Alliance of Specialty Medicine

25TH ANNIVERSARY

Sound Policy. Quality Care.

September 5, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

RE: Medicare and Medicaid Programs; 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

Dear Administrator Oz,

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians across 16 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care by advancing sound health policy, which has guided our response to CMS' proposals in the aforementioned rule on behalf of the undersigned members. Because many of CMS' major proposals affect Alliance member specialties differently, our comments focus on the fundamental policy issues that cut across all of our specialties, with the expectation that each member society will submit its own detailed, specialty-specific feedback.

CY 2026 Conversion Factor

For CY 2026, CMS proposes dual conversion factors as required under the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*, which established separate payment updates based on participation in the Quality Payment Program (QPP); that is, +0.75% for Qualifying Alternative Payment Model (APM) Participants (QPs) and +0.25% for non-QPs (e.g., MIPS participants). The proposed conversion factors (i.e., $33.5875 for QPs and $33.4209 for non-QPs), also reflect:

- A temporary, one-time +2.5% update for CY 2026 under the *Omnibus Budget Bill Budget Adjustment (OBBBA) of 2024*; and

- An approximately +0.55% budget-neutrality adjustment stemming from CMS proposals', and primarily, the implementation of an "efficiency" adjustment.

This year marks the first implementation of MACRA's value-based updates, with physician fee schedule payments differentiated based on QPP participation. However, as we have shared since the outset of MACRA's implementation, many specialists – including most Alliance member specialties – have few viable pathways into the Advanced APM track. Many of the existing models, including variations of Accountable Care Organizations (ACOs), are primary care-focused and not designed to meaningfully incorporate specialty care. Even when specialists are able to participate in such models, they often face limited opportunities to meaningfully engage and may have little or no access to shared savings distributions, despite contributing to cost and quality improvements.

In recent years, the CMS Innovation Center (CMMI) has touted a "strategy refresh," which includes designing and standing up new models intended to encourage greater specialist integration with primary care and population-based models. However, as the Medicare Payment Advisory Commission (MedPAC) observed in a November 2024 presentation, *"[m]ost A-APMs are available only in certain areas of the U.S. and are geared toward a handful of specialties*," leaving many specialists without a viable path to participate. The limited opportunity to engage in qualifying APMs has direct implications under MACRA, as the variation in PFS payment updates—intended to reward value-based care participation—does not reflect the current realities of specialty medicine. MedPAC has further warned that this differential-update approach may widen payment disparities over time.

Equally important, both updates remain well below the growth in physician practice costs, as measured by the Medicare Economic Index (MEI), and are further diluted by budget-neutrality requirements and other across-the-board reductions. In its March 2025 *Report to the Congress*, the Medicare Payment Advisory Commission (MedPAC) stated that:

> *Under current law, in 2026, payment rates are expected to increase by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other clinicians. Given recent high inflation, cost increases in 2026—which are currently projected to be 2.3 percent—could be difficult for clinicians to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.*
>
> *Given these mixed findings, for calendar year 2026, the Commission recommends that the Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point. Based on CMS's MEI projections at the time of this publication, the update recommendation would be equivalent to 1.3 percent. Our recommendation would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current*

> *law for 2021 through 2024, which have each increased payment rates for one year only and then expired.*

Consistent with our past comments and recognizing that CMS does not have the authority to update physician payments using an inflation proxy, we urge caution when proposing and finalizing payment policies that adversely impact the conversion factor.

Most importantly, however, ***we urge CMS to work with Congress on a long-term solution to the long-standing challenges facing the PFS, including the lack of a meaningful payment update based on practice costs. When combined with inflation and rising practice costs, the current statutory updates are unsustainable and already forcing some practices to close. We also urge CMS to expand efforts to develop specialty-relevant APM opportunities that enable all Alliance member organizations to meaningfully participate, qualify for the higher MACRA update, and access any shared savings and future APM bonus payments.***

Efficiency Adjustment

The Alliance recognizes CMS' goal of improving the accuracy of work RVUs and time inputs to reflect the resources required to furnish services. However, we disagree with the fundamental premise underlying the proposed across-the-board 2.5% "efficiency adjustment" for non-time-based services-that physicians inevitably and permanently become more efficient in delivering these services.

While clinicians in every specialty may experience some gains in workflow efficiency as they become more familiar with the services they deliver and the population that receive them, these gains are often temporary. Specialty medicine is not provided in a static environment: changes in technology, updated clinical guidelines, new safety and documentation requirements, and increasingly complex patient populations can all increase the time and intensity of a service, dampening or even reversing any supposed gains. CMS' proposal for a blanket reduction that it will continue to apply in future years assumes a one-directional trend toward efficiency that is not supported by the reality of medical practice, particularly in specialty care.

We also note that time-based services, such as evaluation and management (E/M), care management, and behavioral health services, inherently cannot achieve efficiencies in the same way. These services depend on direct patient interaction and complex clinical judgment, so reducing the time spent is often not appropriate and can harm the quality of care and patient outcomes. Yet under this proposal, these time-based services would realize payment increases funded by reductions to non-time-based services, even though those latter may not actually have become more efficient and the former cannot realistically be made more efficient.

CMS' impact analysis shows that procedural and surgical specialties would bear the brunt of the reductions, while certain primary and cognitive specialties would generally see increases. Although *all* specialties would benefit from a modest increase in the conversion factor through budget neutrality, this does not mitigate the risks of undervaluing certain services without solid empirical evidence. Recognizing there will be both "winners" and "losers" under this policy among its member societies, the Alliance maintains that the basic premise of the "efficiency adjustment" is flawed. It distorts relative values, devalues essential services, and creates instability across all specialties – undermining the Resource-Based Relative Value Scale (RBRVS) payment system on which the PFS is built. For these reasons, ***we urge***

CMS to replace its across-the-board approach with alternatives developed in collaboration with specialty societies and through existing processes to identify which services have realized efficiencies and which have not.

Practice Expense Methodology Proposals

The Alliance does not take a position on use of the AMA's updated Physician Practice Information (PPI) Survey and Consumer Price Index (CPI) Survey data, but agrees that updated, reliable cost data, are essential to ensuring accurate rate setting and strongly support use of specialty-society derived data. As we have shared in prior comments, CMS must work toward a more consistent and regular approach to updating all direct and indirect practice expenses (PEs). Last year, CMS completed its 4-year phase-in of clinical labor price updates, a policy that created significant reimbursement challenges for many Alliance specialties due to the budget-neutral nature of the PE component of the PFS, putting some services "underwater" when physicians cannot recoup the cost of delivery.

In addition, we continue to be interested in the work CMS has contracted to the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs, including technologies and service delivery models that rely on Software as a Service (SaaS) and artificial intelligence (AI). This work includes analyzing the updated AMA data as part of a revised PE methodology. And, we continue to support a 4-year review for direct practices expense inputs (i.e., clinical labor, supplies, and equipment).

However, the Alliance has concerns about CMS' proposal to reduce the portion of facility-setting indirect PE RVUs allocated based on work RVUs to half the amount allocated in the non-facility setting. While CMS aims to align practice expense payments with evolving practice ownership trends and believes many facility-based physicians no longer maintain separate offices, its proposed policy is based on speculation – not solid evidence. As such, it is a flawed premise on which to make policy changes that would shift significant Medicare dollars across the PFS.

As CMS' impact analysis shows, most office-based specialties would see increases in PE RVUs, providing much-needed relief as they face untenable pressure to consolidate. However, facility-based physicians would see substantial reductions regardless of whether they are employed by a hospital or operate independently, potentially accelerating their consolidation into larger systems. We note that many facility-based physicians – including several Alliance specialties – are still independent and privately-owned. According to the AMA's 2024 Physician Practice Benchmark Survey, over 42% of physicians overall remain in private practice, and ownership rates are especially high in certain facility-based specialties and subspecialties, such as ophthalmology. While they primarily deliver care in facilities, these specialists are *not* hospital or health system employees; they maintain independent office space, pay rent and utilities, employ schedulers, coders, billers, and compliance staff, and bear ongoing costs for office equipment, supplies, hardware and software, just like their office-based colleagues in medicine. Even among hospital-employed physicians, we have heard reports that some hospitals charge rent or overhead fees for office space, meaning these providers may also shoulder significant indirect costs.

The arbitrary reduction in facility-setting indirect PE allocation risks undervaluing the resource costs for many specialists. Physicians whose services must be delivered in hospitals or ASCs should not be penalized with depressed payments when they incur the same staffing, administrative, and operational expenses as their office-based counterparts. ***The Alliance urges CMS to explore alternatives that strengthen support for office-based practices without harming facility-based physicians who face the***

same economic pressures. More targeted approaches could include distinguishing between hospital-employed and independent facility-based physicians and collecting data on overhead arrangements between physicians and larger health systems. Finally, ***should CMS adopt practice expense changes that result in significant payment shifts, CMS should phase in those changes to avoid practice disruptions that could jeopardize patient access.***

E/M Visits: Complexity Add-on Code (HCPCS G2211)

CMS proposes to allow HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management (E/M) visit code family (CPT codes 99341–99345, 99347–99350), including an update to the descriptor. While some Alliance member organizations have adopted the code, our concern is not with the policy change itself but with the underlying utilization assumptions, particularly given the significant impact this code has already had on the conversion factor. Expanding the settings in which G2211 may be billed could further inflate CMS' projected utilization, triggering larger budget neutrality adjustments.

As we shared in our response to CMS' *Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information*, the agency's budget neutrality estimates for new codes are often overstated. This occurs when CMS projects high utilization for a new service, leading to a substantial negative budget neutrality adjustment, only for actual claims data to show much lower use. The American Medical Association (AMA) found this happened in CY 2024 when CMS established separate payment for G2211: CMS projected it would be used with 38 percent of all office and outpatient E/M visits, yet 2024 data suggest actual use closer to 11 percent. That overestimate not only drove a budget neutrality adjustment exceeding 2 percent but, according to the AMA, continues to suppress PFS spending by nearly $1 billion annually.

Under CMS' current policy, these overestimates are not corrected after the fact, meaning the resulting reduction to the PFS conversion factor becomes permanent. The Alliance believes that when actual utilization data confirm an overstatement of budget neutrality impacts, CMS should use its administrative authority to adjust the conversion factor accordingly. As an immediate step, ***CMS should apply this correction for G2211 in the CY 2026 final rule.***

Strategies for Improving Global Surgery Payment Accuracy

Individual Alliance organizations are impacted differently by CMS' global surgery proposals and will provide feedback in their individual comments. We remind CMS, however, that the vast majority of specialty societies within the Alliance invest considerable time and resources to participate in the AMA's Specialty Society Relative Value Scale Update Committee (RUC) and develop work and practice expense relative value recommendations for the services they provide. This process is widely recognized as open and transparent, with active participation from CMS staff. If the Agency has concerns about the relative value of services paid under the PFS, including the inputs used to establish those values (e.g., post-operative evaluation and management services), they should be addressed through appropriate channels, including the AMA RUC process.

Telehealth

CMS includes several proposals that would streamline access to Medicare telehealth services and make permanent certain flexibilities that have been in place since the public health emergency (PHE) for COVID-19. These include proposals to:

- Modify the Medicare Telehealth Services List and review process, including to consider all services that are currently on the Medicare Telehealth Services List as included on a permanent basis
- Permanently remove frequency limitations for Medicare telehealth subsequent care services in inpatient settings, subsequent care services in nursing facility settings, and critical care consultations
- Permanently define direct supervision to allow "immediate availability" of the supervising practitioner using audio/video real-time communications technology for all "incident to" services, except for services that have a global surgery indicator of 010 or 090

The Alliance strongly supports these proposals and appreciates the policies' emphasis on the physicians' professional judgment in determining whether services may be furnished via telehealth or supervised using telecommunications technology. The Alliance agrees that physicians are best positioned to determine whether services can be safely and effectively furnished via telehealth, based on each individual patient's clinical conditions and needs.

We highlight, however, that the statutory Medicare telehealth flexibilities that allow most beneficiaries to receive telehealth services from their homes are set to expire at the end of September. If Congress does not act to extend the flexibilities, beneficiaries who have come to rely on telehealth will experience unnecessary barriers to accessing safe and effective care from their homes. ***We therefore urge CMS to continue working with Congress to make permanent the statutory Medicare telehealth flexibilities that have been in place since the COVID-19 PHE, including elimination of originating site requirements and geographic restrictions.***

Finally, we raise concerns about the lack of any discussion in the proposed rule regarding the current flexibility for physicians to continue reporting their currently enrolled practice location instead of their home address when providing telehealth services from their homes beyond 2025. ***We urge CMS to extend and make permanent this flexibility, which has been critical for ensuring providers' privacy and safety, as well as for minimizing unnecessary administrative burden associated with updating enrollment records.*** If CMS declines to extend this flexibility, CMS should ensure that physicians are notified of the need to update their enrollment records and put in place processes to expedite processing of home addresses as new service locations. We are concerned that newly requiring reporting of home addresses with less than 5 months' notice will result in significant disruption in physicians' ability to furnish telehealth from their homes, ultimately reducing access and delaying care for Medicare beneficiaries.

Prevention and Management of Chronic Diseases – Request for Information

As directed under Executive Order (EO), "Establishing the President's Make America Healthy Again Commission," the Administration is directing its focus towards understanding and lowering chronic disease rates, including thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. The EO directs agencies to ensure the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits to support beneficial lifestyle changes and disease prevention. As such, CMS seeks feedback on multiple questions, including how CMS could better support prevention and management, including self-management, of chronic disease. The Alliance appreciates CMS' interest in supporting the prevention and management of chronic disease. However, these efforts cannot succeed if patients cannot access specialty medical care or the treatment and medication therapies central to managing their chronic illnesses. Without timely, reliable access to evidence-based care, patients are less able to maintain stability, prevent disease escalation, or fully engage in lifestyle changes. We support the administration's policy directive to make America healthier, but emphasize that this goal must be pursued alongside timely access to specialty treatment for disease, cancer, and injury. At the same time, we must strengthen the well-being of our healthcare providers, or risk undermining the very foundation of our health system and leaving patients without the support they need to care for themselves and their families.

Increasingly, Medicare beneficiaries face barriers such as prior authorization, step therapy, and non-coverage of clinically appropriate care. These utilization management practices not only delay or deny medically necessary services, but can also result in unnecessary or duplicative treatment. For example, step therapy in ophthalmology may delay access to longer-lasting therapies for macular degeneration and diabetic retinopathy, forcing patients to undergo additional visits, injections, and imaging – all of which raise costs and increase the risk of infection. The same dynamic is seen in gastroenterology and rheumatology, where step therapy and prior authorization delay access to more effective therapies, forcing patients to repeatedly "try and fail" on less effective medications and prolonging disease activity that worsens symptoms and increases disability. Such practices undermine disease prevention efforts and increase the risk of avoidable complications, including hospitalizations. Meaningfully addressing overly restrictive utilization management requirements is essential to advancing CMS' prevention and disease management goals. Voluntary pledges by payers are insufficient, regulatory action is needed.

In addition to the abovementioned barriers, certain CMS policies themselves prevent access to essential therapies. The Self-Administered Drug (SAD) Exclusion List is one such example, where the Agency's interpretation of the statute has categorically excluded coverage of specific physician-administered medications, even for beneficiaries facing physical or cognitive challenges, forcing them to pay out-of-pocket for their medicine or forego treatment altogether. This issue has prompted a class-action lawsuit, *Beitzel v. Becerra*, filed by Medicare patients harmed when a formerly covered drug, Stelara (ustekinumab), was added to the SAD List without notice, resulting in beneficiaries receiving unexpected bills; one beneficiary received a bill for over $40,000 each for four treatments. ***While we appreciate that CMS acknowledged concerns with the SAD List in its CY 2024 Medicare PFS as part of a request for information, revisiting the SAD List is critical to ensuring beneficiaries have access to the full range of appropriate treatments needed to prevent disease progression, reduce complications, and improve quality of life.***

Quality Payment Program

Merit-Based Incentive Payment System (MIPS)
MIPS Performance Threshold

The Alliance strongly supports CMS's proposal to retain the MIPS performance threshold at 75 points for the CY 2026 performance period through CY 2028. Maintaining this threshold provides important stability and predictability for practices and minimizes the chance of physicians incurring penalties at a critical time when Medicare payments are not keeping up with inflation.

MIPS Value Pathways (MVPs)
General

The Alliance continues to urge CMS to maintain MVPs as a voluntary pathway for clinicians, alongside traditional MIPS, so that clinicians have a choice of reporting pathways that best reflects their patient populations and practice needs. Among those specialties with an MVP, many of those MVPs do not have sufficient subspecialty coverage in the quality and cost categories for their subspecialists to be able to avoid a MIPS penalty. Therefore, rather than focus on this single new pathway, we urge CMS to continue to preserve choice while working with relevant clinical stakeholders and Congress to fundamentally improve the program.

Unfortunately, the MVP framework is not enough of a departure from traditional MIPS and fails to resolve underlying problems with the program that some Alliance member specialties believe have limited meaningful clinician engagement and hampered progress towards higher quality care. MVPs preserve the siloed nature of the four MIPS performance categories and fail to provide cross-category credit or recognize more comprehensive investments in quality improvement. MVPs also continue to rely on complex scoring and reporting rules, as well as qualified clinical data registry (QCDR) policies, that often disincentivize the development and use of more clinically-focused measures and participation pathways that align with clinical practice.

Subgroups

In preparation for 2026, when multi-specialty practices participating via MVPs are required to form subgroups, CMS proposes to modify the definition of a single specialty group to mean a group that consists of clinicians in one specialty type *or clinicians involved in a single focus of care,* and to revise the definition of a multispecialty group to mean a group that consists of clinicians in two or more specialty types *or clinicians involved in multiple foci of care*. CMS also proposes to require groups to attest to their specialty composition during the MVP registration process. Additionally, CMS proposes to exempt multi-specialty small practices from the subgroup reporting requirement.

In general, the Alliance requests that CMS reconsider its earlier decision to mandate subgroup reporting for multi-specialty group practices participating through the MVP pathway starting in 2026. We do not believe that CMS has the authority to mandate subgroup reporting under MACRA. The statute provides significant flexibility to MIPS eligible clinicians regarding participation. Where it is prescriptive, it states that CMS must establish a process to assess group practices on the quality performance category of MIPS and enables the Secretary to establish processes for assessing group practices on the other categories of MIPS. The statute also encourages MIPS participation by groups via

combining tax identification numbers (i.e., what is now known as virtual groups) rather than participation by subgroups, which involves subdividing TINs. As such, we do not believe that MACRA can reasonably be interpreted as requiring subgroup reporting for multi-specialty groups wishing to report MVPs at the group level. In addition, CMS does not yet have a sufficient foundation of data related to subgroup reporting, nor does it have a sufficiently robust inventory of MVPs or viable subspecialty measures to force groups to segment off into subgroups for purposes of MIPS compliance. According to the 2023 QPP Experience Report, 20,484 clinicians submitted MVP data during the CY 2023 performance year, but only 6,790 received a final score from MVP reporting. Importantly, only 101 clinicians participated via subgroups, which represents only 0.02% of all MIPS eligible clinicians in 2023. Given these numbers, we believe that CMS should continue to maintain it as a voluntary option while it collects more data on subgroup reporting patterns, practices, and challenges. This delay will also allow CMS time to develop additional MVPs to cover more specialties and subspecialties, develop additional measures to populate MVPs, and address MIPS scoring issues that continue to disincentivize the use of more specialized measures.

Regardless of whether CMS moves forward with the subgroup requirement in 2026, or maintains it as a voluntary reporting pathway, it is critical that CMS provide practices with the flexibility and autonomy to declare the composition and focus of their group. ***As such, the Alliance strongly supports CMS's proposal that group practices reporting via an MVP be required to attest to their group composition (either single- or multi-specialty) during registration.*** We strongly support this self-attestation approach in lieu of CMS using claims data to designate a group as either a single specialty or a multispecialty group.

We also support CMS's proposal to revise the definitions of single and multi-specialty groups to account not only for the specialty types in the group, but the group's clinical focus, which will ensure that multi-specialty groups with a single clinical focus (e.g., cardiovascular care) would not be required to form subgroups for purposes of MVP reporting.

Finally, we support CMS's proposal to exempt multi-specialty small practices from the subgroup reporting requirement. There is adequate data to demonstrate the challenges that small practices continue to face in MIPS, and this proposal ensures small practices will not be further stretched by this mandate.

In regard to the revised definitions of single and multi-specialty groups, we request that CMS make the following modifications to its proposed definitions to more accurately capture what we believe is CMS's intent under this proposal and to ensure the definitions are mutually exclusive:

- *Multispecialty group means a group as defined at § 414.1305 that consists of clinicians in two or more specialty types NOT involved in a single foci of care or clinicians in two or more specialty types involved in multiple foci of care.*
- *Single specialty group means a group that consists of one specialty type or consists of clinicians in two or more specialties involved in a single focus of care.*

Core Elements MVP RFI

CMS is considering a policy to require an MVP Participant to select one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements," for one of their four required quality

measures. ***The Alliance questions the value of this policy, particularly to patients looking to MIPS performance data to make determinations about a specific condition or treatment.*** MVPs are intended to focus on specific types of care and patient populations. CMS's vision of "core elements" within each MVP seems to contradict that approach. If anything, the MIPS program needs incentives for the development and use of more specialized measures; not more broad, cross-cutting measures. The former can be of great value to the patient, while the latter might simply add to clinician reporting burden without any clear benefit.

We are also concerned about CMS's common practice of looking at a measure title and assuming it is applicable to a broader population than is described in the measure's specifications. **We have seen measures in MVPs that CMS considered to be cross-cutting – applicable to the broad range of specialties reporting the MVP – but are, instead, limited to only certain specialties in the measure specification.** Last year, CMS finalized a Surgical Care MVP that included measure 357: Surgical Site Infection, which CMS assumed was cross-cutting. However, measure 357 does not reflect the range of surgical procedures captured by the Surgical Care MVP. For example, none of the CPT codes representing neurosurgical procedures are included in the denominator of the measure. As a result, most neurosurgeons are not even eligible to report this measure. ***Overall, we believe that cross-cutting measures should only be included in MVPs if they remain optional.***

Measure Procedural Codes RFI

CMS is considering a potential future policy to require clinicians to report a specific MVP based on the procedural codes that they bill. Since there may be measures within an MVP that are more relevant to an individual specialist based on the types of services they perform, CMS is further considering requiring specialists to report specific measures within an MVP.

The Alliance strongly urges CMS not to pursue the use of procedural codes to assign clinicians to MVPs. CMS should instead continue to allow clinicians to self-select MVPs to report, and to select specific measures and activities from within their chosen MVP that are most relevant to their practice and patient population. As we discuss below in our comments related to the proposed Ambulatory Specialist Model (ASM), we have serious concerns about assigning clinicians to a specific set of measures based on claims data given the fact that claims data has numerous limitations and does not always accurately capture a clinician's specific scope of practice**. Importantly, CMS acknowledges the limitations of claims data in its discussion about subgroup reporting. In that section, CMS cites the challenges and nuances of using claims analyses to accurately identify the specialty composition of a group, and recognizes that utilizing claims data would result in CMS incorrectly identifying the specialty composition of a group.** CMS instead proposes to give groups the freedom to attest to the specialty composition of their group due to this limitation. ***We strongly urge CMS to take a similar approach when it comes to measure selection, as only the clinician or group itself truly understands what measures are most applicable to their patient populations.***

MIPS Quality Category

Inventory of Quality Measures

CMS has stated numerous times within and outside of rulemaking that the large number of measures in MIPS is one of the primary contributors to the program's complexity and reporting burden. More recent statements by the Administration seem to suggest that it would like to significantly pare back the number of available MIPS measures in the coming years. ***The Alliance strongly disagrees with this sentiment and urges CMS to better incentivize a more diverse inventory of measures while focusing on fixing other more challenging aspects of the program***. While there are numerous aspects of MIPS that make it complex and limit its effectiveness— including the siloed performance categories, each of which has its own set of reporting and scoring rules— the number of available measures is not one of them. It is actually more burdensome for a clinician to identify measures to report when the options are limited and only marginally relevant to a clinician's patient population. **Greater measure choice, on the other hand, results in a program that is less challenging to navigate and more meaningful to clinicians and their patients.**

MIPS is unlike any other CMS quality program in that it focuses on clinician-level accountability. The same assumptions that apply to facility-focused and population-health focused quality programs— where measure sets are more limited, focus on large teams of clinicians working together towards an end goal, and pin accountability to an overarching entity that has the infrastructure to manage such care—do not work in MIPS. ***So long as MIPS remains tied to physician payment and physician-level accountability, it is critical that CMS employ a comprehensive measure inventory that reflects the diversity of physician practices and focuses on actions over which each specialist has direct control.*** With existing tools such as MIPS specialty sets and the evolution of MVPs, which organize measures into subsets focused on a specific specialty or condition, it is disingenuous for CMS to claim that navigating a large measure inventory is one of the biggest challenges that clinicians face under MIPS. ***The Alliance strongly advises CMS to abandon its goal of attaining a more parsimonious set of MIPS measures and to instead develop policies and technical assistance that encourage the development and reporting of measures that are directly meaningful to both clinicians and their patients.***

Administrative Claims Measures

Beginning with the 2025 performance period, CMS proposes to revise the benchmark methodology for administrative claims quality measures so that it would be based on standard deviation, median, and an achievement point value that is derived from the performance threshold. Based on its analysis of quality measure scores for the CY 2022 performance period/2024 MIPS payment year, CMS observed lower scores for the administrative claims-based quality measures than for the non-administrative claims-based quality measures. This proposal is expected to increase the mean quality performance category score about 3.67 points and aligns with the revised benchmarking methodology finalized for MIPS cost measures in the CY 2025 MPFS final rule, starting with the 2024 performance year.

Ideally, the Alliance would like CMS to remove these administrative claims measures from MIPS since they do not capture costs within the direct control of individual clinicians and are more appropriate for facility or system-level accountability programs. However, if administrative claims measures remain in the program, then the Alliance supports CMS's proposal to update the benchmark methodology and appreciates CMS taking action to address this problem. Most of the specialties we represent are often scored on these measures and often do not perform well on them relative to other quality measures, yet find it challenging to understand what role they played in overall performance.

Transition Towards Digital Quality Measurement RFI

CMS aims to transition to a fully digital quality measurement (dQM) landscape that promotes interoperability and increases the value of reporting quality measure data. CMS hopes to leverage standardized data and models to accelerate and support the transition to a data-driven healthcare system. As part of that transition, CMS seeks feedback on its anticipated approach to the use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting for the MIPS quality performance category. ***The Alliance appreciates efforts to transition to more seamless and automatic methods for reporting and analyzing quality data, but we remind CMS of the ongoing challenges related to the implementation of eCQMs. Transitioning fully to eCQMs, and eventually dQMs, will require significant investments in new technologies, infrastructure, and staff training, which is challenging for many organizations. We request that CMS keep these real challenges and the current landscape of real world EHR functionality in mind as it continues to develop a plan for transitioning to digital quality measurement. This is particularly important given the challenges noted earlier in capturing practice expense data; any significant increase in practice expenditures such as a transition to dQMs thus may not be adequately accounted for in current models.***

MIPS Cost Category

Informational Feedback Period

Beginning with the 2026 performance period, CMS proposes to provide a 2-year informational-only feedback period for new cost measures. ***The Alliance very much appreciates and strongly supports this proposal as it will provide CMS and the public with additional time to test new cost measures in actual practice, and potentially revise them, if necessary, before they are tied to payment.*** Many of our members societies have contributed clinical expertise to assist CMS and Acumen with the development of episode-based cost measures to date. This work has been challenging, complex, and often results in final measures for which consensus is not fully reached. In addition, the field testing of these measures continues to identify issues related to the administration of associated performance feedback reports. The Alliance believes this proposal will provide more time to address some of these ongoing challenges.

Updates to the Total Per Capita Cost (TPCC) Measure

Beginning with the 2026 performance period, CMS also proposes substantive changes to the TPCC measure that would limit instances when the measure is attributed to highly specialized groups based solely on billing of advanced care practitioners (ACPs). CMS proposes to revise the measure so that 1) clinicians are only attributed costs for beneficiaries that have had at least two qualifying services from the same clinician group, and where both services were provided by a clinician that is not excluded from measure attribution due to the specialty exclusion; and 2) ACPs are excluded from attribution in situations where *all* physicians in the group are excluded based on the specialty exclusion criteria.

The Alliance appreciates CMS's effort to try to improve this highly flawed measures, which has suffered from problems for many years now. While most specialties are technically excluded from this measure, which specifically emphasizes the role of primary care in managing overall healthcare costs, they are often unexpectedly pulled into this measure and held accountable for total patient costs due to a

severely flawed attribution methodology. Making matters, specialists often receive relatively low scores on this measure even though they are not the intended target of this measure.

Ideally, the Alliance would like to see CMS retire the TPCC measure from MIPS. We appreciate CMS's proposed updates to the measure, but do not believe they will sufficiently solve the ongoing problems with this measure. Furthermore, as CMS continues to expand its portfolio of episode-based cost measures, we see no reason to maintain such a problematic measure in the program.

In the absence of removing the TPCC measure from the program, the Alliance supports updates to the measure to ensure it only accounts for costs within the direct control of the physician and excludes all specialties as intended. We appreciate CMS's proposed changes, but do not believe the second proposed criteria, which would only exclude ACPs from attribution in situations where <u>all</u> physicians in a group are excluded based on the specialty exclusion criteria, is an adequate approach. This 100% threshold could still result in non-primary care practices being held accountable for the measure if it includes a single non-excluded specialty. ***Instead, we urge CMS to consider a better approach for ensuring that specialists are excluded from this measure, such as the use of patient-relationship codes or other similar attestations.*** This would also align with CMS's earlier proposal in this rule related to subgroups, where CMS proposes to account not just for the specialty composition of the group, but the clinical focus of the group through self-attestations.

Finally, if CMS opts to maintain and update this measure, we strongly urge CMS to apply any finalized improvements starting with the 2025 performance period, rather than 2026. The public has voiced concern about the far-reaching negative impact of this flawed measure since it was first used in the Value Modifier program, making timely adjustments to this measure critical. We believe it is possible for CMS to finalize these revisions earlier than proposed since MIPS cost measures rely on performance-year benchmarks and this policy would technically be finalized prior to the end of the 2025 performance year.

<u>Qualifying Participants (QPs) in Advanced APMs</u>

Eligible clinicians who meet threshold levels of participation in Advanced APMs to become QPs are excluded from MIPS reporting requirements and payment adjustments. QPs will receive a 1.88% APM Incentive Payment in the CY 2026 payment year (based on CY 2024 eligibility), which is the last year that the APM Incentive Payment is available under law. Beginning with the CY 2026 payment year, QPs will also receive a higher PFS payment rate, calculated using the differentially higher QP conversion factor update of 0.75%, while non-QPs will receive a smaller update of 0.25%. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

CMS assesses the level of participation in Advanced APMs to determine QP status based on specific payment amount or patient count thresholds that are set in statute. These thresholds increase substantially under law starting with the CY 2025 performance year/CY 2027 payment year. The threshold percentages are calculated using the ratio of attributed beneficiaries to attribution-eligible beneficiaries. If the Threshold Score (using either the payment amount or patient count method), generally calculated at the APM Entity, meets or exceeds the relevant QP threshold, all of the clinicians on the APM Entity's Participation List achieve QP status for such year.

Similar to last year, CMS proposes to determine QP status at the individual level, as well as the APM Entity level. CMS also proposes to use Covered Professional Services as the set of services used for QP determinations (rather than just E/M services) to more accurately reflect eligible clinicians' actual participation in Advanced APMs and to minimize incentives for APM Entities to exclude specialists from their Participation Lists.

The Alliance has long voiced concern about barriers to specialty participation in APMs, including the ongoing lack of relevant APMs, but also policies that result in APMs excluding specialists from their Participation Lists. ***As such, the Alliance supports CMS's proposal to add an individual level calculation to QP determinations for all eligible clinicians participating in an Advanced APM. We also support CMS's proposal to expand the definition of "attribution-eligible beneficiary" to include any beneficiary who has received a covered professional service furnished by the eligible clinician for whom CMS is making the QP determination, beginning with the 2026 QP performance period.*** This proposal would help to address the current issue of specialists being excluded from APM Participation Lists based simply on the types of services they bill.

At the same time, we continue to have concerns that these policies, in isolation, will only have a small impact on specialty participation in APMs. CMS notes that the quantitative effects of these proposals will be small in light of the significant threshold level change to QP determinations, starting with the CY 2025 performance year/CY 2027 payment year. Additionally, specialists still lack meaningful models to choose from. ***We continue to urge the Innovation Center to work with specialty societies (some of which have invested heavily in the development of thoughtful models) to test innovative, non-mandatory APMs that better capture the value of specialty care. The Alliance also requests that CMS work with us to urge Congress to make technical changes to MACRA that would extend the APM incentive payment and return QP thresholds to their previously lower level to 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.***

Ambulatory Specialty Model

The Alliance appreciates CMS' commitment to improving care for Medicare beneficiaries with chronic conditions through the development of alternative payment models (APMs). ***However, we have significant concerns with the proposed Ambulatory Specialty Model and strongly urge CMS to not move forward with the model as currently designed. Instead, we encourage CMS to work directly with specialty societies to develop voluntary opportunities that improve patient outcomes, incentivize care transformation, and support providers in managing chronic and complex conditions.***

As proposed, the Ambulatory Specialty Model would mandate participation for all eligible specialty physicians in selected geographic areas beginning in 2027. This approach raises serious concerns. Although CMS states that mandatory participation is necessary to eliminate selection bias and ensure sufficient sample size, ***the Alliance does not believe mandatory participation is appropriate in a model that imposes downside risk, restricts reporting flexibility, and relies on an untested performance framework.*** Physicians vary significantly in their readiness to participate in APMs, and mandating participation disregards differences in infrastructure, data and analytic capabilities, staffing, and capital. Imposing such requirements without adequate preparation risks both clinician disengagement and unintended consequences for patients. Instead, models should be designed to provide participants who are ready with meaningful opportunities to engage and share in appropriate financial risks and rewards

for reducing costs and driving quality improvements under the model. CMS should also establish incentives and supports that enable practices to build the necessary capabilities to successfully transition into value-based care models.

CMS has also chosen to build the Ambulatory Specialty Model around the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) framework, despite widespread concern among specialties that MVPs do little to address the fundamental flaws in traditional MIPS. For example, MVPs do not meaningfully integrate the four MIPS performance categories, resulting in duplicative and burdensome reporting requirements. MVPs also continue to rely on measures that often lack clinical relevance, do not reflect the complexity of managing chronic conditions, and fail to adequately capture the team-based nature of care delivery. Importantly, MVPs have not demonstrated their ability to prepare clinicians for Advanced APM participation, despite being intended as a pathway towards such models. By mandating reliance on this unproven MVP framework, CMS risks compounding existing flaws rather than creating a true path forward for specialists to meaningful engage in value-based care.

The Alliance is also concerned that the Ambulatory Specialty Model would require physicians to participate and report as individual clinicians, even if they have historically reported MIPS as part of a group or APM entity. This shift would increase administrative burden and limit the ability of physicians to leverage team-based structures that are central to managing chronic conditions. **Further, unlike in MIPS, Ambulatory Specialty Model participants will be required to report on a subset of measures, many of which may not be clinically relevant to the participants' practices or the care they furnish.**

The financial design of the Ambulatory Specialty Model raises additional concerns and further undermines its viability. Under the proposed model, clinicians could be subject to financial penalties as high as 12 percent of Medicare Part B spending in the later years of the model, exceeding the maximum penalty under MIPS. The escalation in financial risk is likely to disproportionately affect small and resource-constrained practices, as well as clinicians with limited experience in value-based care. Moreover, unlike MIPS, which is designed to be budget neutral, the Ambulatory Specialty Model reduces the amount of funds available for payment adjustments by 15 percent. While this approach guarantees savings for the Medicare program, it does so by significantly reducing the amount of funds available to be redistributed to high-performing clinicians, thereby weakening incentives under the model.

Finally, we are concerned that the Ambulatory Specialty Model would not qualify as an Advanced APM under the Quality Payment Program. Specialists have consistently called for additional opportunities to participate in Advanced APMs, yet this proposal does not include an opportunity while increasing the amount of financial risk that clinicians could be subject to. **If CMS seeks to meaningfully engage specialists in value-based care, models must provide a pathway into Advanced APM participation rather than simply reinforcing the limitations of MIPS.**

The Alliance believes that specialty-focused models should be developed through robust engagement with the clinicians who will be most affected. Past efforts have too often lacked adequate specialty input, resulting in models with metrics that are not clinically relevant, designs that do not reflect the realities of specialty care, and mandatory structures that simply result in payment cuts rather than true opportunities to transform care delivery.

Specialists play a critical role in managing chronic conditions, often moving care upstream and preventing escalation to more acute, costly settings. Yet existing APMs, which are largely led by primary care, do not adequately account for this role. This has contributed to delayed referrals, misaligned financial incentives, and reduced patient access to appropriate specialty care. Often these models have been developed without adequate specialty input, resulting in metrics that are not clinically relevant, processes that do not reflect the realities of care delivery, and structures that prioritize cost savings over patient access and outcomes. Innovative payment models should instead seek to improve patient outcomes and quality of life by expanding access to high-value specialty care. Models should also reflect the team-based, complex nature of chronic care management and should align incentives in ways that foster collaboration rather than redundancy.

For these reasons, the Alliance strongly urges CMS not to finalize the Ambulatory Specialty Model as proposed. Instead, we encourage CMS instead to work collaboratively with specialty societies to design models that are voluntary, grounded in clinically meaningful measures, structured to incentivize rather than mandate participation, and aligned with a pathway to Advanced APM participation. Such an approach would better serve beneficiaries with chronic conditions, foster genuine care transformation, and advance the Administration's goals of improving quality and reducing costs.

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We appreciate the opportunity to comment on these important issues and welcome the opportunity to meet with you to discuss them in more detail. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Association of Neurological Surgeons
American Academy of Otolaryngology – Head and Neck Surgery
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Dermatologic Surgery Association
American Society of Echocardiography
American Society of Retina Specialists
American Urological Association
Congress of Neurological Surgeons
North American Spine Society
Society of Interventional Radiology