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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 Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist.

Thank you for the opportunity to share feedback on your questions designed to modernization programs established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Question 1. 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?

To ensure future CMMI models can be implemented and scaled without undermining patient access, ***Congress should establish guardrails that prevent models from shifting financial risk to rheumatologists for costs they do not control.***

Rheumatology care is heavily dependent on physician-administered and self-administered biologic therapies that now represent the standard of care for chronic autoimmune disease. While we understand that these therapies account for a large share of episode spending, rheumatologists do not set drug prices, control manufacturer rebates, or determine formulary placement. As such, models that embed drug costs into performance calculations are structurally misaligned with rheumatology practice and hamper – not improve – the cost and quality of care.

CSRO's experience with cost measurement illustrates the risk of incorporating drug costs into performance metrics. During field testing of the rheumatoid arthritis (RA) episode-based cost measure, which was adopted for use in the Merit-Based Incentive Payment System (MIPS) and the Advancing Rheumatology Patient Care MIPS Value Pathway (or MVP), rheumatologists reported that results were dominated by costs outside their control. For these reasons, the measure received a "do not recommend" vote from CMS'

consensus-based entity (CBE). CMS ignored the recommendation of the CBE and finalized the cost measure for use in MIPS and the rheumatology MVP without correcting these flaws.

These challenges are compounded by existing Medicare policies that constrain treatment selection, including step therapy requirements, prior authorization, restrictive formulary design, and the Self-Administered Drug (SAD) Exclusion List. CSRO, along with like-minded stakeholders, have urged CMS to establish a “formulary adequacy standard” so that Medicare Advantage and Part D plans cannot impose formulary ≥restrictions when a “fail first” medication is not able to be acquired and administered by a practice. We have also called on CMS to reinterpret the statutory underpinning of the SAD Exclusion List and to establish a “bypass” mechanism so that beneficiaries who require the physician-administered formulation of a medication on the SAD Exclusion List would not be responsible for the full cost of their therapy. ***Holding rheumatologists accountable for drug spending while simultaneously limiting their ability to select or furnish therapies creates conflicting incentives and undermines the validity of any value-based model.***

In addition, the recently announced Global Benchmark for Efficient Drug Pricing (GLOBE) Model – a new CMMI model framed as a manufacturer-focused initiative – is also likely to have downstream effects on rheumatology practices that must acquire and administer drugs at Medicare payment rates that already fail to reflect acquisition cost. Our practices are already operating near or below cost for many infused therapies, and the GLOBE Model risks exacerbating access challenges if it drives Average Sales Prices (ASPs) below the prices rheumatologists pay to stock GLOBE Model drugs.

Finally, rheumatology practices have faced barriers to participation in CMMI models and Accountable Care Organizations (ACOs) because current benchmarking and savings methodologies often treat rheumatology drug costs as avoidable or discretionary, rather than as standard-of-care treatment for chronic autoimmune disease. In practice, this has led some model sponsors and ACOs to limit rheumatology participation or exclude rheumatologists altogether, based on concerns that high-cost therapies will negatively affect benchmarks or shared-savings performance. These exclusions occur despite the fact that effective rheumatologic management can prevent flares, increased steroid use, hospitalizations, disability, and long-term costs. Without model designs that appropriately account for the role of specialty drug therapy in chronic disease management, rheumatologists will continue to face structural barriers to participation in CMMI models.

To enable CMMI models that can be implemented and scaled without harming access, CSRO urges Congress to:

- Exclude drug costs in CMMI performance calculations when physicians do not control pricing, rebates, or formulary placement, including for both physician-administered and self-administered therapies;
- Ensure ASP-based payment methodologies are not further depressed by manufacturer price concessions in ways that disconnect Medicare reimbursement from physician acquisition cost, particularly under CMMI models such as GLOBE;
- Require CMS to address Medicare policies that restrict treatment selection, including Medicare Advantage step therapy for Part B drugs and the lack of a bypass mechanism under the SAD Exclusion List; and
- Increase transparency around specialty participation in CMMI models, including ACOs, by requiring public reporting on which specialties participate and the number of clinicians from each specialty included.

Absent these reforms, CMMI models will continue to shift financial risk to physicians and decrease beneficiary access to adequate treatment without delivering measurable improvements in quality or cost.

Question 2. 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?

For rheumatology practices, participation in MIPS is an exercise in avoiding payment penalties, rather than a program that informs clinical decision-making or drives meaningful improvement. The administrative burden associated with participation is substantial, yet MIPS has not demonstrated improvements in outcomes or cost efficiency for patients with rheumatologic diseases. Program requirements, scoring methodologies, and cost attribution rules change frequently, making it difficult for practices to understand expectations, invest in improvement, or meaningfully respond to performance feedback.

As noted above, the inclusion of the RA episode-based cost measure illustrates these shortcomings. CSRO has consistently supported the development of specialty-specific measures that evaluate clinical decisions and resource use within the physician's control. However, the RA cost measure produces results that are dominated by medication costs and services unrelated to rheumatologic decision-making, offering little insight into how physicians could change care delivery to improve performance. For many practices, the only apparent lever suggested by the measure would be to delay or withhold appropriate therapy, an outcome that is inconsistent with evidence-based care and harmful to patients.

More broadly, meaningful cost measurement in rheumatology is not possible unless CMS first addresses policies that hamper treatment selection and reimbursement, including step therapy mandates, restrictive formulary design, Self-Administered Drug (SAD) Exclusion List policies, and inadequate payment for provider-administered biosimilars that remain financially unsustainable in the office setting. Until these issues are resolved, cost attribution will continue to deem appropriate, evidence-based care as inefficient.

If MIPS were replaced, a physician-led quality program for rheumatology should reflect the realities of chronic autoimmune disease management. Measures should focus on outcomes that matter to patients and clinicians, such as disease activity control, flare reduction, avoidance of increased steroid usage and hospitalizations, and preservation or improvement of function, rather than short-term cost fluctuations. Programs should exclude costs and services over which rheumatologists do not have meaningful control and recognize that the benefits of appropriate rheumatologic care often accrue over multiple years, not within a single performance period.

Finally, any successor program must meaningfully reduce administrative burden and avoid accelerating consolidation. Independent rheumatology practices should not be disadvantaged by reporting requirements that divert limited resources away from patient care. A quality program that physicians engage with solely to avoid penalties, without producing actionable feedback or supporting improvement, will not achieve Medicare's value-based care goals.

Thank you for considering our feedback on these important issues to practicing rheumatologists who care for Medicare beneficiaries. Please do not hesitate to contact us at info@csro.info should you require additional information.

Respectfully,

Handwritten signature of Aaron Broadwell in black ink.

Aaron Broadwell, MD, FACR
President
Board of Directors

Handwritten signature of Madelaine A. Feldman in black ink.

Madelaine A. Feldman, MD, FACR
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