NATIONAL ACADEMY OF NEUROPSYCHOLOGY

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September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via Regulations.gov

Re: Medicare and Medicaid Programs; CY 2027 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-1848-P]

Dear Administrator Oz,

On behalf of the National Academy of Neuropsychology (NAN), I appreciate the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule.

NAN is a professional organization representing approximately 4,500 professional and student members across 35 countries. Our members work in world-renowned hospitals, academic and governmental institutions, and are in private practice. Our mission is to advance the research and clinical care of brain conditions, educate professionals in the area of brain disease and brain health, and promote public understanding of brain health.

Neuropsychology is a specialized area of healthcare focused on assessing and treating the effects of brain and nervous system conditions that impact cognition, behavior, emotion, and everyday functioning. Neuropsychologists evaluate, diagnose, and develop treatment recommendations for individuals with neurological, medical, neurodevelopmental, and psychiatric conditions that affect the brain. Even in the absence of a diagnosed disease, neuropsychologists are well positioned to identify and address modifiable factors that can support and optimize brain health and cognitive functioning.

Neuropsychologists provide medically necessary services across the continuum of care. Their expertise includes differential diagnosis of dementia and other age-related neurological disorders; presurgical evaluation for conditions such as epilepsy and Parkinson's disease; assessment and treatment planning following traumatic brain injury and stroke; identification of learning and neurodevelopmental disorders in children; and evaluation and monitoring of cognitive changes associated with medical conditions, treatments, or other illnesses.

Neuropsychological evaluation provides clinically meaningful information that informs critical medical and functional decisions, including surgical candidacy, rehabilitation planning, treatment selection, return-to-work or school, and capacity or competency determinations. By distinguishing cognitive and behavioral changes attributable to neurological disease from those related to potentially modifiable medical, psychological, or lifestyle factors, neuropsychologists can help prevent unnecessary interventions, guide appropriate treatment, and facilitate earlier identification and management of conditions affecting brain health.

NAN also encourages CMS to undertake a broader review of the neuropsychological testing code family in future rulemaking, including the neurobehavioral status examination (CPT codes 96116, 96121), neuropsychological testing evaluation services (CPT codes 96132, 96133), and related testing administration and scoring codes. These services are highly specialized, time-based professional services that play a critical role in diagnosing cognitive impairment, dementia, neurological conditions, and other complex disorders, yet their valuations have not kept pace with comparable behavioral health services that have received targeted upward adjustments in recent years.

Conversion Factors (CF) and Need for Long-Term Medicare Physician Payment Reform

NAN is deeply concerned by the reduction in the Medicare Physician Fee Schedule (PFS) conversion factors (1.68% lower for Non-Qualifying APM and 1.19% lower for Qualifying APM than the comparable 2026 CFs) resulting largely from the expiration of the temporary congressional payment adjustment at the end of 2026. While CMS has limited authority over statutory payment updates, the proposed reduction underscores a broader and longstanding structural problem within the Medicare physician payment system—the absence of a stable, predictable, and inflation-adjusted framework for Medicare reimbursement.

For neuropsychologists, recurring reductions in payment create significant uncertainty and undermine the ability of clinicians and practices to maintain access to high-quality care for Medicare beneficiaries. Neuropsychological services are labor-intensive, highly specialized, and dependent on substantial clinical expertise. Practices face rising costs associated with personnel, compliance, technology, rent, and other operational expenses, yet Medicare payment rates have largely failed to keep pace with inflation. As a result, many providers are being asked to deliver increasingly complex care while operating under reimbursement levels that continue to erode in real terms.

The expiration of this most recent temporary congressional fix further highlights the unsustainable nature of relying on short-term interventions to avert scheduled payment reductions. Annual uncertainty surrounding the conversion factor impedes long-term planning, workforce development, and investment in patient care infrastructure.

NAN urges CMS to continue working with Congress and the provider community to identify and advance policies that promote long-term payment stability. As CMS evaluates future payment policies, NAN

encourages the agency to continue highlighting for policymakers the impact that declining inflation-adjusted physician reimbursement has on beneficiary access to care. Ensuring a stable and sustainable Medicare payment system is essential to preserving access to care for neuropsychology services.

RFI on Intensive Lifestyle Interventions to Slow Progression of Alzheimer's Disease

What are the essential domains to address in a multi-domain intensive lifestyle intervention to reduce the risk of cognitive decline for older adults at risk for developing AD/ADRD that would be appropriate to include under Medicare?

Essential domains that have considerable evidence supporting their efficacy as potentially playing a role in cognitive promotion and dementia prevention include physical activity/exercise, social engagement, intellectual engagement/hobby activity, adhering to a Mediterranean style diet, adequate sleep maintenance, and stress management. In addition, cultivating and maintaining a strong sense of purpose in daily life has been associated with a number of positive brain health outcomes.

Should these interventions be made available as a one-time service (that is, to teach older adults how to make changes in their lifestyle to help reduce AD/ADRD risk) or on a recurring (for example, annual) basis?

From a population health perspective, one-time services that inform older adults about evidence-based lifestyle changes that reduce dementia risk should be made available (e.g., presentations at local community centers), although recurring interventions would have a stronger impact in helping older adults adopt and sustain brain-healthy lifestyle changes over time.

Should the eligibility for these services be restricted to beneficiaries with a diagnosis of mild cognitive impairment (MCI), or early-stage dementia? If so, how should this diagnosis be made or confirmed?

These services should be made available regardless of presence or absence of a specific diagnosis, particularly given that proactive interventions may ultimately have the strongest impact on a broader population level. However, interventions designed for individuals with MCI or dementia would also be valuable at mitigating the impact of cognitive impairment, and potentially slowing progression of disease. Clinical neuropsychologists are the professionals of choice to diagnose cognitive disorders such as MCI and early-stage dementia based on use of comprehensive neuropsychological evaluations, which include extensive psychosocial interviews with patients and informants, thorough review of historical information/medical records, administration of comprehensive cutting-edge cognitive assessments, synthesis of all psychosocial and assessment data, and communication with patients and family members about complex cognitive profiles and evidence-based brain health lifestyle strategies.

Given ILI's are multi-domain, and likely include physical activity, nutrition, potentially additional domains such as sleep and stress management, who are the essential interdisciplinary team members that CMS should account for in developing appropriate resource costs for future services?

Clinical neuropsychologists are particularly qualified to provide ILIs/services to individuals in clinics and in communities around the country given their expertise in brain health, cognitive diagnostics, and behavioral interventions. Also important would be collaboration with allied colleagues such as primary care physicians, neurologists, geriatricians, physical and speech therapists, psychotherapists, and other professionals who can work with individuals on an ongoing basis to reinforce lifestyle interventions.

What is the minimum frequency of sessions for an AD/ADRD ILI per week? What is the minimum number of weeks that will be necessary?

This would again depend on level of cognitive impairment. For those with no impairment seeking to promote cognitive skills, research indicates that roughly 3–6 months of an exercise intervention (1-3 sessions/week) is associated with more persistent benefits for cognition. Individuals with documented impairment would require at least that much time for interventions to be effective. Guidelines are less clear for other lifestyle domains such as social engagement, consuming Mediterranean diets, and intellectual/hobby activity, although a minimum of 1x/week sessions over the course of several months would likely be necessary to ensure adequate adherence to new lifestyle changes and to increase the likelihood of cognitive and functional benefits from interventions.

Quality Payment Program (QPP)

Concerns Regarding the Proposed Sunset of Traditional Merit-based Incentive Payment System (MIPS) Reporting After 2028

NAN appreciates CMS' ongoing efforts to simplify quality reporting and reduce administrative burden within the QPP. However, we are concerned about the proposal to sunset traditional MIPS reporting after performance year 2028. While modernization of Medicare quality programs is an important goal, eliminating traditional MIPS pathways before viable and specialty-appropriate alternatives are fully available could have significant unintended consequences for neuropsychologists.

Neuropsychology practices are predominantly small and independent physician or psychologist-led practices that often lack the administrative resources, health information technology infrastructure, and organizational scale available to large health systems and integrated delivery networks. Transitioning to new reporting pathways before adequate alternatives are available may create additional reporting complexity and administrative burden rather than reducing it.

Once traditional MIPS reporting sunsets, participating providers will have to choose to participate in an advanced APM or a MIPS Value Pathway (MVP). NAN is concerned that neither of these options is viable for neuropsychologists. There are currently no APMs that are operational, broadly accessible, and appropriate for neuropsychologists. Alternatively, the neuropsychology MVP was just recently finalized in the 2026 PFS rule, giving practices a limited opportunity to gain experience within the MVP framework prior to CMS eliminating traditional reporting. Further, there remains very few neuropsychology-specific MIPS quality measures to report. NAN urges CMS to delay sunsetting traditional MIPS reporting until there is a more viable pathway for neuropsychologists.

Need for Specialty-Relevant Cognitive Health and Dementia Quality Measures

NAN remains concerned that Medicare's quality measurement framework does not adequately capture the value of neuropsychological services or the unique role neuropsychologists play in the care of beneficiaries with cognitive, neurological, and behavioral conditions.

Neuropsychologists provide essential diagnostic and assessment services for patients with Alzheimer's disease and related dementias, traumatic brain injury, stroke, Parkinson's disease, epilepsy, multiple sclerosis, and other neurologic disorders. Existing quality measures often focus on primary care,

procedural specialties, or broader population health metrics that do not reflect the specialized diagnostic and cognitive assessment services furnished by neuropsychologists.

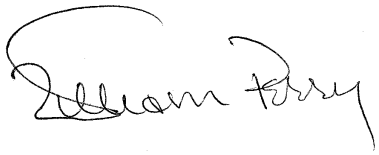
As CMS transitions toward new quality reporting structures, NAN encourages the agency to collaborate with specialty societies to develop and implement clinically meaningful measures addressing:

- Comprehensive cognitive assessment and differential diagnosis of conditions affecting cognition, behavior, and functional status;
- Early identification, evaluation, and management of dementia and other disorders affecting brain health, including assessment of patient safety, functional needs, and caregiver support;
- Behavioral health, psychosocial functioning, and other factors that influence cognitive and clinical outcomes; and
- Patient-centered communication, care coordination, and the effective integration of neuropsychological findings into treatment planning and ongoing care.
- Without meaningful specialty-specific measures, neuropsychologists may be evaluated using metrics that do not accurately reflect the quality of care they provide, and they risk getting penalized for not having enough relevant measures—which is outside of their control.

Conclusion

Thank you for the opportunity to comment on the 2027 PFS proposed rule. NAN looks forward to work with CMS and be a resource on issues concerning neuropsychology. If you have any questions, I can be reached at wperry@nanonline.org.

Sincerely,



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