January 16, 2026

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

Dear Members of the GOP Doctors Caucus and Democratic Doctors Caucus:

On behalf of the Society of General Internal Medicine (SGIM), thank you for your request for information regarding ways to improve the Center for Medicare and Medicaid Innovation's (CMMI's) payment models and reforms to the Merit-based Incentive Payment System (MIPS).

SGIM is a member-based medical association of more than 3,400 of the country's leading general internal medicine physicians, who are dedicated to delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician to coordinate a comprehensive approach to their care. Many of our members are physician-scientists committed to advancing biomedical research, as well as delivering high quality care and ensuring patients have access to a well-trained physician workforce.

High-functioning primary care delivers acute and chronic care and preventive services. Advanced practices also integrate behavioral health, social work, nutrition, and pharmacy services. This care must be patient-centered, with electronic access, timely results, and 24-hour coverage for urgent needs.

Unfortunately, chronic global underinvestment in primary care, coupled with the traditional fee-for-service (FFS) model not supporting this model of care financially, has led to our health care system's inability to keep pace with the growing volume of non-visit-based work, including population health management, electronic and telephone communication, medication management, home care coordination, and other asynchronous services. Legislative reform is needed to adequately fund comprehensive primary care, both in CMMI models and in non-model-participating practices, and to modernize provider compensation. Given this significant need, we appreciate you exploring these topics and have provided answers to your questions below.

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?

SGIM shares CMMI's goals to improve health outcomes while reducing the cost of care, and many of our members have participated in their models. However, there are often significant challenges that have limited both participation in and the impact of these models.

Participation in CMMI models often includes significant and burdensome data reporting requirements, limiting uptake and resulting in a high rate of dropout. Therefore, results from the models being tested do not accurately reflect the program's potential impact in different regions across the country, making the programs less generalizable if they are expanded. Further complicating the provider burden is the typical exclusion of certain

patients based on their insurance such as those with Medicare Advantage or those who are dually eligible for Medicare and Medicaid. Medicare FFS beneficiaries are only a portion of a provider's population. It is hard to make the meaningful operational, cultural, and workflow changes required to implement the payment and care delivery models as intended when only a portion of the provider's population are included.

In addition, many demonstrations require additional resources coupled with phased-in downside financial risk to participants. This can lead to fewer participants and higher dropout rates, particularly among smaller, independent practices and those serving rural and underserved populations.

In response to the additional financial burden and hesitation to participate, CMMI has typically resorted to bonus payments, which leads to higher spending, making fewer demonstrations cost-neutral or cost-saving. Many worthy primary care demonstration models were not expanded for this reason.

Potential Solutions:

- Streamline the enrollment process and reduce reporting requirements to the minimum necessary.
- Incentivize or require multi-payer participation to align models with other payers.
    - Engage and partner with States to foster multi-payer alignment.
- Increase specialist engagement in payment models being tested.
    - Models focused solely on primary care have improved quality, reduced ER visits and medical hospitalizations, but have demonstrated less impact on costly surgical interventions, hospitalizations, and total cost.
- To recruit practices (such as small, independent, and rural) that have traditionally not participated in CMMI models, use hybrid payment models to balance the need for stable prospective payments with the perceived uncertainty of moving away from the FFS model.
- Ensure total investment in primary care is measurable, with targets for achieving a minimum level of investment in primary care that currently varies between states (who are using different methods for estimating such investment).[1]
- Create more opportunities for public input.
    - In addition to having a physician-focused technical advisory committee, there is opportunity for greater levels of input from model participants, potential model participants, and Medicare beneficiaries.
    - Given the scope of some of the models tested by CMMI, we also recommend implementing a notice and comment period to seek input from the broadest range of stakeholders. As an example, neither physicians nor patients are not the model participants in the WISeR model. However, this model imposes new prior authorization requirements in FFS Medicare that directly affect physicians and patients who had no input into the model.

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.

The creation of the Merit-based Incentive Payment System (MIPS), while laudable in its aims, has largely fallen short of its intended purpose of moving from FFS to rewarding providers for delivering high-quality care.

[1] https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/primary-healthcare-spending-technical-brief_0.pdf

Retrospective pay-for-performance bonuses and penalties inherently reward larger, well-resourced health systems with the data resources to identify the most beneficial quality measures to select. They furthermore reward systems caring for less complex patient populations, as medical and social complexity are not adequately accounted for in these programs. This has been demonstrated in the legacy programs upon which MIPS was built, and in the MIPS program since its inception. Smaller and rural practices, as well as those which care for more medically and socially complex patients are consistently penalized in such payment systems.

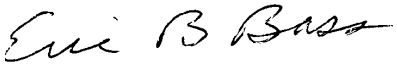
Cost-of-care is a flawed metric for quality, creating a disincentive for physicians to provide care for high-risk older adults. It also does not account for differences in care delivery requirements for certain populations, such as those in rural and urban settings and patients with comorbid conditions who see multiple providers that are responsible for the quality of their care. Finally, MIPS reporting is burdensome, complex, and does not allow for accurate comparison across providers, provider types, and settings.

A reformed MIPS or new quality program should:

- Streamline reporting and reduce burden on providers;
- Reward primary care practices that deliver comprehensive care with a team-based approach;
- Account for differences across patient populations and care settings to allow more accurate comparison;
- Reward, rather than punish, providers for managing care for complex patients; and
- Be based on quality measures that have been identified as important by clinicians and Medicare beneficiaries.

Thank you again for the opportunity to provide feedback on CMMI and MIPS. As your caucuses further explore the future of the program, SGIM would welcome the opportunity to continue providing our perspective on existing challenges and potential solutions. Should you have any questions, require further information, or would like to discuss anything in this response, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,



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