Alliance of Specialty Medicine

Sound Policy. Quality Care.

January 16, 2026

Republican Doctors Caucus
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: MACRA Modernization

Dear members of the House Republican and Democratic Doctors Caucuses:

The Alliance of Specialty Medicine (Alliance) welcomes the opportunity to comment on policies 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. Our comments below include information in response to your specific questions, along with an outline of our serious concerns with the structural challenges and instability of the Medicare Physician Fee Schedule (MPFS).

What legislative reforms are most needed to ensure future Center for Medicare & Medicaid Innovation (CMMI) models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

The Alliance urges Congress to:

- Require the Centers for Medicare and Medicaid Services (CMS) to release more granular and timely data regarding specialty participation in CMMI-tested models and other CMS alternative payment models (APMs); the impact of those models on quality, value, and access to specialty care; and eligibility for the Advanced APM track of the Quality Payment Program (QPP) by specialty. CMS has released very little specialty-specific APM data to date, making it challenging to fully understand the availability and impact of models.
- Require CMMI to employ more transparent processes when developing and evaluating models. 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.
- Similarly, require that CMMI work collaboratively with specialty societies to improve the APM pipeline, and provide specialists more opportunities to participate meaningfully in APMs and qualify for the Advanced APM track of the QPP.
- Require CMMI to provide more guidance to specialists and their societies on how to get more APMs approved for testing. Specialty societies have invested significantly in the development of models that have been repeatedly rejected or ignored.

- For population-based models that have been more geared toward primary care, such as Accountable Care Organizations (ACOs), provide model entities with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists could play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease.
- Restore and extend the full 5% APM incentive payment and restore the lower Qualifying APM Participant (QP) thresholds to facilitate specialty physician movement into Advanced APMs, including new and more relevant models that have not yet materialized.

The specialty community has faced substantial challenges in terms of gaining access to data that will help it to better understand specialty engagement in, and barriers to, APM participation. Despite multiple requests, both CMS and the Medicare Payment Advisory Commission (MedPAC) have been reluctant to provide data on the number and type of specialists in APMs to help us better understand and overcome these challenges. Although in recent years, MedPAC has begun to release some basic data on the participation rates of select specialties in Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs),[1] the data are limited to a single program, do not cover all specialties, and do not provide insight on the rates at which different specialties qualify as QPs in Advanced APMs. Similarly, CMS recently released its 2023 QPP Experience Report,[2] but it only includes aggregate national data on the number of clinicians that were QPs in an Advanced APM. It does not provide any insight into specialty-specific trends, nor does CMS make such data available through the QPP Public Use File (PUF).[3]

From what we have gathered from our members, most specialty physicians have struggled to meaningfully engage in the Advanced APM track of the QPP, as there are only a few APMs that are applicable to specialty care. Through discussions with Alliance member organizations and the physicians they represent, we have found that ACOs are often the only option for APM engagement and usually the result of specialists' hospital or health system employment. Specialists often have little control over their decision to participate in these ACOs, and the current set of metrics used to measure the quality of care provided under the ACO do not reflect the more focused care provided by specialists.

Alliance organizations continue to hear from their specialty physician members that active and meaningful engagement in APMs is near impossible. Previously tested specialty-focused APMs (e.g., the Bundled Payments for Care Initiative–Advanced (BPCI-A)), as well as more recently announced models (e.g., the Transforming Episode Accountability Model (TEAM) and the Ambulatory Specialty Model (ASM)), have only targeted a limited number of conditions or procedures and were initially developed without broad specialty society input, leaving the vast majority of specialists without a dedicated or clinically meaningful model. Previously tested models also have failed to provide high-performing practices with an incentive to stay in the program since they are held to exceedingly challenging spending targets that simply do not support high quality, appropriate care. Additionally, "participants" in population-based models, such as ACOs, are usually part of large hospitals or health systems, and their role is passive; they do not have an opportunity to meaningfully engage in quality improvement or cost containment activities specific to the ACO, as the accountability measures do not consider the conditions they treat, nor the services they provide.

At the same time, CMS policies adopted under the QPP and the MSSP have largely discouraged APM Entities from including specialists on their Participation Lists to date. These findings are not just speculative. As highlighted in MedPAC's July 2022 Data Book,[4] *Health Care Spending and the Medicare Program*,

[1] https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf
[2] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf
[3] https://data.cms.gov/quality-of-care/quality-payment-program-experience/data
[4] https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_SEC_v2.pdf

> *Many specialties account for a larger share of clinicians in larger ACOs. This finding may reflect smaller ACOs being more often composed of independent physician practices with relatively fewer specialists, while larger ACOs are often affiliated with hospitals or health systems that have a broader range of specialists. (p. 44)*

MedPAC also explains that,

> *Specialists' participation in ACOs relative to their share of all clinicians varies by specialty. For example, cardiologists comprise about 2% of all clinicians participating in fee-for-service (FFS) Medicare, but a larger share of clinicians participating in ACOs. By contrast, specialties such as anesthesiology and ophthalmology are underrepresented in ACOs relative to their share of all FFS clinicians. (p. 44)*

At the outset of the QPP, the Alliance and its member organizations — independently and collectively — proactively connected with the ACO member organization to discuss opportunities for improving specialists' participation in ACOs. One approach discussed, which is contemplated in a Health Affairs blog post by senior CMMI officials,[5] was the development of "shadow bundles." This concept of nesting more specific episode-based or condition-specific models in population-based total cost of care (PB-TCOC) models was also discussed in the PTAC's 2023 Request for Information (RFI) on Integrating Specialty Care in Population-Based Models[6] and its follow-up 2024 RFI on Implementing Performance Measures for PB-TCOC.[7] At the time, further attempts to coalesce around this concept with the ACO community were stalled. Ultimately, we were told that specialty medical care and treatment were expensive and hurt ACOs' financial performance, and — in the case of primary care-led ACOs — there was no appetite for sharing "savings" with specialists.

The Alliance appreciates CMMI's recent recognition that a comprehensive approach to accountable care must account for both primary care and specialty care and that it is exploring opportunities to build on the shadow bundle concept. However, to date, Alliance members have not seen any meaningful progress. Some Alliance member organizations have already invested in this type of work, yet they continue to face challenges in terms of getting CMS to adopt these models. The American Society of Cataract and Refractive Surgery (ASCRS), for example, developed the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS), which aims to promote same-day bilateral cataract surgery to appropriate patients at a lower cost for both patients and Medicare. Under this model, the Cataract Surgery Team (the surgeon, facility and anesthesiologist) would receive a single bundled payment — rather than separate payments — for all services associated with the surgery. Importantly, the patient would also have a single cost-sharing amount for those services, and there would be fewer trips needed to the surgery center and to the physician for follow-up visits, which would reduce out-of-pocket expenses for the patient and family and be particularly important for rural and disadvantaged populations. This proposal also includes a warranty, where physicians take a risk for avoidable complications and is site neutral based on the current facility payment amount performed in an ASC. Despite multiple encouraging meetings where CMS/CMMI leadership expressed support for the model, the agency has yet to take any action. In an effort to move the proposal forward, ASCRS developed the model in multiple ways, so that the bundled payment could be offered in traditional Medicare, Medicare Advantage, and within an ACO. The BPBCS is an example of a thoughtfully developed framework that could work in tandem with CMS PB-TCOC models — such as ACOs — as a separate voluntary agreement with a cataract surgery team without requiring specialists to be part of an ACO. The Alliance continues to urge CMS and CMMI to work more closely

[5] https://www.healthaffairs.org/content/forefront/cms-innovation-center-s-strategy-support-person-centered-value-based-specialty-care
[6] https://aspe.hhs.gov/sites/default/files/documents/2cd91b29eac2742fbc9babaf8f3b7962/PTAC-Specialty-Integration-RFI.pdf
[7] https://aspe.hhs.gov/sites/default/files/documents/823f7133bbde9de118d693a4330d2645/PTAC-Perf-Meas-RFI.pdf

with the specialty community and to take advantage of investments that have already been made in this space.

The Alliance also acknowledges CMS' recent adoption of revised methodologies to mitigate disincentives to include specialists on Participation Lists. While we appreciate these efforts, we remind Congress that the simultaneous increase in the QP threshold, required by statute in 2025, is expected to negate any benefit associated with these new policies.

Overall, we are disappointed by the ongoing lack of models and relevant participation pathways for specialists. As a starting point, Congress could direct the U.S. Government Accountability Office (GAO) to conduct a study on APMs that documents gaps in current availability of APMs for specialists, identifies current barriers to specialist participation in APMs, collects insights from specialists and other physicians on how they would like to see APMs designed, and evaluates more specifically the reasons why specialty-focused models have not moved forward. The Alliance looks forward to working with Congress to address ongoing impediments to meaningful specialty engagement in APMs, but to also ensure that any standards adopted to address these gaps do not inadvertently stymie innovation and progress.

Furthermore, Congress should require CMMI to adopt more transparent processes for developing and evaluating models. 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. Similarly, CMMI should be required to publicly explain why models are terminated early or not expanded to identify lessons learned in order to inform future models.

Specialists are further disadvantaged by provisions in statute that disincentivize movement into APMs. Under MACRA, the QP thresholds were scheduled to increase starting with the 2023 payment year, and the 5% APM incentive payment was scheduled to expire starting with the 2025 payment year. Recognizing the challenges that specialists face in terms of meeting QP eligibility criteria, and the importance of the incentive payment in terms of allowing clinicians to invest in APMs, Congress acted multiple times to extend the incentive payment and to freeze the QP thresholds.[8] While the Alliance very much appreciated these actions, they have all since expired. Substantially higher QP thresholds kicked in on January 1, 2025, and the APM incentive payment is scheduled to end following the 2026 payment year. As a result, many specialists will never have had an opportunity to benefit from the APM incentive payment and will lack the resources to prioritize investments in APMs going forward. Even if specialists can invest in APMs, fewer clinicians overall are expected to qualify as QPs in the coming years due to the increasing eligibility thresholds. These shifts in policy contradict the Congressional intent of MACRA, which was to encourage clinician movement into APMs, using MIPS as a springboard, not as a long-term solution. Unfortunately, these changes also come at time when we were finally starting to see measurable progress in terms of the number of clinicians transitioning from MIPS into Advanced APMs. In fact, the 2024 performance year was the first time since the enactment of MACRA that the number of QPs exceeded the number of MIPS eligible clinicians. Without additional Congressional action, we expect to see a reversal in this progress.

[8] To become a QP, clinicians must meet certain thresholds, set forth in MACRA, to demonstrate that they participate sufficiently in an Advanced APM. Under the Consolidated Appropriations Act, 2021, Congress froze the thresholds for payment years 2021 through 2024, at a level where clinicians had to receive at least 50% of Medicare Part B payments or see at least 35% of Medicare patients through an Advanced APM during the performance year to become a QP. Although there were Congressional attempts to extend this freeze (e.g., the *Preserving Patient Access to Accountable Care Act* (H.R. 786 / S. 1460)), these thresholds ultimately increased to 75% of Medicare Part B payments or 50% of patients as of January 1, 2025, which is expected to result in a significant decrease in the number of QPs (90 FR 49927).

Overall, the Alliance appreciates the steps Congress has taken to date in an attempt to continue to support the movement of physicians into APMs. However, we are still very concerned about the negative impact these shifting policies will have on the already slow movement of specialists into APMs. There have been very limited opportunities for specialists to participate meaningfully in APMs and qualify as QPs to date. With the APM incentive payment no longer available, most specialists will never even have had the opportunity to qualify for this critical source of funding, which has been immensely helpful to physicians who must invest in infrastructure and analytics to participate successfully in an APM. Similarly, higher QP thresholds will result in even fewer specialists qualifying for this track. The Alliance is concerned that these and other shifting policies will create a situation where MIPS incentive payments exceed APM incentive payments, causing reverse movement away from APMs and back into MIPS, contrary to Congress' vision of the QPP. We urge CMS to reinstate the APM incentive payment and to reduce current QP thresholds.

If MIPS were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes?

The Alliance urges Congress to:

- Give CMS the authority to move beyond the four siloed performance categories of MIPS and instead recognize more comprehensive and innovative investments in high value care.
- Better recognize the value of clinical data registries and their role in the QPP by, for example, allowing clinicians to receive credit across all four MIPS categories for registry participation that meets minimum standards and recognizing similar participation pathways that are more meaningful to specialists.
- Require CMS to better incentivize the development and use of specialty-focused metrics through technical assistance, less resource-intensive measure testing policies, and revised MIPS scoring policies.
- Allow physicians to meet Promoting Interoperability requirements via "yes/no" attestation of using Certified Electronic Health Record Technology (CEHRT) or technology that interacts with CEHRT, such as participation in a clinical data registry. The Assistant Secretary for Technology Policy (ASTP) recently issued the HTI-5 proposed rule,[9] which significantly streamlines requirements imposed on EHR vendors under the Health Information Technology Certification Program, acknowledging the evolution of efforts to incentivize interoperability and the fact that many program requirements are now either obsolete or have become market baseline. Requirements imposed on clinicians should similarly recognize the maturity of EHR adoption and aim to minimize reporting burden.

- Allow CMS to modify the MIPS Cost category by:
    - Removing the primary care-based total per capita costs measure mandate that continues to hold physician practices — including specialties that are explicitly excluded from the measure — responsible for costs outside of their control.
    - Removing the requirement that episode-based cost measures account for at least 1/2 of Part A and B expenditures to ensure prioritization of episodes with high variability and that specialists can directly impact.

[9] 90 FR 60970

    - Requiring that any evaluation of cost also simultaneously account for any changes in quality indicators meaningfully tied to cost performance among the same patient population to ensure cost-containment efforts do not result in poorer quality care or negatively impact access to care.
- Enforce MACRA's requirement that CMS provide access to Medicare claims data to assist specialties and their registries with a better understanding of existing gaps in care and support the development of quality and cost measures.
- Require CMS to release more granular and timely data regarding physician participation in MIPS.
- Terminate the Ambulatory Specialty Model recently finalized by CMS.

Implementation of MACRA's two-track value-based payment system, the QPP, has been ineffective and, arguably, detrimental to the delivery of most specialty medical care. Many specialists perceive MIPS, in particular, as an enormous administrative hassle that simply diverts critical resources away from more meaningful activities that could directly impact the quality and value of specialty care. Often under MIPS, specialty physicians often have no other choice but to report on marginally relevant measures that result in data that is of little use to physicians or their patients. Further, CMS has not produced any evidence 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.

In contrast to the promises of MACRA, MIPS has evolved into an overly complex, disjointed, burdensome, and clinically irrelevant program for many specialists. Even the GAO,[10] in an October 2021 report, expressed concern that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes, and highlighted the program's low return on investment. In its March 2024 environmental scan of value-based payment models,[11] PTAC notes: "Overall, there is little evidence that pay-for-performance and public reporting of quality measures have improved overall quality of care in the United States."

The Alliance requests that Congress consider the following fundamental flaws that continue to plague MIPS:

- **Siloed Performance Categories**. CMS has failed to produce a more unified quality reporting structure, as promised under MACRA. MIPS continues to rely on four separate performance categories that each have distinct and complex reporting requirements and scoring rules, making program compliance extremely resource intensive with little to no evidence of value. Additionally, for many specialties, what is being measured on the quality side rarely aligns with what is being measured on the cost side, resulting in a flawed value equation. The Alliance has repeatedly asked CMS to provide cross-category credit for more comprehensive value-based activities, such as reporting and regularly tracking performance through a clinical data registry, which would minimize duplicative and misguided reporting mandates while rewarding more meaningful investments in value-based care. However, CMS continues to cite statutory constraints, including the mandate to measure clinicians on each of the four MIPS performance categories as dictated by MACRA. As a result, the program is not only challenging to navigate and comply with, but for many specialties, it does not meaningfully reflect the overall value of care.
- **Constantly Shifting Goalposts**. Each year, CMS changes MIPS participation rules, including rules around eligibility, reporting requirements, and available measures. CMS also has the authority to update performance thresholds, which it has done many times since the program launched. As a result, it is challenging for physicians to keep up with the program and to make year-to-year

[10] https://www.gao.gov/assets/gao-22-104667.pdf
[11] https://aspe.hhs.gov/sites/default/files/documents/dae3de25b874112a649445d6381f527e/PTAC-Mar-25-Escan.pdf

comparisons regarding their performance. It is equally challenging for CMS to analyze the overall impact of the program over time accurately.

- **Lack of Incentives for Specialty Measures**. Many specialties have also faced challenges developing more specialty-focused quality measures and getting members to report on those measures as a result of MIPS scoring policies and other challenging requirements associated with maintaining a Qualified Clinical Data Registry (QCDR).
    - QCDRs were authorized by Congress to provide a more flexible and rapid pathway for specialties to introduce more innovative and clinically relevant measures under MIPS. Instead, due to unnecessarily excessive and costly measure testing and data validation requirements imposed by CMS, many prominent specialty-sponsored registries have been given no other choice but to leave the program. This is unfortunate since clinician-led registries tend to collect more relevant and meaningful clinical outcomes data, 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.
    - CMS quality measure scoring policies also disincentivize the development and use of more focused, specialty-specific measures — especially measures such as patient-reported outcomes measures, which are more time-consuming to collect but more meaningful to patients and physicians.
- **Barriers to Accessing Claims Data.** Specialty societies and QCDRs have also faced major challenges in accessing claims data. Claims data acquisition is costly and time-consuming, and specialty societies continue to face delays in trying to access such data. Specialty societies are willing to assist CMS with more robust quality and cost analyses but cannot do this without reasonable access to timely Medicare claims data.
- **Flawed Cost Measures**. Cost measures adopted for MIPS are also extremely difficult to interpret and take meaningful action on, and efforts to implement cost measures under MIPS to date have uncovered a variety of complex issues that make physician-level accountability an ongoing challenge. They often reflect care decisions and costs that are outside of a specialist's direct control and rarely align directly with quality measures other than in the title. For example, autoimmune diseases such as rheumatoid arthritis and Crohn's disease are managed with highly complex medications, including biologics, both originators and biosimilars, that physicians have little control over. Depending on the patient's unique biology, disease progression, and other clinical factors, one therapy may be clinically indicated, recommended and prescribed over another. Additionally, regardless of the condition or disease, measuring the cost of care *in isolation* is dangerous as it fails to account for the impact that changes in spending have on care quality and access to care. However, there is no meaningful way to align cost performance with applicable quality measures. This is even true under CMS' MIPS Value Pathways (MVP) Framework, which was intended to align performance assessment across the four MIPS performance categories. Unfortunately, MVPs too often include a cost measure addressing a specific condition, but no corresponding quality measures addressing the same condition. Therefore, it is not clear if the MIPS participant achieved good cost performance by improving value, or by simply stinting care.
- **Lack of Flexibility to Promote Interoperability**. The MIPS Promoting Interoperability category continues to take a one-size-fits-all approach to care that fails to appreciate the diversity and readiness of practices across the nation. The category also continues to focus on very specific EHR functionalities rather than promoting innovative use cases of health information technology, such as clinical data registries, clinical decision support tools, and tracking data from wearables and other digital devices that are more common among specialty patients. EHR adoption and federal policies supporting interoperability have advanced significantly since the enactment of MACRA. There is much more widespread use of CEHRT among clinicians, and CEHRT requirements have evolved to a

point where users of CEHRT are inherently satisfying the actions that the current set of MIPS Promoting Interoperability measures originally set out to capture and incentivize (e.g., secure data exchange). As a result, this category of MIPS has become outdated and should be revised to represent the current landscape better and minimize unnecessary reporting burden.

- **Failure to Provide a Glidepath to APM Participation**. The intent of MIPS, as envisioned by MACRA, was to prepare physicians to move into APMs. However, the current program — even as revised through the MVP Framework — largely fails to align with measures used under APMs and does little to ready specialists to move into APMs. Further, there are ongoing barriers to APM participation among specialists, as explained earlier.
- **Misguided Efforts to Improve MIPS**. Although CMS' MVP Framework was intended to address many of the problems outlined above, it simply reshuffles the deck while doing very little to address the program's foundational flaws, which increases frustration and disillusionment among physicians at a time when physician burnout is at an historical high. Compounding these concerns, CMS has recently finalized a new mandatory APM – the Ambulatory Specialty Model (or ASM) – which builds directly on the MVP framework, despite widespread concern among specialties that MVPs do little to core shortcomings of traditional MIPS. As noted in our comments to CMS, the Alliance believes the 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 Congress to prohibit CMS from implementing the Ambulatory Specialty Model. Instead, CMS should 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

Medicare Physician Payment Reform

Prior to the enactment of MACRA, the costs associated with running a physician practice were on the rise. We continue to see substantial increases in prices for medical supplies, equipment, and clinical and administrative labor, as demonstrated by the Consumer Price Index (CPI) and the Medicare Economic Index (MEI).[12] MACRA established physician payment updates without a yearly automatic inflation adjustment unlike other Medicare providers, which receive annual payment updates based on an inflation proxy, such as the CPI. Given the lack of an automatic payment update, when adjusted for inflation in practice costs, Medicare physician payments declined 33% from 2001 to 2025.[13] While Congress anticipated that physicians would receive value-based incentives and differential payment updates based on their participation in either the MIPS or APM tracks, many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

The Medicare Trustees[14] and other policy experts have raised concerns about the lack of an inflation measure in the MPFS. According to MedPAC, this downward financial pressure on physicians has forced many to sell their practices to health systems and private equity groups and enter into employment arrangements with these entities, further consolidating health care systems and increasing health care costs to taxpayers and beneficiaries.[15] Research by the American Medical Association (AMA) found that 42.2% of physicians remained in private practice as of 2024, but many are selling their practices because inadequate payment

[12] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf
[13] https://fixmedicarenow.org/sites/default/files/2025-01/Medicare Gap Chart_2025.pdf
[14] https://www.cms.gov/oact/tr/2025
[15] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch15_sec.pdf

rates, soaring resource costs, and overwhelming regulatory and administrative burdens make independence increasingly unsustainable.[16]

Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. In fact, physicians continue to "pay down" the significant budget neutrality adjustment prompted by 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 absorb CMS' 2022 implementation of revised clinical labor prices (an update that lagged two decades). For 2024, CMS commenced paying for a new E/M add-on payment that Congress previously prohibited CMS from implementing, prompting yet another substantial budget neutrality adjustment and concomitant reduction to the MPFS CF. We appreciate congressional efforts to reduce CF cuts temporarily; however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. The 2026 MPFS CF equals $33.40 for non-qualifying APM participants (or $33.57 for qualifying APM participants). In 2016, it was almost $36.00.

The Alliance recognizes that Congress provided a 2.5% increase to the Medicare conversion factor in 2026, but calls on Congress to simultaneously embrace long term reforms to **prevent recurring annual Medicare cuts** and **enact permanent solutions to stabilize Medicare physician payments, support investments in value-based care, and improve the quality of care provided to Medicare beneficiaries.**

Thank you for the opportunity to comment on these important issues. If you have any questions, please do not hesitate to contact us at info@specialtydocs.org.

Sincerely,

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

[16] https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever