Alliance of Specialty Medicine

Sound Policy. Quality Care.

May 14, 2026

The Honorable Greg Murphy, MD, Co-Chair Republican Doctors Caucus
The Honorable John Joyce, MD, Co-Chair Republican Doctors Caucus
The Honorable Kim Schrier, MD, Chair, Democratic Doctors Caucus
U.S. House of Representatives
Washington, DC 20515

Sent electronically to catherine.hayes@mail.house.gov; amy.zhou@mail.house.gov

RE: Feedback on MACRA Discussion Draft (4/23/2026 - G:\M\19\JOYCPA\JOYCPA_043.XML)

Dear Chairs Murphy, Joyce, and Schrier:

The undersigned members of the Alliance of Specialty Medicine (Alliance) thank you for your leadership and welcome the opportunity to comment on your April 23 Discussion Draft to modernize the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). The Alliance, which represents 15 specialty organizations and more than 100,000 physicians, is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. The Alliance greatly appreciates your proactive engagement and willingness to collaborate with us and other stakeholders.

For your convenience, we have organized our comments to follow the Titles and Sections of your discussion draft. We would be happy to meet with you to discuss it in greater detail.

TITLE I—STRENGTHENING REIMBURSEMENT AND PATIENT ACCESS

SEC. 101. MODIFYING THE CONVERSION FACTOR UPDATES APPLICABLE TO PHYSICIANS' SERVICES UNDER THE MEDICARE PROGRAM. (pp. 2-3)

We appreciate that the discussion draft would incorporate a Medicare Economic Index (MEI)-based update into the Medicare physician fee schedule (PFS), however, applying adjustments or caps to that update falls short of ensuring that physician payment reflects the full cost of providing care. As we have emphasized in prior comments, ***Medicare physician payment must include an annual, predictable update tied to the full MEI to account for inflation in practice costs***. ***We, therefore, support the provisions in H.R. 6160, Strengthening Medicare for Patients and Providers Act, which would provide a permanent, inflation-based update equal to 100 percent of the MEI, without reductions or caps.*** A full MEI update is essential to promote long-term stability in the Medicare physician payment system and help ensure continued patient access to specialty medical care.

SEC. 102. INCREASING PAYMENTS FOR PRIMARY CARE SERVICES. (pp. 3-5)

We are concerned that the proposal to increase payments for primary care services keeps the Medicare PFS on an imbalanced pathway that fails to address broader issues of payment adequacy across *all* of medicine. Specialty and subspecialty care are also facing significant workforce and reimbursement challenges. The proposal also compounds existing payment disparities across specialties and services and may further accelerate consolidation. As seen in the past, practices that are not eligible to receive additional payments will face increasing financial pressure to sell to or merge with larger hospital and health systems, further reducing independent, community-based practices.

In addition to these broad concerns, we note that the draft does not define "primary care services," instead leaving this determination to the Secretary. Policymakers and its advisors- including the Medicare Payment Advisory Commission (MedPAC)- have historically viewed primary care services as office and outpatient evaluation and management (E/M) service codes. However, "primary care" may be delivered through a broader set of services, including care management and longitudinal, complexity-based services (e.g., chronic care management [CCM], transitional care management [TCM], and the complex care add-on code [G2211]). As drafted, it is unclear whether the policy is intended to align with the historical "office visits" definition or apply more broadly to other primary care-focused services. This lack of clarity has implications for physicians across specialties, including those who furnish the aforementioned services in certain contexts. ***We urge the Joint Doctors' Caucuses to clarify the scope of services eligible for the payment increase to support transparency and allow stakeholders to assess the potential impact of the policy.***

In addition, while staff have clarified that the proposed $500 million payment increase across the 5-year MIPS transition period is intended to be cumulative over time, the discussion draft text referencing an "amount specified" (p. 4. line 14) relative to "payment amounts otherwise determined under this section" (p. 4, lines 4-5) suggests the increase is applied each year and then reset. The accompanying summary document, which describes the payment as an "add-on," supports this interpretation. This structure would be more consistent with a fixed annual add-on, similar to the MIPS exceptional performance bonus, which was funded through a pre-determined funding pool and did not result in a significant financial cliff, rather than a cumulative update. This distinction has significant implications for the Medicare program, taxpayers, and beneficiaries, particularly with respect to the cost of the policy and its potential impact on beneficiary premiums; a $2.5 billion investment vs. a $7.5 billion investment represents a materially different commitment. ***The Alliance urges the Joint Doctors' Caucuses to revise the discussion draft to clarify its intent to ensure transparency and predictability in Medicare payment policy.***

TITLE II – MIPS

SEC. 202. PAYMENT REFORM. (pp. 6-18)

Performance Categories

The discussion draft proposes to remove the Promoting Interoperability performance category, as well as the Improvement Activities category. It would preserve the Quality and Resource Use categories (i.e., currently referred to as "Cost' under MIPS) and add a new performance category titled, "Cost Containment." The draft also assigns the following weights to these categories: Quality: (50%); Resource Use (25%); and Cost Containment (25%).

Quality

The Alliance opposes shifting more weight to the Quality category prior to addressing current disincentives to develop, maintain, and report more specialty-relevant MIPS quality measures. Although this draft also establishes a Task Force tasked with initially prioritizing quality measures for specialties with an inadequate set of measures, the Task Force only has the authority to make *recommendations* regarding such measures. Our interpretation of the current language is that these recommendations are not binding, meaning CMS is under no obligation to adopt measures recommended by the Task Force. In addition, there does not appear to be any mechanism in this discussion draft to incentivize or provide financial and/or technical support for the actual development, maintenance and use of new specialty-focused quality measures. As a result, the current inventory of quality measures will remain inadequate for many specialists, a situation that is only expected to get worse as CMS continues to cut back on measures.

Additionally, we remind Congress of the negative impact this could have on small practices. In finalizing performance category redistribution policies in the past, even CMS acknowledged that small practice face unique

infrastructure and resource limitations that cause them to do worse on quality than larger practices and that it would be unfair to shift too much of their weight to the Quality category.[1]

Resource Use/Cost Containment

The Alliance is deeply concerned about the draft proposal to maintain the Resource Use performance category while also adding a new and seemingly similar Cost Containment category. ***We request clarification on the definition and intent of "Cost Containment," which is not described in the current draft, and how this new category would differ from the current Resource Use (i.e., Cost) category.***

The Alliance also strongly opposes adding more weight to cost-focused metrics given all the challenges CMS has encountered and yet to resolve related to cost measurement. These include, but are not limited to, the following:

- Challenges related to the development of accurate attribution and risk-adjustment methodologies;
- Limitations related to cost measures derived solely from claims data;
- Misalignment of cost and quality measures, including measuring cost in isolation and failing to account for the direct impact that changes in spending have on quality and access to care;
- Measures that disincentivize the appropriate use of interventions based on medical judgment;
- Challenges related to clinician-level accountability and measures that reflect care decisions and costs that are outside of an individual clinician's direct control (particularly in regard to existing Total Cost of Care measures); and
- Overly complex and inactionable cost performance feedback.

This draft proposes to assign 50% of a clinician's total score to Resource Use and Cost Containment, versus the current program, which only assigns 30% to Resource Use (i.e., Cost). ***We strongly urge Congress <u>not</u> to shift additional weight to cost-related measurement and instead shift resources to addressing ongoing challenges related to cost measurement at the clinician-level.***

Congress should also:

- ***Repeal Section 1848(r)(5)(C)(i) of the SSA, which requires the Secretary to use total per capita cost measures to measure resource use***. These measures continue to hold physician practices — including specialties that are explicitly excluded from the measure — responsible for costs outside of their control; and
- ***Repeal Section 1848(r)(2)(D)(i)(I) of the SSA, which requires the Secretary to establish episode-based cost measures that account for at least 1/2 of part A and B expenditures (with such target increasing over time as appropriate).*** While we recognize that this target is intended to identify significant areas of Medicare spending for evaluation, it forces CMS to develop measures based on volume, rather than on opportunities to reduce variations in care and produce savings in Medicare. Removing this requirement would help to ensure prioritization of episodes with high variability and that specialists can directly impact.
- ***Require that any evaluation of physician cost simultaneously account for any changes in quality and access to care among the same patient population to ensure cost-containment efforts do not have a negative impact on care***. At the very least, Congress should require CMS to produce regular reports evaluating the impact of cost-related measures on quality and access.

Improvement Activities

While the Alliance appreciates Congress' attempt to reduce the number of performance categories, we oppose the removal of the Improvement Activities category, which has historically allowed clinicians to demonstrate their commitment to innovative and impactful care improvement activities that are not easily captured through the numerator/denominator format of traditional measures. Improvement Activities are also more flexible in nature. This allows different specialties to work towards the same goals, but in ways that are unique and

[1] https://www.federalregister.gov/d/2021-14973/p-3077

meaningful to their practice and patient population. In contrast, quality measures have rigid specifications and strict inclusion and exclusion criteria that make certain measures unsuitable for certain specialties, even if they seem applicable in title.

Improvement Activities also represent a range of themes that encompass and transcend existing MIPS performance categories (e.g., care coordination, beneficiary engagement, expanded practice access, enhancing health and wellness, transparency, resource use, and even promoting interoperability). This makes the Improvement Activities category the ideal tool for recognizing clinicians who engage in comprehensive value-based activities that satisfy numerous CMS priorities, such as reporting and regularly tracking performance through a clinical data registry.

Examples of current improvement activities that would no longer be recognized if this category were to be removed include:

- Program*s* that support clinician well-being,
- Participation in private payer clinical practice improvement activities,
- Enhanced engagement of Medicaid and other underserved populations*,*
- Cost display for laboratory and radiographic orders,
- Implementation of analytic capabilities to manage total cost of care for practice population,
- Implementation of financial navigation programs for patients,
- Use of interoperable clinical-decisions support tools to manage workflow and adherence to clinical guidelines,
- Participation in Maintenance of Certification, and
- Using Qualified Clinical Data Registry (QCDR) data for ongoing practice assessments and improvements.

We strongly recommend that Congress continue to employ the Improvement Activities category as it provides meaningful opportunities for clinicians to shape both the culture and effectiveness of their practice and, ultimately, to improve the overall value of care.

Quality Reform Task Force

Overall Intent

As we have expressed in the past, current policies disincentivize investment in specialty-specific measures and QCDRs. It is extremely resource intensive for specialists to develop, test, submit for approval, and maintain MIPS quality measures over time, particularly as CMS continues to raise the bar on acceptable measures, insisting almost exclusively on outcome and electronically-specified measures. Even when meaningful measures are available to a specialty, MIPS reporting and scoring policies have created disincentivizes for clinicians to report them. This, in turn, results in the removal of such measures from the program, which leaves specialists with fewer relevant measures and further disincentivizes specialty society investment in new measure development. As a result of these policies, there has been a considerable shift in specialty society willingness to invest in MIPS measure development and QCDRs, which were originally authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. This trend is regrettable since clinician-led registries tend to collect more meaningful and comprehensive measures, including patient-reported outcomes data, that cannot be captured through claims. They also provide more timely and actionable feedback that is often more relevant to participating clinicians and their patient populations than what is provided by CMS under MIPS.

The Alliance is concerned that the new Quality Reform Task Force does not address the underlying issues that are increasingly standing in the way of more relevant and meaningful measures being used in the program. While we appreciate that the Task Force would have representation from different specialties and prioritize specialties with an inadequate set of such measures, it would simply be making recommendations on measures that should be used in the program. As far as we can tell, it does nothing to address ongoing barriers, such as

providing resources and/or technical support for the development, maintenance and use of specialty-focused quality measures. Since there is no mandate for CMS to adopt measures recommended by the Task Force, it also seems similar to current law,[2] which already requires the U.S. Department of Health and Human Services to contract with a consensus-based entity (CBE) to vet and make recommendations about the use of certain measures in federal programs, while providing CMS with the flexibility to ignore the CBE's recommendations. ***We urge Congress to: 1) require CMS to better incentivize the development and use of specialty-focused metrics through technical assistance, less resource-intensive measure testing and maintenance policies, and revised MIPS scoring policies; and 2) require that CMS adopt measures recommended by the Task Force.***

Task Force Authority

If Congress declines to require CMS to adopt measures recommended by the Task Force, an alternative could be to establish an independent appeals panel, with members appointed by Congress, vested with explicit authority to review any quality measure that has been approved by the Task Force but subsequently rejected by CMS. Review by the panel should be triggered automatically upon any such rejection. CMS should be required to submit to the panel, and to the specialty society that proposed the measure, a written justification for the rejection. The justification should include specific information regarding the clinical, methodological, data-related, and resource-related grounds for the decision, as well as all underlying analyses and supporting materials considered by the agency. The panel should be required to review the complete record and issue a binding determination within a defined statutory timeframe. Such a mechanism would create a meaningful safeguard against the unjustified rejection of measures vetted through the Task Force process while preserving CMS's broader role in program administration.

Prioritization of Measures

The Alliance also recommends that the Task Force prioritize the development and recommendation of new quality measures, particularly for specialties, subspecialties, and clinical areas with inadequate measure inventories, rather than directing its limited resources toward revisiting measures already in the program. Focusing the Task Force's initial efforts on closing existing measure gaps will better align the body's work with the underlying purpose of its establishment and help ensure that all specialties have access to clinically meaningful, validated measures within a reasonable timeframe.

Specialty Representation

The Alliance recommends that the legislation require representation of the relevant specialty or subspecialty on the Task Force whenever a measure pertaining to that specialty is under consideration. Without specialty or subspecialty representation at the time of deliberation, the Task Force risks recommending measures that are clinically unsuitable, technically infeasible, or unrepresentative of contemporary practice.

Certified EHR Technology (CEHRT) Submission Requirement

The Alliance opposes the proposed restriction limiting the Task Force to recommending only those quality measures for which data can be submitted through CEHRT. The Task Force should be allowed to recommend measures to the extent that data for such measure can be reported through CEHRT or a clinical data registry. Conditioning Task Force authority on electronic specification would arbitrarily exclude clinically meaningful, validated measures and would further disadvantage specialties whose measure development has not yet been, or cannot reasonably be, aligned with electronic specifications. This change would also harmonize this section of the bill to match Section 202(3)(A)(III).

CEHRT and QCDRs for Reporting Quality Measures

Under current law, CMS is only required to **encourage** clinicians to report quality measures via CEHRT or QCDR. However, under this draft legislation, beginning in 2027, a MIPS eligible professional who fails to report on an

[2] 42 U.S. Code § 1395aaa

applicable quality measure through the use of CEHRT or a clinical data registry will receive the lowest potential score on such measure.

The Alliance very much appreciates this effort to encourage the use of registry reporting. However, we request that Congress clarify that for purposes of this scoring policy, reporting through either a Qualified Clinical Data Registry (QCDR) or a Qualified Registry would satisfy this requirement. We also request that Congress clarify whether this new language would preserve or negate existing exceptions that apply to clinicians with special status, such as small practice clinicians who might still report measures via Part B claims due to a lack of resources or other technical barriers related to reporting by registry or EHR. ***We strongly urge Congress to preserve CMS' authority to adopt flexible policies for special status clinicians, including exceptions from the requirement to report on measures via CEHRT or clinical data registry when applicable***.

Definition of Clinical Data Registry

In addition, the Alliance requests clarification regarding the use of the term "clinical data registry" throughout the discussion draft. It is unclear whether this term is intended to be synonymous with "clinician-led clinical data registry" (i.e., a Qualified Clinical Data Registry, or QCDR) or whether it is intended to encompass a broader category of registries, including those developed or operated by entities other than clinician-led organizations. Given the unique role that clinician-led registries play in capturing meaningful, specialty-relevant performance data — including patient-reported outcomes and other data elements that cannot be captured through claims or general-purpose registries — and given the longstanding congressional intent to support such registries as a flexible reporting pathway under MIPS, ***the Alliance recommends that the discussion draft be amended to use the term "clinician-led clinical data registry" wherever the intended reference is to QCDRs and clinician-led registries specifically.***

SEC. 203. EXPANDED ACCESS TO CLAIMS DATA TO FACILITATE RESEARCH AND QUALITY IMPROVEMENT. (pp. 18-20)

The Alliance is very supportive of the language in this section as we have long urged Congress to address challenges that specialty societies and QCDRs face in terms of accessing claims data. Specialty societies are willing to assist CMS with more robust quality and cost analyses. However, we cannot do this without reasonable access to timely Medicare claims data.

SEC. 204. TEMPORARY REDUCTION OF MIPS PAYMENT ADJUSTMENTS. (pp. 20-21)

The Alliance appreciates the proposed five-year reduction in the maximum MIPS payment adjustment, which would be reduced from 9% to 2% from the 2029 payment year through the 2033 payment year. ***While this five-year reprieve aims to give CMS time to ensure all specialties have a relevant set of quality measures, we are concerned that five years is an insufficient amount of time to accomplish this goal. We are also concerned about the sudden leap back to 9% in a single year (i.e., payment year 2034) and urge Congress to include a more gradual transition to higher payment adjustments based on the readiness of the program to accurately and sufficiently measure the performance of all specialties.***

We also recommend that any return to the 9% MIPS payment adjustment be expressly conditioned on the Quality Reform Task Force having completed its first full round of measure approvals for each medical specialty. Restoring such substantial payment adjustments before all specialties have access to a relevant and adequate set of measures would perpetuate the very inequities the Task Force was created to remedy and would expose specialists to payment penalties for failing to perform on measures that do not reflect the care they deliver. ***Should Congress instead adopt a more gradual ramp-up to higher payment adjustments, which the Alliance supports for the reasons described above, the Alliance similarly recommends that the ramp-up not commence until the Task Force has approved an adequate set of measures for each specialty.*** Tying the timing of any increase in payment adjustment levels to the readiness of the underlying measurement infrastructure is essential to ensuring fair and accurate assessment of physician performance under MIPS.

SEC. 205. MODIFICATION OF APPROPRIATE USE CRITERIA DATA COLLECTION FOR APPLICABLE IMAGING SERVICES. (pp 21-30)

The Alliance urges the Joint Doctors' Caucuses to remove Section 205 from this legislation and instead address appropriate use of advanced diagnostic imaging through the Quality Reform Task Force established in Section 202(E), where societies representing specialties that order and furnish imaging can vet AUC-based measures within a reformed MIPS framework rather than through a standalone mandate.

The history of the Protecting Access to Medicare Act (PAMA)-authorized Appropriate Use Criteria (AUC) program supports this approach. CMS rescinded all AUC program regulations in November 2023 and affirmed in the CY 2024 Physician Fee Schedule Final Rule that a siloed program is not the most effective path to appropriate imaging use. Section 205 does not resolve the core structural problem: when health systems select clinical decision support mechanisms (CDSMs) based on cost and convenience, clinicians lose access to specialty-developed AUC that best reflect clinical evidence, with direct consequences for care quality.

If Section 205 is retained, the Alliance urges the following amendments at minimum. Imaging furnished as part of the standard of care for a procedure (e.g., intraoperative, peri-procedural, and procedurally indicated diagnostic imaging) should be expressly exempted from consultation and attestation requirements, as such imaging is clinically required within an established procedural plan and not a discrete ordering decision. The Secretary should be required to ensure CDSMs include AUC developed or endorsed by specialty societies. Additionally, AUC consultation should not be limited to CMS-qualified CDSMs, compliance thresholds should be set through notice-and-comment rulemaking with full specialty society participation, and payment consequences should not be imposed prior to the GAO study. The Alliance stands ready to work with your office on an approach that promotes appropriate imaging use through the Quality Reform Task Force rather than a parallel mandate.

SEC. 206. TECHNOLOGY MODERNIZATION. (p. 30)

We understand this section is currently a placeholder in the discussion draft. As you determine the intent of this section, ***we request that any language inserted here account for the costs, time, and other resources associated with technology modernization.*** **We also request that the language in this section** ***clearly recognize technology capabilities and upgrades that remain within the control of health information technology vendors or the institutions in which clinicians practice.*** Clinicians should not be held accountable for aspects of adoption and use of modernized technologies that remain outside of their direct control.

TITLE III – APM IMPROVEMENT

SEC. 301. QUALIFYING APM PARTICIPANT THRESHOLD FREEZE. (pp. 30-31)

The intent of this section seems to be to extend the Qualifying APM Participant (QP) thresholds at their lower level, which is a policy that the Alliance supports, particularly since specialists have faced numerous barriers in terms of QP eligibility. We believe the intent of the discussion draft is to extend the freeze an additional year (i.e., for 2027/2029). However, the language as amended would technically authorize the lower thresholds from payment year 2021 through 2029, as illustrated in the following redlined excerpt:

> *Title III – APM Improvement*
> *(2) Qualifying APM participant*
> *(B) 2021 through ~~2026 and 2028~~2029*
> *With respect to each of 2021 through ~~2026 and 2028~~2029, an eligible professional described in either of the following clauses:*
> *(i) Medicare payment threshold option…*
> *(ii) Combination all-payer and medicare payment threshold option*

As a reminder, under current law, the schedule of thresholds is as follows:

QP Thresholds

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

The proposed revised language in this draft would technically fix the 2025/2027 "gap year" that was never addressed by Congress. While we would normally support this, there are concurrent factors that need to be accounted for. CMS already determined which clinicians were QPs for 2025. Clinicians who were not QPs and eligible for MIPS already submitted MIPS data for 2025, which is currently being evaluated by CMS and will soon be assigned a payment adjustment. If this legislation were to pass, the lower threshold would need to be applied to the 2025 performance year *retroactively* and some clinicians who did not originally meet the higher QP threshold for 2025, and instead participated in MIPS, might now be considered a QP for 2025. As a result, they would not get credit for their MIPS performance (even if they performed really well).

In the past, it was much more favorable to earn QP status than to fall under MIPS since QPs were eligible for a 5% incentive payment. However, for the 2025 performance year/2027 payment year, there is no QP incentive payment. Under current law, QPs are simply subject to a higher conversion factor update (0.75%) than MIPS participants (0.25%), as shown below:

APM Incentive

- 2022/2024: 5%
- 2023/2025: 3.5%
- 2024/2026: 1.88% (+ differential CF update for QPs and non-QPs)
- **2025/2027: Just differential CF update**
- 2026/2028: 3.1% (+ differential CF update)

This means that for the 2025 performance year/2027 payment year, a MIPS adjustment might be more advantageous than earning QP status, yet the draft legislation seems like it could take that option away from MIPS participants. ***If the intent is to apply the lower threshold to the 2025 performance year/2027 payment year, then the Alliance recommends that the discussion draft add language here to ensure clinicians in the predicament described above would receive the more favorable of the two payment adjustments (i.e., either from MIPS or QP status) for the applicable payment year to ensure their investment in MIPS in 2025 does not go unrecognized.***

SEC. 302. CMI MODEL REQUIREMENTS. (pp. 31-32)

(g) Report to Congress

Under current law, the Secretary is required to submit to Congress biennially a report describing models tested, the number of individuals participating in such models, any models chosen for expansion, and the results from evaluations under subsection (b)(4). As a result, reports are outdated once released (e.g., the last report was in December 2024 and covered FYs 2022-2024). The discussion draft proposes to add language to this section stating the following:

> *"Each such report submitted in 2027 or a subsequent year shall contain, with respect to each model tested under subsection (b), a description of any savings generated by such model."*

The Alliance requests that the discussion draft also includes language requiring the Secretary to submit more timely <u>annual</u> reports and that these annual reports include data on clinician participation in CMMI models broken down by specialty, as well as QP status by specialty. CMS has released very little specialty-specific APM

data to date, despite our repeated requests, making it challenging to fully understand the availability and impact of models. These data are important to help specialties better understand how their members are engaging in APMs and where there are remaining gaps and opportunities.

The Alliance would also like to see additional language in this section that requires CMMI to employ more transparent processes when developing and evaluating models. The discussion draft proposes language in this section that would require "notice-and-comment rulemaking," but it is limited to terminating or modifying the design and implementation of a model. While we support this language, we would like to see additional language that would require transparency and relevant clinical stakeholder input during the development and introduction of new models. In recent years, impacted specialties have been caught off guard by the introduction of new CMMI models that directly impact their members and were disappointed to have never had a chance to discuss model design with CMMI prior to the model being announced to the public.

The Alliance believes that CMMI should be held accountable to Congress and the public in a manner that builds trust in these processes, but is not so cumbersome as to stifle progress and innovation. ***Specifically, CMMI should be required to consult with potentially impacted stakeholders prior to implementing a model and be required to publish a notice of model concepts early in the model development phase***. This would promote greater transparency in model design and ensure all stakeholders have an opportunity to meaningfully engage with CMMI on the development of models.

REQUESTED ADDITION OF A NEW SECTION 303 (Changing current Section 303 to 304)

The Alliance requests the addition of more concrete requirements for CMMI's consideration and evaluation of specialty society-developed models. Specifically, we request the following:

- ***Require CMMI to begin prioritizing the evaluation, development, testing, and implementation of specialty society-developed voluntary models.*** Many current models are primary care-focused and do not measure specialties like ophthalmic care, therefore very few ophthalmologists are involved or participate in Advanced APMs. Although some ophthalmologists are able to participate in an Accountable Care Organization (ACO), they are generally not involved in the management of the ACO and are often not able to contribute quality data to the ACO due to the focus on primary care measures. In the past, several specialties submitted Advanced APM proposals to PTAC and worked collaboratively with PTAC to improve the models. PTAC recommended several of these specialty-developed models for implementation, however CMMI never followed through on those recommendations. In one example, in 2019, ASCRS developed a bundled payment model – the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS) model – which would enable appropriate patients to receive same-day bilateral cataract surgery. The model has many desirable features including savings for the Medicare program, better outcomes and lower, more predictable cost-sharing for beneficiaries, site neutrality and a warranty for avoidable complications. Because of recent innovative advances and innovations, same-day, bilateral cataract surgery can be safe and effective for many patients, but the current payment policy (i.e., the multiple procedure payment reduction) is a barrier. In addition, the model was developed in multiple ways so that the bundled payment could be offered in traditional Medicare, Medicare Advantage, and within an ACO. Despite multiple encouraging meetings where CMS/CMMI leadership expressed support for the model, the agency has yet to take any action.
- ***Require CMMI to transparently and collaboratively evaluate models developed by specialty societies and to provide guidance to specialty societies on the factors CMMI believes would improve submissions.*** As noted earlier, the Alliance supports transparency and relevant clinical stakeholder input during the development and introduction of new models.

SEC. 303. REPORT ON BARRIERS TO PARTICIPATION IN VALUE-BASED PAYMENT MODELS. (p. 32)

The Alliance is very supportive of the language proposed for this section, which would require, no later than December 31, 2029, that the Comptroller General of the United States, in consultation with the Medicare Payment Advisory Commission, submit to Congress a report on ongoing barriers to participation in value-based payment

models for specialty providers under the Medicare program, as well as specific policy recommendations to reduce such barriers. ***Again, we recommend that this report includes data on specialty-specific participation trends and gaps.***

TITLE IV – PHYSICIAN PAYMENT IMPROVEMENTS (pp. 32-41)

The Alliance **supports the provisions included in Title IV of the discussion draft** and notes that they are identical to H.R. 8163, the *Provider Reimbursement Stability Act*. We appreciate that this Title seeks to modernize and update the budget neutrality mechanism of the MPFS.

As you know, the MPFS is plagued by challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. Physicians are still experiencing the downstream effects of significant redistributions associated with the Centers for Medicare & Medicaid Services (CMS) 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively, as well as the 2022 implementation of revised clinical labor prices (an update that lagged two decades). Compounding the issue, CMS relies on utilization assumptions when new services are added to the MPFS, but when those projections overestimate actual use - as with the complex care add-on code (HCPCS G2211) and Transitional Care Management (TCM) services - the resulting savings are not returned through the conversion factor (CF).

Medicare physician reimbursement has failed to keep pace with rising inflation, leading to inadequate reimbursement. The layers of cuts imposed on physicians due to the applicable statutes create immense challenges in maintaining solvent practices, retaining and recruiting qualified staff, and ensuring patient access to health care. Because of the routine reductions in Medicare reimbursements over the past several years, more and more physician practices have been forced to take drastic measures, such as limiting the number of Medicare patients they see, consolidating with larger hospital or health care systems, which increases costs to the Medicare program, or retiring early and permanently closing their doors.

In addition, we request that additional language be included to require the GAO to conduct a study on the historical calculations used to inform Medicare Physician Fee Schedule budget neutrality adjustments that would provide Congress with more information including an analysis of the data elements that CMS utilizes to calculate spending (i.e., pricing, inputs for establishing utilization assumptions, and other relevant components) in the upcoming CY to estimate the budget neutrality adjustment. We offer the language below for your consideration:

Sec. 405. GAO Report on Medicare Physician Fee Schedule Budget Neutrality Adjustments.

a. Study.—The Comptroller General of the United States shall conduct a study on the historical calculations used to inform Medicare Physician Fee Schedule budget neutrality adjustments. Such study shall include—

1. An analysis of the data elements that the Centers for Medicare and Medicaid Services (CMS) utilizes to calculate spending in the upcoming CY to estimate the budget neutrality adjustment required. The analysis shall cover pricing, inputs for establishing utilization assumptions, and any other relevant components for each CY 2010 to 2026.

2. A review for each year regarding policies that could have triggered a budget neutrality adjustment due to the Secretary of Health and Human Services adjusting "the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures," specifically noting those policies that did not exceed the statutory $20 million threshold in place at that time.

3. The Identification of policies that triggered the budget neutrality adjustment for each year that the Secretary adjusted the dimensions mentioned in subparagraph (2), including the amount sought to be recovered through budget neutrality adjustments for each item, and the

total dollar amount and specific details for each of the data elements identified in subparagraph (1).

4. *A breakdown for each CY from 2010 to 2027 of actual expenditures associated with each item identified in each year of implementation under subparagraph (3).*

b. Report.—Not later than June 1, 2028, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations to improve the accuracy of Medicare physician fee schedule budget neutrality adjustments.

ADDITIONAL ISSUES NOT ADDRESSED IN THE DRAFT LEGISALTION

REPORT TO CONGRESS ON IMPACT OF MIPS (OR MIPS REPLACEMENT)

CMS has produced very little evidence to date to suggest that quality, efficiency and outcomes for Medicare's seniors, the disabled, and underserved populations have demonstrably improved as a result of the MACRA-established quality programs. ***We urge you to include language that would require Congress to issue an annual report on the impact of MIPS (or its replacement) on the quality and value of care provided to Medicare beneficiaries.***

TERMINATION OF THE AMBULATORY SPECIALTY MODEL

In the 2026 Medicare Physician Fee Schedule final rule, CMS finalized the Ambulatory Specialty Model (ASM), which is set to begin in 2027. This new mandatory APM builds directly on the MIPS Value Pathways (MVP) framework, despite widespread concern among specialties that MVPs do little to resolve critical shortcomings of traditional MIPS. As noted in our comments to CMS (see p.14), the Alliance believes this model further exacerbates existing flaws in MIPS rather than creating a true path forward for specialists to engage meaningfully in value-based care. ***For these reasons, the Alliance strongly urges you to prohibit CMS from implementing the ASM, particularly as Congress is trying to replace the flawed program on which ASM is based. Instead, CMS should work collaboratively with specialty societies to design models that are grounded in clinically meaningful measures, feasible reporting strategies, and fair methodologies; structured to incentivize rather than mandate participation; and aligned with a pathway to Advanced APM participation.***

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 Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists