flaw in the practice expense (PE) methodology; the assumption that physicians generally maintain office practices even when furnishing services in facility settings. To do so, CMS proposes to reduce the portion of facility PE RVUs that are allocated based on work relative value units (RVUs) to half the amount allocated to non-facility PE RVUs.

  The CAP urges CMS not to finalize this proposal. The current indirect PE RVU methodology already accounts for site-of-service differences and the proposed changes risk disproportionately impacting certain specialties. Specifically, CMS's approach assigns higher indirect PE RVUs to services with greater work RVUs per minute of physician time, creating a misalignment in which services requiring equal physician time but varying intensity receive unequal indirect PE payments. While the intensity (RVUs per minute) of physician services is significant in many ways, the indirect PE is not one of them, and specialties such as pathology, which often provide services with relatively low work RVUs per minute, are already disadvantaged under the existing methodology.

- **Practice Expense Data Collection and Methodology:** The AMA completed its Physician Practice Information (PPI) survey in 2024, which included updates to practice expense per hour (PE/HR) data and cost share weights. CMS, however, has raised serious concerns about the reliability of the PPI data. The CAP shares these concerns, particularly regarding the small specialty-level sample sizes that create significant statistical uncertainty. For this reason, the CAP supports CMS's proposal to retain the current PE/HR data and not adopt the updated specialty-level values from the PPI survey at this time.

  That said, the CAP believes the PPI cost share weights more accurately capture the proportion of total PFS payments that should be attributed to physician work. The CAP agrees with CMS on the need for continued collaboration with the AMA and other stakeholders to determine whether and how the cost share weight data should be applied in future PFS rate setting. To ensure independent laboratories are represented in these discussions, the CAP urges CMS to include the CAP, which separately contracted with

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Mathematica to gather independent laboratory cost data through the Clinician Practice Information (CPI) Survey, as a stakeholder.

- **Potentially Misvalued Services:** The CAP supports CMS's assessment that Fine Needle Aspiration (CPT 10021, 10004, 10005, 10006) is not misvalued and that mechanical separation of plasma (CPT 36514) should not be nominated.

- **Autologous Cell-Based Therapies:** The CAP urges separate payment for harvesting and preparatory procedures for Chimeric Antigen Receptor T-cell (CAR-T) therapy (CPT 38225–38227) and recommends CMS not extend the current bundled policy to other autologous therapies until proper recognition of physician work is ensured.

- **Software as a Service (SaaS):** The CAP emphasizes the role of the AMA CPT Editorial Panel, Digital Medicine Payment Advisory Group (DMPAG), and Digital Medicine Coding Committee (DMCC) in guiding coding, coverage, and payment policy for digital medicine and AI services to ensure patient access.

- **Transforming the Quality Payment Program (QPP) MVPs:** The CAP supports several of CMS' proposals regarding MVPs, including the proposal to maintain the MVP group reporting option for groups with a small practice designation, the proposal to allow self-attestation process for groups to identify themselves as single or multispecialty during MVP registration, and the proposal granting QCDRs and qualified registries a one-year delay after finalization of the MVP to support the MVP.

- **Development of New MIPS Value Pathways (MVPs)**: The CAP strongly recommends several changes to the proposed Pathology MVP, notably the addition of CAP 41, Basal Cell Skin Cancer: Complete Reporting to the proposed Pathology MVP. We also request addition of other important pathology measures including CAP 22 and CAP 38. Finally, we suggest changes to measure QID 397 prior to inclusion in the Pathology MVP.

- **Additional CY 2026 Modifications to the Quality Payment Program**: The CAP supports CMS' proposal to adopt an informational-only 2-year feedback period for new cost measures and the proposal to recategorize IAs from the Achieving Health Equity subcategory into other categories, especially the reassignment of IA_AHE_6, "Provide Education Opportunities for New Clinicians" to the Expanded Practice Access subcategory. With respect to proposals regarding topped out measures, the CAP is in favor of including MVPs in the analysis used to identify the list of topped out measures impacted by limited measure choice and of including the pathology measures on this list. Finally, we are supportive of the proposal to maintain the performance threshold at 75 points for the 2028, 2029 and 2030 MIPS payment years.

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- **Advanced APMs**: The proposal to continue making QP determinations at the practice level as well as the individual NPI level maximizes the chance for clinicians to participate in APMs. Therefore we support this proposal, in combination with the proposed changes to the definition of attribution-eligible beneficiaries. We also support CMS' proposal to modify the criteria of "attribution-eligible" to include any beneficiary who received a covered professional service furnished by the eligible clinician for whom the QP determination is being made.

DETAILED COMMENTS

The following sections provide detailed comments on the specific topics addressed in the proposed rule, including:

1. Methodology for Establishing Work RVUs - Proposed Efficiency Adjustment
2. Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
3. Development of Strategies for Updates to Practice Expense Data Collection and Methodology
4. CY 2026 Identification and Review of Potentially Misvalued Services
    - Fine Needle Aspiration (FNA) (CPT codes 10021, 10004, 10005, 10006)
    - Mechanical Separation of Plasma from Blood (CPT code 36514)
5. Autologous Cell-based Immunotherapy and Gene Therapy Payment
6. Comment Solicitation on Payment Policy for Software as a Service (SaaS)
7. CY 2026 Updates to the Quality Payment Program (QPP)
    - Request for Information: Core Elements
    - Request for Information: Medicare Procedural Codes
    - Request for Information: Toward Digital Quality Measurement in CMS Quality Programs
    - Request for Information: Data Quality
    - Request for Information: Future MIPS Performance Thresholds

1. Methodology for Establishing Work RVUs - Proposed Efficiency Adjustment:

To reflect changes in medical practice and better capture the resources used in providing services paid under the Physician Fee Schedule (PFS), CMS is proposing a -2.5 percent efficiency adjustment to the work relative value units (RVUs), along with updates to the intraservice portion of physician time inputs for non-time-based services. The CMS proposes this adjustment to address concerns about the accuracy of American Medical Association (AMA) Relative Value Scale Update Committee (RUC) survey data and to recognize efficiencies gained as practitioners gain experience, technology improves, and other operational enhancements occur. **However, the CAP believes the proposed efficiency adjustment is unnecessary and will cause relativity issues across the PFS. Therefore, the CAP urges CMS not to finalize the proposed efficiency adjustment.**

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Instead, the CAP recommends that CMS work with the RUC to develop strategies that ensure services paid through the PFS are priced based on current and accurate data.

In justifying the proposed efficiency adjustment, CMS discusses several concerns with the RUC surveys that may result in inaccurate recommendations. These concerns include low survey response rates, which may cause response bias if practitioners who participate differ significantly from those who do not. CMS also points out that the clinical vignettes used in the survey process may not represent the typical patients, potentially overestimating the time required for services.

The RUC processes provide all of medicine a powerful voice in describing the most accurate resources required to provide physician services. The RUC is an independent entity, comprised of volunteer physicians and staffed and funded by the AMA, national medical specialty societies and other health care professional organizations.

Since 1991 the RUC has submitted numerous recommendations to the CMS that enhance the underlying data used to create relative values units (RVUs). The RUC, in conjunction with the AMA's Current Procedural Terminology (CPT) Editorial Panel, has created a process where physicians can develop relative value recommendations for new, revised and potentially misvalued codes, as well as update RVUs to reflect changes in medical practice. The RUC's annual cycle for developing recommendations is closely coordinated with both the CPT Editorial Panel's schedule for annual code revisions and CMS's schedule for annual updates in the Medicare Payment Schedule. Due to the close coordination between RUC and CPT and the timely submission of recommendations to CMS, beneficiaries and physicians have the benefit of organized medicine's input into relative values for new codes in the same year that the coding changes appear in CPT.

The methods used by the RUC are appropriate to accurately value all services and procedures. The underlying resource-based relative value scale (RBRVS) methodology remains relevant today and the RUC valuation process continues to improve with the development of numerous standards/policies/conventions to improve relativity and ensure consistency. Standard packages for pre-service time, post-service time, practice expense direct input benchmarks, and pre-service clinical staff time packages have been implemented, allowing for enhanced relativity and comparison among all services.

Through its unique structure and process improvements, the RUC has created the best possible volunteer resource and data for physician payment: physicians. It is the work of these dedicated physicians who contribute their time, energy and knowledge that make the RUC process a success that enhances patient care delivery while benefiting all practicing physicians. **The CAP stands in full support of the RUC process to provide the most accurate resources, clinical processes, and payment methodology information to CMS.**

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CMS also raises concern about the lack of adjustments for efficiency gains in work RVUs for non-time-based services. According to CMS, procedures, radiology services, and diagnostic tests should become more efficient over time: as they are performed more frequently, practitioners gain experience, technology advances, and operational processes improve. To support this view, CMS cites studies suggesting that the ratio of fee schedule time to empirical time is often inflated. However, the CAP is concerned that CMS is relying on the same studies to draw two distinctly different conclusions: in one instance attributing the gap to RUC overvaluation, and in the next to efficiency gains.

CMS is reminded that under 1848(c)(1) of the Social Security Act the *"work component"* refers to *"the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service."* Applying an across-the-board adjustment to all non–time–based physician work RVUs based on a global assumption of efficiency disregards this principle, which requires valuation to reflect the actual physician time and intensity of a service. Indeed, as CMS acknowledges, "accruing efficiencies does not apply equally to all services" (90 FR 32403).

Applying such broad-brush adjustments across a vast range of services overlooks the wide variation in clinical scenarios. For example, the efficiencies potentially gained in lengthy surgical procedures differ significantly from those in diagnostic tests or pathology. **The CAP maintains that it is inappropriate for CMS to impose a general efficiency adjustment that does not accurately reflect the varying degrees of efficiency, if any, that may accrue within individual services.**

The proposed efficiency adjustment, applied broadly, overlooks the realities of modern medical practice. It does not reflect factors that actually increase physician workload, such as rising patient complexity and the evolution of medical technologies. For instance, emerging tools such as artificial intelligence (AI) may generate significant amounts of additional information, requiring added interpretive work. Increased patient complexity may also require additional physician review, confirmation of findings, or correlation with other studies. All these changes demand added time and cognitive effort that often goes uncompensated. **Rather than creating net efficiencies, changes in medical practice may intensify the interpretive and documentation burden placed on physicians.**

Instead of providing concrete justification for the broad-based efficiency adjustment, CMS simply assumes that as practitioners become more experienced with a given service, both the intraservice physician time and the overall work intensity (including mental, technical, and physical effort, as well as the risk of patient complications) will decline. With experience, practitioners develop greater familiarity with the service's components, adapt more easily to variations in patient anatomy, and gain confidence in managing unexpected challenges. CMS uses evidence from a cross-specialty observational study that found that increased surgical experience was associated with significant

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reductions in operative time for coronary artery bypass grafting, total knee replacement, and bilateral reduction mammoplasty.

The CAP acknowledges that physicians experience a learning curve as they gain proficiency. However, this does not simply translate into efficiency adjustments in work RVUs: as technology and techniques turn over, so does the practicing physician workforce. RUC surveys sample across the entire specialty, capturing the full range of experience levels, and their aggregated results reflect the "typical" physician. CMS overlooks the fact that the physician workforce is continually renewing—experienced physicians retire while new physicians enter practice. As a result, individual efficiency gains from experience are offset by the arrival of less experienced practitioners, cancelling the assumed net efficiency gain at the aggregate level.

CMS also contends that, when a new procedure or service is introduced, experience accumulates across the entire health system as practitioners adapt to it. As collective experience grows, workflows typically evolve, leading to improvements that make the service more efficient. This same gained experience enhances the diagnoses, treatment, and outcomes of patient care, thus reducing the cost and increasing the benefits to the patient. Additionally, given the infrequency of service revaluations under the PFS and the limitations of relying on RUC survey data, CMS is concerned that the RVUs assigned to services under the PFS may fail to capture these efficiencies as practitioners gain experience, workflows evolve, and new technology is adopted. **The CAP reminds CMS that such efficiency issues related to new procedures or services are already explicitly addressed by the RUC's Relativity Assessment Workgroup (RAW).**

The RAW is responsible for identifying potentially misvalued services using objective mechanisms for reevaluation. In addition, the workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of "new technology" services. Codes are designated as new technology based on recommendations from the relevant specialty society and consensus among RUC members during the service's initial RUC review. In evaluating potential new technology services, RAW members consider factors such as recent FDA approval, the novelty of the service, the use of an existing service in a new way, and the transition of a service from a Category III to a Category I CPT code. As of May 2025, the RAW has identified 902 services for potential re-review, recommending 60 for re-examination and holding another 253 pending the availability of three years of Medicare claims data.

The CAP maintains that the proposed additional efficiency adjustment is therefore unnecessary and inappropriately overlaps with the role of the AMA RUC. Beyond its flawed rationale, the proposal is also inconsistent in design, inappropriately penalizing specialties like pathology with low time-based E/M utilization while benefiting specialties, such as primary care, that predominantly bill time-based E/M services.

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The first indication of flawed design is CMS's intended exclusion of time-based services from the efficiency adjustment proposal. The term "intended" is used because CMS has not applied this exclusion consistently across all time-based services. **The CAP urges CMS to correctly classify pathology clinical consultations CPT codes 80503, 80504, 80505, and 80506 as time-based services and to exclude them from the proposed efficiency adjustment.** These codes are billed based on medical decision-making or total time, following exactly the same time-based structure as the time-based E/M services that are excluded from the proposal, such as CPT code 99213.

The CAP believes that if CMS is going to implement the efficiency adjustment, despite the concerns raised in the foregoing paragraphs, CMS should at least be consistent in applying the proposal across all services and specialties, including time-based E/M services. In excluding time-based services, CMS notes that the resources used in furnishing the work portion of E/M services are primarily a function of the time the clinician spends with the patient and, therefore, are not amenable to efficiency gains. This assumption may hold if a service is paid solely on a per-minute basis, but that is not how the time-based E/M services that are excluded from the proposed efficiency adjustment are paid: these services, such as the CPT 99211 to 99215 family, are paid based either on time or on medical decision-making.

Similar efficiency gains CMS attributes to non-time-based procedural services apply equally to E/M services when characterized on their alternative basis of medical decision-making. Early in their careers, patient-facing physicians expend considerable mental effort exploring every diagnostic possibility. With experience, they more readily recognize a broader range of patient presentations, accelerating diagnosis. Over time, they develop more effective approaches to structuring patient interviews, physical exams, and documentation. This efficiency gain does not reduce the level of medical decision making but makes the physician more efficient at making the decision. This efficiency gain is likely most pronounced for primary care physicians due to the longitudinal relationships they build with patients. Familiarity with patients' histories, preferences, and health patterns reduces time spent reviewing charts during each visit. Thus, the introduction of the E/M add-on code G2211, by incentivizing physicians to cultivate and maintain these longitudinal relationships, should further enhance primary care efficiency. The CAP reminds CMS that pathologists do not have such ongoing patient relationships and are not subject to such longitudinal efficiency gains.

When evaluating E/M efficiencies due to new procedures and services, CMS appears to overlook the expansion of telemedicine and its finalized reimbursement policies as part of their 2025 rate setting. In February 2023, the CPT Editorial Panel created a new E/M subsection for telemedicine services, adding 17 codes: eight for synchronous audio-video visits (CPT 98000–98007), eight for synchronous audio-only visits (CPT 98008–98014), and one for asynchronous services (CPT 98016). Each audio-video and audio-only subset includes parallel codes for new and established patients, reportable by medical decision-making (MDM) level or total time.

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The RUC recommended work RVUs for these codes, noting that audio-only E/M codes generally have lower work RVUs than their office/outpatient counterparts. However, under section 1834(m) of the Social Security Act, Medicare must pay the same amount for a telecommunications service as for an in-person service. Citing no programmatic reason to differentiate payment, CMS declined to adopt the new audio-video and audio-only CPT codes (98000–98015). Instead, CMS will allow physicians to bill audio-video and audio-only telehealth services using the existing E/M CPT codes that best describe the service (e.g., 99202–99215). In effect, while acknowledging that audio-only visits have lower work RVUs at each MDM level, CMS's decision to rely on existing E/M codes without adjusting reimbursement could result in an overvaluation of this subset of services within the E/M code family.

The CAP does not however contend that time-based E/M services are generally overvalued. Instead, the CAP maintains that penalizing non-time-based services based on flawed reasoning, while exempting time-based services, will create significant relativity distortions across the PFS. **The CAP urges CMS to not finalize the proposed efficiency adjustment and collaborate with the AMA RUC to ensure that PFS payments are based on current and accurate data.**

2. Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

Beginning in CY 2026, CMS is proposing to reduce the portion of facility practice expense (PE) relative value units (RVUs) that are allocated based on work RVUs to half the amount allocated to for non-facility PE RVUs. This change aims to correct what CMS views as a flawed assumption in the Physician Fee Schedule (PFS) PE methodology, namely that physicians generally maintain office practices even when providing services in facility settings. CMS backs this proposal with data indicating that fewer than half of physicians currently own their practices.

However, in developing this proposal, CMS appears to overlook the fact that the existing indirect PE RVU calculation already differentiates by site of service. In non-facility settings, indirect PE is based on both direct cost inputs and the physician work RVU. In facility settings, indirect PE is based solely on the physician work RVU. Therefore, by excluding direct costs, the indirect PE RVU methodology already reflects the lower indirect costs for facility-based physicians.

CMS acknowledges that facility-based physicians continue to incur certain indirect expenses such as billing, coding, and scheduling. In fact, these same costs are incurred regardless of site-of-service. The use of physician work RVUs in calculating indirect PE RVUs helps account for these shared costs. **The CAP believes that CMS is attempting to fix a problem that the current methodology already addresses.** Instead, CMS should focus on more fundamental issues with the indirect PE methodology, particularly that the indirect PE RVU disproportionately penalizes specialties such as pathology that typically bill less intense services (lower physician work RVU per minute of physician time).

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As noted, CMS agrees that indirect practice expenses, such as coding, billing, and scheduling, continue to be incurred by facility-based physicians. These costs should remain relatively consistent across services that require the same amount of physician time. However, by differentially using the physician work RVU to allocate indirect PE in the facility setting, CMS implicitly assigns higher indirect PE RVUs to services with greater physician work RVUs per minute of physician time. This creates a misalignment where services of equal physician time (which is what drives indirect PE) but differing intensity receive unequal indirect PE payments.

For example, consider the following two CPT codes:

- 80503 - Pathology clinical consultation, 15 minutes of total physician time
- 99212 - Office or other outpatient E/M established patient – 16 minutes of total physician time

In 2025, the facility indirect PE RVUs for CPT codes 80503 and 99212 are 0.20 and 0.30, respectively. Applying the 2025 conversion factor, this equates to $0.43 in indirect PE reimbursement per minute for a pathologist performing 80503, compared to $0.61 per minute for a physician providing 99212. The CAP calls on CMS to explain this 40% higher indirect payment, given that both services occur in the same facility setting and both physicians are likely to incur essentially similar indirect costs.

CPT Code	Physician Time	2025 Facility PE RVU	2025 PE Payment	2025 PE Payment Per Minute
80503	15	0.2	$6.47	$0.43
99212	16	0.3	$9.70	$0.61

The CAP does not request an immediate overhaul of the indirect PE RVU methodology but asks CMS to consider how the proposed updates to the practice expense methodology would disproportionately impact specialties like pathology, which typically provide services with low physician work RVUs per minute of physician time. **The CAP urges CMS not to finalize the proposal to reduce the portion of facility PE RVUs allocated based on work RVUs to half the amount allocated in the non-facility setting.**

3. **Development of Strategies for Updates to Practice Expense Data Collection and Methodology**

Beginning in 2010, CMS began using data from the AMA Physician Practice Information (PPI) Survey in the Physician Fee Schedule (PFS) rate setting process to enhance the accuracy and consistency of practice expense (PE) relative value units (RVUs). In 2023, CMS issued a Request for Information (RFI) to gather public feedback on updating PE data collection and methodology to reflect changes in the health care landscape. In response, the CAP and most specialty societies

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acknowledged the AMA's ongoing efforts to update the PPI survey and recommended that CMS delay major changes until the updated data became available.

The AMA completed its PPI survey efforts in 2024 and submitted the data to CMS for potential use in the 2026 PFS rate setting process. This included updates to PE per hour (PE/HR) data and cost share weights. However, upon review, CMS expressed substantial concerns about the reliability of the new data. Key issues included low response rates and representativeness, small sample sizes and sampling variation, lack of comparability to previous survey data, and potential measurement error. As a result, CMS questioned both the quantity and quality of the updated AMA data.

The CAP shares the same concerns regarding the updated PPI data. Specifically, CAP is troubled by reliance on small sample sizes, which introduce statistical uncertainty at the specialty level. As shown in Figure A-B1, the 95 percent confidence intervals for the specialty-level PE/HR derived from the updated PPI survey are so wide that they encompass most of the current PE/HR values. In many cases, the new data fail to demonstrate statistically significant changes from previous estimates. **The CAP finds the projected 8 percent cut to pathology payments, as shown in column F of Table 108 of the proposed rule, unjustified as it is based on data that lack statistical significance and reliability. Due to the overarching concerns with the updated PPI survey data, the CAP urges CMS to finalize its proposal to retain the current PE/HR data and refrain from implementing the updated specialty-level PE/HR data from the PPI survey.**

While the CAP opposes using the updated specialty-level PE/HR values from the PPI Survey, it acknowledges the AMA data appears to represents an improvement over the Service Annual Survey (SAS) data CMS relied on to develop the proposed, though not finalized, Medicare Economic Index (MEI) cost share weights in the 2023 PFS rulemaking.

When calculating the proposed 2023 cost share weights, CMS excluded nearly 200,000 facility-based physicians by ignoring data from general medical and surgical hospitals. This exclusion resulted in the omission of over $30 billion in physician compensation and more than $7 billion in professional liability insurance costs. Consequently, the proposed cost share weights significantly understated the share of work and professional liability insurance expenses associated with services paid under the PFS. In contrast, the updated PPI survey data includes facility-based physicians. **The CAP believes that relative to 2023 CMS estimates, the cost share weights derived by the PPI survey data better represent and are less likely to underestimate the proportion of total PFS payments that should be allocated to physician work.**

Small sample size concerns related to the PPI survey are reduced when calculating cost share weights as the data are more aggregated relative to the specialty-level PE/HR data used in the practice expense methodology. However, the CAP recognizes that issues such as measurement error and sample representativeness may remain relevant. Additionally, the CAP is concerned by

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CMS's indication that data from the Clinician Practice Information (CPI) Survey may not be included in the cost share weights. The CAP contracted with Mathematica to obtain cost data for Independent Laboratories using the CPI survey with the understanding that this data would be included in the overall totals.

The CAP believes that when allocating nearly $91 billion annually through the Physician Fee Schedule, it should be done using accurate data and methodologically sound processes. As demonstrated in Table 108 of the proposed rule, specifically in the comparison of columns G and H, methodological changes can result in substantial shifts in physician payment. **Before deciding on whether and how the PPI data could be used in future PFS rate setting, the CAP agrees with CMS on the importance of collaborating with interested parties, including the CAP, AMA, and others. However, at this time, the CAP urges CMS to finalize its proposal not to implement the cost shares derived from the AMA's survey data and to collaborate with the CAP, AMA, and other interested parties to determine the appropriate role of the PPI survey data in future rate setting.**

Furthermore, the CAP acknowledges CMS's ongoing contract with the RAND Corporation to explore and develop alternative approaches for measuring practice expense and related inputs. The CAP encourages CMS to enhance transparency around RAND's activities, consistent with its stated intention to engage interested parties regarding the use of PPI survey data.

4. **CY 2026 Identification and Review of Potentially Misvalued Services**

- Fine Needle Aspiration (FNA) (CPT codes 10021, 10004, 10005, 10006)

An interested party asked the CMS to consider fine needle aspiration CPT codes 10021, 10004, 10005, and 10006 as potentially misvalued due to alleged undervaluation since 2019. However, **the CAP agrees with the CMS that these codes are not misvalued and urges the CMS to finalize its proposal to not to nominate the fine needle aspiration as potentially misvalued.**

- Mechanical Separation of Plasma from Blood (CPT code 36514)

An interested party nominated CPT code 36514 (Therapeutic apheresis; for plasmapheresis) as potentially misvalued due to concerns about practice expense. The CAP appreciates that this is a complex patient service that requires the need for highly trained apheresis nurses to manage patients with serious and complex conditions. However, the CAP believes that the clinical labor issue raised by the nominator was addressed by the RUC in 2024 and by the CMS as part of 2025 rulemaking.

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To elaborate, the therapeutic apheresis CPT code family was nominated as potentially misvalued as part of CMS rulemaking in 2024. In response, the RUC reviewed the clinical labor type associated with CPT code 36514. The RUC agreed that the clinical staff code L042A (RN/LPN) assigned to CPT code 36514 did not appropriately represent the work of an Apheresis Nurse Specialist. Since there is not a clinical staff code for Apheresis Nurse Specialist, the RUC agreed with the specialty societies' recommendation that the training and experience of an oncology nurse (clinical staff code L056A, RN/OCN) would accurately reflect the work of an Apheresis Nurse Specialist. The RUC submitted new practice expense recommendations for this code family based on the use of the L056A clinical labor type. These practice expense recommendations were finalized by CMS without refinement as part of 2025 rulemaking. **The CAP continues to support the RUC's practice expense recommendation and urges CMS to not nominate CPT code 36514 as potentially misvalued.**

5. **Autologous Cell-based Immunotherapy and Gene Therapy Payment**

As part of 2025 rulemaking, the CMS finalized a policy to bundle the payment for the harvesting and preparatory procedures associated with chimeric antigen receptor T-cell (CAR-T) therapy (CPT codes 38225, 38226, and 38227) into the payment for the product itself. For 2026, the CMS continues the payment policies for CAR-T therapy and proposes extending this policy to other autologous cell-based therapies. **The CAP continues to disagree with the finalized CAR-T payment policy and urges CMS not to extend this payment policy to other autologous cell-based therapies.**

The CAP met with CMS on February 3, 2025, to advocate against the finalized CAR-T payment policy on the basis that it does not appropriately recognize the work of the pathologist. The CPT codes associated with CAR-T therapy represent separate and distinct processes. Each step is labor intensive and requires the expertise of physicians and professional oversight and monitoring. Each step represents a medically significant and distinct clinical service, which requires complex decision-making, intensive physician and staff labor, coordination across time and sites, and specialized resources. These services are fundamentally different from manufacturing and therefore warrant separate valuation and reimbursement.

The CAP has emphasized the importance of recognizing and valuing each separate step involved in CAR-T therapy appropriately. The process includes: (1) lymphocyte harvesting from the patient with cancer; (2) creation of cancer-targeting lymphocytes in vitro using various immune modulators; (3) selection of lymphocytes with reactivity to cancer antigens using enzyme-linked immune-assay; (4) depletion of the patient's remaining lymphocytes using immunosuppressive agents; and (5) transfusion of the cancer-targeting lymphocytes back into the patient with cancer – this transfusion represents one treatment.

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Bundling these services understates the complexity of care, diminishes recognition of the physician work value, and may discourage providers from engaging in these intensive, life-saving therapies. Furthermore, CMS's proposal to include manufacturer-covered tissue procurement costs in average sales price (ASP) calculations does not address the core issue of the physician medical decision making and clinical labor involved in managing the critically ill patients in need of these therapies.

CAR-T patients are very sick and must be monitored for specific treatment-related complications. By not reimbursing CAR-T physician services, the CMS is failing to recognize the medical decision making and physician work associated with managing such complex and extremely sick patients. CPT codes 38225, 38226, and 38227 represent patient care and management and should not be considered part of the drug manufacturing process. **To appropriately recognize physician work, CMS should pay separately and individually for each CPT code service through the Physician Fee Schedule.**

While continuing to oppose the finalized CAR-T payment policy, the CAP notes that CMS has not provided guidance for cases in which a physician completes the harvesting and preparatory steps, but the CAR-T product is never administered, whether due to manufacturing failure or patient complications. If bundling remains, the CAP requests that CMS provide clear and actionable guidance for reimbursement when the CAR-T product is ultimately not administered (e.g., when a patient cannot proceed after collection).

The CAP is also hearing of reimbursement disputes when CAR-T harvesting and administration occur at different facilities. Under the finalized policy, the harvesting physician must often negotiate payment from the administering facility—negotiations that are frequently contentious. This puts the harvesting physician at a disadvantage, particularly when the administration facility is unknown at the time of harvest and advance arrangements cannot be made.

Accordingly, the CAP urges CMS to reconsider the finalized CAR-T payment policy and to pay separately and individually for each CPT coded service through the Physician Fee Schedule. If CMS declines to revise the policy, the CAP requests clear guidance on reimbursement when the CAR-T product is not administered, as CMS has yet to establish a framework that ensures the work of the harvesting physician is appropriately recognized. Additionally, the CAP urges CMS not to extend this policy to other autologous cell-based or gene therapies.

6. **Comment Solicitation on Payment Policy for Software as a Service (SaaS)**

In recent years, there have been rapid developments in the use of software-based technologies, referred to as software as a service (SaaS), to support clinical decision-making in the outpatient and physician office settings. Historically CMS has considered most computer software and associated

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analysis and licensing fees to be indirect costs. However, for 2022, CMS finalized service-specific policies to allow for PFS payment of SaaS and AI applications in certain circumstances.

When evaluating SaaS technologies for payment. CMS has observed wide variations in the purported costs of clinically similar SaaS technologies. In addition, because these technologies evolve quickly, there are often no suitable existing medical services for comparison, and Medicare claims data is limited despite the growing development and coding of digital health services.

Interested parties have raised concerns about the absence of a consistent payment framework for SaaS and AI applications. Many have urged CMS to establish a stable policy that can be applied across care settings, payment systems, and service types. In response, CMS is requesting public comment on approaches for paying for SaaS under the PFS.

The CAP shares this interest in SaaS and AI payment policy but emphasizes that CMS should be deliberate in the development of such policy and should proceed with an abundance of caution rather than a sense of urgency. With this in mind, the CAP offers the following in response to CMS' comment solicitation.

- **What factors should we consider when paying for SaaS?**
  CAP Response: Before deciding what factors should be considered when paying for SaaS, it is essential to first decide how to define and codify these services into CPT. The CAP recommends that CMS work directly with the AMA CPT Editorial Panel to establish a coding framework that supports innovation, patient access, and the integrity of the CPT code set. The CPT Editorial Panel is keeping pace by continually evolving its thinking about coding solutions that will accommodate the role of advanced digital technologies in healthcare.

  The AMA's CPT Editorial Panel created an AI working group of the AMA-convened Digital Medicine Payment Advisory Group (DMPAG), which generated the content for the CPT code set's Appendix S, which is where the CPT AI taxonomy is housed. The taxonomy was introduced in 2022 and has been implemented for CPT codes to classify AI medical services and procedures as assistive, augmentative or autonomous. That classification is based on the work performed by the AI application on behalf of the physician or other qualified health care professionals.

  It is anticipated that more services will become driven by AI and other digital health tools going forward, therefore the AMA's CPT Editorial Panel has convened the AMA Digital Medicine Coding Committee (DMCC). The DMCC will provide advisory input to the CPT Editorial Panel, and seek consistency and predictability in the code set regarding AI and digital medicine. Specifically, the committee will:

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- *Frame goals of AI and digital medicine codification and payment in terms of harmonization, synchronization, and alignment with the FDA and the CMS.*
- *Perform critical review of digital health code-change applications.*
- *Work on the Horizon 2030 project seeking to ensure that the AI definitions in Appendix S remain contemporary through the end of this decade.*
- *Consider coding solutions for autonomous AI and population-health services.*

The committee includes representatives from several physician specialties as well as a seat formally reserved for an FDA representative and informal representation from CMS.

- **How should CMS value the physician work associated with utilizing and interpreting the clinical outputs associated with SaaS and AI devices?**
  CAP Response: The DMCC is currently developing comprehensive recommendations on coding, coverage, and payment for digital medicine. This includes discussions related to a new category of CPT codes for algorithmic services that do not include traditional interpretative physician or other qualified health care professional (QHP) work. The new categorization for digital medicine codes will focus on the distinction between augmentative and autonomous services so as to account for and appropriately value physician work.

- **How may CMS best evaluate the quality and efficacy of SaaS and AI technologies?**
  CAP Response: The DMCC's development of a new category of CPT codes for digital medicine will also include criteria for evaluating the quality and efficacy of SaaS and AI technologies, including clarification of what constitutes a clinical meaningful algorithmic analysis output.

Digital medicine offers the potential to expand access and provide effective care to a large swath of patients with varied needs. **The CAP therefore recommends that CMS work directly with the AMA CPT Editorial Panel, DMPAG, and DMCC on issues that enable physicians and their patients to obtain appropriate access to digital medicine and AI clinical services.**

7. CY 2025 Updates to the Quality Payment Program

The CAP looks forward to continuing engagement with the CMS on the Quality Payment Program (QPP), including multiple aspects of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) to determine how to appropriately measure providers who typically do not furnish services that involve face-to-face interaction with patients, including pathologists. Through the years, the CAP has advocated to ensure flexibility for pathologists in a way that recognizes and accounts for the value pathologists contribute to patient care as non-patient facing clinicians in an inherently patient-facing program. These considerations will be especially important as CMS moves forward with implementation of MIPS Value Pathways (MVPs). Below, the

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CAP provides feedback in response to proposals on the QPP.

TRANSFORMING THE QUALITY PAYMENT PROGRAM: MIPS VALUE PATHWAYS (MVPS)

Subgroup Reporting

CMS requests feedback on group reporting, subgroup participation, and mandatory subgroup formation for multispecialty groups. CMS has previously established that starting in 2026, multispecialty groups choosing to report MVPs would need to form subgroups so performance could be evaluated in a meaningful manner. Given that MVPs remain optional, any potential changes that make MVP participation more difficult or increase the burden could cause participants to return to reporting traditional MIPS, as it is more familiar. The CAP appreciates the need to balance increased burden with the desire for meaningful reporting by multispecialty groups. We support CMS' previous revision to the subgroup process that allows multispecialty groups to form subgroups as they see fit rather than imposing specific requirements, such as the requirement for a subgroup to be composed of a single specialty. Furthermore, we applaud CMS for recognizing the increased challenges that small groups, even small multispecialty groups, face in participating in MIPS. We agree that small multispecialty groups are likely to face case volume challenges if they are forced to subdivide into subgroups, as many small pathology practices already encounter case volume challenges in the current system. **Therefore, we support CMS' proposal to maintain the MVP group reporting option for groups with a small practice designation**.

Proposal to Modify the MVP Group Registration Process

As described above, many multispecialty groups will need to form subgroups as part of the MVP registration process starting in 2026. In order to promote use of MVPs, the CAP supports easing of restrictions on registration, subgroup formation, and other administrative processes. The CAP and other stakeholders had previously raised logistical concerns regarding the use of Claims data to determine multispecialty status because that information is insufficient to fully capture practice patterns: neither subspecialty (dermatopathology, hepatopathology, etc) information nor information about scope of care are available via Claims data. Therefore, we appreciate CMS' proposal to allow multispecialty groups to self-identify to mitigate instances when a group practice consists of clinicians across multiple specialty types but provides care in a single clinical area. However, we request additional information regarding CMS' intentions to verify this information once obtained. If CMS intends for multispecialty status to be subject to routine random audits like other information, additional guidance about acceptable documentation would be needed. **In general, however, we support CMS' proposal for a self-attestation process for groups to identify themselves as single of multispecialty during MVP registration, and the conforming proposals to update accompanying definitions.**

Request for Information: Core Elements

As background, pathologists could be currently captured in one MVP, Dermatological Care, and a pathology-specific MVP is proposed for 2026. However, the Dermatological Care MVP only includes

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two quality measures for pathologists; thus, only pathologists in a multispecialty group with dermatologists could successfully report this MVP. Pathologists cannot meaningfully participate in any other MVP since broad or cross-cutting measures do not apply to them as non-patient-facing specialists. As CMS has stated that their intention is for each specialty to have only one MVP, it seems likely that MIPS-eligible pathologists in single-specialty practices or who form pathology-specific subgroups will report the Pathology MVP.

However, within the practice of pathology, there is tremendous diversity of subspecialty. A gastrointestinal pathologist and a dermatopathologist may not see any cases in common, and a genitourinary pathologist would see a different set of cases altogether. Therefore the quality measures that are meaningful to one subspecialty of pathology may not be meaningful to another subspecialty. In fact, another subspecialty may not even meet the case minimum. This is part of the reason that pathologists overwhelmingly report as groups rather than individuals; in order to meet the case minimum for 6 different quality measures, several subspecialties likely must be represented. There are few if any areas within pathology for which 6 relevant quality measures exist, and as noted above, pathologists can only report pathology measures since they are non-patient-facing. CMS has recognized this challenge by including the pathology MIPS CQMs on the list of topped-out measures with limited measure availability for two years. The CAP greatly appreciates this recognition; pathology practices, especially small practices, struggle to meet the performance threshold due in part to the limited number of measures. The CAP continues to develop measures to address the relatively narrow set of measures available to pathologists.

The breadth of subspecialties within pathology, however, means that there are no measures in the proposed Pathology MVP that all MIPS-eligible pathologists could report on. Even assuming group reporting by all MVP participants, it is difficult to know whether any measures could be considered "core" or foundational to the MVP. Some practices may see twenty-five cases of one specimen type but several thousand of another specimen type; thus while they meet the case minimum for the former, it would not be central to their practice. It is also difficult to determine which measures would be the most meaningful for patients; a patient with melanoma would consider the Melanoma Reporting measure the most important while a caregiver whose father has prostate cancer would prioritize Radical Prostatectomy Pathology Reporting. One measure is not more important than the other *a priori*.

The CAP also provides specific responses to the questions in this request for information below:

- **Are there other ways to ensure MVP reporting results provide comparative performance data for patients on critical measures?**
  CAP Response: The CAP generally does not believe that Core Elements are necessary within the Pathology MVP at this time for the reasons described above. Instead, we recommend that CMS consider an approach less focused on specific measures. As noted

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above, due to subspecialization within pathology, there are no pathology-specific measures in the Pathology MVP that every MIPS-eligible pathologist can report.

Instead, the CAP recommends that CMS assign each measure a category that describes what it is measuring. Scores on the categories can be reported and may be more meaningful to patients. Quality measures are often technical and while they represent clinical best practices, they may not be meaningful to patients. Furthermore, since measures cannot be reported by all clinicians, comparisons of individual measure scores will always be incomplete. However, by grouping measures, CMS can report to patients on the general performance of clinicians or groups. For instance, consider the pathology measure Radical Prostatectomy Reporting. Since not every practice can report this measure, comparing practices on it will be difficult. The measure Lung Cancer Reporting—Resections does not cover the same clinical area but could be considered part of the same conceptual group: "complete evaluation of resection specimens". Knowing that a practice scores highly on "complete evaluation of resection specimens" is more valuable to a patient than the absence of data on a specific measure.

- **We request feedback on the ideal number or percentage of Core Elements in MVPs**. *CAP Response: Although the CAP generally believes that a narrow set of options for clinicians can be unnecessarily limiting, Core Elements by their nature risk complicating MVPs. Having many Core Elements to choose from could be even more confusing, as clinicians may require significant support to understand the difference between measures in the Core Element set, measures in the MVP, and measures in MIPS broadly. We urge CMS to consider alternative approaches.*

- **One possible solution would be to include Core Elements with several different collection types, when possible, to provide clinicians with some choice of collection type. Are there other flexibilities or options that could reduce this limitation?** *CAP Response: The CAP continues to promote use of Qualified Clinical Data Registries (QCDRs), which provide the maximum support and flexibility for clinicians participating in MIPS. CMS should not take actions that disincentivize use of QCDRs. If CMS intends for an MVP to include more than one Core Element, whether that is a measure or measure group, we recommend that multiple collection types including QCDRs be available.*

- **We request feedback on ways to include measures that are applicable for more clinicians, such as including cross-cutting and broadly applicable measures.** *CAP Response: As noted above, cross-cutting and broadly applicable measures do not apply to pathologists, therefore the CAP strongly discourages their inclusion in the Pathology MVP. The inclusion of population health measures is likely to be confusing to clinicians, since these measures do not apply to pathologists either, and including additional non-*

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applicable cross-cutting measures would not add value. In general, the CAP suggests avoiding inclusion of irrelevant measures in MVPs. If the issue prompting consideration of Core Elements is an excess of measure choice, adding more measures, especially measures outside of the clinical area of the MVP, is not an efficient solution. Additionally, we submit that patients are unlikely to choose a specialist based on his or her performance on cross-cutting measures and the additional information may muddy the waters for patients.

- **We also request feedback on ways to avoid disadvantaging clinicians without an applicable Core Element, such as attesting to no applicable and available Core Element.**
  CAP Response: As previously noted, we have significant concerns about the viability of Core Elements, whether specific to one MVP or across all MVPs, as it relates to pathology. Therefore, if CMS moves forward with implementation of Core Elements, it will be necessary to institute some mechanism by which clinicians can attest to lack of Core Elements or to omit entire MVPs from the Core Element program. If possible, we additionally recommend that CMS consider whether this can be assessed via Claims, similar to the current Eligible Measures Applicability (EMA) process. Rather than requiring clinicians to attest that they cannot report measures, we suggest that CMS evaluate MVP participants on the codes included in Core Element quality measure(s) and determine whether they are applicable or not. As with EMA, this determination would be subject to Targeted Review and would therefore align with current processes.

- **[W]e are interested in receiving feedback on specific measures that should or should not be considered for the Core Elements requirement**
  CAP Response: The CAP continues to believe that non-applicable measures should not be included in MVPs, which are intended to be cohesive sets of clinically related activities.

- **We request feedback on our goal to consider the Core Elements policy for proposal in the CY 2027 PFS proposed rule.**
  CAP Response: The CAP expresses concern about the idea of Core Elements as such. However, if CMS determines that this is necessary to move forward, we recommend implementing it as a test concept prior to the performance year when MVPs are mandatory, suggested to be CY 2029. This will allow clinicians to become familiar with the idea and CMS and QCDRs to assess potential pitfalls.

- **We request feedback on whether the Core Elements reporting requirement would impact your decision to report an MVP while traditional MIPS remains a reporting option.**
  CAP Response: Although the Pathology MVP is not available currently, previous experience suggests that anything that makes the MIPS program more complicated is likely to decrease

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participation. We appreciate CMS' efforts to keep large parts of the program the same for 2026 and suggest that while MVPs are still relatively new (and would be entirely new for pathologists), efforts should be made to avoid altering the underlying structure of them, especially in ways that add complexity. To promote voluntary uptake, MVPs should be as straightforward as possible and score as highly as possible. Overcomplicating MVPs will lead to clinicians choosing the more familiar traditional MIPS

Request for Information: Medicare Procedural Codes

As background, the CAP notes that many pathology quality measures, even in disparate clinical areas such as prostate cancer and Barrett's esophagus, utilize an overlapping set of procedural codes. Due to the importance of anatomic pathology to patients, most existing pathology quality measures are focused on specimens such as biopsies and resections. These are also the clinical procedures most directly attributable to a single MIPS-eligible clinician. However, the same set of procedural codes describes evaluation of most such specimens. Among specialists, these codes are only used by pathologists but apply to most pathology measures. Additionally, the same codes would also be utilized as part of procedures that are not included in any pathology quality measure such as evaluation of a mastectomy specimen. Therefore, simply assessing procedural codes could neither assign a pathologist to the Pathology MVP (since activities outside of these measures use these codes) nor would this be useful in excluding other clinicians from the Pathology MVP. Since there is no overlap between pathology codes and patient-facing codes, use of procedural codes is unnecessary to narrow the set of clinicians reporting the Pathology MVP.

The idea of using Medicare procedural codes to assign specialists to MVPs is additionally complicated by the inclusion of two pathology measures in the Dermatological Care MVP. As noted above, these measures use the same procedural codes as other, non-dermatological measures such as lung cancer reporting. Attempting to assign a pathologist to the Dermatological Care MVP based on his or her billing of the procedural codes in QID 397 and 440, the pathology MIPS CQMs in the Dermatological Care MVP, would not be correct. Alternatively, attempting to prevent a pathologist in a multispecialty group from reporting those measures as part of the Dermatological Care MVP or trying to assign that pathologist to the Pathology MVP based solely on codes would also not be correct.

The CAP also provides specific responses to the questions in this request for information below:

- **If we do not suggest or assign MVPs to clinicians, how else can we encourage specialty reporting of relevant MVPs based on the scope of care provided?**
  CAP Response: Determinations of the clinicians' scope of practice and therefore the clinically appropriate MVP should be left to the MIPS-eligible individual and/or his or her practice. While CMS may encourage specialists to report MVPs, we do not believe it is appropriate or necessary to assign MVPs. As well, given that CMS has limited the available

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MVPs to approximately one per specialty or condition, clinicians can generally determine which is the appropriate MVP.

If the concern remains that specialists are being captured in a primary care MVP (i.e. Value in Primary Care), this concern will be largely addressed by the requirement that starting in 2026, multispecialty groups must form subgroups to report MVPs. This will allow multispecialty groups to report specialty MVPs where appropriate. However, it should also be recognized that the quality measures included in primary care MVPs are important to patients and have value across the healthcare system. Clinicians should not be prevented from using such measures if they are applicable.

We also suggest that CMS should encourage voluntary reporting of MVPs rather than forcing or assigning clinicians to MVPs. Incentives such as additional bonus points could be considered to encourage MVP reporting by a broad set of clinicians. We also continue to urge CMS to collaborate closely with the relevant specialty societies as MVPs are developed and updated. Specialty societies are best positioned to understand the complex needs of their clinician population, including what measures may be truly relevant to each specialty.

- **What data sources should we consider using to assign clinicians to an MVP?**
CAP Response: The CAP would like to express some concerns regarding available data sources. As commenters have noted in the past, Medicare Part B Claims data is not the most reliable way to assign clinicians to a specialty and therefore potentially to an MVP. CMS has acknowledged this fact elsewhere in the CY 2026 proposed rule by proposing that multispecialty groups self-describe for the purposes of MVP reporting. We agree with CMS that designations by the group will be the most reliable way for clinical specialty to be determined. Therefore we recommend against utilizing this data; if it is not sufficiently reliable, specific, and valid to be used for multispecialty group determination, then it is likely that the same concerns apply to determination for MVP assignment.

  Additionally, as noted above, the Medicare procedural codes represented in pathology measures are not a sufficiently specific way to assign pathologists to particular MVPs. Hepatopathologists may bill the same codes as dermatopathologists but should not be assigned to the Dermatological Care MVP on the basis of those codes.

- **Given these constraints, how long would clinicians need to prepare for a suggested MVP based on Medicare Part B claims data? How long would clinicians need to prepare for a required MVP based on Medicare Part B claims data?**
CAP Response: The CAP believes that the idea of assigning clinicians to MVPs should not be undertaken until MVPs are mandatory and a specific issue regarding clinician participation in MVPs has been identified. That is, given the limited adoption of MVPs at this

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time, it is difficult to know the extent of any issue with clinicians using suboptimal MVPs. Use of Medicare procedural codes is complicated and could turn out to be a solution in search of a problem once there is greater uptake of MVPs. Given that CMS' priority currently is encouraging increased voluntary use of MVPs, any action to limit choice of MVP or make MVP reporting more complicated is contrary to that goal.

We also note that CMS has already proposed a mechanism to accomplish the same goal as use of Medicare procedural codes by introducing stratification of MVPs by clinical conditions. This additional description provides more information to clinicians regarding related measures in each MVP. We suggest that if using procedural codes is formally proposed, at the very least, CMS should assess whether this additional format describing the most applicable measures for a clinical condition addresses CMS' concerns.

Finally, the CAP would also like to point out the value of team-based care and the importance of comparable data across practices. As described in the Core Elements Request for Information, one of the goals of MVPs is to provide patients with more relevant, equivalent information to assess clinicians and groups. Assigning specialists to an MVP based on the codes they bill may not be an accurate representation of their practice and may reduce the ability of patients to compare across practices.

QPP REPORTING AND DATA SUBMISSION
CY 2026 MVP Development and Maintenance

Development of New MIPS Value Pathways (MVPs)
As background, the CAP notes that when it comes to development of new quality measures, the QCDR measure pathway has been a successful and highly used way to introduce new quality measures into the program more rapidly than the MIPS CQM process. CMS continues to state that traditional MIPS will sunset, possibly as soon as CY 2029. When this occurs, the QCDR measure process becomes unclear, since the timeline of MVPs in the proposed rule does not align with the timeline of self-nomination for QCDRs with new QCDR measures. For instance, if the CAP were to propose a new QCDR measure for CY 2027, that measure could not be part of the Pathology MVP in 2027, because self-nomination of QCDR measures occurs after the CY 2027 proposed rule is released. In the absence of traditional MIPS, it is unclear what would happen to this measure; MIPS-eligible clinicians could not report it so there would be no benefit for a registry to support it. Furthermore, CMS has incentivized reporting of new measures by setting a floor of 7 points for measures in their first year of use, which has been invaluable to the CAP in terms of earning benchmarks for QCDR measures. However, if traditional MIPS no longer exist and a QCDR measure cannot be in an MVP in its first year of use, the 7-point floor is significantly devalued.

The CAP acknowledges CMS' desire to continue developing MVPs with a goal of having an MVP for

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each specialty and the introduction of new MVPs to support this goal. While the CAP appreciates CMS providing an opportunity to comment on candidate MVPs prior to proposal in the notice and comment rulemaking process, we remain unclear on measure selection criteria after public comment. In the case of the proposed Pathology MVP, the candidate version included 4 QCDR measures owned by the CAP and 4 QCDR measures owned by another steward. Although there were no public comments against any specific quality measures in the candidate MVP, the version in the CY 2026 proposed rule now only includes three CAP QCDR measures with no further explanation. **We recommend the addition of CAP 41, Basal Cell Skin Cancer: Complete Reporting to the proposed Pathology MVP**. This measure was included in the candidate MVP, and we request its re-addition. As well, the CAP continues to request the inclusion of CAP22: Biopsy Reporting Time to Clinician and CAP38: Prostate Cancer Reporting Complete Analysis to the Pathology MVP quality measure set. Both measures assess critical reporting elements used for clinical decision-making and promote quality and safety of patient care. CAP22 and CAP38 will maximize the number of pathologists who can report the MVP and ensure wide clinical coverage and choice of measures. In fact, CAP 22 is the closest thing to a cross-cutting measure that all pathologists can report since it covers biopsies, a common specimen type, for almost all anatomic locations.

More broadly, we do not recommend selecting measures solely based on performance gap; this is a difficult metric to track completely since utilization of any one measure is optional. It is self-evident that clinicians who are not performing the quality action for a measure may simply choose not to report it. Thus the lack of gap may not be a full representation of nationwide performance. We suggest using gap as only one of several factors to select measures. Other factors include how well aligned measures within a model are, how closely linked to patient outcomes they are, and whether they drive integration across the care team.

Additionally, we request additional information regarding how feedback will be provided to MVP participants. One of the original benefits of MVPs was enhanced performance feedback from CMS. We look forward to more information on that aspect of MVPs. We also request that CMS codify that the current EMA process will be applied to MVPs and similarly the current Targeted Review process will be applied to MVPs. Finally, we would appreciate additional clarification regarding the role of facility-based scoring once traditional MIPS sunsets. Will facilities be expected to report MVPs? Or will aspects of traditional MIPS be maintained for facilities, given that many clinicians score better via facility-based scoring? These are a few of the issues that remain to be resolved prior to sunsetting traditional MIPS.

Third Party Intermediaries Support of MVPs

While we understand CMS' desire to make MVP reporting as widely available as possible, we have been pleased to see the increased flexibility CMS has allowed for third party intermediaries regarding support for MVPs. We appreciate that CMS only requires third party intermediaries to support MVPs

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that are relevant to their clientele and only QCDR measures they own or license. Supporting MVPs in addition to traditional MIPS, especially MVPs with low scoring potential or uptake, is an increased burden on third party intermediaries and can necessitate negotiation to license QCDR measures after the measures are approved in the fall.

Therefore, we support the proposal granting QCDRs and qualified registries a one-year delay after finalization of the MVP to support the MVP. The time between publication of the final rule establishing the MVPs and the start of the performance year is short and many registries are already midway through their yearly build cycle in order to comply with CMS' requirement for readiness on January 1st. This delay will provide registries sufficient time to gain access to as many QCDR measures as possible and build them into the registry following their standard practices.

Request for Information: Toward Digital Quality Measurement in CMS Quality Programs
The CAP is pleased to provide these comments in response to part (3) of this RFI, General Solicitation of Comments. The CAP is highly supportive of CMS' broad goal of reducing burden by transitioning to digital measurement. The manual process of data entry that characterizes current systems is inefficient for clinicians and reduces utility of data across the system. Some challenges in the current process relate to difficulty accessing data and the general lack of interoperability between different electronic health records (EHRs) such as hospital EHR and a practice EHR, as well as unwillingness of hospitals to share data in a timely fashion. While better application programming interfaces (APIs) may increase system interoperability, information hoarding by large healthcare systems remains a barrier, as described more in a later section.

Also, other challenges related to interoperability in quality measurement remain. Notably, integration of multiple digital data sources beyond defined fields in EHRs is difficult. Although electronic clinical quality measures (eCQMs) have the advantage of being specified in a standard electronic format and using data electronically extracted from EHR data, widespread development and uptake of eCQMs has been slow due to the complex, rigid requirements of eCQMs. Therefore, we urge CMS to move beyond narrowly defined eCQMs and instead invest in the development of more broadly-defined digital quality measures (dQMs). Unlike eCQMs, dQMs allow incorporation of data from other sources, including patient data from wearable devices, as well as data from other health information systems outside the EHR. dQMs are not tied to traditional EHRs, which patients historically cannot access; dQMs therefore allow patients more control over the data about them in the healthcare system. Broadening the focus beyond eCQMs will capitalize on the promise of new, advanced health technologies, both patient-facing and provider-facing. dQMs also capture more nuance than eCQMs by including unstructured information from other sources such as the Laboratory Information System (LIS).

The CAP recognizes that a major goal of the digital measurement effort is to reduce burden on providers and promote efficiency across the system. Therefore, some standards and structure will be

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needed within dQMs. Moving to a standard based on Fast Healthcare Interoperability Resources (FHIR) will theoretically provide the desired standardization without imposing unnecessary restrictions on clinicians and practices. In general, we support standards systems that are open and transparent, allowing input from all interested parties. We encourage CMS to continue partnering with existing standards organizations, as has been done with HL7 for FHIR and FHIR APIs, rather than creating new standards systems.

While the CAP does not believe the current state of FHIR is sufficient for use with all types of quality measures in all programs and all specialties, we support the idea of using FHIR for quality measurement and we reiterate that focusing exclusively on eCQMs is too narrow. Instead, efforts should be aimed at developing the necessary resources, implementation guides, and support for creating dQMs with FHIR, in collaboration with all interested stakeholders. This will allow organizations who primarily use EHRs to proceed with developing eCQMs now if they wish while also incorporating broader data sources such as patient-reporting information, administrative claims data, and data from other electronic health sources like LISs into dQMs.

The transition to fully digital measurement requires considerable effort on the part of clinicians and groups, measure developers, health technology vendors, and others in the healthcare system. Thus we suggest that CMS develop a detailed timeline of activities needed for this transition as well as determine how CMS will support all interested parties including providing financial support, technical resources, and regular discussions and feedback. As well, we note that collaboration across the healthcare system will be required. No single party can be allowed to block progress and complaints of information blocking, lack of cooperation, etc, should be taken seriously by CMS, whether the information blocking is by a clinician, a hospital or a health IT vendor. Additionally, CMS should establish mechanisms to incentivize this transition. While it may not equal the scale of the transition from paper to electronic health records undertaken as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, moving to a fully interoperable system of quality measurement is a major undertaking requiring effort spanning the local practice level all the way to the national payer level.

In terms of specific dates, we do not believe that a mandatory transition to FHIR should be enforced or that a firm deadline should be put in place. Organizations must first assess the existing FHIR capabilities to understand where gaps are, identify a plan for closing those gaps, then develop a timeline on which that development can occur. Until there is a better sense across the ecosystem of measure developers and end users of where gaps in FHIR standards exist, it is premature to suggest that all measures could be converted to FHIR. The process of implementing FHIR is multi-step and multistakeholder: it is not entirely within the control of any one party to deploy FHIR

We look forward to continuing to work with CMS on development of the FHIR standard in a manner that is appropriate for pathology and LIS, acknowledging the unique structure and function of these

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systems.

MIPS Performance Category Measures and Activities

Quality Performance Category
As with other aspects of the MIPS program in 2026, the CAP appreciates CMS' efforts towards stability with respect to the Quality Performance Category. Although addition and removal of some quality measures is necessary, limiting such efforts will ensure sufficient choice for clinicians while maintaining a parsimonious measure set. We support the current status of the Pathology Specialty Measure Set for 2026.

Cost Performance Category
The CAP supports a careful analysis of any new cost measures to ensure they do not have unintended consequences on MIPS-eligible clinicians and that they accurately and completely capture the relevant services in the control of the attributed clinician. Therefore, given the lack of support from the Partnership for Quality Measurement, CMS' consensus-based entity, for the latest round of cost measures, we support CMS' decision not to proposal any new cost measures for 2026.

Additionally, given the nature of cost measures as attributed to a clinician or group rather than reported by a clinician or group, the accuracy of attribution must be extremely high. Although clinicians can know well in advance which cost measures will be in the MIPS program each performance year, they may not know whether they will be attributed a cost measure due to variations in practice patterns and even more importantly, they will likely not know how they will score on the measure. Without accurate information regarding their scores, clinicians lack the ability to improve. In the current system, clinicians and groups receive feedback on their performance six months or more after the performance period, meaning that at least half of the next performance period has elapsed before they are able to take any action to improve their efficiency. Given these challenges, **the CAP supports CMS' proposal to adopt an informational-only 2-year feedback period for new cost measures**, including the proposal to provide confidential scores to clinicians and group during that time.

Improvement Activities Performance Category
Although Improvement Activities (IAs) represent a smaller proportion of the score for many MIPS-eligible clinicians, as non-patient-facing clinicians who are not attributed cost measures, pathologists place a high value on IAs and use them to drive practice improvements that are not captured in traditional quality measures. The CAP continues to develop and submit for consideration new IAs, given the limited number that pathologists can meaningfully fulfill.

The CAP appreciates the breadth of activities available within the Improvement Activities category. Although the value of a manageable, parsimonious set of activities is clear, more IAs are generally

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beneficial, especially given CMS' desire for practices to avoid repeatedly using the same IA year after year. Therefore, we are generally supportive of the new category of IAs, Advancing Health and Wellness. The number of applicable items within this category that are relevant for pathologists may be low, however in the future it may be possible to craft a relevant IA.

Due to the low number of applicable IAs for pathology, the CAP is supportive of CMS' decision to recategorize useful IAs from the Achieving Health Equity subcategory, which is proposed for removal, into other categories. Specifically, we support the reassignment of IA_AHE_6, "Provide Education Opportunities for New Clinicians" to the Expanded Practice Access subcategory. Supporting educational opportunities for new clinicians is a critical activity in the healthcare system and not one that can be captured by a quality measure. We appreciate CMS' recognition of the value of clinician education and the fact that it can be accomplished by all practicing clinicians, not just those at strictly academic centers.

Request for Information: Data Quality

As background, the CAP would like to remind CMS that pathologists almost exclusively utilize Laboratory Information Systems (LISs) not traditional EHRs for clinical documentation purposes. LISs transmit pathology and clinical laboratory information to the EHR and receive limited clinical information from the EHR, but generally they are not eligible for CEHRT certification. The complex interplay between the LIS and the EHR provides an additional interoperability challenge for pathologists and means that timely, consistent, and reliable access to data from hospitals is critical for pathologists.

The CAP agrees with CMS that poor data quality is a threat to patient safety if providers are treating patients based on inaccurate or incomplete information. Pathologists have a key role to play in ensuring that treating physicians have the most up to date and complete diagnostic information in a timely fashion. Similarly, we support CMS' statement that poor quality data poses risks beyond immediate health care delivery because health data serves as the foundation for public health reporting and clinical research. To ensure the most accurate reporting for public health decision-making, pathology practices must be able to easily access all the health information they generate to provide a complete picture of the status and threats to public health and promote high quality research. As we have stated previously, we do not believe hospitals or health systems should be able to hoard data and prevent practices from accessing it in a seamless, timely manner and we are encouraged by CMS' recognition of the potential threats this poses.

The CAP also provides specific responses to the questions in this request for information below:

- **What data quality challenges does your health care organization experience (for example,** discrepancies in data accuracy, completeness, reliability, and consistency)?
  CAP Response: The major challenge relates to data completeness and data access. Hospital systems and EHRs often refuse to share data or charge exorbitant fees to providers

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and clinical data registries to obtain data for quality measure reporting. This prevents deployment of innovative applications and leaves physicians with few options other than manual or swivel-chair data entry. Although standard APIs such as FHIR APIs ease some interoperability burdens, without the willingness to share data, improved technology at the connection point does not fully mitigate the problem. Thus the data that independent pathology practices have access to can be limited, incomplete, or inconsistent due to circumstances beyond their control.

- **What are the primary barriers to collecting high-quality data? What resources do you believe could help your organization address these challenges?**
  CAP Response: As noted above, inconsistent, slow, and restricted access to data from large health systems and EHRs remains a major challenge. This is especially true for smaller pathology practices attempting to access their data in order to integrate with a QCDR or other clinical data registry. Hospitals and EHRs have been known to outright refuse to work with registries or put registry access to data so low on the list of priorities that it simply never happens. As well, some EHRs charge independent practices exorbitant amounts to access their own data.

- **What steps should CMS consider to drive further improvement in the quality and usability of health information being exchanged? What methods should CMS and other partners explore to further rectify data quality issues in the health care community?**
  CAP Response: We encourage CMS to continue partnering with stakeholders to promote timely access to quality health information. Specifically, we suggest that CMS and the Assistant Secretary for Technology Policy (ASTP) together re-examine the "fees exception" to the information blocking rule. While we understand the necessity of EHRs charging fees to support the activities needed to set up data flows with practices, this exception is increasingly being invoked by EHR vendors and large health systems to block access to data requested by practices. Clinical data registries continue to face substantial barriers in accessing essential data from EHR vendors and hospital systems. EHR vendors frequently decline to engage in good-faith negotiations with practices to enable the transfer of clinical data to registries, effectively denying registries any access to such data.

  As well, we encourage CMS to explore opportunities for incentives to promote interoperability. Changes or updates to electronic health systems, including implementation of new standards systems, require significant time and effort on the part of practices. Although the current digital transformation may not equal the effort to convert paper records to EHRs undertaken as part of the HITECH Act, it is nonetheless a substantial change to the current health information ecosystem. Improving interoperability to make data transfer faster and more seamless will improve data quality across the health care system; we therefore

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encourage CMS to explore ways to support the digital transition as a means to improve data quality.

ADDITIONAL CY 2026 MODIFICATIONS TO THE QUALITY PAYMENT PROGRAM
MIPS Final Score Methodology

Performance Category Scores: Topped Out Measures with Limited Measure Choice
While the CAP understands CMS' belief that measures with high performance do not demonstrate room for continuous improvement, and are therefore topped out, we have long held that continuous improvement should not be the only metric of success in the quality performance category. Just as most consumers would not find it acceptable to have airline flights that were only 98% safe, many patients would not be satisfied with healthcare that was only 98% safe or accurate. Nor would consumers accept that safety should no longer be measured simply because a single metric had been achieved. That is to say, we believe that the current topped out measure policy does not appropriately incentivize maintenance of the highest quality care for patients. We continue to encourage CMS to continue to evolve the overall goals of the quality performance category away from narrowly-defined continuous improvement to a broader definition of quality that recognizes maintenance of high quality over consecutive years.

In the meantime, **the CAP is supportive of CMS' proposal to include MVPs in the analysis used to identify the list of topped out measures impacted by limited measure choice**. Although the limited set of measures in an MVP may assist clinicians in identifying quality measures and the reduced number of measures required as part of an MVP lowers the burden on practices, these two factors could also contribute to clinicians having difficulty scoring well within an MVP. Therefore, the scoring potential analysis of MVPs is an important evaluation of whether MVPs can drive quality improvement.

As pathologists have few measures to choose from and cannot report the broadly applicable MIPS quality measures, **the CAP is supportive of the inclusion of pathology measures in the list of measures impacted by limited measure choice**. We appreciate CMS' desire to ensure fair scoring of all specialties and recognition that the limited measures available to pathology and certain other specialties prevent equitable scoring opportunities. However, we continue to suggest that CMS consider setting a two-year time frame for evaluation of measures on the list impacted by limited availability. That is, a measure proposed for inclusion on the 2026 list would be re-evaluated for the 2028 performance period. Constant change to policies and procedures is a significant challenge for practices and a single year may not be enough time for practices to change their reporting structure if they have moved away from topped out measures.

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MIPS Payment Adjustments

Proposed Performance Threshold for the CY 2026 Performance Period/2028 MIPS Payment Year through the CY 2028 Performance Period/2030 MIPS Payment Year
The CAP appreciates that CMS is taking into consideration the burden placed on clinicians by raising the performance threshold rapidly and is considering the importance of stability and predictability within the MIPS program. Based on feedback from MIPS participants, constant changes to policies and procedures are a significant challenge for practices so we encourage consideration of what other policies can be viewed through a longer time lens.

We agree that data from payment years 2021 through 2023 are likely unreliable due to the effects of the COVID-19 pandemic and that the introduction of new policies such as MVPs shortly after the public health emergency (PHE) also contributes to skewing of scores. Additional policies under consideration by CMS such as establishing core elements of MVPs and transitioning to digital quality measures (dQMs) would also necessitate additional time and effort by practices and MIPS-eligible clinicians to adapt to and implement. Therefore, **we are supportive of the proposal to maintain the performance threshold at 75 points for the 2028, 2029 and 2030 MIPS payment years**. As noted by CMS, this also mitigates the potential harm on small, rural and/or solo practitioners inflicted by raising the performance threshold in subsequent year.

Request for Information: Future MIPS Performance Thresholds
The CAP appreciates this opportunity to provide feedback on future MIPS performance thresholds. As noted above, constant change to the MIPS program is a burden for clinicians regardless of the specific changes themselves. Therefore as CMS considers future performance thresholds, stability will be a key factor, in combination with realistic goals for the MIPS program.

The CAP provides specific responses to the issues in this request for information below:

- **Establishing the performance threshold for single versus multiple years (for example, 1, 2, or 3 years at a time) via rulemaking**
  CAP Response: The CAP continues to emphasize the importance of stability in the MIPS program. Therefore, if possible, we suggest establishing a performance threshold that spans multiple years. While we understand the desire to re-evaluate how the performance threshold is contributing to the goals of the program each year, it may not be possible to make such a determination on a year-by-year basis. Instead, we suggest that 2 or 3 years of data would provide a more accurate picture of real performance when evaluated against a new threshold

  However, we also suggest that CMS maintain statutory flexibility in setting the performance threshold. While stability in the MIPS program is critical in the steady state of MIPS, given the uncertain nature of healthcare and the need to be responsive to major external events,

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we recommend that CMS use 2 or 3 years as the default timeframe for a new performance threshold, but be open to the possibility of changing it sooner in the event of significant threats to the program such as a major cyberattack or pandemic.

- **As we approach later years in MIPS, increasing the performance threshold based on data from a prior period which potentially would provide larger positive MIPS payment adjustments for MIPS eligible clinicians with MIPS final scores higher than such performance threshold.**
  CAP Response: While it is true that calculating the performance threshold from the mean or median of recent data may yield a higher threshold number and therefore drive higher payment adjustments for some clinicians, we urge CMS to consider other aspects of the program as well. MIPS is intended to improve quality and a higher performance threshold is likely to reward those who are already doing well rather than supporting increases in quality for other clinicians. Data show that small practices already perform worse than large practices; raising the threshold would widen this gap and could drive additional revenue from small independent practices to large consolidated systems. Rewarding the top performers at the expense of those who need to improve would not improve the healthcare system as a whole but could lead to a wider gap. We suggest that CMS consider other ways to assist practices in improving quality instead of relying solely on the performance threshold. For instance, CMS could collaborate with stakeholders including measure developers to phase in new measures that address critical gaps in specialty performance. CMS could also broaden the definition of allowable measures to think creatively about what constitutes quality for different specialties and different practices within a specialty. These strategies would be more likely to drive real quality improvement than simply raising the performance threshold.

  We also suggest that CMS consider all aspects of the program when setting the performance threshold. This includes changes such as the introduction of new MVPs, significant changes to most or all existing MVPs, or a move to make MVPs mandatory. As the program evolves, it will be important that clinicians can focus on understanding and evolving their practices towards the new paradigm rather than focusing on a changing performance threshold. Also, significant changes to the program may necessitate re-evaluation of performance and we recommend stability for several years after any change to generate sufficient data for assessment prior to subsequent changes.

ADVANCED APMS
QP Determinations

Individual QP Determination
As background, the CAP supports efforts to increase specialist participation in APMs, especially

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Advanced APMs. The transition to value-based care is critical for the entire healthcare system. However, we continue to stress that the development of any APMs must be done in consultation with those specialties impacted by the models. Not only have models been developed by the Center for Medicare and Medicaid Innovation (CMMI) that dramatically change providers' clinical decision-making without considering the input of those specialties, but CMMI has not tested as proposed any specialist-developed APMs recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was meant to provide an important opportunity for specialists to develop their own models and submit them for review and recommendation. More innovative payment and delivery models must be developed in an open and transparent fashion with the input of those specialties impacted by the models.

As noted by CMS, the CAP and other stakeholders have previously expressed concerns about moving solely to a system of individual Qualifying APM Participant (QP) determination. When proposed in the CY 2024 proposed rule, there was no data available regarding effects on physicians across specialties and APMs. We also had concerns regarding the increased burden and administrative infrastructure that could be necessitated by such a change. Also, we were concerned that the proposed change to individual QP determinations does not consider the breadth of roles and responsibilities of clinicians within an APM and instead goes against the idea of team-based care.

However, we also strongly agreed that it is not beneficial for an APM Entity to exclude certain specialists. Specifically, a provider who is not furnishing direct services may be making other important contributions to practice such as consultation or training of new clinicians. The CAP supports team-based care. The idea that APM Entities may be removing specialists from their rolls because some specialists do not bill evaluation and management codes and therefore do not add to the total number of attributed beneficiaries, is problematic. Furthermore, the increase in specialty models presents more opportunities for specialists to participate in APMs even if the APM Entity does not achieve full QP status. We now believe that the proposal to continue making QP determinations at the practice level as well as the individual NPI level maximizes the chance for clinicians to participate in APMs. Therefore we support this proposal, in combination with the proposed changes to the definition of attribution-eligible beneficiaries (see below).

Attribution-eligible Definition

As mentioned above, the CAP is supportive of opportunities for more clinicians to participate in APMs. This is especially relevant for pathologists, who do not have a dedicated APM and who apply their expertise to the diagnosis and management of a wide variety of medical conditions and thus are integral to any care coordination initiatives. It is imperative that they are recognized in APMs and not disenfranchised from participation in the value-based care.

The current definition of attribution-eligible beneficiaries for the majority of models excludes pathologists and other specialists who do not regularly bill evaluation and management codes. While

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a small number of models use alternative definitions of attribution-eligible beneficiaries, that set has been limited. This narrow definition can lead to devaluation of team-based care and of specialty services. To increase participation in value-based care, **we therefore support CMS' proposal to modify the criteria of "attribution-eligible" to include any beneficiary who received a covered professional service furnished by the eligible clinician for whom the QP determination is being made**. Additionally, we encourage CMS to consider other substantial efforts to increase options for specialist participation in Advanced APMs.

The College of American Pathologists appreciates the opportunity to provide comments on these important issues and thanks you for your consideration. Questions regarding items 1–6 may be directed to James Carver (jcarver@cap.org) or Todd Klemp (tklemp@cap.org), and questions regarding QPP matters may be directed to Colleen Skau (cskau@cap.org).

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