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PHYSICIAN CLINICAL REGISTRY COALITION

August 21, 2026

VIA ELECTRONIC MAIL

The Honorable John Joyce, M.D.
Co-Chair
GOP Doctors Caucus
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Gregory F. Murphy, M.D.
Co-Chair
GOP Doctors Caucus
U.S. House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier, M.D.
Chair
Democratic Doctors Caucus
United States House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

Re: Physician Clinical Registry Coalition's Endorsement of and Recommended Edits to the *Patients First Act*

Dear Chairs Joyce, Murphy, and Schrier:

The undersigned members of the Physician Clinical Registry Coalition ("Coalition") appreciate your leadership in advancing Medicare legislation that would establish a clinically meaningful quality measurement and payment framework. We also appreciate your continued commitment to working with stakeholders as you refine the *Patients First Act of 2026*. The Coalition is a group of medical society-sponsored clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care. We are committed to advocating for policies that encourage and enable the development of clinician-led clinical data registries and enhance their ability to improve quality of care through the analysis and reporting of clinical outcomes.

We commend Title II's recognition of the critical role that clinician-led clinical data registries play as the foundational infrastructure for quality measurement, improvement, and value-based payment. In particular, we appreciate the inclusion of provisions in the bill that:

- Help ensure that the role of Qualified Clinical Data Registries ("QCDRs") in the development, maintenance, and refinement of measures is preserved or strengthened;
- Encourage quality measure reporting through registries;

- Protect the ownership and intellectual property rights of QCDRs;
- Incorporate the *Access to Claims Data Act*, which would establish a process to provide QCDRs or clinician-led clinical data registries with timely, comprehensive, and continuous access to federal claims data; and
- Incentivize clinicians to report new measures, substantively changed measures, or measures lacking established benchmarks.

We welcome the opportunity to serve as an ongoing resource to the Joint Doctors Caucus, and we respectfully offer the following comments and recommendations regarding Title II of the *Patients First Act* governing the "Patient Outcome Improvement National Tabulation System" or "POINTS."

Terminology Used in the *Patients First Act*

We respectfully request that the Joint Doctors Caucus utilize the term "**clinician-led clinical data registries**" as opposed to "clinical data registries." The 21st Century Cures Act defines the term "clinician-led clinical data registry" as a clinical data repository that is established or operated by a clinician-led or controlled, tax-exempt professional society or other similar organization; designed to collect detailed, standardized data on an ongoing basis for medical procedures, services, or therapies for particular diseases, conditions, or exposures; provides feedback to participating data sources; provides ongoing participant training and support; and meets certain quality standards. Pub. L. No. 114-10, § 101(c), 129 Stat. 87 (2015).

Clinician-led clinical data registries benefit from direct involvement and oversight of medical specialty experts, helping ensure that the data collected and measures developed are clinically accurate, relevant, and meaningful to specific patient populations. By contrast, vendor-led registries may lack comparable clinical expertise or an in-depth understanding of the complexities of quality measurement and patient care. Vendor-led registries may be developed primarily for commercial objectives. For example, for-profit companies, such as electronic health record ("EHR") companies, may have more limited records of contributing to peer-reviewed scientific literature or evidence-based clinical practice guidelines. These important distinctions between clinician-led clinical data registries and vendor-led registries should be recognized in the development of a Medicare quality measurement and payment policy.

Section 202: Payment Reform

The Coalition thanks the Joint Doctors Caucus for its support for payment reform that would increase the predictability and sustainability of physician payment and reward clinicians for activities that improve quality of care. We offer the following recommendations related to the Care Efficiency performance category and topped out measures.

Care Efficiency Category

Under POINTS, beginning January 1, 2032, performance would be assessed across only three categories: Quality, Resource Use, and Care Efficiency. We respectfully request greater specificity from the Joint Doctors Caucus regarding the purpose and intended scope of the Care Efficiency performance category, including how this category would be distinguished from the

Quality and Resource Use performance categories. Greater clarification is necessary to ensure that it does not duplicate existing reporting requirements or impose unnecessary administrative burden. To the extent that the Care Efficiency performance category substantially overlaps with the Quality and Resource Use performance categories, we recommend that it be eliminated. To the extent it is maintained in this framework, we believe that compliance should be assessed through attestation-based activity.

Topped Out Measures

We also recommend that the Joint Doctors Caucus include language addressing the Centers for Medicare and Medicaid Services' ("CMS's") policy regarding "topped out" quality measures. Topped-out measures are quality measures for which performance is consistently so high that CMS has determined the measure has limited ability to meaningfully differentiate performance among clinicians. *See* 42 C.F.R. §§ 414.1305, 414.1380. In general, measures identified as topped out by CMS for two or more consecutive years receive no more than 7 measure achievement points. *Id*. § 414.1380(b)(iv)(B).

We believe that this 7-point scoring cap policy unduly penalizes clinicians for achieving high levels of quality and disincentivizes the use of clinically important measures that may continue to provide value for monitoring care. Accordingly, we recommend that the Joint Doctors Caucus eliminate this policy by incorporating the following language:

> "The Secretary shall not remove, retire, cap the points available for, or otherwise limit the use or scoring of a quality measure, including a qualified clinical data registry measure, solely on the basis that the measure has been identified as topped out or demonstrates high performance."

In alignment with this recommendation, we also request that the Joint Doctors Caucus remove the statutory reference to topped out measures at 42 U.S.C. § 1395w-4(q)(2)(D).

Section 203: Quality Reform Task Force

The Coalition offers the following recommendations and comments regarding the bill's provisions governing the Quality Reform Task Force's duties and membership, as well as the application of those provisions to existing measures.

Task Force Membership

We applaud the Joint Doctors Caucus for considering the need for relevant medical specialties and subspecialities to be adequately represented on the task force when a measure affecting that specialty or subspecialty is under consideration. However, we request additional clarification regarding the length and structure of a member's term on the task force, including whether the member would serve on a rotational basis. We recommend that a member's term be tied to the consideration of applicable measures, rather than to a predetermined term length or rotation.

With respect to the task force's composition, the Coalition noticed that the bill excluded physicians from the definition of "designated health care practitioners." The legislation provides

that the "majority of the Task Force is comprised of designated health care practitioners (as defined in section 1866H(f)) or representatives of designated health care professional-led professional organizations described in subclause (I)(bb)." Section 1886H(f) defines "designated health care practitioners" as follows: "The term 'designated health care practitioner' means a physician assistant, a nurse practitioner, a clinical nurse specialist, a physical therapist, an occupational therapist, or such other health care practitioner as the Secretary may specify." The term "physician" is omitted from this definition.

Therefore, we recommend the following revisions to section (bb):

> ''(bb) a majority of the Task Force is comprised of physicians and designated health care practitioners (as defined in section 1866H(f)) or representatives of physicians and designated health care professional-led professional organizations described in subclause (I)(bb);"

Given the expertise that QCDRs have in measure development, we respectfully request that QCDRs also be added as required members of the task force.

Lastly, task force membership is capped at 25 members. We are concerned that this limitation could restrict the task force's ability to obtain input from specialty and subspeciality experts with knowledge and experience essential to the evaluation of measures. Accordingly, we recommend that the legislation provide the task force with flexibility to establish subcommittees comprised of additional experts when appropriate, particularly when the 25-member cap is reached. These subcommittees would supplement the expertise of the task force by providing subject-matter input and recommendations without expanding its formal membership. We suggest language along the following lines:

> "SUBCOMMITTEES.— The Task Force may establish subcommittees composed of additional representatives, as appropriate, to provide expertise, technical assistance, and recommendations to the Task Force in connection with the development, review, evaluation, or modification of measures. Individuals serving on a subcommittee under this subclause shall not be considered members of the Task Force for purposes of the limitation on Task Force membership."

Existing Measures

We respectfully request additional clarification regarding how the task force's measure review process would affect existing measures in the Quality Payment Program. To ensure continuity and avoid unnecessary disruption, the Coalition recommends that existing measures be grandfathered and remain available for reporting unless and until they are substantively changed or retired by the measure steward.

If the Joint Doctors Caucus intends for the task force to review all existing measures, we also respectfully request greater clarification regarding the anticipated timeline and process for conducting such reviews.

We also request that the Joint Doctors Caucus clarify how the POINTS framework will impact existing CMS processes or tools related to developing, reviewing, and maintaining quality measures, including Pre-Rulemaking Measure Review and Partnership for Quality Measurement.

Ensuring Adequate Measure Choice

Medical societies have consistently raised significant concerns regarding the development and implementation of MIPS Value Pathways ("MVPs") relevant to their specialties. Many MVPs include a narrow set of measures that do not reflect the clinical activities, priorities, or composition of various specialties and subspecialties. Across MVPs, there is substantial variation in measure choice, with some MVPs containing only six quality measures and some containing up to twenty. With clinicians required to report on four quality measures, clinicians with limited measure choice have a reduced ability to achieve high scores in the program. Even with perfect performance, some MVPs cannot achieve the maximum points available under the program.

Further, specialty societies continue to report insufficient collaboration and transparency in the MVP development process. Although CMS has engaged in discussions with specialty societies, the agency has declined, on numerous occasions, to incorporate clinically meaningful quality measures, including QCDR measures, into MVPs. CMS also has not provided an adequate rationale for excluding numerous measures recommended by those specialty societies. As a result, many MVPs do not reflect the nature, scope, or complexity of contemporary clinical practice. Compounding these concerns, the 2027 Medicare Physician Fee Schedule proposed rule, if finalized, would require clinicians to report "core measures" within each MVP. This proposal would further limit clinicians' reporting flexibility.

Accordingly, we believe that POINTS must ensure that there is adequate measure choice and flexibility under the program for clinicians to meaningfully report on quality aspects that are applicable to and appropriate for their specialty or subspecialty. To ensure adequate measure flexibility and choice, we suggest the following language:

> "In determining the quality measures to be included, the Quality Reform Task Force shall preserve choice and flexibility in the selection of quality measures that are clinically relevant to the professional's specialty, subspecialty, scope of practice, and patient population."

Task Force Operationalization

We appreciate the Joint Doctors Caucus's recognition of the time and effort that it will take to implement the POINTS framework, and we support the effective date of 2032 for POINTS implementation for purposes of clinician reporting. We believe that clear standards and an appropriate transition period will be important to provide predictability for clinicians and avoid disruptions in quality reporting and performance assessment. However, we believe that it is important for the Quality Reform Task Force to begin reviewing measures earlier than 2032—perhaps 2029 or earlier—to facilitate a smooth transition to POINTS, particularly if the task force will be required to review a significant number of existing measures. We also believe that the Secretary should provide technical assistance (e.g., detailed written guidance and educational

materials, webinars, office hours) to support stakeholders in understanding and complying with the POINTS in advance of the implementation date.

Finally, we recommend that measures recommended by the Quality Reform Task Force and approved by the Secretary remain approved for a minimum of five years to provide clinicians with greater stability and predictability in quality reporting.

> "INCLUSION TIMEFRAME.—Measures approved by the Secretary under this paragraph shall remain included for a minimum of five years."

Section 205: Modifying Requirements and Approval Periods for QCDRs

The *Patients First Act* would establish requirements for registries to be considered QCDRs. Beginning January 1, 2027, QCDRs must be established and operated by a professional society that is considered controlled or led by a "designated practitioner," defined as "a physician assistant, a nurse practitioner, a clinical nurse specialist, a physical therapist, an occupational therapist, or such other health care practitioner as the Secretary may specify." As noted above, the term "physician" is not included in the definition of "designated health care practitioner." Accordingly, we recommend the following edits to subparagraph (I):

> ''(I) be established and operated by a professional society that is controlled or led by a physician or designated practitioner (as defined in section 1866H) and that has demonstrated expertise in developing evidence-based clinical practice guidelines and quality measures for improving patient outcomes;"

Additionally, the *Patients First Act* specifies that a determination by the Secretary that a registry qualifies as a QCDR is effective for three years, and such approval can be extended for subsequent three-year periods.

We urge the Joint Doctors Caucus to extend this timeframe to five years. In addition, we believe that all approved QCDR measures should remain approved for a period of five years to provide clinicians with greater stability and predictability in quality reporting and align with non-QCDR measures.

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We would be happy to meet to discuss these issues in further depth at your earliest convenience. If you have any questions, please contact Leela Baggett or Delaney Bounds at Powers Pyles Sutter & Verville, PC (Leela.Baggett@PowersLaw.com or Delaney.Bounds@PowersLaw.com).

Respectfully submitted,

American Academy of Ophthalmology
American Academy of Otolaryngology–Head and Neck Surgery
American Association of Neurological Surgeons
American College of Gastroenterology
American College of Rheumatology
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Outpatient Endovascular and Interventional Society
Society of Interventional Radiology
Society of NeuroInterventional Surgery
The Society of Thoracic Surgeons

cc: CATHERINE.HAYES@MAIL.HOUSE.GOV
AMY.ZHOU@MAIL.HOUSE.GOV