Alliance of Specialty Medicine

Sound Policy. Quality Care.

September 1, 2026

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 2027 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 15 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 2027 Conversion Factor

Once again, physicians are facing sizeable reductions in Medicare payments despite continued increases in practice costs and ongoing inflation. This ongoing instability makes it increasingly difficult for practices to recruit and retain staff, invest in new technologies, and maintain beneficiary access to care. ***We recognize that CMS cannot reform the Medicare physician payment system in a way that appropriately accounts for rising inflation, but it can and should avoid policies that further exacerbate longstanding structural problems.***

Over the past several years, CMS has repeatedly established new coding and payment policies that increase reimbursement for selected physician services, many of which are intended to strengthen primary care, care management, and preventive services – and now including "lifestyle" medicine – while simultaneously adopting policies that reduce reimbursement for specialty physician care to satisfy statutory budget neutrality requirements. The cumulative effect has been a continued redistribution of limited Medicare physician payment dollars away from specialty care, despite their essential role in

diagnosing, treating, and managing serious, chronic, and complex diseases affecting Medicare beneficiaries. CMS should not rely on payment reductions to specialty physician services to finance new payment policies for primary care services, as it threatens the long-term financial stability of specialty physician practices and, ultimately, beneficiary access to medically necessary specialty care.

Until Congress enacts broader Medicare physician payment reform, CMS should prioritize policies that strengthen the PFS for all physicians rather than shifting reimbursement from specialty care to primary care. This is particularly true where, as with the proposed payment policies for shared medical appointments and health coaching discussed below, CMS is proposing to direct limited PFS resources toward new and untested concepts without empirical evidence supporting their value, utilization, or broader adoption. Such concepts may be more appropriately tested through limited demonstrations before being incorporated into the PFS.

Separately, under the current *Medicare Access and CHIP Reauthorization Act* (MACRA) framework, many specialists remain unable to access the higher statutory payment update because few specialty-focused Advanced Alternative Payment Models (APMs) exist. While certain physician specialties have viable opportunities to participate in Advanced APMs, most Alliance specialties do not. From our perspective, the differential payment updates reflect the availability of qualifying models rather than a specialist's willingness or ability to participate in value-based care, which further compounds the inequities created when limited PFS resources are redistributed away from specialty care. ***Therefore, we urge CMS and the CMS Innovation Center (CMMI) to work collaboratively with specialty physician organizations to develop voluntary, specialty-focused APMs that provide physicians across all specialties with a meaningful opportunity to participate in value-based care and qualify for the higher payment update.***

Determination of Practice Expense RVUs

Indirect Practice Expense Methodology

CMS proposes several significant changes to the indirect practice expense (PE) methodology, including phasing out the indirect practice cost index (IPCI) over two years and replacing it with a new stabilization adjustment that would generally limit annual changes in PE RVUs to 5 percent. ***The Alliance is deeply concerned with these substantial changes to the indirect PE methodology and urges CMS to withdraw the proposals until a more thoughtful and transparent alternative can be developed and proposed for consideration.***

While CMS has expressed concerns with the existing data, it has not identified a better source of specialty-level practice cost data. In prior comments, the Alliance has not taken a position on the use of the AMA's updated Physician Practice Information (PPI) Survey or Consumer Price Index (CPI) Survey data, but has strongly supported the continued use of specialty society-derived data to ensure that the indirect costs of specialty physician practices are appropriately recognized. Although the proposed stabilization factor is intended to limit year-to-year fluctuations in PE RVUs, several specialties would still face significant reductions under the proposed methodology. More importantly, the stabilization factor does nothing to address the need for specialty-level practice cost information currently reflected through the IPCI. As a result, PE payments may be less, rather than more, reflective of differences in indirect costs across physician specialties.

More broadly, the Alliance is concerned with the number and pace of changes CMS is proposing to the PE methodology and the lack of transparency regarding their true impacts. Making multiple PE changes simultaneously makes it difficult for stakeholders to understand the impact of each proposal in isolation, how the policies interact, and what is ultimately driving significant shifts in payment across services and

specialties. In a recent briefing, CMS declined requests for additional data that would allow stakeholders to better understand these effects, leaving significant unanswered questions and limiting our ability to evaluate the proposals and provide meaningfully comment. This is particularly concerning given CMS' stated priority of supporting independent physician practices, which could be further disadvantaged by significant changes to the allocation of indirect PE without adequate data and analysis.

Again, the Alliance urges CMS to withdraw the proposed changes to the indirect PE methodology for CY 2027 and maintain the current methodology while it identifies an appropriate source of current specialty-level practice cost data and more fully evaluates the individual and cumulative impacts of the proposed changes. Any future approach should include sufficient service- and specialty-level analyses to allow the medical community to understand and independently evaluate the resulting payment impacts before CMS proceeds with significant changes to the allocation of indirect PE under the PFS.

CY 2026 Site-of-Service Payment Differential Update

The Alliance recognizes CMS' interest in addressing differences in practice expense across sites of service. However, we continue to have significant concerns regarding the policy of allocating half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting, particularly for specialists who furnish services in hospitals or ambulatory surgical centers (ASCs) and who own and maintain independent practices where they treat patients for other conditions, including post-operative visits.

As we emphasized in our comments as part of the CY 2026 PFS rulemaking, CMS' assumption that many facility-based physicians no longer maintain separate offices does not reflect the circumstances of many of the specialists represented by the Alliance, who continue to incur significant indirect practice expenses. To date, CMS has not demonstrated that these specialists have lower indirect practice costs. At a time when independent specialty practices already face significant pressure to consolidate or to be acquired by private equity, this policy only serves to further accelerate these changes – an outcome that runs counter to CMS' stated objective of supporting independent physician practices through this policy.

We support CMS' solicitation of additional information and encourage CMS to consider refinements that better account for differences in practice and employment arrangements without disadvantaging independent physician practices, including the adoption of a modifier for hospital employed physicians.

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

Payments Using Modifier -25

CMS proposes to reduce payment when a separately identifiable office or outpatient evaluation and management (E/M) service is furnished by the same physician, or a physician in the same group practice, on the same day as a procedure with a 0-, 10-, or 90-day global period. Under the proposal, Medicare would pay 100 percent of the total relative value units (RVUs) for the highest-valued service and reduce payment for all other same-day services by 50 percent. CMS states that this proposal is intended to account for efficiencies that may exist when multiple services are furnished during the same patient encounter and reduce what it believes may be duplicative payment. ***The Alliance vehemently opposes this proposal and urges CMS to withdraw it entirely.***

First and foremost, modifier -25 already signifies that the E/M service is significant, separately identifiable, and medically necessary beyond the work already included in the procedure. By definition, these services represent distinct physician work and should not be presumed to overlap with the procedural service simply because they occur on the same day and are furnished by the same physician or physician group. Importantly, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) already accounts for duplication in pre-service physician work during the valuation process when a procedure is typically reported with a same-day E/M service more than 50 percent of the time.

Moreover, CMS has not demonstrated that the physician work and practice expenses associated with these services are reduced by 50 percent simply because another service is furnished on the same day, nor has it explained why a uniform reduction would be appropriate across a diverse range of services and clinical circumstances. The clinical circumstances in which modifier -25 is reported vary considerably, and the Alliance believes any concerns regarding overlap should be supported by service-specific evidence rather than generalized assumptions. We are also concerned that CMS has not explained what evidence or circumstances have *changed* since it was previously considered and declined to finalize a similar payment policy. Such a significant expansion of prior proposals warrants a clear explanation of the underlying rationale and supporting data.

We remind CMS that the medical community has long opposed policies that inappropriately penalize physicians for the appropriate use of modifier -25. In a 2023 letter to Cigna, the AMA and more than 100 physician and health care organizations emphasized that appropriately reported E/M and procedural services should both be paid in full, explaining that use of the modifier "*supports prompt diagnosis and streamlined treatment—which in turn promotes high-value, high-quality, and patient-centric care*." The organizations further cautioned that policies discouraging same-day care could force patients to schedule multiple visits and incur additional cost sharing.

Finally, we are deeply offended by CMS' suggestion that physicians may delay medically necessary care to avoid the proposed reduction and that revisions to the conditions of payment may be needed to address potential abuse. Physician practices cannot reasonably be expected to sustain financial losses when furnishing medically necessary care, yet such losses are a foreseeable outcome of this policy and directly undermine CMS' stated goals of supporting small, independent physician practices and reducing consolidation. Were physicians to adjust clinical workflows in response to this policy, it would only be to ensure their practices remain open and able to deliver specialty medical care to their Medicare patients.

We urge CMS to withdraw this proposal in its entirety.

Valuation of Specific Codes, Including Potentially Misvalued Codes

Evaluation and Management Visit Complexity (HCPCS Code G2211)

CMS proposes to replace the current flat payment for HCPCS code G2211 with a percentage-based payment adjustment that would be reported through a new modifier (MOD1) appended to the underlying office/outpatient or home/residence E/M service. Rather than paying a fixed amount regardless of the level of the E/M service, CMS proposes to increase payment by 16 percent of the associated E/M service when MOD1 is reported. CMS also proposes a second modifier (MOD2), valued at 32 percent of the associated E/M service, for certain clinicians participating in Medicare Accountable Care Organizations (ACOs). CMS states that the proposed percentage adjustments were established using a weighted average of G2211 utilization across E/M visit levels and were calibrated to maintain budget neutrality.

The Alliance has significant concerns regarding the methodology used to establish the proposed percentage-based payment adjustment. In replacing a flat payment with a percentage-based adjustment, CMS assumes that the inherent complexity associated with longitudinal care increases proportionally with the level of the underlying E/M service; however, CMS has not provided sufficient evidence to support that assumption. While higher-level E/M services appropriately reflect greater complexity associated with a particular patient encounter, the ongoing work associated with serving as the continuing focal point for a patient's care may not necessarily vary in the same manner. ***Accordingly, the Alliance urges CMS to maintain the existing add-on HCPCS code (G2211), and the associated RVUs and payment rate for complex care.***

Separately, the Alliance remains concerned that CMS has not addressed the flawed budget neutrality assumptions associated with HCPCS code G2211. As we noted in our comments on the CY 2026 proposed rule, CMS substantially overestimated utilization when it first established separate payment for the code, projecting that G2211 would be reported with approximately 38 percent of office and outpatient E/M visits, resulting in a significant budget neutrality adjustment that reduced the conversion factor. Actual claims experience has demonstrated considerably lower utilization, yet the budget neutrality adjustment associated with those original assumptions remains embedded in the physician fee schedule, resulting in continued reductions in physician payment based on spending that never materialized. ***We urge CMS to use actual claims experience to recalibrate the utilization assumptions underlying this policy so that future budget neutrality adjustments accurately reflect real-world physician billing patterns.***

Shared Medical Appointment (HCPCS Code GSMAS) & Health Coaching (CPT codes 0591T, 0592T, and 0593T)

CMS proposes to establish coding and payment for Shared Medical Appointments (SMAs) by creating a new HCPCS code (GSMAS) describing a voluntary, 60-minute group-based medical session involving between two and ten beneficiaries with common medical conditions. The service would combine group education, counseling, and peer support with individualized clinical assessment and care and would be valued using a building-block methodology based on CPT codes 99213 and 96202, resulting in a proposed work RVU of 1.73 and 45 minutes of physician work for each billed service. CMS further proposes that the code be billed separately for each participating beneficiary, meaning that a single 60-minute session involving up to ten beneficiaries could generate ten separately payable Medicare claims. In addition to coding and payment for SMA, CMS proposes to establish Medicare payment for Health Coaching services (CPT codes 0591T, 0592T, and 0593T).

While the Alliance appreciates CMS' intent to support chronic disease management, patient education, and healthy behaviors, we are concerned that the proposals are premature. First, CMS has not provided sufficient evidence demonstrating that SMAs or Health Coaching would improve outcomes or otherwise provide meaningful benefit for the Medicare population. Second, CMS has not adequately addressed how these services would interact with existing Medicare-covered services that appear to involve similar activities, raising questions about potential overlap and duplicate payment. Finally, we have significant program integrity concerns, particularly with the proposed SMA billing structure, which appears to create substantial opportunities for inappropriate billing, overutilization, and fraud, waste, and abuse.

Rather than establishing coding and/or payment for these services under the PFS, we believe SMAs and Health Coaching are better suited for testing through a limited demonstration or an alternative payment model (APM). For example, accountable care organizations (ACOs) could evaluate whether these services

are effective in the Medicare population, improve quality and patient outcomes, and reduce overall Medicare spending or other downstream costs. Such models would also allow CMS to assess utilization, potential overlap with existing services, and program integrity risks before considering broader payment. ***Absent such evidence and appropriate safeguards, the Alliance does not support establishing separate coding and/or payment for SMAs or Health Coaching under the PFS.***

Requests for Information

AMA & CPT

Most Alliance member organizations are heavily engaged in efforts to develop codes and relative value recommendations through the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel and the AMA/Specialty Society Relative Value Scale Update Committee (RUC). Our organizations are deeply concerned that replacing CPT or introducing a competing coding system could create significant disruption and administrative burden for physician practices. The existing Medicare physician payment system, including the assignment of relative values and payment rates, is built around CPT, and transitioning to a new coding system would require substantial changes to billing systems, payer policies, and practice workflows.

The Alliance also strongly supports the continued role of the AMA RUC. As we have emphasized in prior comments, Alliance member societies invest considerable time and resources in the RUC process to develop recommendations regarding the physician work and practice expenses associated with the services they provide. This process allows specialty societies to bring their clinical expertise and direct knowledge of the resources required to furnish services to the development of relative value recommendations, while CMS retains ultimate authority for establishing values under the PFS. Toward that end, ***the Alliance urges CMS to carefully weigh the significant implementation costs and burdens against any potential benefits before pursuing fundamental changes to CPT or the existing processes used to value professional services.***

Redesigning Primary Care to Make America Healthy Again

CMS seeks input on reconsidering the relative payment for primary care services under the PFS, the role of technology-enabled primary care, and the establishment of prospective primary care payment within the Medicare Shared Savings Program and potentially more broadly across Original Medicare. The Alliance recognizes the importance of strengthening primary care and improving prevention, early diagnosis, care coordination, and chronic disease management. However, we disagree with any approach that would strengthen primary care by shifting limited PFS resources away from specialty medicine or that presumes primary care physicians are the exclusive source of longitudinal, coordinated care.

Many Medicare beneficiaries with serious, chronic, or complex conditions rely on specialists to diagnose and manage their conditions over many years. Specialists develop and modify treatment plans, manage high-risk medications, monitor disease progression, coordinate care, and prevent complications and costly downstream care. Increasing payment for one category of physicians through reductions to others does not address the underlying inadequacy of Medicare physician payment and could undermine access to the specialty care necessary to achieve CMS' broader goals for prevention and improved health outcomes.

As CMS considers future payment reforms, including prospective and technology-enabled approaches, it should recognize the complementary roles of primary and specialty care and ensure that new payment models do not create incentives to delay or limit clinically appropriate referrals. ***The Alliance encourages CMS to engage specialty societies in the development of any future proposals and pursue policies that***

strengthen collaboration and appropriately value both primary and specialty care rather than prioritizing one at the expense of the other.

Payment for Medicare Telehealth Services

The Alliance appreciates that the *Consolidated Appropriations Act, 2026* (CAA, 2026) extended key Medicare telehealth flexibilities through December 31, 2027, but continues to urge CMS to work with Congress to make permanent the statutory flexibilities that allow beneficiaries to receive telehealth services from their homes without geographic restrictions. Beneficiaries and physician practices need long-term certainty rather than a series of temporary extensions that complicate care planning and investment in telehealth infrastructure.

We also recognize that the CAA, 2026 requires CMS to establish modifiers for certain telehealth claims, including services furnished through a virtual platform under specified contractual or payment arrangements and services furnished incident to a physician's or practitioner's professional service. CMS indicates that it will implement these requirements through new modifiers BB and BC, with additional instructions to be issued through subregulatory guidance. ***We urge CMS to issue this guidance well in advance of the January 1, 2027 effective date and provide physicians and other stakeholders an opportunity to review and provide feedback on the requirements, including any administrative burden associated with determining when the modifiers apply and appropriately reporting them on claims.***

Quality Payment Program

Proposal to Update Timeline for Full MIPS Value Pathways (MVPs) Implementation

CMS proposes that beginning with the CY 2029 performance period, all MIPS eligible physicians, with the exception of physicians reporting through the Alternative Payment Model (APM) Performance Pathway (APP), must report through an MVP. ***The Alliance strongly opposes setting a fixed date to transition to mandatory reporting of MVPs due to unresolved challenges with the framework and MIPS, in general. As CMS works with stakeholders to find solutions to these ongoing issues, we urge CMS to maintain MVPs as a voluntary pathway for physicians, alongside traditional MIPS, so that physicians have a choice of reporting pathways that best reflects their patient populations and practice needs.***

The Alliance appreciates and supports the goals of the MVP pathway, which are to provide a set of clinically relevant measures and activities that better reflect physicians' scope of care while also simplifying the program, minimizing reporting burden, and improving comparable physician performance data. However, full implementation of MVPs requires the ability of all specialties to participate, and we do not believe MVPs are a significant enough departure from traditional MIPS to achieve that level of participation.

Most notably, the MVP pathway is hampered by its reliance on the existing MIPS measure inventory, which still suffers from major gaps in specialty-specific measures. Specialty-specific measures remain inaccessible for a variety of reasons, including: the resource-intensive process of developing measures, gaining CMS approval, and stewarding measures over time; the historic removal or rejection of specialty specific measures from the program; scoring policies that cap points regardless of performance due to a measure's topped out status or lacking a benchmark; and unnecessarily rigid Qualified Clinical Data Registry (QCDR) requirements, which have caused many specialties with robust registries to leave the program. As a result, specialists often have few other options than to report on measures that are of limited relevance to their practice rather than measures that truly matter to their patients. While we appreciate that MVPs require reporting on a smaller set of quality measures than traditional MIPS, which

should help to mitigate challenges related to ongoing specialty measure gaps, it does not fully resolve the problem. Additionally, MVP participants face a significantly smaller choice of measures since they may only report on measures associated with their selected MVP. This lack of flexibility makes successful and meaningful participation even more challenging for specialists.

As we have mentioned in the past, MVPs also preserve the siloed nature of the four MIPS performance categories and fail to provide cross-category credit or recognize more comprehensive investments in high value care that satisfy multiple components of MIPS, such as tracking detailed performance analyses over time through a physician-led clinical data registry. The MVP framework also carries over from traditional MIPS concerning scoring policies that put specialists at risk for low scores no matter how well they perform. While the Alliance appreciates that CMS recently adopted policies to mitigate the negative impact of scoring caps—such as removing the 7-point scoring cap from select topped out measures and applying scoring floors to measures that lack a benchmark in their first two years— these protections only apply in limited circumstances and do not cover the full suite of measures that have been negatively impacted by MIPS scoring caps. As a result, many measures that populate specialty-specific MVPs will still be subject to scoring caps, which will limit the success of specialists reporting those measures, regardless of performance.

Instead of focusing on transitioning to MVPs, there is an urgent need for CMS to make fundamental improvements to MIPS, including additional policies, funding and technical support to incentivize the development and use of additional, more meaningful specialty-specific measures. Investing in these resources would result in more meaningful quality information for patient and physician decision-making, ensure the availability of more quality measures to better align with the growing number of episode-based cost measures, and provide physicians with the opportunity to be successful in CMS' quality programs beyond MIPS, including APMs. There is a misconception within CMS that the large measure inventory is what makes MIPS so complex and burdensome when in fact, most specialists feel hampered by the lack of measures that meaningfully represent their patient population and would welcome additional measures to choose from. CMS has allocated extensive resources to the development and refinement of episode-based cost measures and should devote a comparable level of resources to developing and refining quality measures so that every MIPS eligible clinician has appropriate measures to report.

Overall, until MVPs accurately and completely align with clinical practice, we urge CMS to continue to preserve choice in the program while working with relevant clinical stakeholders and Congress to fundamentally improve the program.

Proposal to Designate MIPS Core Measures

Beginning with the CY 2027 performance period, CMS proposes to remove the current quality measure data submission requirement of one outcome measure (or one high priority measure if an outcome measure is not available) for traditional MIPS and MVP reporting and to replace it with a new requirement to report at least one MIPS core measure as one of the four required measures in MVPs and one of the six required measures in traditional MIPS. For 2027, CMS proposes to designate 78 measures within the MIPS measure inventory as "core." This includes designating a minimum of three core measures per MVP that CMS believes are most reflective of the care central to the clinical specialty or medical condition represented by the MVP.

Selection of the MIPS core measures would be based on the following factors:

- Whether the measure is an outcome-based measure;
- Measure collection type availability and the clinician's ability to meet reporting requirements to the extent practicable. CMS is not proposing to designate any QCDR measures as core to ensure core measures are broadly available and accessible for all clinicians;
- Measure adoption and current and historic performance rates for each measure; and
- Whether the measure is most reflective of the care that is central to the clinical focus of the selected MVP, represents best practices essential to the MVP's specialty or medical condition, or addresses important areas for improving care.

CMS also proposes that if a MIPS eligible clinician does not have an available and applicable MIPS core measure, they could attest during the data submission period to avoid a penalty and choose another measure to report. Additionally, CMS proposes that clinicians that meet the definition of small practice would be exempt from the proposed MIPS core measure requirement and would not need to submit an attestation. Finally, CMS proposes that topped out core measures would not be subject to the 7-point scoring cap and instead would be eligible for up to 10 performance achievement points under CMS' newly adopted "defined topped out measure benchmark."

The Alliance supports CMS' proposal to remove the current requirement to report on one outcome or high priority measure for traditional MIPS and MVP reporting. The current requirement to report one outcome/high priority measure is especially problematic in the context of mandatory MVPs, where physicians face a more limited selection of measures and might not be able to identify a relevant outcome or high priority measure. In this situation, the requirement would simply increase administrative burden by forcing physicians to report measures that are of limited applicability to their practice rather than measures that truly matter to their patients.

***The Alliance also has concerns about the core measure proposal since it would also box physicians into reporting specific measures and adds another layer of complexity at a time when CMS is trying to streamline the program. Ideally, physicians should be provided with the flexibility to choose measures that are most relevant to their unique practice*.** We appreciate that CMS is trying to increase reporting on select measures that are most important to physicians and patients and that reflect the care that is central to an applicable specialty, medical condition, or episode of care. However, we believe that CMS can accomplish this through other strategies, such as incentivizing the development and adoption of new measures; extending the 7- and 5-point scoring floor to *all* measures that lack a benchmark and not just measures that are new to the program; and removing the topped out scoring cap from *all* MIPS measures, rather than just select measures. As we have expressed in the past, the topped out scoring cap puts physicians who maintain high quality care over time at a disadvantage and limits scoring potential for reasons unrelated to performance. We appreciate CMS' recent updates to its topped out measure policy, but exempting some measures from the cap and not others is arbitrary and confusing. Applying these favorable scoring policies more universally will incentivize more frequent use of topped out and non-benchmarked measures, expand the population of reporters, help to build more accurate and representative benchmarks and potentially demonstrate that performance on some measures is not truly as high as perceived.

If CMS opts to move forward with the core measure proposal, it is critical that it also adopt the following policies:

- ***CMS must allow physicians to attest to not having an available, relevant core measure, as proposed;***
- ***CMS must exempt small practices from the core measure requirement, as proposed;***

- ***CMS must exempt all core measures from the 7-point topped out scoring cap and instead make them eligible to earn up to 10 points under CMS' "defined topped-out measure benchmark," as proposed; and***
- ***Prior to finalizing this policy, CMS must consult with impacted specialties to determine which measures should be classified as "core" and ensure that registry and EHR vendors are ready to support core measures. We are concerned that CMS made decisions about which measures should be classified as core without consulting specialty societies impacted by each MVP. These decisions should be made in a transparent manner and with the input of specialty-specific experts.***

RFI on MVP Scoring

As CMS moves toward full implementation of MVPs in 2029, it is exploring an MVP scoring methodology that would compare clinician performance to others reporting the same MVP. Specifically, CMS is assessing whether an MVP score normalization is needed within an MVP to ensure scoring fairness across MVPs. CMS is also considering the timing for implementation of a new MVP scoring methodology: beginning with the 2029, consistent with the proposed timeline for full MVP implementation, or whether an earlier pilot rollout would be appropriate to give clinicians experience with the new scoring approach while traditional MIPS reporting is available. CMS requests feedback on policy options for MVP scoring and when potential changes to MVP scoring should be implemented.

The Alliance appreciates CMS' efforts to refine MIPS scoring methodologies to help it ensure appropriate comparisons between clinicians participating in different MVPs, since each MVP focuses on measures and activities that are relevant to a given specialty or medical condition. ***As part of this effort, the Alliance urges CMS to expand the recently revised benchmarking methodology, which now applies to administrative claims-based quality measures and cost measures, to all MIPS quality measures, including those used in MVPs***. This methodology, which relies on a standard deviation, median, and an anchored point value that is derived from the performance threshold, is an improvement over the existing decile-based quality measure benchmark methodology and could encourage more physicians to report condition-specific measures. Under the current decile-based approach, physicians can be penalized for performing better than the majority of physicians, rather than being rewarded. Additionally, if most physicians' scores differ only slightly from each other, then a small difference in a physician's score could lead to a large penalty when in reality, the difference likely reflects random variation in patient characteristics rather than an actual difference in physician performance. Data from the 2024 Quality Payment Program (QPP) Public Use File (PUF) demonstrates a considerable improvement in cost measure scores once this new benchmarking methodology was applied.

We also urge CMS to adopt uniform benchmarking methodologies across the program to reduce administrative burden and confusion. Currently, physicians are scored under MIPS using three distinct methodologies: the decile approach used for non-administrative claims-based measures, the newly revised approach applied to cost and administrative claims quality measures as described above, and a separate ABC benchmark methodology used for Care Compare. Employing three different approaches makes it challenging for physicians to understand why they received a high or low MIPS quality score and adds to the complexity of the program.

As CMS considers other approaches to ensure fairness within and across MVPs, we urge against trying to compare performance between clinicians reporting the same MVP. At this time, MVPs are not granular enough to ensure accurate or meaningful comparisons between participants of the same MVP.

Additionally, comparisons between participants would not be fair or accurate since each MVP participant may choose a unique set of four measures to report. For example, we do not believe it would be appropriate or provide meaningful data to physicians or patients if CMS compared neurosurgeons reporting four distinct measures from the Surgical Care MVP to a thoracic surgeon who might be reporting on four different measures from the Surgical Care MVP.

Finally, the Alliance strongly supports CMS initially piloting different approaches to ensure scoring fairness within and across MVPs before implementing such policies and tying them to payment adjustments. Pilot testing should include the provision of confidential feedback reports to physicians, but also analytics related to the testing of different approaches that are available to the public for review and comment.

RFI on Transitioning to Fast Healthcare Interoperability Resources (FHIR®)-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs

Subject to future rulemaking, CMS seeks feedback on developing a phased transition to FHIR-based digital quality reporting for applicable measures across its quality programs. Under MIPS, CMS would introduce a 2-year transition period beginning with the CY 2028 performance period during which existing quality collection types for clinical quality measures (CQMs) and electronic clinical quality measure (eCQMs) would continue to be available while FHIR-based digital quality measure (dQM) options are introduced for selected measures, including both new and existing measures. Following this transition period, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM collection types during the transition period, beginning with the CY 2030 performance period.

The Alliance supports CMS' ongoing efforts to transition to more seamless and automatic methods for reporting and analyzing quality data, but urges the Agency to balance modernization goals with practical implementation. We appreciate that CMS envisions a transition that would begin with a limited set of measures for which FHIR-based digital specifications are available initially and would expand over time as technical infrastructure and implementation experience grow. ***However, even in situations where digital specifications are available, CMS should not require the use of digitally specified measures, but instead incentivize their use while maintaining flexible options for those for which it is still not feasible***. Resource constraints and reporting burden differ significantly among facilities versus physician offices, and even within the ambulatory setting, between solo practitioners, small and rural practices, and practices in underserved areas. Currently, physicians find it difficult enough to implement eCQMs, with relatively few MIPS eligible clinicians using this data collection type. Transitioning even further to dQMs will require significant investments in new technologies, infrastructure, and staff training, which is challenging for many physicians and will warrant additional flexibilities or support. We request that CMS keep these real challenges and the current landscape of real-world health information technology functionality in mind as it continues to develop a plan for transitioning to digital quality measurement. ***Additionally, although Innovation Center models may have separate requirements, timelines, and levers to incentivize FHIR-based digital quality measurement and reporting, we request that CMS align policies across its program to the extent feasible***.

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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 Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology–Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Interventional Radiology