Alliance of Specialty Medicine

Sound Policy. Quality Care.

May 20, 2026

The Honorable Brett Guthrie
Chair
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2323 Rayburn House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
Chair, Health Subcommittee
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
House Energy and Commerce Committee
2323 Rayburn House Office Building
Washington, DC 20515

RE: Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms

Dear Chairs Guthrie and Griffith, and Ranking Members Pallone and DeGette,

The Alliance of Specialty Medicine (Alliance) thanks the House Energy and Commerce Subcommittee on Health for holding a hearing on such an important topic. We write to share our ideas about Medicare physician payment reform and opportunities to better measure and reward high value care among physicians. The Alliance, which represents 15 specialty organizations and more than 100,000 physicians, is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. The Alliance greatly appreciates your proactive engagement and willingness to collaborate with us and other stakeholders.

Below we share our recommendations on legislative reforms to improve the Medicare physician payment system, the Quality Payment Program (QPP), and the Center for Medicare and Medicaid Innovation (CMMI).

Medicare Physician Payment Reform (MPFS)

Prior to the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the costs associated with running a physician practice were on the rise. We continue to see substantial increases in prices for medical supplies, equipment, and clinical and administrative labor, as demonstrated by the Consumer Price Index (CPI) and the Medicare Economic Index (MEI).[1] MACRA established physician payment updates without a yearly automatic inflation adjustment unlike other Medicare providers, which receive annual payment updates based on an inflation proxy, such as the CPI. Given the lack of an automatic payment update, when adjusted for

[1] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

inflation in practice costs, Medicare physician payments declined 33% from 2001 to 2025.[2] While Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the Merit-based Incentive Payment System (MIPS) or alternative payment model (APM) tracks, many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

The Medicare Trustees[3] and other policy experts have raised concerns about the lack of an inflation measure in the Medicare physician fee schedule (MPFS). According to the Medicare Payment Advisory Commission (MedPAC), this downward financial pressure on physicians has forced many to sell their practices to health systems and private equity groups and enter into employment arrangements with these entities, further consolidating health care systems and increasing health care costs to taxpayers and beneficiaries.[4] Research by the American Medical Association (AMA) found that 42.2% of physicians remained in private practice as of 2024, but many are selling their practices because inadequate payment rates, soaring resource costs, and overwhelming regulatory and administrative burdens make independence increasingly unsustainable.[5]

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. In fact, physicians absorbed substantial budget neutrality adjustment prompted by the Centers for Medicare and Medicaid Services' (CMS') 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as CMS' 2022 implementation of revised clinical labor prices (an update that lagged two decades). While these adjustments were implemented prospectively, the resulting reductions permanently lowered the MPFS conversion factor baseline. Compounding the issue, CMS relies on prospective utilization assumptions when estimating the budget neutrality impact of newly payable services. However, when those projections overestimate actual utilization, which occurred with Transitional Care Management (TCM) services and the complex care add-on code (HCPCS G2211), the resulting reductions to the MPFS conversion factor (CF) are not subsequently restored.

We appreciate congressional efforts to reduce CF cuts temporarily; however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. The 2026 MPFS CF equals $33.40 for non-qualifying APM participants (or $33.57 for qualifying APM participants). In 2016, it was almost $36.00.

The Alliance recognizes that Congress provided a 2.5% increase to the Medicare conversion factor in 2026, but calls on Congress to simultaneously embrace long term reforms to **prevent recurring annual Medicare cuts** and **enact permanent solutions to stabilize Medicare physician payments, support investments in value-based care, and improve the quality of care provided to Medicare beneficiaries.**

Requested Legislative Reforms to the MPFS

The Alliance urges Congress to:

- Provide a permanent, inflation-based update equal to MEI, without reductions or caps.
- Modernize and update the budget neutrality mechanism by increasing the threshold to $54.3 million and indexing it to MEI every five years, requiring that direct cost calculations and valuations be updated every five years in consultation with relevant stakeholders, and limiting year-to-year variance of the conversion factor to 2.5%.

[2] https://fixmedicarenow.org/sites/default/files/2025-01/Medicare Gap Chart_2025.pdf
[3] https://www.cms.gov/oact/tr/2025
[4] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf
[5] https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever

Merit-Based Incentive Payment System (MIPS)

Implementation of MACRA's two-track value-based payment system, the QPP, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Many specialists perceive MIPS, in particular, as an enormous administrative hassle that simply diverts critical resources away from more meaningful activities that could directly improve the quality and value of specialty care. Often under MIPS, specialty physicians have no other choice but to report on marginally relevant measures that result in data that is of little use to physicians or their patients. Further, CMS has not produced any evidence to date to suggest that quality, efficiency and outcomes for Medicare's seniors, the disabled, and underserved populations have demonstrably improved as a result of the MACRA-established quality programs.

In contrast to the promises of MACRA, MIPS has evolved into an overly complex, disjointed, burdensome, and clinically irrelevant program for many specialists. Even the Government Accountability Office (GAO), in an October 2021 report,[6] expressed concern that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes, and highlighted the program's low return on investment. In its March 2024 environmental scan of value-based payment models,[7] the Physician-Focused Payment Model Technical Advisory Committee (PTAC) noted: "Overall, there is little evidence that pay-for-performance and public reporting of quality measures have improved overall quality of care in the United States."

The Alliance requests that the Committee consider the following fundamental flaws that continue to plague MIPS:

- **Siloed Performance Categories**. CMS has failed to produce a more unified quality reporting structure, as promised under MACRA. MIPS continues to rely on four separate performance categories that each have distinct and complex reporting requirements and scoring rules, making program compliance extremely resource intensive with little to no evidence of value. Additionally, for many specialties, what is being measured on the quality side rarely aligns with what is being measured on the cost side, resulting in a flawed value equation. The Alliance has repeatedly asked CMS to provide cross-category credit for more comprehensive value-based activities, such as reporting and regularly tracking performance through a clinical data registry, which would minimize duplicative and misguided reporting mandates while rewarding more meaningful investments in value-based care. However, CMS continues to cite statutory constraints, including the mandate to measure clinicians on each of the four MIPS performance categories as dictated by MACRA. As a result, the program is not only challenging to navigate and comply with, but for many specialties, it does not meaningfully reflect the overall value of care.
- **Constantly Shifting Goalposts**. Each year, CMS changes MIPS participation rules, including rules around eligibility, reporting requirements, and available measures. CMS also has the authority to update performance thresholds, which the agency has done many times since the program launched. As a result, it is challenging for physicians to keep up with the program and to make year-to-year comparisons regarding their performance. It is equally challenging for CMS to analyze the overall impact of the program over time accurately.
- **Lack of Incentives for Specialty Measures**. Many specialties have also faced challenges getting more specialty-focused quality measures approved for the program due to excessively burdensome and costly measure testing and maintenance requirements, including those that apply to Qualified Clinical Data Registries (QCDR). QCDRs, in particular, were authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. Instead, many prominent specialty-sponsored registries have had no other choice but to leave the program. This is unfortunate since clinician-led registries tend to collect more relevant and robust clinical outcomes data, including patient-reported outcomes data, that cannot be captured through claims. They also provide more timely and actionable feedback that is often more meaningful to participating

[6] https://www.gao.gov/assets/gao-22-104667.pdf
[7] https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf

clinicians and their patient populations than what is provided by CMS under MIPS. And even when specialty-focused measures are approved for MIPS, our organizations still face challenges getting members to report the measures due to MIPS scoring policies that disincentivize the use of such measures— especially measures such as patient-reported outcomes measures, which are more time-consuming to collect, but more meaningful to patients and physicians.

- **Barriers to Accessing Claims Data.** Specialty societies and QCDRs have also faced major challenges in accessing claims data. Claims data acquisition is costly and time-consuming, and specialty societies continue to face delays in trying to access such data. Specialty societies are willing to assist CMS with more robust quality and cost analyses but cannot do this without reasonable access to timely Medicare claims data.
- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on, and efforts to implement cost measures under MIPS to date have uncovered a variety of complex issues that make physician-level accountability an ongoing challenge. They often reflect care decisions and costs that are outside of an individual physician's direct control and rarely align directly with quality measures other than in the title. While Total Cost measures are the most problematic, even more focused episode-based cost measures often hold physicians responsible for costs that they cannot control. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics, that physicians have little control over. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically indicated, recommended and prescribed over another. Additionally, MIPS cost measures to date have measured cost of care *in isolation*, failing to account for the impact that changes in spending have on care quality and access to care. This is even true under CMS' new MIPS Value Pathways (MVP) Framework, which was intended to align performance assessment across the four MIPS performance categories. Unfortunately, MVPs too often include a cost measure addressing a specific condition, but no corresponding quality measure that addresses the same condition/ population. Therefore, it is not clear if the MIPS participant achieved good cost performance by improving value, or by simply holding back on appropriate care.
- **Lack of Flexibility to Promote Interoperability**. The MIPS Promoting Interoperability category continues to take a one-size-fits-all approach to care that fails to appreciate the diversity and readiness of practices across the nation. The category also continues to focus on very specific EHR functionalities rather than promoting innovative use cases of health information technology, such as clinical data registries, clinical decision support tools, and tracking data from wearables and other digital devices that are more common among specialty patients. EHR adoption and federal policies supporting interoperability have advanced significantly since the enactment of MACRA. There is much more widespread use of CEHRT among clinicians, and CEHRT requirements have evolved to a point where users of CEHRT are inherently satisfying the actions that the current set of MIPS Promoting Interoperability measures originally set out to capture and incentivize (e.g., secure data exchange). Where they are not, it is not the fault of the clinician, but the EHR vendor or institution deploying the technology. As a result, this category of MIPS has become outdated and should be revised to better represent the current landscape and minimize unnecessary reporting burden.
- **Failure to Provide a Glidepath to APM Participation**. The intent of MIPS, as envisioned by MACRA, was to prepare physicians to move into APMs. However, the current program — even as revised through the MVP Framework — largely fails to align with measures used under APMs and does little to ready specialists to move into APMs. Further, there are ongoing barriers to APM participation among specialists, as explained earlier.
- **Misguided Efforts to Improve MIPS**. Although CMS' MVP Framework was intended to address many of the problems outlined above, it simply reshuffles the deck while doing very little to address the program's foundational flaws, which increases frustration and disillusionment among physicians at a time when physician burnout is at an historical high. Compounding these concerns, CMS recently finalized a new mandatory APM – the Ambulatory Specialty Model (or ASM) – which builds directly on the MVP framework, despite widespread concern among specialties that MVPs do little to address the

shortcomings of traditional MIPS. As noted in our comments to CMS[8], the Alliance believes the model further exacerbates existing flaws in MIPS rather than creating a true path forward for specialists to engage meaningfully in value-based care. For these reasons, the Alliance strongly urges Congress to prohibit CMS from implementing the Ambulatory Specialty Model. Instead, CMS should work collaboratively with specialty societies to design models that are grounded in clinically meaningful measures, structured to incentivize rather than mandate participation, and aligned with a pathway to Advanced APM participation.

Requested Legislative Reforms Related to MIPS

The Alliance urges Congress to:

- Give CMS the authority to move beyond the four siloed performance categories of MIPS and instead recognize more comprehensive and innovative investments in high value care.
- Better recognize the value of clinical data registries and their role in the QPP by, for example, allowing clinicians to receive credit across all four MIPS categories for registry participation that meets minimum standards and recognizing similar participation pathways that are more meaningful to specialists.
- Require CMS to better incentivize the development and use of specialty-focused metrics through technical assistance, less resource-intensive measure testing policies, and revised MIPS scoring policies that promote the reporting of such measures.
- Allow physicians to meet Promoting Interoperability requirements via "yes/no" attestation of using Certified Electronic Health Record Technology (CEHRT) or technology that interacts with CEHRT, such as participation in a clinical data registry. Since MACRA was first signed into law, the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with CMS, has finalized numerous regulations intended to better support the electronic exchange of data, incentivize the use of technology, and promote interoperability. In the most recently issued HTI-5 proposed rule,[9] ONC even proposes to significantly streamline requirements imposed on EHR vendors under the Health Information Technology Certification Program, acknowledging that efforts to incentivize interoperability have evolved and that many program requirements are now either obsolete or have become market baseline. Requirements imposed on clinicians should similarly recognize the maturity of EHR adoption and aim to minimize reporting burden. The majority of impediments to further progress in this space are not in the direct control of physicians, but rather EHR vendors and the facilities or health systems in which physicians practice.
- Allow CMS to modify the MIPS Cost category by:
    - Removing the primary care-based total per capita costs measure mandate in MACRA that continues to hold physicians — including specialties that are explicitly excluded from the measure — responsible for costs outside of their control.
    - Removing the MACRA requirement that episode-based cost measures account for at least half of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.
    - Requiring that any evaluation of cost also simultaneously accounts for any changes in quality indicators meaningfully tied to cost performance, including within the same patient population, to ensure cost-containment efforts do not result in poorer quality care or negatively impacts access to care (i.e., true measures of value).
- Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with a better understanding of existing gaps in care and support the development of quality and cost measures.
- Require CMS to release more granular and timely data regarding physician participation in MIPS.

[8] https://specialtydocs.org/wp-content/uploads/2025/09/Alliance_CY-2026-MPFS-Comments_FINAL-submitted.pdf
[9] 90 FR 60970

The Center for Medicare and Medicaid Innovation (CMMI) and Alternative Payment Models (APMs)

CMS has released very little specialty-specific APM data to date, making it challenging to fully understand the availability and impact of these models on specialists, as well as barriers to engagement. While CMS' annual QPP Experience Report[10] and associated QPP Public Use Files (PUF)[11] include comprehensive participation and performance data related to the MIPS, it only includes aggregate national data on the total number of clinicians that were QPs in an Advanced APM. It does not provide any detailed breakdown of QP status or APM participation by specialty or by practice type (e.g., small practice, rural, facility-based, etc.).

In addition, most specialty physicians have struggled to meaningfully engage in the Advanced APM track of the QPP, as there are only a few APMs that are applicable to specialty care and meet the Advanced APM criteria. Through discussions with Alliance member organizations and the physicians they represent, we have found that accountable care organizations (ACOs) are often the only option for APM engagement. However, the decision to participate in an ACO is often made by a specialist's hospital or health system, or a result of healthcare consolidation, and the specialist's role in the model is often passive. Additionally, specialists do not have an opportunity to meaningfully engage in quality improvement or cost containment activities specific to their patient population since ACO measures do not reflect the conditions they treat or the services they provide.

As a result, active and meaningful engagement in APMs is nearly impossible. Previously tested specialty-focused APMs (e.g., the Bundled Payments for Care Improvement–Advanced (BPCI-A)) have only targeted a limited number of conditions or procedures and failed to provide high-performing practices with an incentive to stay in the model due to exceedingly challenging spending targets that simply do not support high quality, appropriate care. More recently announced models, such as the Ambulatory Specialty Model (ASM), are mandatory and were developed without specialty society input. As a result, specialists are increasingly being forced to participate in models that rely on misguided measures and methodologies.

The Alliance appreciates CMMI's recent recognition that a comprehensive approach to accountable care must account for both primary care and specialty care and that it is exploring opportunities to build on the "shadow bundle" concept where specific episode-based or condition-specific models are nested in population-based total cost of care (PB-TCOC) models. However, we are concerned that these initiatives are being rolled out without broader specialty engagement or input and may offer limited opportunities for meaningful specialist involvement. Some Alliance member organizations have already invested in this type of work, yet they continue to face challenges in terms of getting CMS to adopt these models.

The Alliance is disappointed with the ongoing lack of models and relevant participation pathways for specialists. We are also frustrated by the limited opportunities that specialists have had to date to become Qualifying Participants (QPs) in Advanced APMs under the QPP. As a reminder, under current law, the QP thresholds are scheduled to increase and the APM incentive is scheduled to end starting with the 2027 performance year/2029 payment year, as reflected below:

QP Thresholds

- 2022/2024: 50% Part B Payments/ 35% Part B Patients
- 2023/2025: 50% Part B Payments/ 35% Part B Patients
- 2024/2026: 50% Part B Payments/ 35% Part B Patients
- 2025/2027: 75% Part B Payments/ 50% Part B Patients
- 2026/2028: 50% Part B Payments/ 35% Part B Patients
- 2027/2029: 75% Part B Payments/ 50% Part B Patients

[10] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf
[11] https://qpp.cms.gov/resources/performance-data

APM Incentive Payment

- 2022/2024: 5%
- 2023/2025: 3.5%
- 2024/2026: 1.88% (+ differential CF update for QPs (0.75%) vs. non-QPs (0.25%))
- 2025/2027: No incentive payment; just differential CF update
- 2026/2028: 3.1% (+ differential CF update)
- 2027/2029: No incentive payment; just differential CF update

The Alliance very much appreciates that Congress has acted multiple times to freeze the QP threshold and extend the APM incentive payment. However, without a further extension of these provisions, many specialists will never have had an opportunity to benefit from the APM incentive payment, which allows physicians to invest in the infrastructure and analytics needed to engage successfully in such models and provide higher value care. These shifts in policy contradict the Congressional intent of MACRA, which was to encourage clinician movement into APMs, using MIPS as a springboard, not as a long-term solution. Unfortunately, these changes also come at time when we are finally starting to see measurable progress in terms of the number of clinicians moving into Advanced APMs. The 2024 performance year was the first time since the enactment of MACRA that the number of QPs exceeded the number of MIPS eligible clinicians. Although we do not know what proportion of QPs have been specialists, without additional Congressional action, we expect to see a reversal in this progress and potentially a situation where MIPS incentive payments begin to exceed APM incentive payments, causing movement away from APMs, contrary to Congress' vision.

Requested Legislative Reforms Related to the CMMI and APMs

The Alliance urges Congress to:

- Require CMS to release more granular and timely data regarding specialty participation in CMMI-tested models and other CMS alternative payment models (APMs); the impact of those models on quality, value, and access to specialty care; and eligibility for the Advanced APM track of the QPP by specialty.
    - As a starting point, Congress should direct GAO to conduct a study on APMs that documents gaps in current availability of APMs for specialists, identifies current barriers to specialist participation in APMs, collects insights from specialists and other physicians on how they would like to see APMs designed, and evaluates more specifically the reasons why specialty-focused models have not moved forward.
- Require CMMI to employ more transparent processes when developing and evaluating models. Specifically, CMMI should be required to consult with potentially impacted stakeholders prior to implementing a model and be required to publish a notice of model concepts early in the model development phase. This would promote greater transparency in model design and ensure all stakeholders have an opportunity to meaningfully engage with CMMI on the development of models. Similarly, CMMI should be required to publicly explain why adopted models are terminated early or not expanded to identify lessons learned in order to inform future models. CMMI should be held accountable to Congress and the public in a manner that builds trust in these processes, but is not so cumbersome as to stifle progress and innovation.
- Congress should also require CMMI to work collaboratively with specialty societies to improve the APM pipeline. This could include requiring CMMI to technical assistance and more specific guidance to specialists and their societies on how to get APMs approved for testing. Specialty societies have invested significantly in the development of models that have been repeatedly rejected or ignored.
- For population-based models that have been more geared toward primary care, such as ACOs, provide model entities with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease.

- Extend opportunities for specialists to meet the eligibility criteria to become a QP in an Advanced APM under the QPP. Restore and extend the full 5% APM incentive payment, as well as the lower QP thresholds to facilitate specialty physician movement into Advanced APMs, including new and more relevant models that have not yet materialized.
- Terminate the deeply flawed Ambulatory Specialty Model (ASM) recently finalized by CMS.

Thank you for your ongoing leadership in addressing Medicare physician payment and quality programs. We welcome the opportunity to work with you on these important issues. If you have any questions, please do not hesitate to contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
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