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PHYSICIAN CLINICAL REGISTRY COALITION

April 16, 2026

VIA ELECTRONIC MAIL

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 Proposals

Dear Chairs Joyce, Murphy, and Schrier:

The undersigned members of the Physician Clinical Registry Coalition ("Coalition") appreciate the opportunity to offer recommendations on legislative reforms to modernize the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). This letter builds upon the Coalition's letter, dated January 16, 2026, which responds to the Doctors Caucus's Request for Information on MACRA. *See enclosed letter*. The Coalition is a group of medical society-sponsored clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care. We are committed to advocating for policies that encourage and enable the development of clinical data registries and enhance their ability to improve quality of care through the analysis and reporting of clinical outcomes.

We appreciate the Caucus' recognition of the critical role clinician-led clinical data registries play as the foundational infrastructure for quality measurement, improvement, and value-based payment, as well as its interest in further incentivizing their use. We welcome the opportunity to serve as an ongoing resource to the Caucus as it advances legislation aimed at modernizing quality measurement and addressing provider burden. We respectfully offer the following comments to inform and support the Caucus in developing legislation.

Clinical Data Registries and Medicare Quality Reporting

Clinician-led clinical data registries are organized data collection and analysis systems operated by or affiliated with a national medical society, hospital association, or other health care associations. These registries collect and analyze data on specified outcomes submitted by physicians, hospitals, and other types of health care providers related to a wide variety of medical procedures, diagnostic tests, and/or clinical conditions. They perform data aggregation and related benchmarking analyses that support one or more predetermined scientific, clinical, or policy purposes, including, but not limited to, describing the natural history of disease, determining the effectiveness (including the comparative effectiveness) of therapeutic modalities, and measuring/improving quality of care.

These registries are uniquely positioned to reflect real-world data, incorporate clinical nuance, and support more accurate and relevant assessments of care quality. The data they capture exceeds what is available through electronic health records (“EHRs”) or administrative claims alone. Clinician-led clinical data registries enable clinicians to report on measures that are more clinically meaningful and tailored to their specialty or patient population. Their role in the Merit-based Incentive Payment System (“MIPS”) allows for more precise evaluation of clinician performance and the provision of timely feedback and performance insights that clinicians can use to drive improved patient outcomes. Moreover, registries address gaps in existing MIPS metrics through clinically grounded measure development, particularly in specialties or subspecialties where applicable measures may be limited. Indeed, medical specialty societies maintain over 60 percent of the current MIPS quality measure inventory.

Considerations for Legislative Reforms

As the Caucus considers reforms to MACRA, we recommend the following guiding principles to sustain registry operations and participation, preserve the integrity of critical quality measurement tools, and mitigate the risk of unintended consequences.

- **Preserve and Support Use and Operations of Clinician-Led Clinical Data Registries**: In developing legislation to reform MACRA, we respectfully urge the Caucus to preserve and support clinician-led clinical data registries. Reforms should reinforce utilization of registry-based operations and reporting. Policies that reduce financial burdens and administrative complexity are critical. Maintaining registries and their measures are time- and resource-intensive. Policies that inadvertently disrupt registry participation, funding, or measure development could undermine years of progress in advancing specialty-relevant and outcomes-focused measurement. Any legislative reforms should empower registries to remain responsive to clinical and patient needs. To the extent that the draft legislation mandates the use of registry reporting, we encourage the Caucus to ensure that the mandate does not disadvantage specialties that do not have their own Qualified Clinical Data Registry (“QCDR”). The Coalition is open to working with the Caucus to develop innovative approaches to evaluating performance when a specialty does not have a QCDR.

- **Protect Specialty-Driven Measures:** Specialty societies should remain the primary drivers of measure development and maintenance. Specialty societies possess the subject matter expertise necessary to develop clinically meaningful, evidence-based measures that support real-world quality improvement. Specialty-driven measures are well positioned to reflect nuances of clinical practice and care needs of patient populations. To the extent the Caucus is considering the development of a Quality Care Reform Task Force, we recommend ensuring that registry autonomy and measure development and decision-making is preserved and strengthened.

- **Differentiate Between Clinician-Led Clinical Data Registry and Vendor-Led Registry**: The 21st Century Cures Act defines the term "clinician-led clinical data registry" as a clinical data repository that is established or operated by a clinician-led or controlled, tax-exempt professional society or other similar organization; designed to collect detailed, standardized data on an ongoing basis for medical procedures, services, or therapies for particular diseases, conditions, or exposures; provides feedback to participating data sources; provides ongoing participant training and support; and meets certain quality standards.[1] Clinician-led clinical data registries are designed by clinical experts within a specific medical specialty, ensuring that the data are clinically accurate, relevant, and meaningful to specific patient populations. In contrast, vendor-led registries do not have clinical expertise or in-depth understanding about quality measurement. Instead, they are created only for commercial purposes. For-profit companies, such as EHR companies, do not appear to have any population health impact, as measured by published articles in the scientific peer-reviewed literature and practice guidelines for clinicians. This differentiation between clinician-led clinical data registries and vendor-led registries should be recognized in any legislative reform of MACRA.

- **Protect the Integrity of Measures**: QCDR measures are created by subject matter experts, undergo significant expert vetting, and are supported by literature, guidelines, and data. When a QCDR develops a new measure, measure testing is required, with an average cost of $1,000,000 per measure. QCDR measures constitute works of authorship that are subject to copyright protection. This legal framework gives the measure developers exclusive rights to control how their measures are used and who may use them. Measures can be complex to develop and implement, and measure owners often provide a significant amount of technical assistance and support to third parties using their measures. Therefore, continued preservation of QCDR ownership of measures is essential to protecting intellectual property rights of QCDRs and the integrity of the measures themselves.

- **Protect the Integrity of Specialty Society-Developed Guidelines:** Specialty society-developed clinical guidelines are foundational to evidence-based care for that specialty. They are often created through rigorous review of literature and expert consensus. These guidelines are often intellectual property of the society that invested significant resources in their development and maintenance. As such, their integrity and appropriate application and utilization must be preserved. Legislative proposals requiring the incorporation of such guidelines into EHRs without the explicit approval and oversight of the specialty society infringes on those rights and risks selective implementation, outdated use, and misinterpretation. We therefore recommend that any use of such guidelines within EHRs be

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[1] MACRA, Pub. L. No. 114-10, § 101(c), 129 Stat. 87 (2015).

subject to formal authorization and ongoing oversight by the relevant society to ensure accuracy and alignment with standards of care.

- **Burden of Unfunded Mandates**: Unfunded federal requirements pose a considerable threat to the viability of clinical data registries. CMS has imposed an increasing number of requirements that shift the financial and administrative burden of operating in the MIPS program onto specialty societies and their registries. For instance, the existing measure testing requirement introduces substantial costs and operational challenges that are not accompanied by federal funding, leading some QCDRs to scale back or discontinue measure development. Additionally, the current policy on data validation is highly resource-intensive and burdensome on registries and clinicians. As the Caucus considers the role of registries in a redesigned federal framework, we recommend the inclusion of dedicated federal funding or incentives to sustain registry operations and measure innovations.

- **Access to Medicare Claims Data**: Improved access to claims data by registries for quality improvement, patient safety, and research purposes is vital to building evidence-based models of value-based care that benefit patients. We respectfully encourage the Caucus to include as part of this proposal bipartisan legislation—H.R. 4331, the Access to Claims Data Act—introduced by Dr. Joyce and Dr. Schrier. This legislation would establish a process to provide clinician-led clinical data registries with timely, comprehensive, and continuous access to federal claims data. The integration of clinical registry data with claims data would most accurately evaluate value and the use of appropriate measures to assess cost.

We would greatly appreciate the opportunity to meet with Caucus staff to discuss these issues in further depth at your earliest convenience. We applaud your leadership and continued commitment to working with stakeholders to develop a quality measurement framework that is clinically meaningful and focused on advancing patient care. If you have any questions, please contact Leela Baggett or Delaney Bounds at Powers Pyles Sutter & Verville, PC (Leela.Baggett@PowersLaw.com or Delaney.Bounds@PowersLaw.com).

Respectfully submitted,

American Academy of Dermatology Association
American Academy of Ophthalmology
American Association of Neurological Surgeons
American College of Emergency Physicians
American College of Gastroenterology
American College of Rheumatology
American Psychological Association
American Society for Gastrointestinal Endoscopy
American Urological Association
Center for Professionalism and Value in Health Care (ABFM PRIME)
College of American Pathologists
Outpatient Endovascular and Interventional Society
Society of Interventional Radiology
Society of NeuroInterventional Surgery
The Society of Thoracic Surgeons

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