SUBMITTED ELECTRONICALLY VIA WWW.REGULATIONS.GOV

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments on the 2025 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule (CMS-1807-P)

Dear Administrator Brooks-LaSure:

The Advocacy Council of the American College of Allergy, Asthma and Immunology ("ACAAI") together with its sponsoring organization, the ACAAI, appreciate the opportunity to submit comments on the 2025 Medicare Physician Fee Schedule and Quality Payment Program proposed rule ("Proposed Rule"). The Advocacy Council and the ACAAI represent the interests of more than 6,000 allergists-immunologists and allied health professionals. Our members provide patient services across a variety of settings ranging from small or solo physician offices to large academic medical centers.

In the Proposed Rule, the Centers for Medicare and Medicaid Services ("CMS") offer numerous proposals impacting provider payment under Medicare. Our comments are confined to the following proposed policies:

- Changes to the Medicare physician fee schedule conversion factor and related reimbursement rates;
- Flexibility for direct supervision;
- Telehealth flexibilities; and
- Policies concerning the Merit-based Incentive Payment System ("MIPS") program and MIPS Value Pathways ("MVPs").
- Building Upon the MVPs Framework to Improve Ambulatory Specialty Care Request for Information ("RFI")

Cuts to Physician Reimbursement

The Advocacy Council and the ACAAI oppose the proposed 2025 conversion factor of $32.3562, which is a decrease of $0.93 (or 2.80%) from the 2024 conversion factor ($33.2875). The proposed reduction of the conversion factor, if finalized in its current form, will adversely

impact reimbursement to all providers participating in the Medicare program—including allergists. Further, the proposed Medicare payment cuts will likely have a ripple effect beyond the Medicare program, as many commercial payers link their reimbursement rates to Medicare payment levels. These payment cuts will place significant financial burden on physician practices, particularly small and rural practices, that are already dealing with high inflation rates and workforce shortages.

In fact, the agency's own projections for estimated MIPS scores for the 2025 performance period for solo and small practitioners are dismal. CMS estimates the median positive payment adjustment in the 2027 payment year will be 1.31%, while the median penalty will be -1.48%. However, solo practitioners and small practices will fare worse, with median expected penalties of -6.42% and -5.88%, respectively. Unfortunately, more of these physicians are expected to receive the maximum -9% penalty compared to larger practices.

	Estimated Median Final Score	Estimated % Receiving a Penalty
All MIPS Eligible Clinicians	86.42	15.47%
All Solo Practitioners	75.00	45.65%
All Small Practices	86.02	20.93%

In light of the rising cost of practicing medicine, it is unrealistic for Congress and CMS to assume that physician practices will tolerate dwindling payment rates. We urge CMS to work with Congress to mitigate or eliminate the effects of these cuts and identify longer-term "fixes" to this annual issue.

Direct Supervision

Medicare rules generally require that a physician be immediately available on-site if the physician uses clinical staff to aid in the furnishing of a service. This principle is known as direct supervision. CMS temporarily relaxed this direct supervision requirement in response to the COVID-19 public health emergency ("PHE"). This flexibility allowed the supervising physician/practitioner to be "immediately available" through virtual presence via real-time video and audio technology.

CMS is now proposing to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using real-time audio and visual interactive telecommunications for the following subset of services:

- Services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).

- Services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel that the billing practitioner employs and who are working under the billing practitioner's direct supervision, and for which the underlying HCPCS code has been assigned a Professional Component ("PC")/Technical Component ("TC")

indicator of '5' as listed in the PFS Relative Value Files. A '5' indicator describes codes for services covered incident to a physician's service when auxiliary personnel are employed by the physician and work under their direct supervision.

The latter proposed services include CPT codes 95012 (Exhaled nitric oxide meas), 95044 (Allergy patch tests), 95052 (Photo patch test), 95056 (Photosensitivity tests), 95115 (Immunotherapy one injection), and 95117 (Immunotherapy injections). We support and appreciate CMS's decision to permanently adopt a flexible definition of direct supervision with respect to these services. However, we believe that CMS should expand this policy to CPT code 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)), so that allergists can continue to satisfy the direct supervision requirement through the use of real-time video and audio technology. Remote supervision of allergen extract preparation during COVID-19 has provided efficiency gains to allergy practices without increased patient risk.

Telehealth Services

The COVID-19 PHE highlighted the importance and convenience of telehealth services in the delivery of healthcare to meet patient needs. We understand that there are statutory limitations on CMS's authority to extend certain telehealth flexibilities after 2024. We strongly urge CMS to work with Congress to enact legislation that would permanently extend Medicare telehealth policies. We believe that it is important that Medicare beneficiaries have the option to continue receiving certain healthcare services in their homes.

We also support the agency's proposal to permanently change the definition of an interactive telecommunications system to include two-way, real-time audio-only communication technology for telehealth services furnished to patients in their homes. We also encourage the agency to re-evaluate their authority to pay for the new CPT codes (9X075-9X090) for synchronous audio-video and audio-only E/M services in 2025.

In addition, the Advocacy Council and ACAAI appreciate the agency's policy for telehealth practitioners to bill from their currently enrolled location (i.e., their hospital or office location) instead of their home address when providing telehealth services from their home. We believe that this policy safeguards physician privacy and safety. Accordingly, we support CMS's proposal that it will continue, through 2025, to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. We urge the agency to permanently adopt this policy after 2025.

MIPS Value Pathways

I. *Sunsetting the Traditional MIPS Program*

Although CMS did not propose to establish the timing for ending the traditional MIPS program, the agency is seeking feedback on clinicians' readiness to sunset the traditional MIPS program by the 2029 performance period. We strongly believe that CMS should continue to recognize MVP participation as voluntary. A rushed timeframe to retire traditional MIPS may disenfranchise clinicians without meaningful MVPs. We believe that it is premature to consider retiring the traditional MIPS program, as the current MVP program must be further refined to streamline and simplify MIPS requirements. Therefore, we urge CMS to continue to recognize MVP participation as voluntary for the foreseeable future.

We also encourage the agency to meaningfully reform the traditional MIPS program to address the current, burdensome requirements and complexities that plague the MIPS program. We strongly support legislation that would replace elements of the MIPS program with the proposed Data-Driven Performance Payment System ("DPPS"). Please see the enclosed letter supporting this legislation.

II. *MVP Development*

The MVP program provides an opportunity to increase scoring simplicity and predictability, appropriately evaluate and reward performance improvement, collaborate with specialty societies to identify and address priority areas, ensure that quality measurement is clinically relevant to physicians, and focus on patient-centered care. As mentioned above, in developing the MVP program, we encourage the agency to adopt MVP policies that will remedy the substantial administrative burdens of the current, traditional MIPS program.

In general, medical societies, including ACAAI, have expressed serious concerns regarding the development of MVPs applicable to their specialties. Medical societies are concerned that measures included in proposed MVPs are not meaningful to practitioners. In addition, we believe the agency needs to provide more transparency with respect to the development of MVPs. During the MVP development process, ACAAI recommended several changes to the quality measures in the draft Pulmonology Care MVP, as discussed below. The agency declined to adopt these recommendations without providing sufficient details regarding its rationale. This impedes the ability to medical societies to work collaboratively with CMS to develop a clinically meaningful MVP. We believe that the agency needs to work collaboratively with stakeholders to develop a proper MVP framework that results in more clinically relevant and meaningful performance data for specialties.

III. *Pulmonology* Care MVP

CMS is proposing a new MVP related to pulmonology that would be available starting with the 2025 performance period. The Advocacy Council and the ACAAI remain concerned that the Pulmonology Care MVP is not a viable reporting option for allergists. In fact, when the agency listed practitioners who would typically utilize this MVP, they did not include allergists.

If CMS moves forward with this MVP as currently proposed, we urge CMS to develop a separate MVP for the practice of allergy. We stand ready to work with CMS to develop an allergy-specific MVP that is meaningful to allergists. Alternatively, if CMS does not intend to develop an allergy-specific MVP, we respectfully request that CMS revise the Pulmonary Care MVP in accordance with the following recommendations.

Quality Measures in the Pulmonary Care MVP

CMS has stated that the intent of the MVP "is to allow some flexibility and choice to clinicians in reporting a subset of measures and activities within a proposed MVP." However, the Pulmonology Care MVP does not offer sufficient reporting options for allergists. Currently, only three quality measures in the Pulmonology Care MVP are regularly utilized by allergists:

1. Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan;
2. Quality ID #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention; and
3. Quality ID #398: Optimal Asthma Control.

Although we appreciate CMS's efforts to incentivize screening for Social Drivers of Health ("SDOH"), we are concerned that allergists are not as familiar with Quality ID #Q487: Screening for SDOH. Moreover, the medical practice of allergy does not typically concern advance care plans or surrogate decision makers. Conversations regarding such documents are typically handled by primary care physicians, not allergists, and it is unclear whether Quality ID #Q047: Advance Care Plan would be reported by allergists. Accordingly, there are only three quality measures truly applicable to the field of allergy.

Therefore, we respectfully urge CMS to include in the Pulmonology Care MVP the following additional measures:

1. Quality ID #130: Documentation of Current Medications in the Medical Record;
2. Quality ID #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use); and
3. Quality ID # 331 Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse).

Quality ID #130: Documentation of Current Medications in the Medical Record

CMS should include Quality ID #130 Documentation of Current Medications in the Medical Record in the MVP because this measure will be applicable to allergists, along with other pulmonary specialists. This quality measure examines the percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. In order to develop and maintain the most effective and appropriate plan of care for Medicare beneficiaries, allergists must have an accurate and timely list of current medications. Therefore, this measure is clinically important for allergists.

Quality ID #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) & Quality ID #331 Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)

Sinusitis, also referred to as a sinus infection, concerns the inflammation of the sinuses—air-filled cavities that are located within the bony structure of the cheeks, behind the forehead and eyebrows, on either side of the bridge of the nose, and behind the nose directly in front of the brain. An infection of the sinus cavity close to the brain can be life-threatening, if not treated. Individuals who have allergies, asthma, structural blockages in the nose or sinuses, or individuals with compromised immune systems are more likely to develop bacterial or fungal sinus infection. Allergists commonly prescribe antibiotics to treat bacterial sinus infections, and knowing what kind of bacteria is causing the infection can lead to more effective antibiotic therapy. Therefore, CMS should include both Quality IDs #331 and 332 in the Pulmonary Care MVP. The inclusion of these quality measures will help improve patient outcomes.

Small Practices

With respect to small practices, we understand that such practices are not required to report four quality measures included in an MVP provided that the small practice reports each Medicare Part B claim measure that is applicable. Under the Pulmonary Care MVP, there are three Medicare Part B claims measures: (1) Q047: Advance Care Plan, (2) Q128: Preventive Care and Screening: BMI Screening and Follow-Up Plan, and (3) Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. As stated above, we question whether Q047: Advance Care Plan is applicable to the practice of allergy. Allergists are not typically the providers who discuss advance care plans or surrogate decision makers with their patients. This is typically handled by the primary care provider. We seek clarification from CMS whether allergists in small practices are required to report Quality ID #Q047 Advance Care Plan.

Allergy/Immunology Specialty Set

We support CMS's decision to add the following quality measure to the Allergy/Immunology specialty set:

- Adult COVID-19 Vaccination Status: Percentage of patients aged 18 years and older seen for a visit during the performance period that are up to date on their COVID-19 vaccinations as defined by CDC recommendations on current vaccination.

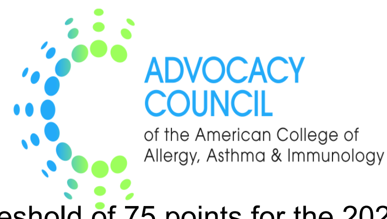
Data Completeness

CMS previously finalized a policy increasing the data completeness threshold to 75 percent for the 2024 and 2025 performance periods. The agency also maintained the data completeness criteria threshold at 75 percent for the 2026 performance period. CMS is now proposing to maintain the data completeness criteria threshold of at least 75 percent through the 2028 performance year.

The Advocacy Council and the ACAAI appreciate the agency's decision to not increase the data completeness threshold through the 2028 performance year. Such an increase would be inconsistent with the agency's goals of reducing burden on practitioners in the MIPS program. Higher data completeness thresholds have a disparate impact on participants that manually extract and report quality data. Further, higher percentage requirements do not account for physicians who provide care beyond a single site and wrongly assume that data is fluid between sites.

Performance Threshold

The Advocacy Council and the ACAAI applaud CMS's decision not to increase the performance threshold for the 2025 performance period. The establishment of a higher, more rigorous performance threshold would increase administrative burden on physicians and place a financial strain on smaller practices. The payment cuts associated with a higher performance threshold would compound the financial distress currently facing physicians who are dealing with high inflation, workforce shortages, and substantial proposed cuts in overall Medicare physician reimbursement. These burdens would be magnified for small physician practices. Accordingly,



we support CMS's proposal to maintain a performance threshold of 75 points for the 2025 performance year. We also are advocating for legislation that would establish the DPPS. The DPPS would freeze the performance threshold at 60 points for at least three years.

Performance Category Reweighting

CMS proposes to add a new circumstance in which the agency may reweigh certain performance categories. Beginning with the 2024 performance period, CMS may reweigh quality, improvement activities ("IA"), or promoting interoperability ("PI") performance categories when a clinician was unable to submit data for these categories because the data submission was delegated to a third-party intermediary which did not submit the data. We support the agency's proposed reweighting policy to ensure that clinicians are not unfairly penalized due to third party intermediary actions outside of the clinician's control.

Cost Performance Category

The Advocacy Council and the ACAAI have repeatedly expressed concern to CMS about the potential negative impact of the Cost performance category on allergists' final MIPS scores. CMS is now proposing to modify the methodology for scoring cost measures beginning with the 2024 performance period. CMS proposes to tie the median score to a point value derived from the performance threshold. CMS estimates this proposed methodology would increase the mean cost performance category score (unweighted) from 59 out of 100 to 71 out of 100. We support this proposal as it would likely have a positive impact on allergists' MIPS scores beginning in 2024.

Improvement Activities

Most clinicians currently must submit two to four IAs to receive the maximum IA score of 40 points. Under the Proposed Rule, with respect to traditional MIPS reporting, clinicians, groups, and virtual groups with the small practice, rural, or health professional shortage area special status must attest to one activity. All other clinicians, groups, and virtual groups must attest to two activities. CMS is also proposing that clinicians, groups, and subgroups reporting via MVPs must attest to one activity, regardless of special status.

We appreciate the agency's interest in assisting practitioners by reducing administrative burden. The Advocacy Council and the ACAAI support these policies and believe it will particularly benefit small practices, rural practices, and practices in health professional shortage areas. These practitioners are disproportionately impacted by workforce shortages and may experience difficulty meeting the current reporting requirements.

Promoting Interoperability

Currently, when CMS receives multiple data submissions with conflicting data for the PI category, the agency will assign a PI score of zero. However, under the Proposed Rule, beginning with the 2024 performance period, CMS will instead calculate a score for each data submission and use the highest score received as the PI score. The Advocacy Council and the ACAAI support this policy as a reasonable approach to scoring that does not unduly disadvantage clinicians.

Data Submission for the Performance Categories

Currently, the agency will consider any submission received during the designated MIPS submission period as a data submission and assign a score for the submission. CMS is proposing that a submission for the quality performance category must include numerator and denominator information for at least one quality measure to be considered a data submission and scored. In other words, data submission with only a date and practice ID would not be considered a data submission and would be assigned a "null" score.

In addition, under the Proposed Rule, a submission for the IA performance category must include a "yes" response for at least one IA to be considered a data submission and scored.

Further, under the Proposed Rule, beginning with the 2024 performance period (data submission period in calendar year 2025), CMS is proposing that a data submission for the PI performance category must include all of the following elements to be considered a qualifying data submission and scored:

- Performance data, including any claim of an applicable exclusion, for the measures in each objective;
- Required attestation statements;
- CMS CEHRT ID from the Certified Health IT Product List; and
- The start date and end date for the applicable performance period.

In other words, a submission with only a date and practice ID would not be considered a data submission and would be assigned a "null" score. Also, it would not override reweighting of the PI category.

We support these proposals as we believe that the current submission policies not only adversely impact the clinician's score, but it can also override the reweighting of the PI and/or other categories if requested by the clinician.

Building Upon the MVPs Framework to Improve Ambulatory Specialty Care

CMS is exploring developing a mandatory payment model for specialists in ambulatory settings that would leverage the MVP framework. Under this model, participants would not receive a MIPS payment adjustment. Instead, the participant would receive a payment adjustment based on (1) a set of clinically relevant MVP measures that they are required to report and (2) comparing the participant's final score against a limited pool of clinicians (other model participants of their same specialty type and clinical profile, who are also required to report on those same clinically relevant MVP measures).

We believe that it is premature to move forward with a new mandatory payment model until CMS has had an opportunity to refine the MVP program and analyze all other appropriate frameworks. Instead, the Advocacy Council and the ACAAI urge the agency to collaborate with specialty societies to develop more appropriate, specialty-focused payment models. For instance, we encourage the agency to examine the Patient-Centered Asthma Care Payment

("PCACP"), which is an Alternative Payment Model designed to give physicians specializing in asthma care and primary care physicians the resources and flexibility they need to deliver accurate diagnoses and appropriate, cost-effective treatment for patients with asthma and asthma-like symptoms. As a reminder, in 2020, the Physician-Focused Payment Model Technical Advisory Committee unanimously voted to refer ACAAI's PCACP to the Department of Health and Human Services for special attention and further consideration.

* * *

We appreciate your consideration of our comments and recommendations. If you have any questions regarding this letter, please contact Susan Grupe, Director of Advocacy Administration, at suegrupe@acaai.org.

Sincerely,

Gailen D. Marshall, Jr. MD, PhD, FACAAI President, ACAAI	Travis A. Miller, MD, FACAAI Chair, Advocacy Council

July 24, 2024

<table>
<tr><td>The Honorable Mike Johnson
Speaker
United States House of Representatives
H-232, The Capitol
Washington, DC 20515</td><td>The Honorable Charles Schumer
Majority Leader
United States Senate
S-221, The Capitol
Washington, DC 20510</td></tr>
<tr><td>The Honorable Mitch McConnell
Minority Leader
United States Senate
S-230, The Capitol
Washington, DC 20510</td><td>The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives
H-204, The Capitol
Washington, DC 20515</td></tr>
</table>

Dear Speaker Johnson, Majority Leader Schumer, Minority Leader McConnell, and Minority Leader Jeffries:

The undersigned national medical societies and state medical associations write to collectively urge Congress to prioritize and advance several key bills and legislative proposals that provide greater fiscal stability for physicians and reform key elements of the Medicare Access and CHIP Reauthorization Act (MACRA). The current Medicare Physician Payment System (MPPS) is increasingly unsustainable and the necessary policy reforms can no longer be delayed without severe repercussions for patient access and quality of care.

The foundational component of strengthening the current payment system is refining the Medicare Physician Fee Schedule (MPFS) to accurately reflect the fiscal and clinical realities of medical practice today. To accomplish this pressing task, we focus on four key areas of reform:

1. Enacting an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index (MEI);
2. Budget Neutrality reforms;
3. An overhaul of MACRA's Merit-based Incentive Payment System (MIPS); and
4. Modifications to Alternative Payment Models (APM).

MEI Update

The cost of practicing medicine has risen dramatically over the past two decades with the Centers for Medicare & Medicaid Services (CMS) estimating that the MEI increased by 4.6 percent in 2024. Despite this steep increase, physician payment rates were reduced by 3.37 percent in early 2024 followed by Congress only mitigating a portion of this cut for the remainder of the year. **On July 10, CMS released the Calendar Year 2025 MPFS Proposed Rule and, for the fifth straight year, physicians are slated for an additional payment reduction, specifically a 2.8 percent cut that, absent Congressional intervention, is expected to take effect on January 1. This latest inexcusable cut looms despite the fact that CMS also projects the increase to the MEI to be 3.6 percent in 2025, thus confirming that inflationary costs associated with running a practice continue to rise**. This series of annual payment

reductions and the lack of an inflationary update continue to threaten the viability of physician practices, add considerable burden to the practice of medicine, and stifle innovation.

Non-partisan governmental entities also continue to sound the alarm about the negative impact of continued payment cuts, especially on patient access to care. The 2024 Medicare Trustees Report, again, reiterated their concern that, without Congressional action to change the delivery system or level of payment update, **"the trustees expect access to Medicare participating physicians to become a significant issue in the long-term."**[1] In the June 2024 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) expressed concern about how the lack of an inflation-based update for physician payment is exacerbating the site of service differential, which distorts competition and could increase vertical consolidation, increasing spending by the Medicare program, patients, and taxpayers.[2] Without an annual inflation update, physicians will continue to struggle to maintain the option of independent, private practice.

Physician practices, many of which are small businesses, face rising costs for office rent, clinical and administrative staff wages, and professional liability insurance. The unfortunate reality is that these costs are not adequately reflected in current Medicare payment rates. Hospitals and other providers receive annual updates tied to inflation; it is critical that physician payments receive a similar adjustment. As a result, we strongly support the swift passage of H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," bipartisan legislation that would provide an annual physician payment update in Medicare tied to the MEI. This reform would stabilize physician payments, allowing for long-term planning, investment in practices, and the delivery of high-quality, patient-centered care.

Budget Neutrality Reform

Targeted modifications to statutory budget neutrality requirements within the MPFS is another key pillar of the underlying effort to enact Medicare physician payment reform. When certain services are unbundled within the MPFS, current law requires them to be implemented in a budget-neutral manner, sometimes based on inaccurate utilization predictions that have led to compounding financial losses. To ensure that these challenging utilization predictions formulated by CMS can be adjusted and not lead to losses year after year, H.R. 6371, the "Provider Reimbursement Stability Act," mandates the Agency to implement a narrow, two-year look-back period that provides the capability to prospectively correct these misestimates and adjust the future MPFS conversion factor accordingly. This look-back adjustment would only be applicable when services are unbundled and have a corresponding utilization assessment assigned to them. The legislation would, in turn, require the Agency to compare the CMS developed utilization assumptions to 12 months of actual claims data. There would be no retroactive correction or

[1] https://www.cms.gov/oact/tr/2024.
[2] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch1_MedPAC_Report_To_Congress_SEC.pdf.

adjustment; any subsequent changes to the conversion factor due to an under-or-overestimation of utilization of the unbundled code identified at the conclusion of this look-back period would be made prospectively. In other words, this narrowly tailored policy is not a claw-back that seeks to recoup or repay any difference in spending made in previous years. Instead, it helps ensure the accuracy of the overarching MPFS.

Additionally, the bill ensures that the $20 million threshold triggering budget neutrality adjustments, which was established in 1989 and has not been increased since, is updated to $53 million to account for inflation. The legislation also mandates that CMS update key elements of direct practice costs, specifically clinical wage rates, prices of medical supplies, and the prices of equipment, simultaneously and no less often than every five years. Finally, to guard against dramatic positive or negative changes to the MPFS, the legislation prevents the conversion factor from increasing or decreasing by more than 2.5 percent in a given year. Statutorily mandated increases to the conversion factor, such as 0.25 percent or 0.75 percent for MIPS or APMs, respectively, or a future MEI increase, would be exempt from this cap.

Congress should pass H.R. 6371 to achieve greater stability and predictability to the MPFS.

MIPS Reform

The MIPS program, as currently structured, places undue administrative burdens on physicians without demonstrable improvements in patient outcomes or quality of care. Small, rural, and underserved practices are disproportionately penalized. In turn, the undersigned organizations support legislative proposals to replace key elements of MIPS with a Data-Driven Performance Payment System (DPPS) that:

1. Freezes performance thresholds for three years to allow recovery from the COVID-19 pandemic and Change Healthcare cyberattack.
2. Eliminates the current tournament model and replaces corresponding payment penalties of up to nine percent with payment adjustments assessed as a percentage of statutorily mandated payment updates (i.e., 0.25 percent or MEI).
3. Ensures CMS provides at least three quarters of claims feedback reports and exempts physicians from all penalties should the Agency fail to provide this data.
4. Aligns program requirements with other CMS hospital value-based programs, simplifies reporting by allowing cross category credit, and enhances measurement accuracy.

We urge Congress to pass these crucial reforms to the MIPS program before the end of 2024.

APM Reform

Finally, Congress must advance legislation that would continue key policy proposals that support physicians transition into APMs. More specifically, federal lawmakers should expeditiously pass

legislation that extends APM incentive payments and freezes the current revenue threshold that physicians must meet to be eligible for the bonuses. Current APM bonuses expire at the end of 2024 and the 50 percent revenue threshold is also scheduled to jump to a nearly impossible-to-reach 75 percent on January 1, 2025. As a result, Congress should consider enacting S. 3503/H.R. 5013, the "Value in Health Care (VALUE) Act," bipartisan legislation that extends the original five percent APM incentive payments and freezes the 50 percent revenue threshold for an additional two years. In addition, it is crucial that CMS and the Center for Medicare and Medicaid Innovation work to develop a robust pipeline of APMs that are available to all physicians, particularly specialists and those in rural areas.

We stand ready to work with Congress to implement these critical legislative reforms to ensure a sustainable and effective Medicare physician payment system. We urge lawmakers to heed this call by working together and acting quickly to preserve access to care in the Medicare program.

Sincerely,

American Medical Association
Academy of Consultation-Liaison Psychiatry
Academy of Physicians in Clinical Research
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Geriatric Psychiatry
American Association of Child and Adolescent Psychiatry
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology

American College of Legal Medicine
American College of Lifestyle Medicine
American College of Medical Genetics and Genomics
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Rheumatology
American Epilepsy Society
American Gastroenterological Association
American Geriatrics Society
American Medical Women's Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Laser Medicine & Surgery, Inc.
American Society for Radiation Oncology
American Society for Surgery of the Hand Professional Organization
American Society of Cataract & Refractive Surgery
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Nephrology
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Society of Transplant Surgeons
American Urogynecologic Society
American Urological Association
American Venous Forum
Association for Clinical Oncology
Association of Academic Radiology
Association of American Medical Colleges
Congress of Neurological Surgeons
Heart Rhythm Society
International Pain and Spine Intervention Society
Medical Group Management Association
National Association of Medical Examiners
National Association of Spine Specialists

North American Neuromodulation Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Cardiovascular Magnetic Resonance
Society for Pediatric Dermatology
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Cardiovascular Computed Tomography
Society of Hospital Medicine
Society of Interventional Radiology
The American Society of Breast Surgeons
The American Society of Dermatopathology
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association

Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society