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January 16, 2026

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

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

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

Re: Physician Clinical Registry Coalition's Comments on Medicare Access and CHIP Reauthorization Act of 2015 Modernization

Dear Chairs Joyce, Murphy, and Schrier and Members of the GOP and Democratic Doctors Caucuses:

The American College of Rheumatology (ACR), representing over 10,000 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to support the bipartisan efforts of the Republican and Democratic Doctors Caucuses as they consider opportunities to improve access to care under the Medicare Access and CHIP Reauthorization Act (MACRA).

In April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) eliminated the Medicare payment system based on the Sustainable Growth Rate formula and implemented a transition period intended to incentivize payments based on value. 2025 was the ninth year of the Merit-Based Incentive Payment System (MIPS), which scores providers based on (i) Quality (based on PQRS), (ii) Promoting Interoperability (formerly Advancing Care Information, and based on Meaningful Use), (iii) Clinical Practice Improvement, and (iv) Cost. Providers' performance on MIPS measures will provoke payment adjustments, in the form of bonuses or penalties two years after the reporting year unless providers join an Alternative Payment Model (APM).

Overall, the MACRA framework forces providers to choose between the uncertainty and financial risk of joining an APM and the possibility of financial burdens from the MIPS system. A third option, the MIPS Value Pathway (MVP) has been instituted to help ease providers, especially the smaller groups and solo practitioners, from MIPS to APMs and began implementation in 2023. The initial reporting period is through 2025 and in 2026 multispecialty groups will be required to form subgroups. These three

programs must allow for meaningful and streamlined quality measurement without placing an unnecessary burden on the provider. Practices may see fewer Medicare patients or opt out of Medicare altogether if they are not able to succeed under these programs. Patients could be left with longer wait times and travel distances or increased out-of-pocket costs.
The ACR appreciates your ongoing efforts to engage the physician community to improve MACRA and protect access to care for patients. We offer specific recommendations below in response to your two questions.

I. What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

ACR would call for a CMMI model that, among other improvements and safeguards, engages in appropriately scaled, time-limited demonstration projects, greater transparency, improved data-sharing, and broader collaboration with the private sector. Adoption of these principles can help to ensure that demonstrations are widely embraced and supported, a contrast to previous episodes that saw widespread resistance from patients and the healthcare community to proposals that went well beyond conventional demonstrations or tests.

The ACR suggests that CMMI:

- Foster strong, scientifically valid testing prior to expansion. Initial CMMI experiments of new payment and delivery models should have comprehensive, methodologically sound, transparent evaluation plans and occur via appropriately scaled, time-limited tests in order to protect beneficiaries and participants from unintended or adverse consequences. Participation in model tests must be voluntary and should be structured in such a way to ensure valid results.
- Respect Congress's role in making health policy changes. The legislative branch has a responsibility to oversee CMMI and must approve model expansions and related changes to Medicare and Medicaid. CMMI's important work in testing new models that improve quality or reduce costs without harming beneficiary access or healthcare outcomes should inform congressional decisions on national health policy.
- Consistently provide transparency and meaningful stakeholder engagement. CMMI's process for developing, testing, and expanding models must be more open, transparent, and predictable to provide meaningful opportunities for stakeholder input, ensure safeguards for patients and providers, and improve accountability. This includes developing new models in close consultation with affected stakeholders, maintaining complete transparency in decision-making and program procedures, and fully evaluating data and seeking patient and stakeholder input prior to model expansions.
- Improve sharing of data from CMMI testing. Data from CMMI model tests should be made public on an ongoing basis to facilitate assessments of their impact on healthcare quality and spending, and to inform parallel efforts in the private sector.

- Strengthen beneficiary safeguards. Beneficiaries must not be compelled to participate in a demonstration project and must be adequately educated about the project as well as protected by safeguards to ensure continued access and care quality.
- Collaborate with the private sector. For CMMI to have an optimal impact on improving healthcare quality and cost-efficiency, it must work collaboratively with the private sector and harness market competition and innovation. In selecting demonstration projects, priority should be given to partnerships involving providers, payers, and other private sector entities throughout the healthcare continuum. CMMI models should support private sector organization efforts to advance healthcare value, rather than impeding such efforts by picking winners and losers in the market.

The ACR also supports the development of APMs that place adequate value on rheumatology care and are feasible for small practices, such as the ACR rheumatoid arthritis APM. This includes:

- Lowering the payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM and minimize initial risks to which providers are exposed to encourage smaller practices, many of which are in under-served areas, to participate in APMs.
- Implementing efficient evidence-based performance measures that improve the quality of care and promote fair reimbursement for work done by rheumatologists and rheumatology interpersonal team members in collecting and reporting administrative data.
- Ensure that APMs recognize the lifetime specialty care required by patients with chronic and rheumatic disease by ensuring that APMs reward the prevention of downstream complications, not just short-term cost reductions and patient endpoints.

Further, the ACR supports clinicians' ability to measure and report cost and quality via Qualified Clinical Data Registries (QCDRs) such as the ACR's Rheumatology Informatics System for Effectiveness (RISE) registry. RISE is the first and largest electronic health record (EHR)-enabled rheumatology registry in the United States, serving more than 1,000 clinicians and 3.5 million patients. To leverage this resource, the ACR supports Congressman Joyce and Congresswoman Schrier's bill, H.R. 4331, the Access to Claims Data Act to establish a process to expand access to claims data under certain Federal health plans to facilitate research and quality improvement. Clinician-led Qualified Registries (QR) and QCDRs allow the best insight into costs and outcome measures only when they have real-time access to claims data.

The success of quality improvement and cost efficiency programs requires participation to be financially feasible. Participation in MIPs costs $12,800 per physician annually and over 200 hours of staff time[1]. As the Doctors Caucuses leaders are too well aware, CMS physician reimbursement has fallen 33% since 2001 due to increasing practice costs and a failure of the system to recognize inflation. Legislation that

[1] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

would support innovations in cost and quality would support physician salaries by requiring an annual update to the CF equal to the MEI.

II. 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.

Broadly, a physician-led healthcare program of any sort would allow for appropriate allocation for actual costs of providing care. This requires repealing the balanced budget requirement which limits the resources available to Medicare as the base for all pricing in our healthcare system. Additionally, it requires that physician reimbursements reflect the economy in which they are expected to cover the costs of providing care and therefore must be tied to inflation. The ACR appreciates the support of members of the Doctors Caucuses on these vital issues to patient access and care. Additionally, repealing the ACA restriction on physician-owned hospitals would allow physicians to invest in their communities and profession while providing higher quality care often at lower costs and with better outcomes.

I. The Data-Driven Performance Payment System (DPPS)

Specifically, the ACR supports the AMA's "Data-Driven Performance Payment System" (DPPS) which would lower burdens for physician practices, support small, rural practices by substantially lowering penalties that they now experience under MIPS, and provide performance, cost and quality measures that are more clinically relevant and accurate.[2] Under the DPPS:

- Payment adjustments would increase or decrease by a percentage of a physician's annual payment update [e.g. 0.25 percent under current law or an increase equivalent to the Medicare Economic Index (MEI)], similar to Medicare's hospital performance-based programs, thus creating more alignment across settings;
- Payment adjustments would not reduce a physician's payment update to below zero, thus stabilizing Medicare payments; and
- Performance thresholds would be frozen for at least three years and gradually increased thereafter to allow practices to recover from the pandemic and Change cyberattack and to implement DPPS changes.

These changes provide much needed flexibilities through streamlined reporting requirements and recognizing quality efforts that span the four existing performance categories. Additionally, it would allow physicians to meet the health IT requirements by answering "yes or no" as to whether they use certified electronic health record technology, participate in a clinical data registry, other less burdensome means. If a practice participated in a qualifying registry, it would automatically count toward fulfilling improvement activities. Finally, it aligns with other Medicare value-based programs, giving physicians the opportunity to be measured on the care they provide in hospitals and other settings without having to report duplicative data.

[2] https://fixmedicarenow.org/sites/default/files/2024-07/AMA_How-DPPS-Would-Improve-MIPS_1.pdf

For small and rural practices, these changes would eliminate the win-lose tournament model in MIPS and reduce the maximum penalty from negative 9% to one-half of a physician's annual payment update. The annual update would be 0.25% under current law or the increase in the Medicare Economic Index (MEI) if the Strengthening Medicare for Patients and Providers Act is reintroduced in the 119th Congress and passes. That approach is similar to other Medicare programs, such as the Hospital Inpatient Quality Reporting Program. Additionally, it would reinvest excess penalties in quality improvement and alternative payment model readiness by helping under-resourced practices with their value-based care transformation. Finally, it would freeze the performance threshold at 60 points for at least three years to reduce penalties as physician practices continue to recover from the COVID-19 public health emergency and the Change Healthcare data breach.

The DPPS increases accuracy as well by giving CMS incentives to fulfill its statutory obligations to share data on a quarterly basis, allowing physicians to improve performance on quality and cost measures. It addresses cost variability that a physician can influence by replacing current broad, problematic cost measures with more targeted, episode-based cost measures. Finally, it would give physicians pay-for-reporting credit for three years if they report new or significantly revised quality measures, increasing the incentive to report on new quality measures and improving data accuracy.

II. Development of Accurate Cost Measures

It is also critical that any physician-led quality program includes an accurate way to score providers who frequently administer high-cost treatments. In 2018, CMS implemented the resource use, or cost, category as a component of MIPS scoring. We continue to be concerned about the resource use category as Part B drug costs are included in the cost component and count toward a practitioner's score – though Part D drug costs are not included. Under this system, rheumatologists may be penalized for providing medically necessary Part B drug treatments to their patients. The ACR supports new cost measures that are developed and integrated in a way that accurately reflects the complexities of cost measurement and does not inadvertently discourage clinicians from caring for high-risk and medically complex patients. This will safeguard practitioners, especially specialists like Rheumatologists, where there is a higher use of necessary and effective, yet expensive, medications such as biologics.

Flexibility in the design of the MIPS and future MVPs, along with simplicity in implementation, should drive the refinement of these programs. Participation in APMs would be improved by lowering payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM and by minimizing initial risks to which providers are exposed. Appropriate data and measurements should be used to develop these programs to ensure there are no biases against certain patients and their physicians.

To accomplish this, the ACR supports:

- Appropriate management of MACRA and protecting access to rheumatology care by:
    - Use of metrics that are clinically relevant, efficient, and promote quality of rheumatologic care in the components of the MIPS and implementation of MVPs.

    - Creating and giving proper accreditation to a variety of APMs and demonstration projects that recognize the value of care provided by rheumatologists and rheumatology interprofessional team members.
    - Counting participation in a Qualified Clinical Data Registry such as RISE toward MIPS participation under MACRA.
    - Transparency in MIPS, MVPs, and APMs, allowing practicing physicians to easily understand and implement these programs.
    - Improving transparency and accountability of the processes by which Medicare Administrative Contractors implement Local Coverage Determinations and ensure provider input on all new or revised policies.
- Excluding Part B drug costs from the cost component of MIPS score calculations.
    - Alternatively, if drug costs are to be included, the ACR cannot support including Part B drug costs without also including Part D drug costs.
- Congressional action to control excessive drug price increases.
- Simplifying the MIPS and MVPs program through reduced reporting requirements and flexibility to account for practice variation.
- Continuing a minimum 90-day reporting period for MIPS domains of Promoting Interoperability and Improvement Activities.
- Ensuring that providers who participate in a Qualified Clinical Data Registry (QCDR), such as RISE, can maximize credit in MIPS for doing so.
- Ensuring providers will be informed of performance outcomes in real time to enable them to make changes before the next performance period.
- Minimizing barriers to forming virtual groups to report performance.

The ACR has long supported policies that would alleviate administrative burden and allow rheumatologists to provide high quality care unimpeded. We thank the Doctors Caucuses for allowing us the opportunity to voice concerns and suggest modifications to this crucial program. Please contact Lennie McDaniel, JD, Senior Director, Advocacy and Government Affairs, at LMcDaniel@rheumatology.org if you have any questions.

Sincerely,

Amanda Myers, MD
American College of Rheumatology
Chair, Government Affairs Committee