September 11, 2025

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Merit-Based Incentive Payment System (MIPS) Quality Measures

Dear Administrator Oz:

On behalf of the undersigned organizations, we write to express our concerns and continued frustration with the Centers for Medicare & Medicaid Services (CMS) process for reviewing and selecting quality measures for its programs. There is an urgent need for CMS to consider and accept more measures into the Merit Based Incentive Payment (MIPS) program to better ensure alignment with the growing number of episode-based cost measures, alternative payment models (APMs) and other quality and certification programs. In addition, new measures would further equip patients with usable quality information and provide physicians with the opportunity to be successful in CMS' quality programs and APMs. If these gaps are not filled, we believe that the future of the program is in further jeopardy, specifically the transition and adoption of meaningful MIPS Value Pathways (MVPs).

There is a false belief among the Administration, CMS and its contractors that decreasing the number of measures and MVPs will minimize burden. **However, it is not the number of measures or MVPs that cause physician burden, but rather the morass of reporting requirements and poorly designed programs.** The program should allow physicians to track and measure individual health conditions, episodes of care, or major procedures that can be directly linked to and drive quality improvement activities. Therefore, **CMS must maintain a robust portfolio of quality measures that enable quality improvement in addition to promoting accountability.**

In recent years, CMS started to combine multiple measures into one (e.g., a composite), increasing complexity and adding additional burden to reporting. While this process allows CMS to reduce the number of measures listed in a program, a measure such as a composite still requires physicians to report multiple clinical processes or outcomes, and only provides an aggregate score across the components, reducing its potential to inform quality improvement and patient decision-making. For example, CMS recently replaced several individual screening measures in MIPS with a *Preventive Care and Wellness* (composite), which consists of seven individual screening measures of varying age ranges, genders, and patient populations. None were designed or tested as a composite, and it remains unclear how feasible it is to collect the required data. CMS also maintains several of the same individual measures for MVPs and the APM Performance Pathway Plus set (e.g., Breast Cancer Screening), leading to duplication and additional burden to maintain separate specifications. Therefore, CMS should reconsider the removal of the individual measures as each address important preventive activities and aligns with the Administration's focus on health and well-being. **We urge CMS to avoid adapting and selecting measures of this complexity and duplication in the future.**

In addition, we are extremely concerned that disease-specific measures will not be approved for use in MVPs going forward. In a specialty like rheumatology, it may not be clinically appropriate to combine similar clinical assessments for different diseases into one measure. For example, CMS requested that a

developer combine measures on disease activity assessment even though the best tools for rheumatoid arthritis are not appropriate for psoriatic arthritis (PsA). Requiring that these concepts be combined increases complexity and implementation burden for practices. More importantly, it makes it even more difficult for physicians to access actionable data, and truly understand their performance among those distinct populations, especially if performance among the larger patient population (i.e., rheumatoid arthritis patients) is already topped-out and may give the false impression that performance among smaller patient populations (i.e., PsA) is better than it is. **CMS must evaluate what valuable information will be lost if measure concepts are combined just to reduce the number of measures in a program.**

Consistent with statute, CMS should revive and promote the Qualified Clinical Data Registry (QCDR) option. Throughout the Medicare Access and CHIP Reauthorization Act (MACRA), Congress referenced and acknowledged the importance of QCDRs and specifically allowed for a separate pathway for measure review outside of the formal Measure Under Consideration (MUC) process. However, CMS now outright rejects QCDR measures for use in the MIPS quality category and MVPs. For example, in October 2024, the American College of Radiology (ACR) reviewed CMS's draft Diagnostic Radiology MVP and advocated for the inclusion of more Qualified Clinical Data Registry (QCDR) measures to better reflect the practice of radiology. ACR emphasized the need to reduce administrative burden, maintain flexibility for non-patient-facing clinicians, and ensure clear reporting guidance. Despite these recommendations, CMS removed several key QCDR measures in the CY 2026 proposed rule—citing a desire to reduce the total number of QCDR measures. CMS also replaced ACRad34 (QCDR measure) with CQM ID 494 (Excessive Radiation Dose), claiming duplication, even though CMS' former consensus-based entity contractor during the 2022-2023 measure under consideration process identified them as complementary.
As a result of examples such as this one from ACR, the number of available QCDRs has greatly dwindled and more QCDRs will stop participating in the program, which is counter to the MACRA statute.

The lack of viable QCDR options is unfortunate because capturing data through a registry allows for its collection and tracking across settings and disease states including but not limited to, acute episodes versus chronic disease and resource-intensive versus relatively inexpensive therapies and are used for other purposes including quality improvement, clinical guideline development, and research. It also allows for quality measurement to advance towards digital data sources and move beyond snapshots of care which focus on random individual measures to a learning system with a broad focus. **CMS must recognize and prioritize the value of specialty-led QCDRs and actively select QCDR measures for MVPs.**

The undersigned organizations have been committed to the successful implementation of MACRA. To our dismay, it has often been a one-sided partnership. The agency must maintain a comprehensive portfolio of measures in its physician quality programs and move to a participatory measure consideration process to better ensure that physicians will find quality measures to use within MIPS/MVPs and APMs that are clinically relevant and meaningful for their practices and settings of care, as well as administratively actionable and useful in providing better care and value for patients. We urge CMS to evaluate its process for incorporating measures into MIPS/MVPs and APMs and ensure there is a sufficient suite of MVPs by condition.

Sincerely,

American Medical Association

American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Physical Medicine & Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma and Immunology
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American Society of Hematology
Association for Clinical Oncology
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Endocrine Society
Medical Group Management Association
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Renal Physicians Association
Society of Hospital Medicine
The Society of Thoracic Surgeons