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Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov

RE: 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 (CMS-1832-P)

Dear Administrator Oz,

The American Urological Association (AUA) appreciates the opportunity to provide comments on the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule (CMS-1832-P). The AUA is a globally engaged organization with more than 24,000 physicians, physician assistants, and advanced practice nursing members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 17,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research, and the formulation of health policy.

The AUA respectfully submits comments to the Centers for Medicare & Medicaid Services (CMS) on the following provisions of the proposed rule:

- Conversion Factor Update
- Proposed Valuation of Specific Codes for CY 2026
- Updates to the Practice Expense (PE) Data Collection and Methodology and Updates to the PE Methodology
- Proposed Efficiency Adjustment
- Strategies for Improving Global Surgery Payment Accuracy
- Quality Payment Program Proposed Provisions

PROPOSED VALUATION OF SPECIFIC CODES FOR CY 2026

The AUA is pleased to see CMS' acceptance of the RUC-recommended values for most urology CPT codes surveyed during this cycle. This alignment with the RUC recommended work and practice expense values for several new and revised urology codes without CMS refinement reinforces the integrity of the RUC process. The AUA would like to comment on four of the codes CMS proposes revisions to.

CPT Code 52649 – Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)

CMS disagrees with the RUC recommended work RVU of 14.56 and proposes an RVU of 13.00 instead, based on a crosswalk to CPT code 53500 *Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (for example,postsurgical obstruction, scarring* (work RVU = 13.00, 90 minutes intra-service time and 289 minutes total time). CMS believes that the RUC-recommended work RVU of 14.56 is too high and should be lowered due to the decrease in intra-service time of 30 minutes (from 120 minutes to 90 minutes), and the decrease in total time by 16 minutes (from 279 minutes to 263 minutes).

The RUC notes that the 30-minute decrease in intra-service time from when this was last surveyed in 2010 has likely occurred due to the diffusion of skilled surgeons performing this procedure nationally. Utilization of this code has increased substantially over the past ten years as increasing surgeon skill has allowed for the treatment of larger prostate glands with laser enucleation of the prostate. Studies have demonstrated improved voiding outcomes for patients with prostates greater than 100 grams undergoing laser enucleation compared to other bladder outlet procedure options. The increase in size of the typical prostate being treated with laser enucleation has led to a significant increase in procedural intensity.

CPT code 52649 involves laser enucleation to remove a majority of the patient's prostate adenoma from the inside out, as opposed to the other procedures in this family. The concern for rectal injury caused by posterior perforation of the capsule is significantly higher, due to the inside-out approach that occurs with laser enucleation of the prostate. This approach allows a greater amount of prostate tissue to be removed but significantly increases the difficulty and intensity required to perform CPT code 52649 compared to the other codes within this family.

The use of laser enucleation to remove larger gland's adenoma has led to the use of intraoperative morcellators, which are passed transurethrally, to remove the significant volume of prostatic tissue, without having to make an open suprapubic incision. While this avoids an open incision for the patient, this means passing a rotational sharp-bladed device transurethrally and utilizing skill and effort to morcellate the prostatic tissue intravesically, without injuring/morcellating the bladder wall. This adds another layer of intensity.

Therefore, the **AUA believes the current value of 14.56 appropriately values this service using magnitude estimation compared to services within this family.**

CPT code 53500 is not an appropriate crosswalk given significant differences in procedural intensity between 53500 and 52649. CPT code 52649 is much more intense and complex to perform since it requires careful preservation of the prostatic capsule and bladder neck to prevent the formation of recto-urethral fistulae and bladder neck injury resulting in significant patient morbidity. In addition, it can require intravesical morcellation of the prostatic adenoma. 52649 is a significantly more intense procedure than 53500. A recently published peer-reviewed study of complication rates in 206 patients undergoing holmium laser enucleation of the prostate (CPT 52649), demonstrated a 5.2% major complication rate. Mean prostate volume in this study was 82.7grams[1].

53500 is performed through an open transvaginal incision. Visualization is typically far superior when performing 53500 compared to 52649 given the narrow field of view that exists when performing 52649 as the cystoscope is used to create a plane between the prostatic adenoma and prostatic capsule. 53500 is performed through an open transvaginal incision allowing far greater surgical control and visualization. There is also no component of tissue morcellation with a rotational sharp-bladed device at all in 53500. Recent published literature describing complication rates for CPT 53500 states, "Possible complications such as bleeding, urethral, or bladder injury have been discussed. If hemostasis is difficult to obtain despite prolonged manual pressure, the procedure should be completed as quickly as possible and vaginal packing placed. Repair of lacerations should be performed at the time of recognition[2].

The AUA urges CMS to accept the RUC recommended work RVU of 14.56 for CPT code 52649.

CPT Code 558X2 – Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes

CMS disagrees with the RUC's direct crosswalk code CPT code *27059 Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater* (work RVU= 29.35, intra-service time of 220 minutes) and instead proposes to use direct crosswalk code 50543 *Laparoscopy, surgical; partial nephrectomy* (work RVU= 27.41, intra-service time of 240 minutes). However, the AUA supports the RUC crosswalk to 27059 for code 558X2. 558X2 is clinically intense as patients undergoing 558X2 have more advanced prostate cancer compared to patients undergoing 55866 or 558X1. Nomograms are utilized to determine the necessity of node dissection for prostate cancer patients so patients undergoing this most complex prostate cancer surgery have disease advanced enough to require full pelvic lymph node dissections to achieve optimal cancer control. Prostate cancer has also experienced stage migration in the past fifteen years based on changes in recommendations regarding PSA screening and the increased utilization of active surveillance for low-risk prostate cancer patients. This has also led to 558X2 being performed on higher risk patients with more advanced disease than was previously typical.

[1] Deuker, Marina et al. (2020). Holmium laser enucleation of the prostate: efficacy, safety and preoperative management in patients presenting with anticoagulation therapy. *World J Uro*l,39(4):1219–1226. doi: 10.1007/s00345-020-03272-2

[2]Gleich, Lauren et al. (2024) Urethrolysis. *Neurourology and Urodynamics.* https://doi.org/10.1002/nau.25387

558X2 is a surgery that involves not only removal of an organ (prostatectomy), it also involves a comprehensive lymph node dissection. This means additional efforts to dissect around the obturator nerve, iliac vessels, and along the aorta itself, to comprehensively remove these lymph node packets. These are different surgical spaces throughout the pelvis and lower abdomen, different from the deep pelvis from site of prostatectomy. **The AUA urges CMS to accept the RUC recommended crosswalk of 27059 for 558X2 with a work RVU of 29.35.**

CPT Code 55867 – Laparoscopy, surgical prostatectomy, simple subtotal (including robotic assistance, if performed)

The AUA is appreciative of CMS' acceptance of the direct PE inputs for this code family and agrees with CMS' proposed correction for the bundled post-operative office visits. The AUA concurs that CPT code 55867 includes one 99214 visit and one 99213 visit; this is the only code in the family that does not include two 99214 visits, and this distinction is clinically appropriate. CPT code 55867 is not performed for prostate cancer but for benign indications. As such, the patient population and post-operative care differ significantly. **The AUA agrees with the proposed PE changes and the resulting changes to the work for CPT Code 55867.**

CPT Code 52XX2 – Cystourethroscopy with initial transurethral anterior prostate commissurotomy with non-drug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed

The AUA requests the reconsideration of the following PE inputs for CPT Code 52XX2:

- ***CA023 (Clinical Staff Time – 5 minutes of non-multi-tasking monitoring):***
  CPT 52XX2 is an invasive cytoscopic procedure for the treatment of benign prostatic enlargement, comparable to CPT 52441 as indicated by survey respondents as the key reference code. The typical patient requires close monitoring for bleeding, uncontrolled pain, and other complications in the immediate post-operative period when performed in the non-facility setting. Given the elderly patient population typically undergoing this procedure, vital signs monitoring is especially important. During this period, clinical staff cannot perform other tasks. **Five minutes of non-multi-tasking monitoring time is therefore justified and should be included**. This occurs prior to the monitoring described in CA022 and should have been more clearly articulated in the non-facility PE summary of recommendations.

- ***CA025 (Equipment Cleaning – Additional 10 minutes):***
  We request CMS maintain the additional 10 minutes above the standard 30-minute cleaning time to reflect the dual equipment use during this procedure.
  CPT 52XX2 requires use of both a transrectal ultrasound (TRUS) probe and a cystoscope. The TRUS probe remains in place throughout the procedure and requires the standard 10 minutes of cleaning. The cystoscope also requires the standard 30 minutes of cleaning. Thus, the additional 10 minutes reflects clinically accurate resource use. This rationale also addresses ES031 and ES018, as the additional cleaning time is directly tied to the second scope used.

- ***SM022 (Sanitizing Wipes – Surfaces/Equipment):***
  SM022 is appropriately included for surface and equipment cleaning at the conclusion of the procedure and therefore should be retained as a PE input. Four sanitizing wipes are required to wipe down all surfaces and equipment involved in care delivery, including the patient bed, equipment tables, and ultrasound equipment.

- ***SM021 (Sanitizing Wipe – Patient):***
  In addition to the five wipes already included in the standard cystoscopy pack for patient cleaning, one additional wipe (SM021) is required for this service. This is due to the need to insert a transrectal ultrasound probe, which requires cleaning of the peri-rectal area. This step is not typically required for standard cystoscopy procedures and should be included as a PE input.

We appreciate CMS' efforts to ensure that PE inputs accurately reflect the clinical realities of these services. The adjustments outlined above are critical to ensure that the valuation of CPT 52XX2 reflects the actual resource costs of performing the service.

CONVERSION FACTOR UPDATE

CMS proposes two separate conversion factors for CY2026. The first conversion factor will increase to $33.59, an increase of 3.83%, for practitioners in a qualifying advanced Alternative Payment Model (APM). The second conversion factor will increase to $33.42, an increase of 3.62%, for practitioners not participating in a qualifying APM. These increases reflect the statutory updates included in the *Medicare Access and CHIP Reauthorization Act* and the 2.5% increase to the 2026 conversion factor included in the reconciliation package recently adopted by Congress. **While the AUA is pleased to see an increase in the conversion factor and supports the incentive for providers to participate in APMs to promote value-based care, the AUA urges CMS to reconsider other proposals in the rule that would negate the increases to the conversion factor.** Consistent reductions in the conversion factor in prior years and budget neutrality offsets already contribute to the financial uncertainty for specialty practices. We remain concerned that the proposed PE methodology and efficiency adjustments will further erode stability in the MPFS, and potentially limit Medicare beneficiaries' access to medically necessary urologic services.

UPDATES TO THE PRACTICE EXPENSE (PE) CALCULATION, DATA COLLECTION AND METHODOLOGY

CMS is proposing a new indirect practice expense (PE) calculation with a site of service payment differential for CY2026 which will negatively impact physician payment despite the proposed update to the conversion factor. Additionally, CMS is proposing to not use the American Medical Association's (AMA) Physician Practice Information Survey (PPIS) data for 2026 rate setting. CMS is instead maintaining current PE per hour (PE/HR) data and cost shares due to the low response rates and lack of representativeness in the PPIS survey. The PE/HR will remain at 2017 levels for 2026.

The AUA has significant concerns with this proposal. While we understand CMS' rationale for the shifts in physician employment and the distribution of practice costs, the proposal does not accurately reflect the realities of actual practice.

CMS's proposal to change the methodology for the allocation of indirect PE within the physician payment formula will negatively impact urologists. Facility-based services will have their indirect PE allocation based on work RVUs reduced to half the amount allocated to non-facility PE RVUs if this proposal is finalized. This proposal assumes that more physicians are hospital-employed and therefore incur lower indirect practice expenses, such as costs for rent, utilities, and administrative staff. While more physicians are employed by hospitals, this generalization risks disadvantaging independent physicians who continue to incur overhead costs even when practicing in hospital settings. The non-facility practices continue to be responsible for rent, staffing, and administrative overhead even while physicians are operating in a hospital. Additionally, many urologists bill from both facility and non-facility settings Additionally, some urologists are employed by hospitals that maintain both facility-based and non-facility-based clinics, and pay rent to the hospital, further complicating how indirect costs are distributed.

We are also concerned that the data supporting this proposal may not accurately capture current trends in physician practice. Rapid consolidation and acquisitions by private equity, for example, mean that data can become quickly outdated. Additionally, many employers struggle to classify sites as "facility" or "non-facility," making this proposal difficult to implement if finalized.

The AUA urges CMS to consider collecting empirical data to inform any changes to the indirect PE methodology to ensure its policy is evidence-based before implementation. Delaying these changes for at least one year will allow for refinement of this methodology and collection of relevant data to support a revised proposal. Considering the impact of this proposal on access and stability of physician practices is critical before finalizing a methodology change such as this. However, if CMS chooses to finalize this proposal, the AUA recommends reducing the adjustment to 25% to limit negative impacts on physicians or implementing a stratified approach based on employment status.

PROPOSED EFFICIENCY ADJUSTMENT

CMS is proposing an efficiency adjustment (payment cut) to improve the accuracy of work RVUs and intraservice physician time estimates for non-time-based services. The agency believes that the current valuations and valuation process do not account for efficiency gained over time. The efficiency adjustment of -2.5% will be applied to nearly all services on the MPFS including procedures, radiology services, and diagnostic tests. The AUA disagrees with CMS' proposed efficiency adjustment, which will be applied broadly to all work RVUs and intraservice times for non-time-based services. CMS cites productivity adjustments within the Medicare Economic Index (MEI) as justification; however, this sweeping reduction is arbitrary and does not reflect the complexity of physician work.

The RUC currently accepts the 25th percentile for intraservice time for many procedures that are newly valued or recently revalued. Using the 25th percentile instead of the median automatically incorporates time adjustments that would be further decreased by this proposal. Additionally, not all procedural minutes are created equal. These adjustments do not account for the reality of

surgical practice. Physician work encapsulates stress, intensity, complexity, and risk. Cases are becoming increasingly complicated and workforce changes such as retirement of experienced surgeons and the entry of newer physicians' efficiency in ways not captured by a universal cut. Lastly, the surgical learning curve is not consistent across procedures and all procedures cannot be judged equally based on intraoperative time. For example, robotic prostatectomy and robotic partial nephrectomy typically require 50-60 cases to achieve proficiency, while cystoscopy, hydrocele repair, cystolitholapaxy, and vasectomy require only 10-15 cases. The current definition of "time" in this proposal also excludes pre- and postoperative activities that contribute to long turnover times in between cases; the efficiency adjustments only impact physicians and disproportionately so. Lastly, surgical excellence should not be equated with speed. Quality outcomes for the patient require judgment, attention, and learning, which are not captured in this approach.

While the AUA urges CMS not to implement this proposal, if CMS opts to implement this proposal, the AUA requests that codes valued within the last ten years be exempted from this adjustment. CMS should also consider delaying implementation until inclusive and robust data sources are available. The AUA recommends a more nuanced approach to measuring physician efficiency, including new data sources on physician time and studies that consider studies that account for all phases of care, not just intraoperative time.

STRATEGIES FOR IMPROVING GLOBAL SURGERY PAYMENT ACCURACY

CMS continues to express concern about the accuracy of post-operative visits included in the valuation of 10- and 90-day global surgical procedures. The AUA cautions against undervaluing post-operative work, especially time spent outside of face-to-face visits. Patient communication has grown more complex with physicians frequently managing post-operative care through the patient portal, emails, and phone calls. For example, many spend about two hours per week on portal messages, and some urologists report receiving 30 or more messages per week or 50 or more inbox items per day. these communications have enabled patients to manage their healthcare effectively. These interactions increase the workload for urologists and are not fully captured in the global periods and existing E/M codes. CMS is also concerned about "double payment" with the current global surgery payment model. However, transfer of care modifiers, (e.g., -55) exist to address these situations. **The AUA encourages CMS to focus on providing better education to ensure appropriate use of modifiers and analyze claims data to determine the prevalence of these situations before implementing broad policy changes that could harm urologists and patient access to urologic care. CMS should also acknowledge and reimburse the time required to manage electronic communication, as patients now expect immediate responses; doing so would more accurately reflect modern care.**

SOFTWARE AS A SERVICE (SaaS) AND ARTIFICIAL INTELLIGENCE TOOLS

CMS is requesting feedback on how to consider paying for software as a service (SaaS) due to the rapid development in the use of software-based technologies to support clinical decision-making in the outpatient and physician office setting. The AUA appreciates the opportunity to comment on how these tools should be valued under the MPFS and urges CMS to approach the valuation process

with caution to ensure that policies reflect both the realities of clinical practice and the need to preserve physician oversight of patient care.

Currently, costs affiliated with technology use are not incorporated into PE methodology. While SaaS tools may improve physician workflow, they do not eliminate the physician's responsibility to interpret results and integrate them into patient care. Even with software support, a physician is still responsible for clinical decision-making and therefore these tools do not reduce the level of expertise, judgement, or liability required from the physician.

Additionally, the use of such technologies is still relatively limited, and there is insufficient evidence of consistent clinical benefit across specialties. **CMS should ensure that the clinical literature demonstrates measurable improvements in outcomes, efficiency, or patient access before incorporating new reimbursement streams. Lastly, if adopted, the use of SaaS products in patient care and clinical decision making should be accounted for as part of the PE of the service not as a separate reimbursable service.**

QUALITY PAYMENT PROGRAM PROPOSED PROVISIONS

Performance Threshold

CMS has proposed maintaining the MIPS performance threshold at 75 points for the next three years (i.e., for performance year (PY) 2026-PY2028). **The AUA strongly supports this proposal** and appreciates the predictability and stability this will provide for program participants.

MIPS Performance Categories

QUALITY

CMS has proposed removing QPP487 (Screening for Social Drivers of Health) and QPP498 (Connection to Community Service Provider) from the MIPS quality measure inventory. Given the well-known impact of social factors on both individual and population health outcomes (e.g., higher risk of post-operative complications after minimally invasive radical prostatectomy), and the utility of these measures for identifying and evaluating needed improvements in care delivery, **the AUA strongly disagrees with their removal from the MIPS program**. We continue to believe clinicians should have maximum flexibility to select and report measures they believe will most effectively lead to improved care outcomes for the patients and families they serve. **Rather than decreasing burden of measurement, removal of such measures (or other reliable and valid measures, simply because they are process measures or do not meet evolving definitions of "high priority") increases burden when clinicians must then collect data and report measures that do not reflect their patient populations and practice patterns or support their quality improvement goals.**

CMS also has proposed aligning the scoring methodology for administrative claims-based quality measures with that used for cost measures. The new methodology, which would be applied beginning in PY2025, would be based on the standard deviation, median, and an achievement point value derived from the performance threshold. Using data from PY2024, CMS estimated that this change would have increased the average quality performance category score by more than 3.5 points. The AUA appreciates CMS's consideration of the shortcomings of the current scoring

approach for claims-based quality measures and the resultant proposal that addresses the issue and increases consistency in its scoring approaches across performance categories. Accordingly, **we strongly support this proposed change**.

Cost

Under its current process, CMS assesses performance on all cost measures attributed to MIPS participants. However, for new cost measures, participants do not receive performance information until approximately midway through the second year of use. To help address this lack of timely and actionable information, CMS has proposed implementing a two-year, information-only feedback period for newly implemented MIPS cost measures beginning in PY2026. If finalized, new cost measures would not be used to calculate cost-category or final MIPS scores (or in associated payment determinations) until the measures' third year in the program. However, CMS would provide the score and other performance feedback to participants on an annual basis during the informational-only feedback period. The AUA agrees that offering an information-only feedback period will allow time for clinicians to understand their potential for attribution to new cost measures, become familiar with new cost measures, provide feedback on measure functionality, if needed, and develop performance improvement strategies as needed. As such, **we support the 2-year information-only feedback period for new cost measures**. We also strongly encourage CMS to move toward provision of more frequent and meaningful performance feedback for all cost measures.

The Total Per Capita Cost (TPCC) measure assesses overall cost of care and is intended to focus on the primary care patients receive from their provider(s). Urology is one of the many specialties that technically is excluded from the measure. However, various medical specialty societies have argued that the measure's current methodology has resulted in inappropriate attribution, with potential attendant negative scoring and payment repercussions. CMS has proposed modifying the TPCC attribution methodology beginning in PY2026 by excluding events initiated by advanced care practitioners (ACPs) such as nurse practitioners and physician assistants, if all other non-ACPs in their group are excluded due to their specialty, and by requiring second candidate events to be an evaluation and management ("E/M") or other related primary care service billed by a non-excluded clinician (such as ACPs). **The AUA believes these changes will alleviate some inappropriate attribution of this measure and therefore we support CMS's proposals. Moreover, we recommend that CMS apply these changes to the TPCC measure as of PY2025.** However, we are concerned that these changes alone are not sufficient, and **we encourage CMS to adopt additional revisions to resolve inappropriate attribution**. For example, it is our understanding that only a relatively small percentage of TINs with ACPs include excluded specialists only. Also, it is becoming increasingly more common for a urology practice to include a single medical oncologist to help provide care for patients with advanced urologic cancer. It is our understanding that in this scenario, ACPs—and the urology practice as a whole—likely would not be excluded from this measure, even though their work does not focus on primary care.

Improvement Activities (IAs)

CMS has proposed adding three new IAs, removing eight, modifying one, and reassigning six to other subcategories. CMS also has proposed removing the *Achieving Health Equity* subcategory and adding one new subcategory (i.e., *Advancing Health and Wellness*). The AUA believes that quality improvement efforts must be selected based on local circumstances and thus we support the

availability of a wide and varied IA inventory for MIPS participants to choose from. Moreover, we prefer inclusion of activities with empirical evidence of their ability to drive improvements in both healthcare and health outcomes. As such, **we generally support the addition of the three new IAs and the modification of the one** (although we note that CMS's rationale for the new IA related to documenting AI-attributable patient safety events is pragmatic rather than evidence-based). Similarly, we do not support the removal of IAs when there is evidence—direct or indirect--linking them to desired health outcomes. **We specifically question the removal of IA_AHE_5 (MIPS Eligible Clinician Leadership in Clinical Trials or CBPR), IA_AHE_9 (Implementation Food Insecurity and Nutrition Risk Identification and Treatment Protocols), and IA_AHE_12 (Practice Improvements that Engage Community Resources to Address Drivers of Health),** as CMS has not provided information regarding the underlying evidentiary support or lack thereof**. We urge CMS to keep these measures in the IA inventory if sufficient evidence regarding linkage to desired outcomes exists.** If removal is finalized nonetheless, in the interests of transparency, we ask CMS to explicitly state in the final rule whether or not there is lack of empirical evidence linking these activities to improved care/outcomes. We encourage additional transparency by requesting that CMS publish information regarding the strength of the evidence linking IAs to desired health outcomes when proposing removals in future years.

Promoting Interoperability (PI)

CMS has proposed several changes to the promoting interoperability category for PY2026. These include adding a second attestation to the security risk analysis measure (i.e., meaningful management of security risks rather than simply conducting a security risk analysis), requiring use of the 2025 version SAFER guidelines (rather than the 2016 version), adopting the Public Health Reporting Using Trusted Exchange Framework and Common Agreement™ (TEFCA™) measure as an optional bonus measure, and two measure suppression proposals (one regarding a new policy to take effect in PY2026 and the other to exclude the Electronic Case Reporting measure from MIPS scoring for PY2025). **The AUA supports all of these proposals**. We agree with the CMS stance regarding the need for vigilance and ongoing risk reduction activities to ensure that health information is adequately protected and secured. Additionally, we understand the 2025 version of the SAFER guidelines focuses on the highest risk, most commonly occurring issues that can be addressed through technology or practice changes. Regarding the inclusion of the TEFCA™ measure, we agree that standardization should eventually help to simplify and expand health information exchange for public health reporting and, moreover, we favor having options for reporting. However, we note that TEFCA reporting may impose integration costs on specialty groups who do not benefit directly from public health reporting and therefore we suggest CMS consider voluntary phase-in if the measure is mandated in the future. Regarding the measure suppression proposals, we agree that CMS should have the flexibility to suppress scoring for measures impacted by conditions beyond the control of MIPS eligible clinicians. We agree that the pause by the CDC in case reporting registration and onboarding of new health care organizations provides an example of such, and therefore we agree the Electronic Case Reporting measure should not be included in PY2025 scoring, even though MIPS participants must still continue to report the measure.

MIPS Value Pathways (MVPs)

SUBGROUP REPORTING

CMS previously finalized that, beginning in PY2026, multispecialty groups will no longer be able to report an MVP as a single group, meaning that clinicians in such groups must report either an MVP as an individual or as a subgroup (although group reporting via traditional MIPS is still an option). However, in the current proposed rule, CMS has suggested relaxing the mandatory subgroup reporting requirement for small practices. Specifically, CMS has proposed that multispecialty groups designated as a small practice (i.e., with 15 or fewer eligible clinicians) will not be required to divide and report as subgroups and can continue to report an MVP as a single group. **Because we agree that subgroup reporting by small practices may not make sense clinically, may limit ability to meet case minimums for certain measures, and may dis-incent small practices from reporting via MVPs, the AUA strongly supports this proposal**.

However, given the limited availability of subspecialty measures within many MVPs, as well as the complexities associated with subgroup formation, **we once again urge CMS to revise its policy for mandatory subgroup reporting for all multispecialty groups**. Instead, CMS should continue its promotion of voluntary subgroup reporting, as reasonable, at least until all MVPs are robust enough (e.g., in terms of having enough measures worth an adequate number of points) to support subgroup reporting and the many challenges related to subgroup formation have been addressed. **Moreover, the AUA strongly urges CMS to reconsider its plan to sunset traditional MIPS and fully transition to MVPs, particularly as early as PY2029**. We believe that current MVPs do not include a sufficient number of benchmarked quality measures to adequately reflect care provided by specialists and subspecialists, nor do they include a sufficient number of relevant cost measures. In addition, we believe the ability to develop and test new measures (for potential future inclusion in MVPs) will become more difficult and costly if traditional MIPS is sunset.

SINGLE AND MULTISPECIALTY DEFINITION AND SELF-ATTESTATION

CMS previously finalized that clinician groups would be designated by CMS as multi- or single-specialty, based on Medicare Part B claims. However, CMS has since discovered difficulties in accurately identifying the specialty composition of groups based on claims data and, consequently, has postponed its decision to use claims data for this purpose. Consequently, CMS has proposed modifying the definition of single- and multi-specialty groups and allowing self-attestation. Specifically, a single-specialty group would be defined as a group that *consists of clinicians in one specialty type or clinicians involved in a single focus of care*, while a multi-specialty group would be defined as a group that *consists of clinicians in two or more specialty types or clinicians involved in multiple foci of care*. Further, CMS has proposed that multispecialty groups attest to its designation as a group that meets the requirements of a single specialty group, or as a multispecialty group that meets the requirements of a small practice, if appropriate, during the MVP registration process, beginning in PY2026. **Because we agree with the concept that "single specialty" should also reflect the clinical focus of a practice (not just the specialties of its clinicians) and we believe clinicians are best equipped to identify their practice's composition and focus(es) of care, the AUA generally agrees with CMS's recommendations on this topic.** However, we suggest the definitions of single- and multi-specialty groups be tightened a bit to ensure they are truly mutually exclusive.

SCORING FOR TOPPED-OUT MEASURES

Beginning in PY2025, CMS finalized an alternative scoring methodology for certain topped-out measures in CMS-defined specialty sets where measure choice is limited and thus meaningful participation in MIPS is at risk. For PY2026, CMS has proposed extending this alternative scoring methodology by applying the same analysis and finalized criteria to MVPs as well as to specialty measure sets. **We agree with this proposal, as we believe scoring rules for MVPs and traditional MIPS should be consistent**. **Additionally**, **we strongly urge CMS to apply this revised scoring methodology to QCDR measures in MVPs**. QCDR measures meet the same evidentiary and scientific requirements of other measures in the program and thus should not be treated differently in this regard. However, **we also strongly encourage CMS to re-evaluate its strategies regarding benchmarking and topped-out measures more broadly**, given that many measures likely only appear to be topped out due to the reporting incentives inherent in the MIPS program.

THIRD PARTY INTERMEDIARY SUPPORT OF NEW MVPS

In previous years, CMS finalized the rule that qualified clinical data registries (QCDRs) and qualified registries (QRs) must support MVPs that are applicable to the participants on whose behalf they submit MIPS data. The expectation has been that this support must commence during the first year of a new MVP's approval for the program. However, CMS has recognized that the timeframe for this implementation (i.e., generally two months) can be problematic or even infeasible (e.g., when licensing of QCDR measures is required but the process is lengthy). Thus, beginning in PY2026, CMS has proposed allowing QCDRs and QRs up to one year after a new MVP has been finalized before being required to fully support that MVP. **The AUA appreciates CMS's recognition of the challenges of short-turnaround implementation and therefore we support CMS's proposal to allow more time for full MVP implementation**.

OPTIMAL CARE FOR PATIENTS WITH UROLOGIC CONDITIONS ("UROLOGY") MVP

For PY2026, CMS has proposed removing one quality measure and three IAs from the Urology MVP. **The AUA opposes the removal of quality measure QPP487** (*Screening for Social Drivers of Health*) **and IA IA_AHE_12** *(Practice Improvements that Engage Community Resources to Address Drivers of Health),* for reasons noted in the above sections on the quality and IA performance categories. **We also disagree with removing IA_PSPA_19** *(Implementation of formal quality improvement methods, practice changes, or other practice improvement processes)*. We believe inclusion of this IA in the Urology MVP is warranted because—as stated by CMS itself earlier in the proposed rule—it "allows for significant flexibility in the focus area of the quality improvement completed". By extension, we believe inclusion of this IA will make it easier for MIPS participants to work on activities that can directly improve patient outcomes (thus adhering to CMS's stated priorities and intent for IAs). However, **we agree with removal of IA_PM_26** (Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B), as we prefer the IAs in this MVP to be clinically relevant to care provided by urologists and align more closely with the quality measures included in the MVP.

Regarding the reformatting of the MVP tables, we recognize that stratifying the quality measures in MVPs by clinical condition/episode of care can be helpful and we like the inclusion of the outcome/high priority flags. However, we believe repeating the cost measures in the last column is confusing because it implies that some cost measures may not be scored for participants who do

not submit linked quality measures, even though such measures may be attributed to them. For the Urology MVP, we suggest that measures for conditions within clinical groupings be grouped as appropriate. For example, in the Urological Cancer grouping, it is confusing to have prostate cancer measures "intermixed" with bladder cancer measures and therefore CMS should list the prostate cancer measures first, then the bladder cancer measures (or vice-versa). More importantly, CMS should **move measure QPP476** (Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia) from the Urological Cancer grouping to the General Urology grouping, because, by definition, benign prostatic hyperplasia (BPH) is not cancer (and BPH does not put men at risk for prostate cancer).

RFI: Core Elements in MVP

CMS is considering designating a subset of quality measures within each MVP as "core elements" and requiring MVP participants to report at least one of those measures. The rationale for such a policy is the desire to "*emphasize and increase reporting on select quality measures that are most important to clinicians and patients and reflect care that is at the crux of the MVP's applicable specialty, medical condition, or episode of care*", and in so doing, better support patient choice. CMS has noted that such "core elements" might include measures from the "Advancing Health and Wellness category grouping. CMS also has acknowledged that some clinicians may not have an applicable core element due to "*existing quality measure gaps for certain specialists and subspecialists*".

The AUA strongly disagrees with mandated reporting of "core elements" within MVPs. First, MVPs **by design** already include a subset of quality measures that are relevant and meaningful for the specialty or condition, which can be considered "foundational measures" for that specialty or condition. Second, over time, as MVP reporting becomes more common, sufficient comparative performance data will become available for many of the measures included in MVPs **without needing to mandate reporting of specific measures**. Third, it is likely that for most MVPs, **only cross-cutting measures** would be applicable for a majority participants reporting a particular MVP and thus practical candidates as "core elements"—yet these generally are not the measures that are most relevant to the care provided by MVP participants. Fourth, we believe such a change will simply **complicate the MVP reporting process, make it even more confusing for participants, and discourage voluntary MVP reporting**, as well as being a departure from traditional MIPs, when consistency has been a goal. Fifth, **we want MIPS participants to use and report on measures that are most relevant to their own improvement needs**. Mandating reporting of a specific measure would take away that flexibility and **impose opportunity costs and burden** by shifting focus from other needed measurement and improvement activities. Finally, we have **concerns about the fairness** of mandating reporting of specific measures and agree that some clinicians will be disadvantaged more than others (in fact, per the above, we believe that clinicians **without** a "core element" would have the advantage).

For the Urology MVP, there is only one measure in the Advancing Health and Wellness category (i.e., screening for future fall risk). While we think this is an important measure for urology and agree with its inclusion in the MVP, **we do not think it reflects "care that is at the crux" of urologic care, nor do we think results on this measure would meaningfully enhance patient choice**. Of the remaining measures in the Urology MVP, most are not applicable for all urology care providers, particularly at the individual level and thus would not serve as a "core element" (e.g., many who provide cancer care do not focus on stones and vice-versa). In fact, we think only the CAHPS

measure would be both applicable to most urologic patients and providers and help support patient choice. However, this measure is quite burdensome for clinicians to employ and is available for group reporting only, which limits its utility as a "core element".

RFI: Procedural Codes for MVP Assignment

CMS is also considering using Medicare procedural codes to assign providers to a particular MVP or even to mandate reporting of specific measures within an MVP. **The AUA strongly disagrees with these potential changes for reasons four, five, and six noted in the above section on "core elements".** We believe clinicians themselves are the ideal source for deciding which MVP to participate in, as they know their own patients, care processes, improvement needs, and reporting capacities best. Such changes would further complicate the program and add to clinician burden without attendant improvement in care quality. CMS could help encourage specialty reporting of MVPs by providing financial support to specialty societies and others to develop relevant and useful measures and by including a variety of measure types, topics, and data collection modalities within MVPs.

RFI: Query of Prescription Drug Monitoring Program (PDMP) Measure

CMS has asked for feedback on potentially changing the "Query of PDMP" measure in the Promoting Interoperability performance category from an attestation-based measure to a performance-based measure (i.e., reporting a numerator and a denominator) and expanding the types of drugs to which this measure would apply (i.e., all Schedule II drugs rather than only opioids). The AUA appreciates CMS's desire to promote patient safety via the PDMP pathway. However, we believe that even large practices will encounter staffing and other resource challenges in providing numerator and denominator information and would require adequate time to meet the measure if these updates are implemented. We suggest CMS work with a few varied practice types (including small and rural practices as well as larger practices in both community and academic settings) in a "pilot" to better understand the barriers to successful implementation of both numerator/denominator reporting and expanded Schedule II reporting and to inform questions related to risk and potential exclusions. Once barriers and potential solutions are better understood, we recommend a 2-3 year on-ramp, at minimum, for full implementation. However, we also recommend adding two new bonus/optional measures for those providers who can more quickly expand reporting and can report numerator/denominator results.

RFI on Transition Toward Digital Quality Measurement

CMS continues to promote the transition to digital quality measurement (dQM) and has invited specific feedback on use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting. The AUA agrees with the overall promotion of dQM using consensus-based standards such as FHIR and the QI-Core Implementation Guide and we recognize and appreciate the progress thus far in areas related to availability of core data elements and tools to support eCQM development and testing. However, we have several concerns. These include our belief that many EHR vendors currently meet only minimum interoperability standards and are not yet ready for full FHIR implementation. Also, we believe that two years would not be enough time for migration and certification of QI-Core based reporting of eCQMs, especially if such a timeline overlaps other substantive changes to MIPS participation (e.g., mandatory MVP reporting). More generally, we note the substantive investment

(e.g., in time, training, etc.) that will be required for entities such as QCDRs to meet eventual dQM goals, and our worry that such may be out of reach for some.

We are grateful to CMS for the opportunity to provide these comments on the CY2026 Medicare Physician Fee Schedule proposed rule and welcome the opportunity to continue to work together on these important policy issues. Please contact Bhavika Patel at bpatel@auanet.org with any questions.

Sincerely,

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