Alliance of Specialty Medicine

25TH ANNIVERSARY

Sound Policy. Quality Care.

June 10, 2025

The Honorable Mehmet Oz
Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information

Dear Administrator Oz:

The Alliance of Specialty Medicine (Alliance) appreciates the opportunity to share key opportunities to streamline regulations and reduce administrative burdens on specialty physicians and their patients participating in the Medicare program. 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. Our comments below, which respond to specific questions in the RFI, focus on current Medicare policies that are particularly burdensome to specialty physicians and interfere with providing the highest quality patient care.

Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Improving the Effectiveness and Efficiency of the Merit-Based Incentive Payment System (MIPS)

MIPS is in need of a significant overhaul as it has become little more than an exercise in compliance rather than a program that promotes high value patient care. The program is hampered by its four siloed

performance categories (Quality, Cost, Promoting Interoperability and Improvement Activities), which are each associated with a distinct set of measures, reporting requirements, benchmarks, and scoring rules. This results in an absurdly complex program that is nearly impossible to comply with without a significant investment of resources. In fact, the Quality Payment Program (QPP) Resource Library includes over 120 resources developed by CMS to guide participants through MIPS compliance for the 2024 performance year alone. Many of these resources are zip files with numerous technical and lengthy downloads, while others are standalone guidance documents and fact sheets that are over 30 pages long.

Siloed Performance Categories and Duplicative Reporting

MIPS performance categories are also siloed in that participants cannot earn cross-category credit for investments in higher value care that satisfy the goals of multiple categories. For example, many quality measures capture actions described in clinical improvement activities (and vice versa) and should not require separate submissions. Although MACRA requires the use of four performance categories in determining a composite performance score, nothing in statute prohibits CMS from awarding credit across categories when a measure or action addresses multiple categories. Yet, CMS continues to require MIPS eligible clinicians to comply with the distinct metrics and rules that comprise each separate category. In addition, there are only select instances where physicians can receive MIPS credit for performance data reported through other CMS quality initiatives (i.e., MIPS facility-based scoring, which relies on Hospital Value-Based Purchasing Program scores). This results in duplicative reporting and accountability, confusing performance feedback, and time diverted from direct patient care. Physicians who practice in facilities are particularly vulnerable to being caught in the cross-fire of numerous CMS quality reporting mandates since they must comply with MIPS, but also contribute to measures that the facility must report to CMS under its own payment system.

Scoring Rules Arbitrarily Hamper Success of Specialists

MIPS also suffers from scoring rules that disincentivize the development and use of specialty-focused measures and add another layer of unnecessary complexity to an already convoluted program. For example, an increasing number of measures are topped out, meaning most physicians are already achieving high scores on the measure, making it difficult to measure meaningful differences between them. These measures are eventually subject to a scoring cap, which limits the points a participant can earn on a measure regardless of performance. As a result, CMS scoring rules punish, rather than reward physicians who maintain a high level of quality care over time. Additionally, CMS penalizes physicians by assigning 0 points to reported measures that lack a benchmark. This disincentivizes the use of these measures, which are often specialty-focused, and in turn, further perpetuates the absence of data needed to build a benchmark. To address this problem, CMS adopted a policy, beginning with the 2022 performance year, to apply a scoring floor to measures reported in their first two years in the program. While the Alliance very much appreciates this policy, it only applies to measures adopted in 2022 or later. There are numerous specialty-focused measures in the program that were adopted prior to 2022, continue to lack a benchmark, and are at risk for removal from the program since there is no mechanism to incentivize their use.

Ineffective Benchmarking

Additionally, the program is plagued by benchmarking methodologies that fail to discern meaningful differences in performance. Rather than focus on outliers, the program assigns points based on nominal differences in performance. The rules and goalposts of the program are also constantly shifting, which makes year-to-year compliance and performance comparisons challenging.

Barriers to Specialty-Led Registries
Similarly, the program lacks incentives to support the use of specialty-led registries, known as Qualified Clinical Data Registries (QCDRs), and the more meaningful specialty-focused measures they offer. QCDRs were authorized under MACRA to incentivize the use of more innovative measures and more robust data collection and performance feedback than CMS has the capacity to administer on its own for each unique specialty. However, an increasing number of specialty-led registries are pulling out of the program due to unnecessarily onerous and rigid requirements imposed on QCDRs that require significant investments and divert from other more impactful data collection efforts. The Alliance is disappointed that CMS has failed to recognize the innovative role that clinical data registries could play in satisfying the four performance categories of MIPS, as well as meeting the goals of other CMS quality programs. Enhancing the role of specialty-led registries in MIPS would not only result in more meaningful metrics and more actionable performance feedback, but it would shift some of the responsibility off of CMS in regard to program administration, freeing up resources for participant education and program integrity.

Lack of Access to Claims Data
Additionally, contrary to Section 105(b) of MACRA, CMS has not provided clinician-led clinical data registries with a meaningful way to gain continuous access to Medicare claims data. Without access to claims data, registries cannot reach their full potential of assessing the *value* of care provided to patients. Tying Medicare claims data to clinical outcome information would enable clinician-led clinical data registries to better track patient outcomes over time, expand their ability to assess the safety and effectiveness of medical treatments and provide them with the information necessary to evaluate the cost-effectiveness of alternative care pathways.

Rigid and Outdated Promoting Interoperability Requirements
In regard to the Promoting Interoperability category, the requirements are rigid and adhere to an all-or-nothing approach. The category relies on a standard set of measures, which all eligible participants must report on regardless of specialty or patient population. There is also little flexibility in that failing to meet any one of the required measures and attestations for this performance category results in a zero score. The Alliance questions the ongoing need for this category, or at least the manner in which it is administered, given EHR adoption rates. As of 2021, nearly 9 in 10 (88%) of U.S. office-based physicians adopted any electronic health record (EHR), and nearly 4 in 5 (78%) had adopted a certified EHR.[1]

Flawed and Inadequate MIPS Cost Measures
Finally, MIPS cost measures are extremely concerning and in critical need of a re-assessment. MIPS cost measures rely strictly on CMS assessments of administrative claims data. Claims data was structured primarily for billing purposes and does not provide sufficient details about a patient or their care to produce accurate assessments of quality, cost or overall value. Importantly, MIPS cost measures fail to simultaneously monitor levels of patient quality in relation to spending. Many MIPS cost measures, particularly the total cost measures (e.g., the Total Per Capita Cost (TPCC) measure and the Medicare Spending Per Beneficiary (MSPB) measure), also hold physicians accountable for costs outside their direct control. Additionally, MIPS cost measures fail to account for long-term savings since assessment is limited to the length of an episode or the MIPS performance year. These numerous limitations result in overly technical cost measure performance feedback that is incomprehensible, inactionable, and not an accurate assessment of value.

[1] https://www.healthit.gov/data/quickstats/office-based-physician-electronic-health-record-adoption

Overall Negative Impact and Lack of Demonstrated Value of MIPS
Overall, most specialists view MIPS as an enormous administrative hassle that diverts critical resources away from more meaningful activities that could directly improve patient care. MIPS has failed to demonstrate a positive impact on outcomes and value to patients and physicians and has done very little to prepare clinicians to transition to APMs, which was the primary intent of the program as envisioned by Congress. In an October 2021 report, the Government Accountability Office (GAO) questioned whether the program helps improve quality and patient outcomes, highlighting the program's low return on investment. Another study found that practices spend over $12,000 and over 200 hours per physician per year[2] to avoid a 9% Medicare payment penalty and potentially qualify for a maximum bonus payment that has historically hovered around 2%. The challenge and cost of compliance is even greater for small practices and those with at-risk patient populations.

Limitations of MIPS Value Pathways in Addressing Core Flaws of MIPS
Under the first Trump Administration, CMS developed a new framework, known as the MIPS Value Pathways (MVPs), to respond to some of the ongoing challenges with MIPS. In 2023, CMS began offering MVPs as an optional MIPS participation pathway that was intended to offer physicians a more streamlined and cohesive participation experience. As part of the MVP framework, CMS also introduced a new reporting option known as subgroup reporting, which was meant to encourage more focused reporting among the varied members of a multi-specialty group practice. CMS determined through regulation that starting in 2026, subgroup reporting would be mandatory for multi-specialty group practices participating through MVPs. CMS also contemplated making MVPs mandatory starting in 2029, but has yet to finalize that policy.

Unfortunately, MVPs fail to resolve the foundational flaws of MIPS described above. MVPs continue to hamper meaningful progress towards higher quality care by preserving the siloed nature of the four MIPS performance categories; maintaining the rigid, distinct, and ever-changing requirements of each category that makes the program so complex; and failing to better recognize and incentivize the use of more meaningful QCDRs. Policies that would require practices to break into subgroups for purposes of MIPS compliance also fail to recognize the unique nature and needs of each practice and add yet another layer of burden to an already overly complex program.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers?

To address our concerns outlined in response to question 1B, the Alliance requests that CMS take the following concrete steps to simplify and streamline MIPS, while also making it more meaningful to patients and physicians:

- ***Allow participants to earn credit across the four MIPS performance categories to minimize reporting burden and compliance complexity***. For example, CMS should deem physicians who participate in CMS-approved QCDRs that satisfy minimum requirements related to the goals of each of the four MIPS categories as having complied with the program. Our member societies would be happy to work with CMS to develop those minimum requirements.
- ***Adopt more flexible participation pathways that allow physicians to satisfy the goals of each category in a manner that is most relevant to their specialty/patient population, rather than the current program's one-size-fits-all approach to medicine***.

[2] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

- Many specialties are already engaged in efforts to measure and monitor the quality and value of their members through registries, maintenance of certification requirements, and other internal activities that are much more robust and meaningful to the physicians and their patients. ***CMS should provide MIPS credit to physicians engaged in these alternative efforts so long as they meet certain minimum standards that satisfy the goals of each performance category, as envisioned by Congress***. Again, our member societies would be happy to work with CMS to develop these minimum standards.
- ***CMS should also expand upon opportunities for physicians to receive credit under MIPS for providing high quality care in practice settings that are already being held accountable by CMS under different payment systems***. The current MIPS facility-based scoring policy aims to achieve this goal, but has had limited reach to date and should be reassessed and expanded.
- ***CMS should also think outside the box in terms of cost measurement***. First, CMS should remove the TPCC and MSPB measures from the program since they hold clinicians accountable for costs that are outside of their direct control. CMS should also pause measurement on existing episode-based cost measures given the work of a recent CMS Technical Expert Panel to develop more accurate measures of "value." We remind CMS that MACRA instructs CMS to measure "resource use" and does not specifically refer to measures of "cost." It also gives CMS the authority to "use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes)." We believe there is enough flexibility in the statute for CMS to consider alternative approaches to satisfying this category, including appropriate use measures, which measure the appropriateness of procedures or care decisions based on clinical guidelines.

- ***Given current levels of CEHRT adoption, CMS should permit physicians to satisfy the Promoting Interoperability category through attestation only, similar to the Improvement Activities category.***
- ***Adopt a more nimble approach to measure testing and adoption that minimizes unnecessary burden and expenditures and results in more rapid adoption of innovative and meaningful measures.***
- ***Reduce the complexity of scoring rules and benchmarking methodologies.***
  - Focus performance assessments on outliers, rather than nominal differences in performance.
  - Address scoring rules that disincentive the use of specialty-focused measures. CMS should replace its topped-out scoring policy in favor of a policy that rewards, rather than penalizes, physicians for maintaining high performance on measures over time. It should also adopt a grandfather clause that makes all quality measures in the program prior to 2022 that continue to lack a benchmark eligible for the two-year new measure scoring floor.
- ***Maintain stable policies, thresholds, and performance targets for multiple years to ease burden, but also to allow for more accurate annual comparisons of CMS policies and clinician performance.***
- ***Ensure that MVPs, as well as subgroup reporting, remain voluntary.*** There is no statutory requirement for CMS to adopt the MVP framework or for MIPS participants to use it. Given its failure to address foundational problems associated with the program, and in light of the diverse needs of physician practices and their patient populations, it is critical that MVPs remain an

option under MIPS. We also urge CMS to continue to work to identify more effective strategies to improve the program rather than looking to MVPs as the ultimate solution.

- ***Work with Congress to provide specialty societies and QCDRs with better access to Medicare claims data, as prescribed in MACRA.*** Providing improved access to these data will allow specialty societies to better assist CMS in meeting the goals of MIPS, as well as result in a more efficient administration of the program.

Topic 4: Additional Recommendations

4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

Medicare Physician Payment Reform

As we noted in our response to the U.S. Department of Justice (DOJ) Anticompetitive Regulations Task Force request for public input, [3] there is an urgent need to enact significant long-term reform to how Medicare physician payments are established under statute. Since 2020, Medicare payment rates for services under the Medicare Physician Fee Schedule (MPFS) have declined by more than 10%, reflecting five consecutive years of payment reductions. These payment reductions are the result of longstanding structural problems with the Medicare physician payment system, combined with policy decisions and flawed analyses that further exacerbate payment challenges.

To begin, statute does not provide any mechanism for payment updates to meaningfully account for the impact of inflation. In fact, for each year from 2020 through 2025, statute specifies that base annual payment updates under the MPFS are equal to 0%. Under current law, beginning in 2026, physician payment rate updates under the MPFS will rise to either 0.25% or 0.75%, based on physicians' participation in one of two tracks of the Quality Payment Program (QPP). While an improvement over the flat updates over the past several years, these nominal updates will not vary when practice costs expense growth is high, are not sustainable, and will ultimately impact beneficiary access to care.

In addition to payment rates that do not keep up with costs, payments under the MPFS are further subject to budget neutrality adjustments. Problematically, policy changes in the last five years have contributed to sizeable negative budget neutrality adjustments that – in combination with lack of inflationary updates and other downward financial pressures – have brought physician payments levels to nominal levels not seen since 1993.

These constraints on Medicare physician payments have jeopardized practices' financial sustainability, promoted consolidation, and left physicians behind other provider groups such as hospitals which, unlike physicians, continue to receive annual inflationary payment updates under Medicare. In light of the above, ***we urge CMS to work with Congress to pursue long-term Medicare physician payment reform.***

We also highlight that CMS can be more cautious when proposing and finalizing policies that adversely impact the conversion factor. This includes policies that prompt significant, negative budget neutrality adjustments. In many cases, we are concerned that the benefits of such policies do not outweigh the costs of the resulting across-the-board payment reductions that further impair physicians' ability to

[3] https://specialtydocs.org/alliance-letter-to-doj-on-anticompetitive-regulations/

receive fair and reasonable payment updates. ***We therefore urge CMS to carefully assess costs and benefits when implementing policies with significant budget neutrality adjustments under the MPFS.***

We also note that, too often, CMS' estimates for budget neutrality impacts are overstated, with actual utilization data reflecting a much lower level of utilization than what was estimated for the calculation of the budget neutrality adjustment. However, once budget neutrality adjustments are applied, reductions to MPFS payment rates are "baked in" under current CMS policy. As a result, payment rates are improperly suppressed on a permanent basis. Notably, recent analysis by the American Medical Association (AMA) suggests that such an overstatement of budget neutrality impacts occurred in calendar year 2024 MPFS rulemaking, when CMS established separate payment for HCPCS code G2211 *(Visit complexity inherent to evaluation and management).* While CMS estimated that the code would be used with 38% of all office and outpatient evaluation and management (E&M) visits, contributing to a budget neutrality adjustment of more than 2%, actual utilization data for 2024 suggest much lower utilization, estimated at roughly 11% of office and outpatient E&M visits. AMA estimates that this discrepancy inappropriately reduces spending under the MPFS by almost $1 billion annually. ***The Alliance believes that, when data substantiate that initial budget neutrality adjustments are overstated, CMS should exercise its administrative authority to adjust the conversion factor and correct the overstatement. As an immediate step, CMS should apply this approach to correct the underpayment associated with HCPCS code G2211 based on actual utilization in the CY 2026 MPFS proposed and final rules.***

Prioritizing Opportunities for Specialists in Alternative Payment Models (APMs)

Under the current QPP, specialists are generally limited to participation in MIPS, given there is a scarcity of advanced alternative payment models (A-APMs) and the majority focus on the delivery of primary care services. In the case of the Medicare Shared Saving Program (MSSP), specialists may participate in accountable care organizations (ACOs), but ACOs tend to limit their involvement. Overall, a majority of providers are still not participating in any APM (56%), and participation rates have plateaued. Less than half of all primary care physicians and only about a third of specialists are Qualifying APM Participants (QPs), with rates varying by specialty.[4]

As we approach the tenth performance year of the QPP, we are dismayed that meaningful pathways for specialists to engage in A-APMs have not been established, and that specialists remain at a disadvantage. This disparity has persisted for far too long and must be addressed swiftly to ensure specialists have the same access to the A-APM track as primary care practitioners to realize the reduced reporting burden and increased financial incentives that were envisioned when MACRA was enacted. Part of the problem is the ongoing lack of specialty-focused models. However, other policies, such as those that disincentive the inclusion of specialists on ACO Participant Lists, have also precluded specialists from participating meaningfully in ACOs and achieving QP status. Last year, CMS sought feedback on potentially relying on the MVP framework to fill ongoing gaps in specialty APMs and APM participation. CMS also proposed last year, but did not finalize, a policy that would have revised the definition of attribution-eligible beneficiary to encourage APMs to include specialists on their Participant List.

[4] https://www.healthaffairs.org/content/forefront/assessing-provider-adoption-medicare-advanced-alternative-payment-models

To address ongoing gaps in opportunities for specialists to engage meaningfully in APMs, the Alliance recommends the following:

- ***CMS must work with specialty societies to prioritize the development and testing of specialty-focused A-APMs***. In developing these APMs, CMS should consider recommendations from the Physician-Focused Payment Model Technical Advisory Committee (PTAC), as well as models brought directly to the Innovation Center. It is also critical that APMs targeting specialists are developed with direct input from clinical expert members of those specialties. APMs also should be developed in tested in a transparent and non-mandatory manner.
- ***CMS should also work with specialty societies to consider ways to better recognize the contributions of specialists, as well as access to specialists, in existing population-based models, such as ACOs***.
    - Adopt policies that encourage a more active role for specialists in ACOs.
    - Provide ACOs with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists could play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease.
    - Require ACOs to maintain and publicly-post a list of specialty physician participants on their websites, including their specialty designation.
    - Adopt specialty designations for non-physician practitioners to ensure specialty practices are not limited to participation in a single ACO.
    - Closely examine the referral patterns of ACOs and establish benchmarks that will foster an appropriate level of access to and care coordination with specialists, in addition to collecting feedback from beneficiaries on access to specialty care.
    - Adopt QP determination policies that ensure specialists have an equal opportunity to achieve QP status, such as policies that encourage the inclusion of specialists on ACO Participant Lists.
- ***The Alliance is also strongly opposed to relying on the MVP framework to fill ongoing gaps in specialty APMs and APM participation***. As discussed in our response to question 1b, the MVP framework sits on the flawed chassis of MIPS rather than offering more innovative reforms and is simply not an adequate solution to the ongoing lack of specialty-focused APMs. We also oppose CMS' desire to implement this in a mandatory manner, which ignores the fact that each practice has its own unique patient population, practice setup, and level of available resources and administrative capabilities. Mandatory models also force physicians that have already adopted their own unique strategies to providing high-value care to alter those processes in ways that might reverse progress made in terms of outcomes and efficiencies.
- ***CMS should work with Congress to make technical changes to MACRA that would extend the expiring APM incentive payment and freeze QP thresholds.*** CMS must encourage continued movement toward value-based payment models, especially among specialists who have had little opportunity to engage meaningfully or to qualify for APM incentive payments to date.
- ***CMS must release more comprehensive and accessible data on specialty participation in APMs***.

* * *

Thank you for the opportunity to comment 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 Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society of Interventional Radiology